

The Auditor-General
Audit Report No.50 2012–13
Performance Audit

Administration of the GP Super Clinics Program

Department of Health and Ageing

Australian National Audit Office

© Commonwealth of Australia 2013

ISSN 1036-7632

ISBN 0 642 81370 1 (Print)

ISBN 0 642 81371 X (On-line)

Except for the content in this document supplied by third parties, the Australian National Audit Office logo, the Commonwealth Coat of Arms, and any material protected by a trade mark, this document is licensed by the Australian National Audit Office for use under the terms of a Creative Commons Attribution-NonCommercial-NoDerivatives 3.0 Australia licence. To view a copy of this licence, visit

<http://creativecommons.org/licenses/by-nc-nd/3.0/au/>

You are free to copy and communicate the document in its current form for non-commercial purposes, as long as you attribute the document to the Australian National Audit Office and abide by the other licence terms. You may not alter or adapt the work in any way.

Permission to use material for which the copyright is owned by a third party must be sought from the relevant copyright owner. As far as practicable, such material will be clearly labelled.

For terms of use of the Commonwealth Coat of Arms, visit It's an Honour at <http://www.itsanhonour.gov.au/coat-arms/index.cfm>.

Requests and inquiries concerning reproduction and rights should be addressed to:

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

Or via email:

webmaster@anao.gov.au





Canberra ACT
20 June 2013

Dear Mr President
Dear Madam 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 to the Parliament. The report is titled *Administration of the GP Super Clinics Program*.

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

A handwritten signature in black ink, appearing to read 'Ian McPhee', is positioned above the printed name.

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

ANAO audit reports and information about the ANAO are available at our internet address:

<http://www.anao.gov.au>

Audit Team

Angus Martyn
Clifford Lloyd
Claudia Shepherd
Ryan Wilson
Fiona Knight

Contents

Summary and Recommendations	7
Summary	8
Introduction	8
Audit objective and scope	10
Overall conclusion.....	10
Key findings by chapter.....	14
Summary of agency response	21
Recommendations	22
Audit Findings	23
1. Introduction	24
Improving primary healthcare	24
Grants administration framework.....	32
Audit objective, scope, criteria and methodology	34
Previous audit coverage	36
Structure of the audit report	36
2. From Policy to Program	37
Introduction	37
Announcement of the 32 initial clinic locations	38
Developing the program.....	39
Announcement of additional clinic locations	49
Grant funding processes.....	52
Location of clinics and the distribution of funding	54
Conclusion	57
3. Selection Processes.....	59
Introduction	59
Framework for assessing applications.....	59
Addressing local needs.....	62
Assessment of value for money.....	66
Treatment of unsuccessful Invitation to Apply processes.....	72
Conclusion	75
4. Rolling out the Clinics.....	77
Introduction	77
Managing the clinic roll-out	80
The completion of clinics.....	91
Conclusion	94
5. Reporting and Assessing Clinic and Program Outcomes.....	96
Development of program key performance indicators and evaluation framework	96
External evaluation of the GP Super Clinics program	99

ANAO assessment of the GP Super Clinics program.....	101
Management information and clinic operational reporting	107
Conclusion	109
Appendices	111
Appendix 1: Announced GP Super Clinics	112
Appendix 2: ANAO methodology to assess effectiveness of program administration	114
Appendix 3: Distribution of GP Super Clinics and funding based on electoral type	116
Index.....	119
Series Titles.....	121
Current Better Practice Guides	127
Tables	
Table 1.1 Announcement of clinic locations	27
Table 1.2 Progress in establishing the GP Super Clinics program	30
Table 1.3 Structure of the audit report.....	36
Table 2.1 Number of clinics meeting GP Super Clinic location factors	41
Table 2.2 Initial identification and responses to program level risks	46
Table 2.3 Funding application process, competitive and non-competitive.....	53
Table 3.1 Value for money—factors to be considered in assessing applications.....	67
Table 4.1 Time from execution of funding agreement to clinic completion— first round clinics.....	91
Table 4.2 Operational first round clinics—delays to anticipated clinic completion	92
Table 4.3 Non-operational first round clinics—delays on anticipated clinic completion	92
Table 5.1 Performance of 18 operational clinics against selected indicators...	103
Table A.1 Distribution of clinic locations included in the ANAO sample	115
Table A.2 Distribution of GP Super Clinic locations, by electorate.....	117
Table A.3 Distribution of GP Super Clinic funding as announced, by electorate	117
Table A.4 Distribution of GP Super Clinic locations, by marginal electorate	118
Table A.5 Distribution of GP Super Clinic funding as announced, by marginal electorate	118
Figures	
Figure 1.1 Location of GP Super Clinics	31
Figure 3.1 Site Map of Palmerston GP Super Clinic	65
Figure 5.1: Patient presentations.....	105
Figure 5.2 Share of patient presentations by service type	106

Summary and Recommendations

Summary

Introduction

1. *New Directions for Australia's Health: Delivering GP Super Clinics to local communities* (the GP Super Clinics policy) was released by the Australian Labor Party (ALP), then in opposition, on 24 August 2007.¹ The policy outlined a plan to fund the establishment of an unspecified number of 'GP Super Clinics' across the country that would provide multidisciplinary care and help reduce pressure on Australia's hospitals.² In regard to the specific location of Super Clinics, the policy provided that the 'factors that will be taken into account ... will include' areas:

- where there is currently poor access to services, particularly where this is due to shortages of doctors;
- where there is currently poor health infrastructure;
- where a clinic could help take the pressure off local public hospital services; and
- with high levels of chronic disease and/or demographics with high needs, such as large numbers of children or elderly residents.

2. Following the release of the policy, the locations of 32 proposed GP Super Clinics³ were announced progressively in the lead-up to the 2007 federal election, held on 24 November, along with the indicative maximum level of grant funding for each location. Another five proposed locations were announced in August 2009 by the Labor Government, taking the total of 'first round' clinic locations to 37. A second round of funding, as part of the National Primary Health Care Strategy, was announced in the context of the May 2010 Budget, to establish 'around' 23 new GP Super Clinics. The locations for 28 new clinics were subsequently announced by the Government during the 2010 election campaign. With the exception of the five clinics announced in

¹ The policy was announced as part of a wider \$2 billion National Health and Hospitals Reform Plan.

² Australian Labor Party, *New Directions for Australia's Health: Delivering GP Super Clinics to local communities*, ALP, Canberra, 2007, p. 3.

³ Clinics announced in 2007 included a Hobart clinic ('Hobart Eastern Shores') which was to have branches at two locations approximately 15 kilometres apart. These locations were subsequently funded through separate grant processes, and funding agreements were executed with two different recipients. For the purposes of this audit they are treated as two clinics.

2009, the location of individual GP Super Clinics reflected policy announcements made in the context of the 2007 and 2010 federal elections.

3. Across the two funding rounds, \$418.7 million in grant funding was announced to establish 65 GP Super Clinics. As at 5 April 2013, \$396.6 million has been committed through executed funding agreements, with \$278.4 million expended. Funding for individual clinics has ranged from \$1 million to \$15 million, and a number of clinics have been jointly funded by state and territory governments.

4. While the incoming government's 2007 GP Super Clinics policy did not specify how capital funding for the clinics would be made available, the GP Super Clinics program subsequently established in 2008 provided for a mix of competitive and non-competitive grant processes. Typically, non-competitive grant processes were adopted where a clinic was to be built by a state health department, regional or community health service, Division of General Practice or local council. In total, non-competitive processes were adopted for 22 of the 65 locations.⁴

5. The Department of Health and Ageing (DoHA) administers the GP Super Clinics program. The department's responsibilities have included the: provision of policy and program advice; development of program guidelines; assessment of grant applications; selection of a preferred applicant for each location; negotiation of funding agreements; and administration of funding agreements. While the two funding rounds are now largely complete⁵, there will be an ongoing administrative role for DoHA, as a condition of the grant funding is that the clinics must operate for 20 years and continue to report to DoHA during this time.

6. Commencing in December 2007, at the time the GP Super Clinics program was under development, significant enhancements were made to the Australian Government's grants administration framework. The enhancements included the introduction, initially through Finance Minister's Instructions promulgated in 2007 and revised in 2009, of requirements for published program guidelines, departmental advice on grant applications, and public reporting of the award of grants. In July 2009, the *Commonwealth Grant*

⁴ Applications submitted under non-competitive grant processes were subject to the same assessment procedures as those used for the competitive grants.

⁵ Funding agreements have yet to be executed for four second round clinic locations.

Guidelines (CGGs)⁶ came into effect and related changes were made to the *Financial Management and Accountability Regulations 1997* (FMA Regulations). Whilst 16 first-round GP Super Clinic grants were awarded before the CGGs and associated FMA Regulations amendments came into force on 1 July 2009, the enhancements to the grants framework introduced between 2007 and 2009 applied to the program, as did the financial framework requirement for the ‘proper use’ of public money, which pre-dated the CGGs and applied to all GP Super Clinic grants.

Audit objective and scope

7. The objective of the audit was to assess the effectiveness of DoHA’s administration of the GP Super Clinics program to support improved community access to integrated GP and primary health care services.

8. The audit examined DoHA’s compliance with the mandatory requirements of the CGGs and the extent to which DoHA adopted sound practices in relation to the key principles for grants administration in the CGGs. In cases where grants were approved prior to the CGGs coming into effect the audit examined compliance with the applicable parts of the relevant Finance Minister’s Instructions of December 2007 and January 2009.

9. While the audit examined whether DoHA had considered the issue of local health needs in its administration of the program, it did not assess whether GP Super Clinics had a direct business or economic impact on existing primary healthcare facilities.

Overall conclusion

10. The GP Super Clinics program is one of a number of health infrastructure grant programs administered by DoHA in recent years⁷, and is intended to improve access to integrated primary health care services⁸ and

⁶ Department of Finance and Deregulation, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, Canberra, July 2009. The CGGs, issued under Regulation 7A of the FMA Regulations, represent the whole-of-government policy framework for grants administration and apply to all departments and agencies subject to the *Financial Management and Accountability Act 1997* (FMA Act). The second edition of the CGGs was released in March 2013, with effect from 1 June 2013.

⁷ These have included the Primary Care Infrastructure Grants program, examined in ANAO Audit Report No.44 2011–12 *Administration of the Primary Care Infrastructure Grants Program*; and the Health and Hospitals Fund program, examined in ANAO Audit Report No.45 2011–12 *Administration of the Health and Hospitals Fund*.

⁸ A team based approach to primary health care would bring together general practitioners (GPs), nurses and allied health care professionals such as dietitians and physiotherapists. A team based approach differs from co-location, which simply puts various medical professionals within close proximity of each other.

improve opportunities for education and training placements in a multidisciplinary setting. Over two funding rounds administered by the department between 2008 and 2012, grant funding of \$418.7 million has been announced for 65 GP Super Clinics across Australia. Individual clinics have variously received capital funding, recurrent funding and relocation incentives, through a combination of competitive and non-competitive grants processes. As a condition of Commonwealth funding, clinics are expected to operate in accordance with the program objectives for 20 years, leaving an administrative role for the department which will continue long after the clinics are established and grant funds are disbursed.

11. Overall, DoHA's administration of the GP Super Clinics program has been generally effective and consistent with government policy. In support of the incoming government, DoHA acted quickly, within relatively tight timeframes, to consult with stakeholders on program design, assess and plan for risks, and draft grant guidelines, and was consequently in a position to provide well developed first round program guidelines for ministerial consideration by April 2008. These guidelines addressed the key elements of the program's operation and formed the basis for a generally sound grants application and assessment process. Revised program guidelines were issued for the second round and essentially the same application process was employed. The funding agreements used by the department evolved over time, in light of experience and in response to emerging issues.⁹ The department also placed considerable emphasis on operational reporting; recognising the challenges the clinics would face in their construction and early operational phases.

12. As part of developing the relevant new policy proposal (NPP), in less than four weeks following the election of the new government in 2007, DoHA advised the incoming Minister on a range of program implementation risks. A risk identified by DoHA in its advice was the degree of 'acceptance and support' for the announced clinics by local communities and health professionals, including possible concerns about impacts on existing health services. The department proposed that this risk be managed through consultations with stakeholders both nationally and at the local level, with the latter focussing on ensuring that proposals addressed local needs and priorities

⁹ These included issues relating to land acquisition and development approvals, which at times contributed to delays in the rollout of clinics across the program.

and complemented existing services. However, while the department provided the Minister with some general background information on the Divisions of General Practice in which the announced clinics were located, its advice did not address whether it was aware of any particular implementation risks applying to the specific locations announced in the context of the 2007 election.

13. Further, notwithstanding the incoming government's decision that all guidelines for new discretionary grant programs be submitted for consideration by the Expenditure Review Committee of Cabinet (ERC)¹⁰, this was not done. While the program guidelines were approved by the Minister in April 2008, DOHA's briefing seeking ministerial approval did not advise her of the requirement for ERC consideration. The guidelines for the second round were however submitted for ERC consideration.

14. As discussed above, DoHA assessed potential risks and their treatment early, in the context of its original planning and design of the program. One issue that would have benefited from further consideration related to the use of both competitive and non-competitive processes to select funding recipients within the one program¹¹, and the attendant risks to be managed.¹² In the event, non-competitive processes were adopted for 22 of the 65 locations, typically where a clinic was to be built by a state health department, regional or community health service, Division of General Practice or local council.

15. DoHA's approach to risk management for the program has evolved over time, drawing on lessons learned from the first round. The department sought to better manage risks through changes to funding agreement requirements and its internal processes; measures which improved the overall effectiveness of program administration in the second funding round. Nonetheless, a range of complex issues, including land acquisition and development approval matters which have delayed the completion of certain clinics, are likely to remain an ongoing challenge for the department. These

¹⁰ The decision was promulgated in Finance Minister's Instructions dated 14 December 2007. The Instructions required guidelines to be developed for any new discretionary grant programs and for these guidelines to be considered by the ERC.

¹¹ The ANAO's Better Practice Guide on grants administration suggests that 'in establishing the form of application and selection process to be applied to a particular grant program, it is advisable for agencies to document consideration of the risks, costs and benefits of the available options', ANAO Better Practice Guide—*Implementing Better Practice Grants Administration*, June 2010, Canberra, p. 60. The Commonwealth Grant Guidelines, which were introduced in July 2009 and applied to the second funding round, provide that 'In the case of grant programs, unless specifically agreed otherwise, competitive, merit based selection processes should be used, based upon clearly defined selection criteria'. *Commonwealth Grant Guidelines*, op. cit., p. 29.

¹² Potential risks included the capability of the potential grant recipient to: develop a proposal meeting program objectives, manage the development approval and construction processes, and successfully operate the clinic once completed.

and related issues have emerged in the other infrastructure grants programs administered by DoHA, and the ANAO has observed in previous audits¹³ that DoHA has over time strengthened its capacity to effectively administer such grant programs, informed by practical experience and initiatives such as the establishment of the Centre for Capital Excellence within the department, comprising staff with expertise in infrastructure project management.

16. In light of the experience gained by DoHA in the administration of a variety of infrastructure projects over some years, there is scope for the department to draw on and document its experience, including the scope for applying a more consistent and systematic approach to the assessment of value for money. This process could consider the use of commercially available 'cost per square metre calculation' tools in infrastructure programs, which did not feature in the assessment process for the first round of GP Super Clinics.¹⁴

17. As at 5 April 2013, funding agreements for all of the first round locations have been executed and 29 of the 36 clinics¹⁵ have been completed and are operational; with seven not yet completed.¹⁶ For the second round, funding agreements for 24 of the 28 clinic locations have been executed and one clinic is operational, with so-called 'early services'¹⁷ being provided from existing premises at another seven locations. The time taken from the execution of funding agreements to the completion of clinics has varied considerably, reflecting amongst other things, delays associated with resolving often complex issues of land tenure, development approvals and construction works.

18. The ANAO's analysis of operational reporting to DoHA on 18 first round clinics indicates that the majority of these clinics are making good progress towards achieving some key service delivery expectations, though recruiting and retaining sufficient staff has been the biggest challenge for most clinics. However, the key performance indicators for the program are framed

¹³ Audit Report No.44 2011–12 *Administration of the Primary Care Infrastructure Grants Program*, Audit Report No.45 2011–12 *Administration of the Health and Hospitals Fund*.

¹⁴ The ANAO also identified that there was scope to use cost per square metre calculations in the grant assessment process in Audit Report No.44 2011–12 *Administration of the Primary Care Infrastructure Grants Program*, p. 61.

¹⁵ While 37 clinics were announced in the first round, the Commonwealth withdrew funding from the proposed Sorell clinic in Tasmania, leaving 36 clinics.

¹⁶ DoHA has advised that a further clinic was open for business as at 31 May 2013.

¹⁷ DoHA advised the ANAO that, to be classified as 'early services', these must be 'additional to the services previously available to the community and form part of the services at the GP Super Clinic when it is operational'.

in a qualitative and descriptive manner and there would be merit in enhancing them to support longer term reporting to the Parliament and government on the extent to which the program is achieving its intended outcomes. With the maturing of an increasing number of clinics, it is timely for DoHA to consider revising the overarching framework for reporting on the performance of individual GP Super Clinics and the program as a whole.

19. The ANAO has made four recommendations. One relates to providing Ministerial advice on implementation risks in the establishment phase of grant activities, one addresses better practice assessment of value for money for health infrastructure projects and two propose improvements to the framework for reporting on program performance.

Key findings by chapter

Chapter 2: From Policy to Program

20. The ANAO has previously observed that departments should advise Ministers on any measures considered necessary to manage risks to the Commonwealth achieving value for money when acting on election commitments.¹⁸ In the lead up to the 2007 election the ALP announced 32 proposed locations for GP Super Clinics. Following the election, DoHA provided advice to the Minister that a key implementation risk was the degree of ‘acceptance and support’ for the announced clinics by local communities and health professionals—including possible concerns about impacts on existing health services—and proposed that this risk be managed through consultations.

21. However, the department did not advise the Minister whether it was aware of any particular implementation risks applying to the specific locations announced in the context of the incoming government’s 2007 election policy. A range of options were potentially available for doing so, including some analysis, in the time available, of the extent to which the announced locations potentially satisfied some or all of the four factors outlined in the incoming

¹⁸ ANAO Audit Report No.14 2007–08, *Performance Audit of the Regional Partnerships Program*, Volume 2, p.148.

government's GP Super Clinics policy.¹⁹ The department advised the ANAO that it considered there was insufficient and unsophisticated data available at the time to draw conclusions on location issues. While some information and analysis was provided to the Minister's office by DoHA on a number of factors that might inform the choice of clinic locations in the second round in 2010, that information was of a relatively informal nature through emails to ministerial staff rather than a formal briefing to the Minister.²⁰ To inform the development and administration of infrastructure grant activities, the ANAO has proposed that the department advise Ministers of any significant risks to the effective implementation of election policy commitments.

22. In response to a question on notice at Senate Estimates in early 2011 regarding the 65 locations announced across the two rounds, DoHA commissioned a broad post-hoc analysis against the four factors in the 2007 election policy, plus an additional fifth factor of high population growth. The analysis indicated that a high proportion (83.8 per cent) of first round clinic locations met one or two of the five factors.²¹ Conversely, a reasonably high proportion (71.4 per cent) of second round clinics met three or more factors.

23. Over one-third of the 65 locations were subject to non-competitive grant processes. The choice of competitive or non-competitive processes was informed by the media statements released in the election context²², and bilateral discussions with other jurisdictions where relevant.²³ Based on these considerations, DoHA sought and received confirmation from the Minister for both rounds as to which process should apply to the individual clinics

¹⁹ In this context, the ANAO's 2002 *Better Practice Guide—Administration of Grants* noted that: 'Even where the Government does take a specific decision regarding the establishment of a program, agencies should still consider whether further needs analysis would assist in targeting the areas or projects most in need of funding assistance, consistent with the Government's objectives. For example, the Government may establish a program to improve regional Australia's access to information technology. In these circumstances, the relevant agency should consider conducting analysis to determine those regions in greatest need or those services needed most', p.8. The same sentiment is expressed in the ANAO's 2010 *Better Practice Guide—Implementing Better Practice Grants Administration*: 'it is advisable that agencies consider, as part of the implementation process, whether further needs analysis would assist in ensuring the available funding will be directed towards funding recipients or projects that will maximise the effectiveness of, and value for money achieved by, the program', p. 21.

²⁰ The ANAO similarly observed in a previous grants administration audit that there was scope for DoHA to better assist the Health Minister through more comprehensive advice: ANAO Audit Report No.45 2011–12, *Administration of the Health and Hospitals Fund*, p. 86.

²¹ The 2007 GP Super Clinics policy indicated that the clinic locations would be chosen by taking into account the factors.

²² A number of media statements released by the ALP and the Government in the context of the 2007 and 2010 elections referred to whether selection processes would be competitive or not.

²³ In one first round location (Palmerston) the Minister did not decide that the funding would be a non-competitive process until late 2008: up until that point the funding process was unclear. In the second round, there were three occasions (Lower Hunter, Emerald, and Townsville (Northern Beaches)) where, following community consultation sessions, the Minister decided to change the process from competitive to non-competitive.

announced by the Government. However, DoHA's advice to the Minister on program implementation did not address the risks to be managed²⁴ in adopting a non-competitive process for specific locations. The ANAO observed that typically, non-competitive grant processes were adopted where a clinic was to be built by a state health department, regional or community health service, Division of General Practice or local council.

24. While the first round GP Super Clinics program guidelines suggested that the program was at that stage restricted to the 32 locations announced in the 2007 election context, a number of unsolicited proposals for GP Super Clinics funding were submitted to DoHA and the Minister during 2008 and 2009. These received varying treatment. One proposal received in early 2008 for the establishment of a clinic in the Australian Capital Territory was rejected by the Minister on the basis that a GP Super Clinic 'was not planned for the [ACT] at this time'.²⁵ However, a further five unsolicited proposals received over the period late 2008 to early 2009 were the subject of detailed departmental advice to the Minister and were subsequently included in the program. The department's advice did not address the issue of whether, in the absence of any analysis against other areas of poor access to health services, and the reference in the program guidelines to the specified locations, it was equitable or appropriate that the new locations be considered for potential funding. Following further development, these proposals were formally assessed by the department and collectively received \$26.2 million of funding under the program.

25. Analysis of the distribution of the clinic locations announced in the 2007 election context shows that 54.8 per cent of clinics were located in marginal electorates; these clinics also accounted for 65.7 per cent of the announced indicative funding. This compares with 31 per cent of electorates being marginal in the 2007 election. In relation to the remaining clinics—the five announced in 2009 and those announced in the 2010 election context—43.8 per cent were in marginal electorates; these clinics also accounted for 43.7 per cent of the announced indicative funding. This compares with 37 per cent of electorates being marginal in the 2010 election. Further analysis of clinics announced in marginal electorates, on the basis of District of

²⁴ Footnote 12 outlines a number of the potential risks.

²⁵ Following further contact from the proponent, the Minister subsequently agreed to provide funding of \$220 000 for the proposal under the General Practice Infrastructure Training Support program.

Workforce Shortage (DWS) status²⁶, shows that 82.4 per cent of these clinics announced in 2007 were in a DWS. For the remaining clinics announced in 2009 and 2010 that were in marginal electorates, 57.1 per cent were also in a DWS.

Chapter 3: Selection Processes

26. DoHA established a generally sound and well documented framework for assessing applications.²⁷ The department made extensive use of relevant expertise from medical and independent financial advisers and accessed probity advice to align its approach with better practice in grants administration.

27. While the GP Super Clinics program guidelines required applications to address the extent to which a proposed clinic could impact on existing health services, this issue was not explicitly or substantively considered in the overall application assessment.²⁸ DoHA faced challenges in determining whether applications for funding would meet local needs and whether a proposed clinic would affect existing health services. There was limited, if any, specific information from independent sources about existing health services available to assessment panels, which had to rely almost entirely on information contained in applications, which was of variable quality.

28. The ANAO observed a number of opportunities for DoHA to improve how it assessed value for money. In respect to the assessment of physical infrastructure, assessment panels were not asked to use commercially available 'cost per square metre calculation' tools during the first round. The consideration of value for money was also hampered by a lack of clear and specific guidance to assessment panels on assessing the value for money of physical infrastructure, resulting in a lack of clarity and consistency in how the concept was applied in the assessment and selection process. In terms of the

²⁶ DWS status is determined by DoHA, using Australian Bureau of Statistics population data and Medicare Australia billing data. In general, an area is considered to be a DWS if it falls below the national average for the provision of medical services, indicating that it has unmet healthcare needs. See DOHA, *DWS Fact Sheet*, available at <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/dwsFactsheet> [accessed April 2013].

²⁷ The framework was supported by parallel processes that allowed for risks to be identified, probity issues to be addressed and for associated financial administration and management issues to be considered. DoHA also provided support for the application process through local consultation processes at most GP Super Clinic locations. An interested parties list was created and used to notify potential applicants and provide access to Invitation to Apply (ITA) documentation via advertising competitive ITAs in the press and on the Department's GP Super Clinics Website and tenders and grants webpage.

²⁸ In one case in the ANAO's sample, the positioning and design of a GP Super Clinic which opened in 2010 has resulted in the main pedestrian access to a pre-existing GP practice being via the waiting area of the new GP Super Clinic.

services to be delivered by clinics, of the six locations in the ANAO's sample where a grant of up to \$15 million was available to establish a GP Super Clinic, DoHA did not explicitly assess whether the specialised services required under the program guidelines for these locations were appropriately addressed in the applications.

29. In instances where the initial Invitation to Apply process did not identify a successful applicant, DoHA used a variety of strategies and processes to generate new or substantially revised applications and subsequently assess the merits of those applications. The processes adopted in these cases were generally adequate and there was a positive trend in the second round where DoHA involved the Minister earlier in advising on risks and options, especially where non-competitive processes were involved. However, the absence of a full panel assessment in some instances meant that the expertise of a medical adviser was not used in assessing some applications.

Chapter 4: Rolling out the Clinics

30. In establishing the program, DoHA assessed and planned for a range of program implementation risks. During the first funding round, there were nonetheless occasions when DoHA's risk management approach in the awarding of grants, and subsequently managing risks in the early stages of clinic roll-out, lacked rigour. This contributed to the eventual inability to establish a clinic at Sorell, where the estimated cost of constructing a clinic exceeded available grant funding by around \$880 000, as well as being a factor in the long delay in opening the Redcliffe clinic.²⁹

31. In the case of Sorell, DoHA took six months to fully recognise and respond to the risks of a budget shortfall after the funding recipient advised the department that it had concerns about the adequacy of the amount available under the GP Super Clinics grant. While the department responded appropriately once the shortfall was confirmed (after the receipt of building quotes), earlier engagement with the funding recipient on building design and construction costs would have enabled the department to better manage the risk. In the case of the Redcliffe project, while the department identified a number of financial risks during the assessment stage of the initial \$5 million grant, and a mitigation strategy was proposed (including finding a financial

²⁹ The Redcliffe clinic was originally expected to open around September 2011, but has yet to open.

guarantor for the project and / or reducing its capital cost), the FMA Regulation 9 documentation did not refer to whether the identified risks had in fact been treated, and a funding agreement for \$5 million was subsequently signed without explicit provisions relating to those risks. In the event, the recipient was unable to secure a loan to fund any of the project's cost³⁰, resulting in a significant increase in the Commonwealth contribution towards construction works; from \$5 million to \$13.2 million.

32. Overall, DoHA's compliance with the requirements of the Commonwealth financial management framework in the awarding of grants has been generally sound. Exceptions related to the FMA Regulation 9 documentation for Redcliffe, discussed above, and non-compliance (identified during the audit) with the mandatory public reporting of grants as required under the Finance Minister's Instructions and later by the *Commonwealth Grant Guidelines*.

33. As at 5 April 2013, funding agreements for all of the first round locations have been executed and 29 of the 36 clinics have been completed and are operational; with seven not yet completed.³¹ Of the 29 completed clinics, three were completed within the timeframe originally specified in the funding agreement, while four clinics were completed 12 months or more after the specified date and 22 clinics were completed less than 12 months after the specified date. For the second round, funding agreements for 24 of the 28 clinic locations have been executed and one clinic is operational, with so-called 'early services' being provided from existing premises at another seven locations. The time taken from the execution of funding agreements to the completion of clinics has varied considerably, reflecting amongst other things, delays associated with resolving often complex issues of land tenure, development approvals and construction works.

³⁰ The funding recipient, the Redcliffe Hospital Foundation, was created under, and subject to specific Queensland legislation, and therefore required approval from the Queensland Government to take out loans that were intended to co-finance the construction of the Super Clinic.

³¹ DoHA has advised that a further clinic was open for business as at 31 May 2013.

Chapter 5: Reporting and Assessing Clinic and Program Outcomes

34. The ANAO's analysis of the operational reports of the 18 clinics in its sample indicates that the majority of these clinics are making good progress towards achieving some key service delivery expectations. Recruiting and retaining sufficient staff have been the biggest challenges for most clinics. However, an analysis of patient presentations does not show any particular trend, at this stage, in support of DoHA's objective to achieve a significant shift towards an increasing proportion of overall services at GP Super Clinics being delivered by nurses and allied health professionals.

35. The development of key performance indicators (KPIs) for the ten GP Super Clinic program objectives was originally to occur in 2008, but this process was not commenced by the department until 2010. A set of detailed and measurable KPIs were agreed between DoHA and the Department of the Prime Minister and Cabinet (PM&C) and DoHA sought the Minister's formal endorsement of these in March 2011.³² The Minister directed that the KPIs be reworked, and a revised set of KPIs, now framed in a more qualitative manner, was approved by the Minister in November 2011. As discussed below, there remains scope for revised KPIs to support longer term reporting on the extent to which the program is achieving its intended outcomes.

36. With the maturing of an increasing number of clinics, it is timely for DoHA to consider whether more quantifiable information on the services provided by clinics—focusing particularly on those that involve integrated, multidisciplinary team based care and preventative care—should be collected and publicly reported on an aggregated basis. Similarly, aggregated public reporting of the numbers of vocational placements and other education and training activities for medical, nursing and allied health professional students, including GP registrars, could be commenced. This reporting would usefully be supported by analysis of whether the more mature clinics are providing vocational placements and educational activities at proportionally higher levels than other comparable primary healthcare facilities. In addition to information provided by the clinics, reporting could be informed by data collected by the Department of Human Services as part of its administration of healthcare-related financial payments.

³² DoHA, *Minute to the Minister—Response to Cabinet Implementation Unit Assessment Report GP Super Clinics*, 23 March 2011.

37. As already noted, the GP Super Clinics program will have an effective life of 20 years, and a revised performance and reporting framework would provide an improved basis for assessing the extent to which the program is achieving its key intended outcomes: improved access to integrated, multidisciplinary primary care health services; and increased education and training placements in a multidisciplinary care setting for the future primary care workforce.

Summary of agency response

38. The Department of Health and Ageing notes the audit report and agrees with the recommendations.

Recommendations

Recommendation No.1
Para 2.18

To inform the development and administration of infrastructure grants activities, the ANAO recommends that DoHA advise Ministers of any measures considered necessary in managing any significant risks to the effective implementation of election policy commitments.

DoHA response: *Agreed.*

Recommendation No.2
Para 3.36

To maximise the benefit from DoHA's experience in the administration of health infrastructure grant programs, the ANAO recommends that the department document a better practice approach for the assessment of value for money for health infrastructure projects.

DoHA response: *Agreed.*

Recommendation No.3
Para 5.11

To improve longer-term reporting on program outcomes, the ANAO recommends that DoHA revise the GP Super Clinics performance and reporting framework to include measurable KPIs on the extent to which the program is achieving its key intended outcomes.

DoHA response: *Agreed.*

Recommendation No.4
Para 5.41

To support a more outcome-focused performance reporting framework for the GP Super Clinics program, it is recommended that DoHA put in place arrangements with the Department of Human Services to obtain information on claimable services provided by operational GP Super Clinics, as well as information regarding vocational placements, medical education and training for GP Registrars and allied health professionals.

DoHA response: *Agreed.*

Audit Findings

1. Introduction

This chapter provides the context for the audit, including an overview of the GP Super Clinics policy and subsequent grants program, and outlines the audit objective, scope, criteria and methodology.

Improving primary healthcare

1.1 Primary healthcare is care provided by health professionals working in the community, as opposed to hospitals, institutions or specialist services. It is usually considered to include general practitioners (GPs), dentists and nurses working in private practices, community health services or Aboriginal Medical Services, allied health professionals (such as physiotherapists, dietitians and mental health counsellors) and pharmacists. Funding for primary healthcare is shared between the Commonwealth and the states and territories³³, although the proportion varies according to the particular service.

1.2 There has been considerable effort over the last two decades to improve the degree of integration between various primary healthcare providers as well as other parts of the healthcare sector. The aim is to foster more structured, coordinated and multidisciplinary care and increase the emphasis on preventative health and early detection of disease, particularly in light of the growing incidence of chronic diseases and an ageing population. Initiatives introduced as part of this process include: the establishment of the Divisions of General Practice and the Medicare Locals network; Commonwealth incentive payments such as the GP Links program³⁴ and Practice Incentives program;³⁵ the Primary Care Infrastructure Grants program;³⁶ and various initiatives to fund general practice education and training³⁷ and facilitate Medicare funding for a greater range of primary healthcare services.³⁸ State and territory

³³ The Commonwealth funds general practices (via Medicare), but the states and territories do not. Both levels of government contribute funding for community health services and Aboriginal Medical Services.

³⁴ This program provided financial incentives for general practice businesses to merge so as to provide a larger business that would support employment of larger numbers of nursing staff and an increased range of services.

³⁵ This program was examined in ANAO Audit Report No.5 2010–11 *Practice Incentives Program*.

³⁶ This program was examined in ANAO Audit Report No.44 2011–12 *Administration of the Primary Care Infrastructure Grants Program*.

³⁷ Including the General Practice Education and Training program, which was examined in ANAO Audit Report No.34 2010–11 *General Practice Education and Training*.

³⁸ Notably these include Chronic Disease Management (formerly called Enhanced Primary Care) items on the Medicare Benefit Schedule.

governments have also adopted a range of programs targeting healthcare integration.

The GP Super Clinics policy

1.3 *New Directions for Australia's Health: Delivering GP Super Clinics to local communities* (the GP Super Clinics policy) was released by the Australian Labor Party (ALP), then in opposition, on 24 August 2007. The policy was announced as part of the ALP's \$2 billion National Health and Hospitals Reform Plan (NHHRP). Among a number of proposed initiatives in the NHHRP aimed at improving the country's health system, the GP Super Clinics policy outlined a plan to fund the establishment of an unspecified number of 'GP Super Clinics' across the country that would provide multidisciplinary care and help reduce pressure on Australia's hospitals. The policy stated that:

The first and most common contact that Australian families have with the health system is through their GP. The family doctor plays a critical role in helping treat illnesses as well as helping families keep themselves healthy and out of hospital.

However, as a result of workforce shortages, long-term under-investment in infrastructure and a lack of strategic planning around the Medicare Schedule, GPs are finding it harder to meet the community's health needs and mums and dads are finding it harder to get their kids or parents to the doctors.

The nature of general practice and the general practice workforce are also changing. Increasingly, new doctors want more flexibility in their careers and working conditions that general practice, particularly in regional areas, don't always allow.

This means that young doctors and other health professionals are not being attracted to regions that need them most. As a result, the universality of Medicare is under threat – not because people aren't entitled to services, but because doctor shortages and poor health infrastructure mean they can't access them locally or close to home.

And with an increase in the prevalence of many chronic diseases and the ageing population, doctors are seeing more and more patients with complex care needs. This takes time, and adds pressure to a primary care system already under strain.

Many individual Australians suffer poor health as a result.

And it means our health system suffers too. It also puts pressure on our public hospitals. People who can't get good primary care in their community, inevitably end up in the emergency departments of our hospitals...

- Labor will provide capital funding for the establishment of GP Super Clinics around the country, in areas where access to primary health care services is poor and need is high.
- GP Super Clinics will provide the infrastructure for GPs and other health professionals and services to come together in the one space – to facilitate multidisciplinary team work and provide a greater focus on chronic disease prevention and management.
- GP Super Clinics will provide space and training facilities for medical students and trainees.
- GP Super Clinics will provide greater convenience and better access to services for patients.³⁹

Grant funding rounds

1.4 Following the release of the policy, the ALP progressively announced the locations of 32⁴⁰ proposed Super Clinics in the lead-up to the 2007 federal election, held on 24 November, along with the indicative maximum level of grant funding available for each location. Another five proposed locations were announced in August 2009, taking the total of ‘first round’ clinic locations to 37. Together, the indicative maximum grant funding amounts announced for the first round was \$176.7 million.⁴¹ Maximum funding amounts for each location were not set according to any publicised formula or other criteria, and varied considerably from \$1 million to \$12.5 million.

1.5 A second round of grant funding, as part of the National Primary Health Care Strategy, was announced by the Labor Government in the May 2010 Budget.⁴² The Budget announcement specified that the second round

³⁹ Australian Labor Party, *New Directions for Australia's Health: Delivering GP Super Clinics to local communities*, ALP, Canberra, 2007, pp. 3, 18.

⁴⁰ Clinics announced in 2007 included a Hobart clinic ('Hobart Eastern Shores') which was to have branches at two locations approximately 15 kilometers apart. These locations were subsequently funded through separate grant processes and funding agreements were executed with two different recipients. For the purposes of this audit they are treated as two clinics.

⁴¹ Excluding GST. Unless otherwise noted, all grant funding figures quoted in the audit report exclude GST.

⁴² Department of Health and Ageing, *Building a 21st Century Primary Health Care System: Australia's First National Primary Health Care Strategy*, Canberra, May 2010.

would constitute ‘around’ 23 new GP Super Clinics.⁴³ Subsequently, however, locations for 28 new clinics were announced by the Government during the 2010 election campaign, with the total maximum indicative funding for this round at \$242 million. Maximum second round funding amounts fell into three broad bands, with eight locations having maximum funding amounts of \$15 million, 18 locations having maximum indicative funding amounts in the range of \$5 million to \$7 million, and another two being allocated smaller amounts.⁴⁴

1.6 A summary of announcements, clinic numbers and maximum funding amounts across both funding rounds at the date of announcement, is shown in Table 1.1 below. A full list of announced clinics can be found in Appendix 1.

Table 1.1

Announcement of clinic locations

Round	Period when locations announced	Number of clinics	Total maximum funding amount ^A
First Round	1 September–17 November 2007	32	\$150.5 million
First Round	14–31 August 2009	5	\$26.2 million
Second Round	28 July–17 August 2010	28	\$242.0 million
Total		65	\$418.7 million

Source: ANAO analysis of media releases and DoHA documentation.

Note: (A) The amounts reflect the available grant amount indicated at the time the relevant clinics were first announced. Additional funding, totalling \$13.2 million, was announced in 2010 and 2011 for three first round clinics—Mt Isa, Wallan and Redcliffe.

1.7 The ALP’s 2007 GP Super Clinics policy did not specify how capital funding for the clinics would be made available. However, the subsequent GP Super Clinics program established in government provided for a mix of

⁴³ N Roxon, (Minister for Health and Ageing), ‘More GP Super Clinics and Extra GP Infrastructure’, media release, Canberra, 11 May 2010. The qualifier ‘around’ which appeared in the media release did not appear in the relevant budget papers, also released on 11 May 2010. See 2010–11 Australian Government Budget — Budget Paper No.2, which stated that ‘The Government will...improve access to primary health care by establishing an additional 23 GP Super Clinics’; p. 228. Neither the media release nor the Budget papers identified the total funding amount that would be dedicated to GP Super Clinics only – rather they specified a combined figure of \$355.2 million covering *both* the expansion of the GP Super Clinics program *and* the establishment of the new Primary Care Infrastructure Grants Program.

⁴⁴ The proposed clinics with maximum funding amounts of \$15 million were intended to include the provision of specialised services such as renal dialysis, palliative care, chemotherapy, hospital-in-the-home support and/or Home and Community Care.

competitive and non-competitive grant processes. Under the non-competitive grant process subsequently established by DoHA for specified locations, only the entity specified by the Minister for Health and Ageing was eligible to apply for the available grant for the relevant location. Typically, non-competitive grant processes were adopted where a clinic was to be built by a state health department, regional or community health service, Division of General Practice or local council. Applications submitted under non-competitive grant process were subject to the same assessment procedures as those for competitive grants. A number of the clinics, under both competitive and non-competitive grant processes, were also to be jointly funded by state governments.

Program Objectives and grant funding conditions

1.8 The overarching objective of the GP Super Clinics program is to facilitate access to high quality, affordable, team based primary healthcare.⁴⁵ More specifically, the program has ten objectives, which constitute the ‘core characteristics’ that each of the clinics is expected to demonstrate. These reflect key points of the GP Super Clinics policy, including: providing accessible and affordable multidisciplinary care that is responsive to local community health needs, having a greater focus on chronic disease prevention and management, and providing education and training opportunities for medical students and trainees.

1.9 Under the GP Super Clinics program, the grants provided for individual clinics could incorporate up to three elements:

- capital funding—for the purchase of land, construction, refurbishment, and building fit-out costs; and the purchase of medical, information technology and computing equipment. Up to five per cent of the total grant funds could also be used for preparatory purposes, including costs incurred in establishing the clinic business and operating structure;

⁴⁵ Department of Health and Ageing, *GP Super Clinics national program guide 2008*, DoHA, Canberra, 2008, p. 5.

- recurrent funding—up to 12.5 per cent of the total grant funds could be spent on administrative support, records management, centre managers and nursing staff⁴⁶; and
- relocation incentives—subject to certain conditions, to assist GPs, allied health professionals, nurses and pharmacy services relocate to the new facilities.⁴⁷

1.10 A further condition of the funding was that the clinics had to operate for 20 years—known as the ‘designated use period’. The Commonwealth’s interests in ensuring compliance with this condition are protected mainly through a combination of financial or similar securities over the clinic premises, along with ‘step-in’ rights that enable it, either directly or via a third party, to take control of a clinic. In this respect, the program leaves an administrative role for the Department of Health and Ageing (DoHA) which will continue long after the clinics are established and grant funds disbursed.

Administering agency

1.11 DoHA is responsible for administering the GP Super Clinics program. The department’s program responsibilities have included the: provision of policy and program advice; development of program guidelines; assessment of grant applications; selection of a preferred applicant for each location; negotiation of funding agreements; administration of funding agreements; and reporting.

Progress in implementing the GP Super Clinics program

1.12 As at 5 April 2013, funding agreements for all of the first round locations had been executed and 29 of the 36 clinics⁴⁸ were operational, with a further two providing so-called ‘early services’.⁴⁹ For the second round, funding agreements for 24 of the 28 clinic locations have been executed and one clinic is operational, with early services being provided from existing

⁴⁶ Grant funds could not be used for ongoing costs such as rent, maintenance costs or the purchase of consumables. All funds, whether for capital, recurrent or relocation purposes, were required to be spent within four years of the award of the grant.

⁴⁷ Up to \$15 000 per general practitioner, with lesser amounts to assist allied health professionals, nurses and pharmacy services to relocate to the new facilities. The general practitioner relocation payment was discontinued in the second round. Payments were made to the GP Super Clinic, not to the individual relocating to the clinic.

⁴⁸ While 37 clinics were announced in the first round, the Commonwealth withdrew funding from the proposed Sorell clinic in Tasmania, leaving 36 clinics.

⁴⁹ DoHA advised the ANAO that, to be classified as ‘early services’, these must be ‘additional to the services previously available to the community and form part of the services at the GP Super Clinic when it is operational’.

premises at another seven locations. Eight second round clinics are currently under construction. The progress made in implementing the GP Super Clinics program is set out in Table 1.2.

Table 1.2

Progress in establishing the GP Super Clinics program

Progress	First round locations	Second round locations
Clinic fully operational	29	1
Under construction	6 ^(A)	8 ^(B)
Funding agreement executed, construction not yet started	1	15 ^(C)
No funding agreement executed	0	4
Total	36	28

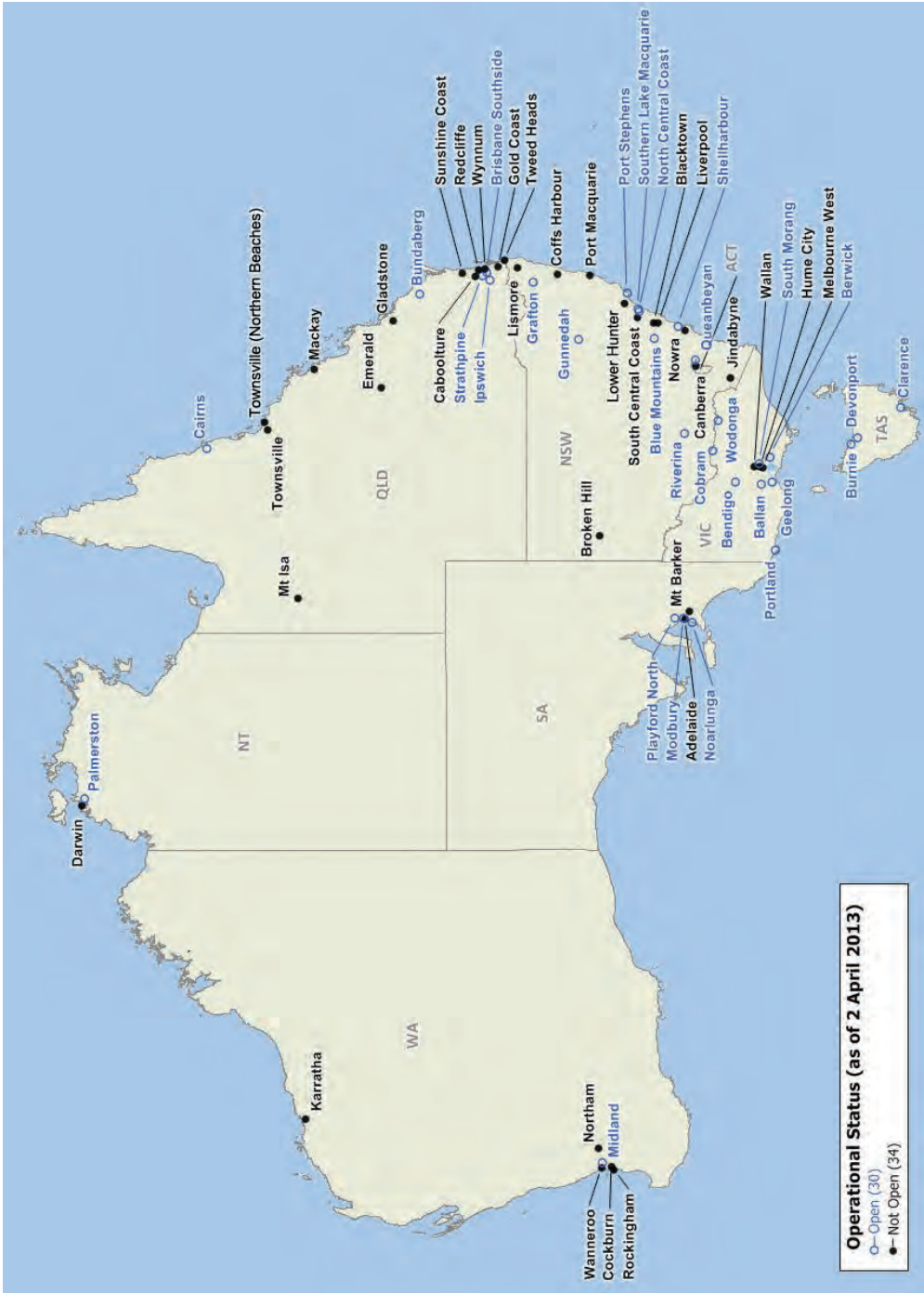
Notes: (A) Early services are being provided at two of these locations.

(B) Early services are being provided at two of these locations.

(C) Early services are being provided at five of these locations.

1.13 The geographic locations and corresponding operational status of all clinics are shown in the following map.

Figure 1.1
Location of GP Super Clinics



Grants administration framework

1.14 Grants administration is an important activity for many Australian Government agencies, involving the payment of billions of dollars of public funds each year. Commencing in December 2007, at the time the GP Super Clinics program was under development, significant enhancements were made to the Australian Government's grants administration framework in light of significant parliamentary and ANAO concerns with the administration of various grants programs over a number of years. The initial enhancements included the introduction, through Finance Minister's Instructions, of requirements for guidelines to be developed for any new discretionary grant programs⁵⁰ (such as the GP Super Clinics program), and considered by the Expenditure Review Committee of Cabinet (ERC). The December 2007 Finance Minister's Instructions further required:

- agencies to have adequate arrangements in place to manage grant programs in accordance with relevant legislation, regulations and guidance; and
- Ministers to receive departmental advice on the merits of grant applications relative to the guidelines for the relevant program before making any decisions on discretionary grants (where funding decisions are made by Ministers).⁵¹

1.15 Revised Finance Minister's Instructions issued in January 2009 retained these requirements and expanded their coverage to all types of grant programs (rather than being limited to discretionary grant programs). These revised Instructions were introduced to reflect government decisions made in December 2008 in response to the July 2008 report of the Strategic Review of the Administration of Australian Government Grant Programs (Strategic Review). Also consistent with the recommendations of the Strategic Review, with effect from 1 July 2009, the *Commonwealth Grant Guidelines* (CGGs)⁵² were

⁵⁰ Discretionary grants were defined as: 'grants where the Minister or agency has discretion in determining whether or not a particular application receives funding and may or may not impose conditions in return for the funding' and not including 'entitlement-based and demand-driven payments or rebates.'

⁵¹ In the case of the GP Super Clinics program, the financial approver under the FMA Act and Regulations was a DoHA official, not the Minister.

⁵² The CGGs issued under Regulation 7A of the FMA Regulations, represent the whole-of-government policy framework for grants administration and apply to all departments and agencies subject to the *Financial Management and Accountability Act 1997* (FMA Act). The CGGs also stipulate a number of policy and statutory requirements with which Ministers must comply when performing the role of financial approver in relation to grants. The second edition of the CGGs was released in March 2013, with effect from 1 June 2013.

issued and related changes were made to the Financial Management and Accountability Regulations 1997 (FMA Regulations). The CCGs:

- outline the legislative and policy framework for grants administration, including certain mandatory process requirements;
- set out seven key principles for grants administration⁵³; and
- provide guidance⁵⁴ on sound practice in grants administration that agencies should have regard to in implementing grant programs.

1.16 During election campaigns political parties typically release policy statements and may make announcements of their intention to provide certain benefits, services or facilities in the event the party is elected or re-elected to government. In the case of the proposed GP Super Clinics announced by the ALP in the lead-up to the November 2007 election, the election commitments were confirmed by the Strategic Budget Committee of Cabinet in December 2007. In the lead-up to the 2010 election, the bulk of the second round funding (for 23 clinics) was considered in the May 2010 Budget and funding identified, while the specific clinic locations and the increased funding to cover the five additional locations announced during the August 2010 election campaign (making a total of 28 clinics) were confirmed by the Expenditure Review Committee of Cabinet in October 2010.

1.17 Whilst 16 first-round GP Super Clinic grants were awarded before the CCGs and associated FMA Regulations amendments came into force on 1 July 2009, the enhancement to the grants framework introduced between 2007 and 2009 applied to the program, as did the financial framework requirement for the 'proper use' of public money, which pre-dated the CCGs and applied to all GP Super Clinic grants.⁵⁵

⁵³ The seven key principles are: (1) Robust planning and design; (2) An outcomes orientation; (3) Proportionality; (4) Collaboration and partnership; (5) Governance and accountability; (6) Probity and transparency; and (7) Achieving value with public money.

⁵⁴ This guidance is supplemented by associated Finance Circulars issued by the Department of Finance and Deregulation and complemented by the ANAO Better Practice Guide, *Implementing Better Practice Grants Administration*, which was revised and reissued in June 2010 following the promulgation of the CCGs. A previous version of the 2010 Better Practice Guide was published in 2002.

⁵⁵ FMA Regulation 9 prohibits the approval of a spending proposal unless the approver is satisfied, after making reasonable inquiries, that it would be a proper use of Commonwealth resources. 'Proper use' in this context means the 'efficient, effective, economical and ethical use of Commonwealth resources that is not inconsistent with the policies of the Commonwealth'. Often, this is referred to as a 'value for money' test. Since 1 July 2009, the enhanced grants administration framework has also required decision-makers to record the basis upon which they were satisfied that a proposed grant represents proper use of public money. Prior to that date, the recording of reasons for decisions was recognised as better practice but was not a statutory requirement.

1.18 The GP Super Clinics program is an executive grants scheme without a legislative basis.⁵⁶

Audit objective, scope, criteria and methodology

Audit objective

1.19 The objective of the audit was to assess the effectiveness of DoHA's administration of the GP Super Clinics program to support improved community access to integrated GP and primary health care services.

Audit scope

1.20 The audit examined DoHA's compliance with the mandatory aspects of the CGGs and the extent to which DoHA adopted sound practices in relation to the CGG key principles for grants administration. In cases where grants were approved prior to the CGGs coming into effect the audit examined compliance with the applicable parts of the relevant Finance Minister's Instructions of December 2007 and January 2009.

1.21 Under the GP Super Clinics program guidelines, clinics funded by the program 'must complement and enhance existing health services'.⁵⁷ While the audit examined whether DoHA had considered the issue of local health needs in its administration of the program, it did not assess whether GP Super Clinics had a direct business or economic impact on existing primary healthcare facilities.

Audit criteria

1.22 The audit criteria examined whether DoHA:

⁵⁶ The *Financial Framework Legislation Amendment Act (No. 3) 2012* (the Act), which commenced on 28 June 2012, was enacted in response to the High Court decision of 20 June 2012 in *Williams v Commonwealth*, which related to the validity of Commonwealth spending programs not supported by legislation other than an appropriation Act. The Act amended the *Financial Management and Accountability Act 1997* (the FMA Act) with the purpose of establishing legislative authority for the Commonwealth to make payments in relation to particular programs, grants and arrangements; and transitional provisions were included in the Act with the purpose of protecting programs, grants and arrangements in place before the Act commenced. The Act also amended the Financial Management and Accountability Regulations 1997 (FMA Regulations) to include a new schedule which specifies relevant grants and programs drawing legislative authority from the FMA Act for payments, where such authority does not otherwise exist. Schedule 1AA, Part 4 (item 415.033) of the FMA Regulations specified 'Health Infrastructure' and government spending intended to 'invest in the renewal and refurbishment of acute and primary care facilities, medical technology equipment, and major medical research facilities and health related projects'.

⁵⁷ Department of Health and Ageing, *GP Super Clinics national program guide 2008*, p. 14 and p. 35 Department of Health and Ageing, *GP Super Clinics national program guide 2010*, p. 24.

- established and initiated the program so that it was fit for the purpose of delivering infrastructure grants intended to improve community access to integrated GP and primary healthcare services;
- established an appropriate application and assessment process, including with respect to the provision of Ministerial advice on assessment outcomes;
- appropriately managed the negotiation and financial approval of funding agreements;
- effectively managed clinic roll-outs from execution of funding agreements through to clinics becoming fully operational; and
- evaluated and reported on clinic performance and compliance with relevant funding agreements, and has an appropriate program evaluation strategy in place.

Audit methodology

1.23 The audit methodology was designed to ensure that there was sufficient and appropriate evidence to form a reliable audit opinion. The audit methodology included:

- interviewing key personnel at DoHA's Central Office regarding the development, roll-out and evolution of the program;
- interviewing medical advisers who sat on the application assessment panels;
- contacting a range of stakeholders and inviting comments on the program and its administration by DoHA;
- reviewing relevant DoHA documentation, including policies, procedures, agreements, briefings, advice and correspondence;
- visiting 12 projects funded under the first round and interviewing the relevant grant recipients, and clinic directors where possible;
- examining the hard copy and electronic files for a sample of 36 of the 65 proposed clinic locations, including the documents relating to the assessment of applications, the awarding of grants, the administration of the roll-out, and the operational performance of the clinics; and
- examining patient presentation data trends across all of the operational clinics.

Previous audit coverage

1.24 The ANAO has not previously audited DoHA's administration of the GP Super Clinics program. The ANAO has, however, examined DoHA's administration of other health care infrastructure grants programs in Audit Report No.44 2011–12 *Administration of the Primary Care Infrastructure Grants Program* and Audit Report No.45 2011–12 *Administration of the Health and Hospitals Fund*.

Audit standards and cost

1.25 The audit was conducted in accordance with ANAO auditing standards, at a cost to the ANAO of around \$560 000.

Structure of the audit report

1.26 The structure of the audit report is outlined in Table 1.3.

Table 1.3

Structure of the audit report

Chapter 2 From Policy to Program	This chapter examines DoHA's role in developing the GP Super Clinics program based on the August 2007 GP Super Clinics policy and subsequent decisions by the Government and the Minister for Health and Ageing.
Chapter 3 Selection Processes	This chapter examines DoHA's process for assessing applications to select a preferred applicant to receive funding under the GP Super Clinics program.
Chapter 4 Rolling Out the Clinics	This chapter examines how DoHA administered the program from the completion of the assessment process to getting clinics into operation. It focuses on the major issues that arose during this period and DoHA's response to manage risk, including issues that potentially led to financial risks and delays.
Chapter 5 Reporting and Assessing Clinic and Program Outcomes	This chapter examines how DoHA developed and implemented a program evaluation framework, including key performance indicators. It also includes the ANAO's assessment of the performance of some aspects of the operational clinics in the ANAO's sample, as well as looking at patient presentation trends across the program as a whole. Finally it examines how DoHA is using the information submitted by operational clinics, both in the context of individual clinics and the program as a whole.

2. From Policy to Program

This chapter examines DoHA's role in developing the GP Super Clinics program based on the August 2007 GP Super Clinics policy and subsequent decisions by the Government and the Minister for Health and Ageing.

Introduction

2.1 The GP Super Clinics program was one of the first infrastructure grants programs focussed on privately provided healthcare services to be administered by DoHA. As a relatively new function for the department, there were many challenges in progressing the policy from an election commitment to a government funded grants program.

2.2 As outlined in chapter 1, the GP Super Clinics policy was set out in the document *New Directions for Australia's Health: Delivering GP Super Clinics to local communities* released in August 2007. The policy provided the basis for implementing the program once the ALP formed government. Under the policy, clinics were intended to help get 'doctors and other health professionals into areas that need them most'. The policy also placed a high priority on communicating with key stakeholders and engaging local health professionals so that clinics were tailored to local health needs.

2.3 From the early stages of its announcement and implementation, the GP Super Clinics policy and program has been subject to significant stakeholder interest. The Australian Medical Association (AMA), for example, while supporting some elements of the program such as the provision of additional clinical training facilities through the clinics⁵⁸, viewed the policy as lacking detail⁵⁹, and the selection of clinic locations as lacking transparency and consultation with the medical profession.⁶⁰ The AMA also made representations to the Auditor-General in October 2011 to consider commencing an audit of the program.

2.4 This chapter examines the progression of GP Super Clinics from an election policy commitment to inception as a program by considering:

⁵⁸ AMA, 'Labor's GP Super Clinics—More Questions than Answers', media release, 27 August 2007.

⁵⁹ Ibid.

⁶⁰ AMA, 'GP Super Clinics—Another example of failing to consult with the medical profession', media release, 9 February 2011; AMA, 'GP Super Clinics not so super—need for a proper audit', media release, 12 October 2011.

- how the clinic locations were announced and the factors that influenced those locations;
- DoHA's actions in developing the program, including the scope of its advice to the Government and Minister for Health and Ageing;
- grant funding arrangements; and
- the location of clinics and distribution of funding.

Announcement of the 32 initial clinic locations

2.5 The ALP's GP Super Clinics policy stated that a Labor government would 'work with the states and territories to identify areas most in need of services, as well as areas which would benefit from co-location of government funded services'. As to the specific location of clinics, the policy provided that the 'factors that will be taken into account will include' areas:

- where there is currently poor access to services, particularly where this is due to shortages of doctors;
- where there is currently poor health infrastructure;
- where a clinic could help take the pressure off local public hospital services; and
- with high levels of chronic disease and/or demographics with high needs, such as large numbers of children or elderly residents.

2.6 The ALP progressively announced the locations of 32⁶¹ proposed clinics in the lead-up to the November 2007 federal election, along with the indicative maximum level of Commonwealth grant funding available for each location. Maximum indicative funding amounts in the first round varied significantly, ranging from \$1 million to \$12.5 million.

2.7 The relevant ALP media releases typically made broad mention of some of the proposed services that would be available through the clinics, and stated that a Labor government would work with local doctors, health professionals, and the local community to finalise the details of the services. The announcements also generally gave a reason or reasons for selecting a

⁶¹ Clinics announced in 2007 included a Hobart clinic ('Hobart Eastern Shores') which was to have branches at two locations approximately 15 kilometres apart. These locations were subsequently funded through separate grant processes, and funding agreements were executed with two different recipients. For the purposes of this audit they are treated as two clinics.

particular location—that there was a shortage of GPs in the area, that it was an area of high population growth, or that the clinic would help take pressure off the local hospital.

2.8 Most locations announced were identified by reference to a town, regional city, suburb, or occasionally an electorate⁶², although some were very specific (such as in the grounds of a nominated local hospital) or alternatively were fairly broad (such as ‘Brisbane Southside’).

Developing the program

2.9 During election campaigns political parties typically release policy statements and may make announcements of their intention to provide certain benefits, services or facilities in the event the party is elected or re-elected to government. As part of the process for implementing election commitments following an election, agencies are responsible for assessing and providing early advice to government on options for seeking to fund the commitments. Where election commitments are intended to be implemented through grants, it is necessary to consider the most appropriate administrative arrangements for considering those proposals, including the source of funding for commitments that may later be approved to receive payments of public money. Any significant risks to the implementation of the policy should also be identified together with advice on appropriate mitigation strategies.

2.10 In less than four weeks following the election of the new government in 2007, DoHA developed a new policy proposal (NPP) for implementation of the GP Super Clinics policy through the establishment of a dedicated grants program to fund clinics in the announced locations. This was done against the backdrop of the development of an enhanced grants administration framework by the incoming government. The initial enhancements, introduced in December 2007 through Finance Minister’s Instructions, included the requirements for program guidelines to be developed for new discretionary grant programs, and consideration of these guidelines by the Expenditure Review Committee (ERC) of Cabinet.

2.11 From this early stage, DoHA recognised that there were a number of risks to successful implementation of the program. These risks included attracting appropriate workforces to the clinics, ensuring the financial viability

⁶² Examples of electorates identified were Charlton and Riverina, both in New South Wales.

of clinics and the potential construction delays associated with capital works projects. DoHA's advice to the new government was that these risks could be addressed through a variety of means, such as economic incentives, grant assessment processes and contract management measures.

2.12 A further risk identified by DoHA in its advice was the degree of 'acceptance and support' for the announced clinics by local communities and health professionals, including possible concerns about impacts on existing health services. The department proposed that this risk be managed through consultations with stakeholders both nationally and at the local level, with the latter focussing on ensuring that proposals address local needs and priorities, and complement existing services. However, while the department provided the Minister with some general background information on the Divisions of General Practice in which the announced clinics were located, its advice did not address whether it was aware of any particular implementation risks applying to the specific locations announced in the context of the 2007 election.⁶³ A range of options were potentially available for doing so, including some analysis, in the time available⁶⁴, of the extent to which the announced locations potentially satisfied some or all of the four factors outlined in the incoming government's GP Super Clinics policy. However, the department advised the ANAO that it considered there was insufficient and unsophisticated data available at the time to draw conclusions on location issues.

2.13 A broad analysis of the proposed clinic locations (that is, the 32 announced in 2007 and the 33 announced subsequently) against the four factors outlined in the ALP's policy was eventually undertaken and released by DoHA in early 2011 in response to a question on notice at Senate

⁶³ In this context, the ANAO's 2002 Better Practice Guide — Administration of Grants noted that: 'Even where the Government does take a specific decision regarding the establishment of a program, agencies should still consider whether further needs analysis would assist in targeting the areas or projects most in need of funding assistance, consistent with the Government's objectives. For example, the Government may establish a program to improve regional Australia's access to information technology. In these circumstances, the relevant agency should consider conducting analysis to determine those regions in greatest need or those services needed most', p.8. The same sentiment is expressed in the ANAO's 2010 Better Practice Guide—*Implementing Better Practice Grants Administration*: 'it is advisable that agencies consider, as part of the implementation process, whether further needs analysis would assist in ensuring the available funding will be directed towards funding recipients or projects that will maximise the effectiveness of, and value for money achieved by, the program', p. 21.

⁶⁴ The time available included the caretaker period as well as the period immediately after the 2007 election and the deadline for the NPP.

Estimates.⁶⁵ This post-hoc analysis is reproduced in summary form in Table 2.1.

Table 2.1

Number of clinics meeting GP Super Clinic location factors

	Number of clinics (first round)	Number of clinics (second round)	Total across both rounds
Meeting all five factors	0	4	4
Meeting four factors	1	7	8
Meeting three factors	5	9	14
Meeting two factors	25	8	33
Meeting one factor	6	0	6

Source: ANAO analysis.

2.14 DoHA's 2011 analysis is against five factors, not four, with the fifth being 'high population growth'. Population growth was mentioned in the ALP's 2007 GP Super Clinics policy⁶⁶, and a number of ALP press releases announcing proposed clinics in 2007 made explicit reference to population growth as an important consideration in choosing the respective locations. These references provided the basis for the inclusion of high population growth in DoHA's 2011 analysis alongside the four specific location factors contained in the ALP's 2007 GP Super Clinics policy.

2.15 DoHA's 2011 analysis indicates that a high proportion (83.8 per cent) of first round clinic locations met one or two of the five factors. Of the six first round clinics that met one factor, five of these met the 'high population growth' factor. Conversely, a reasonably high proportion (71.4 per cent) of second round clinics met three or more factors.

2.16 The 2007 NPP, which included the list of 32 announced locations and their respective funding amounts, was agreed by the Strategic Budget Committee of Cabinet on 17 December 2007. Following government approval, DoHA immediately provided the Minister with advice on a suggested approach for implementing the policy. This advice, which was partly informed by previous discussions between the Minister and the department, canvassed a

⁶⁵ Answer to question on notice, E11-149, Senate Community Affairs Committee. Additional Estimates 2010-11, 23 February 2011.

⁶⁶ The policy noted that 'fast growing outer suburbs...tend[ed] to be under serviced by health professionals'.

range of matters, including: developing the grant program guidelines, seeking the views of health sector stakeholders; engaging with state and territory governments about program implementation; funding processes, including assessment of grant applications; and consulting with local communities in areas where the proposed clinics were intended to be located. On 27 December 2007, the Minister formally endorsed DoHA's implementation approach.

2.17 As discussed in paragraph 2.45, while some information and analysis was provided to the Minister's office by DoHA on a number of factors that might inform the choice of clinic locations in the second round in 2010, that information was of a relatively informal nature and did not take the form of advice to the Minister. As in the first round, the Minister did not receive advice as to whether the department was aware of any particular implementation risks applying to specific locations. The ANAO has previously observed that departments should advise Ministers on any measures considered necessary to manage risks to the Commonwealth in achieving value for money when acting on election commitments⁶⁷, and there would have been benefit in providing specific advice to the Minister on whether the department was aware of any particular implementation risks applying to clinic locations announced in the 2007 and 2010 election context.⁶⁸

Recommendation No.1

2.18 To inform the development and administration of infrastructure grants activities, the ANAO recommends that DoHA advise Ministers of any measures considered necessary in managing any significant risks to the effective implementation of election policy commitments.

DoHA response:

2.19 *Agreed.*

⁶⁷ ANAO Audit Report No.14 2007–08, *Performance Audit of the Regional Partnerships Program*, Volume 2, p.148.

⁶⁸ The ANAO similarly observed in a previous grants administration audit that there was scope for DoHA to better assist the Health Minister through more comprehensive advice: ANAO Audit Report No.45 2011–12 *Administration of the Health and Hospitals Fund*, p. 86.

Developing program guidelines

2.20 The Minister approved draft program guidelines in late January 2008.⁶⁹ The guidelines were intended to provide guidance to potential applicants on the context and objectives of the program, the amount of available funding, conditions of funding, expectations about the content and format of applications, and an outline of the assessment process.

2.21 Following the Minister's approval, DoHA disseminated the draft guidelines to stakeholder groups—including those representing key sectors of the healthcare workforce, training organisations, medical students and healthcare consumers—for comment and feedback. DoHA provided copies of comments to the Minister, and after making some amendments to the guidelines in light of the comments, provided the amended version for Ministerial approval.

2.22 Input on the draft guidelines was also received from the states and territories via a senior officials' inter-jurisdictional working group established by DoHA. In addition, this group provided a conduit for DoHA to provide advice to the Minister about implementation issues at specific locations, including state and territory preferences about funding processes, integration of clinics with state-funded services, and prioritising the establishment of sites. A GP Super Clinics implementation plan was also approved by the Health and Ageing Working Group of the Council of Australian Governments (COAG) in March 2008.

2.23 The program guidelines were approved by the Minister in April 2008. However, the DoHA brief seeking the Minister's approval for the guidelines did not advise the Minister about the then requirement under the relevant Finance Minister's Instructions⁷⁰ for the guidelines to be considered by the Expenditure Review Committee of Cabinet (ERC). As a consequence, the guidelines were not submitted for ERC consideration prior to their public release.

⁶⁹ The December 2007 Finance Minister's Instructions, introduced by the new government, required guidelines to be developed for any new discretionary grant programs. Discretionary grants were defined in the Instructions as: 'grants where the minister or agency has discretion in determining whether or not a particular application receives funding and may or may not impose conditions in return for the funding' and not including 'entitlement-based and demand-driven payments or rebates guidelines'.

⁷⁰ Department of Finance and Deregulation, Finance Minister's Instructions of 14 December 2007.

Community consultation

2.24 DoHA's advice to the Minister of December 2007 suggested that a program of:

locally based consultation/briefing sessions [be held] in each area identified for a clinic...which would serve the dual purpose of briefing interested parties on the program parameters and submission process and allowing input on local community needs on priorities.

2.25 DoHA subsequently conducted community consultation sessions for all of the 32 initially announced locations. The first session was held in Ballan, Victoria, in May 2008. Sessions were held in all but three locations by February 2009.⁷¹ Meetings were advertised in the local press, and attracted between 60 and 160 people depending on the location, with local health professionals often being the largest group.

2.26 Feedback received by the ANAO from a relatively small sample of funding recipients, during visits to twelve operational clinics, indicated that perceptions of the usefulness of these sessions to applicants varied. There were a number of positive comments⁷², but in relation to two of the earlier sessions, recipients considered that DoHA did not clearly explain the objectives of the Commonwealth in establishing the clinics, or that the views of peak group stakeholders invited to the session 'crowded out' the opportunity for members of the local community to provide their views. However, judging by the attendance levels noted above, the sessions provided a vehicle for raising awareness of the proposal for a clinic in the area, and of the funding process to be applied for that location. DoHA also advised the ANAO that senior departmental officials met, or offered to meet, with AMA representatives immediately before each of the first round consultation sessions.

2.27 The main points raised in these sessions were compiled in short reports and a one-page summary. One-page summaries were posted on the DoHA GP Super Clinics website and DoHA advised the ANAO that 'themes from the consultations were contained in the [invitation to apply (ITA)] documentation' for the relevant location. However, the ANAO's review of the ITA document against these consultation reports, based on the 21 first round projects in its

⁷¹ The Berwick, Brisbane Southside and Gladstone consultation sessions were delayed for various reasons.

⁷² More particularly, positive comments were made by funding recipients about the community consultation sessions conducted in two clinic locations in Queensland and one in Victoria.

overall sample of 36 clinics, indicates that key information from feedback/consultation sessions was not always included in the ITA documentation. The ITA documentation for those second round locations that were subject to consultative processes did however contain weblinks to consultation session summaries.

Risk management

2.28 Risk management should form part of the design and planning of a grants program.⁷³ Risk management involves the systematic identification, analysis, and treatment of risks on a dynamic and continual basis, given that risks may emerge at different stages in grants administration.⁷⁴

2.29 DoHA developed risk management plans on two main levels: at the program level and the project level.

Program level risk management plans

2.30 From the earliest stages of the program's development in December 2007, DoHA prepared broad, program level risk management plans, called enterprise level risk management plans. The sources of risk to the timely implementation of the GP Super Clinics program identified in those plans, along with the (then) current and proposed responses to those risks, are shown in Table 2.2. These risks were consistent with DoHA's advice provided to the Government through the NPP process.

⁷³ ANAO 2002 *Better Practice Guide—Administration of Grants*, op. cit., p 10. The importance of risk management in the design and planning stage of grants programs is also recognised in the *Commonwealth Grant Guidelines*, op. cit., p 15.

⁷⁴ *ibid.*

Table 2.2

Initial identification and responses to program level risks

Sources of risk to GP Super Clinics program implementation	Program level responses
<ul style="list-style-type: none"> • Insufficient clarity of program description and definition of the role of the Commonwealth and State and Territory Governments. • Failure to engage the support of local communities and health professionals. • No suitable proposals received from the call for submission process. • Clinics once established may not attract or retain the necessary workforce. • Threat to competitive neutrality could produce grievances for particular sites. • Delays in building construction / refurbishment may delay establishment of the clinics. 	<ul style="list-style-type: none"> • Advice is being sought from the Minister's Office with regard to the preferred arrangements for the roll-out of the initiative. • Regular reporting to the Division Head on progress on implementation. • Initial stakeholder consultation on Program Guidelines. • Establishment of a senior cross-jurisdictional governance group to oversee the implementation of the GP Super Clinics program. • Development of a consultation strategy targeting primary care health professionals and community members in all areas where GP Super Clinics have been announced. Local consultation will focus on ensuring that the clinics meet local needs and priorities, and complement existing services. • Appropriate technical expertise engaged to support the submission for funding process to ensure detailed analysis of business cases and workforce strategies as part of the assessment process. • Development of clear, transparent and fair application and assessment processes within a nationally agreed framework that allows local flexibility.

Source: DoHA Enterprise Risk Management Plan December 2007

2.31 As the program matured and DoHA gained more experience in the assessment, roll-out and operational performance of clinics, it identified additional program level risks. These risks included:

- delays due to state or local government approval processes or unavailability of suitable land;
- poor project management by recipients;
- clinics not being financially viable or sustainable;
- unrealistic political or public expectations about the clinics, including timeframes for delivery of services; and

- insufficient appropriately skilled DoHA staff to manage the volume and complexity of infrastructure projects.

2.32 Later versions of these risk management plans, from 2010 on, also contained DoHA's assessment of whether the relevant risk was rated as low, medium or high.⁷⁵ A comparison of 'current risk rating' to 'target risk rating' in the program level risk management plans indicates that the assessed risk level remained above the target risk rating for the majority of identified risks. Whilst various risk treatments were included in the plans, the ratings suggest that DoHA had difficulties, at the program level, in reducing risks to its preferred level, although all risk ratings were nonetheless stated in the plans as being 'acceptable'.

2.33 In 2012, as part of a department-wide administrative change, DoHA introduced revised risk templates for the assessment and management of risks, resulting in the reclassification of various risk ratings in the program. Risks rated as 'likely' or 'possible' to occur, with 'major' consequences, included:

- clinics not being financially viable;
- clinics failing to recruit or retain the necessary workforce; and
- insufficient skilled staff in DoHA's GP Super Clinic Branch to manage the value and complexity of the program.⁷⁶

2.34 DoHA advised the ANAO in March 2013 that 'an executive level risk management session' is planned in the near future.

2.35 The need to engage external technical expertise during program design and administration was identified in the successive program level risk management plans. As at March 2013, approximately \$5.1 million (or just over 1 per cent of total GP Super Clinic grant funding) has been spent or committed for external expertise, including \$2.8 million on legal advice for both program-wide and clinic-specific issues.

Project level risk management

2.36 Individual, formal risk management plans were developed for all proposed clinics at the start of the grant invitation to apply process. The plans were considered for updating at key decision-making points, specifically: the

⁷⁵ These ratings have been derived from combining the likelihood of the risk event occurring with the consequence of such an occurrence.

⁷⁶ DoHA, GPSC Risk Management Plan, Assessment and Evaluation, December 2012.

approval of assessment reports; when offering funding agreements; and the acceptance of milestones under funding agreements during the pre-construction, construction and operational phases.

2.37 Significant effort was also devoted to managing risk through the development of a standard form GP Super Clinics grant funding agreement. External legal advisers were retained to undertake drafting and provide advice on options to protect the Commonwealth's interests in the planning, construction and operation of each clinic, including during the 20 year designated use period.⁷⁷ Funding agreements also went through extensive modifications from mid-2008 to better manage the Commonwealth's risks. This was done mainly by increasing the obligations placed on recipients in respect of construction budgeting and planning, operational planning, and progress and performance reporting. In the second round, enhanced due diligence requirements were introduced, particularly relating to land acquisition and development approval, and the provisions regarding sufficiency of funds to complete clinic construction were strengthened.

2.38 Overall, risk management considerations appropriately informed DoHA's development and administration of the program from the outset. However, DoHA's ability to identify and effectively manage all significant risks, particularly at an early stage, was hampered due to limited previous experience in planning and administering infrastructure designed to facilitate the delivery of multidisciplinary primary healthcare services in a competitive private sector environment. There was consequently a need to revise program arrangements in response to the ongoing assessment of risks. Further, the department had to contend with expectations about timeframes for delivery that in some cases were difficult to meet, particularly when complications arose in assessment, funding agreement negotiation, land acquisition, development approval or construction processes.

⁷⁷ As mentioned in chapter 1, a condition of being awarded a GP Super Clinic grant was that the recipient must operate the clinic over the designated use period. More specifically, the clinic must provide 'multidisciplinary care services that are responsive to local community needs and priorities and that operate so as to best achieve the Program Objectives'. Should the recipient wish to sell the clinic or the property on which it is located, this requires the permission of the Commonwealth. The buyer must also enter into a legal agreement with the Commonwealth to continue to operate the clinic for whatever remains of the designated use period.

Announcement of additional clinic locations

2.39 Following the announcement of the initial 32 clinics in 2007, the Government made two further announcements about program locations and funding. These related to:

- five additional locations announced in August 2009; and
- a second round of funding for 28 additional locations announced in 2010.

Announcement of five additional locations

2.40 In late 2008 and early 2009, DoHA received five unsolicited⁷⁸ proposals from various organisations for the establishment of clinics in locations not included in the group announced in 2007. The locations were Gunnedah (NSW), Cockburn (Western Australia), and Wodonga, Portland and South Morang (all in Victoria). The 2008 program guidelines were silent on whether unsolicited proposals would be considered. However, they stated that ‘GP Super Clinics will be rolled out progressively ... at 31 locations across Australia identified in Attachment A’⁷⁹, suggesting that the program was restricted to applications for locations specified at that time.

2.41 DoHA briefed the Minister on the unsolicited proposals, including the extent to which they satisfied the four ‘location’ factors outlined in paragraph 2.5⁸⁰, noting in particular that all five locations were in areas of poor access to health services. DoHA advised that the proposals would require further information from the applicants specifically addressing the program guidelines before they could be considered for funding. The department’s advice did not address the issue of whether, in the absence of any analysis against other areas of poor access to health services, and the reference in the program guidelines to the specified locations, it was equitable or appropriate that the new locations be considered for potential funding. DoHA did note however that it was aware of ‘wider interest in seeking grant funding to

⁷⁸ The proposals were described as ‘unsolicited’ in DoHA’s advice to the Minister: DoHA, *Minute to the Minister—Potential to fund additional sites under the GP Super Clinics Program*, 12 January 2009.

⁷⁹ Department of Health and Ageing, *GP Super Clinics national program guide 2008*, DoHA, Canberra, 2008, p. 3. As noted earlier in this audit, clinics announced in 2007 included a Hobart clinic (‘Hobart Eastern Shores’) which was to have branches at two locations approximately 15 kilometres apart. These locations were subsequently funded through separate grant processes, and funding agreements were executed with two different recipients. For the purposes of this audit they are treated as two clinics, giving a total of 32 clinics announced in 2007.

⁸⁰ As discussed earlier in this chapter, this had not been done in respect to the 32 proposals announced following the release of the Government’s 2007 election policy.

support integrated multidisciplinary care' and suggested that the Minister consider the development of a separate competitive grants program that would fund smaller health infrastructure projects.⁸¹

2.42 The Minister subsequently wrote to the Prime Minister in January 2009 regarding the five unsolicited projects, and additional funding was identified through the 2009–10 Budget process.⁸² Cabinet approval was given in July 2009 for inclusion of these locations, subject to the usual assessment process, in the GP Super Clinics program.

2.43 The treatment of these five unsolicited locations can be contrasted with at least one other unsolicited proposal received by the Minister in early 2008. This involved a proposed clinic in the Australian Capital Territory (ACT), with the proponent providing some evidence of consistency between the proposal and the GP Super Clinics policy. Evidence of support from local stakeholders, and recently prepared feasibility, business and construction plans were also referred to. In February 2008 the Minister wrote to the proponent, advising that a GP Super Clinic 'was not planned for the [ACT] at this time'.⁸³ In preparing this response for the Minister, DoHA did not provide any accompanying advice about how any future unsolicited GP Super Clinic proposals might be handled. Following further contact from the proponent, the Minister subsequently agreed to provide funding of \$220 000 for the proposal under the General Practice Infrastructure Training Support program.

Second round of GP Super Clinics funding and 28 additional locations

2.44 The Government released its response to the National Health and Hospitals Reform Commission report, and the National Primary Health Care Strategy process, in the context of the 11 May 2010 Budget. In relation to primary healthcare infrastructure, that response included an expansion of the existing GP Super Clinics program:

⁸¹ The advice does not, on its face, record any written response by the Minister to this suggestion. The Government announced the establishment of the Primary Care Infrastructure Grants program in 2010. This \$117 million program provided grants of up to \$500 000 to individual existing practices. This program was examined in ANAO Audit Report No.44 2011–12 *Administration of the Primary Care Infrastructure Grants Program*.

⁸² DoHA was in possession of preliminary cost estimates for these proposals, and maximum funding amounts identified in the 2009–10 Budget process correlated closely with these estimates.

⁸³ The ACT was included in the locations for proposed clinics in the second round, and a funding agreement for a \$15 million grant was executed in April 2012.

The Rudd Government will...construct around 23 new dedicated GP Super Clinics.

Of the new GP Super Clinics, around nine large clinics will be built where doctors, nurses and allied health professionals will be supplemented by more specialised services such as renal dialysis, minor surgical procedures, rehabilitation services and radiology. ...

The remaining new GP Super Clinics will be built along the lines of the 36 clinics already under construction.⁸⁴

2.45 As in the first round⁸⁵, DoHA did not provide advice to the Minister as to whether it was aware of any particular implementation risks applying to specific locations. While some information and analysis was provided to the Minister's office by DoHA on a number of factors that might inform the choice of clinic locations in the second round, that information was of a relatively informal nature through emails to ministerial staff rather than a formal briefing to the Minister.⁸⁶

2.46 The Government did not announce, in the May 2010 budget context, where the proposed additional clinics would be located, or provide any details about when or how the locations would be decided. However, funding of \$355.2 million was announced in the budget papers for both the expansion of the GP Super Clinics program as well as the establishment of the new Primary Care Infrastructure Grants program.⁸⁷

2.47 Immediately following the 2010 budget, DoHA revised the first round guidelines. While there was some additional detail and explanatory information, the changes were modest, and the guidelines were considered and approved by the ERC on 14 July 2010. However, due to the calling of the 2010 election⁸⁸, the guidelines were not publicly released until November 2010.

⁸⁴ N Roxon, (Minister for Health and Ageing), 'More GP Super Clinics and Extra GP Infrastructure', media release, 11 May 2010.

⁸⁵ See paragraph 2.12 and Recommendation 1 (paragraph 2.18).

⁸⁶ While DoHA was able to provide elements of this advice to the ANAO in the form of an email dated 10 May 2010 and an attachment, the records provided to the ANAO could not be retrieved from DoHA's records management system and the link between the documents could not be established.

⁸⁷ 2010–11 Australian Government Budget—Budget Paper No.2, p. 228. As noted in chapter 1, the qualifier 'around' that was contained in the Minister's 11 May 2010 press release regarding the number of new GP Super Clinics did not appear in Budget Paper No.2, also released on 11 May 2010.

⁸⁸ The caretaker period took effect from 19 July 2010 and the election was held on 21 August 2010.

2.48 During the 2010 election campaign, the Government announced 28 new locations⁸⁹, five more than referred to in the May 2010 budget papers.⁹⁰ Following the return of the Government, a new policy proposal (NPP) was prepared by DoHA on the expanded list of 28 locations. Consistent with the approach adopted by DoHA for the 2007 NPP and before the 2010 Budget⁹¹, no advice was provided to the Government or the Minister as to whether the department was aware of any particular implementation risks applying to the specific locations announced in the 2010 context. Notably, however, the NPP stated that the 'implementation risk [of the second round] has been assessed as low'. The NPP, which included additional funding for the expanded list of locations, was approved by Cabinet on 26 October 2010. Subsequently, the Minister announced that, based on feedback she had received from the relevant local Federal members, community consultation sessions would be held in 13 of these locations.⁹² These consultation sessions were undertaken by DoHA from December 2010 through to July 2011.

Grant funding processes

2.49 Grant funding in the two rounds was determined through a mix of competitive and non-competitive processes. The ANAO observed that typically, non-competitive grant processes were adopted where a clinic was to be built by a state health department, regional or community health service, Division of General Practice or local council.

2.50 In total, non-competitive processes were adopted in 22 of the 65 locations, or 34 per cent of locations.⁹³ A summary of the funding processes that applied to each of the locations is presented in Table 2.3.

⁸⁹ A further announcement was made relating to Redcliffe, a first round location, which received a \$5 million grant in the first round. It received a further \$5 million under the second round of funding.

⁹⁰ Of the 28 locations announced in the 2010 election, eight locations had maximum indicative funding amounts of up to \$15 million, with eighteen locations having maximum indicative funding amounts in the range of \$5 million to \$7 million, and another two being allocated smaller amounts.

⁹¹ Discussed in paragraph 2.45.

⁹² N Roxon, (Minister for Health and Ageing), 'Process Commences for the Next 28 GP Super Clinics', media release, 28 October 2010.

⁹³ The general issue of high proportions of non-competitive Commonwealth grant schemes has been noted as a matter of 'significant concern' by the Joint Standing Committee on Public Accounts and Audit (JCPAA), and the committee has expressed the view that it considers competitive processes to constitute 'best practice': JCPAA Report 430, *Review of Auditor-General's Reports Nos. 47 (2010-11) to 9 (2011-12) and Reports Nos. 10 to 23 (2011-12)*, p. 55.

Table 2.3**Funding application process, competitive and non-competitive**

Round	Competitive	Non-competitive (invitation to apply issued to a State Health Department)	Non-competitive (invitation to apply issued to an entity other than a State Health Department)
First round (includes the five clinics announced in 2009) – total of 37 clinics	24	4	9
Second round – total of 28 clinics	19	1	8

Note: There were some instances where an initial process failed to identify a preferred applicant, or the preferred applicant or funding recipient subsequently withdrew from the grants process. In such cases, subsequent processes for the relevant location were sometimes altered from competitive to non-competitive or vice-versa. However, only the initial process is counted for the purposes of this table.

Source: ANAO analysis.

2.51 The 2010 ANAO Better Practice Guide on grants administration suggests that ‘in establishing the form of application and selection process to be applied to a particular grant program, it is advisable for agencies to document consideration of the risks, costs and benefits of the available options’.⁹⁴ Further, the *Commonwealth Grant Guidelines*, which were introduced in July 2009 and applied to the second funding round, provide that ‘in the case of grant programs, unless specifically agreed otherwise, competitive, merit based selection processes should be used, based upon clearly defined selection criteria’.⁹⁵

2.52 In the first round, a total of 13 clinic locations were funded under non-competitive processes, including the five locations announced in 2009. These five locations were added to the program as a result of specific proposals developed by local organisations being submitted to DoHA and the Minister. For all other first and second round locations, the choice of competitive or non-competitive processes was informed primarily by the media statements released in the election context.⁹⁶ As such, the use of non-competitive processes for certain clinics was an elaboration of the original 2007 election

⁹⁴ *Better Practice Guide—Implementing Better Practice Grants Administration*, op. cit., p. 60.

⁹⁵ *Commonwealth Grant Guidelines*, op. cit., p. 29.

⁹⁶ A number of media statements released by the ALP and the Government in the context of the 2007 and 2010 elections referred to whether selection processes would be competitive or not.

policy. Based on these considerations, DoHA sought and received confirmation from the Minister for both rounds as to which process should apply to the individual clinics announced by the Government. While most decisions relating to the adoption of a non-competitive process were informed by statements made in the election context, there were some exceptions to this. In one first round location, Palmerston, the Minister did not decide that the funding process would be non-competitive until late 2008: up until that point the funding process was unclear. In the second round, there were three locations⁹⁷ where, following community consultation sessions, and after receiving advice from DoHA, the Minister decided to change the process from competitive to non-competitive.

2.53 Consistent with the Minister's decision to adopt a hybrid of competitive and non-competitive processes, the program guidelines for both the first and second rounds specified that differing grant funding processes would potentially apply to certain locations.

2.54 However, DoHA's advice to the Minister on program implementation, including in relation to the development of the guidelines, did not address the risks to be managed⁹⁸ in adopting a non-competitive process for specific locations. In this respect, the approach to advising Ministers on risk, proposed in Recommendation 1, is also relevant.

Location of clinics and the distribution of funding

2.55 As outlined in the ANAO's Better Practice Guide on the administration of grant programs:

A measure of achieved grant program outcomes that is frequently the subject of public and parliamentary scrutiny is the distribution of funding awarded under the program. In this respect, the geographic and political distribution of grants may be seen as indicators of the general equity of access to a program, as well as its effectiveness in targeting funding in accordance with the stated policy objectives of the program.⁹⁹

⁹⁷ Lower Hunter, Emerald, and Townsville (Northern Beaches).

⁹⁸ Footnote 12 outlines a number of the potential risks.

⁹⁹ Better Practice Guide—Implementing Better Practice Grants Administration, op. cit., p. 100. Similarly, the ANAO's 2002 *Administration of Grants: Better Practice Guide* observed that: 'Grant administrators should be aware that geographic and political distribution of grants may be seen as indicators of the general equity of the program,' op. cit., p. 22.

2.56 The ANAO assessed the distribution of GP Super Clinics with respect to which party held the electorate at the time the relevant clinic locations were announced, and whether the electorate was classified by the Australian Electoral Commission as a marginal electorate.¹⁰⁰ The ANAO also assessed whether a clinic was in an area of unmet healthcare need at the time its location was announced, based on whether the clinic was located in a District of Workforce Shortage (DWS). Tables showing key elements of the distribution of clinics and funding discussed below are in Appendix 3. It should be noted that the ANAO's analysis has been undertaken based on the locations/expected locations of the clinics, and does not account for the potential of catchment populations from neighbouring areas to use a clinic. For example, based on the electorate boundaries for the 2007 election, while the Berwick clinic is located in the La Trobe electorate in Melbourne, it is adjacent to the neighbouring Holt electorate. At the time the Berwick GP Super Clinic was announced, La Trobe was a marginal electorate held by the Coalition, whereas Holt was a marginal electorate held by the ALP. Similarly, the Noarlunga GP Super Clinic, on the southern fringes of Adelaide, was not in a DWS, but residential areas less than 1 kilometre away were.

2.57 Analysis of the distribution of the clinic locations announced in the 2007 election context shows that 54.8 per cent of clinics were located in marginal electorates; these clinics also accounted for 65.7 per cent of announced indicative funding. This compares with 31 per cent of electorates being classified as marginal at the 2007 election. In relation to the remaining clinics—the five announced in 2009¹⁰¹ and those announced in the 2010 election context—43.8 per cent were in marginal electorates; these clinics also accounted for 43.7 per cent of announced funding. This compares with 37 per cent of electorates being marginal at the 2010 election. Further analysis of clinics announced in 2007 marginal electorates, on the basis of DWS status, shows that 82.4 per cent of the clinics announced in 2007 were in a DWS. For the remaining clinics announced in 2009 and 2010 that were in marginal electorates, 57.1 per cent were also in a DWS.

¹⁰⁰ The analysis is based on 63, rather than 65, clinics. The clinics in Gladstone (announced in 2007) and Karratha (announced in 2010) were excluded from the analyses as the relevant electorates in which the clinics were located were newly created for the 2007 and 2010 elections and as such were not held by any political party at the time the proposed clinic was announced.

¹⁰¹ Whilst this audit report generally treats the five clinics announced in 2009 as 'first round' clinics alongside the 32 announced in 2007, for the purposes of the electoral analysis it is necessary to group them together with the 28 'second round' clinics announced in 2010 as they were announced in the lead-up to the 2010 election.

2.58 Clinic locations announced in the 2007 election context were substantially weighted towards Coalition-held electorates, with 74.2 per cent of clinics in such electorates; these clinics also accounted for 78.4 per cent of announced funding. ALP-held electorates accounted for 22.6 per cent of clinics and 19.9 per cent of announced funding. There was only one clinic in an independent-held electorate, accounting for 1.7 per cent of the announced funding. The proportion of both clinics and allocated funding to Coalition electorates announced in the 2007 election context was high; at the relevant time the Coalition held 58 per cent of seats across Australia compared to the ALP's 40 per cent.

2.59 In contrast, clinic locations announced in relation to the remaining clinics—the five announced in 2009 and those announced in the 2010 election context—were more weighted towards ALP-held electorates, with 56.2 per cent of clinics in such electorates; these clinics also accounted for 66.0 per cent of announced funding. Coalition-held electorates accounted for 37.5 per cent of clinics announced and 29.7 per cent of announced indicative funding. There were two clinics in independent electorates, accounting for 4.3 per cent of announced funding. In terms of the number of clinics, the relative proportion of clinics in ALP and Coalition-held electorates broadly reflects the distribution of seats across parties; at the relevant time the ALP held 55 per cent of seats across Australia compared to the Coalition's 43 per cent.

2.60 Across both funding rounds, 39.7 per cent of announced clinics were located in ALP-held electorates, 55.5 per cent in Coalition-held electorates, and 4.8 per cent in independent-held electorates. In terms of funding, this was almost evenly split between the ALP-held (49.5 per cent) and Coalition-held (47.1 per cent) electorates, with independent-held electorates accounting for 3.4 per cent. The relatively even split was a consequence of the average value of grants announced in 2010 being substantially higher than those announced in 2007, and the fact that ALP-held electorates received seven of the eight highest-value (\$15 million) grants announced in the context of the 2010 election.

2.61 In terms of DWS status, 64.0 per cent of clinics in ALP-held electorates were also in DWS areas. This compares with 57.1 per cent for clinics in Coalition-held electorates. Two of the three clinics in independent-held electorates were also in DWS areas.

Conclusion

2.62 The ANAO has previously observed that departments should advise Ministers on any measures considered necessary to manage any significant risks to the Commonwealth achieving value for money when acting on election commitments. In the lead up to the 2007 election, the ALP announced 32 proposed locations for GP Super Clinics. Following the election, DoHA provided advice to the Minister that a ‘key’ implementation risk was the degree of ‘acceptance and support’ for the announced clinics by local communities and health professionals—including possible concerns about impacts on existing health services—and proposed that this risk be managed through consultations.

2.63 However, the department did not advise the Minister whether it was aware of any particular implementation risks applying to the specific locations announced in the context of the incoming government’s 2007 election policy. A range of options were potentially available for doing so, including some analysis, in the time available, of the extent to which the announced locations potentially satisfied some or all of the four factors outlined in the incoming government’s GP Super Clinics policy. The department advised the ANAO that it considered there was insufficient and unsophisticated data available at the time to draw conclusions on location issues. While some information and analysis was provided to the Minister’s office by DoHA on a number of factors that might inform the choice of clinic locations in the second round in 2010, that information was of a relatively informal nature through emails to ministerial staff rather than a formal briefing to the Minister.

2.64 In response to a question on notice at Senate Estimates in early 2011 regarding the 65 locations announced across the two rounds, DoHA commissioned a broad post-hoc analysis against the four factors in the 2007 election policy, plus an additional fifth factor of high population growth. The analysis indicated that a high proportion (83.8 per cent) of first round clinic locations met one or two of the five factors. Conversely, a reasonably high proportion (71.4 per cent) of second round clinics met three or more factors.

2.65 Over one-third of locations were subject to non-competitive grant processes. The use of non-competitive processes for specific clinics announced in 2007 and 2010 generally reflected election policy commitments, although there were some exceptions to this. In one first round location, Palmerston, the Minister did not decide that the funding would be a non-competitive process

until late 2008: up until that point the funding process was unclear. In the second round, there were three locations¹⁰² where, following community consultation sessions, and receiving advice from DoHA, the Minister decided to change the process from competitive to non-competitive.¹⁰³ DoHA's advice to the Minister on program implementation did not address the risks to be managed¹⁰⁴ in adopting a non-competitive process for specific locations. The ANAO observed that typically, non-competitive grant processes were adopted where a clinic was to be built by a state health department, regional or community health service, Division of General Practice or local council.

2.66 Analysis of the distribution of the clinic locations announced in the 2007 election context shows that 54.8 per cent of clinics were located in marginal electorates; these clinics also accounted for 65.7 per cent of the announced indicative funding. This compares with 31 per cent of electorates being marginal in the 2007 election. In relation to the remaining clinics—the five announced in 2009 and those announced in the 2010 election context—43.8 per cent were in marginal electorates; these clinics also accounted for 43.7 per cent of the announced indicative funding. This compares with 37 per cent of electorates being marginal in the 2010 election. Further analysis of clinics announced in marginal electorates, on the basis of District of Workforce Shortage (DWS) status, shows that 82.4 per cent of the clinics announced in 2007 were in a DWS. For the remaining clinics announced in 2009 and 2010 that were in marginal electorates, 57.1 per cent were also in a DWS.

¹⁰² Lower Hunter, Emerald, and Townsville (Northern Beaches).

¹⁰³ The five clinic locations announced in 2009 were funded under non-competitive process, as these locations were added to the GP Super Clinics program as a result of specific proposals developed by local organisations being submitted to DoHA and the Minister.

¹⁰⁴ Footnote 12 outlines a number of the potential risks.

3. Selection Processes

This chapter examines DoHA's process for assessing applications to select a preferred applicant to receive funding under the GP Super Clinics program.

Introduction

3.1 A key consideration in the administration of grant programs is whether decision-makers have equitably and transparently selected applicants that best represent value for public money in the context of the program objectives and outcomes.¹⁰⁵ In this context, a well designed and robust assessment and selection process will help mitigate risks to achieving program objectives.

3.2 To determine whether DoHA established an appropriate process to assess applications and select a preferred applicant to receive funding under the GP Super Clinics program, this chapter examines:

- the overall framework for assessing applications;
- how applications were assessed to determine whether they appropriately addressed key local healthcare needs;
- how value for money was assessed; and
- DoHA's approach where initial assessment processes failed to identify a preferred applicant.

Framework for assessing applications

3.3 Separate Invitation to Apply (ITA) and assessment processes were run for each location, irrespective of whether they were to be funded under a competitive or non-competitive process. The opening of ITA processes was advertised in the national and regional press and on both the Department's GP Super Clinics webpage and tenders and grants webpage. DoHA also generated 'interested parties' email lists through local consultation processes at most GP Super Clinic locations, and the relevant local list was used to notify potential applicants. Competitively funded locations attracted a varied and sometimes sizeable number of applications, although on two occasions no applications

¹⁰⁵ Department of Finance and Deregulation, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, July 2009, p. 29.

were received¹⁰⁶, which required DoHA run a further ITA process. In total, 216 applications were received across the 65 clinic locations, with the competitively-funded locations accounting for 195 of the applications.

3.4 Apart from some slight variation between the first and second rounds, essentially the same assessment framework and methodology was applied to all locations, irrespective of whether the funding process was competitive or non-competitive. While the program guidelines for both rounds required applicants to identify other funding sources, including State or Commonwealth grants, the ANAO did not observe any formal checks to prevent double dipping or any references to the issue in assessment plans, assessment outcome reports or FMA Regulation 9 approval documentation.¹⁰⁷ DoHA advised the ANAO that enquiries were made by assessment panel members or panel secretariat staff to areas of the department that potentially funded health infrastructure projects, but as these enquiries revealed no instances of double dipping, no records were kept of this process. A better practice approach would have been to retain a written or electronic record of the enquiries that had been made and briefly note the completion of the checks in the assessment outcome report and subsequent FMA Regulation 9 advice to the financial approver.

3.5 Following a compliance check to determine whether applications complied with mandatory requirements¹⁰⁸, applications were assessed by a three to four member panel convened for each location. The panels were chaired at SES level¹⁰⁹, and included a medical adviser. All applications were reviewed by an independent financial adviser and a written report was provided to the relevant panel by the adviser.¹¹⁰

¹⁰⁶ There was also one instance in which no application was received in the initial non-competitive process.

¹⁰⁷ Double dipping refers to grant recipients being able to obtain grant funding for the same project purpose from more than one source. Agencies have long been required to specifically manage this risk, with the (then) Department of Finance and Administration maintaining a register of discretionary grants for this purpose until December 2008 and later through the Commonwealth Grant Guidelines, see Department of Finance and Deregulation, *Commonwealth Grant Guidelines: Policies and Principles for Grants Administration*, July 2009, p.16; ANAO Better Practice Guide *Implementing Better Practice Grants Administration*, June 2010, Canberra, p.47; and ANAO *Administration of Grants: Better Practice Guide*, May 2002.

¹⁰⁸ In the first round three applications were deemed to be non-compliant and excluded from assessment; other instances of non-compliance were considered minor and not grounds for excluding an application. In the second round, there were no instances where applications were excluded on the basis of non-compliance.

¹⁰⁹ The chair was usually the Assistant Secretary of the GP Super Clinics Branch, who provided a high degree of 'corporate memory' across the assessments of different locations, thus promoting consistency of assessment approach.

¹¹⁰ The report assessed applications against various factors including the proposed healthcare services, underlying management and business structures, the experience and capacity of the proponent, and financial and budget information.

3.6 Applications were assessed against selection criteria and given a numerical score out of 100. On occasion, further information was sought by the panel from applicants in order to complete assessments and score the application. In the case of non-competitive processes, such requests could go beyond minor clarification issues and involve the collection of significant amounts of information. Before making such requests, the panel sought advice from DoHA probity advisers.

3.7 Following the completion of assessments, the panel provided a written recommendation to the decision-maker (Division Head) as to whether a preferred applicant for the clinic location had been identified, along with copies of individual application assessment sheets, comparative assessment summaries, a project-specific risk management plan and a covering minute of advice drafted by the DoHA officers who sat on the panel.¹¹¹ The Division Head, who was also the departmental delegate authorised to give financial approval of GP Super Clinic grants under FMA Regulation 9, approved each of the panel's recommendations for the 36 clinics in the ANAO's sample. Where a preferred applicant was identified and approved, the Minister was notified of the assessment outcome. In the majority of cases in the ANAO's sample this was done via a short information brief for the relevant clinic, although DoHA advised the ANAO that on some occasions this information was instead provided to the Minister's office verbally, via email, or through general program update reports provided to the Minister's office.

3.8 Based on the numerical assessment score given by the panel, the extent to which the 'top-ranked'¹¹² applications met selection criteria varied greatly. The ANAO's analysis of top-ranked application scores for all locations where assessments were completed, found that scores for these top-ranked applications ranged from a low of 36 out of 100 in the first round through to a maximum of 100 in the second round. In terms of the average scores given in the initial scoring of applications, top-ranked non-competitive applications were scored lower (average of 60) compared to those applications for

¹¹¹ On a number of occasions the panel reached a view that no applications were acceptable as they failed to score a minimum of 50 out of 100, and hence did not recommend a preferred candidate. As discussed later in this chapter, in such cases advice was provided to the DoHA Division Head on alternative courses of action.

¹¹² The 'top-ranked' application was that with the highest numerical score assigned by the assessment panel. The term 'preferred applicant' was used only when the assessment process resulted in an application that DoHA recommended for a potential funding agreement.

competitively funded locations (average of 70)¹¹³, suggesting that overall, competitive processes resulted in higher quality applications being considered.

Addressing local needs

3.9 The importance of tailoring each GP Super Clinic to address local health needs was a key aspect of the 2007 GP Super Clinic policy. It is also a central consideration in assessing value for money, as each clinic should represent an effective use of grant funds to support improved local access to multidisciplinary and integrated primary healthcare, especially where there are recognised gaps in local services or facilities.¹¹⁴

3.10 The issue of local need was recognised, in part, in one of the program objectives—that clinics were required to demonstrate that they were ‘responsive’ to local community needs and priorities. Information on the nature of local needs was available to applicants and the panel through a number of sources:

- DoHA provided local demographic and health statistics and guidance to applicants as part of its ITA documentation process. This data was readily available and was considered by DoHA to reflect unmet demand for healthcare services;
- where DoHA had undertaken local consultation sessions before opening the ITA, reports from these sessions provided relevant information. However, DoHA did not provide the reports from local consultation sessions to all members of the assessment panels nor were the reports explicitly discussed in panel deliberations¹¹⁵;
- letters of support accompanying applications from organisations within the local community provided a potential source of information on the appropriateness of particular proposals, although the quality of letters provided by applicants varied widely; and

¹¹³ The ANAO also calculated the median numerical scores of the top-ranked applicant for the competitive and non-competitive processes across both rounds. These broadly corroborated the observed difference in the average scores between the two processes, with competitive processes having a median score of 69 compared to 62 for non-competitive processes.

¹¹⁴ The Commonwealth Grant Guidelines emphasise that a fundamental appraisal criterion is that a grant should add value by achieving something worthwhile that would not occur without grant assistance. See *Commonwealth Grant Guidelines*, op. cit., p. 30. See also 2002 ANAO Better Practice Guide—*Administration of Grants*, op. cit., p.39 and 2010 ANAO Better Practice Guide—*Implementing Better Practice Grants Administration*, op. cit., p.64.

¹¹⁵ Specifically, it was noted by a medical adviser that while having these reports was not critical for undertaking the assessments, as other panel members were aware of the issues raised in them, these reports would have been helpful in the context of better understanding local needs and how the applications addressed them.

- some applications provided information on consultations between applicants and health providers relating to community need as well as indicating opportunities for an integrated approach to service planning and delivery.

3.11 The ITA documents and applicant responses relating to the program objective discussed above were the basis for panels to assess and decide on whether an applicant would be responsive to local needs. In the sample of applications examined by the ANAO, significant variability was observed in applicant responses to this issue. Similarly, the panel medical advisers interviewed by the ANAO indicated that the amount of relevant information contained in applications varied and they sometimes attempted to extrapolate information to distinguish whether the services proposed in applications genuinely reflected the needs of the relevant local community rather than just 'looking good on paper'.

3.12 The panel chairperson would sometimes contact applicants to clarify information. However, panels rarely attempted to test the claims or information provided in applications by interviewing applicants or local stakeholders.

Considering the impacts of GP Super Clinics on existing health services

3.13 Public commentary on the GP Super Clinics program has raised the issue of adverse impacts on existing GP practices.¹¹⁶ Criticisms have included that Commonwealth funding has provided a subsidy to recipients that gives them a financial advantage over their local competitors.

3.14 The program guidelines required that applications 'insofar as possible', detail 'the extent to which the proposed GP Super Clinic could have an impact on these existing services'.¹¹⁷ However, the application assessment process, including assessment panel deliberations, did not explicitly consider the issue of whether a proposed clinic would impact on existing GP practices.

¹¹⁶ N Bitá, 'Doctor dearth: why super surgeries are clinically dead', *The Australian*, 13 August, 2011. Australian Medical Association, 'GP Super Clinics—Another example of failing to consult with the medical profession', media release, 9 February 2011.

¹¹⁷ Department of Health and Ageing, *GP Super Clinics national program guide 2008*, p. 15. Department of Health and Ageing, *GP Super Clinics national program guide 2010*, p. 25.

3.15 DoHA advised the ANAO that the department did not have access to independent data on which to reach a conclusion on the impacts of a proposed clinic on existing services, as confidential information regarding privately owned general practices was either not available or unlikely to be made available. As a consequence, DoHA did not attempt to collect information on existing GP practices (or allied health facilities and services) in the selected localities. DoHA further advised the ANAO that proposed clinic locations were in areas where health and demographic data indicated there was 'unmet demand in relation to access to multidisciplinary, team-based services focussed on chronic disease that are at the core of the purpose of GP Super Clinics. The inference of impact on existing GP services is not sustainable as they are not meeting population health needs in relation to the management of chronic disease.' However, this 'no impact' position assumes that there will be minimal overlap between the types of services provided by existing GP practices and GP Super Clinics. The ANAO does not consider that there is any GP Super Clinic reporting information that corroborates this assumption. Providing more comprehensive information on existing health services to assessment panels would have reduced the potential that GP Super Clinics would have unintended impacts on existing services.

3.16 On occasions, GP Super Clinics were built close to existing GP practices. Whilst the audit did not assess the direct business or economic impacts of these clinics on existing healthcare services, the ANAO's attention was drawn to the Palmerston GP Super Clinic in the Northern Territory, which was built less than 50 metres from the existing Farrar Medical Centre. The question of direct competition with established local practices was raised during public consultation, including the risk that GPs would move from existing practices to the GP Super Clinic.¹¹⁸

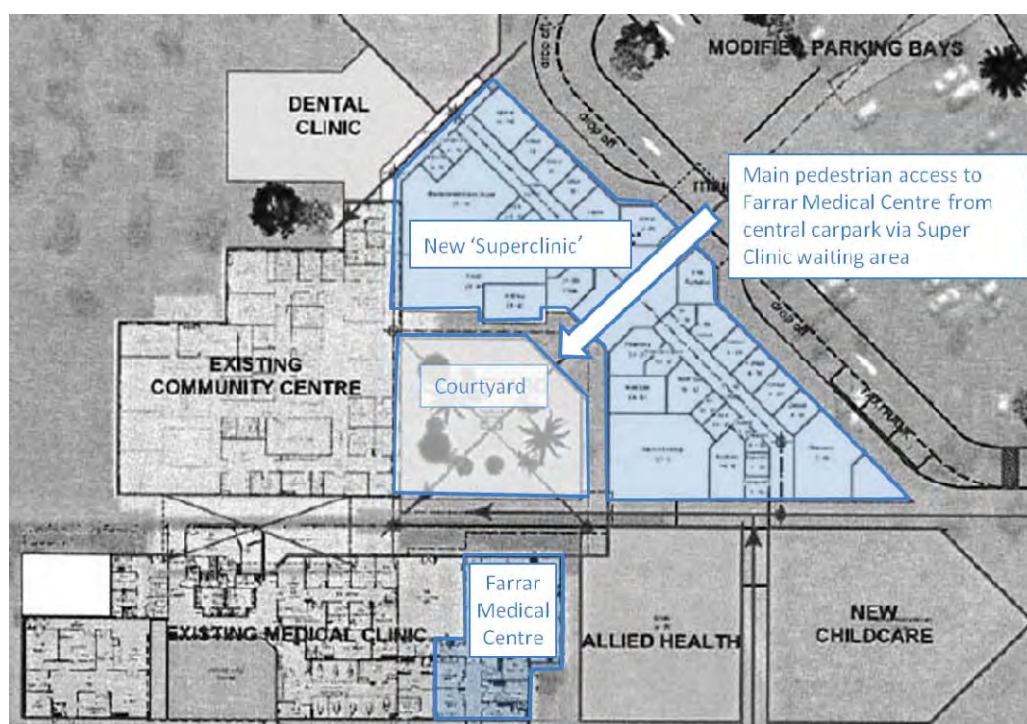
3.17 The ANAO was informed by the principal GP and the practice manager of the Farrar Medical Centre that during the approximately 10 month construction period for the GP Super Clinic, access to the practice had been severely hampered and it had experienced a significant loss of earnings during this period. Further, with the completion of the Palmerston GP Super Clinic in 2010, the main pedestrian access to the Farrar Medical Centre from the central carpark servicing the area is now via the waiting area of the GP Super Clinic.

¹¹⁸ It has since been reported by the Northern Territory Department of Health that the majority of GPs at this GP Super Clinic had come from outside the Northern Territory.

The GP practice advised the ANAO that this has made it more difficult for injured, elderly and disabled patients to access their premises. Whilst the practice supported four GPs before the start of construction of the GP Super Clinic in late 2010, it now has one GP. The remaining GP advised the ANAO that the practice's loss of physical visibility from the street and carpark due to the positioning of the GP Super Clinic meant that the practice was not able to generate enough 'walk in' patients to enable it to grow. This issue had led to one newly recruited GP to leave the practice in May 2011, while another GP had transferred to the GP Super Clinic. Figure 3.1 is a site plan of the Palmerston GP Super Clinic showing the layout of the Super Clinic in relation to the Farrar Medical Centre.

Figure 3.1

Site Map of Palmerston GP Super Clinic



Source: Based on DoHA information.

Notes: The Farrar Medical Centre is now known as the Palmerston Work Injury and GP Clinic.

In 2013, the operators of the Palmerston GP Super Clinic are planning to undertake an internal refit of the Allied Health facility shown immediately to the right of the Farrar Medical Centre in the above site map.

3.18 The assessment panel for the Palmerston clinic noted ‘the location of the proposed clinic was adjacent to a number of existing...private health providers’. However, the issue of potential impacts on these providers, including the Farrar Medical Centre, was not substantively addressed or identified as a significant issue in the panel’s advice to the delegate. Rather, the focus of relevant risks highlighted in the advice was the integration of the clinic with the local Aboriginal Medical Service, and ensuring that appropriate levels of privately practising GPs and allied health professionals would work at the clinic. DoHA’s risk management plan did provide that a local workshop with existing healthcare providers be held to discuss the mix of services to be offered at the GP Super Clinic. Whilst a representative of the Northern Territory General Practice Network did attend this meeting at DoHA’s invitation, no representatives from existing GP practices were invited.

Assessment of value for money

3.19 The GP Super Clinics program is subject to the *Commonwealth Grant Guidelines* (CGGs), which state that achieving value with public money should be a prime consideration in all aspects of grants administration. This key principle reflects the requirement of the Australian Government’s financial management framework, which provides for the ‘proper use’ of Commonwealth resources.¹¹⁹ The requirement for proper use predates the introduction of the CGGs in July 2009, and applies to all spending proposals under the GP Super Clinics Program.

Guidance on value for money

3.20 The assessment plans for each GP Super Clinic location included guidance on the factors to be considered by the assessment panel in reaching a view on the value for money offered by an application. This guidance changed between the two rounds. The ‘whole of life construction cost’ and ‘risk’ factors that featured in the first round guidance were merged in the second round into a broader concept incorporating the efficiency and effectiveness of the capital works. Table 3.1 provides a summary.

¹¹⁹ ‘Proper use’ in this context means the ‘efficient, effective, economical and ethical use of Commonwealth resources that is not inconsistent with the policies of the Commonwealth’, as specified in section 44 of the *Financial Management and Accountability Act 1997* and FMA Regulation 9. Often, this is referred to as a ‘value for money’ test.

Table 3.1**Value for money—factors to be considered in assessing applications**

First Round	Second Round
'Contribution made towards the program objectives'	'Meeting the program objectives'
'Whole of life construction costs'	'How the capital works project will promote the use of resources in an efficient, effective and ethical manner for whole of life costs'
'Risks e.g. the capacity of the applicant to deliver on time and on budget, including the whole of life construction costs'	No specific guidance was provided in application assessment plans on assessing risk as part of value for money considerations

Source: ANAO analysis of DoHA information.

3.21 The ANAO examined the panel's advice to the Division Head on value for money, including the individual assessment sheet for the preferred applicant¹²⁰, the assessment outcome report¹²¹ and the covering minute to the Division Head. The ANAO also reviewed the independent financial adviser's report.¹²²

Physical infrastructure

3.22 DoHA's approach to assessing the value for money of physical infrastructure construction was based on the expectation that applicants would not necessarily provide a fully-costed proposal to professional standards. DoHA advised the ANAO that one of the reasons for adopting this approach was to not deter potential applicants from applying by demanding precise costings and drawings that required a potentially considerable financial outlay on professional advice. Applicants were only required to submit indicative floor and site plans. DoHA further advised that it was reluctant to impose additional costs on applicants as it was mindful that many proposals were subject to a range of processes which had yet to take place; such as council planning and development approval processes or possible land purchases.

¹²⁰ The individual assessment sheets contained detailed comments and a numerical score against each selection criterion, as well as noting the grant amount applied for.

¹²¹ The assessment report summarised the main points of each application, the overall numerical score given to each, a summary of the financial adviser's report on the preferred applicant, and a summary of why the assessment panel considered the preferred candidate's application represented the best value for money.

¹²² The ANAO sample comprised 36 of the 65 clinic locations. It was a targeted, non-statistical sample, consisting of 22 clinics from the first round (including one of the clinics announced in 2009) and 14 from the second round. Further details of the sample are in Appendix 2.

3.23 In their assessment of value for money of physical infrastructure, DoHA advised the ANAO that panel members and panel secretariat support officers had access to guidance provided by DoHA's Independent Construction Adviser on average per square metre construction costs and 'any applications that included indicative costs that fell outside the guide were highlighted to the panel'. However, the construction adviser was only contracted by DoHA in mid 2009, by which time the assessment process for almost all of the 32 initially announced clinics was complete. The ANAO observed that issues of building costs, scale and design elements were considered by the panels in their deliberations, although there was no specific reference in the assessment documentation to the square metre construction costs guidance material provided by the Independent Construction Adviser. DoHA also advised the ANAO that no records were kept of any advice provided to the assessment panel that 'highlighted' construction costs that fell outside the relevant costs contained in the guidance material. Some financial advisers' reports included commentary on construction costs or building design, which the relevant panels took into account in their assessments.

3.24 In the sample of 36 clinics examined by the ANAO, the assessment panels expressed concerns on four occasions about high construction costs contained in the proposals of preferred applicants. In all four cases, the issue was noted in the assessment outcome documentation for approval by the Division Head, although it was not evident in the documentation whether these concerns were reflected in the numerical score given to the proposal.

3.25 Across the 36 locations in the sample used by the ANAO, there was variable treatment in the assessment documentation of whether construction costs represented value for money, often with little or only rudimentary analysis of the issue. The 'value for money' summary in the covering minute to the Division Head tended to be very formulaic. In some assessment outcome reports, commentary on construction costs sometimes appeared in the value for money section, while in other cases an assessment was found elsewhere in the report—such as the financial assessment or summary of assessment. In some cases, there was no substantive assessment at all, just a descriptive statement about the proposed cost of, and/or the timeframe for, the project.

Service delivery

3.26 Assessing value for money in service delivery was a demanding task for assessment panels, not least because each location presented a unique set of circumstances and needs. The broad approach taken by assessment panels was

to consider advice from the independent financial adviser as an input to a more extensive consideration of the applicants' representations, including:

- an overall assessment of whether a proposed business model and clinical governance structure was likely to be viable, sustainable and efficient;
- the proposed service mix;
- the degree to which additional, multidisciplinary services would be provided; and
- whether integration of services would be achieved, including with existing services.

3.27 In the assessment process, the panel sought to determine which proposals were capable of establishing a viable clinic delivering integrated, multidisciplinary primary health care while also providing increased education and training placements in that setting. The reports of the independent financial adviser, in particular, examined the clinical service model and whether it would be workable in practical terms, how appropriate the clinical strategy and service mix was in terms of the health needs of the community, whether the model was viable in terms of delivering the program objectives, and whether there was likely to be a workforce to implement the model. These inputs added value to the assessment process.

Assessing larger grants

3.28 There was an added dimension to achieving value for money, as grant amounts varied. Notably, in the second round of funding, eight proposed clinic locations were eligible for larger grants of up to \$15 million. For these grants, the program guidelines specified that applications had to include information on the specialised services to be delivered.¹²³

3.29 As part of its sample, the ANAO examined the proposals of the preferred applicants for six \$15 million locations.¹²⁴ While the application form referred to the need to provide information on specialised services and each of

¹²³ Illustrative examples of these specialised services were described in the guidelines as including renal dialysis, palliative care, chemotherapy, hospital in the home support and/or home and community care services. *GP Super Clinics national program guide 2010*, pp. 24-25.

¹²⁴ There were a total of eight locations in the second round where the maximum grant amount was \$15 million.

the proposals made provision for the delivery of specialised services, the issue did not consistently receive any attention in assessment documentation.¹²⁵

3.30 For one of the \$15 million locations considered in the second round, the preferred applicant revised their proposal during funding agreement negotiations. DoHA recognised that as a consequence of these amendments specialised services envisaged for the site may not be incorporated. The matter was raised with the Minister's office, which indicated that it was appropriate to proceed nonetheless. However, information about not providing specialised services at this location was not contained in the written advice to the decision-maker with responsibility for approving the grant under FMA Regulation 9, nor is there any indication on the face of the approval that the delegate was aware of this matter.

3.31 DoHA advised the ANAO that 'the Guidelines note the expectation that applicants for larger clinics (\$15 million) must include information on the specialised services to be delivered in these facilities however this was not a key factor in approving these grants. Assessment panels viewed the provision of a greater level and range of general health services (as opposed to specialised services), that were consistent with the local community's needs, as equally important.' However, the second round guidelines, having been approved by the ERC, represented government policy in respect of the GP Super Clinics program. The Government's 2010 budget announcements also indicated that specialised services were an important part of the rationale to provide larger grants.¹²⁶ From this perspective, it was inappropriate for DoHA to effectively downgrade the issue of specialised services in its assessment process without Ministerial agreement; which was not evident in the cases sampled by the ANAO. Overall, DoHA did not explicitly assess whether the value added by the proposed specialised services justified the higher (\$15 million) grant amount in the sampled locations.

¹²⁵ This included the relevant application assessment plan, individual assessment sheets, outcome assessment reports, and minute of advice to the expenditure delegate (DoHA Division Head).

¹²⁶ N Roxon, (Minister for Health and Ageing), 'More GP Super Clinics and Extra GP Infrastructure', media release, Canberra, 11 May 2010.

A way forward in considering value for money

3.32 Value for money was considered in the August 2012 report on the *Evaluation of the GP Super Clinics Program 2007-2008* commissioned by DoHA.¹²⁷ It was recommended that:

the Department should commission a review of existing templates and the preparation of specific value for money criteria for future use in assessment of funding applications for GP Super Clinics.¹²⁸

3.33 This recommendation applied to the first round of GP Super Clinic funding. To address these issues in the longer term, the evaluation proposed that:

The Department should consider longer-term approaches for assessing value for money in the context of primary care.¹²⁹

3.34 DoHA's September 2012 response to the evaluation recommendations did not commit to any action in response to the two recommendations concerning value for money or indicate whether the recommendations had otherwise been addressed by the department. While noting that the assessment processes for all GP Super Clinic locations have now been completed, there would be merit in DoHA considering the above recommendation in the context of any future or ongoing health infrastructure grant programs.¹³⁰

3.35 Administering health infrastructure grants programs has been an increasingly significant activity for DoHA in recent times. DoHA advised the ANAO that their capital works reporting portal indicates that the department has funded over 1300 capital works projects, with total DoHA funding exceeding \$8 billion. The ANAO has observed in previous audits¹³¹ that DoHA has over time strengthened its capacity to effectively administer infrastructure grant programs, informed by practical experience and initiatives such as the establishment of the Centre for Capital Excellence within the department,

¹²⁷ Consan Consulting, *Evaluation of the GP Super Clinics Program 2007-2008*. August 2012. The value for money methodology used in the evaluation focused on physical infrastructure, and included: location, construction type and complexity and timing.

¹²⁸ *Evaluation of the GP Super Clinics Program 2007-2008*, op. cit., p. 66.

¹²⁹ *ibid.*

¹³⁰ The ANAO's recent audit report on the administration of the Primary Care Infrastructure Grants Program also made a recommendation regarding more consistently applying better practice regarding the assessment of value for money in health infrastructure grant applications. That recommendation was accepted by DoHA. ANAO Audit Report No.44 2011-12 *Administration of the Primary Care Infrastructure Grants Program*, p.66

¹³¹ ANAO Audit Report No. 45 2011-12 *Administration of the Health and Hospitals Fund*, p.18; ANAO Audit Report No.44 2011-12 *Administration of the Primary Care Infrastructure Grants Program*, p.15.

comprising staff with expertise in infrastructure project management. In light of the experience gained by the department in the administration of infrastructure projects over some years, there is scope to draw on that experience to document a better practice approach for the assessment of value for money for health infrastructure projects.

Recommendation No.2

3.36 To maximise the benefit from DoHA's experience in the administration of health infrastructure grant programs, the ANAO recommends that the department document a better practice approach for the assessment of value for money for health infrastructure projects.

DoHA response:

3.37 *Agreed.*

Treatment of unsuccessful Invitation to Apply processes

3.38 It is better practice for applications to be assessed using a common appraisal process—where there is a departure from this process the reasons should be documented.¹³² DoHA's assessment documentation recognised that the ITA process may not be successful in identifying a preferred applicant, and this was reflected in assessment plans which stated that successful applications must score a minimum numerical score of 50 per cent. Where this was not achieved, the assessment plans in place for each clinic included a range of options for DoHA to consider. These options included negotiating with an applicant and/or brokering a local solution by engaging with local stakeholders. The possibility of adopting one of these options was explicitly noted in the publicly available guidelines for the second round, but not for the first.¹³³

¹³² ANAO 2002 *Grants Administration—Better Practice Guide*, p.43; ANAO 2010 *Better Practice Guide—Implementing Better Practice Grants Administration*, p. 70; *Commonwealth Grant Guidelines*, op. cit., p. 29.

¹³³ Department of Health and Ageing, *GP Super Clinics national program guide 2010*, p. 25.

3.39 The ANAO identified 11 cases across the entire population of 65 clinic locations where the initial ITA process was unsuccessful in producing a preferred applicant. These included:

- one case in which the only application for the location was non-compliant with the ITA requirements due to lack of key information;
- three cases where the location failed to attract any applications; and
- seven cases where the top-ranked candidate failed to score above 50 per cent or was otherwise assessed as ‘marginal’.¹³⁴

3.40 There was one further case in which funding agreement negotiations failed, resulting in the preferred applicant withdrawing their proposal. DoHA closed the ITA and attempted to broker a local solution, as all of the other applications in that competitive process scored less than 50 per cent. This approach resulted in a revised proposal being submitted by an applicant that was previously unsuccessful for the location.

3.41 In cases where the assessment panel considered the ITA process did not produce a suitable proposal that they could recommend as a preferred applicant, DoHA took the step of first briefing the decision-maker (Division Head) on the views of the assessment panel and any risks or issues identified through the assessment process. This advice also identified a range of options for next steps, such as: closing the ITA process and approving the commencement of negotiations with the top-ranked applicant¹³⁵, and/or other local stakeholders—such as local councils, local Divisions of General Practice and existing local or regional healthcare service providers—in order to generate a new or substantially revised application. In some cases this approach involved offering an interim funding agreement to the top-ranked candidate or another party to facilitate a new or substantially revised proposal, or re-running the ITA process from the beginning.

3.42 There was evidence that DoHA took steps to ensure that in developing these options it received probity advice that assessment processes and

¹³⁴ In one further case in the first round, the proposal went ahead despite not being scored by the panel. The panel considered that the information was insufficient to provide a numerical score, but recommended that the department enter into funding agreement negotiations to resolve identified risks. The recommendation was accepted and following further negotiations, an agreement was signed.

¹³⁵ A top-ranked applicant differs from a preferred applicant in that the latter refers to an application that DoHA recommends for a potential funding agreement.

recommended procedural options complied with probity and transparency requirements.

3.43 In the first round, the decision whether to close the ITA and pursue alternative options was made by the department, generally by the Division Head, although on one occasion the decision was elevated to the departmental Secretary. Once DoHA had made the decision, the Minister was provided with an information brief on steps taken by the Department.

3.44 In the second round, the Minister was involved earlier, particularly in the case of non-competitive processes that had received a poor or marginal quality application. In these cases DoHA, after assessing the proposals, advised the Minister on the risks identified and provided options on a way forward for a decision by the Minister. The options canvassed in the advice differed depending on the circumstances, but variously included offering an interim funding agreement to the applicant, running the process again as a competitive process, or withdrawing funding for the relevant location.

3.45 The provision of limited funds under an interim funding agreement to further develop proposals was adopted on several occasions as a way to manage risk. Typically under such agreements up to 10 per cent of total funding was provided to applicants and/or local stakeholders to support the development and refinement of proposals for resubmission to DoHA before considering entering into an agreement for the remaining funding amount. The specific requirements of such interim funding agreements varied but often required recipients to provide more project and budgetary detail than would otherwise be expected of initial GP Super Clinic applications.

Assessment of revised or new applications following unsuccessful ITA processes

3.46 Once a revised or new application was provided to DoHA, it was forwarded to the financial adviser for a report in the usual manner. Following this, a variety of strategies and responses were used by DoHA to assess applications. In both the first and second rounds, these ranged from reconvening the relevant assessment panel to DoHA internally assessing applications. This latter option meant the proposal was not scored, and the assessment did not have the benefit of input from a medical adviser. Nonetheless, the ANAO found that, based on its sample, there was evidence that the shortcomings and risks identified in the original assessments were scrutinised as part of the assessment of revised or new proposals, and this was reflected in the advice to the expenditure delegate and Minister as to whether

the application represented value for money and would achieve program objectives. In one second round case in the ANAO's sample, the assessment outcome advice provided to the Minister noted that entering into a full funding agreement on the basis of the revised proposal carried substantial risks. In view of this, one option proposed in the advice was closing the ITA and withdrawing the announced funding. The Minister approved an alternative option of seeking to mitigate the risks through DoHA negotiating directly with the applicant. After several months of negotiations, a funding agreement was executed.

Conclusion

3.47 DoHA established a generally sound and well documented framework for assessing applications. The department made extensive use of relevant expertise from medical and independent financial advisers and accessed probity advice to align its approach with better practice in grants administration.

3.48 While the GP Super Clinics program guidelines required applications to address the extent to which a proposed clinic could impact on existing health services, this issue was not explicitly or substantively considered in the overall application assessment. In one case in the ANAO's sample, the positioning and design of a now operational GP Super Clinic in 2010 has resulted in the main pedestrian access to a pre-existing GP practice being via the waiting area of the new GP Super Clinic. DoHA faced challenges in determining whether applications for funding would meet local needs and whether a proposed clinic would affect existing health services. There was limited, if any, specific information from independent sources about existing health services available to assessment panels, which had to rely almost entirely on information contained in applications, which was of variable quality. Providing more comprehensive information on existing health services to assessment panels would have reduced the potential that GP Super Clinics would have unintended impacts on existing services.

3.49 The ANAO observed a number of opportunities for DoHA to improve how it assessed value for money. In respect of the assessment of physical infrastructure, assessment panels were not asked to use commercially available 'cost per square metre calculation' tools during the first round. The consideration of value for money was also hampered by a lack of clear and specific guidance to assessment panels on assessing the value for money of physical infrastructure, resulting in a lack of clarity and consistency in how the

concept was applied in the assessment and selection process. In terms of the services to be delivered by clinics, of the six locations in the ANAO's sample where a grant of up to \$15 million was available to establish a GP Super Clinic, DoHA did not explicitly assess whether the specialised services required under the program guidelines for these locations were appropriately addressed in the applications.

3.50 In instances where the initial Invitation to Apply process did not identify a successful applicant, DoHA used a variety of strategies and processes to generate new or substantially revised applications and subsequently assess the merits of those applications. The processes adopted in these cases were generally adequate and there was a positive trend in the second round where DoHA involved the Minister earlier in advising on risks and options, especially where non-competitive processes were involved. However, the absence of a full panel assessment in some instances meant that the expertise of a medical adviser was not used in assessing some applications.

4. Rolling out the Clinics

This chapter examines how DoHA administered the program from the completion of the assessment process to getting clinics into operation. It focuses on the major issues that arose during this period and DoHA's response to manage risk, including issues that potentially led to financial risks and delays

Introduction

4.1 As discussed in chapter three, the majority of applicant assessment processes resulted in the assessment panel recommending a preferred applicant.¹³⁶ On nine occasions across all clinic locations the panel recommended that the preferred applicant be immediately offered a grant funding agreement by DoHA. However, in 44 locations, the panel identified one or more issues that had arisen in the assessment process, and which it considered as requiring resolution or clarification with the preferred applicant before a funding agreement could be offered. In these instances, DoHA sought to deal with outstanding issues in 'without prejudice' negotiations with the applicant.

4.2 The time taken to conclude negotiations with preferred applicants varied considerably. In the ANAO's sample, negotiations for four clinics took over six months before a funding agreement was executed. On a number of occasions, external legal advisers were asked to provide advice to DoHA on complex property, commercial, contract and taxation matters that arose in negotiations. The resolution of these matters, when they arose, generally added to the time taken to conclude negotiations.

Financial approval of grants

4.3 Where the assessment panel recommended the immediate offer of a funding agreement, the departmental decision-maker (the Division Head) gave financial approval under Regulation 9 of the Financial Management and Accountability Regulations 1997 (FMA Regulation 9).¹³⁷ Where the assessment

¹³⁶ Exceptions occurred where either no applications were received or where no application was assessed as having sufficient merit / carrying acceptable risks to potentially fund.

¹³⁷ Regulation 9 requires the decision maker to be satisfied, after making reasonable inquiries, that giving effect to the spending proposal would be a proper use of Commonwealth resources. Under the Commonwealth's financial framework, the overall test for the 'proper use' of public money is the 'efficient, effective, economical and ethical use of Commonwealth resources that is not inconsistent with the policies of the Commonwealth'. Often, this is referred to as a 'value for money' test.

panel recommended that specified issues required resolution or clarification, in all but three cases DoHA deferred financial approval until the negotiations were completed.¹³⁸

4.4 In the first round, the advice to the decision-maker accompanying the FMA Regulation 9 recommendation generally lacked any information on how the negotiated issues had been resolved. Updated project-specific risk management plans were attached to the Regulation 9 advice, but these did not always record the specific issues that were the subject of funding agreement negotiations. DoHA advised the ANAO that the decision-maker ‘was constantly advised verbally and in writing about all matters impacting on the funding decision...and how negotiation issues were resolved.’ However, it has long been recognised that it is sound practice to document the basis on which an approver has made a decision in respect to grant funding under FMA Regulation 9.¹³⁹ In addition, since 1 July 2009, FMA Regulation 12 has explicitly required the approver of a grant to make a written record of the basis on which they are satisfied that the spending proposal complies with FMA Regulation 9.

4.5 In the case of the Redcliffe project, the relevant assessment panel identified risks to the preferred applicant’s capacity to finance the project. While DoHA had raised these issues in an initial negotiating teleconference with the preferred applicant, the Redcliffe Hospital Foundation, the subsequent advice to the Regulation 9 decision-maker of January 2009 made no specific reference to these issues and the approval was given for a grant of \$5 million in the first round. In the event, the recipient was unable to secure a loan to fund the remainder of the Redcliffe project¹⁴⁰, notwithstanding the receipt of an additional \$5 million in grant funding in the second round. Ultimately DoHA provided a third grant of \$3.2 million to complete construction at a total cost of \$13.2 million.¹⁴¹

4.6 There was a change of approach in the second round. Advice to the Regulation 9 decision-maker included a summary of the issues that had been

¹³⁸ In these cases, which were all first round clinics, conditional Regulation 9 financial approval was given before DoHA started funding agreement negotiations.

¹³⁹ ANAO 2002 *Better Practice Guide—Administration of Grants*, p. 22.

¹⁴⁰ The funding recipient, the Redcliffe Hospital Foundation, was created under, and subject to specific Queensland legislation, and therefore required approval from the Queensland Government to take out loans that were intended to co-finance the construction of the Super Clinic.

¹⁴¹ Completion of the base building was achieved in January 2012. Partly due to complications over the selection of a third-party clinic operator, which was a condition of the Commonwealth’s \$3.2 million ‘top-up’ grant, the clinic was not expected to open until mid 2013.

negotiated with the preferred applicant, and importantly, how these matters had been resolved. This improved the transparency of DoHA's project risk management and provided additional information to the decision-maker to more fully inform them in reaching a view on whether offering a funding agreement to the preferred applicant would constitute a proper use of Commonwealth resources.

4.7 With one exception, where an FMA Regulation 10¹⁴² approval was necessary, it was obtained before giving Regulation 9 approval as required by the financial framework. This instance of non-compliance was reported in DoHA's 2010–2011 Certificate of Compliance.¹⁴³ However, there were at least seven clinics in the first round where funding agreement negotiations resulted in different funding profiles¹⁴⁴ to that in the Regulation 10 approval. In such circumstances, these approvals should have been varied.¹⁴⁵ This oversight was subsequently remedied by DoHA. In the second round, rather than seeking individual Regulation 10 approvals for each clinic, DoHA adopted the practice of obtaining a 'bulk' Regulation 10 approval covering all clinics. This approval was subsequently varied a number of times in 2011 and 2012 to reflect a changed program funding profile resulting from delays in establishing relevant clinics.

4.8 Regulation 8 of the financial framework prohibits the Commonwealth from executing a grant funding agreement unless Regulation 9 approval has been obtained. In all cases, Regulation 9 approval was obtained before execution of the funding agreement.

Mandatory public reporting of the GP Super Clinics grants

4.9 The *Commonwealth Grant Guidelines* include a mandatory public reporting requirement for grants, specifying that information on individual grants must be published on the relevant administering agency's website no later than seven working days after the funding agreement for the grant takes

¹⁴² Regulation 10 of the Australian Government's financial management framework requires the prior approval of the Finance Minister or a delegate to a proposed commitment of public money where there is no current appropriation. It is typically required for multi-year spending proposals, or where a commitment is entered into in one year and payments are due in a subsequent year.

¹⁴³ The Certificate of Compliance is an annual report prepared by all FMA agencies advising the responsible Minister (and copied to the Finance Minister) of the agency's compliance with the financial management framework.

¹⁴⁴ Where grant funds were to be paid in multiple instalments over two or more financial years, the term 'funding profile' means the various total amounts that were to be paid in each successive financial year.

¹⁴⁵ In the first round, Regulation 10 approvals were generally sought just before the start of the ITA process, which was often several months before any funding agreement negotiations.

effect. Before the guidelines were introduced in July 2009, Commonwealth agencies were subject to similar mandatory public reporting requirements under the Finance Minister's instructions of 19 December 2007¹⁴⁶ and 16 January 2009.¹⁴⁷

4.10 DoHA did not comply with these public reporting requirements for around 50 per cent of all GP Super Clinics grants, including several grants awarded in 2012. The extent of the non-compliance was discovered by DoHA after the ANAO sought information in the course of the audit, although 23 breaches of the public reporting requirement for GP Super Clinics grants were also recorded in DoHA's 2011–12 Certificate of Compliance. DoHA advised the ANAO that it has, both at a departmental and divisional level, 'implemented revised processes to increase awareness of the reporting requirements and to minimise the potential for future non-compliance with grant reporting'.

Managing the clinic roll-out

4.11 Across the program as a whole, management of the clinic roll-out once funding agreements were executed took considerable effort by DoHA. At a minimum, DoHA was required to verify the achievement of a number of milestones by the recipient, some of which triggered progress payments. The number and complexity of the milestones increased substantially as the standard form funding agreement was amended six times over 2008–2012. Under the current (August 2012) version of the funding agreement, approval from DoHA to commence clinic construction is the 8th milestone, while the commencement of clinic operations is the 13th and final milestone.¹⁴⁸ A range of pre- and post-commencement progress reports must also be submitted by the recipient.

4.12 The changes made to the standard funding agreement over time reflected the experience acquired by DoHA, and were intended to respond to specific issues that arose in the course of the roll-out as more clinics passed through the funding negotiation, construction, and operational stages. The more significant issues, and DoHA's response, are outlined below.

¹⁴⁶ These required reporting within two days of the announcement of the grant.

¹⁴⁷ These required reporting within seven days of the execution of the grant funding agreement.

¹⁴⁸ These milestones include reports on property acquisition, and would not be required if the recipient already owned the relevant property.

Potential funding shortfalls

4.13 Financial issues mainly arose where recipients were unable to secure contributions or loans that had been anticipated in their proposals, or where capital costs (construction or land acquisition) were greater than anticipated in original applications.

Contributions or loans

4.14 From the outset, in the first standard form funding agreement, recipients were required to warrant that the grant funds, in combination with any other contributions to be made or received by them, would be sufficient to complete the project. In some instances, applicants intended to source these contributions primarily or partly through loans. This was the case for instance in the Redcliffe project. As the recipient, the Redcliffe Hospital Foundation was created under, and subject to specific Queensland legislation, it required approval for loans from the Queensland Government. It had not secured the necessary Queensland approvals at the time of the execution of the initial (first round) or subsequent (second round) GP Super Clinic funding agreement¹⁴⁹, and ultimately the Queensland Government refused to provide approval, citing serviceability concerns amongst others.¹⁵⁰ The recipient was thus unable to complete construction of the clinic—which had remained broadly on budget—until the Commonwealth made a third, ‘top-up’ grant of \$3.2 million in October 2011, outside of the regular merit-based GP Super Clinic process. The third grant was made in the context of the threat of legal action by the builders against the grant recipient for unpaid bills.¹⁵¹

¹⁴⁹ The financial risk to the Redcliffe project arising from the lack of confirmed loan funding was clearly flagged in the assessment panel's advice regarding the proposed second round grant. The panel recommended the applicant 'provide a sound financial strategy' as part of funding agreement negotiations. The subsequent advice accompanying the Regulation 9 recommendation stated that those risks had been addressed by requiring the applicant to deliver a financial action plan shortly after the execution of the funding agreement. That plan was subsequently delivered, triggering a progress payment of \$1.1 million.

¹⁵⁰ The Redcliffe Hospital Foundation was subject to a 'qualified opinion' by the Queensland Auditor-General in respect of its 2011 financial statements: Auditor-General of Queensland, *Report to Parliament No. 11 for 2011*, p. 34. The opinion related to the Auditor-General's finding that the Foundation breached its procurement obligations in the manner it awarded the building contract (it did not go to open tender), and that the funding shortfall in the GP Super Clinic project raised significant uncertainty over the organisation's financial position. A qualified opinion was likewise issued in respect of the Foundation's financial position contained in 2012 financial statements: Auditor-General of Queensland, *Report to Parliament No. 5 for 2012–13*, p. 72.

¹⁵¹ DoHA provided advice to the Minister outlining a number of options in respect of the funding shortfall at Redcliffe. The Minister approved the option of reallocating \$3.2 million of existing GP Super Clinic program funds to allow for the completion of the project. The subsequent FMA Regulation 9 approval by DoHA of 12 October 2011 does not explicitly record the basis on which the additional funds represent a proper use of Commonwealth resources. As such, the approval is not consistent with the requirements of the Commonwealth financial framework under FMA Regulation 12, which requires the basis of all grant approvals to be documented.

4.15 In early 2012, in the light of experience, DoHA amended the standard form funding agreement to provide that *before* acquiring land or awarding a construction contract, the recipient must declare it has, or has *unconditional* access to, funds sufficient to complete the project.

Managing project budgets

4.16 The major capital cost item in the majority of projects was clinic construction, and where land was being purchased, land. From the inception of the program, the standard form funding agreement made it clear that the recipient carried the risk of any cost escalation once the funding agreement was executed. Funding agreements also required a detailed project plan and budget as an early milestone. Whilst these were initially assessed solely by departmental officers, from mid 2009 these documents were also referred to an external construction adviser for assessment. The project plan and budget required DoHA's approval before the project could proceed.

4.17 In order to assess the scope of any capital cost escalations, the ANAO reviewed the 24 clinic final construction reports submitted to DoHA as at December 2012.¹⁵² While the comprehensiveness of the budget information in these reports varied, overall they indicated a relatively low level of variance between the projected budget costs and the final construction costs. There were only three instances where the increases between the projected and actual construction costs was reported as exceeding 10 per cent. In the case of one clinic DoHA was unable to locate the construction report and could not demonstrate that it had been received by the department.

4.18 Escalation of capital costs led to the termination of one grant – Sorell in Tasmania. The initial competitive ITA funding process attracted two applications, but neither scored above 50 per cent at assessment. DoHA then brokered a 'local solution', subsequently awarding a \$275 000 grant to the local Division of General Practice under an interim funding agreement, to amongst other things, develop a building design for the proposed clinic. The eventual funding agreement for Sorell, for \$2.4 million, required the development by the recipient of full building plans to a standard that could be lodged for the purposes of development approval and obtaining construction quotes. At the time the agreement was executed in February 2010, DoHA was aware that the

¹⁵² Recipients were required to submit final construction reports to DoHA within three months of the completion of clinic construction.

recipient entity was attempting to find supplementary funding for the project due to its concerns over the adequacy of the \$2.4 million grant. However, the advice provided to the departmental decision-maker, for the purposes of FMA Regulation 9 approval of the \$2.4 million grant, did not indicate that potential funding shortfalls constituted a risk to the project.

4.19 In May 2010, the Sorell grant recipient informed DoHA that the recently received architect's capital cost estimates for the project were considerably in excess of the \$2.4 million grant. Whilst reiterating that they were seeking other funds to supplement the grant, the recipient's advice to DoHA stated that they would look to 'move back to a balanced budget'. Submittal of the clinic operational plan to DoHA by the recipient triggered a potential milestone progress payment of some \$516 000, subject to DoHA's approval of the plan. The plan clearly highlighted a budget shortfall of at least \$880 000 due to the capital cost escalations. While DoHA undertook an analysis of the plan, the analysis made no comment about the budget shortfall, and no formal written advice was provided to any senior departmental officer as to whether the plan should be accepted. In the event, the \$516 000 milestone payment was goods receipted by an Executive Level 1 officer following approval of the milestone by an Executive Level 2 officer (Director) without any evidence that DoHA was in a position to effectively mitigate the financial risk. Subsequently, DoHA amended its GP Super Clinics risk management plan to provide that 'all milestones to be signed off at Director level or above'.

4.20 Ultimately the budget shortfall issue resulted in the recipients concluding that they were 'unable to establish a viable GP Super Clinic in Sorell within remaining grant funds.' After receiving DoHA advice, the Minister decided that the unallocated funds¹⁵³ of approximately \$1.68 million should be used for alternative primary healthcare infrastructure purposes. The grant was subsequently terminated and \$574 000 of unused funds¹⁵⁴ was returned by the recipient to DoHA. The bulk of the unallocated funds plus \$574 000 of uncommitted program funds were used by DoHA for primary health care infrastructure grants projects in Sorell and Brighton and the surrounding region.¹⁵⁵ However, the failure of the Sorell project meant that

¹⁵³ In this context, the unallocated funds constituted the remaining balance of the total grant amount that had not yet been transferred by DoHA to the Sorell grant recipient, as the relevant funding agreement milestones had not yet been met.

¹⁵⁴ In this context, the unused funds constituted the amount that had been transferred by DoHA to the Sorell grant recipient but had not yet been spent by the recipient.

¹⁵⁵ Brighton is approximately 30km from the Sorell area.

\$490 000 of GP Super Clinic grant funds were spent without any construction commencing or the achievement of any of the program objectives, in the three years between the initial ITA process and the termination of the grant.

4.21 In other cases, where building quotes or potential land acquisition costs were higher than anticipated, recipients sought permission from DoHA to increase the level of their commercial loans. DoHA advised the ANAO that its most recent practice was to refer proposals by recipients for dealing with potential cost increases to both the independent construction adviser and the independent financial adviser prior to being considered for acceptance by the Department.

4.22 DoHA also amended the standard form funding agreement in 2010 to require *both* a 'preliminary project' plan and budget (including a risk management plan) and a 'construction ready' project plan and budget (including an updated risk management plan). The 'construction ready' documentation required approval by DoHA before the recipient sought building quotes.

Increases in grant funding amounts

4.23 There have been two occasions across all GP Super Clinics locations in which the initial funding amount announced by the Government has been subsequently increased.

4.24 In June 2009, following a non-competitive ITA process, DoHA executed a funding agreement for \$2.5 million to construct a GP Super Clinic at Mt Isa. However, in February 2010 the recipient advised that it could no longer establish a clinic for this amount without taking on an 'unmanageable risk to [its] viability', and indicated that a grant of \$5 million was required to establish a GP Super Clinic. The recipient subsequently withdrew from the funding agreement. Increased funding up to \$5 million was approved by the Minister in June 2010, and following the Prime Minister's agreement to the increase, the Minister elected to re-run the Mt Isa ITA process from scratch, this time as a competitive process. A \$5 million funding agreement was subsequently executed with a new organisation in June 2011.

4.25 In mid 2009, an initial competitive ITA process for Wallan failed to produce any applications for the \$1 million available grant. DoHA subsequently brokered a local solution with the Mitchell Community Health Service (MCHS). Before formally offering the grant to MCHS, DoHA advised the Minister that the MCHS proposal involved the refurbishment of the local multipurpose centre, which 'may not meet local expectations of a GP Super

Clinic'.¹⁵⁶ The brief reported on the views expressed by the local Division of General Practice that an amount of \$3.5 million was required to construct a clinic that would be consistent with the program objectives and recommended that the Minister approve an increase in funding to MCHS from \$1 million to \$3.5 million. The increase was agreed and a revised proposal, for a purpose-built facility of 800 square metres, was submitted by MCHS in October 2010 and assessed by DoHA.

4.26 Funding agreement negotiations regarding the \$3.5 million grant commenced with MCHS in December 2010. During these negotiations, DoHA became aware that MCHS had also submitted a \$2.6 million grant application under round three of DoHA's Health and Hospitals Fund (HHF) program in December 2010. The application was for the construction of an 'integrated primary healthcare centre' at Wallan, which would result in an expanded facility of 1300 square metres. DoHA originally expressed some concerns as to whether the larger facility would result in co-location, rather than integration of services. Overall, however, the department concluded that the HHF application was 'largely complementary' to the GP Super Clinic proposal and approved the funding and integration of both proposals.

4.27 A funding agreement for the Wallan GP Super Clinic was executed with MCHS in April 2011 for \$3.5 million. However, the advice to the departmental decision-maker regarding the financial approval and the execution of the agreement did not make any reference to MCHS's HHF grant application, and in that respect did not fully inform the decision-maker of issues relevant to the exercise of the approval.

4.28 In May 2012, MCHS was successful in securing a further \$1 million grant under round four of the HHF program. The grant was for the purchase of land for the combined GP Super Clinic / integrated primary healthcare centre. In January 2013, DoHA gave approval to start construction of the combined facility. The total combined grant funding for the integrated centre is now \$7.1 million, with the currently estimated total project cost around \$9.3 million.

¹⁵⁶ DoHA's assessment noted that the refurbishment would provide five multi-purpose consulting rooms and a nurse's treatment room.

Problems in securing land tenure or development approval

4.29 The GP Super Clinic program guidelines did not require applicants to have secure tenure over a specific site—either through a freehold or leasehold arrangement—at the time applications were submitted. This was to minimise any financial disincentives for grant applicants.

4.30 Demonstration of tenure sufficient for the recipient to operate a clinic at the relevant site for 20 years was required as the first milestone after the signing of the funding agreement. In some cases, recipients have been unable to satisfy this requirement. In the case of the Mt Isa clinic, which was referred to earlier, the preferred applicant in the initial funding process intended to refurbish an existing building owned by the Queensland Department of Housing. The assessment panel's advice, dated 23 June 2009, noted that the possibility of unsuccessful lease negotiations represented a risk to the project and recommended that the preferred risk mitigation strategy was for the applicant to provide evidence of positive negotiations with the Department of Housing before a funding agreement was offered.¹⁵⁷ While this advice on risk mitigation was accepted by the Division Head, the funding agreement was offered the very next day (24 June 2009), and formally executed by DoHA on 25 June 2009. In the event, the negotiations with the Queensland Department of Housing were unsuccessful, and the recipient could not find alternative premises to establish a clinic within the \$2.5 million grant amount. As a consequence, the recipient decided to withdraw from the funding agreement.

4.31 The 2012 evaluation report¹⁵⁸ into the GP Super Clinics program, discussed in chapter 3, found that both DoHA and funding recipients considered land acquisition issues as the most common source of delay to establishment of the clinics, with development approval rated a close second.

4.32 In light of the issues experienced around tenure and development approval, DoHA amended the standard form funding agreement to include:

- a requirement for the submission of property pre-acquisition reports, under which the recipient provides an opinion of: the suitability of the property to construct the works and the property for the designated use, whether the property represents value for money, and whether the

¹⁵⁷ There were also other risks listed requiring resolution in the funding agreement negotiations.

¹⁵⁸ *Evaluation of the GP Super Clinics Program 2007–2008*, op. cit.

property will enable the funding recipient to meet the program objectives;

- notification that the recipient has discussed with the relevant authority (usually the local Council but sometimes the utilities companies or roads authority) the requirements for development (or planning) approval; and
- information about any variations necessary to the project plan and/or budget as a result of obtaining the development (or planning) approval.

4.33 The introduction of these further requirements reflected an increased emphasis on project-specific risk management of land acquisition and pre-construction issues by DoHA during the second round. The implementation of these risk management processes has proven to be a complex process in some cases. In one instance in the ANAO's sample, the proposed clinic site was to be purchased from a third party who had held the land in anticipation that the recipient would use it for the construction of the clinic. The vendor was pressing that the sale go ahead, but DoHA, following the review of the pre-acquisition documentation, initially refused permission for the purchase because of perceived development approval risk and conflicting valuations of the property. DoHA had also required the recipient to commission a consultant to locate and evaluate possible alternative sites.¹⁵⁹ Whilst the issues were later resolved through agreement to a 'conditional' purchase of the land, DoHA maintained close contact with the recipient with a view to minimising any slippage to the original clinic completion timeframes.

Ensuring that recipients maintain a commitment to the GP Super Clinic model

4.34 It was not the Government's intent that the program focus solely on increasing access to healthcare, even in areas that were poorly serviced. One of the three expected program outcomes was 'improved access to *integrated, multidisciplinary* primary care health services'.¹⁶⁰ The nature of the services, and

¹⁵⁹ The report was considered by DoHA. One of the sites contained in the report was adjacent to a medical centre that was recently upgraded through a \$500 000 DoHA grant under the Primary Care Infrastructure Grants program. The site was rejected as it was considered too close to that medical centre.

¹⁶⁰ Department of Health and Ageing, *GP Super Clinics national program guide 2010*, p. 3. Emphasis added by the ANAO.

the way these are delivered through multidisciplinary teams, is fundamental to the program.¹⁶¹

4.35 From the inception of the GP Super Clinics program, recipients have been required under the terms of their funding agreements to provide multidisciplinary health care services, consistent with the program objectives, for a period of 20 years.¹⁶² However, the agreements do not contain any specifics of clinic services or how they would be provided by the recipient.¹⁶³ From January 2009, the standard form funding agreement was amended to include a requirement to develop, during the roll-out period, an operations plan (later named an operational plan). The operational plan requirement was introduced in an attempt to ensure that the clinics' operational arrangements—the services and training opportunities they would deliver, and how they would do it—were consistent with grant recipients' applications and had the potential to meet the program objectives. Operational plans were a positive initiative by DoHA as they improved the transparency of how clinics would deliver on their commitments to provide multidisciplinary health care services consistent with the GP Super Clinic program objectives. The delivery of an operational plan is a milestone and thus requires acceptance by DoHA.

4.36 Achieving an acceptable operational plan sometimes took considerable time on the part of the recipient and often involved extensive negotiations with DoHA, including several iterations of the plans. In the case of the three grants awarded to State government health departments under which operational plans were required, final operational plans were only accepted by DoHA between 12 and 18 months after they were originally targeted for submission.

4.37 In light of the problems experienced in obtaining acceptable operational plans, DoHA again amended the standard funding agreement to require the submission of a *draft* operational plan and then a *final* plan. This allowed DoHA to provide feedback on interim plans and reflected an understanding by DoHA that funding recipients needed time to develop their plans and negotiate with potential service providers. This two stage approach

¹⁶¹ DoHA advised the ANAO that it considers the GP Super Clinics model is concerned with 'transforming the primary care services so that GPs' time is more efficiently used by the delivery of appropriate non-diagnostic services by non-GP health services providers'.

¹⁶² The recipient can potentially sell the clinic or the property on which it is located during this 20 year period, but only with the permission of the Commonwealth. The buyer must also enter into a legal agreement with the Commonwealth to continue to operate the clinic for whatever remains of the period.

¹⁶³ This remains the case for the most recent (August 2012) standard form funding agreement reviewed by the ANAO for the purposes of this audit.

also assisted in avoiding delays in making progress payments because of unsatisfactory operational plans, since acceptance of the plans by DoHA could be a key milestone.

Difficulties with third party operators

4.38 In most cases recipients managed delivery of the clinic's healthcare services themselves by employing staff, contracting individuals or adopting other arrangements. In a small number of instances, more typically when the recipient was a state health department, or occasionally a university, the recipients entered into contracts with so-called 'third party operators' (TPOs) who then managed delivery of the services. In some cases, TPO arrangements with the private sector involved the provision of GP Super Clinic services to be delivered within a larger health facility where the bulk of healthcare services were publicly funded.

4.39 TPO arrangements encountered problems in a number of instances, notably in the case of first round clinics at Palmerston, Modbury, Noarlunga and Redcliffe.

4.40 In the case of Palmerston, where the grant was awarded to the Northern Territory Department of Health, TPO management personnel were in place only five weeks before the clinic opening, leaving very little time to recruit staff, particularly GPs. After opening in October 2010, the clinic operated for several months staffed largely by locum GPs, which were very costly to employ. By mid 2011, financial projections commissioned by the TPO raised concerns that the clinic operations may be unsustainable and could exhaust its recurrent GP Super Clinic funding early in 2012. Amongst a range of responses to these concerns, an officer from the Northern Territory Department of Health was seconded to the clinic to take over its business management. Operational reports from the clinic indicated that as at December 2012 it was operating on a financially sustainable basis, with a significant workforce of GPs and practice nurses, and a range of largely part-time allied health professionals.

4.41 In the case of Modbury, the GP Super Clinic grant was awarded to the South Australian Department of Health, which co-funded two large facilities under a 'hub and spoke' model. The Australian and South Australian Governments each contributed 50 per cent of the total cost of \$25 million. Whilst the great majority of staff at the facilities were State Government employees, the GP Super Clinic grant required that, consistent with the program guidelines, private healthcare providers must also operate at the

main facility. Initially five GPs operated out of the facility from late 2011 under a TPO contract between the South Australian Government and a corporate GP provider. However, the provider ceased providing GP services in April 2012.¹⁶⁴ Following the withdrawal of the corporate GP provider, limited locum GP services were provided, with another corporate GP provider in place from September 2012. As at January 2013, privately provided healthcare services remained at a low level, with around 2.2 full-time equivalent (FTE) GPs and one FTE nurse operating out of the Modbury clinic.

4.42 At the Noarlunga clinic, the Australian and South Australian Governments again each contributed 50 per cent of the total cost of \$25 million. Private GP services were provided from the time it opened in March 2012. These services were provided at the Noarlunga clinic under an interim contract with a large GP practice located nearby, which had insufficient space at its existing premises to properly service its patient demand. Privately provided staffing at Noarlunga was initially two GPs, growing incrementally by the end of 2012 to around 2.5 FTE GPs and one FTE nurse, with some part-time privately provided allied health professional services in place.¹⁶⁵

4.43 At Redcliffe, one of the conditions of the Australian Government's \$3.2 million 'top-up' grant in October 2011 was that the Redcliffe Hospital Foundation identify, via a separate consultancy arrangement, a TPO to operate the clinic. Appointment of the TPO required the approval of both the Commonwealth and Queensland Health departments. However, as at February 2013, action was being taken to novate the funding agreement to a new party, with another TPO tendering process not expected to take place until the novation was finalised. The delay in the appointment of the TPO was expected to delay the clinic's opening to mid 2013, around 18 months after the base building was completed.

4.44 From February 2012, the standard form funding agreement included extensive provisions on TPOs. It required TPOs to enter into a tripartite deed (with DoHA and the grant recipient being the other parties) to comply with all relevant aspects of the main funding agreement. The funding agreement also required DoHA to be given security over the TPO's assets 'to ensure the performance' of the TPO's service obligations at the clinic. DoHA also reserved

¹⁶⁴ No privately provided allied health services operated from the facility during the period that the corporate GP provider was in place.

¹⁶⁵ Similar to the Modbury facility, the great majority of staff at Noarlunga are state-funded staff.

the right to direct the grant recipient to terminate the service contract between the recipient and the TPO if the latter had breached that contract.

The completion of clinics

4.45 The time taken from the execution of funding agreements to the completion of clinics varied considerably. The reasons for this included some of the previously discussed issues, particularly those relating to land tenure or development approval. Other reasons related to the complexity of the construction works and delays experienced during the construction phase of individual clinics. Table 4.1 illustrates the time taken for the 29 first round clinics completed as at 5 April 2013.¹⁶⁶

Table 4.1

Time from execution of funding agreement to clinic completion—first round clinics

Time	Number of clinics
Up to 12 months	3
12-18 months	5
18-24 months	7
24-30 months	5
30-36 months	6
More than 36 months	3
Total	29

Source: ANAO analysis of DoHA documentation.

4.46 Clinics generally became operational on practical completion, or within one or two months after that.¹⁶⁷

4.47 In some cases, issues that arose before or during construction could be managed without impact on anticipated completion dates (the date recorded on the relevant funding agreement as originally executed) but in most cases, they caused delays. Likely delays to completion would result in DoHA extending the practical completion date in the funding agreement by a formal deed of variation. These variations were approved by SES-level officers.

¹⁶⁶ DoHA has advised that a further clinic was open for business as at 31 May 2013.

¹⁶⁷ As noted earlier, Redcliffe is a notable exception to this, with the clinic opening expected to be at least 18 months after the exterior of the building was completed.

extending the practical completion date in the funding agreement by a formal deed of variation. These variations were approved by SES-level officers. Table 4.2 shows that of the currently operational first round clinics, around half were completed no more than three months late while the other half were completed over three months late.

Table 4.2

Operational first round clinics—delays to anticipated clinic completion

Time	Number of clinics
Early or on time	3
Less than 3 months late	11
3-6 months late	6
6-12 months late	5
12-18 months late	2
More than 18 months late	2
Total	29

Source: ANAO analysis of DoHA documentation.

4.48 As Table 4.3 shows, as at 5 April 2013, the other seven first round clinics that have yet to become operational are all late, some considerably so.

Table 4.3

Non-operational first round clinics—delays on anticipated clinic completion

Time	Number of clinics
Early or on time	Nil
Less than 3 months late	2
3-6 months late	Nil
6-12 months late	1
12-18 months late	Nil
More than 18 months late	3
Unknown	1

Source: ANAO analysis of DoHA documentation.

Administering grant milestones and payments

4.49 As noted earlier, the number of milestones established by the funding agreements is large, and has grown over time. The assessment of documentation submitted by recipients has created a significant challenge for DoHA, particularly where the documents are complex. DoHA has responded by using substantial external advice, as well as commissioning the development of a toolkit designed to improve the efficiency and consistency of the administration of key milestones.¹⁶⁸

4.50 DoHA has sought external advice on the administration of the financial reporting requirements under funding agreements. Recipients are required to provide both financial acquittals of grant expenditure and audited financial statements. KPMG was retained during 2012 to assess these documents across a sample of first round clinics and provide advice to DoHA on its administration. A number of the assessments highlighted apparent 'outside of (funding agreement) scope' expenditure of matters such as overseas recruitment, meetings, books or coffee machines, as well as questions being raised about payments between related parties. In most cases, the assessments noted that further information is pending or should be requested from grant recipients. In terms of DoHA's general administration of recipients' financial reporting under funding agreements, KPMG noted a lack of formal procedures for analysing information provided in the reports, varying degrees of financial literacy amongst program staff, and lack of consistency between staff across the responsible branch in resolving common issues arising in financial reporting. DoHA advised the ANAO that action 'had not been finalised on all KPMG findings'.

4.51 The lack of appropriately skilled DoHA staff to manage the complex infrastructure aspects of the program has been noted in successive GP Super Clinics program risk management plans. In recent years the department has administered a range of health infrastructure programs, including the Primary Care Infrastructure Grants program and the Health and Hospitals Fund program. While maintaining access to sufficient appropriately skilled staff may be challenging, it is reasonable to expect that DoHA's past experience, if

¹⁶⁸ A 'GP Super Clinic program toolkit' was developed over late 2012 and early 2013. It is intended to provide guidance material on program administration, focusing on seven priority segments. These segments incorporate key steps in the administration of GP Super Clinic grants, including improving the scrutiny of key funding agreement milestone documentation, such as the acquisition of property reports, tender reports, budgets, insurance certificates, construction reports, risk management plans as well as financial reporting. DoHA anticipates that some material will be suitable for use by other capital works programs within DoHA, potentially including the Health and Hospitals Fund.

appropriately documented, can contribute to the mitigation of program risks. In particular, ensuring that relevant program management tools and procedures are in place early in program rollouts would mitigate the risks of program outcomes not being met in a timely and cost-effective manner. The development of the GP Super Clinic program toolkit, as well as broader departmental capacity-building initiatives such as the Centre for Capital Excellence¹⁶⁹, are positive steps in this regard.

Conclusion

4.52 In establishing the program, DoHA assessed and planned for a range of program implementation risks. During the first funding round, there were nonetheless occasions when DoHA's risk management approach in the awarding of grants, and subsequently managing risks in the early stages of clinic roll-out, lacked rigour. This contributed to the eventual inability to establish a clinic at Sorell, where the estimated cost of constructing a clinic exceeded available grant funding by around \$880 000, as well as being a factor in the long delay in opening the Redcliffe clinic.

4.53 In the case of Sorell, DoHA took six months to fully recognise and respond to the risks of a budget shortfall after the funding recipient advised the department that it had concerns about the adequacy of the amount available under the GP Super Clinics grant. While the department responded appropriately once the shortfall was confirmed (after the receipt of building quotes), earlier engagement with the funding recipient on building design and construction costs would have enabled the department to better manage the risk. In the case of the Redcliffe project, while the department identified a number of financial risks during the assessment stage of the initial \$5 million grant, and a mitigation strategy was proposed (including finding a financial guarantor for the project and / or reducing its capital cost), the FMA Regulation 9 documentation did not refer to whether the identified risks had in fact been treated, and a funding agreement for \$5 million was subsequently signed without explicit provisions relating to those risks. In the event, the recipient was unable to secure a loan to fund any of the project's cost, resulting in a significant increase in the Commonwealth contribution towards construction works; from \$5 million to \$13.2 million.

¹⁶⁹ The Centre was discussed in ANAO Audit Report No.45 2011–12 *Administration of the Health and Hospitals Fund*, p.18.

4.54 Overall, DoHA's compliance with the requirements of the Commonwealth financial management framework in the awarding of grants has been generally sound. Exceptions related to the FMA Regulation 9 documentation for Redcliffe, discussed above, and non-compliance (identified during the audit) with the mandatory public reporting of grants as required under the Finance Minister's Instructions and later by the *Commonwealth Grant Guidelines*.

4.55 As at 5 April 2013, twenty-nine of the clinics announced in the first round (either 2007 or 2009) are now fully operational, with one second round clinic operational. Three (10.3 per cent) of operational first round clinics were completed within the timeframe originally specified in the funding agreement. However, four clinics (13.8 per cent) were completed at least 12 months late. Of the seven first round clinics that have yet to become operational, four are either at least 18 months late or subject to unknown completion dates. Land acquisition and development approval issues have been reported as the most common source of delay. As part of changes introduced to its risk management approach in the second round, DoHA has responded to the acquisition and approval issues by requiring grant recipients to provide it with property pre-acquisition reports and information on its discussions of development approval requirements with relevant regulatory authorities. While it is too early to fully gauge the extent to which these changes have helped reduce delays to getting clinics to construction-ready stage, 19 out of the 28 second round clinics have not yet started construction as at 5 April 2013.¹⁷⁰

¹⁷⁰ See table 1.2 in chapter 1.

5. Reporting and Assessing Clinic and Program Outcomes

This chapter examines how DoHA developed and implemented a program evaluation framework, including key performance indicators. It also includes the ANAO's assessment of the performance of some aspects of the operational clinics in the ANAO's sample, as well as looking at patient presentation trends across the program as whole. Finally it examines how DoHA is using the information submitted by operational clinics, both in the context of individual clinics and the program as a whole.

Development of program key performance indicators and evaluation framework

5.1 The Parliament and the public's consideration of a program's performance, in relation to impact and cost effectiveness, rely heavily on accurate and appropriate performance information. Adequate performance information, particularly in relation to program effectiveness, allows managers to provide sound advice on the appropriateness, success, shortcomings and/or future directions of programs. This information allows for informed decisions to be made on the allocation and use of program resources.¹⁷¹

5.2 Well-designed key performance indicators (KPIs) can provide valuable information on the effectiveness of programs in achieving the objectives in support of desired outcomes (in the case of grants programs these are the intended results, impacts or actions of the grants on the Australian community). This is done within the context of the Australian Government's Outcomes and Programs Framework, released by the Department of Finance and Deregulation in 2009. A key requirement is entity reporting designed to clearly demonstrate achievement against pre-defined program objectives.

Key performance Indicators

Externally reported KPIs

5.3 Since the establishment of the GP Super Clinics program in 2008, DoHA has publicly reported against a single program KPI in both its annual reports and portfolio budget statements. Initially this KPI was the number of

¹⁷¹ ANAO Audit Report No.5 2011–12 *Development and Implementation of Key Performance Indicators to Support the Outcomes and Programs Framework*, p. 13.

grants made, but as clinics became operational, the KPI became the number of clinics that commenced delivery of services, while the number of grants made was reported as a 'quantitative deliverable'.

5.4 While the KPI has, appropriately, been reviewed and amended as the program moved from one phase to the next, it currently demonstrates progress only against the first of the program's three intended outcomes—increased primary health care infrastructure. The KPI does not address the other key program outcomes: improved access to integrated, multidisciplinary primary care health services; and increased education and training placements in a multidisciplinary care setting for the future primary care workforce.

Program KPIs

5.5 DoHA has developed more specific KPIs relating to each of the program's ten objectives. However these are not formally reported on a 'whole of program' basis.¹⁷² The form of these KPIs has been the subject of discussion and debate since the program's earliest days.

5.6 In March 2008, while the program was still under development, the Health and Ageing Working Group (HAWG) of the Council of Australian Governments (COAG) adopted a 'GP Super Clinic Implementation Plan'. A key element of this plan was the development of an evaluation framework which would 'help define the performance indicators in relation to the program's core characteristics'.¹⁷³ The plan indicated that the evaluation framework was to be developed by August 2008, with the actual evaluation of the program to be completed in 2010–11.¹⁷⁴ However, the framework was not developed until 2011.

5.7 Recommendations regarding the design of the program's evaluation framework and development of KPIs were also provided to DoHA by the Cabinet Implementation Unit (CIU) of the Department of the Prime Minister and Cabinet (PM&C). The CIU undertook an initial assessment of the program's implementation progress in mid 2009, with a second report

¹⁷² Edited versions of 'implementation progress sheets' of individual clinics are placed on the DoHA website and periodically updated. These list the range of services provided by the clinic, operating hours, availability of bulk billing, whether clinic staff do home and aged care facility visits, and provide general information on clinic training activities.

¹⁷³ HAWG GP Super Clinic Implementation Plan, p. 3.

¹⁷⁴ Consistent with this intention, the program guidelines for the both of the GP Super Clinic funding rounds indicate that funding recipients would be expected to participate in the evaluation as well as 'report[ing] at regular intervals on operational activities'.

completed in mid 2010. Both assessments recommended the development of KPIs that were ‘measurable and linked to the program objectives’.

5.8 By March 2011, DoHA had developed a set of detailed and measurable KPIs, and sought the Minister’s formal endorsement of these. DoHA’s advice to the Minister noted the draft KPIs had been agreed with PM&C, and the draft KPIs were included in the evaluation framework approved by the Minister in May 2011. The KPIs addressed four of the programs key objectives—improved access to affordable primary healthcare, an integrated multidisciplinary approach, responsiveness to local health needs, and providing vocational placements and other education and training opportunities—with the intention to add more KPIs as clinic ‘operational arrangements mature’.

5.9 The Minister subsequently decided that the draft KPIs should be revised, and the revised KPIs addressing all ten program objectives were approved by the Minister in November 2011 and provided to the Prime Minister as part of the Minister’s response to the recommendations of the CIU. While the original (March 2011) draft KPIs were generally measurable and capable of an objective ‘yes’ or ‘no’ response to whether they had been met, most of the revised KPIs are framed in a more qualitative and descriptive manner. Other than an annotated comment by the Minister on the March 2011 brief from DoHA (returned to the department in November 2011) that the draft KPIs ‘need[ed] more work’, no further advice or other material was provided by DoHA which indicates the rationale for the significant change in the nature of the program KPIs made between March and November 2011.

5.10 The internal debate over program KPIs indicates that there is scope to introduce measurable KPIs for the GP Super Clinics program. Further, as discussed in paragraph 1.10, the designated use period of 20 years, which is a condition of funding, means that the program will continue long after the clinics are established and the grant funds disbursed. There would be benefit in reviewing the program reporting framework to include measurable KPIs as a basis for reporting, in the longer term, on the extent to which the program is achieving its intended outcomes, particularly those relating to the longer term outcomes: improved access to integrated, multidisciplinary primary care health services; and increased education and training placements in a multidisciplinary care setting for the future primary care workforce.

Recommendation No.3

5.11 To improve longer-term reporting on program outcomes, the ANAO recommends that DoHA revise the GP Super Clinics performance and reporting framework to include measurable KPIs on the extent to which the program is achieving its key intended outcomes.

DoHA response:

5.12 *Agreed.*

External evaluation of the GP Super Clinics program

5.13 Following the Minister's endorsement of the program evaluation framework, an evaluation was undertaken by consultants from late 2011 to early 2012. The full report, entitled *Evaluation of the GP Super Clinics Program 2007–2008* (the evaluation report), along with DoHA's response to its various recommendations, was published in August 2012.

5.14 The focus of the evaluation report was the first funding round. The report included an examination of three aspects of the program:

- administration of the program by DoHA;
- the planning and construction of the clinics; and
- the operation of seven clinics¹⁷⁵, particularly in relation to their progress towards the objectives of the program.

5.15 The evaluation was not an 'in-depth' examination of all significant aspects of DoHA's administration of the program. There was little examination of the application assessment process in the report and in general, the treatment of much of DoHA's earlier-stage administration was largely descriptive rather than analytical.

Construction costs

5.16 The planning and construction section of the evaluation report focussed on the issue of delays in clinic roll-out and whether the construction costs of first round clinics were reasonable in terms of representing value for money. As discussed in chapter 3, these were significant issues in the context of the program, including in terms of DoHA's administrative performance.

¹⁷⁵ These clinics had been operating for more than six months, as at mid-2011.

5.17 Only 18 of the 36 first round clinics, including some that were still under construction, responded to the relevant information request by the report's authors. The evaluation concluded that of these 18, six clinics were determined to have not achieved value for money in the capital component of their project. However, the evaluation report also noted that when 'extra-ordinary circumstances' were taken into account, only three of the surveyed projects would have failed to meet the value for money criteria.¹⁷⁶

5.18 The evaluation report advised that because of a lack of data, its assessment of value for money was unable to consider significant components of development costs, namely professional fees and land purchase costs.¹⁷⁷ Incorporation of these project costs would have enabled a more comprehensive evaluation of value for money issues in respect of the establishment of GP Super Clinics.

5.19 Under the requirement for pre-acquisition of property reports introduced by DoHA in the second round, recipients were required to provide a documented assessment confirming that the proposed acquisition represented value for money. As well as addressing the purchase price or lease cost, the documentation requires the assessment of any risks such as any conditions of the purchase or lease. The new requirements should provide DoHA with a firmer basis for assessing value for money before the grant recipient commits grant funds towards the land or building acquisition, which under the GP Super Clinics program can potentially involve millions of dollars. As such, it represents an improvement in DoHA's administration of the program as compared to the first round.

Operational issues

5.20 The final part of the program evaluation, relating to the operational aspect, was informed by an in-depth analysis. The main conclusions were that the program has increased access to primary health care in a multidisciplinary setting and supported the retention and potentially the recruitment of GPs into clinics which have the potential to be at the forefront of primary care reform.¹⁷⁸

¹⁷⁶ These circumstances were: (i) soil contamination requiring remediation; (ii) the clinic being located in a heritage-listed building; and (iii) construction was halted on two occasions.

¹⁷⁷ This latter point was also identified through ANAO's discussions with the medical advisers sitting on the assessment panels. In the course of these discussions, it was noted that a difficulty that the panels faced when undertaking assessments was how to compare land costs in urban and regional / rural areas.

¹⁷⁸ Evaluation of the GP Super Clinics Program 2007-2008, p. 6.

The evaluation noted that progress on some operational aspects related to program objectives was limited, and identified a number of areas for further service development. These areas included:

- the development of guidelines for multidisciplinary team based care;
- development and utilisation of a multidisciplinary team based skills assessment and skills development programs;
- greater focus within the GP Super Clinics on primary prevention services;
- greater use of electronic health records as a record for patient care and as a facilitator of multidisciplinary care through organisational, administrative or quality improvement roles;
- greater focus on ongoing and strategically focused approaches to community engagement, to meet the needs of the community and specific groups with significant health risks; and
- greater emphasis on a progression to an integrated approach to planning, to facilitate the ability of GP Super Clinics to support a range of services in meeting local health needs.¹⁷⁹

5.21 However, the evaluation also noted that the real return on investment in primary health care could only be adequately assessed as the program matured.¹⁸⁰

ANAO assessment of the GP Super Clinics program

5.22 In assessing how the program has performed against its stated objectives and intended outcomes, the ANAO considered both the performance of individual clinics in the ANAO's sample and the program more broadly. The ANAO utilised a number of operational reporting documents provided to DoHA by grant recipients: the regular clinic reports (four-monthly Implementation Progress Sheets (IPSs) and two-monthly Patient Presentation data); clinic operational plans¹⁸¹ supplemented by clinic annual operational reports; interviews conducted by the ANAO during its visits to 12 operational clinics; as well as the findings of the program evaluation.

¹⁷⁹ Ibid, pp. 66-75.

¹⁸⁰ Ibid., p 6.

¹⁸¹ Clinic grant funding agreements require the preparation of an operational plan before a clinic opens.

Clinic operational reporting – progress towards program objectives

5.23 DoHA provides clinics with a template for IPS reporting of their progress against the ten program objectives, which represent the ‘core characteristics’ expected of all GP Super Clinics. Guidance contained in the templates as to the matters that should be reported on under the respective objectives are consistent with the November 2011 KPIs. Edited versions of these IPSs are placed on the DoHA website. These public versions list the range of services provided by the clinic, operating hours, availability of bulk billing, whether clinic staff do home and aged care facility visits, and provide general information on clinic training activities. They do not include information on staff or patient numbers or other operational matters as these are considered to be of a potentially commercially sensitive nature.

5.24 The IPSs require reporting through a mix of qualitative and quantitative information. To assess aspects of the performance of the 18 operational clinics in its overall sample of 36 clinics, the ANAO compared the most recent IPSs with the equivalent information provided in operational plans.¹⁸² To allow for an objective assessment, the ANAO restricted its analysis to where the information in both the operations plan and IPS reporting was in a reasonably quantifiable form or was otherwise generally expressed in a clear, non-descriptive manner. The specific ‘indicator’ issues for which the ANAO analysed performance were:

- operating hours;
- bulk billing policy;
- staff numbers and mix¹⁸³;
- service mix;
- future medical workforce training;
- shared electronic patient records; and
- financial viability.

¹⁸² Operational plans are intended to provide detailed information on proposed services, staffing levels and composition, operating hours, clinical and organisational arrangements, financial modeling of clinic operations, workforce and student training arrangements, and strategies to foster coordination with existing public and private health providers. Where the operational plan indicated that staffing levels, service mix and other operational factors would be expanded over an indicated timeframe, the ANAO analysis attempted to match the appropriate point in the timeframe.

¹⁸³ The ANAO examined whether clinics had the numbers and range of staff across three broad categories—GPs, nurses and allied health professionals—that they estimated they would have in the operational plan.

5.25 The ANAO's analysis addresses a number of the key factors that directly impact on the range, accessibility and affordability of services to the community, as well the important issue of training the future medical workforce. The results of the ANAO's analysis are summarised in Table 5.1.

Table 5.1

Performance of 18 operational clinics against selected indicators

Indicators	Number of clinics meeting or making good progress towards achievement	Number of clinics not meeting or lack of evidence of good progress towards achievement	Insufficient information in operational plan or IPS to make assessment
Operating hours	13 (72.2%)	1 (5.6%)	4 (22.2%)
Bulk billing policy	13 (72.2%)	1 (5.6%)	4 (22.2%)
Staff numbers and mix (numbers of GPs, nurses and allied health professionals)	10 (55.6%)	4 (22.2%)	4 (22.2%)
Service mix (range of healthcare services provided)	14 (77.8%)	1 (5.6%)	3 (16.7%)
Future medical workforce training (medical / nursing / allied health professional students / GP Registers)	12 (66.7%)	1 (5.6%)	5 (27.8%)
Shared electronic patient records	14 (77.8%)	0 (0%)	4 (22.2%)
Indications of financial viability issues	9 (50%)	0 (0%)	9 (50%)

Source: ANAO analysis of GP Super Clinic Operational Plans and/or grant applications, Clinic IPSs (available as at February 2012). The analysis relates to the 18 operational clinics in the ANAO's sample of 36 clinics; it includes 17 clinics from the first round and the only operational clinic from the second round.

5.26 Overall, the sample of IPSs analysed by the ANAO indicated that a majority of clinics have achieved, or are making good progress towards the achievement, of the measures in their operational plans, relating to: operating hours, bulk billing patients, service mix, future medical workforce training, and the adoption of electronic shared patient records.

5.27 The results in relation to staff numbers and mix were somewhat more variable—the ANAO's analysis indicates that attracting and retaining clinic staff was, by far, the most significant challenge in establishing the clinics and

providing the full range of anticipated services. Whilst some existing GP practices that have received GP Super Clinic funding to expand their premises have only recorded modest increases in the number of general practitioners, there have often been significant increases in the numbers of allied health professionals operating at the expanded facility, allowing for a broader range of services to be offered, including relating to preventative care.¹⁸⁴

5.28 Performance regarding the financial viability of individual clinics was less clear, and in a number of cases, there was insufficient information in operational plans or the IPS to make an assessment. DoHA introduced measures in 2012 to improve reporting on the financial viability of clinics.¹⁸⁵

Clinic operational reporting – Patient Presentations

5.29 In addition to collecting information on the performance of individual clinics through their IPSs, DoHA requires clinics to report every two months on the number of patient presentations at the clinic. Numbers are separately reported as presentations to GPs, allied health professionals and nurses.¹⁸⁶ The ANAO analysis is based on patient presentation data from fully operational clinics, starting from April 2011 through to December 2012. Ten fully operational clinics were providing patient presentation data as at April 2011, rising to 29 in December 2012.

Service level (patient numbers)

5.30 In assessing program performance, especially in relation to whether a particular clinic location reflected a need within that community, one approach is to look at the growth in services being provided by clinics over time. As at April 2011, the ten fully operational clinics averaged 2360 patient presentations per month. By December 2012, with the number of fully operational clinics increasing to 29, each clinic was averaging around 3740 patient presentations

¹⁸⁴ Expansions of existing GP practices has also resulted in new or enlarged treatment or surgical theatre rooms, case conferencing and training facilities.

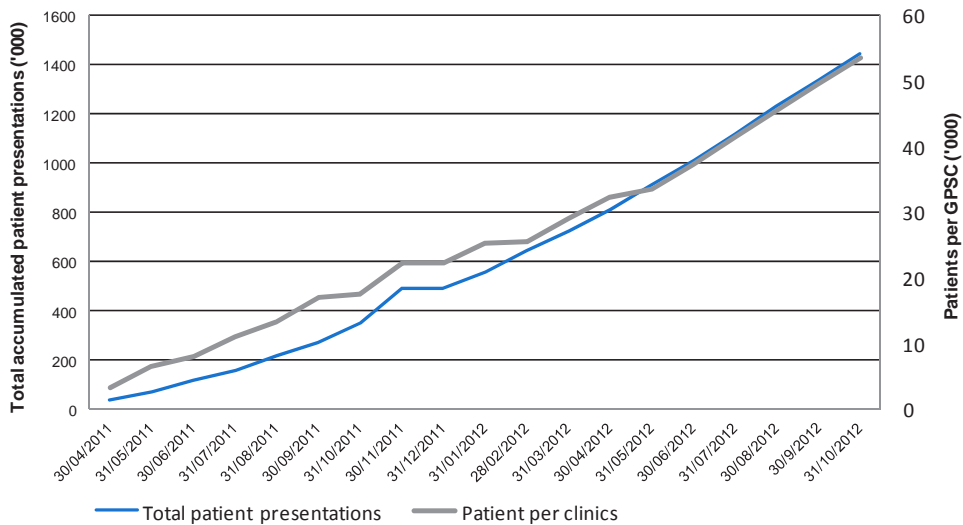
¹⁸⁵ From 2012, the annual operational reports have required a statutory declaration that the clinic is operating a viable, sustainable and efficient business model. The declaration also states the funding recipient has undertaken an assessment of any threats to the viability and sustainability of the operations of the GP Super Clinic for the forthcoming year, with any threats brought to DoHA's attention and risk management strategies implemented. This is potentially a sound risk management strategy. DoHA also advised the ANAO that financial viability is a key focus of regular teleconferences between the Department and funding recipients.

¹⁸⁶ Broadly speaking, a patient presentation is where a patient has a consultation with a clinic staff member. Where a patient has a consultation with a nurse immediately after seeing a GP, this would count as two presentations. A group session with a nurse involving five patients, such as a lifestyle or preventative health education session, counts as five presentations. At one site visit, the practice manager commented that they had submitted reports on Medicare Benefit Schedule item numbers, rather than patient presentations, and as a consequence fluctuations in presentation numbers could result from changes to the Medicare Benefit Schedule rather than actual services delivered at the clinic.

per month, although there was a wide range between clinics. Some clinics were reporting less than 1000 presentations per month, with the upper end being around 10 000 presentations per month. Figure 5.1 shows the accumulated growth in patient presentations over time.

Figure 5.1

Patient presentations



Source: ANAO analysis of DoHA Patient Presentation data.

5.31 There have been different rates of growth in patient presentations over the reporting period across the various clinics. The different rates of growth across clinics reflected a number of factors including: how long the clinic has been operating; whether the project was a new clinic or an expansion of existing facilities; and clinic size, which affects the base level of patients and hence the rate of growth. Patient presentations could also vary over time, even where the general trend was up. Some clinics noted that seasonal fluctuations, including where these related to matters such as flu vaccinations, could significantly impact on patient presentation numbers. Staffing changes, particularly for smaller clinics, could also significantly affect presentation numbers.

Delivery of services by GPs, nurses and allied health professionals

5.32 Whilst the overall proportions of total patient presentations across GPs, nurses and allied health professionals has fluctuated somewhat over time, the current proportions are broadly similar to April 2011. As at December 2012,

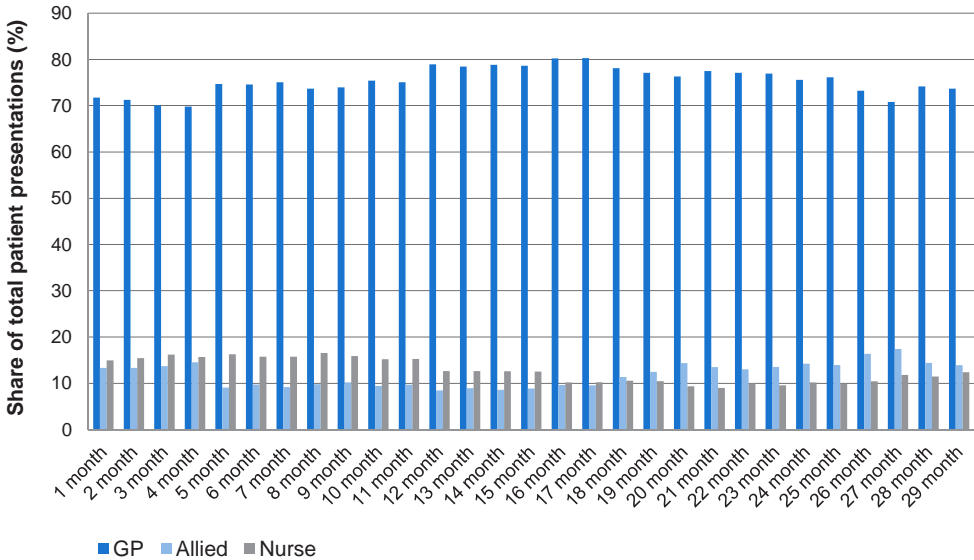
GP presentations are around 72 per cent of total presentations as compared to 73 per cent in April 2011. Nursing presentations are at 14 per cent, down from 15 per cent; while allied health professional presentations are at 14 per cent, up from 12 per cent.

5.33 The overall proportions vary significantly between clinics. Based on December 2012 reporting figures, some clinics had over 90 per cent of patient presentations attributable to GPs. At the other extreme, one clinic that has only been open since mid 2012, had only 30 per cent attributable to GPs, with over 50 per cent of presentations attributable to nursing staff.

5.34 The ANAO also examined whether the service mix varied according to how long clinics had been open, as one intention of the program was to make greater use of nurses and allied health professionals to deliver health services. This is implicit in the program’s objective to provide well integrated multidisciplinary patient centred care. The results are shown in Figure 5.2.

Figure 5.2

Share of patient presentations by service type



Source: ANAO analysis of DoHA Patient presentation data.¹⁸⁷

¹⁸⁷ It should be noted that as the data set is from April 2011, the information does not include presentations from the earliest times for those clinics that were fully operational in 2010 and early 2011.

5.35 Both the proportion of nurse and allied health professional presentations appear to have had discernable 'dips' at specific (but different) stages, but there is some evidence they have since recovered. Conversely, the somewhat increased proportion of GP presentations during these dips has now declined. Overall, an analysis of patient presentations does not show any particular trend, at this stage, in support of DoHA's objective to achieve a significant shift towards an increasing proportion of overall services at GP Super Clinics being delivered by nurses and allied health professionals.

Management information and clinic operational reporting

5.36 Considerable operational reporting is required under the program grant funding agreements, which provides DoHA with sufficient information to effectively monitor clinic operations during the ramp-up stage. This emphasis was appropriate given the various challenges clinics faced during this stage, including, as previously discussed, attracting and retaining sufficient staff to progressively deliver a full range of multidisciplinary healthcare services consistent with program objectives. DoHA provided substantive feedback to, or sought further information from, at least some clinics on its reporting, including where DoHA had potential concerns about slow ramp-up or significant 'dips' in the number of patient presentations. However, whilst the ANAO found records of teleconferences on some electronic files, DoHA does not appear to keep a consolidated record of these communications that could be used to monitor relevant issues over time. A number of clinics visited by the ANAO also considered that they received little or no feedback on their reporting.

5.37 To date, DoHA has not attempted to use the information it collects for the purpose of assessing trends in clinic performance, potential barriers to improving services, or conversely, approaches that have assisted performance of clinics across the program as a whole. There are also no formal mechanisms in place for the verification of any of the operational reporting.

5.38 During site visits by the ANAO, some clinics also suggested that the guidance in the current template for the four-monthly IPS reports led to the provision of repetitive information in each successive report. They suggested that the template should be adapted to allow for more sophisticated information to be reported once clinics have been operational for some time. This is likely to be an ongoing issue as some clinics will have been in operation for up to 5 years by the time the last clinics from the second round start to ramp-up their operations in 2014 and 2015.

5.39 The annual operational reporting requirement, introduced from April 2012, contains some potentially useful aspects. It requires information on planned service delivery for the forthcoming year, and the template notes that this information ‘may be considered in the context of the next Annual Report in 12 months time’—indicating that DoHA may use the information for benchmarking progress of service delivery. The annual report allows clinics to provide commentary on specific achievements against operational and business plans, and importantly, on any barriers preventing or hindering achievement. This could provide useful information on barriers to achieving aspects of program objectives across clinics as a whole. However, this reporting requirement was only introduced in April 2012, and it is unclear whether the information will be used on more than a clinic-specific basis.

5.40 The annual operational report requires clinics to provide anecdotal examples of the provision of both integrated multidisciplinary team based primary care for a patient with a chronic condition, and of primary and/or secondary preventative health services. However, no information is collected by DoHA from either clinics or other organisations such as the Department of Human Services¹⁸⁸ on the number of patients receiving these types of care, or the number of relevant Medicare Benefit Schedule claimable services (such as Chronic Disease Management items), that the clinic has provided over set reporting periods. It is therefore not possible to determine how significant these types of services are as a proportion of a clinic’s operations as a whole. In the absence of that information, it is not possible to make a judgment on whether the clinics, and more particularly those which have been operational for some reasonable amount of time, are delivering meaningful volumes of the types of services contemplated in the GP Super Clinics policy.

¹⁸⁸ The Department of Human Services administers healthcare-related financial payments made by the Commonwealth.

Recommendation No.4

5.41 To support a more outcome-focused performance reporting framework for the GP Super Clinics program, it is recommended that DoHA put in place arrangements with the Department of Human Services to obtain information on claimable services provided by operational GP Super Clinics, as well as information regarding vocational placements, medical education and training for GP Registrars and allied health professionals.

DoHA response:

5.42 *Agreed, noting that DoHA will also work with other agencies and bodies (eg regional training placement organisations and Health Workforce Australia), other than the Department of Human Services, as highly relevant sources of information regarding vocational placements, medical education and training for GP Registrars and allied health professionals.*

Conclusion

5.43 The ANAO's analysis of the operational reports of the 18 clinics in its sample indicates that the majority of these clinics are making good progress towards achieving some key service delivery expectations. Recruiting and retaining sufficient staff have been the biggest challenges for most clinics. However, an analysis of patient presentations does not show any particular trend, at this stage, in support of DoHA's objective to achieve a significant shift towards an increasing proportion of overall services at GP Super Clinics being delivered by nurses and allied health professionals.

5.44 The development of Key Performance Indicators (KPIs) for the ten GP Super Clinic program objectives was originally to occur in 2008, but this process was not commenced by the department until 2010. A set of detailed and measurable KPIs were agreed between DoHA and the Department of the Prime Minister and Cabinet (PM&C) and DoHA sought the Minister's formal endorsement of these in March 2011. The Minister directed that the KPIs be reworked, and a revised set of KPIs, now framed in a more qualitative manner, was approved by the Minister in November 2011. As discussed below there remains scope for revised KPIs to support longer term reporting on the extent to which the program is achieving its intended outcomes.

5.45 With the maturing of an increasing number of clinics, it is timely for DoHA to consider whether more quantifiable information on the services provided by clinics—focusing particularly on those that involve integrated,

multidisciplinary team based care and preventative care—should be collected¹⁸⁹ and publicly reported on an aggregated basis. Similarly, aggregated public reporting of the numbers of vocational placements and other education and training activities for medical, nursing and allied health professional students, including GP registrars, could be commenced. This reporting would usefully be supported by analysis of whether the more mature clinics are providing vocational placements and educational activities at proportionally higher levels than other comparable primary healthcare facilities. In addition to information provided by the clinics, reporting could be informed by data collected by the Department of Human Services as part of its administration of healthcare-related financial payments.

5.46 As already noted, the GP Super Clinics program will have an effective life of twenty years, and a revised performance and reporting framework would provide an improved basis for assessing the extent to which the program is achieving its key intended outcomes: improved access to integrated, multidisciplinary primary care health services; and increased education and training placements in a multidisciplinary care setting for the future primary care workforce.



Ian McPhee
Auditor-General

Canberra ACT
20 June 2013

¹⁸⁹ The frequency of reporting for mature clinics could also be reduced.

Appendices

Appendix 1: Announced GP Super Clinics

First Round (37 clinics)		Second Round (28 clinics)	
Location	Total GP Super Clinic grant (\$ million)	Location	Total GP Super Clinic grant (\$ million)
ACT		ACT	
No Clinic	0	Canberra	15
NSW		NSW	
Blue Mountains	5	Blacktown	15
Grafton	5	Broken Hill	7
Gunnedah (announced 2009)	4.3	Coffs Harbour	7
North Central Coast	2.5	Jindabyne	5
Port Stephens	2.5	Lismore	7
Queanbeyan	5	Liverpool	15
Riverina	1	Lower Hunter	7
Shellharbour	2.5	Nowra	7
Southern Lake Macquarie	2.5	Port Macquarie	7
Northern Territory		Southern Central Coast	7
Palmerston	10	Tweed Heads	7
Queensland		Northern Territory	
Brisbane Southside	7.5	Darwin	5
Bundaberg	5	Queensland	
Cairns	5	Caboolture	15
Gladstone	5	Emerald	5
Ipswich	2.5	Gold Coast	7
Mount Isa	5	Mackay	7
Redcliffe	13.2	Sunshine Coast	15
Strathpine	2.5	Townsville (Northern Beaches)	5
Townsville	5	Wynnum	15
South Australia		South Australia	
Modbury	12.5	Adelaide	15
Noarlunga	12.5	Mt Barker	7
Playford North	7.5	Tasmania	

First Round (37 clinics)		Second Round (28 clinics)	
Tasmania		No clinic	0
Burnie	2.5	Victoria	
Devonport	5	Cobram	1
Sorell (grant terminated)	2.5	Hume City	7
Clarence	5.5	Melbourne West	15
Victoria		Western Australia	
Ballan	1	Karratha	7
Bendigo	5	Northam	3
Berwick	2.5	Rockingham	7
Geelong	7		
Portland (announced 2009)	4.9		
South Morang (announced 2009)	3.7		
Wallan	3.5		
Wodonga (announced 2009)	6.65		
Western Australia			
Cockburn (announced 2009)	6.65		
Midland	5		
Wanneroo	5		

Source: ANAO analysis of DoHA documentation.

Note: Funding amounts reflect any subsequent increase in grant funding from that originally announced. Redcliffe increased from \$5 million to \$13.2 million; Wallan from \$1 million to \$3.5 million; and Mt Isa from \$2.5 million to \$5 million. All amounts exclude GST.

Appendix 2: ANAO methodology to assess effectiveness of program administration

Number of clinics announced by the Government

From 2007 through to 2010, the ALP announced a total of 65 proposed clinics to be funded under the GP Super Clinics program. Thirty-two of these were announced whilst in opposition shortly before or during the 2007 election campaign and another five in 2009 in response to unsolicited proposals. A further 28 were announced during the 2010 election campaign.

ANAO sampling methodology: round one

Whilst some audit findings are based on the entire population of 65 clinic locations, the ANAO also undertook an in-depth analysis of key issues in a targeted, non-statistical sample of 36 locations. The sample for the first round comprised a total of 22 clinics and included 21 of the 32 clinics announced in 2007 and one of the five clinics announced in 2009. The ANAO sample comprised:

- a selection of 17 clinics nationally;
- four clinics that had experienced significant delays and were not operational (Redcliffe, Mt Isa, Wanneroo and Wallan); and
- the one clinic which was cancelled (Sorell).

This relative weighting of 22 clinics was intended to ensure that a sufficient number of operational clinics were included in the sample to enable an assessment of clinics' progress towards meeting the program objectives.

ANAO sampling methodology: round two

The sample for the second round comprised a total of 14 of the 28 clinics announced in 2010 and included:

- a selection of 8 clinics nationally; and
- six of the eight \$15 million grants made in round two (Canberra, Liverpool, Caboolture, Sunshine Coast, Adelaide, and Melbourne West).

Assessing competitive and non-competitive processes

Twenty of the 65 clinics have involved exclusively non-competitive funding processes. Another five have involved both competitive and non-competitive

processes—in most cases this has occurred where an initial invitation to apply process has had to be re-run.

The ANAO sample includes 18 clinics that have exclusively or partly involved a non-competitive process.¹⁹⁰

The following table provides a breakdown of the number of clinics in each jurisdiction that were included in the ANAO's sample.

Table A.1

Distribution of clinic locations included in the ANAO sample

State or Territory	Number of proposed clinics in sample
ACT	1 (Canberra)
New South Wales	5 (Queanbeyan, Shellharbour, Jindabyne Liverpool, Lower Hunter)
Northern Territory	2 (Palmerston, Darwin)
Queensland	8 (Mount Isa, Redcliffe, Strathpine, Brisbane Southside, Bundaberg, Caboolture, Sunshine Coast, Townsville (Northern Beaches))
South Australia	5 (Modbury, Playford North, Noarlunga, Adelaide, Mt Barker)
Tasmania	3 (Hobart Eastern Shores–Sorell, Hobart Eastern Shores– Clarence, Devonport)
Victoria	8 (Ballan, Berwick, Bendigo, Geelong, Wallan, Wodonga, Cobram, Melbourne West)
Western Australia	4 (Midland, Wanneroo, Rockingham, Northam)
	36 (22 in first round and 14 in second round)

Source: ANAO.

¹⁹⁰ The general issue of high proportions of non-competitive Commonwealth grant schemes has been noted as a matter of 'significant concern' by the Joint Standing Committee on Public Accounts and Audit as the committee considered that competitive processes constituted 'best practice': see *Report 430, Review of Auditor-General's Reports Nos. 47 (2010-11) to 9 (2011-12) and Reports Nos. 10 to 23 (2011-12)* pp. 55.

Appendix 3: Distribution of GP Super Clinics and funding based on electoral type

Approach

There are 150 Federal electoral divisions. The Australian Electoral Commission (AEC) reports on 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 AEC 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 announced project was located and its electoral status (based on the party that held the seat and margin on a two-party preferred basis), at the time that the announcement was made. The clinics in Gladstone and Karratha were excluded from the analysis in this appendix as the relevant electorates in which the clinics were located were newly created for the 2007 and 2010 elections and as such were held by any political party at the time the proposed clinic was announced. The Redcliffe clinic, which received grants through both the first and second rounds, is only included in the first round figures.

The location analysis has been undertaken based on the locations/expected locations of the clinics, and does not account for the potential of catchment populations from neighbouring electorates accessing a clinic. For example, based on the electorate boundaries for the 2007 election, the Berwick clinic is located in the La Trobe electorate, but is adjacent to the neighbouring Holt electorate. At the time of the announcement of the Berwick GP Super Clinic, La Trobe was a marginal electorate held by the Coalition, whereas Holt was a marginal electorate held by the ALP.

Table A.2**Distribution of GP Super Clinic locations, by electorate**

Round	Proposed clinics in ALP-held electorates	Proposed clinics in Coalition-held electorates	Proposed clinics in Independent-held electorates
First round (31 clinics)	7 (22.6%)	23 (74.2%)	1 (3.2%)
Second round (32) clinics)	18 (56.2%)	12 (37.5%)	2 (6.3%)
Total (63 clinics)	25 (39.7%)	35 (55.5%)	3 (4.8%)

Source: ANAO analysis. For the purposes of this analysis, the clinics in Gladstone and Karratha are excluded as the relevant electorates in which the clinics were located were newly created for the 2007 and 2010 elections respectively and as such were not held by any political party at the time the proposed clinic was announced. The five 2009 clinics (Gunnedah, South Morang, Portland, Wodonga and Cockburn) are included in the second round as these were announced after the 2007 election.

Table A.3**Distribution of GP Super Clinic funding as announced, by electorate**

Round	Funding in ALP-held electorates	Funding in Coalition-held electorates	Funding in Independent-held electorates	Total funding across all electorates
First round (31 clinics)	\$29 million (19.9%)	\$114 million (78.4%)	\$2.5 million (1.7%)	\$145.5 million
Second round (32) clinics)	\$172.35 million (66.0%)	\$77.55 million (29.7%)	\$11.3 million (4.3%)	\$261.2 million
Total (63 clinics)	\$201.35 million (49.5%)	\$191.55 million (47.1%)	\$13.8 million (3.4%)	\$406.7 million

Source: ANAO analysis. For the purposes of this analysis, the clinics in Gladstone and Karratha are excluded as the relevant electorates in which the clinics were located were newly created for the 2007 and 2010 elections respectively and as such were not held by any political party at the time the proposed clinic was announced. The five 2009 clinics (Gunnedah, South Morang, Portland, Wodonga and Cockburn) are included in the second round as these were announced after the 2007 election. The figures do not take into account increases at Mt Isa and Wallan or second/third grants for Redcliffe (the total increase in grant funding for these three clinics was \$13.2 million).

Table A.4**Distribution of GP Super Clinic locations, by marginal electorate**

Round	Proposed clinics in ALP-held marginal electorates	Proposed clinics in Coalition-held marginal electorates	Proposed clinics in Independent-held marginal electorates
First round (31 clinics)	4 (12.9%)	13 (41.9%)	Nil
Second round (32 clinics)	9 (28.1%)	5 (15.6%)	Nil
Total (63 clinics)	13 (20.6%)	18 (28.6%)	Nil

Notes The percentages in the table above relate to the total number of clinics included in the analysis for the relevant funding round: 31 in the first round and 32 in the second round.

Source: ANAO analysis. For the purposes of this analysis, the clinics in Gladstone and Karratha are excluded as the relevant electorates in which the clinics were located were newly created for the 2007 and 2010 elections respectively and as such were not held by any political party at the time the proposed clinic was announced. The five 2009 clinics (Gunnedah, South Morang, Portland, Wodonga and Cockburn) are included in the second round as these were announced after the 2007 election.

Table A.5**Distribution of GP Super Clinic funding as announced, by marginal electorate**

Round	Funding in ALP-held marginal electorates	Funding in Coalition-held marginal electorates	Funding in all marginal electorates
First round (31 clinics)	\$13.5 million (9.3%)	\$82 million (56.4%)	\$95.5 million (65.7%)
Second round (32 clinics)	\$73 million (28.0%)	\$41 million (15.7%)	\$114 million (43.7%)
Total (63 clinics)	\$86.5 million (21.3%)	\$123 million (30.2%)	\$209.5 million (51.5%)

Notes The percentages in the table above relate to the total funding across all electorates: \$145.5 million for the first round; \$261.2 million for the second round.

Source: ANAO analysis. For the purposes of this analysis, the clinics in Gladstone and Karratha are excluded as the relevant electorates in which the clinics were located were newly created for the 2007 and 2010 elections respectively and as such were not held by any political party at the time the proposed clinic was announced. The five 2009 clinics (Gunnedah, South Morang, Portland, Wodonga and Cockburn) are included in the second round as these were announced after the 2007 election. The figures do not take into account increases at Mt Isa and Wallan or second/third grants for Redcliffe (the total increase in grant funding for these three clinics was \$13.2 million).

Index

A

Audit—scope, 34

Audit—conclusion, 10

Audit—methodology, 35

Audit—objective, 10, 34

Audit—recommendations, 22, 51

C

Clinic construction costs, 68, 99

Clinic roll-out—difficulties with
third party operators, 89, 90

Clinic roll-out—potential funding
shortfalls, 81, 82

Clinic roll-out—problems in
securing land tenure or
development approval, 12, 48, 82,
86, 87

Clinics—analysis of locations, 41,
53, 55, 66, 71, 116

Clinics—announcement of
locations, 8, 13, 14, 16, 26, 27, 38,
49, 51, 55, 118

Clinics—Berwick, 55

Clinics—distribution of funding,
16, 54, 55, 56, 58, 116, 117, 118

Clinics—Emerald, 54, 58

Clinics—factors underlying
locations, 8, 14, 15, 38, 40, 41, 49,
57, 102, 103

Clinics—Gunnedah, 49, 118

Clinics—list of all clinics, 112

Clinics—Lower Hunter, 54, 58

Clinics—map of locations, 30

Clinics—Modbury, 89, 90

Clinics—Mt Isa, 27, 84, 86, 118

Clinics—Noarlunga, 55, 89, 90

Clinics—operational performance,
13, 20, 102, 103, 109

Clinics—Palmerston, 54, 64, 65, 66,
89

Clinics—Portland, 49, 118

Clinics—Redcliffe, 18, 19, 27, 52, 78,
81, 89, 90, 91, 94, 95, 118

Clinics—Sorell, 18, 82, 83, 94

Clinics—Townsville (Northern
Beaches), 54, 58

Clinics—Wallan, 27, 84, 85, 118

Clinics—Wodonga, 49, 118

Commonwealth grant guidelines,
10, 12, 19, 32, 45, 53, 62, 66, 72, 79,
95

Community consultation, 44, 52, 54,
58, 104

Completion of clinics—delays, 13,
19, 79, 92, 95, 99

Completion of clinics—time to
completion, 91

D

Department of Health and
Ageing—health infrastructure
funding, 10, 71, 93

F

Funding —funding amounts, 9, 11,
26, 56, 97, 112

G

GP Super Clinics policy, 8, 25, 40

GP Super Clinics program—
program guidelines, 11, 12, 43,
49, 63, 97

GP Super Clinics program—
program objectives, 96

GP Super Clinics program—
program outcomes, 54

Grant funding process—
competitive and non-
competitive, 9, 12, 52, 53, 54, 57,
61, 62

H

Health and Hospitals Fund, 85

N

New Policy Proposal, 11, 39, 52

P

Patient presentations, 20, 104, 105,
106, 107, 109

Performance management
framework—External evaluation
of the program, 99

Performance management
framework—key performance
indicators, 13, 20, 96, 97, 98, 99,
102, 109

Performance management
framework—operational
reporting, 101, 102, 104, 107, 108

Program Objectives, 28

R

Risk management—program
implementation risks, 11, 14, 18,
40, 52, 57, 94

Risk management—risk
management plans, 45, 47, 61, 66,
78, 83, 93

S

Selection processes— assessment of
local health needs, 10, 34, 101

Selection processes—assessment
framework, 17, 59, 75

Selection processes—assessment of
impacts on existing services, 64,
75

Selection processes—assessment of
value for money, 13, 14, 17, 33,
40, 57, 66, 67, 68, 69, 71, 72, 75, 77,
86

Structure of the audit report, 36

V

Value for money, 13, 14, 15, 17, 33,
40, 57, 66, 67, 68, 69, 71, 72, 75, 77,
86, 99, 100

Series Titles

ANAO Audit Report No.1 2012–13

Administration of the Renewable Energy Demonstration Program

Department of Resources, Energy and Tourism

ANAO Audit Report No.2 2012–13

Administration of the Regional Backbone Blackspots Program

Department of Broadband, Communications and the Digital Economy

ANAO Audit Report No.3 2012–13

The Design and Conduct of the First Application Round for the Regional Development Australia Fund

Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.4 2012–13

Confidentiality in Government Contracts: Senate Order for Departmental and Agency Contracts (Calendar Year 2011 Compliance)

Across Agencies

ANAO Audit Report No.5 2012–13

Management of Australia's Air Combat Capability—F/A-18 Hornet and Super Hornet Fleet Upgrades and Sustainment

Department of Defence

Defence Materiel Organisation

ANAO Audit Report No.6 2012–13

Management of Australia's Air Combat Capability—F-35A Joint Strike Fighter Acquisition

Department of Defence

Defence Materiel Organisation

ANAO Audit Report No.7 2012–13

Improving Access to Child Care—the Community Support Program

Department of Education, Employment and Workplace Relations

ANAO Audit Report No.8 2012–13

Australian Government Coordination Arrangements for Indigenous Programs

Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.9 2012–13

Delivery of Bereavement and Family Support Services through the Defence Community Organisation

Department of Defence

Department of Veterans' Affairs

ANAO Audit Report No.10 2012–13

Managing Aged Care Complaints

Department of Health and Ageing

ANAO Audit Report No.11 2012–13

Establishment, Implementation and Administration of the Quarantined Heritage Component of the Local Jobs Stream of the Jobs Fund

Department of Sustainability, Environment, Water, Population and Communities

ANAO Audit Report No.12 2012–13

Administration of Commonwealth Responsibilities under the National Partnership Agreement on Preventive Health

Australian National Preventive Health Agency

Department of Health and Ageing

ANAO Audit Report No.13 2012–13

The Provision of Policing Services to the Australian Capital Territory

Australian Federal Police

ANAO Audit Report No.14 2012–13

Delivery of Workplace Relations Services by the Office of the Fair Work Ombudsman

Department of Education, Employment and Workplace Relations

Office of the Fair Work Ombudsman

ANAO Audit Report No.15 2012–13

2011–12 Major Projects Report

Defence Materiel Organisation

ANAO Audit Report No.16 2012–13

Audits of the Financial Statements of Australian Government Entities for the Period Ended 30 June 2011

Across Agencies

ANAO Audit Report No.17 2012–13

Design and Implementation of the Energy Efficiency Information Grants Program

Department of Climate Change and Energy Efficiency

ANAO Audit Report No.18 2012–13

Family Support Program: Communities for Children

Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.19 2012–13

Administration of New Income Management in the Northern Territory

Department of Human Services

ANAO Audit Report No.20 2012–13

Administration of the Domestic Fishing Compliance Program

Australian Fisheries Management Authority

ANAO Audit Report No.21 2012–13

Individual Management Services Provided to People in Immigration Detention

Department of Immigration and Citizenship

ANAO Audit Report No.22 2012–13

Administration of the Tasmanian Forests Intergovernmental Contractors Voluntary

Exit Grants Program

Department of Agriculture, Fisheries and Forestry

ANAO Audit Report No.23 2012–13

The Australian Government Reconstruction Inspectorate's Conduct of Value for

Money Reviews of Flood Reconstruction Projects in Victoria

Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.24 2012–13

The Preparation and Delivery of the Natural Disaster Recovery Work Plans for

Queensland and Victoria

Department of Regional Australia, Local Government, Arts and Sport

ANAO Audit Report No.25 2012–13

Defence's Implementation of Audit Recommendations

Department of Defence

ANAO Audit Report No.26 2012–13

Remediation of the Lightweight Torpedo Replacement Project

Department of Defence;

Defence Material Organisation

ANAO Audit Report No.27 2012–13

Administration of the Research Block Grants Program

Department of Industry, Innovation, Climate Change, Science, Research and
Tertiary Education

ANAO Report No.28 2012–13

*The Australian Government Performance Measurement and Reporting Framework:
Pilot Project to Audit Key Performance Indicators*

Across Agencies

ANAO Audit Report No.29 2012–13

Administration of the Veterans' Children Education Schemes

Department of Veterans' Affairs

ANAO Audit Report No.30 2012–13

Management of Detained Goods

Australian Customs and Border Protection Service

ANAO Audit Report No.31 2012–13

Implementation of the National Partnership Agreement on Homelessness

Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.32 2012–13

Grants for the Construction of the Adelaide Desalination Plant

Department of Sustainability, Environment, Water, Population and
Communities

Department of Finance and Deregulation

Department of the Prime Minister and Cabinet

ANAO Audit Report No.33 2012–13

The Regulation of Tax Practitioners by the Tax Practitioners Board

Tax Practitioners Board

Australian Taxation Office

ANAO Audit Report No.34 2012–13

Preparation of the Tax Expenditures Statement

Department of the Treasury

Australian Taxation Office

ANAO Audit Report No.35 2012–13

Control of Credit Card Use

Australian Trade Commission

Department of the Prime Minister and Cabinet

Geoscience Australia

ANAO Audit Report No.36 2012–13

Commonwealth Environmental Water Activities

Department of Sustainability, Environment, Water, Population and Communities

ANAO Audit Report No.37 2012–13

Administration of Grants from the Education Investment Fund

Department of Industry, Innovation, Climate Change, Science, Research and Tertiary Education

ANAO Audit Report No.38 2012–13

Indigenous Early Childhood Development: Children and Family Centres

Department of Education, Employment and Workplace Relations

ANAO Audit Report No.39 2012–13

AusAID's Management of Infrastructure Aid to Indonesia

Australian Agency for International Development (AusAID)

ANAO Audit Report No. 40 2012–13

Recovery of Centrelink Payment Debts by External Collection Agencies

Department of Human Services

ANAO Audit Report No.41 2012–13

The Award of Grants Under the Supported Accommodation Innovation Fund

Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.42 2012–13

Co-location of the Department of Human Services' Shopfronts

Department of Human Services

ANAO Audit Report No.43 2012–13

Establishment, Implementation and Administration of the General Component of the Local Jobs Stream of the Jobs Fund

Department of Education, Employment and Workplace Relations

ANAO Audit Report No. 44 2012–13

Management and Reporting of Goods and Services Tax and Fringe Benefits Tax Information

Australian Taxation Office

ANAO Audit Report No. 45 2012–13

Cross-Agency Coordination of Employment Programs

Department of Education, Employment and Workplace Relations

Department of Human Services

ANAO Audit Report No. 46 2012–13

Compensating F-111 Fuel Tank Workers

Department of Veterans' Affairs

Department of Defence

ANAO Audit Report No. 47 2012–13

AUSTRAC's Administration of its Financial Intelligence Function

Australian Transaction Reports and Analysis Centre

ANAO Audit Report No.48

Management of the Targeted Community Care (Mental Health) Program

Department of Families, Housing, Community Services and Indigenous Affairs

ANAO Audit Report No.49

Interim Phase of the Audits of the Financial Statements of Major General Government Sector Agencies for the year ending 30 June 2013

Across Agencies

Current Better Practice Guides

The following Better Practice Guides are available on the ANAO website.

Preparation of Financial Statements by Public Sector Entities	Jun 2013
Human Resource Information Systems – Risks and Controls	Jun 2013
Public Sector Internal Audit	Sept 2012
Public Sector Environmental Management	Apr 2012
Developing and Managing Contracts – Getting the right outcome, achieving value for money	Feb 2012
Public Sector Audit Committees	Aug 2011
Fraud Control in Australian Government Entities	Mar 2011
Strategic and Operational Management of Assets by Public Sector Entities – Delivering agreed outcomes through an efficient and optimal asset base	Sept 2010
Implementing Better Practice Grants Administration	Jun 2010
Planning and Approving Projects – an Executive Perspective	Jun 2010
Innovation in the Public Sector – Enabling Better Performance, Driving New Directions	Dec 2009
SAP ECC 6.0 – Security and Control	Jun 2009
Business Continuity Management – Building resilience in public sector entities	Jun 2009
Developing and Managing Internal Budgets	Jun 2008
Agency Management of Parliamentary Workflow	May 2008
Fairness and Transparency in Purchasing Decisions – Probity in Australian Government Procurement	Aug 2007
Administering Regulation	Mar 2007
Implementation of Program and Policy Initiatives – Making implementation matter	Oct 2006

