The Auditor-General
Audit Report No.19 2006–07
Performance Audit

Administration of State and Territory Compliance with the Australian Health Care Agreements

Department of Health and Ageing

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
25 January 2007

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled *Administration of State and Territory Compliance with the Australian Health Care Agreements.*

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

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

AUDITING FOR AUSTRALIA

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

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Abbreviations

ACSB	Acute Care Strategies Branch
AHCAs	Australian Health Care Agreements
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
AUS 902	Australian Auditing Standard 902 'Review of Financial Reports'
AUS 904	Australian Auditing Standard 904 'Engagements to Perform Agreed-upon Procedures'
COAG	Council of Australian Governments
COPOs	Commonwealth Own Purpose Outlays
Health	Department of Health and Ageing
HIPIP	Hospital Information and Performance Information Program
MBS	Medicare Benefits Schedule
Minister	Minister for Health and Ageing
NMDS	National Minimum Data Sets
Secretary	Secretary of the Department of Health and Ageing
SPPs	Specific Purpose Payments

Glossary

Specific Purpose Payments (SPPs)	The Constitution permits the Australian Parliament to grant financial assistance to any State or Territory on such terms and conditions as it thinks fit. SPPs typically involve Australian Government financial assistance to State, Territory or local Governments for a specific purpose. Providing financial assistance as SPPs enables the Australian Government to pursue a national policy objective in a particular functional area. As such, SPPs can be drawn from the Consolidated Revenue Fund under the annual general Appropriation Acts or through Special Appropriation Acts. These Acts have a dual role of authorising the expenditure of public moneys and restricting expenditure to particular purposes.

Summary and Recommendations

Summary

The Australian Health Care Agreements

1. The Australian Health Care Agreements (AHCAs) are five-year bilateral agreements between the Australian Government and each State and Territory Government for the provision and joint funding of public hospital services in Australia.[1] The AHCAs are the largest, in monetary terms, of all Australian Government Specific Purpose Payments (SPPs).

2. The current AHCAs provide for Australian Government funding of up to $42 billion over 2003–04 to 2007–08. They also require the State and Territory Governments to contribute an estimated $58 billion to public hospitals over the same period. This means that total government expenditure on public hospital services under the AHCAs in this period will be some $100 billion.

3. In 2004–05, hospital emergency departments treated about 4.3 million people, and public hospitals admitted some 3.7 million public patients.

4. Australian Government expenditure under the current AHCAs was $7.49 billion in 2003–04, $7.95 billion in 2004–05 and $8.32 billion in 2005–06. AHCAs funding for 2006–07 is budgeted at $8.77 billion, or 21 per cent of the Health portfolio budget. After the Medicare Benefits Schedule (MBS), it is the largest program in the Health portfolio.

5. The primary objective of each AHCA (set out in clause 6) is to secure access for the community to public hospital services, based on the following three principles:

(a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals;

(b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

(c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of geographical location.

6. The AHCAs allocate responsibilities and obligations to both the Australian Government and the States and Territories. The Australian

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[1] The AHCAs for each State and Territory are available on Health's website at <www.health.gov.au /internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm>.

Government has three main responsibilities under the AHCAs and these are administered by the Department of Health and Ageing (Health). They involve funding the States and Territories, subject to their compliance with their obligations; funding, and developing policy for, national program activities; and publishing an annual report: *The State of Our Public Hospitals*.

7. The States and Territories must provide public hospital services in accordance with the AHCAs. In order to qualify for the full level of funding available under the AHCAs, each State and Territory must satisfy three specific requirements: adhere to the principles, referred to in paragraph 5; contribute substantial funding of their own and increase this funding at a rate which at least matches the estimated cumulative rate of growth of Australian Government funding under the AHCAs; and meet certain performance reporting requirements.

8. Health is required to test compliance with these requirements to assess whether the States and Territories are meeting their obligations each year, and to advise the Minister for Health (Minister). The level of financial assistance provided is dependent on whether the Minister is satisfied that the State or Territory is meeting its obligations.

Audit approach

9. The objective of this audit was to determine whether Health adequately assessed the State and Territory Governments' compliance with their obligations under the terms of the AHCAs. In conducting the audit, ANAO addressed the following criteria:

- if Health assessed whether the States and Territories were adhering to the AHCAs clause 6 principles that all eligible persons had equitable access to free public health and emergency services on the basis of clinical need within an appropriate period;
- if Health assessed whether the States and Territories were increasing their own source funding at the rate specified in the AHCAs; and
- if Health assessed whether the States and Territories were meeting the performance reporting requirements set out in the AHCAs.

Overall audit conclusion

10. The AHCAs place obligations on the States and Territories to provide free community access to public hospital services, increase their funding for

public hospital services and provide performance information to Health. The Agreements are the result of negotiations between the Commonwealth, and State and Territory Health Ministers. While the AHCAs included performance indicators, they do not contain benchmarks against which Health could assess State and Territory performance in meeting their obligations. Notwithstanding, Health is responsible for advising the Minister on State and Territory performance, as the Minister must be satisfied that each has met these obligations in order to approve the full level of funding.

11. Against this background, Health has developed procedures for monitoring whether the States and Territories were complying with their obligations under the AHCAs. The States and Territories are obliged to adhere to the principles that all eligible persons have equitable access to free public health and emergency services on the basis of clinical need within an appropriate period. Health's assessment of this obligation is largely reliant on the outcomes of investigations by the relevant State or Territory of complaints made to the department or the Minister. This exception-based approach requires Health to exercise judgement as to whether cases, where there is some basis for complaint, are isolated or if they suggest evidence of systematic or ongoing non-compliance by a State or Territory with its obligations.

12. In assessing whether the States and Territories meet their obligations to increase their recurrent expenditure on public hospital services and report performance information, Health relies upon the States and Territories providing the required data in the correct format by the due date. Health had put in place processes which assisted the States and Territories to meet their obligations in these areas. However, there are some definitional issues that Health should clarify with the States and Territories in order to improve the level of assurance it has about each jurisdiction's contribution to public hospital funding.

13. Health addressed State and Territory compliance with each of the three areas of obligation in its advice to the Minister. In the first two years of the current AHCAs, Health advised the Minister that all States and Territories should be considered compliant, while recognising that some had satisfactorily addressed minor breaches of the principles on some occasions.

14. Overall Health has developed and implemented a suitable framework to administer the AHCAs. While there is scope for some improvement in the approach adopted, the department has taken into account the obligations of

the States and Territories under the AHCAs in providing advice to the Health Minister.

Key findings

Health's responsibilities under the AHCAs (Chapter 2)

15. Health administered the Australian Government's responsibilities under the AHCAs through funding the States and Territories, and conducting assessments and advising the Minister of the States' and Territories' compliance with their obligations under the AHCAs. It also published an annual report on the state of public hospitals based on the performance information provided by the States and Territories. Health's responsibility for developing policy for national program activities was outside the audit scope.

16. ANAO found that Health had developed procedures for defining, monitoring and analysing whether the States and Territories complied with their obligations under the AHCAs. Health's *Compliance Monitoring and Assessment Framework* set out procedures for monitoring whether the States and Territories provided the information Health required for its assessment. This document also defined the events or activities that constituted a potential breach of the AHCAs' principles that all eligible persons had equitable access to free public health and emergency services on the basis of clinical need within an appropriate period, and outlined the action Health would take if a breach was identified.

17. Health's *Compliance with AHCA Business Rules* further assisted its staff with compliance assessment. A Complaints Review Group within Health had responsibility for overseeing the AHCAs' compliance requirements, and Health had set up a compliance database for registering potential breaches.

18. Health had not provided its framework to the States and Territories and consequently some were uncertain about Health's compliance assessment procedures. ANAO recommends that Health supply more detailed guidance about its procedures and assessment principles to State and Territory Governments, so that they would be better informed of the Australian Government's requirements. While Health considered it inappropriate to provide its internal framework to the States and Territories, it indicated that it would develop, and provide, a principles document, which included a more detailed summary of its compliance processes.

State and Territory adherence to the clause 6 principles (Chapter 3)

19. Health generally assumed that the States and Territories were adhering to the AHCAs principles that all eligible persons had equitable access to free public health and emergency services on the basis of clinical need within an appropriate period. Health took action when specific complaints or allegations about public hospital services were made to the department or the Minister, or when it identified potential non-compliance from other sources. Health received only a very small number of such complaints and allegations each year considering the large numbers of people who used public hospital services. Health used these to identify potential breaches of the principles.

20. Health required sufficient evidence, and written permission from the complainant, before pursuing complaints and allegations. As a result, Health had referred around half of the complaints received during the first three years of the AHCAs to a State or Territory for investigation. In most of these cases, Health had accepted State and Territory assurances that the events referred were not breaches of the principles. In the few cases where a State or Territory advised that a practice or situation was found to be a minor breach, Health considered the matter resolved if action had been taken to address the issue.

21. The AHCAs require that the range of services available to public patients in each State and Territory should be no less than was available at 1 July 1998. Neither Health nor the States and Territories had compiled lists of the range of services available at 1 July 1998 to public patients free of charge within each jurisdiction. Health accepted States' and Territories' advice about when they had implemented particular services, with little, if any, supporting evidence.

22. Health advised that it could not investigate potential breaches of the AHCAs itself because its limited resources and lack of jurisdiction over public hospitals restricted the collection of evidence. Nor could it carry out investigations to affirm State and Territory advice that complaints referred were not breaches, mainly because of the difficulty of finding substantive evidence. However, during 2006, Health decided to improve its procedures for determining whether the States and Territories had investigated alleged breaches that Health referred to them. Health now consistently asked for more evidence of the investigations, including supporting data, and the steps taken to address any issues.

23. Health analysed some of the annual performance data supplied by the States and Territories which it used when preparing its advice to the Minister

and in preparing its annual report on the state of public hospitals at the end of the year. However, it did not regularly analyse the performance data supplied by the States and Territories each quarter to assist its monitoring or assessment of compliance. Health advised that the States and Territories recorded and reported emergency department and elective surgery waiting time data in different ways, which caused some problems with its consistency and accuracy. Health also considered that it had no specific data which enabled it to readily measure access to services based on geographic location to determine whether such access was equitable.

24. ANAO recommends that Health work with the States and Territories to improve the consistency and accuracy of data on waiting times, and regularly analyse the quarterly data they provide as part of their performance reporting to assist it to confirm adherence to the principles.

25. In its assessment of whether the States and Territories were adhering to the principles, and in its advice to the Minister, Health largely relied on exception reporting of the outcome of the State and Territory investigations into the small number of complaints made to the department or to the Minister. Health exercised judgement in determining whether potential breaches were isolated cases, rather than evidence of systemic or ongoing non-compliance. Subsequently, Health advised the Minister that all States and Territories should be considered compliant, while recognising that some had satisfactorily addressed minor breaches of the principles on some occasions.

26. While recognising that the nature and terms of Agreements are properly matters for Ministers to decide, ANAO considers that Health could explore options and provide advice to its Minister on opportunities to improve the administration of the AHCAs. For example, the development of benchmarks would assist Health and the States and Territories in confirming adherence to the principles. In this regard, Health advised that it had recently received a final report from its consultancy into future options for performance reporting and, during the next six months, it will be liaising with the States and Territories regarding proposed new indicators for equity (and other new measures) with a view to establishing enhanced performance reporting under future agreements.

State and Territory recurrent expenditure growth rate (Chapter 4)

27. ANAO found that Health had procedures in place to monitor whether the States and Territories provided their recurrent expenditure on public

hospital services data on time. Health encouraged the States and Territories to report their expenditure on a timely basis, and followed up outstanding returns. Health used a model that accurately determined State and Territory expenditure requirements, and calculated actual growth rates based on reported recurrent expenditure.

28. While the AHCAs did not specify which components of recurrent expenditure on public hospital services should be included for determining growth rates, Health had agreed definitions with each State and Territory in 2003. ANAO notes that these definitions varied between jurisdictions, making comparisons of expenditure data across States and Territories of limited utility for national reporting and analysis. Subsequently, Health had worked collaboratively with the States and Territories to develop a clear definition of State and Territory recurrent expenditure on 'AHCA-related services' which will apply under agreements from 2008. Health considered that this new methodology will provide it with greater capacity to make reliable comparisons of expenditure across jurisdictions and over time.

29. In 2003–04 and 2004–05, Health recorded that all the States and Territories supplied their recurrent expenditure data, and the supporting statements providing independent verifications of that data by auditors appointed by the States and Territories, by the due date. Health advised the Minister that all the States and Territories had sufficiently exceeded the required rate of growth in their own expenditure in each of the first two years of the current AHCAs to ensure compliance with their funding obligations.

30. However, Health had not agreed with the States and Territories on the procedures to be used by auditors in preparing these statements, while the nature and extent of work done differed between jurisdictions. Health did not examine the statements to identify the scope of the audits or whether the auditors had qualified their opinions. This meant that Health could not be confident that the States and Territories were in compliance with their financial and reporting requirements. Health advised that it had undertaken in good faith to accept signed verifications from auditors and considered that compliance was satisfied if the reports were provided on time.

31. ANAO recommends that Heath clarify the level and nature of assurance it requires from the auditors' statements, and take action to reach agreement with the States and Territories on a consistent approach which provides that assurance. Health should also review statements supplied by State and Territory auditors to identify the impact of any limitations or adverse

findings on its assessment of compliance with the financial reporting obligations.

State and Territory performance reporting (Chapter 5)

32. Health had procedures in place to assess whether the States and Territories were complying with the performance reporting obligations of the AHCAs. Health also provided advice to the States and Territories on how to comply with their obligations, and developed procedures to encourage them to report on a timely basis and in the required format.

33. In 2003–04 and 2004–05, Health assessed all the States and Territories as being compliant with this obligation since they supplied the required performance information in the desired format by the due date. Health provided sufficient information to the Minister to enable a determination of State and Territory compliance with their performance reporting obligations.

34. The AHCAs did not specifically require Health to assess data quality in determining compliance, and Health advised the States and Territories that data quality would not form part of the assessment. Nevertheless, ANAO notes that Health carried out limited checks on data quality in its initial assessment of compliance. Health also analysed the performance information submitted by the States and Territories in publishing its annual report *The State of Our Public Hospitals*.

35. ANAO notes that, along with the data provided to Health, the States and Territories had to provide somewhat different sets of performance information to other Australian Government agencies. ANAO considers that there would be benefit in Health ensuring that its requirements for State and Territory public hospital data were more closely coordinated with these other agencies.

Recommendations

36. ANAO has made three recommendations to assist Health improve its assessment of the State and Territory Governments' compliance with their obligations in its administration of the AHCAs. Health has agreed to all recommendations.

Health's response

37. The Department welcomes the audit findings. As noted in the audit report, some of the suggestions made, such as development of benchmarks, are policy matters and the Department will continue to administer the Australian Health Care Agreements within the policy framework set by the Government when the Agreements were signed. With regard to the assessment processes, the Department will provide the States and Territories with a high level principles document outlining the Department's assessment processes and expectations in its assessment of compliance. Agreements have already been reached with the States and Territories to improve consistency in reporting on the waiting times data and public hospital recurrent expenditure and there will continue to be an ongoing dialogue in this regard.

Recommendations

Recommendation No.1

Para 2.18

ANAO recommends that, to assist the States and Territories clearly understand Health's processes and expectations in its assessment of compliance with the AHCAs, Health provide more detailed guidance of its procedures and assessment principles to the State and Territory Governments.

***Health's response**: Agreed.*

Recommendation No.2

Para 3.16

ANAO recommends that Health work with the States and Territories to improve the consistency and accuracy of their data on emergency department and inpatient waiting times, and regularly analyse the quarterly performance data provided by the States and Territories to assist in confirming their adherence to the AHCAs' principles.

***Health's response**: Agreed.*

Recommendation No.3

Para 4.19

ANAO recommends that Health:

(a) clarify with the States and Territories the level and nature of assurance it requires from independent audits of State and Territory recurrent expenditure on public hospital services; and

(b) review future auditors' statements on State and Territory recurrent expenditure on public hospital services to identify the impact of any limitations or adverse findings on its assessment of compliance with the AHCAs.

Health's response: Agreed.

Audit Findings and Conclusions

1. Introduction

Chapter 1 provides a background to the audit, including a brief description of the AHCAs and an outline of the audit objective, scope, criteria and methodology.

Background

1.1 The Australian Health Care Agreements (AHCAs) are five-year bilateral agreements between the Australian Government and each State and Territory Government for the provision and joint funding of public hospital services in Australia. The AHCAs are the largest, in monetary terms, of all Specific Purpose Payments (SPPs) to the States and Territories.[2]

1.2 As well as the funding provided under the AHCAs, the Australian Government's contribution to recurrent funding for health includes direct expenditure on health programs such as the Medicare Benefits Schedule (MBS), the Pharmaceutical Benefits Scheme and subsidies to providers of health services (for example, residential care); rebates on private health insurance premiums[3]; other SPPs for blood transfusion services and high-cost drugs; and payments made by the Department of Veterans' Affairs for treating veterans and their dependants. In 2004–05, total Australian Government recurrent funding for health was an estimated $39.6 billion.[4]

1.3 The Australian Government will provide funding of up to $42 billion under the current AHCAs over the period 2003–04 to 2007–08. Australian Government expenditure under the AHCAs was $7.49 billion in 2003–04, $7.95 billion in 2004–05 and $8.32 billion in 2005–06. AHCAs funding for 2006–07 is budgeted at $8.77 billion, or around 21 per cent of the Health portfolio budget. After MBS, it is the largest program in the Health portfolio.

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2 Commonwealth of Australia, *Federal Financial Relations 2006–07*, Budget Paper No.3, Appendix B, available from <www.budget.gov.au/2006-07>. See the Glossary of this report for a definition of SPPs.

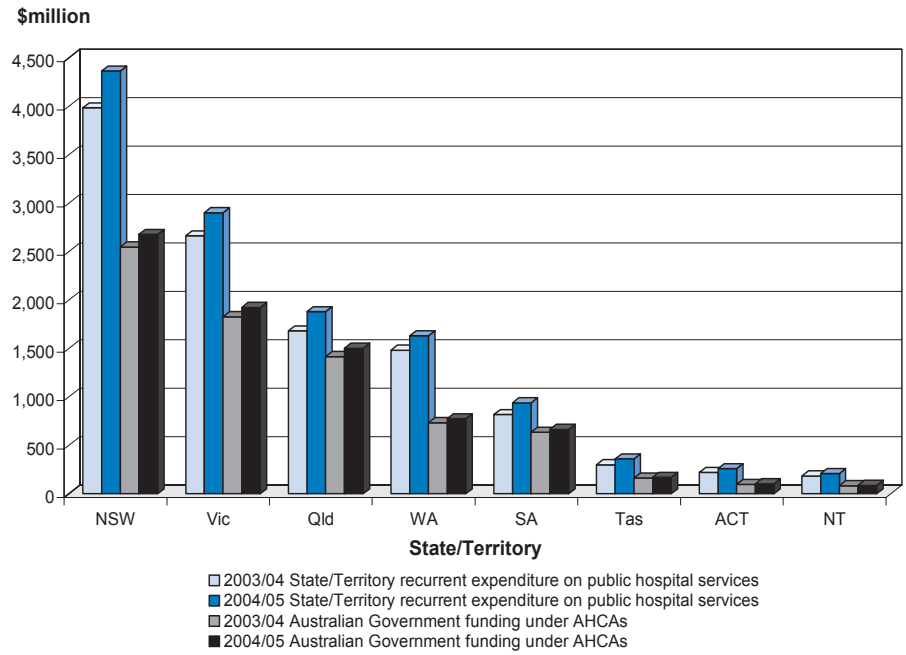
3 Since 1 January 1999, the Australian Government has provided a 30 per cent rebate on the cost of private health insurance for eligible Australians who have private health cover. The rebate increased from 30 per cent to 35 per cent for people aged between 65 and 69 years, and to 40 per cent for people aged over 70 years from 1 April 2005. The rebate is available as a reduction in the premium paid to a private health insurance fund, as a direct payment from Medicare Australia or as a tax rebate through the Australian Taxation Office.

4 Australian Institute of Health and Welfare (AIHW), *Health Expenditure Australia 2004–05*, AIHW, September 2006, pp. 30-35, available at <www.aihw.gov.au/publications>.

1.4 In order to obtain this funding, the State and Territory Governments have to contribute substantial funding of their own and meet certain other obligations specified in the AHCAs. Figure 1.1 charts recurrent expenditure by the States and Territories on public hospital services and the funding from the Australian Government under the AHCAs for 2003–04 and 2004–05.[5]

Figure 1.1

Australian Government funding under AHCAs and State and Territory Government recurrent expenditure on public hospital services, 2003–04 and 2004–05



Source: ANAO and Health.

1.5 The Department of Health and Ageing (Health) administers the AHCAs on behalf of the Australian Government. Health has estimated that the AHCAs require the States and Territories to contribute at least $58 billion to public hospitals between 2003 and 2008. Therefore, combined government expenditure on public hospital services under the AHCAs in this period will be some $100 billion.

[5] State and Territory recurrent expenditure figures for 2005–06 will not be available until early 2007.

The Australian Health Care Agreements 2003–2008

1.6 Funding for the AHCAs is provided to each State and Territory pursuant to the *Health Care (Appropriation) Act 1998*. The level of financial assistance is dependent on whether the Minister for Health (Minister) is satisfied that the State or Territory is meeting certain conditions. The primary objective of each AHCA, set out in clause 6, is to secure access for the community to public hospital services, based on the following three principles:[6]

(a) eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals;

(b) access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period; and

(c) arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of geographical location.

1.7 The AHCAs allocate responsibilities and obligations to both the Australian Government and the States and Territories. Health, on behalf of the Australian Government, has three primary responsibilities under clause 9 of the AHCAs. These are to:

- contribute to the cost of State and Territory public hospital services for eligible persons, on time and at a level specified in the AHCA, subject to each State and Territory meeting its obligations under the AHCA;
- in consultation with the States and Territories, fund and develop policy for national program activities relating to mental health, palliative care and hospital information and performance information programs; and
- publish an annual report: *The State of Our Public Hospitals*.

1.8 States and Territories must provide public hospital services in accordance with the AHCAs, such that eligible persons are able to access public hospital services, free of charge, as public patients. They also have a number of other obligations, including providing support for medical specialist training positions, providing performance information, contributing to the development of new performance indicators (with a particular focus on health outputs and outcomes), and reporting on their financial contributions.

[6] The AHCAs for each State and Territory contain similar clauses. They are available at <www.health.gov.au/internet/wcms/publishing.nsf/Content/health-ahca-agreement.htm>.

1.9 In order to qualify for the full level of funding available, each State and Territory has to comply with three specific requirements (clause 25), as follows:

- adhere to the AHCAs principles set out in clause 6;
- increase its own source funding at a rate which at least matches the estimated cumulative rate of growth of Australian Government funding under the AHCAs (subject to a tolerance of 0.5 percentage points in 2003–04 and 2004–05, and 0.25 percentage points in 2005–06); and
- meet the performance reporting requirements set out in the AHCAs.

1.10 In applying the clause 6 principles, the Australian Government and States and Territories agreed that the range of services available to public patients should be no less than was available on 1 July 1998, and that all public hospital services available to private patients should be accessible on a public patient basis, where there is a demonstrated clinical need.

1.11 Health is required to test compliance with these requirements to determine whether the States and Territories are meeting their obligations each year, and to advise the Minister.

Future Agreements

1.12 The current AHCAs will end on 30 June 2008. In February 2006, the Council of Australian Governments (COAG) agreed that the Australian Government and States and Territories should review SPPs that significantly affected the health system prior to their renegotiation, with the intention of identifying any elements that, if changed, could contribute to better health outcomes.[7] In this regard, the Australian Government and State and Territory Heads of Treasuries have commenced a review of the AHCAs. Health advised that it is preparing for future agreements.

Previous audits

1.13 In 2002–03, ANAO conducted a performance audit that examined aspects of the AHCAs that operated from 1998 to 2003.[8] The audit found that Health had only limited information on the performance of the States and

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[7] Council of Australian Governments' Meeting Communiqué, 10 February 2006, available at <www.coag.gov.au/meetings/100206>.

[8] ANAO Audit Report No. 21 2002–03, *Performance Information in Australian Health Care Agreements*, available at <www.anao.gov.au>.

Territories in meeting the conditions of Australian Government funding for free and equitable access to public hospital services. Further, Health had only partial performance information on the effectiveness and efficiency of those AHCAs.

State and Territory audits

1.14 State and Territory Audit Offices conduct audits within State and Territory public sector entities. Appendix 1 lists a number of recent audit reports related to the services funded under the AHCAs.

Audit approach

1.15 The provision of public hospital funding is a high profile and complex area of public administration. Major issues of public hospital capacity in some of the States and Territories have increased the attention given to the AHCAs in recent years. The House of Representatives Standing Committee on Health and Ageing focussed on the AHCAs during its inquiry into health funding. This Committee made a number of recommendations relating to the funding of public hospital services under future AHCAs, or substitute arrangements, in its report on the inquiry, which it tabled on 4 December 2006.[9]

1.16 ANAO conducted the audit to provide assurance to Parliament that Health was fulfilling its responsibilities in administering the large amount of Australian Government funding provided to the States and Territories through the AHCAs. ANAO also considered that Health could use the findings from the audit in developing the next AHCAs.

Audit objective and criteria

1.17 The audit objective was to determine whether Health adequately assessed State and Territory Governments' compliance with their obligations under the terms of the AHCAs.

1.18 In conducting the audit, the ANAO addressed the following criteria:

- if Health assessed whether the States and Territories were adhering to the AHCAs clause 6 principles that all eligible persons had equitable access to free public health and emergency services on the basis of clinical need within an appropriate period;

[9] The Parliament of the Commonwealth of Australia, House of Representatives Standing Committee on Health and Ageing, *The Blame Game: Report on the inquiry into health funding*, Canberra, November 2006, available at <www.aph.gov.au/house/committee/haa/healthfunding/report.htm>.

- if Health assessed whether the States and Territories were increasing their own source funding at the rate specified in the AHCAs; and
- if Health assessed whether the States and Territories were meeting the performance reporting requirements set out in the AHCAs.

Scope

1.19 The audit focussed on Health's role in carrying out the Australian Government's responsibilities specified in the AHCAs to assess State and Territory compliance with their obligations. Health's responsibility for developing policy for national program activities was outside the audit scope.

1.20 The audit did not assess the activities of the States and Territories in fulfilling their roles and responsibilities under the AHCAs, as such assessment is outside the ANAO's mandate.

Audit methodology

1.21 In conducting the audit, ANAO reviewed the legislation, the previous and current AHCAs, previous audits, and literature and prior studies relevant to the provision of public health services.

1.22 ANAO carried out fieldwork at Health's offices in Canberra during April to June 2006. This involved interviews with staff in Health, particularly staff in the Acute Care Strategies Branch (ACSB) with responsibility for administration of the AHCAs, and the examination of Health's operational documents, files and publications. ANAO also performed checks on Health's performance and compliance data.

1.23 ANAO interviewed various key stakeholders including officers in some State and Territory Government Health or Human Services Departments; officers in Medicare Australia; staff of the Minister for Health; and officers in some State and Territory Audit Offices. The audit team also visited a public hospital to gain an overview of administrative procedures.

1.24 The audit was conducted in accordance with ANAO Auditing Standards at a cost of $367 000.

Structure of the report

1.25 The remainder of this report is structured as follows:

- Chapter 2 describes Health's responsibilities under the AHCAs and considers whether Health's compliance assessment procedures provide a sound basis for carrying out its responsibilities;
- Chapter 3 discusses Health's assessment of State and Territory adherence to the AHCA clause 6 principles and its management of non-compliance;
- Chapter 4 considers Health's assessment of whether the States and Territories are increasing their funding at the rates specified in the AHCAs; and
- Chapter 5 considers Health's assessment of whether the States and Territories are providing performance information as required by the AHCAs, and Health's analysis of the information for its publication *The State of Our Public Hospitals*.

2. Health's Responsibilities under the AHCAs

Chapter 2 describes Health's responsibilities under the AHCAs and considers whether Health's compliance assessment procedures provide a sound basis for carrying out its responsibilities.

2.1 As noted earlier, Health administers the Australian Government's three main responsibilities under the AHCAs. They involve funding the States and Territories subject to their compliance with their obligations; funding, and developing policy for, national program activities; and publishing an annual report entitled *The State of Our Public Hospitals*. As also noted, Health's responsibility for policy development was outside the scope of this audit.

Payments to the States and Territories

2.2 As part of its first responsibility, Health is required to pay and account for the funds it provides through the AHCAs to the States and Territories.

2.3 Full details of the financial assistance available to the States and Territories, and the associated terms and conditions, are set out in Schedule G of the AHCAs. The Schedule includes details of formulae used to calculate the grant entitlements, cash flow arrangements and acquittal requirements. Schedule F of the AHCAs details population weightings to be used to calculate the 'weighted population' where required in the AHCAs.

2.4 In each grant year, Health pays the States and Territories 51 equal weekly instalments based on 7/365 of their total amount and a final instalment amount which is slightly different due to adjustments and rounding. The total amount comprises a number of components. These are:

- the Base Health Care Grant, which comprises general, palliative care, and safety and quality components;
- Non-Base Health Care Grants, comprising funding for mental health reform, some small State-specific payments, and a compliance payment equivalent to four per cent of the Base Health Care Grant;

- Commonwealth Own Purpose Outlays (COPOs)[10], including Hospital Information and Performance Information Program (HIPIP)[11] funding; and
- funding for the Pathways Home program[12].

2.5 Health calculates the payments to each State and Territory using a spreadsheet containing formulae derived from the AHCAs. This provides a summary schedule of grants payments known as the Estimates Model.

2.6 Estimates of annual funding, calculated at the time of signing the AHCAs in September 2003, are shown by State and Territory in Table 2.1, and by component in Table 2.2.

Table 2.1

Annual funding estimates under the 2003–08 AHCAs by State and Territory

	2003–04 $m	2004–05 $m	2005–06 $m	2006–07 $m	2007–08 $m	Total $m
New South Wales	2 542.5	2 679.8	2 815.2	2 959.3	3 109.9	14 106.7
Victoria	1 823.4	1 925.7	2 026.1	2 131.0	2 241.0	10 147.2
Queensland	1 421.5	1 511.2	1 600.4	1 694.4	1 793.9	8 021.4
Western Australia	734.2	778.6	823.2	871.0	921.6	4 128.6
South Australia	638.2	670.1	701.2	733.9	768.1	3 511.5
Tasmania	168.0	176.3	184.1	192.4	201.0	921.8
Australian Capital Territory	99.0	104.7	110.4	116.4	122.7	553.2
Northern Territory	92.3	97.0	102.0	107.4	113.2	511.9
Commonwealth Own Purpose Outlays	19.7	20.5	21.4	22.2	23.2	107.0
Total AHCAs	**7 538.8**	**7 964.0**	**8 384.0**	**8 828.1**	**9 294.5**	**42 009.4**

Source: Health.

Note: Differences between the sums of component items and the totals are due to rounding.

[10] Commonwealth Own Purpose Outlays (COPOs) refer to the Australian Government's funding of services that either supplement or substitute services that the States and Territories usually provide.

[11] The Australian Government maintains the Hospital Information and Performance Information Program (HIPIP) as COPOs under the AHCAs. HIPIP is designed to provide the health care industry with a nationally consistent method of classifying types of patients, their treatment and associated costs for the purpose of measuring and paying for health care services.

[12] Under the 2003–08 AHCAs, the Australian Government provided one-off funding for a new Pathways Home program designed to assist the States and Territories to increase the provision of rehabilitation and 'step-down' (convalescent) care services provided to patients on leaving hospital.

Table 2.2

Annual funding estimates under the 2003–08 AHCAs by component

	2003–04 $m	2004–05 $m	2005–06 $m	2006–07 $m	2007–08 $m	Total $m
Base Health Care Grant						
General	7 237.6	7 634.4	8 043.9	8 477.2	8 932.4	40 325.5
Palliative care	34.7	36.1	37.5	39.1	40.6	188.0
Safety and quality	149.8	153.3	156.6	160.1	163.6	783.4
Subtotal	**7 422.1**	**7 823.8**	**8 238.0**	**8 676.4**	**9 136.6**	**41 296.9**
Less four per cent (a)	(296.9)	(312.9)	(329.5)	(347.1)	(365.5)	(1 651.9)
Total Base Health Care Grant	**7 125.2**	**7 510.9**	**7 908.5**	**8 329.3**	**8 771.1**	**39 645.0**
Non-Base Health Care Grants						
Mental health	61.1	63.6	66.2	68.9	71.6	331.4
Torres Strait (b)	2.8	3.0	3.1	3.2	3.4	15.5
Woomera hospital (b)	1.1	1.1	1.2	1.2	1.2	5.8
Compliance payment (a)	296.9	312.9	329.5	347.1	365.5	1 651.9
Total Non-Base Health Care Grants	**361.9**	**380.6**	**400.0**	**420.4**	**441.7**	**2 004.6**
Commonwealth Own Purpose Outlays						
HIPIP (c)	5.1	5.3	5.5	5.7	6.0	27.6
Mental health	12.2	12.7	13.2	13.8	14.3	66.2
Palliative care	2.4	2.5	2.7	2.7	2.9	13.2
Total COPOs	**19.7**	**20.5**	**21.4**	**22.2**	**23.2**	**107.0**
Pathways Home program	32.0	52.0	54.1	56.2	58.5	252.8
Total AHCAs	**7 538.8**	**7 964.0**	**8 384.0**	**8 828.1**	**9 294.5**	**42 009.4**

Source: Health.

(a) This is the compliance payment of four per cent of the Base Health Care Grant, which is subtracted from the Base Health Care Grant and added to the Non-Base Health Care Grants.

(b) Additional grants are made to Queensland for the costs associated with the movement of Papua New Guinea citizens across the Torres Strait, and to South Australia for the administration of Woomera hospital.

(c) Hospital Information and Performance Information Program.

Note: Differences between the sums of component items and the totals are due to rounding.

Health's assessment of State and Territory compliance

2.7 Health is required to assess State and Territory compliance with the obligations under clause 25 of the AHCAs. Health's Portfolio Budget Statements for 2005–06 and 2006–07 both stated that the Department's focus in that year would be on:

> ensuring the States and Territories continue to meet their obligations under the Agreements, in particular providing free and clinically appropriate public hospital services to all eligible Australians.[13]

2.8 The current AHCAs are the first to provide for funding reductions for non-compliance by a State or Territory with their obligations. The Minister must be satisfied that a State or Territory has met the compliance requirements before it will qualify for the full level of funding each year, including the compliance payment of four per cent of the Base Health Care Grant. If the Minister is satisfied that a State or Territory has failed over consecutive years to meet the compliance requirements, its Health Care Grant will be reduced for the remaining term of the Agreement to the original base grant and indexed up to the relevant year by the Australian Government's Wage Cost Index Number 1 only. No further compliance payments will be made.

2.9 Health advises the Minister annually on whether the States and Territories have complied, detailing all instances of non-compliance, and recommends whether they should receive compliance payments. As shown in Table 2.2, the potential compliance payments for all the States and Territories will be approximately $347 million in 2006–07 and will total some $1 652 million over the duration of the current AHCAs.

Compliance assessment procedures

2.10 In determining whether Health was carrying out its compliance assessment responsibilities, ANAO first considered whether Health had a sound basis for defining, monitoring and analysing State and Territory compliance with the obligations under clause 25 of the AHCAs.

2.11 ANAO found that Health had procedures for monitoring and assessing whether the States and Territories complied with each of the three parts of clause 25 of the Agreement noted above. The *Compliance Monitoring and*

[13] Commonwealth of Australia, *Portfolio Budget Statements 2005–06 Health and Ageing Portfolio*, Budget Related Paper No.1.11, 2005, p. 136 and Commonwealth of Australia, *Portfolio Budget Statements 2006–07 Health and Ageing Portfolio*, Budget Related Paper No.1.11, 2006, p. 160, both available at <www.health.gov.au>.

Assessment Framework sets out Health's procedures for determining whether the States and Territories are complying with their obligations and Health's action if the States and Territories are non-compliant. It also defines the events or activities that constitute a potential breach of the compliance requirements, linking these to the relevant clauses in the AHCAs.

2.12 In this document, Health stated that the Australian Government had an obligation to ensure that it secured value for the money spent to support the public hospital sector, and to hold the recipients of those funds accountable for their use. Therefore, it had based its procedures on the Australian Government's responsibilities of ensuring that the States and Territories delivered the health care reforms and public hospital service delivery outputs for which they were funded, and met the AHCAs compliance requirements.

2.13 Health developed the current version of the *Compliance Monitoring and Assessment Framework* in October 2004. At the time of audit fieldwork in April 2006, Health had not reviewed or revised the framework. ANAO noted that some parts of the framework did not reflect Health's current procedures, and as discussed in Chapter 3, it did not describe Health's policy and principles regarding its assessment of overall compliance. In September 2006, Health advised that it was reviewing its framework, and would provide the revised document to ANAO. ANAO has not yet received the document.

2.14 To assist with its monitoring of the compliance process, Health established a Complaints Review Group and developed a compliance database—the Breaches Register (discussed in Chapter 3). The Complaints Review Group is responsible for overseeing the compliance requirements of the AHCAs.[14] It meets monthly, workload permitting, to advise on the management of compliance issues, including monitoring and reviewing the progress, and confirming outcomes, of each complaint registered.

2.15 In August 2005, Health developed *Compliance with AHCA Business Rules* to further assist its staff with the processes and procedures for assessing whether the States and Territories have met all their compliance requirements.

2.16 During the audit, some State Government representatives indicated that they did not know if Health worked within any particular framework when assessing compliance, other than through applying the broad specifications set out in the AHCAs. This made it difficult for them to

[14] The Complaints Review Group is chaired by the Assistant Secretary, Acute Care Strategies Branch, and includes all Directors in the Branch and the Compliance Officer.

determine how Health made its assessments. ANAO noted that, in July 2004, Health had provided guidance to the States and Territories to assist them in complying with the AHCAs. However, this had not included the detail about Health's compliance assessment processes set out in its framework.

2.17 ANAO considers that Health should provide more detail about its compliance procedures to the States and Territories in order to assist them to clearly understand Health's processes and expectations. Health advised that it had not provided its framework to the States and Territories as it was an internal procedural document developed as a guide for officers administering the AHCAs. However, Health indicated that it would develop a document which included its compliance principles and a more detailed summary of its compliance processes, to provide to the States and Territories.

Recommendation No.1

2.18 ANAO recommends that, to assist the States and Territories clearly understand Health's processes and expectations in its assessment of compliance with the AHCAs, Health provide more detailed guidance of its procedures and assessment principles to the State and Territory Governments.

Health's response

2.19 Agreed. The Department of Health and Ageing will prepare a high level principles document based on the *Compliance Monitoring and Assessment Framework* and distribute it to the States and Territories.

Annual report on public hospitals

2.20 Health is also responsible for publishing an annual report on the state of public hospitals. ANAO notes that the AHCAs provide little direction as to what information Health should include in this report, other than the performance information related to the AHCA objectives which the States and Territories supply under their clause 25(c) obligations.

2.21 ANAO noted that Health had annually published *The State of Our Public Hospitals* report. The June 2004 report contained statistics for the five years from 1998–99 to 2002–03, the June 2005 report contained data for 2003–04 and the June 2006 report contained data for 2004–05.[15]

[15] Department of Health and Ageing, *The state of our public hospitals, June 2006 report*, Commonwealth of Australia, 2006, available at <www.health.gov.au/ahca>.

2.22 Health stated that its annual report on the state of public hospitals 'aims to demonstrate to Australians that all governments are accountable for expenditure on public hospitals'. In 2006, Health reported that of the $20.3 billion spent in public hospitals in 2003–04, $9.2 billion of the funding was from the Australian Government, $9.6 billion was from State, Territory and local Governments and $1.5 billion was from private sources (private health insurance and payments by patients).[16] The Australian Government's contribution included the AHCAs grants, private health insurance rebates and Department of Veterans' Affairs' payments for treating veterans and their dependants.

2.23 Chapter 5 further discusses the performance information that Health analysed in preparing *The State of Our Public Hospitals* reports.

Conclusion

2.24 Health administered the Australian Government's responsibilities under the AHCAs. Its administration included providing the AHCAs' funding to the States and Territories, assessing whether the States and Territories were compliant with their obligations under clause 25 of the AHCAs, and advising the Minister. It also published an annual report on the state of public hospitals as required by the AHCAs.

2.25 ANAO found that Health had developed procedures for defining, monitoring and analysing whether the States and Territories complied with their obligations under clause 25 of the AHCAs. However, ANAO recommends that Health provide more detailed guidance about its procedures and assessment principles to State and Territory Governments, so that they would be better informed of the Australian Government's requirements. Health indicated that it would develop a document including this information and provide it to the States and Territories.

[16] ibid., p. 12. Health noted that 2003–04 was the latest year for which full year expenditure figures were available when it published its 2006 report.

3. State and Territory Adherence to the Clause 6 Principles

This Chapter discusses Health's assessment of State and Territory adherence to the AHCA clause 6 principles and its management of non-compliance.

3.1 In order to determine if Health was adequately assessing State and Territory adherence to the clause 6 principles that all eligible persons had equitable access to free public health and emergency services on the basis of clinical need within an appropriate period, ANAO first considered whether Health identified potential breaches of these principles and obtained sufficient information to assess whether a breach had occurred. Second, ANAO determined whether Health had adequate procedures in place to follow-up potential breaches and analyse State and Territory responses to ascertain whether the potential breaches were being adequately addressed. ANAO also considered how Health assessed State and Territory compliance and whether the assessments provided sufficient information to the Minister to inform a determination on compliance.

Identification of potential breaches of clause 6

3.2 ANAO notes that the division of health care responsibilities between the Australian Government and the State and Territory Governments, and the complexity of funding and delivery arrangements, results in an environment where there is potential for service providers to breach the clause 6 principles by, for example, cost-shifting.[17]

3.3 ANAO found that Health assumed that the States and Territories were adhering to the clause 6 principles, unless:

- Health or the Minister received specific complaints or allegations, about public hospital services, which were considered to be potential breaches of the principles; or

[17] Cost-shifting occurs when service delivery is arranged so that responsibility for services can be transferred by one player in the health services sector to programs financed by other players, without their agreement. (B Ross, J Snasdell-Taylor, Y Cass and S Azmi, *Health Financing in Australia: The Objectives and Players*, Occasional Papers: Health Financing Series Volume 1, 1999, p. 37, available from <www.health.gov.au>.) One example is where a public hospital, which is funded under the AHCAs to provide free treatment to public patients, charges the MBS for such treatment.

- Health identified potential non-compliance from other sources (such as media reports, hospital circulars or State and Territory websites) or from analysis of performance information supplied by the States and Territories.

3.4 Potential breaches included complaints that public hospitals had influenced patients to elect to be treated as private patients because they had private health insurance, or had charged patients for services that should have been provided free of charge. They also included allegations that public hospitals charged services provided to public patients to the MBS (potential cost-shifting) or required patients to obtain referrals to named specialists in order to access outpatient services.

Complaints and allegations

3.5 In the first three years of the current AHCAs, a total of 133 complaints or allegations about public hospital services was received by Health or its Minister—30 in 2003–04, 51 in 2004–05 and 52 in 2005–06. The Minister's office and all areas in Health referred any complaints they received to the department's Compliance Officer for action.

3.6 ANAO noted that this was a very small number of complaints considering that, annually, public hospital emergency departments treat over four million persons, and almost four million persons are admitted to hospitals as public patients. Most of the complaints or allegations made to the Minister or Health were from public hospital staff, medical practitioners or private health insurers. Medicare Australia also referred allegations of cost-shifting by State or Territory health services, with the consent of the informant, to Health for investigation to determine whether they involved breaches of the AHCAs.

3.7 Members of the public who made complaints about the services they received at public hospitals mostly directed the complaints to the public hospital concerned or to State or Territory health authorities. Very few members of the public directed complaints to the Australian Government Minister or Health. ANAO notes that public patients were generally unlikely to make complaints about issues covered by the AHCA principles, unless they were asked to pay for services which they thought should be provided free of charge. State and Territory health authorities reported that most complaints made by public patients related to the quality of medical treatment or hospital care they received, issues which were outside of the AHCAs.

3.8 Health also initiated some investigations of potential breaches in response to media reports or other information such as circulars issued by a

State health authority to service providers. For example, in early 2006, Health raised with Queensland Health the media report that the State was intending to introduce means-testing of patients in public hospitals and co-payments for access to public health services, which would have breached the AHCAs.

3.9 Health's procedures specified its responsibility for gathering and analysing sources of information relevant to the assessment of State and Territory compliance. Health advised that it had previously undertaken sporadic intelligence gathering but had to be mostly reactive and reliant on allegations made by others, as it was often unable to take other action due to workload constraints. ANAO notes that Health had commenced some analysis of available statistics regarding complaints made to the State and Territory Health Departments, or their respective complaints bodies.[18] However, as ANAO noted above, Health found that many of these complaints related to issues outside of the AHCA principles.

State and Territory performance information

3.10 Health's procedures also indicated that it would analyse the quarterly and annual performance information supplied by the States and Territories to assess whether all eligible persons had equitable access to free public health and emergency services on the basis of clinical need within an appropriate period as required by the clause 6 principles. This reflected the AHCAs requirement that the Minister consider a range of information, including a minimum list of performance indicators[19], when deciding whether the States and Territories had met the compliance requirements. The list of performance indicators included in the AHCAs is at Appendix 2.

3.11 The procedures specified that analysis of quarterly and annual data on emergency department and inpatient waiting times could indicate whether patients were not able to access services based on clinical need within a clinically appropriate period, as required by clause 6(b). They also specified that analysis of annual data could indicate whether all eligible persons had equitable access to services regardless of their geographic location (clause 6(c)).

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[18] Under Schedule D of the 2003–2008 AHCAs, each State and Territory agreed to maintain an independent complaints body to resolve complaints made by eligible persons about the provision of public hospital services. These bodies also collect and report complaints data in their annual reports and on their websites. For example, information from the Office of the Health Services Commissioner in Victoria is available at <www.health.vic.gov.au/hsc>.

[19] These performance indicators are included at Appendix A to Schedule C of the AHCAs.

3.12 Health analysed some of the annual performance data supplied by the States and Territories when preparing its advice to the Minister and in preparing its annual report on the state of public hospitals at the end of the year. For example, it included in its briefing to the Minister annual national data and data showing comparisons between jurisdictions, on the proportions of patients treated in emergency departments, and admitted for elective surgery, within a clinically appropriate time.

3.13 However, Health advised that it could not rely on the States' and Territories' emergency department and elective surgery waiting time data because the States and Territories recorded and reported in different ways, causing some problems with consistency and accuracy. Health also considered that it had no specific data which enabled it to readily measure access to services based on geographic location to determine whether such access was equitable.

3.14 ANAO considers that Health should work with the States and Territories to improve the consistency and accuracy of the waiting time data so that Health could be assured of its quality for use in the assessment of compliance and annual reporting. Health advised that improvements to the quality and range of data continued through the National Health Information Group.[20]

3.15 Health did not regularly analyse the performance data supplied by the States and Territories each quarter to assist its monitoring or assessment of compliance. ANAO considers that conducting regular analyses of the quarterly performance data would assist Health in identifying trends that may indicate potential breaches of principles 6(b) and 6(c) throughout the year.

Recommendation No.2

3.16 ANAO recommends that Health work with the States and Territories to improve the consistency and accuracy of their data on emergency department and inpatient waiting times, and regularly analyse the quarterly performance data provided by the States and Territories to assist in confirming their adherence to the AHCAs' principles.

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[20] The National Health Information Group was established by the Australian Health Ministers' Advisory Council in 2003 to coordinate and direct the implementation of the National Health Information Agreement. It advises on planning and management requirements, and manages and allocates resources for national health information projects and working groups. Membership consists of all Australian jurisdictions, the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics. (AIHW, *Australia's Health 2006*, pp. 7-12, available from <www.aihw.gov.au>.

Health's response:

3.17 Agreed. The Department of Health and Ageing has established consistent processes for the calculation of waiting times for elective surgery and emergency departments through the National Health Data Dictionary. However, different business practices operated by the States and Territories in managing surgery waiting lists can affect how patient status may be counted and recorded.

3.18 The Department will continue to discuss with the States and Territories how to establish consistent business rules without unreasonably interfering with their local clinical practices.

3.19 The Department is also working with the States and Territories to further improve coverage of emergency department data collection.

3.20 The Department does review and check the quarterly performance data as it is received to monitor for any extraordinary change. As the AHCA data compliance requirements focus on the annual data provided by the States and Territories, the Department's formal advice to the Minister also focuses on the annual results.

Breaches register

3.21 ANAO found that Health had set up a 'Breaches Register'—a database where it recorded reported complaints, all documents supporting assessments of those complaints, and its decisions on whether these were breaches of the clause 6 principles. The Compliance Officer was responsible for the Register.

Investigation of complaints

3.22 Health's *Compliance Monitoring and Assessment Framework* and *Compliance with AHCA Business Rules* set out the processes and procedures that it followed in investigating whether a reported complaint or allegation was a potential breach of the clause 6 principles. These involved:

- determining whether there was sufficient evidence to proceed, which required obtaining a written report (email or letter) from the complainant, and obtaining a legal opinion where necessary;
- determining whether the complaint or allegation fell within the scope of its framework definition of an event or action that constituted a potential breach of the clause 6 principles;

- recording the complaint on its database if it had sufficient information to indicate that a potential breach existed; and
- seeking permission from the complainant to provide their name and individual details to the appropriate State or Territory.

3.23 In cases where the complainant did not provide a written report, Health recorded on the Breaches Register that it would take no further action due to insufficient evidence. Health considered that it did not have sufficient evidence to proceed with 23 of the 133 complaints made in the first three years of the current AHCAs. Similarly, Health had recorded no further action when complainants would not provide written permission to identify them in providing details to the relevant State or Territory for investigation. This had occurred in 29 cases during the three year period.

3.24 ANAO noted that the Compliance Officer had recently raised some issues of general concern with the States and Territories without mentioning the individual complainant. This ensured that State and Territory health authorities were at least aware that Health was receiving these types of complaints, and this information could be used to generally remind service providers of their obligations under the AHCAs.

3.25 Table 3.1 shows the outcome of Health's assessment for all complaints and allegations received during the first three years of the AHCAs.

Table 3.1

Outcome of Health's assessment of complaints received in 2003–04, 2004–05 and 2005–06 by State and Territory

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Insufficient evidence	2	4	7	5	0	0	3	2	23
Permission not received	12	3	8	4	0	1	0	1	29
Issue not related to AHCAs	7	6	4	1	1	0	0	0	19
Potential breach pursued with State/Territory incl. still active (a)	16	8	24	2	10	1	1	0	62
Total complaints received	**37**	**21**	**43**	**12**	**11**	**2**	**4**	**3**	**133**

Source: Health.

(a) Health's assessment or State/Territory investigation was still proceeding as at 30 June 2006.

3.26 Health determined that 19 of the 133 complaints received during the three years did not involve events or actions that were potential breaches of the clause 6 principles. These related to such issues as contract disputes between public hospitals and specialists, complaints about administrative arrangements in public hospitals or complaints about private hospitals. However, ANAO noted that Health had raised some of these complaints with the relevant States as they were major issues affecting local communities.

Follow-up of potential breaches of clause 6

3.27 Once Health decided to pursue an alleged breach, it wrote to the State or Territory health authority concerned, as specified in its procedures. Health's correspondence set out the details of the identified complaint and sought an investigation and explanation from the authority. Health also referred some matters to Medicare Australia for investigation. These related to MBS claims that may have been in breach of the *Health Insurance Act 1973*.

3.28 ANAO noted that, because of Health's assessment procedures, it formally pursued around half (62) of the 133 potential breaches of the AHCAs during the first three years.

3.29 The complaints that Health assessed as potential breaches encompassed a range of issues, as follows:

- patients not being given the choice to be treated as public patients[21] or being pressured into electing to be private patients;
- hospitals billing the patient or MBS for services which should be provided free of charge to public patients, such as pathology or diagnostic imaging, or for after-care visits related to an admitted public patient hospital service;
- public outpatients being bulk-billed to the MBS for specialist visits; and
- hospitals removing an eligible person's choice to receive non-admitted services as public patients, such as outpatient departments insisting on a referral to a named doctor to ensure they can be billed to the MBS.

3.30 Health's correspondence with the States and Territories requested satisfactory responses to individual complaints within 28 days. Some State Government representatives indicated to ANAO that 28 days did not provide

[21] As specified in the national standards for public hospital admitted patient election processes included at Schedule E of the AHCAs.

adequate time for their investigations. They stated that it often took longer to obtain the information required by Health, as their procedures required them to work through Area Health Regions in communicating with individual hospitals. However, ANAO noted that Health usually provided additional time for responses if a State or Territory requested an extension.

3.31 Health's procedures also specified that it would escalate its follow-up of alleged breaches through its Secretary or the Minister if a State or Territory did not respond to Health's initial request, or if its response was unsatisfactory. Health advised that it has not yet needed to take such action.

Analysis of State and Territory responses

3.32 ANAO analysed a sample of correspondence between Health and the States and Territories relating to potential breaches of the principles contained in clause 6 of the AHCAs. ANAO found that up to late 2005, Health had generally accepted States' and Territories' assurances that they had taken action to resolve reported potential breaches and were complying with the AHCAs. Health had not directly investigated potential breaches nor had it undertaken any further investigations of State or Territory assertions. Health advised this was mainly due to the difficulty of finding substantive evidence to contradict or confirm advice from a State or Territory health authority. Health also advised that it was limited in undertaking investigations as it had no jurisdiction over individual public hospitals, and resource considerations restricted the collection of evidence by departmental officers.

3.33 However, during 2006, Health decided to begin requesting further evidence from the States and Territories regarding the outcome of their investigations into complaints, rather than just accepting their assurances. This included detailed explanations of the circumstances and the steps taken to remedy the situation, or data for individual hospitals showing trends in the provision of particular services to public patients.

3.34 ANAO notes that Health does not have procedures for the States and Territories to follow in acting upon notification of potential breaches, including documenting outcomes of their investigations and providing these to Health. Health advised that the document it will develop to provide to the States and Territories would summarise the processes for investigating a suspected breach and include advice on the timing requirements for a response.

3.35 The results of Health's findings on potential breaches of the clause 6 principles, which it had referred to the States and Territories for investigation during 2003–04 and 2004–05, are summarised in Table 3.2.

Table 3.2

Health's findings in respect of potential breaches pursued in 2003–04 and 2004–05 by State and Territory (a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Found to be compliant	9	3	11	0	0	0	0	0	23
Free service not provided prior to 1 July 1998	0	1	0	0	5	0	0	0	6
Found to be a minor breach	1	4	0	0	0	0	1	0	6
Total pursued	**10**	**8**	**11**	**0**	**5**	**0**	**1**	**0**	**35**

Source: Health.

(a) Health could not provide information on the outcomes of the 27 complaints raised with States and Territories in 2005–06 as the Minister will not make a compliance determination until early 2007.

3.36 Health concluded that in the majority (23) of the matters referred in 2003–04 and 2004–05, the States and Territories were compliant, based on assurances that there was no evidence that the situations raised were breaches of the clause 6 principles. A further six of the complaints involved practices which Health had previously raised with particular States and found to be compliant. These related to services that these States did not have to provide free of charge under clause 7(a) of the AHCAs as they were not among the range of free services available at 1 July 1998.

3.37 In six cases, the responsible State or Territory had advised that its investigations had revealed a practice or situation in the relevant public hospital which Health considered to be a minor breach of the AHCAs. The State or Territory also informed Health that it had taken action to resolve the reported breach by instructing the hospital to cease the practice at issue or to clarify ambiguous information provided to patients or doctors. Health treated the matters as resolved.

Assessment of State and Territory compliance

3.38 ANAO notes that while the AHCAs specify (in clause 44) that the Australian Government would take account of certain breaches in considering compliance with the clause 6 principles, they do not specify how compliance is to be measured overall. The relevant AHCA clauses (28 and 31) state that the Minister must be satisfied that the State or Territory had met all three components of the compliance requirements set out in clause 25 to qualify for full funding. As noted earlier, the AHCAs (clause 28) also required the Minister to have regard to a range of information, including the list of performance indicators, when deciding whether the States and Territories had met the compliance requirements.

3.39 However, the AHCAs did not specify benchmarks for those performance indicators, for example the time taken to treat emergency department patients or admit patients for elective surgery. This made it difficult for Health to confirm that the States and Territories were complying with the AHCAs or to decide that a particular State or Territory was in breach of the principles if it did not meet a particular performance level.

3.40 ANAO also noted that Health and the States and Territories had difficulties with the interpretation of various compliance clauses due to a lack of clarity or definition. ANAO found that this led to disagreements between the parties as to whether certain practices were breaches of the principles.

3.41 In particular, Health had problems in determining whether the States and Territories were complying with clause 7(a)—that the range of services available to public patients should be no less than was available on 1 July 1998—and thus with the clause 6(a) principle. This was because neither Health nor the States and Territories had compiled lists of the range of services at 1 July 1998 available to public patients free of charge within each jurisdiction. This resulted in Health having to accept States' and Territories' assertions about when they had implemented particular services, with little, if any, supporting evidence.

3.42 The lack of benchmarks and baseline data causes uncertainty about how Health determined the numbers or types of breaches that warranted advising the Minister that a State or Territory was non-compliant within a particular year.

3.43 Health's procedures did not establish measures to assist assessment of the extent of breach necessary for Health to advise that a State or Territory was

non-compliant. Health stated in its advice to the Minister that it considered there was room for some discretion in making its assessment, and it had applied the principle that a State or Territory was fully compliant unless:

- there was clear evidence of a severe or systemic abuse of the clause 6 principles; or
- the State or Territory repeatedly failed to take remedial action where instances of potential breaches were brought to its attention; or
- Health's requests for explanations and advice from the State or Territory received unsatisfactory responses or were not answered.

3.44 Health advised that it exercised judgement in making its assessment, in that it looked for evidence of 'systemic' and 'ongoing' breaches rather than at isolated cases. However, ANAO notes that Health's procedures did not include its assessment principle (noted above), or guidance on 'systemic' or 'ongoing' breaches.

3.45 Health also had difficulty in assessing whether the States and Territories were complying with the clause 6(b) and 6(c) principles. Health stated in its annual advice to the Minister that it believed it would be difficult to propose sanctioning any State or Territory for its particular performance against principle 6(b)—providing public patients with access to health and emergency services on the basis of clinical need within a clinically appropriate period. This was because it considered that the AHCAs did not set a benchmark for waiting times and because, as noted earlier, it considered that there were problems with the consistency and accuracy of State and Territory waiting times data. Health also stated that it had no specific data which would enable it to readily measure access to services based on geographic location to determine whether such access was equitable under principle 6(c).

3.46 The AHCAs specified that three of the performance indicators would be used to measure compliance with principle 6(b). These included waiting times for elective surgery by urgency category, waiting times for emergency departments by triage category and admission from waiting lists by clinical category. The States and Territories provided information for the first two of these indicators within categories that Health could use as a basis for developing appropriate performance benchmarks. For example, the categories

used to report emergency waiting times were based on the clinical benchmarks for triage categories set by the Australasian College of Emergency Medicine.[22]

3.47 ANAO found that Health's analysis of State and Territory performance data on emergency department waiting times for 2004–05 showed that the States and Territories were not providing treatment within the times specified for most triage categories.[23] One example was for emergency triage category two, where around 76 per cent of patients nationally were seen within the recommended time of ten minutes. Achievement ranged from over 80 per cent in Victoria to 60 per cent in the Northern Territory.

3.48 ANAO suggests that the development of benchmarks for performance expectations would assist Health to compare performance within and across jurisdictions over time. In particular, Health requires measures and data to enable it to assess whether States and Territories were providing equitable public hospital access to people in rural and remote areas, as well as in the fast-growing areas on the edges of major cities.

3.49 Health advised that the AHCAs did not give it a mandate to define, negotiate or apply performance benchmarks, and that setting benchmarks for assessment, such as the acceptable proportion of patients to be seen within the recommended times, was a Government policy matter. However, ANAO notes that the absence of such benchmarks causes difficulties in assessing whether the States and Territories are complying with the AHCAs.

3.50 While recognising that the nature and terms of Agreements are properly matters for Ministers to decide, ANAO considers that Health could explore options and provide advice to its Minister on opportunities to improve its measurement of State and Territory performance and thus its assessment of compliance with their obligations under the AHCAs.

3.51 Health also advised that it recently received a final report from its consultancy into future options for performance reporting. During the next six months, it will liaise with the States and Territories regarding proposed new indicators for equity (and a number of other new measures) with a view to establishing enhanced performance reporting under future agreements.

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[22] Department of Health and Ageing, *The state of our public hospitals, June 2006 report*, Commonwealth of Australia, 2006, p. 37, available at <www.health.gov.au/ahca>.

[23] ibid., p. 39.

Compliance payments

3.52 Receipt of the annual compliance payment of four per cent of the Base Health Care Grant was subject to the Minister being satisfied that States or Territories had met the compliance requirements. These payments amount to many millions of dollars for each State or Territory Government. Representatives of State and Territory health authorities interviewed during the audit were aware of this requirement and were keen to avoid breaching the AHCAs. Some mentioned that Health worked cooperatively with them to remedy issues in order to remain compliant.

3.53 Funding under the AHCAs is provided to the State or Territory Governments rather than to specific service providers, such as public hospitals. The system is therefore reliant on the State or Territory Governments controlling compliance at their local levels. Some State representatives stated that they used the threat of the potential loss of the compliance payment as an impetus to enforce hospital compliance within their jurisdictions.

3.54 However, some State and Territory representatives were concerned that Health's assessment could result in the full compliance payment being withheld for a one-off breach by one hospital as compared to more severe breaches. A further matter raised was the lack of dispute resolution procedures in the AHCAs. States considered that they had no recourse if they disagreed with Health's assessment about their response to a particular complaint and the Minister determined that they were non-compliant based on that assessment.

3.55 ANAO observes that other jurisdictions have used different options to encourage compliance, such as rewards or graduated scales of penalties. ANAO also notes that COAG's Guide to Intergovernmental Agreements[24] suggests that agreed dispute resolution procedures be included in such agreements.

Advice to the Minister

3.56 Health's *Compliance Monitoring and Assessment Framework* sets out the processes used for compiling its annual advice to the Minister on whether the States and Territories were compliant with the AHCA requirements during the previous financial year. As soon as possible after 31 December each year,

[24] Council of Australian Governments, *Guide to Intergovernmental Agreements*, COAG, December 2005, available at <www.coag.gov.au/guide_agreements.htm>.

Health submitted advice and recommendations on whether the Minister should make compliance payments to the States and Territories.

3.57 Health's correspondence to the Minister in February 2005 and March 2006, about State and Territory compliance for 2003–04 and 2004–05 respectively, set out Health's assessments of State and Territory performance in respect of their obligations and Health's recommendations for action.

3.58 As discussed in the previous section, ANAO noted that Health had exercised judgement in making its assessment that all States and Territories were fully compliant, having found that some had breached the clause 6 principles on some occasions. Health stated that there was no clear evidence of any severe or systemic abuse of the principles because Health had received satisfactory responses to its requests for explanations or the State or Territory had taken remedial action.

3.59 ANAO noted that, based on Health's advice, the Minister was satisfied that States and Territories had met all of their compliance requirements under the AHCAs, and all had received their full payments for 2003–04 and 2004–05.

3.60 However, in each year Health had also advised the Minister that it continued to have some concerns with States' and Territories' compliance with the clause 6 principles, and recommended that the Minister express his concern with the continued complaints about potential breaches of the principles in his letters to State and Territory Health Ministers.

Conclusion

3.61 ANAO found that Health generally assumed that the States and Territories were adhering to the AHCAs clause 6 principles, subject to receipt of specific complaints or allegations about non-compliance by public hospitals, or it identified potential non-compliance from other sources. Health received very few such complaints and allegations each year having regard to the large numbers of people who used public hospital services.

3.62 Where Health had sufficient evidence and written permission from a complainant, it referred potential breaches of the AHCAs to a State or Territory for investigation. In most cases, Health accepted assurances that the events referred were not breaches of the principles. Health did not investigate potential breaches or State and Territory assertions.

3.63 In the small number of cases where a State or Territory admitted to a practice or situation which Health considered to be a minor breach, Health

considered the matter resolved if action had been taken to address the issue raised. During 2006, Health decided to improve its procedures for determining whether the States and Territories had investigated alleged breaches of the clause 6 principles referred to them.

3.64 It was difficult for Health to confirm that the States and Territories were complying with the AHCAs principles, as the specified performance indicators did not contain targets or benchmarks. In its assessments and advice to the Minister, Health largely relied on reporting the outcome of State and Territory investigations into the small number of complaints made to the department or to the Minister. Health exercised judgement in determining whether such potential breaches were isolated cases, rather than indicators of systemic or ongoing non-compliance.

3.65 Health considered that there were problems with the consistency and accuracy of State and Territory waiting times data, and it had no specific data which enabled it to readily measure access to services based on geographic location to determine whether such access was equitable. ANAO recommends that Health work with the States and Territories to improve the consistency of data on waiting times, and regularly analyse the quarterly data provided as part of their performance reporting.

4. State and Territory Recurrent Expenditure Growth Rate

This Chapter considers Health's assessment of whether the States and Territories were increasing their own funding for public hospitals at the rates specified in the AHCAs.

4.1 In signing the AHCAs with the Australian Government, the State and Territory Governments agreed that they would increase their recurrent expenditure on public hospital services at a rate which at least matched the cumulative rate of growth of Australian Government funding (clause 25(b)). This was subject to a degree of tolerance in the first three years.[25]

4.2 In determining if Health was adequately monitoring and assessing State and Territory compliance with this commitment, ANAO first considered whether Health had agreed with the States and Territories what components of health expenditure were to be included for matching purposes, and how these were to be consistently measured. ANAO then determined whether Health had procedures to encourage the States and Territories to report on their expenditure on a timely basis, and to follow up outstanding reports. ANAO also considered whether Health provided sufficient information to the Minister to inform a determination on State and Territory compliance with clause 25(b).

Measuring State and Territory recurrent expenditure

4.3 Under the AHCAs, each State or Territory committed to a base level of recurrent spending for public hospital services. ANAO notes that the AHCAs do not define the nature of such recurrent expenditure. They only specify that it would be expenditure for services of a kind that included admitted patient services and non-admitted patient services which were being provided at that date, or were provided on 1 July 1998, by hospitals that were wholly or partly funded by the State or Territory.

4.4 The AHCAs required the Australian Government and each State or Territory to agree the definition of recurrent expenditure prior to signing the AHCAs. ANAO notes that Health had separately agreed with each State and Territory the content of its recurrent expenditure by accepting the data that each supplied for the period 1998 to 2003 under the sign-on arrangements, and in using the 2002–03 data as the base level for matching purposes.

[25] The recurrent expenditure growth rate matching obligation of the State or Territory is measured in accordance with clause 10 of Schedule G to the AHCAs.

4.5 In August 2003, Health issued advice to the States and Territories as to how it would calculate recurrent expenditure. It used, as its starting point, existing aggregate data on State or Territory recurrent health expenditure. This included recurrent expenditure on acute inpatient, outpatient and emergency department services, mental health and palliative care services, professional training of medical workforce in the acute setting and patient assistance transport schemes. Health then adjusted this to exclude spending that was not related to public hospital services, as well as deducting some revenue such as Australian Government funding of the AHCAs.

4.6 ANAO notes that no State or Territory uses the AHCA-related concept of recurrent expenditure on public hospital services in its own accounting or budget reporting systems. State and Territory Health Department Annual Reports showed that jurisdictions structured their health programmes and accounts in different ways. Consequently, they had adopted different approaches to collecting, and reporting on, their public hospital related recurrent expenditure. As a result, there was significant variance between jurisdictions. Some State and Territory representatives interviewed during the audit indicated that they excluded depreciation, while another included it in its formula. Similarly, some jurisdictions included expenditure on ambulatory services but others did not. This made comparisons of States' and Territories' recurrent expenditure of limited utility for national reporting and analysis.

Recurrent expenditure guidelines

4.7 ANAO notes that the AHCAs required the States and Territories to work with the Australian Government to develop a comprehensive, standardised system for determining recurrent health expenditure by June 2005 (clause 36). ANAO found that Health, in consultation with the States, Territories and other Australian Government agencies,[26] had refined the existing approach to develop a new standardised system for reporting recurrent health expenditure, in line with the AHCAs' requirement. All parties agreed that the States and Territories would report under this new system in parallel with the current system for the remaining term of the 2003–08 AHCAs, rather than replace the existing system immediately.

[26] Departments of the Treasury, Finance and Administration, and Prime Minister and Cabinet.

4.8 Health produced guidelines to assist the States and Territories with this new reporting system.[27] The guidelines noted that the intent of the new system was to allow State and Territory contributions to recurrent health expenditure on public hospital services to be compared on a consistent basis, including comparisons with the Australian Government's contribution.

Monitoring procedures

4.9 As discussed in Chapter 2, Health's *Compliance Monitoring and Assessment Framework* sets out its procedures for assessing State and Territory compliance with clause 25(b). These procedures required Health to write to the States and Territories by 31 January each year to advise of their required expenditure growth rates for the next financial year. Under the AHCAs, the States and Territories then had to provide their recurrent expenditure data for the previous financial year to Health by 31 December.

4.10 Health's procedures required it to check that each State and Territory had provided its recurrent expenditure on public hospital services on time and included the agreed components, had independent verification, and met its required growth rate for the year.

Reporting by the States and Territories

4.11 ANAO noted that Health wrote to the States and Territories at the end of each November, reminding of the need to submit expenditure data for matching purposes by 31 December. ANAO found that Health received the data as a certified return from the Chief Finance Officer of each State and Territory Health Department. ANAO reviewed the returns for 2003–04 and 2004–05 and found that Health had received all returns by the due date. However, ANAO noted that Health did not perform checks to ensure that each State's and Territory's recurrent expenditure on public hospital services included the agreed components.

Independent verification

4.12 While the AHCAs required States and Territories to provide independent verification of their financial information, the AHCAs did not

[27] These are *Guidelines for Reporting Recurrent Health Expenditure under the Australian Health Care Agreements* (June 2005) and *Depreciation Guidelines for Reporting Recurrent Health Expenditure under the Australian Health Care Agreements* (April 2006), available on Health's website <www.health.gov.au>.

prescribe what this should include.[28] ANAO found that Health provided some clarification to the States and Territories in August 2003. This explained that they could provide verification by State and Territory Auditors–General, or by private sector accountancy firms, but not by State and Territory Health Departments' internal auditors. ANAO considers this implied that verification be undertaken by independent persons who have adequate competence in auditing, in line with the requirements of the professional accounting bodies in Australia.

4.13 ANAO analysed the supporting statements providing independent verifications of State and Territory recurrent expenditure data for 2004–05, as supplied by auditors appointed by the States and Territories, to determine the methodology used and findings reported. The States and Territories, with one exception, engaged either their Auditors–General or external accountancy firms to verify the financial information submitted to Health. One Health Department had employed a firm which was also its internal auditor in the same year.

4.14 Health had not agreed with the States and Territories on the procedures to be used by auditors in preparing these statements, and ANAO found that the nature and extent of work done differed between jurisdictions. ANAO also noted that Health did not assess the statements to identify the scope of the audit, or whether the auditors had qualified their opinions. Health advised that it had undertaken in good faith to accept the signed verifications from independent auditors and considered that compliance was satisfied if the States and Territories provided reports on time.

4.15 ANAO noted that auditors in two States stated that they used procedures which were limited to ensuring that the information came from audited financial records and did not review the methodology the State department used to compile the reported financial information. Some auditors performed agreed-upon procedures in accordance with the Australian Auditing Standard AUS 904 'Engagements to Perform Agreed-upon Procedures'.[29] Another auditor undertook a review in accordance with AUS 902 'Review of Financial Reports'.[29] In this review, the auditor determined the scope and procedures, and provided assurance that nothing had come to the auditor's attention to indicate that the recurrent expenditure figures

[28] Clauses 33-35 of the AHCAs.

[29] Australian Auditing Standards, available from the Auditing and Assurance Standards Board website <www.auasb.gov.au>.

provided to Health by the State were not presented fairly in accordance with the AHCAs' requirements.

4.16 One State's auditor found that the State department reported its recurrent expenditure on a cash basis. This meant that the amount reported was not in accordance with accounting standards or mandatory financial reporting requirements.[30] ANAO considers it is quite possible that reporting on a cash basis rather than an accrual basis could affect compliance with a State's growth rate matching requirement by under or over-stating expenditure in any particular year. Health had not determined whether there were material differences in the State providing financial data on a cash basis rather than an accrual basis.

4.17 One jurisdiction's auditor carried out procedures to ensure the methodology applied in calculating the level of public hospital expenditure was consistent with prior years' acquittals. ANAO noted this did not ensure that the methodology complied with Health's requirements under the current AHCAs, as it was not required to include verification of the completeness or accuracy of information used to populate the acquittal spreadsheet. The auditor stated only that the health authority sourced the data from its financial system.

4.18 ANAO considers that Heath should clarify the level and nature of assurance it requires from the auditors' statements, and take action to reach agreement with the States and Territories on a consistent approach which provides that assurance. Health should also review statements supplied by the States' and Territories' auditors to identify the impact of any limitations or adverse findings on its assessment of their compliance with their obligations.

[30] Australian Auditing Standard AUS 29 'Financial Reporting by Government Departments' requires State and Territory Government departments to report on an accrual basis of accounting. This requires them to recognise revenues and expenses (as well as assets and liabilities) in the reporting period to which they relate, regardless of when cash is received or paid. Accrual accounting assists in ensuring that government departments are accountable for all their operations for the relevant reporting period.

Recommendation No.3

4.19 ANAO recommends that Health:

(a) clarify with the States and Territories the level and nature of assurance it requires from independent audits of State and Territory recurrent expenditure on public hospital services; and

(b) review future auditors' statements on State and Territory recurrent expenditure on public hospital services to identify the impact of any limitations or adverse findings on its assessment of compliance with the AHCAs.

Health's response:

4.20 Agreed. The Commonwealth and all States and Territories have worked together to produce guidelines on financial information reporting that will in the future give greater consistency and surety. The revised arrangements are to commence in the 2006–07 reporting year and run in tandem with the current arrangements until the end of the current Agreements. Under the new arrangements all States and Territories will be reporting on an accrual basis. Independent verifiers will provide a statement that the financial information reported has been derived in accordance with the methodology agreed by States and Territories under clause 36 of the 2003-08 Australian Health Care Agreements.

4.21 The Department of Health and Ageing will review the future auditors' statements in relation to State and Territory public hospital expenditure and fully investigate any limitations or adverse findings raised by verifiers.

Assessment of State and Territory compliance

Modelling State and Territory expenditure matching requirements

4.22 ANAO found that Health maintained a *Master Record of Matching Data Received from States and Territories* (the Master Record) to determine and record compliance on the part of each State or Territory with expenditure matching requirements. This included the date Health received the information.

4.23 The Master Record is a spreadsheet covering the entire period of the 2003–08 AHCAs. Health revised it each January for changes in the estimated cumulative growth rate target as advised by the Australian Government to the States and Territories. Health revised the matching rates annually to reflect

changes in weighted populations as determined by the Australian Bureau of Statistics, as well as the Australian Government's Wage Cost Index Number 1.

Comparing expenditure against requirements

4.24 Once the States and Territories had provided their recurrent expenditure data on public hospital services, Health used formulae built into the spreadsheet to calculate the actual percentage growth in expenditure for each State and Territory against the agreed base level of expenditure. Health compared this rate with the cumulative growth rate target needed to ensure compliance with matching requirements. Health maintained a version of the Master Record spreadsheet on file with the signatures of responsible officers, which provided an audit trail of all decisions.

4.25 ANAO checked the State and Territory data in the Master Record against State and Territory returns and auditors' statements to ensure that Health had correctly recorded the information. ANAO calculated the percentage growth rates for each State and Territory, confirmed the accuracy of calculations in the spreadsheet and verified that matching requirements had been met. ANAO found that the Master Record was an effective tool in Health's administration of the matching requirements which accurately determined the level of expenditure growth rates.

4.26 ANAO noted that no instructions existed for the maintenance of the Master Record, which could cause difficulties if staff responsible for the calculation process departed. Health indicated that it would develop instructions for updating and reviewing its Master Record and include these in its procedures.

Advice to the Minister

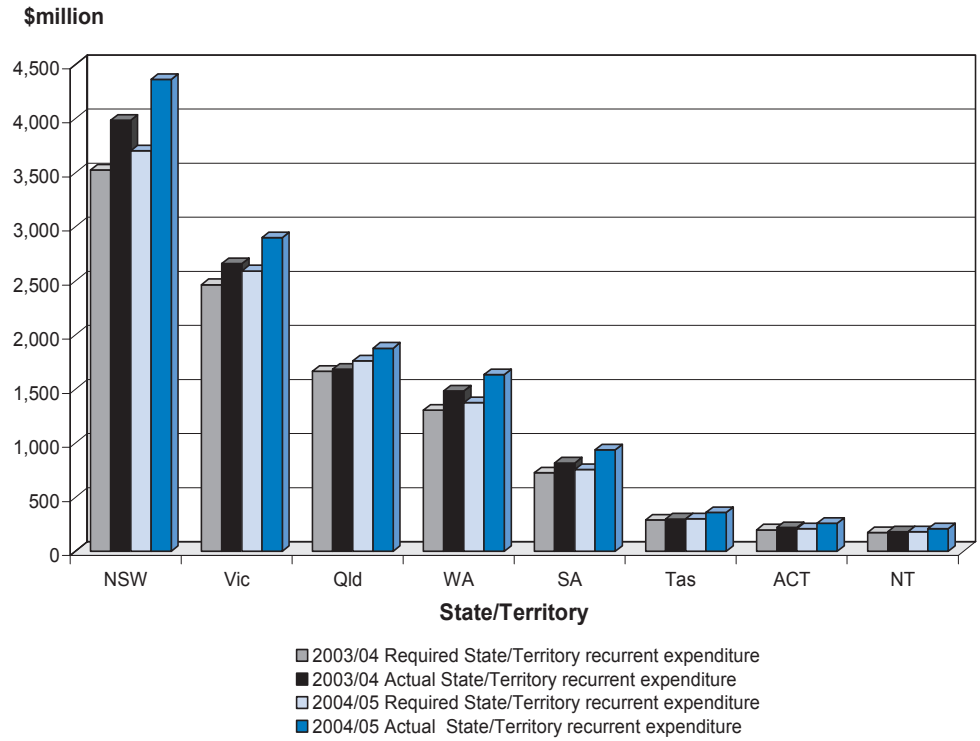
4.27 As noted in Chapter 3, ANAO assessed Health's advice to the Minister for 2003–04 and 2004–05 on State and Territory compliance with the AHCAs. In both years, Health advised the Minister that all the States and Territories had provided independently verified recurrent health expenditure reports by 31 December; and all had sufficiently exceeded the required rate of growth in their own expenditure to ensure compliance with their obligations.

4.28 Health accompanied its advice with a graph illustrating the required and reported expenditure for each State and Territory, and the Australian Government's funding for each jurisdiction.

4.29 Figure 4.1 compares what the States and Territories were required to spend on public hospital services under the AHCAs with their actual expenditure on these services in 2003–04 and 2004–05. ANAO notes that, in all cases, the States and Territories actual recurrent expenditure on public hospital services had exceeded the required rates of growth.

Figure 4.1

State and Territory recurrent expenditure under the AHCAs, 2003–04 and 2004–05



Source: ANAO, using State/Territory data provided to Health, and Health's Master Record.

Conclusion

4.30 Health had procedures in place to monitor whether the States and Territories increased their recurrent expenditure on public hospital services at the rates required by the AHCAs. However, Health had not agreed with the States and Territories on the procedures that auditors appointed by the States and Territories should use in preparing the supporting statements providing independent verifications of the recurrent expenditure data.

4.31 ANAO's analysis found that the nature and extent of work done in preparing these statements differed between jurisdictions. Health did not examine the statements to identify the scope of the audit or whether the auditors had qualified their opinions which meant that Health could not be confident that the States and Territories were in compliance with their financial and reporting requirements.

4.32 As a result, ANAO recommends that Heath clarify the level of assurance it requires from the auditors' statements, and take action to reach agreement with the States and Territories on a consistent approach which provides that assurance. Health should also review statements supplied by the States' and Territories' auditors to identify the impact of any limitations or adverse findings on its assessment of their compliance with their obligations.

5. State and Territory Performance Reporting

This Chapter considers Health's assessment of whether the States and Territories are providing performance information as required by the AHCAs, and Health's analysis of the information for its publication The State of Our Public Hospitals.

5.1 In this Chapter, ANAO considers if Health was adequately assessing whether the States and Territories were meeting the AHCA requirements for performance reporting, and providing sufficient information to the Minister to inform a determination on compliance. ANAO also considers whether Health analysed the performance information submitted by the States and Territories in producing its *State of Our Public Hospitals* publication as required under the AHCAs.

Performance reporting requirements

5.2 In signing the AHCAs in 2003, each State and Territory agreed to comply with clauses 5 to 11 in Schedule C of the AHCAs. These clauses set out the data collections that the States and Territories were to provide, the scope of performance measures derived from this data for compliance assessment, the deadlines for the provision of data and the data standards. The AHCAs also specified that the National Minimum Data Sets (NMDS) supplied were to include all agreed data items and be in a format advised by Health.

5.3 Health's *Compliance Monitoring and Assessment Framework* identified the information that States and Territories were required to provide to satisfy these requirements. Health's procedures stated it would assess compliance with the performance reporting requirements that the States and Territories supply all of their annual performance data in the specified format by the due date, and on the quality and completeness of the data.

5.4 ANAO found that, in July 2004, Health provided advice to the States and Territories on how to comply with the performance reporting requirements. In this advice, Health specified that the States and Territories must supply all annual performance data and information by 31 December each year and the required quarterly performance data within three months after the end of each quarter. Health attached to this advice a Data Compliance Schedule which listed the annual and quarterly data required by Schedule C of the AHCAs.

Procedures for State and Territory reporting

5.5 Health's procedures for assessing annual compliance with clause 25(c) required it to ensure that the States and Territories had provided all relevant annual NMDS and performance indicator data in the prescribed format by 31 December. If any did not comply, Health was to issue a follow-up letter by 5 January advising of non-compliance in data supply.

5.6 ANAO noted that Health advised the States and Territories in July 2004 that it was developing strategies to assist them in meeting their performance reporting obligations. These involved Health:

- sending reminder letters before the end of each reporting period;
- providing a checklist to accompany the data, which the States and Territories could use to certify that all required NMDS and performance indicators had been provided;
- consulting with the States and Territories and the Australian Institute of Health and Welfare (AIHW) to simplify the data format to assist the States and Territories in meeting the reporting timeframes; and
- providing a data checking programme to reduce the time taken to process data and improve the quality and timeliness of data supply.

5.7 Health's procedures stated that Health would encourage the States and Territories to supply their annual performance data by 21 December. This would enable the States and Territories to fix any critical errors that Health identified and make corrections to the data before submitting it formally to Health with the covering checklist certifying that they had supplied all NMDS.

5.8 ANAO noted that Health's advice encouraged the States and Territories to use the format supplied by Health for providing the 2003–04 data in December 2004. However, Health stated that it was mandatory to use the format for all annual data from 31 December 2005. Health considered that the provision of data in a single format would enable it to direct staffing resources more efficiently to data analysis rather than data processing.

5.9 The current AHCAs require the States and Territories to derive the performance indicators as well as submitting raw data in the correct format. ANAO noted that Health produced *Performance Indicator Guidelines* and templates, in consultation with the States and Territories, for each of the first two years of the current AHCAs (2003–04 and 2004–05).

5.10 Health also designed a data checking programme and provided this to the States and Territories through Health's website on 29 November 2005.[31] Health stated this would assist the States and Territories to supply their data in the format specified by Health and ensure data fields conformed to the National Health Data Dictionary (as required by clause 14 of Schedule C of the AHCAs). Health first developed this data checking programme in consultation with the States and Territories, and AIHW, so that it could review the 2003–04 returns. This programme was further refined through liaison with the States and Territories and AIHW, and used to assess the 2004–05 returns.

5.11 The AHCAs did not specifically require Health to conduct any assessment of data quality for the purpose of compliance with clause 25(c). However, ANAO noted that Health had included an assessment of the quality of data in its procedures required for compliance purposes. While its compliance assessment was limited to issues Health could ascertain about data quality by 15 January, Health later carried out further quality checks in analysing the data for its annual report on the state of public hospitals.

5.12 Health's processing and data cleansing included checks for completeness, comparison of numbers with previous years, checks that field values were valid, and logical comparison between fields. Where Health found errors in data items that were important components of the minimum datasets or were critical for calculation of derived fields required for the production of Health's publication, Health invited the State or Territory to resubmit its data. ANAO noted that, on occasion, Health had determined that some data was inadequate for publication in the *State of Our Public Hospitals* report and consequently requested the particular State or Territory to resubmit its data. For example, one State had re-supplied its 2004–05 data on 31 March 2006.

Assessment of State and Territory compliance

5.13 Health monitored the timing of quarterly and annual data receipt and contacted the States and Territories if performance data returns were late. ANAO noted that Health also issued a reminder letter to each State and Territory at the end of November 2004 and 2005. Health assessed that the States and Territories had supplied all 2003–04 and 2004–05 data on time.

5.14 ANAO noted that completed checklists had not accompanied the data returns for 2003–04 and 2004–05. Health advised that it always carried out its

[31] AHCAs Data Checker, available at <www.health.gov.au/internet/wcms/publishing.nsf/content/health-casemix-software-ahcadatachecker>.

own checks to determine whether all NMDS were included. Health also checked that the NMDS were in the prescribed format and all cells contained the expected data. Health advised the States and Territories in February 2006, that almost all of the 2004–05 data supplied had been in the correct format, and where there were inconsistencies, these had been relatively easy to fix.

5.15 Health performed quality checks on the raw data supplied by the States and Territories and compared the results to their returns for reasonableness. Health stated that it had been able to replicate State and Territory results to within one per cent. This provided Health with additional assurance that the States and Territories had complied with performance reporting requirements. Health also provided the results of this checking process to the States and Territories for confirmation.

5.16 ANAO noted that, because Health had not provided its data checking programme to the States and Territories until late November 2005, some had not had time to correct errors identified in the 2004–05 performance data supplied in December 2005. In these cases, Health accepted the uncorrected data as meeting the requirements as it had advised the States and Territories that data quality would not form part of the assessment. Health advised that it would supply the programme earlier in future.

5.17 Overall, Health assessed that the States and Territories had complied with their performance reporting obligations for 2003–04 and 2004–05.

Advice to the Minister

5.18 ANAO reviewed Health's advice to the Minister in respect of State and Territory compliance with their performance reporting requirements under the AHCAs for 2003–04 and 2004–05. ANAO noted that Health accompanied its advice each year with a table which summarised the performance reporting by each State and Territory against the information requirements.

5.19 In February 2005, Health advised the Minister that the States and Territories had provided their quarterly and annual performance data for 2003–04 in the required format within the timeframes set by the AHCAs, with two minor exceptions. Health also advised the Minister that 'its initial analysis of the datasets had indicated some minor quality issues that the jurisdictions were cooperating to correct'. However, Health considered that these matters were not sufficient to warrant the Minister withholding the four per cent compliance payment.

5.20 In its March 2006 assessment of State and Territory compliance for 2004–05, Health advised the Minister that all the States and Territories had supplied their performance data on time and in the format specified by Health or in a format that it could easily convert into the correct format. Consequently, it considered that all States and Territories had complied with their obligations.

5.21 As ANAO noted in Chapters 3 and 4, the Minister was satisfied, based on Health's advice, that the States and Territories had met their compliance requirements under the AHCAs, and all received their compliance payments for 2003–04 and 2004–05.

Analysis of performance information

5.22 The AHCAs directed that Health annually publish (by 30 June in the subsequent year), in relation to the AHCAs' objectives and principles, the performance information submitted by the States and Territories, including performance against the minimum list of indicators.

5.23 As ANAO noted in Chapter 2, Health published *The State of Our Public Hospitals* report in 2004, 2005 and 2006. These reports included analyses of the annual performance information provided by the States and Territories. The report for June 2004 contained data for the five years from 1998–99 to 2002–03, the period covered by the previous AHCAs. Subsequent reports included analyses of the data provided under the current AHCAs. The June 2005 and June 2006 reports contained data for 2003–04 and 2004–05 respectively.[32] Both also reported on trends in public hospital activities since 1998–99.

5.24 ANAO noted that Health had designed its reports to be summary reports, so they did not include the full set of data tables supplied by the States and Territories. The 2005 and 2006 reports showed public hospital service trends and performance at state, territory and national levels, and provided answers to frequently asked questions on public hospitals. They also provided information about private hospitals and the care received by persons choosing to be private patients in public hospitals. The 2006 report included data on staff employed in public hospitals, and public hospitals in rural and remote areas.

[32] These reports are available at <www.health.gov.au/ahca>.

5.25 Both reports contained overviews for each State and Territory which summarised the performance of public hospitals against key measures.[33] These included:

- the average number of available beds, the total number of admissions and the number of public patient admissions;
- State and Territory recurrent expenditure per person;
- the number of public patients admitted for elective surgery, the percentages of these seen within the clinically recommended time[34], and the median waiting times for selected procedures; and
- the number of patients presenting at emergency departments, their median waiting times, and the percentage seen within the clinically recommended time[34].

5.26 ANAO noted that Health could not obtain a number of the reported performance indicators from the States' and Territories' admitted patient care NMDS. Health obtained these from other previously published data, including data from the Australian Institute of Health and Welfare (AIHW).

5.27 ANAO found that, as well as having to provide public hospital performance information to Health to meet their AHCAs requirements, the States and Territories are required to annually provide similar data to the AIHW under the National Health Information Agreements, and to the Productivity Commission. The AIHW published indicators on hospital performance in its annual *Australian Hospital Statistics*.[35] The Steering Committee for the Review of Government Service Provision also published such indicators in its *Report on Government Services 2006*.[36]

5.28 During the audit, some State and Territory representatives commented on the additional effort involved in having to provide these slightly different sets of performance information on public hospital services to three Australian Government agencies. ANAO considers that, in order to increase efficiencies

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[33] Many of these data are reported per 1 000 weighted population, which is calculated using population numbers weighted by age and sex according to the expected hospital use of each age-sex group in the population. This allows more meaningful comparisons of the data over time and between jurisdictions.

[34] The clinically recommended waiting times for elective surgery and emergency department treatment are used only for reporting purposes and are not considered by Health to be benchmarks or targets.

[35] Australian Institute of Health and Welfare (AIHW) Health services series No. 26, *Australian hospital statistics 2004–05*, AIHW, May 2006.

[36] Steering Committee for the Review of Government Service Provision, *Report on Government Services 2006,* Vol. 2 Part E 'Health', January 2006, available at <www.pc.gov.au/gsp/reports/rogs/2006>.

and reduce the amount of data collection, extraction and collation by State and Territory health authorities and service providers, the Australian Government should require only one coordinated set of information from the States and Territories. It would be of benefit if Health and the other Australian Government agencies could agree on a consolidated dataset which each could use for its different purposes.

5.29 ANAO also notes that the current differences in collection and definition produced differences in the reporting of public hospital statistics by the different agencies. For example, there were differences between the 2004–05 data reported in Health's June 2006 report and the AIHW's *Australian Hospital Statistics 2004–05*. Although Health and the AIHW worked together to try to ensure the data provided was the same, the fact that the data was provided under two different agreements meant there were some differences between the two datasets despite both being based largely on the NMDS specified in the National Health Data Dictionary. In addition, some methods of analysis differed between the two reports.

5.30 Health stated that while it tried to synchronise with the AIHW data wherever possible, some differences were unavoidable because the AIHW's reports had a different purpose and a different audience to Health's reports. However, in reviewing the data analysis used for its future reports, Health will try to ensure that its published data aligns as closely as possible with that published by the AIHW.

5.31 Health also used its analysis of State and Territory performance information to assist its determination of compliance with the clause 6 principles. ANAO commented on this aspect in Chapter 3.

Conclusion

5.32 Health had appropriate procedures in place to assess whether the States and Territories were complying with their AHCAs performance reporting requirements, and provided sufficient information to the Minister to inform his determination on compliance. Health also provided advice to the States and Territories on how to comply with the performance reporting requirements, and had developed procedures to encourage the States and Territories to report on a timely basis and in the appropriate format.

5.33 Health analysed the performance information submitted by the States and Territories and published the results in its report *The State of Our Public Hospitals*. However, ANAO considers there would be benefit in Health

ensuring that its requirements for State and Territory public hospital data are more closely coordinated with those of other Australian Government agencies.

Ian McPhee
Auditor-General

Canberra ACT
25 January 2007

Appendices

Appendix 1: State and Territory Audit Reports

State and Territory Audit Offices conduct audits within State and Territory public sector entities. Some recent audit reports related to the services funded under the AHCAs included:

New South Wales:

- *Emergency Mental Health Services, NSW Department of Health*, May 2005;
- *NSW Department of Health and Ambulance Service of NSW: Transporting and Treating Emergency Patients*, July 2004;
- *Department of Health, NSW Ambulance Service: Code Red: Hospital Emergency Departments*, December 2003; and
- *NSW Department of Health: Waiting times for elective surgery in public hospitals*, September 2003;

at <www.audit.nsw.gov.au/publications/reports/performance/performance_

reports.htm>.

Victoria:

- *Access to specialist medical outpatient care*, June 2006; and
- *Managing emergency demand in public hospitals*, May 2004;

at <www.audit.vic.gov.au/reports_par/performance_audit_reports.html>.

Western Australia:

- *Early Diagnosis: Management of the Health Reform Program*, Report 5, June 2006; and
- *Patients Waiting: Access to Elective Surgery in Western Australia*, Report No 11, December 2003;

at <www.audit.wa.gov.au/reports/index.html>.

Tasmania:

- *Elective surgery in public hospitals*, Special Report No 61, August 2006, at <www.audit.tas.gov.au/publications/reports/specialreport/index.html>.

Australian Capital Territory:

- *Waiting Lists for Elective Surgery and Medical Treatment*, Report No 8, December 2004, at <www.audit.act.gov.au/reports.shtml#2004>.

Appendix 2: Minimum List of Performance Indicators in the AHCAs

1. Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals.	
(a)	Public patient weighted separation rate per 1,000 weighted population*
(b)	Same day and overnight separations by patient accommodation status*
(c)	Number of separations by care types and mode of separation*
(d)	Emergency department occasions of service *
(e)	Outpatient occasions of service*
2. Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period.	
(a)	Waiting times for elective surgery by urgency category*
(b)	Waiting times for emergency departments by triage category*
(c)	Admission from waiting lists by clinical urgency**
3. Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.	
(a)	Number of public and private hospital separations by Indigenous and Non-indigenous Status per 1,000 population**
(b)	Mental health patient days by Psychiatric and Non-Psychiatric hospitals public and private**
(c)	Psychiatric care by Indigenous and Non-indigenous Status**
4. Indicators of efficiency and effectiveness of public hospital services.	
(a)	Recurrent expenditure, public acute and psychiatric hospitals**
(b)	Revenue, public acute and psychiatric hospitals**
(c)	Cost per casemix adjusted separation in public hospitals**
5. Indicators of quality and patient outcomes in relation to the delivery of public hospital services.	
(a)	Number of accredited medical specialist training positions by specialty (using latest available data)*
(b)	Public hospital accreditation status*
6. Indicators of Rehabilitation and Stepdown Services.	
(a)	Distribution of rehabilitation episodes by mode of separation, sex, age group and accommodation status*

** Currently reported in 1998-2003 Australian Health Care Agreement Annual Performance Report*

***Currently reported in Report on Government Services*

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Management of Army Minor Capital Equipment Procurement Projects
Department of Defence
Defence Materiel Organisation

Audit Report No.4 Performance Audit
Tax Agent and Business Portals
Australian Taxation Office

Audit Report No.5 Performance Audit
The Senate Order of the Departmental and Agency Contracts (Calendar Year 2005 Compliance)

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