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Performance Audit

Administering Round the Clock Medicare Grants

Department of Health and Ageing

Australian National Audit Office

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Australian National Audit Office

Canberra ACT
27 February 2008

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 *Administering Round the Clock Medicare Grants.*

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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Contents

Abbreviations

AHPMC	After Hours Primary Medical Care
ANAO	Australian National Audit Office
CMAU	Contract Management Advisory Unit
CO	Central Office
Divisions	Divisions of General Practice
DoHA	Department of Health and Ageing
GP	General Practice and General Practitioner
IAHGPS	Investing in After Hours General Practice Services
LSB	Legal Services Branch
MBS	Medicare Benefits Schedule
MDS	Medical Deputising Services
PAR	Performance Assessment Rating System
PIP	Practice Incentives Program
RMP	Risk Management Plan
RRMA	Rural, Remote and Metropolitan Area
RTCM	Round the Clock Medicare
STO	State and Territory Office

Glossary

After hours general practice	After hours general practice refers to the provision of general practice outside standard business hours. For the Round the Clock Medicare grants program, after hours is classified as: before 8:00am and after 6:00pm weekdays; before 8:00am and after 1:00pm Saturdays; and all day on Sundays and public holidays.
MDS	Medical Deputising Services are generally defined as after hours and related services that are provided by doctors as their sole function.[1]
Operating subsidy	Operating subsidies support new or recently established, well-located after hours GP clinics and MDSs wishing to establish clinic based after hours services. Individual subsidies worth a maximum of $200 000 per year are offered on a recurrent basis for up to three years.
RRMA	RRMA refers to the Rural, Remote and Metropolitan Areas classification system. The system divides Australia into areas according to city status, population, rurality and remoteness. There are seven RRMA classifications distributed within three categories: metropolitan; rural and remote.
Start-up grant	Start-up grants assist existing general practices and dedicated after hours clinics wishing to remain open after hours and mobile MDSs wishing to establish clinic-based after hours services. The start-up grants provide up to $200 000 over two years and are primarily used to establish infrastructure and staffing support for the services to remain open after hours.

[1] Australian Government Productivity Commission, *Australia's Health Workforce Productivity Commission Research Report* [Internet]. Australian Government Productivity Commission, 22 December 2005, available from <http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkfoce.pdf> [accessed 28 August 2007] p. 282.

Supplementary grant	Supplementary grants assist after hours services to meet their marginal costs. These grants can provide up to $50 000 for two years.

Summary and Recommendations

Summary

Introduction

After hours general practice in Australia

1. Primary care is an essential component of the health system through which Australians access a range of diagnostic, pharmaceutical and acute health care services. The ability to access a general practitioner (GP) after hours is an important element of primary care. Over the period 2001–02 to 2005–06, there was a nine per cent decrease (from 56 per cent to 47 per cent) in the proportion of GPs providing after hours primary care.[2] The capacity of GPs to meet after hours service demands has been linked to, among others things, the current GP workforce shortage.

2. The Australian Government has implemented a number of programs to address the need for after hours GP services. Administered by the Department of Health and Ageing (DoHA) or Medicare Australia, these initiatives include: Round the Clock Medicare (RTCM); After Hours Primary Medical Care Program; Practice Incentives Program; and the National Health Call Centre Network.

Round the Clock Medicare: Investing in After Hours General Practice Services

3. RTCM was announced as part of the Coalition Government's 2004 election policy and commenced in 2005. RTCM has two components—RTCM: Higher Rebates for After Hours General Practice Services and RTCM: Investing in After Hours General Practice Services. This audit report focuses on the grants aspect of RTCM, that is, Investing in After Hours General Practice Services. Administered by DoHA, Investing in After Hours General Practice Services aims to 'improve after hours GP access in metropolitan and regional Australia'.[3]

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[2] Bettering the Evaluation and Care of Health Project, *General Practice Activity in Australia 2005-06, General Practice Series No.19* [Internet]. Bettering the Evaluation and Care of Health Project, 17 January 2007, available from <http://www.aihw.gov.au/publications/gep/gpaa05-06> [accessed 30 August 2007] p. 79.

[3] Health and Ageing Portfolio, *Portfolio Budget Statements 2005–06: Budget Related Paper No. 1.11,* May 2005, p. 90.

4. For the period 2004–05 to 2008–09, RTCM: Investing in After Hours General Practice Services has a total budget of $62.5 million. This amount funds three different components:

- supplementary grants—provide up to $50 000 for two years, to assist after hours services to meet their marginal costs;
- operating subsidies—are worth a maximum of $200 000 per year for up to three years. They are used to support new or recently established well located after hours clinics and Medical Deputising Services (MDS) establishing clinic based after hours services;
- start-up grants—provide up to $200 000 over two years. They are used to assist existing general practices and dedicated after hours clinics to remain open and mobile MDSs wishing to establish clinic based after hours services.

5. The 2004 Coalition election policy identified five sites to receive 2004–05 start-up grants. The full program commenced in 2005–06, with three competitive grants rounds completed and a fourth expected in 2008–09. To October 2007, DoHA had executed 144 funding agreements, with a further 85 under negotiation, as shown in Figure 1.

Figure 1

Number of funding agreements, as at October 2007

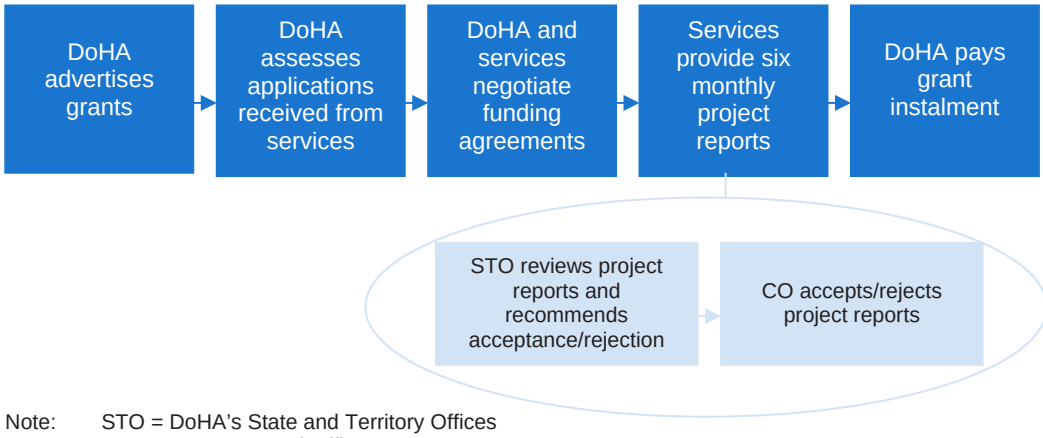
Grant type	Being negotiated	Executed
2004–05 Start-up Grants	-	4
Supplementary Grants	53	99
Operating Subsidies	8	16
Start-Up Grants	24	25
Total	85	144

Source: ANAO analysis of DoHA data.

6. Figure 2 provides a brief overview of DoHA's administration of the program.

Figure 2

Overview of the program



Note: STO = DoHA's State and Territory Offices
CO = DoHA's Central Office

Source: ANAO analysis.

Audit scope and objectives

7. The objective of the audit was:

- to examine the effectiveness of DoHA's administration of the Round the Clock Medicare: Investing in After Hours General Practice Services program.

8. The audit focused on the grants aspect of RTCM—Round the Clock Medicare: Investing in After Hours General Practice Services. The audit did not include an examination of DoHA's role in providing Medicare rebates to after hours GP services.

Audit conclusion

9. In 2004–05, DoHA responded to the Coalition Government's decision to introduce RTCM, rapidly implementing the grants program. The aim of the RTCM grants program is to provide greater incentives for GPs to practice after hours and to invest in after hours GP infrastructure. The Coalition Government's intention was to target the funding of services in areas of high demand, such as outer metropolitan, regional and remote areas.

10. To administer RTCM, DoHA developed functional program documents, including application forms and guidelines for applicants, and a

process for assessing grant applications. Following the 2004–05 funding round, DoHA reviewed and reissued its program guidance and application forms and established procedures to assess grant applications and negotiate funding agreements in a timely manner. GP services are generally supportive of DoHA's processes and report a good working relationship with the Department.

11. The grants program has been established for three years and, as such, it is now timely for DoHA to consolidate and build on the lessons learned. DoHA's administration of RTCM could be strengthened by improvements at the operational level and by evaluating the extent to which the program is meeting its objectives.

12. At the operational level, DoHA could better target its assessment of project performance reports to obtain adequate assurance about the accuracy of data provided by grant recipients. Grant recipients supply these data to illustrate progress and compliance with the conditions of their funding agreements. To ensure program integrity, it is important that DoHA establish a cost-effective risk-based system to verify data provided by funded services.

13. In addition, evaluating RTCM would assist DoHA to determine whether it is succeeding in its aim to provide greater incentives for GPs to practice after hours and to invest in after hours GP infrastructure and, consequently, to understand how the program is impacting on the provision of after hours GP services in Australia. While DoHA recognises the need to evaluate RTCM, it does not have a current plan to do so. Accordingly, after three years, DoHA has little analysis to inform decisions about any possible changes that may improve the services provided.

14. For DoHA to be in a position to determine whether the program is meeting its aims, it also needs to develop and make use of a more effective performance management framework. The RTCM performance indicator is a single broad measure of performance that assesses the number of services funded. It does not capture other key elements of the objectives of the program, particularly the provision of services to areas of high demand. Measuring and reporting the number of services funded does not inform DoHA, Parliament, or the Australian public, about where, when or how these services are being provided, the quality of the service, the patients being treated, or the workforce providing the services. Nor does the indicator assist DoHA's program managers to administer the program.

15. The ANAO has made a number of suggestions and three recommendations to DoHA that will assist it to improve its administration of RTCM.

Key findings

Design and Planning (Chapter 2)

Establishing the RTCM framework

16. RTCM's program documents state that priority for funding will be given to services in outer suburban, regional and remote areas of Australia. The early planning phase of the program explored options on how to prioritise areas of need. However, none of these options had been implemented. Furthermore, the grant promotion and written assessment processes do not have a mechanism to allow for priority to be given to outer suburban, regional or remote areas.

17. The Program Guidelines state that services should aim to become self-sustainable within the grant funding period. DoHA recognises that, for some services to remain viable, they may require longer term financial support. Nevertheless, sustainability of funded after-hour GP services is a goal of RTCM. However, sustainability has not been built into many of the services' models receiving grants. Without ongoing Government support, these services may be unsustainable in the long term.

Performance management

18. DoHA has not established an effective performance management framework for RTCM. A single performance indicator for the program is outlined in DoHA's Portfolio Budget Statements and measures the program's progress by the number of services funded. However, there is no link between this high level performance indicator and other key elements of the program, particularly the provision of services to areas of high demand.

19. At an operational level, DoHA monitors services' progress and compliance with funding agreements through a six-monthly reporting system. However, the focus of the reporting system is the progress of individual services. DoHA's monitoring and analysis does not include an examination of trends across time or progress within and across grant types, across regions, or across the program as a whole.

20. DoHA has not established a performance baseline for the program or its individual funding components. Prior to the introduction of RTCM Medicare Benefits Schedule (MBS) items, Medicare items did not provide DoHA with sufficient information to determine the extent of existing after hours GP coverage. Without this baseline information it will be difficult for DoHA to measure the success of the program and ascertain the extent to which the grant categories are meeting their objectives.

Key definitions

21. Terms such as 'after hours' and 'access' are not clearly articulated in DoHA's program documentation. Additionally, the definition of 'after hours' in RTCM differs from that used in other government initiatives. When evaluating RTCM, DoHA should consider the benefits and costs of employing a clear and consistent definition of after hours across all of its programs.

Evaluating the program

22. DoHA has not evaluated RTCM and it is currently drafting an evaluation plan. Although DoHA had developed a draft evaluation framework in early 2005, it was unable to provide the ANAO with any later reference to the framework. Without implementing a strategy to evaluate RTCM, DoHA will find it difficult to determine whether the program's objectives are being achieved.

Assessing and Allocating Grants (Chapter 3)

Guidance for DoHA personnel

23. Clear, consistent and well-documented guidance material is an important component of an efficient and effective grants program. DoHA personnel from both Central Office (CO) and State and Territory Offices (STOs) undertake their roles and responsibilities with the support of a variety of guidance materials. These include the Project Manager's Toolkit, the Program Guidelines and the Program Management Guide. Staff also have access to specialist areas within DoHA, such as the Legal Services Branch (LSB) and the Primary and Ambulatory Care Division's Contract Management Advisory Unit (CMAU). However, DoHA has not developed a central program management guide for its staff. Such a guide, regularly updated, would assist consistency in decision making and efficient administration of the program.

Assessing grant applications

24. DoHA has established an appropriate process to assess grant applications. The Department has also produced relevant documentation to support this process. DoHA's approach includes establishing criteria against which to assess grant applications and appointing panels to assess the applications. Panel members are provided with a Guide for Assessors and assessment templates. The Guide includes the application forms and Program Guidelines. Services and the assessors expressed support for DoHA's process for assessing potential RTCM grants.

Negotiating funding agreements

25. DoHA has suitable procedures in place to negotiate and execute funding agreements with successful grant applicants. Generally, negotiations are documented and agreements are cleared by DoHA's LSB and CMAU. The negotiation process is reasonably timely and agreements are executed on DoHA's behalf by appropriate delegates. In interviews with the ANAO, services reported a good working relationship with DoHA.

Monitoring Grants (Chapter 4)

Project reporting

26. DoHA's process for assessing project reports is complex. Grant recipients are required to submit six-monthly project reports which are assessed by STOs using a standardised State/Territory Office—Project Report Assessment template. CO is then responsible for reviewing STO project report assessments. Once CO approves a project report, this triggers the next instalment of the service's grant payment.

27. The ANAO understands that it may have been necessary in the early stages of the program for CO to review all STO project report assessments. Nevertheless, as the program enters Round 3: 2007–08, DoHA could look for efficiencies in the process by adopting a risk-based approach to assessing and approving project reports.

Verifying data and paying grant instalments

28. DoHA has established an effective invoicing and payments system. Payments are generally made in a timely manner and, when necessary, DoHA's payments system includes procedures to reduce, withhold or recover payments. However, DoHA does not verify important data contained in project reports. The data in these reports is the basis upon which payments are

made. Therefore, it is important that DoHA gains adequate assurance on the accuracy of the data received. Also, this will enhance DoHA's monitoring of services' progress and compliance with the conditions of funding agreements.

29. The RTCM budget for 2004–05 to 2006–07 is $28.5 million, while grant payments to services in the same period amounted to $9.12 million. The underspend is a result of the number of grants issued being less than those available, some applicants requesting less than the maximum available funding, and an unrealistic assumption that the grants would be executed on 1 July each year. In February 2007, DoHA received approval to reallocate funding within the RTCM program.

Department of Health and Ageing's Response

30. The Department of Health and Ageing (DoHA) supports the recommendations of the performance audit into its administration of the Round the Clock Medicare: Investing in After Hours GP Services (RTCM) Program.

31. DoHA accepts that the performance management framework currently in place to monitor and assess the performance of the program against its stated objectives could be improved. It also acknowledges the need to evaluate the effectiveness of the program, and to adopt a more systematic, risk-based approach to the verification of data provided by funding recipients in project progress reports. To this end, the Department has commenced work to implement the audit's recommendations.

32. In addition to the recommendations, the ANAO has made a number of other suggestions to assist the Department improve its administration of the RTCM Program. These include, amongst others, ways for streamlining DoHA's processes for assessing project deliverables, and issues that could be addressed as part of the planned evaluation of the program. DoHA is grateful for the suggestions made by the ANAO and has already commenced action to implement some of these suggestions. However, whilst the Department will consider all suggestions for improvement to the administration of the program made by the ANAO, action to implement these suggestions will be dependent upon a thorough assessment by the Department of the relative costs and benefits, and resources required, to implement the ANAO's proposals.

Recommendations

Recommendation No.1

Para. 2.37

The ANAO recommends that DoHA develop, document and implement an effective performance management framework that includes useful, measurable performance indicators that inform future data collection and analysis, and program evaluation.

DoHA's response: Agreed.

Recommendation No.2

Para. 2.50

The ANAO recommends that DoHA develop and implement a plan to evaluate how effectively RTCM is achieving its objective and how effectively DoHA is administering the program.

DoHA's response: Agreed.

Recommendation No.3

Para. 4.10

The ANAO recommends that DoHA develop and implement a cost-effective, systematic, risk-based approach to verifying data provided by funded after hours services, which is key to measuring compliance with funding agreements and assessing progress against the RTCM's objective.

DoHA's response: Agreed.

Audit Findings and Conclusions

1. Introduction

The relevant features of Round the Clock Medicare: Investing in After Hours General Practice Services are examined in this chapter. The chapter also provides a background to the audit, including the audit objective, approach and methodology.

After hours general practice in Australia

1.1 Primary care is the most commonly accessed part of the health system. It is through the primary care sector, predominantly general practice (GP[4]), that Australians access a range of diagnostic, pharmaceutical and acute care services. After hours GP is one aspect of primary care. The ability to access a GP around the clock is an important element in providing high quality health care for Australians.

1.2 Recent studies have highlighted the need to increase the Australian public's access to quality after hours primary care. For example, a 2005–06 study reported a nine per cent decrease in the proportion of GPs providing after hours services (from 56 per cent in 2001–02 to 47 per cent in 2005–06), with a corresponding increase in GPs relying on Medical Deputising Services (MDS).[5] In 2002, nearly 60 per cent of after hours primary care in inner metropolitan areas was being provided through MDSs.[6] The capacity of GPs to meet after hours service demands is linked to current shortages in the GP workforce. In 2006, the Australian Institute of Health and Welfare reported that the supply of GPs decreased from an average of 192 to 179 per 100 000 population between 2000 and 2005.[7] This shortage is more prominent in rural and remote areas and Indigenous communities.[8] In 2003, there were

[4] In this report, GP refers to both general practice and general practitioner.

[5] Bettering the Evaluation and Care of Health Project, *General Practice Activity in Australia 2005-06, General Practice Series No19* [Internet]. Bettering the Evaluation and Care of Health Project, 17 January 2007, available from <http://www.aihw.gov.au/publications/gep/gpaa05-06> [accessed 30 August 2007] p. 79.

[6] Australian Government Productivity Commission, *Australia's Health Workforce Productivity Commission Research Report* [Internet]. Australian Government Productivity Commission, 22 December 2005, available from <http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkfoce.pdf> [accessed 28 August 2007] p.282.

[7] Australian Institute of Health and Welfare, *Australia's Health 2006* [Internet]. AIHW, Canberra, 2006 , available from <http://www.aihw.gov.au/publications/index.cfm/title/10321> [accessed 31 August 2007] p. 317.

[8] Australian Government Productivity Commission, *Australia's Health Workforce Productivity Commission Research Report* [Internet]. Australian Government Productivity Commission, 22 December 2005, available from <http://www.pc.gov.au/study/healthworkforce/finalreport/healthworkfoce.pdf> [accessed 28 August 2007] p. 12.

326 medical practitioners per 100 000 population in major cities compared with 155 and 154 medical practitioners per 100 000 population in outer regional and remote areas respectively.[9] There is also a general trend of GPs working fewer hours, with average working hours falling from 48.3 hours per week in 1995 to 44.4 in 2003.[10] The feminisation and ageing of the GP workforce are two factors driving this trend.

Australian Government after hours general practice programs

1.3 The Australian Government has implemented a number of initiatives to address the need for after hours GP services. These programs, administered by the Department of Health and Ageing (DoHA) or Medicare Australia, include Round the Clock Medicare (RTCM), After Hours Primary Medical Care (AHPMC), Practice Incentives Program (PIP), and the National Health Call Centre Network. These programs are described briefly in Figure 1.1.

[9] Australian Institute of Health and Welfare, *Australia's Health 2006*, AIHW, 2006, p. 325.

[10] CM Joyce, JJ McNeil, and JU Stoelwinder, 'More doctors, but not enough Australian medical workforce supply 2001–2012' *Medical Journal of Australia* 184 (9) 2006, available from <http://www.mja.com.au/public/issues/184_09_010506/joy10149_fm.html> [accessed 29 August 2007].

Figure 1.1

A selection of Australian Government after hours GP programs

Round the Clock Medicare (RTCM) commenced in 2005. It has two components: Higher Rebates for After Hours General Practice Services and Investing in After Hours General Practice Services. Under the first of these components, on 1 January 2005 new after hours Medicare benefit items were introduced to the Medicare Benefits Schedule (MBS). The new MBS items provide an additional $10 Medicare rebate for payment to GPs providing services after hours. The second component of RTCM, Investing in After Hours General Practice Services, aims to 'improve after hours GP access in metropolitan and regional Australia'.[11]

After Hours Primary Medical Care (AHPMC) commenced in 2001–02. The objectives of the program are to facilitate the development and implementation of new and/or improved AHPMC services where there is a demonstrated need, improve consumer access to AHPMC services and improve the providers' ability to give quality care at all times through the lessening of unreasonable after hours work demands, and improve continuity of care provided after hours. Between 2001–02 and 2008–09 the program was allocated funding of $101.6 million.[12,13] In 2007–08, DoHA will continue to fund ten service development grants and four regional projects through AHPMC.

Practice Incentives Program (PIP) targets, among other areas, after hours primary care provision. PIP payments to GPs are intended to help resource a quality after hours service.[14] In 2006–07, a total of $279.1 million worth of incentive payments, including payments for after hours service, were made and 4 784 practices were registered as participating in PIP on 30 June 2007.[15]

The **National Health Call Centre Network** is jointly funded by the Australian Government ($96 million over four years from 2006–07) and the State and Territory Governments ($80 million).[16] It began operating on 25 July 2007, providing services to the residents of the Australian Capital Territory, Northern Territory and Western Australia. A limited service is also being provided in South Australia. It is anticipated that full Network services will be provided to residents of South Australia by February 2008 and New South Wales from August 2008. Full national coverage is expected in four years. Once fully established, the program will allow anyone, anywhere in Australia, to ring for health triage, information and advice on health matters 24 hours a day, seven days a week.[17]

Source: ANAO analysis.

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11 Health and Ageing Portfolio, *Portfolio Budget Statements 2005–06: Budget Related Paper No. 1.11,* May 2005, p. 90.

12 ibid, p. 142.

13 *Budget Paper No. 2 Part 2: Expense Measures Health and Ageing,* available from <http://www.budget.gov.au/2005-06/bp2/html/expense-14-b.htm> [accessed 5 September 2007].

14 Medicare Australia *Practice Incentives Program,* available from <http://www.medicareaustralia.gov.au/providers/incentives_allowances/pip/calculating-pip-payments/after hours.shtml> [accessed 20 April 2007].

15 Medicare Australia, *2006–07 Annual Report*, October 2007 p. 99.

16 Media Release: Tony Abbott, *Health Direct Australia begins Operation,* 24 July 2007, available from <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/3EC2C840217FD324CA2573220022 1726/$File/abb090.pdf> [accessed 25 July 2007].

17 Department of Health and Ageing, *Department of Health and Ageing Annual Report 2005–06,* p. 84.

Round the Clock Medicare: Investing in After Hours General Practice Services

1.4 RTCM: Investing in After Hours General Practice Services is the focus of this audit report.[18] Announced as part of the Coalition Government's 2004 election policy, RTCM commenced in 2005 and is administered by DoHA. The program aims to 'improve after hours GP access in metropolitan and regional Australia'.[19] There are three funding components:

- supplementary grants;
- operating subsidies; and
- start-up grants.

1.5 RTCM's original budget was $62.5 million for the period 2004–05 to 2008–09, as illustrated in Figure 1.2.[20]

Figure 1.2

RTCM budget

Grant Type	**Budget** ($ million per financial year)					
	2004–05	2005–06	2006–07	2007–08	2008–09	Total
Supplementary grants	-	2.5	5.0	5.0	5.0	17.5
Operating subsidies	-	2.0	5.0	6.0	6.0	19.0
Start-up grants	2.0	6.0	6.0	6.0	6.0	26.0
Total	$2.0	$10.5	$16.0	$17.0	$17.0	$62.5

Source: DoHA.

1.6 Supplementary grants assist after hours services to meet their marginal costs. These grants can provide up to $50 000 for two years.

1.7 Operating subsidies support new or recently established, well-located after hours GP clinics and Medical Deputising Services (MDSs) wishing to establish clinic based after hours services. Individual subsidies worth a maximum of $200 000 per year are offered on a recurrent basis for up to three years.

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[18] In this report, references to RTCM refer to Round the Clock Medicare: Investing in After Hours Services unless otherwise specified.

[19] Health and Ageing Portfolio, *Portfolio Budget Statements 2005–06: Budget Related Paper No. 1.11,* May 2005, p. 90.

[20] In February 2007, DoHA was granted approval to reallocate funding within the RTCM grants program, subject to the number and quality of applications received (refer to Chapter 4 for more details).

1.8 Start-up grants assist existing general practices and dedicated after hours clinics wishing to remain open after hours and mobile MDSs wishing to establish clinic-based after hours services. The start-up grants provide up to $200 000 over two years and are primarily used to establish infrastructure and staffing support for the services to remain open after hours.

1.9 The RTCM grants program was initiated in 2004–05 with five start-up grants of up to $200 000 each.[21] The full program commenced in 2005–06. In addition to the five 2004–05 grants, there have been three competitive grant rounds to date, with a fourth expected in 2008–09. As at October 2007, 144 funding agreements had been executed and a further 85 were being negotiated.[22] Figure 1.3 provides a breakdown of funding agreements administered.

Figure 1.3

Number of funding agreements, as at October 2007

Grant Type	Being negotiated				
	2004–05 Start-Up	Round 1: 2005–06	Round 2: 2006–07	Round 3: 2007–08	Total
Supplementary Grants	-	-	-	53	53
Operating Subsidies	-	-	4	4	8
Start-up Grants	-	-	-	24	24
Total	-	-	4	81	85

Grant Type	Executed				
	2004–05 Start-Up	Round 1: 2005–06	Round 2: 2006–07	Round 3: 2007–08	Total
2004–05 Start -Up	4	-	-	-	4
Supplementary Grants	-	49	50	-	99
Operating Subsidies	-	9	6	1	16
Start-up Grants	-	13	12	-	25
Total	4	71	68	1	144

Source: ANAO analysis of DoHA data.

[21] The Government's Election 2004 Policy identified the locations for these five grants. The five sites were: Kallangur (Queensland); Tweed Heads (New South Wales); Ryde (New South Wales); Glenside (South Australia); and Williamstown (Victoria).

[22] Data for Round 1: 2005–06 and Round 2: 2006–07 is current as at 11 October 2007, data for Round 3: 2007–08 is current as at 31 October 2007.

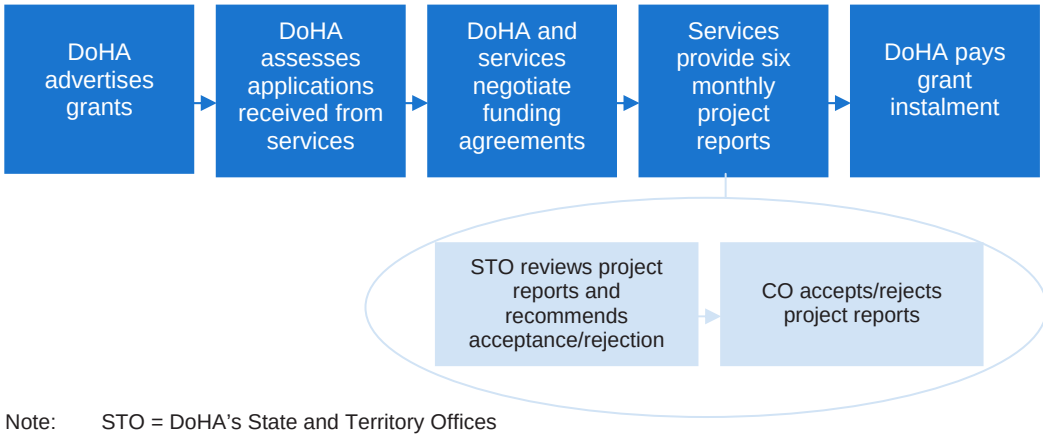
1.10 While services can apply for more than one grant, no service is able to receive more than one grant at any one time. Therefore, some Round 1: 2005–06 applicants with grants due to expire this financial year have applied in Round 3: 2007–08. For example, 17 of the 65 supplementary grant applicants in Round 3: 2007–08 are current round one recipients and three of the 22 Round 3: 2007–08 operating subsidy applicants are also round one recipients.

Administering RTCM grants

1.11 Figure 1.4 provides an overview of the administration of the RTCM program; and the major steps are explained below.

Figure 1.4

Overview of the administration of the RTCM program



Note: STO = DoHA's State and Territory Offices
CO = DoHA's Central Office

Source: ANAO analysis.

1.12 Each grant funding round is advertised in newspapers and the medical press. Before advertising, DoHA informs major stakeholders such as the Australian Medical Association and the Australian General Practice Network about the impending grant round.

1.13 Assessment panels appointed by DoHA's Central Office (CO) assess applications against the selection criteria. Applicants are advised whether or not their applications have been successful. DoHA then engages in 'without prejudice' funding agreement negotiations with successful applicants. This process ensures that the funding agreement is appropriate for the specific service being funded and records mutually agreed objectives and activities.

1.14 Once agreements are finalised and funding commences, services are required to provide project reports to DoHA every six months. DoHA

provides reporting templates to services. The templates request information about, inter alia, how the service is meeting community needs, consultation numbers in the after hours period, and the service's financial viability.

1.15 Project reports are first received by DoHA's State and Territory Offices (STOs), who assess the report and recommend to CO whether it should be accepted or rejected. If necessary, STO personnel contact services to clarify the information provided and follow up any additional information required. The acceptance of a report triggers the next grant payment if appropriate, which is administered by CO. [23]

Previous audit coverage

1.16 The ANAO audits the financial statements of DoHA annually. Other related ANAO performance audit reports and guides are:

- *Administration of Primary Care Funding Agreements,* Department of Health and Ageing, ANAO Audit Report No.41, 2005–06; and
- *Administration of Grants*, ANAO Better Practice Guide, May 2002.

The audit

Audit objective and criteria

1.17 The objective of the audit was:

- to examine the effectiveness of DoHA's administration of the Round the Clock Medicare: Investing in After Hours General Practice Services program.

1.18 The ANAO's opinion was formed based on an examination of the following three criteria:

- DoHA effectively designed and planned the program;
- DoHA effectively assesses and allocates grants; and
- DoHA effectively monitors and evaluates the program.

Audit scope and methodology

1.19 The audit focused on the grants aspect of the RTCM program—RTCM: Investing in After Hours General Practice Services. The audit did not include

[23] DoHA only makes a grant payment if there is not a level of unspent funds that would support a deferral or reduction in the payment.

an examination of DoHA's role in providing Medicare rebates to after hours GP services.

1.20 To form an opinion on the audit's objective, the ANAO interviewed key DoHA personnel, a selection of grant recipients in three states and key stakeholders. The ANAO also tested a selection of grant applications, funding agreements and project reports, and reviewed other relevant DoHA files and documentation.

1.21 The audit was conducted in accordance with ANAO Auditing Standards at a cost of $240 000.

Report structure

1.22 This report is divided into four chapters, as described below.

Chapter 1 **Introduction**	The relevant features of the RTCM: Investing in After Hours General Practice services are summarised in Chapter 1. This chapter also provided background to the audit, including the audit objective, approach and methodology.
Chapter 2 **Design and Planning**	Chapter 2 analyses RTCM's objectives and DoHA's management and reporting of program performance, and examines some of the issues arising from the program's design. The chapter also examines DoHA's risk and probity management and its plans to evaluate the program.
Chapter 3 **Assessing and Allocating Grants**	Chapter 3 examines how DoHA supports grant applicants and its personnel though written guidance and training. The chapter also examines how grants are promoted, applications are assessed, and funding agreements are negotiated with successful applicants. The chapter concludes with an analysis of DoHA's management of stakeholder relationships.
Chapter 4 **Monitoring Grants**	Chapter 4 assesses DoHA's monitoring of the performance of individual grant recipients through project reporting, including verifying and analysing data, and its grant payments system. The chapter also examines how DoHA captures lessons learned.

2. Design and Planning

This chapter analyses the objectives of RTCM and DoHA's management and reporting of program performance. Key issues arising from the program's design are also examined, along with DoHA's risk and probity management and its plans to evaluate the program.

2.1 Effective planning is essential to achieve a cost-effective grants program. Important elements of the planning phase include establishing the necessary steps and processes to be undertaken throughout the life of the program, determining the program's strategic and operational objectives, and establishing targets and mechanisms to enable the grant administrator to assess and report the extent to which individual projects and the program overall are meeting their objectives.[24] The ANAO examined DoHA's approach to:

- establishing the RTCM framework;
- risk and probity;
- performance management;
- key definitions; and
- evaluating the program.

Establishing the RTCM framework

2.2 The aim of the RTCM grants program is to provide greater incentives for GPs to practice after hours and to invest in after hours GP infrastructure. The Coalition Government's intention was to target the funding of services in areas of high demand, such as outer metropolitan, regional and remote areas.[25]

2.3 The Coalition's 2004 election policy formed the basis of the RTCM program. During late 2004 and early 2005 DoHA built on the policy outline, determining the approach to promoting grants, assessing applications, and monitoring grant recipient performance. This planning phase resulted in Program Guidelines, agreed procedures for most stages of the grants process, and templates for key documents. The ANAO recognises DoHA's positive

[24] Australian National Audit Office, May 2002, *Administration of Grants Better Practice Guide,* ANAO, pp. 5–6.

[25] Health and Ageing Portfolio, *Portfolio Budget Statements 2005–06: Budget Related Paper No. 1.11,* May 2005, pp. 90–91.

efforts in rapidly implementing the program in response to the Coalition Government's policy decision. However, there was limited documentation supporting the design features of the program's development. As such, the ANAO was unable to review the rationale for some elements of the current program, in particular whether DoHA considered alternative grants processes and models, and the basis for the adoption of the selection criteria.

Funding services in areas of need

2.4 The Coalition Government decided that the program would be implemented through a formal grant application process for which eligibility criteria and selection processes will be developed by DoHA. The 2005–06 Federal Budget examined the provision of recurrent funding for services in areas of high demand.

2.5 The grant application process DoHA implemented is an open, competitive model whereby grant applications are elicited through publicly advertised funding rounds. While the Program Guidelines state that priority will be given to services in outer suburban, regional and remote areas of Australia, this approach has not been adopted. During the early planning phase of the program DoHA briefly explored how to prioritise areas of need, including using weighted selection criteria, but did not adopt any of the options. The competitive grants promotion and application process does not target or account for the location of a service, the patient catchment area or the demographics of those patients.

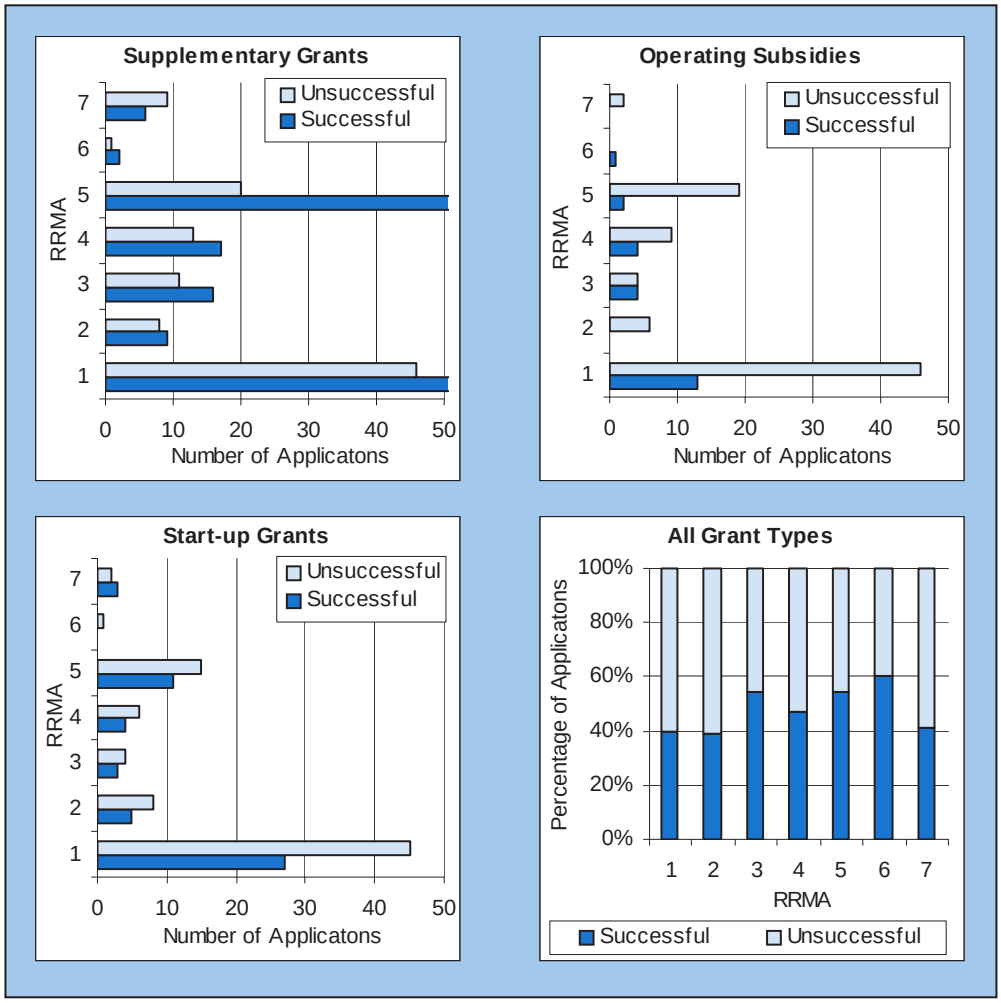
2.6 DoHA has informed the ANAO that application assessors are provided with the Rural, Remote and Metropolitan Areas (RRMA) classification for each application and the guidance provided to assessors states that a service's location should be taken into account when assessing the application. However, the templates assessors use to record their qualitative assessment and quantitative ratings do not mention giving priority to outer suburban, regional or remote areas. Given the emphasis on regionality, DoHA should ensure that the assessment procedures and assessors guidance are explicit regarding the priority to be given to services in outer metropolitan, regional and remote areas.

2.7 ANAO analysis of the total applications reveals that, generally, the proportion of successful to unsuccessful applications was marginally higher in regional and remote areas in comparison to metropolitan areas. Figure 2.1

provides a summary of the successful and unsuccessful applications received by RRMA classification.

Figure 2.1

Applications by RRMA, 2004–05, 2005–06 and 2006–07 funding rounds



Note: RRMA classifications are:

Metropolitan	1	Capital cities
	2	Other metropolitan centres (urban centre with population > 100,000)
Rural	3	Large rural centres with population 25,000 - 99,000
	4	Small rural centres with population 10,000 - 24,999
	5	Other rural areas with population < 10,000
Remote	6	Remote centres with population > 5,000
	7	Other remote areas with population < 5,000

Source: ANAO analysis.

2.8 Around half of the applications (45.2 per cent) were from services located in RRMA 1. The proportion of applications from RRMA 2 (7.1 per cent), RRMA 3 (8.3 per cent), RRMA 4 (10.5 per cent), RRMA 6 (1.0 per cent) and RRMA 7 (4.4 per cent) was relatively small. However, RRMA 5 accounted for 23.4 per cent of applications, largely due to a high number of supplementary grant applications in Round 2: 2006–07. The ANAO found that 45.4 per cent of all applications received were successful. Successful applications by RRMA classifications varied between 38.9 per cent in RRMA 2 and 60 per cent in RRMA 6.

2.9 Adopting a competitive process, rather than targeting areas or particular services in high needs areas, is simpler for DoHA to implement and administer. However, it may result in inequities in services' access to funding. Small practices, with limited time, resources and experience participating in a competitive grants process, may find the effort required to apply for a RTCM grant daunting, or it may not be cost-effective to apply for a grant given the amount available.

2.10 Feedback from assessment panels supports this contention. One Round 1: 2005–06 panel noted that the quality of applications from Divisions of General Practice (Divisions) and privately owned multipurpose centres was higher than those from solo and small co–operative general practices in rural areas. Round 2: 2006–07 panellists reported that applications from larger corporate practices were better 'put together'. The Round 1: 2005–06 panel noted that there was a resultant inequality in access to RTCM grants, observing that often applications from smaller more rural services that require assistance were unsuccessful because of the poor quality of their applications.

Meeting the selection criteria – evidence of local support

2.11 The RTCM program includes two overriding principles:

- services must have the demonstrated support of local GP communities; and
- services must not compete unfairly with existing practices offering after hours services.

2.12 In their grant applications, services are required to provide evidence of local community and GP support for their after hours service, and details about other medical services, including after hours, provided in the local area. Evidence of support from local GPs is an indicator for the requirement to not unfairly compete with existing services.

2.13 However, DoHA acknowledges the difficulty of providing evidence of support. Services competing for grants to provide after hours assistance to the same patient group are unlikely to support each other in applications. And it is difficult to assess grant applications against this criterion, as DoHA does not have complete information about all existing services providing an after hours facility. Therefore, the viability of existing after hours services may be threatened by another service in the same area receiving a RTCM grant. Or, as budgeted costs and income forecasts in applications are usually predicated on existing after hours service levels, the future viability of proposed services may be reduced if more than one service is funded in an area. Additionally, the Guide for Assessors states that applications for grants must be assessed on their own merits. This means that where there is more than one application covering the same patient population, each application is to be assessed independently.

2.14 Not providing evidence of support will result in applications failing against the criterion and, therefore, being assessed as ineligible for funding. DoHA noted that a significant number of applications for grants in Round 1: 2005–06 and Round 2: 2006–07 did not meet this criteria and were assessed as being ineligible for funding. To minimise this problem with Round 3: 2007–08, DoHA informed the ANAO that applications for operating subsidies and start-up grants which were found unsuitable only because of the absence of evidence of support will be recommended for funding subject to such evidence being provided.

Sustainability and viability

2.15 Services are required to address future financial viability when applying for start-up grants and operating subsidies and, when applying for supplementary grants, describe how the grant will contribute to the improved long term financial viability of the service. The emphasis on long term viability was introduced in Round 3: 2007–08. DoHA has informed the ANAO that long term viability was highlighted in Round 3: 2007–08 to make it clearer to prospective applicants that the objective of supplementary grants is to provide financial support to assist them to remain financially viable in the short term (that is, two to three years), but that they must be able to demonstrate self-sustainability beyond the funding period.

2.16 Services are then required to report on their viability in project reports. Two of the services receiving supplementary grants, analysed by the ANAO, noted in project reports that financial viability was unlikely. One service said

that it did not expect the grant to increase financial viability, while the other noted that the grant does not contribute to financial viability as it was paid to general practitioners.

2.17 The After Hours Primary Medical Care (AHPMC) program evaluation found that the key determinants of service sustainability are an adequate GP workforce and financial viability.[26] Many RTCM services have reported difficulties in attracting and retaining staff for their after hours services. Of the service files examined by the ANAO, 25 services had submitted project reports.[27] Seven of these reported workforce shortages: four of the 18 services receiving supplementary grants; one of the two services receiving operating subsidies; and two of the five services receiving supplementary grants.

2.18 The ANAO also found that sustainability has not been built into many of the services' models receiving grants. For example, of the 34 supplementary grants files analysed, 29 allocated a portion of their grant to monetary incentives for GPs. In total, 60.6 per cent of the $3.1 million allocated to the 34 grants was for GP incentives. A further 11.1 per cent was allocated to salaries for nurses and 8.7 per cent to clerical and administration staff. Other items funded include motor vehicle and accommodation allowances and paging services. For operating subsidies analysed, one third of the total grant monies was allocated to nursing and administration staff salaries.

2.19 It is understandable that to remain open, these payments to GPs and other staff are necessary, particularly given the difficulty of attracting medical practitioners to working after hours. By adequately staffing the after hours service, the service should build their patient throughput and, therefore, their Medical Benefits Schedule (MBS) income. However, when these payments are no longer available at the end of the grant period, there is a risk that the services will not be able to attract and retain sufficient staff in the after hours period. Therefore, these services could require ongoing financial assistance, or they will close.

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[26] Australian Healthcare Associates, *Final Evaluation Report, After Hours Primary Medical Care Program,* June 2005, p. 17.

[27] The ANAO analysed the files for 40.9 per cent of the services with executed funding agreements. At the time the ANAO selected the files, 110 funding agreements had been executed. The ANAO examined DoHA's files for:
- 34 (40.0 per cent) of the 85 services receiving supplementary grants;
- 5 (31.3 per cent) of the 16 services receiving start-up grants; and
- 6 (66.7 per cent) of the 9 services receiving operating subsidies.

2.20 In summary, there are several issues that, given the maturity of the program, it would be timely for DoHA to consider:

- funding services in areas of need;
- the requirement for services to provide evidence of local support in their grant applications; and
- sustainability and viability of services in the long term.

2.21 DoHA has not evaluated RTCM. The proposed future evaluation of the program should include an assessment of the relevance of the current program parameters, whether the issues examined above are impacting on the success of the program and whether an outcome of the current model is that the areas in greatest need of assistance are benefiting.

Risk and probity

2.22 In 2005, DoHA developed a Risk Management Plan (RMP) as part of its planning for the 2005–06 funding round. DoHA has revised the RMP prior to each subsequent funding round. The RMP is a high level document focusing on program risks. The current RMP covers a variety of risks, including those related to contract negotiations, use of grant payments, program management, and stakeholders. The RMP includes an indication of the likelihood of each risk occurring, the potential consequences if it does, and outlines the risk mitigation treatment for each risk.

2.23 At the individual grant level, effective risk management involves risks being identified early during the application and funding process, then reassessing, monitoring and actioning, when necessary, the risks throughout the life of the grant. DoHA's Program Management Guide 2006–07 states that an individual risk management plan will be created and maintained for each funding agreement. This does not occur. Nevertheless, risks associated with individual grants are considered at each stage of the grants management process. When assessing grant applications, assessors are not explicitly required to consider the potential risks of the proposed after hours service. Assessors, when assessing applications, noted uncertainties and potential risks, which they considered when rating proposals against the selection criteria.

2.24 During the period of the grant, risks are considered in project performance reports. Services are asked to provide details about challenges and to identify barriers and key factors contributing to progress. These, and other issues reported in the project reports, are considered as part of the project

report assessment process. State and Territory Offices (STOs), when assessing project reports, do not have access to application assessors reports; they have funding agreements, which do not include a discussion of risks. The project report assessment template includes sections on challenges and unresolved issues and risks that have impacted on the project's operation. When analysing project reports, STOs are expected to identify issues from the information provided and, where necessary, pursue them with the service.

2.25 Therefore, while risks are considered, the ANAO proposes that DoHA clearly link its ongoing monitoring of services' performance with the risk management plan. This would assist DoHA to adopt a more consistent approach to managing program and grant risks, and to identify trends or issues across grants and over time.

2.26 DoHA has also developed a Probity Plan for the program. The Probity Plan is based on a number of sources, including the *Government Procurement Guidelines*[28] and *Guidance on Ethics and Probity in Government Procurement.*[29] It covers the principles of probity and ethical decision-making and describes how probity is embedded in RTCM documents and processes. The ANAO did not audit DoHA's compliance with the Probity Plan. However, it did examine the relevant Round 3: 2007–08 documents and found that they comply with the probity-related elements described in the plan. For example, the Probity Plan lists the minimum requirements to be documented in the grants application pack. The ANAO found that the application pack included all listed elements.

Performance management

2.27 An effective performance measurement framework is essential for grant administrators to assess the effectiveness of a program. Performance management should be considered as a key component of planning.[30]

2.28 DoHA's vision is to achieve better health and active ageing for all Australians. RTCM contributes to this aim through DoHA's Outcome 5—Primary Care.

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[28] Department of Finance and Administration, *Government Procurement Guidelines, Financial Management Guidance No.1*, Finance, January 2005.

[29] Department of Finance and Administration, *Guidance on Ethics and Probity in Government Procurement, Financial Management Guidance No.14*, Finance, January 2005

[30] Australian National Audit Office, May 2002, *Administration of Grants Better Practice Guide,* ANAO, p. 25.

Figure 2.2

Departmental and program objectives

DoHA
To achieve better health and active ageing for all Australians.

↳ **Outcome 5—Primary Care**
Australians have access to high quality, well-integrated and cost-effective primary care.

↳ **RTCM**
To improve after hours GP access in metropolitan and regional Australia. The program involves providing greater incentives for GPs to practice after hours and investing in after hours GP infrastructure.

Source: Department of Health and Ageing, *Corporate Plan 2006–09,* DoHA, 2006; *Portfolio Budget Statements 2007–08, Health and Ageing Portfolio, Budget Related Paper No. 1.12*, May 2007, p.97; and *Portfolio Budget Statements 2005–06, Health and Ageing Portfolio, Budget Related Paper No. 1.11*, May 2007, pp.90–91.

2.29 RTCM's purpose, as described above, accords with the Coalition Government's policy and DoHA's strategic objective. DoHA's Portfolio Budget Statements describe the performance information relevant to RTCM, as shown in Figure 2.3

Figure 2.3

RTCM performance indicators

Indicator	Measured By	Reference Point or Target
A range of primary care service delivery models are supported or implemented.	Progress achieved towards implementation or support of models of primary care service delivery.	• up to 76 after hours services supported or implemented in 2005–06 • up to 95 after hours services supported or implemented in 2006–07 • up to 85 after hours services supported or implemented in 2007–08

Note: RTCM is one of three programs contributing to this indicator. The other two programs are the National Health Call Centre Network and AHPMC.

Source: *Health and Ageing Portfolio, Portfolio Budget Statements 2006–07, Budget Related Paper No.1.11*, p.100, and *Health and Ageing Portfolio, Portfolio Budget Statements 2007–08, Budget Related Paper No.1.12*, p.102.

2.30 The RTCM performance indicator is a single measure of performance that assesses the Coalition Government's progress against its 2004 election commitment in relation to the number of services funded. DoHA's external reporting on the program's progress and outcomes is focused on reporting against this measure in its annual reports.

2.31 This single broad measure does not capture other key elements of the objectives of the program, particularly the provision of services to areas of high demand. Measuring and reporting the number of services funded does not inform DoHA, Parliament, or the Australian public, about where, when or how these services are being provided, the quality of the service, the patients being treated, or the workforce providing the services. Nor does the indicator assist DoHA's program managers to administer the program. Overall, the ANAO considers that DoHA could improve the effectiveness of its performance management framework for RTCM.

2.32 In addition, DoHA has not established a performance baseline for the program or its funding components. The new RTCM MBS items were introduced in January 2005. Prior to their introduction, there were separate Medicare items for after hours services in urgent (emergency) situations only. Standard Medicare items applied to other, non-urgent, after hours consultations. Therefore, the Medicare data available at the start of RTCM did not provide DoHA with sufficient information to determine the extent of after hours GP coverage. As such, it will be difficult for DoHA to measure the extent to which the grant categories are meeting their objectives or the success of the overall program. That is, without knowing the level of service provision at the start of the program, it will be difficult for DoHA to assess the extent to which the program has improved access to after hours services.

2.33 In October 2007, DoHA informed the ANAO that it is implementing a system to obtain national quarterly MBS data for after hours GP attendances per 100 000 persons from 1 January 2005. It is also examining the feasibility of obtaining quarterly MBS data for a sample of local catchment areas containing a RTCM grant recipient. It will be difficult for DoHA to establish causal links between RTCM grants and any change in after hours GP service, as RTCM grants are only one of a number of factors impacting on the provision of, and access to, such services. Nevertheless, using MBS data will assist DoHA to better understand access to after hours GP care.

2.34 At the individual grant level, funding agreements set out the conditions and requirements under which DoHA funds recipients. The agreements include a project aim and objective, outcomes and activities. They also include service details such as opening hours and the reporting requirements. The ANAO found that the objectives and activities of individual funding agreements are consistent with the intent of the program and are, generally, specific and measurable. For example, the project aim outlines how a grant will be used, with the activities providing the detail. Therefore, in relation to

DoHA's monitoring of individual services, these project activities serve as performance indicators.

2.35 DoHA monitors services' progress and compliance with the funding agreements via a six-monthly reporting regime. Project reports assist DoHA to understand the issues facing individual services and how they are progressing against the activities listed in their funding agreements. They are not designed to assist DoHA to measure the performance of the whole program. The focus of the reporting process is the progress of individual services.

2.36 Therefore, while DoHA has established a single broad performance indicator and monitors performance of individual grants, its monitoring and analysis does not include an examination of trends across time, within and across grant types, across regions, or across the program as a whole. DoHA has not established an explicitly linked, effective framework for measuring and managing performance at all levels of the program.

Recommendation No.1

2.37 The ANAO recommends that DoHA develop, document and implement an effective performance management framework that includes useful, measurable performance indicators that inform future data collection and analysis, and program evaluation.

DoHA's response

2.38 Agreed. DoHA acknowledges that whilst it has an overall performance indicator in place for the RTCM and it regularly monitors the performance of individual grants against project objectives, the performance management framework for RTCM could be improved to ensure information related to other key aspects of the program's objective, and DoHA's administration of the program, is captured and assessed. To this end, the Department has recently developed a number of key performance indicators for RTCM for inclusion in Round 3 Funding Agreements. These performance indicators will be reviewed prior to the next funding round. The evaluation of RTCM planned for the first half of this year will also inform the development of a performance management framework for the program.

Key definitions

2.39 DoHA has not articulated in its program documentation clear definitions for some of the key RTCM terms, including 'after hours' and 'access'.

2.40 The definition of after hours for RTCM grants differs from the definitions currently used in other initiatives, including RTCM Medicare rebates, urgent out-of-hours Medicare rebates and the Practice Incentives Program (PIP).

Figure 2.4

What is 'after hours'?

Program	After hours Definition		
	Monday to Friday	Saturday	Sunday and Public Holiday
RTCM Grants	before 8am; after 6pm	before 8am; after 1pm	all day
RTCM Medicare items	before 8am; after 8pm	before 8am; after 1pm	all day
Urgent after hours Medicare items[31]	before 8am; after 8pm	before 8am; after 1pm	all day
PIP	before 8am; after 6pm	before 8am; after midday	all day

Source: DoHA and Medicare Australia.

2.41 The ANAO recognises that applying a consistent definition across all DoHA programs would have financial implications for the Australian Government. For example, allowing earlier access to the higher rebates for RTCM Medicare items would result in an increase in the cost of Medicare. DoHA agrees that definitional consistency has inherent merit, but states that any changes would have financial and workforce implications that would need to be considered in a broader policy context.

2.42 Nonetheless, 'after hours' is a fundamental term. As part of an evaluation of RTCM, and when planning any future programs in this area, DoHA should consider the benefits and costs of employing, in the longer term, a clear and consistent definition of after hours across all of its programs.

2.43 Improving access to after hours services is the goal of RTCM. However, DoHA has not clearly defined access. Improving access could have a multiplicity of meanings, including increasing the number of after hours services or the number of GPs working in those services, or even improving

[31] A category of Medicare items cover 'urgent after hours during unsociable hours'. Medicare rebates for these items are available between 11:00pm and 7:00am.

the physical access to existing after hours services. The detail in RTCM documents, such as the Program Guidelines, provides some direction, suggesting that access is intended to refer to the public's ability to consult with a GP during the after hours period wherever they may live in Australia.

2.44 DoHA has informed the ANAO that RTCM seeks to improve access to after hours GP care through maintenance of existing hours and the provision of additional hours of operation in the after hours period, improved operational systems in services, and the attraction and retention of GPs providing after hours care. There would be benefit in DoHA consolidating its existing guidance on significant RTCM terms, such as access, into clear and comprehensive definitions. These definitions should be included in the Program Guidelines and other relevant, publicly available, RTCM documents.

Evaluating the program

2.45 Evaluations should be planned when designing and developing a program, with performance indicators and key data requirements linked to the requirements of future evaluations.[32] In addition, funding agreements should be informed by the performance framework and monitoring strategy, resulting in the collection and analysis of data relevant to an evaluation of the individual grant and the program as a whole.

2.46 In early 2005, DoHA developed a draft evaluation framework. The framework noted the need for evaluation to be considered during the initial planning phase of the program. The framework, which was distributed to STOs prior to the first RTCM staff workshop in April 2005, described the scope of the RTCM evaluation as including:

- local evaluation, on site, for individual projects;
- administrative evaluation, including an annual review of application, selection, monitoring and reporting procedures; and
- program evaluation in the third year of the program by an external agency, examining the program's success in meeting its objectives.

2.47 DoHA was unable to provide any later reference to the draft evaluation framework, and current Central Office program staff were unaware of its existence. DoHA has not yet evaluated any aspect of RTCM, including its administration, as foreshadowed in the framework, nor does it have a current

[32] ANAO, 2002, *Administration of Grants Better Practice Guide*, ANAO, Canberra.

evaluation plan. However, DoHA has acknowledged the need to evaluate RTCM and, as an initial step, it is establishing a system to collect and analyse MBS RTCM data.[33]

2.48 The funding agreements also require that services participate in an external evaluation of RTCM. Services have not been provided with any details about when or how this evaluation will occur, or what level of participation DoHA is expecting. Consequently, services are unable to plan or budget for evaluation. The ANAO found that, of the executed funding agreements reviewed, only one included evaluation and reporting in its budget.

2.49 DoHA's Contract Management Advisory Unit has implemented a Performance Assessment Rating system (PAR) in the Primary and Ambulatory Care Division. The PAR rates the performance of parties external to DoHA involved in projects worth over $50 000 for procurement and over $100 000 for other funding initiatives. As such, services receiving RTCM grants over $100 000 will be assessed using this system. DoHA informed the ANAO that where a RTCM grant is subject to a PAR, it will be conducted at the end of the funding agreement. To date, no RTCM grant recipients have been involved in a PAR assessment.

Recommendation No.2

2.50 The ANAO recommends that DoHA develop and implement a plan to evaluate how effectively RTCM is achieving its objective and how effectively DoHA is administering the program.

2.51 In relevant places throughout this audit report, the ANAO has made suggestions about the issues that DoHA should consider when planning its evaluation.

DoHA's response

2.52 Agreed. The Department has commenced development of a plan for evaluation of the RTCM program. This evaluation will be conducted during the first half of 2008. As identified in the ANAO proposed audit report, a major challenge for the evaluation will be to isolate the impact of RTCM on the provision of after-hours GP services in Australia. This is because RTCM grants are only one of a number of factors impacting on the provision of, and access to, such services. This may influence the focus of any evaluation activity.

[33] In January 2007, DoHA advised the ANAO that it is drafting a plan to evaluate the program.

2.53 The Department is also putting in place a system to collect and analyse after-hours MBS data now that the rebates for after-hours GP services have been in place for three years. Whilst the difficulty in establishing causal links between RTCM grants and any change in after hours GP service remains, the availability of this data will assist DoHA to better understand issues surrounding access to after hours GP care.

3. Assessing and Allocating Grants

This chapter examines how DoHA supports grant applicants and its personnel though written guidance and training. The chapter also examines how grants are promoted, applications are assessed, and funding agreements are negotiated with successful grant applicants. The chapter concludes with an analysis of DoHA's management of stakeholder relationships.

Supporting grant applicants and DoHA personnel

Guidance for grant applicants

3.1 DoHA has produced Program Guidelines for services. The first version of the guidelines was produced for the 2004–05 start-up grants. This version reflected the Coalition's 2004 election policy. When developing the Program Guidelines, DoHA consulted with key stakeholder groups, providing them with copies of the draft Program Guidelines and grant application forms for comment.

3.2 DoHA reviewed the Program Guidelines following each funding round, with the latest version, *RTCM: IAHGPS Program, Program Guidelines, Round 3: 2007–08*, released in April 2007 for the 2007–08 funding round. Similarly, the application forms and list of frequently asked questions, which accompany the Program Guidelines, have been updated following each funding round. The changes have been informed by feedback from application assessment panels and discussions between program staff.

3.3 The Program Guidelines contain the eligibility criteria for the program, priority areas, details about the assessment process and contracting arrangements. For each of the funding components, they also include an explanation of the type of services eligible for funding and the selection criteria. The services interviewed by the ANAO reported that the Program Guidelines were clear, concise and accessible.[34]

3.4 As part of the application pack, DoHA issues application forms for use by services applying for RTCM grants. There is a separate application form for each grant type. The application forms require services to provide details about how they satisfy the selection criteria. Application forms are structured and align with the selection criteria. They include instructions about how to

[34] The Program Guidelines and application forms are available on DoHA's website, <www.health.gov.au> .

complete the forms, including the type of details to be provided in each section and the evidence to be provided in support of the application.

3.5 Services' opinions of the application forms were mixed, with only one service providing only positive comments. While eight services described the forms as clear and easy to complete, other comments included that they were long and repetitious, and that some sections were difficult and time-consuming to complete. For example, three services reported difficulty estimating and providing adequate detail about project budgets.

3.6 DoHA acknowledges the poor quality of financial information provided in Round 1: 2005–06 and Round 2: 2006–07 grant applications and the lack of details about service delivery models in Round 2: 2006–07 applications. However, it has not improved the guidelines or the guidance in the three application forms in a way that would assist services to better complete these sections. The changes to the application forms have focussed on the wording of some sections and placing an emphasis on details for the proposed service. The budget templates included in each of the application forms have not changed since Round 1: 2005–06. In addition, while applicants are required to sign a verification when submitting their applications, DoHA does not verify the financial information included in applications. Applications are accepted at face value.

Guidance for DoHA personnel

3.7 While DoHA has not developed a central program management guide for RTCM program staff, Central Office (CO) and State and Territory Office (STO) personnel have access to a variety of guidance material and sources, as illustrated in Figure 3.1.

Figure 3.1

Guidance for DoHA personnel

Source: ANAO analysis.

3.8 DoHA CO compiled the Program Management Guide to assist its staff to negotiate funding agreements. The guide is a compilation of lessons learned over the life of the program. It was originally assembled after Round 1: 2005–06 and has been updated as necessary. The guide contains details about the standard clauses in the agreement and the items in the schedule to the agreement, plus step-by-step guidance on negotiating and executing funding agreements. It also contains copies of all the RTCM documents relevant to this phase of the process. However, this guide only assists CO staff when negotiating funding agreements. It does not cover any other facet of the program's management, for example contact with services prior to selection or ongoing grant monitoring following execution of the funding agreement.

3.9 DoHA has created templates for:

- applying for grants;
- assessing grant applications;
- completing project reports; and
- assessing project reports.

3.10 The purpose of the templates is to guide grant applicants, recipients and DoHA staff when performing specific tasks. RTCM funding agreements are based on DoHA's standard funding agreement, with the schedule tailored for the individual services. DoHA staff use the Program Guidelines, templates and funding agreements as key sources of program guidance.

3.11 DoHA's CO and STO responsibilities are outlined in the 'State/Territory and Central Office Responsibilities January 2006' (Responsibilities). CO originally prepared the Responsibilities in consultation with the STOs in 2005. The Responsibilities were revised minimally in January 2006. In essence, CO are responsible for the administration of all stages of the program until the funding agreements are executed, plus approving the six-monthly project reports and processing grant payments. During the ANAO's fieldwork, the STO role was limited to the ongoing monitoring of the grant recipients, including assessing the project reports. CO, in consultation with STOs, is reconsidering the appropriate division of responsibilities for the program.[35]

3.12 All of the STOs visited compiled their own guidance folders containing some or all of the documents mentioned above. For example, the Victorian STO has collected into a folder all relevant program documents, including the application forms, funding agreements, project report assessment template and the Responsibilities.

3.13 The Project Managers' Toolkit is a computer-based software package available to all DoHA personnel. The Toolkit provides information to DoHA staff about the policies and procedures that govern program management across the Department. It contains a range of resources, including manuals, flowcharts, templates and checklists. CO staff informed the ANAO that the Toolkit was useful, particularly during the early stages of the grants process. STO staff said that, as their role in the program is limited, they do not need to refer to the Toolkit.

3.14 RTCM program staff also have access to specialist areas within DoHA, including the Legal Services Branch (LSB) and the Primary and Ambulatory Care Division's Contract Management Advisory Unit (CMAU). LSB provide advice on legal matters in the funding agreements and more widely on the

[35] In December 2007, DoHA informed the ANAO that CO and STOs have agreed to a revised division of program responsibilities. The only significant change is the devolution of responsibility for reviewing and accepting (or not accepting) supplementary grant progress reports to STOs. The new arrangements will be reviewed at the end of June 2008.

program. CMAU provides advice, quality assurance and training to support program mangers.

3.15 Often, the first source of advice for program officers will be their colleagues and managers who may have dealt with similar issues. In addition, all STO staff interviewed by the ANAO stated that they would refer to CO for advice. However, one STO suggested to the ANAO that the advice and guidance received from different CO officers can be inconsistent.

3.16 In summary, RTCM program staff have access to a range of information sources, which, they informed the ANAO, is adequate. Nevertheless, clear, consistent and well documented program management guidelines are an important component of an effective program administration system. A single reference source for policy guidance, program documents and standard forms helps to ensure consistent and efficient administration. DoHA would benefit from a centrally controlled and regularly updated program guide, which would be available to all program officers.

Training for DoHA personnel

3.17 Individual DoHA staff training needs are addressed through their Performance Development Scheme agreements with supervisors. The ANAO found that CO and STO program officers had the generic skills and experience to perform in their roles, and had access to relevant training, such as contract management, project management and negotiation skills. Staff interviewed by the ANAO were confident that they had received adequate generic training and possessed the capabilities necessary to administer the program. Two staff suggested that it would be beneficial for new starters to attend contract management training as soon as practicable after joining the Department.

3.18 However, DoHA had provided little program specific training, particularly to STO staff. Generally, the focus of program specific training was on the individual officer's introduction to the program and ongoing on-the-job training. The quality of this introduction and training was variable, and depended upon the knowledge and competency of the supervisor.

3.19 CO has hosted three program workshops for staff—in April 2005, January 2006 and October 2007. For each workshop, CO funded one staff member from each STO to attend. The focus of the first workshop was to provide STO staff with an introduction to the program, including the responsibilities of the CO and STOs, the Program Guidelines and application forms, and contracting and reporting arrangements. The second workshop

provided an update on Round 1: 2005–06 and the process to be implemented for Round 2: 2006–07. It also included a discussion of lessons learned from funding Round 1: 2005–06. The third workshop discussed, inter alia, future directions for after–hours GP programs, the new CO/STO responsibilities, and Round 3: 2007–08. These workshops are useful fora for staff to discuss issues arising from the funding rounds, changes to the program and lessons learned, and should result in enhanced consistency across the program. However, the level of turnover in CO and STOs means that many attendees of the first two workshops are no longer working on the program. The ANAO encourages DoHA to schedule periodic workshops.

Promoting the grants

3.20 As described previously, DoHA does not target services or areas of need to elicit applications for funding. The program is promoted through media advertising and via the major stakeholder groups.

3.21 For each funding round, the approach to promotion has been similar. Advertising is print-based and encompasses national and regional newspapers and the medical press. Prior to the start of each advertising campaign, DoHA provides the major stakeholder groups with details about the advertisement and its placement. In addition, for Round 3: 2007–08, DoHA emailed the current grant recipients to advise them of the upcoming funding round and their eligibility if their grant is due to expire shortly after the application due date. DoHA has not reviewed the effectiveness of its approach to advertising RTCM grants.

3.22 The timelines for promotion and closing dates for applications are listed in Figure 3.2.

Figure 3.2

Advertising and application deadlines

Funding Round	Advertising Started	Applications Due
2004–05 - Start-up Grants	22 January 2005	22 February 2005
Round 1: 2005–06	28 May 2005	18 July 2005
Round 2: 2006–07	22 April 2006	30 June 2006
Round 3: 2007–08 - Start-up Grants	21 April 2007	15 June 2007
Round 3: 2007–08 - Operating Subsidies		15 June 2007
Round 3: 2007–08 - Supplementary Grants		25 May 2007

Source: ANAO analysis of DoHA documents.

3.23 As the figure shows, for the 2004–05 funding round, the period between advertising and the close of applications was one month. DoHA justified the short timeframes by advising that the five sites were announced in September 2004 as part of the Federal Coalition's election policy and that stakeholder organisations were consulted about the Program Guidelines in December 2004. Even so, internal DoHA correspondence notes that the brevity of this period attracted some criticism from the industry and media.

3.24 The deadline for applications in Round 1: 2005–06 and Round 2: 2006–07 was seven and ten weeks respectively after the grants were advertised, giving services more time to prepare applications. The timeline for Round 3: 2007–08 was revised. While the application period for start-up grants and operating subsidies remained at eight weeks, the period for supplementary grants was reduced to five weeks. DoHA stated that it has adopted this approach because completing applications for supplementary grants is less onerous than for the two other types of grants.

Assessing grant applications

3.25 DoHA has established a suitable process to assess grant applications, and the documentation to support that process. As part of this approach, DoHA has:

- developed a process that is generally supported by the services and application assessors interviewed by the ANAO;
- included, in the Program Guidelines, the criteria against which applications are assessed;
- appointed panels to assess the applications; and
- provided those panels with a Guide for Assessors and assessment templates.

Selection criteria

3.26 Applications are assessed against weighted selection criteria. DoHA did not document the rationale for many of its decisions during the planning for RTCM. This includes the development of the selection criteria. DoHA informed the ANAO that the criteria are based on the principles of good business practice and the two principles: that services can demonstrate support from the local GP community; and that services do not compete unfairly with

existing practices offering after hours services. The selection criteria are included in the Program Guidelines.

Figure 3.3

Funding Round 3: 2007–08 selection criteria

Supplementary Grants		Operating Subsidies and Start-up Grants	
A justified service delivery model	25 pts	A justified service delivery model	20 pts
Demonstrated community need	25 pts	Demonstrated community need	20 pts
Sound methodology for utilising the supplementary grant	25 pts	Demonstrated support for the proposed service delivery model	20 pts
An appropriate and well defined budget	25 pts	A justified business case	30 pts
		Demonstrated capacity to implement and manage the proposed service delivery model	10 pts

Source: *RTCM: IAHGPS Program, Program Guidelines, Round 3: 2007–08*, DoHA, pp. 9, 11, and 13.

3.27 To be eligible for funding, applications must achieve at least half of the available points for each selection criterion and an overall score of at least 60 points. Assessors are also required to provide a qualitative appraisal of the assessment.

Assessment panels

3.28 Assessment panels are convened for each grant type and each round. The assessment panels consist of one DoHA staff member, acting as chair, and two external panellists. Membership of the panels is consistent intra-rounds.

3.29 DoHA does not have a documented process to select external panellists; it informed the ANAO that the external panellists are selected for their experience in grants management and/or the health sector. Assessors are required to declare any conflicts of interest and sign confidentiality agreements, and that the grants selection process is structured. Nevertheless, to protect DoHA against perceptions of bias and to enhance the fairness and transparency of the selection process, it is advisable to record the reasons for selecting panellists, including their relevant qualifications and experience.

Guidance for assessors

3.30 Assessors are provided with adequate guidance to assess grant applications. Assessors are provided with a Guide for Assessors to assist them to assess the grant applications. The Guide for Assessors was developed in

2005 and is reviewed prior to each funding round.[36] Panel members are also provided with a package of information, which includes the application forms and Program Guidelines. The Panel Member's Assessment Template, which follows the selection criteria, includes a list of the information that is required to meet each criterion, based on the information requirements listed in the grant application forms.

3.31 In addition to the Guide for Assessors, one CO program officer, who chairs an assessment panel, has independently developed a guide for rating supplementary grants. This guide divides the points for each selection criterion into four ranges and describes the circumstances that would warrant a rating in each range. Figure 3.4 illustrates the ratings guide using one example from criterion 2 'demonstrated community need'.

Figure 3.4

Example of scoring supplementary grants against selection criterion 2

Scoring Range	Description
20 - 25	Information provided is comprehensive indicating strong community need. Provides research supporting need.
15 - 19	As above but some information may be missing so that a very strong case is not made. There are limited alternative after hours services nearby.
12.5 - 14	Just enough information to justify it meets this criterion. There may be other after hours services nearby and this grant would create unfair competition.
Fail	Not addressed. Other after hours service(s) close by and grant would provide unfair advantage to applicant.

Note: The descriptions are examples from a list of circumstances that would warrant each rating.

Source: A Guide to Scoring Supplementary Grants, DoHA.

3.32 The ANAO acknowledges that such a guide may be useful to assessors, as it builds on the guidance already provided by DoHA. DoHA should review the appropriateness and usefulness of this guide and, if deemed necessary, develop similar guides for use when assessing the two other grant types.

3.33 DoHA used mapping software to map the geographic location of RTCM and After Hours Primary Medical Care (AHPMC) grant recipients and

[36] DoHA was unable to provide the ANAO with a copy of the original Assessors Guide used in the assessment of the 2004–05 start-up grants.

practices receiving Practice Incentives Program (PIP) payments.[37] These maps are available to panel chairs to check the number, location and remoteness of services in different regions.

Funding restrictions

3.34 Services can only receive one RTCM grant at any one time, and may not be in receipt of AHPMC funding. No further restrictions are placed on services receiving Australian Government funding. Therefore, services can receive funding from other DoHA programs, such as PIP, as well as receiving a RTCM grant.

3.35 To identify services currently in receipt of RTCM grants or AHPMC funding during the application assessment process, DoHA relies on a database of those services and the knowledge of CO personnel. This process is adequate given the present size of the program and the limited number of funding rounds to date. However, as the program matures, the number of past and present recipients will grow, rendering this approach cumbersome and, possibly, inaccurate. For future funding rounds, DoHA would benefit from a more structured approach to identifying RTCM and AHPMC funding recipients.

Negotiating funding agreements

3.36 DoHA negotiates funding agreements with successful applicants. The terms and conditions of these funding agreements are based on DoHA's standard funding agreement, with the schedules tailored for individual services. The schedules are based on the application forms, assessors' reports and verbal overview by the panel chairs, and discussions with the services. The schedule includes a description of the service to be funded, the amount of the grant, and the reporting requirements.

3.37 DoHA has satisfactory procedures to negotiate and execute funding agreements with services. Funding agreement negotiations are generally documented. Agreements are cleared by LSB and CMAU and executed on behalf of DoHA by appropriate delegates. Services are informed of the process and are given adequate opportunity to discuss issues and concerns with CO; and CO is responsive to services' needs. The funding agreements are straightforward and understandable.

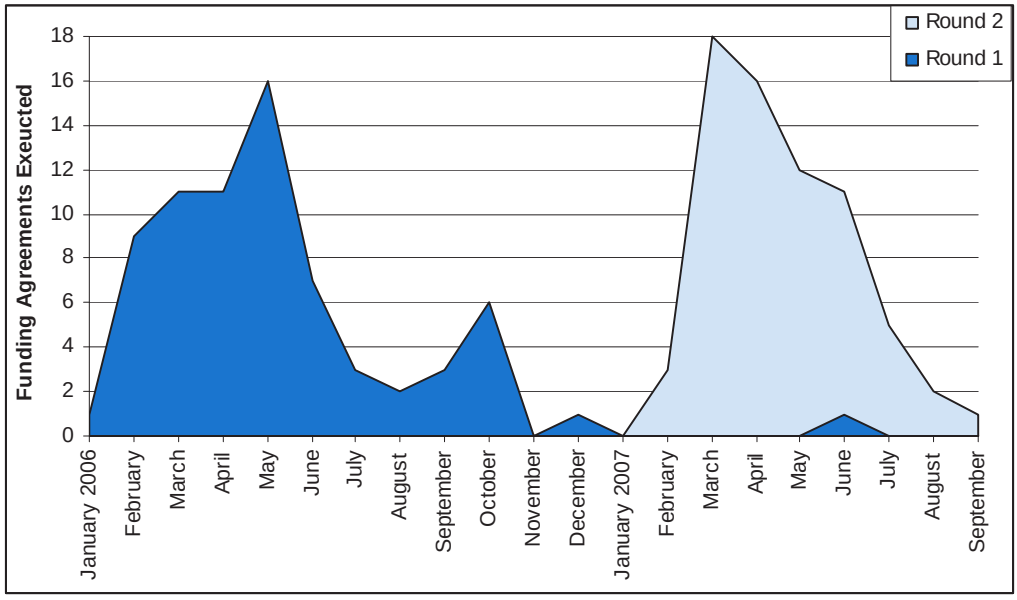
[37] That is, GPs receiving PIP payments that provided greater than 2000 after hours services in the previous financial year and claimed RTCM Medicare rebates.

3.38 Part of the negotiation process is clarifying areas highlighted by application assessors, or that are unclear in the applications. For example, in Round 2: 2006–07, ten applications were recommended for funding, subject to the outcome of budget negotiations, and a further four were recommended subject to confirmation of GP support. As a result of the poor quality of financial information in applications, the main discussions at this time centre on the budget. Also, services underestimate some costs, such as administration, or fail to include some costs, such as marketing. These issues are resolved during negotiations.

3.39 Generally, the process from application assessment to executed funding agreement is straightforward. The first Round 1: 2005–06 funding agreement was executed in January 2006, two months after DoHA commenced negotiations in November 2005. Just over two thirds of the agreements (67.6 per cent) were executed by May 2006. Following Round 2: 2006–07, the first agreement was executed in February 2007, also two months after negotiations were opened with successful applicants in December 2006. By April 2006, over half (51.4 per cent) of Round 2: 2006–07 funding agreements had been executed. Figure 3.5 illustrates the number of agreements executed by month.

Figure 3.5

Funding agreements executed, by month, as at October 2007



Source: ANAO analysis.

3.40 However, for some grants the negotiations are complex and the process is not timely. For example, one Round 1: 2005–06 funding agreement was not executed until June 2007.

Grant Outcomes

Outcome of the 2004–05 funding round

3.41 The 2004 election policy nominated the five areas to receive the 2004–05 start-up grants. These areas were:

- Glenside, South Australia;
- Kallangur, Queensland;
- Ryde, New South Wales;
- Tweed Heads, New South Wales; and
- Williamstown, Victoria.

3.42 In response to the call for applications for services in these five areas, DoHA received five applications and four expressions of interest. DoHA assessed only the five complete applications, which were for services in Kallangur (2 applications), Tweed Heads (2 applications) and Glenside (1 application). No applications were received covering the Williamstown and Ryde areas. Two of these five proposals, covering Tweed Heads and Kallangur, were considered suitable for funding. The funding agreement for the service in Tweed Heads was executed on 22 June 2005. DoHA withdrew its offer of funding to the service in Kallangur in November 2006 after the service failed to respond to correspondence and requests for information. In Round 2: 2006–07, a different service provider submitted an application for a start-up grant in Kallangur. On 5 June 2007 a funding agreement was executed with this provider.

3.43 Following the round, DoHA approached local Divisions and providers in the three other areas (Glenside, Ryde and Williamstown). Subsequently, funding agreements were executed for services in Williamstown on 25 November 2005 and Glenside on 8 June 2006.[38] The service in Williamstown ceased operating in March 2007 as a result of an unsustainably low level of patient throughput. Following continued lack of interest from GPs in the Ryde

[38] The service provider in Glenside subsequently changed, and a funding agreement was executed with the new provider on 13 June 2007.

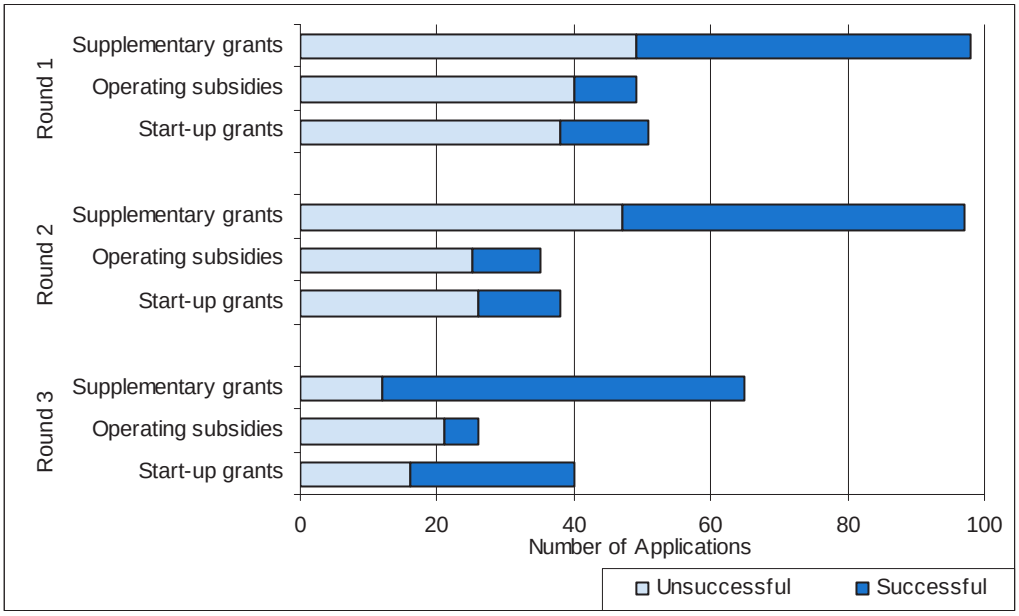
area, DoHA opened discussions with a deputising service. A funding agreement with this provider was executed on 26 July 2007.

Outcome of the 2005–06, 2006–07 and 2007–08 funding rounds

3.44 The outcomes of the 2005–06, 2006–07 and 2007–08 funding rounds are displayed in Figure 3.6. In Round 1: 2005–06, a total of 198 applications were received, with 35.9 per cent successful. In Round 2: 2006–07, 42.4 per cent of the 170 applications were successful. In Round 3: 2007–08, of the 131 applications received, 62.6 per cent were successful.

Figure 3.6

Successful and unsuccessful applications, as at October 2007



Note : 'Unsuccessful' includes applications that were successful but were later withdrawn or where funding agreement negotiations with the service ceased before an agreement was executed.

Source: ANAO analysis of DoHA data.

3.45 Victoria and New South Wales accounted for 61.7 per cent of the Round 1: 2005–06, Round 2: 2006–07 and Round 3: 2006–07 applications. Victoria attracted 158 applications, of which 77 (48.7 per cent) were successful. There were 150 applications for services in New South Wales, with 51 (34.0 per cent) successful. Almost half (45.2 per cent) of all the applications received were for services in capital cities (Rural, Remote and Metropolitan Area [RRMA] 1[39]).

[39] See Figure 2.1 in Chapter 2 for RRMA classifications.

The second highest source of applications for each grant type and in total was other rural areas with populations less than 10 000 (RRMA 5) which accounted for 23.4 per cent of applications. Generally, the proportion of successful applications was higher in regional and remote areas.

Managing relationships

Stakeholder engagement

3.46 DoHA's implementation plan for Round 1: 2005–06 described how to manage engagement with GPs and Medical Deputising Services (MDSs) and their representative organisations, local communities, and the Minister for Health and Ageing. For Round 1: 2005–06 and Round 2: 2006–07, DoHA developed a communications strategy to inform internal and external stakeholder engagement. The strategies briefly described the timing and activity of areas within DoHA, and between DoHA and stakeholders. Generally, DoHA's engagement with stakeholders has focused on consultation in the early phases of the program, and at the start of each funding round. The ANAO found that DoHA implemented its communications strategies.

3.47 In 2005, when developing the Program Guidelines and application forms, DoHA consulted the four key GP stakeholder groups—the Australian Medical Association, the Australian General Practice Network[40], the Royal Australian College of General Practitioners and the Rural Doctors Association of Australia. DoHA also notifies these groups just prior to commencing advertising for a new funding round.

3.48 When speaking with these groups, the ANAO found that awareness of RTCM was low. That is, the stakeholder groups had not received reports from their members about the program, either positive or negative. This may be interpreted in a number of ways, including: that the program is operating efficiently and services do not have any complaints (or praise); the program is not as important to services and stakeholders in comparison to other priorities; and/or services are not aware of the program. DoHA considers that the number of applications received in each round suggests that awareness of the program is satisfactory. However, as DoHA has not evaluated the program, it is difficult to confirm this claim or to identify the most likely reason(s) for the very limited stakeholder feedback. In its future program evaluation, DoHA

[40] Formerly the Australian Divisions of General Practice.

should consider including an evaluation of stakeholder awareness and, if appropriate, how it might enhance that awareness.

Communication with services

3.49 DoHA's contact with services is focused on negotiating the terms and conditions of the funding agreements and the ongoing monitoring of those funding agreements via six-monthly project reporting. All services interviewed by the ANAO reported having a good relationship with DoHA, at both the CO and STO level. For example, during the negotiations process, services stated that DoHA personnel were accessible, helpful and responsive, and explained the process clearly.

4. Monitoring Grants

This chapter assesses DoHA's monitoring of the performance of individual grant recipients through project reporting, including verifying and analysing data, and its grant payments system. The chapter also examines how DoHA captures lessons learned.

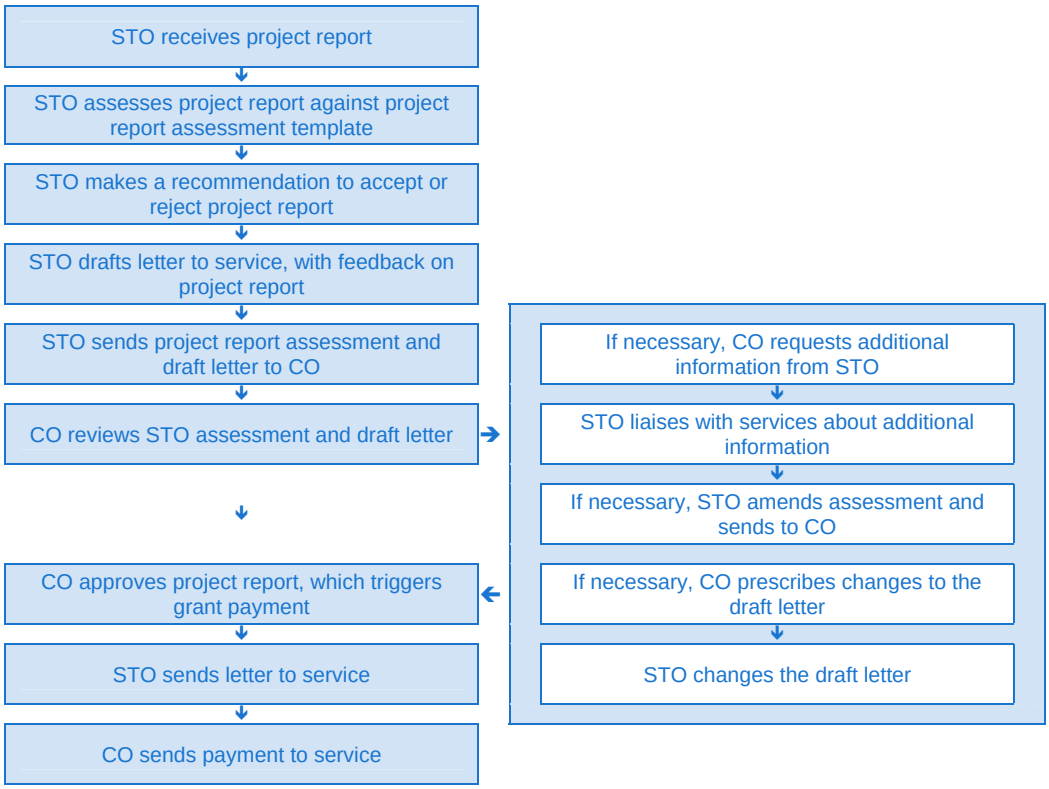
Project reporting

4.1 DoHA monitors RTCM grants through a six monthly project reporting process. Each grant recipient is required, as specified in their funding agreement, to provide DoHA with six monthly reports of their progress. The project reports are assessed by DoHA's State and Territory Office (STO) using a standardised State/Territory Office—Project Report Assessment template. DoHA's process for assessing and approving project reports is depicted in Figure 4.1.[41]

[41] This figure reflects DoHA's process during the ANAO's fieldwork. In December 2007, DoHA informed the ANAO that responsibility for assessing supplementary grant project reports will be devolved to STOs from January 2008.

Figure 4.1

Assessing project reports



Note: STO = DoHA's State and Territory Offices
CO = DoHA's Central Office

Source: ANAO analysis.

4.2 The ANAO understands that it may have been necessary in the early stages of the program for Central Office (CO) to review all STO project report assessments. Nevertheless, as the program enters Round 3: 2007–08, DoHA could look for efficiencies in the process by adopting a risk-based approach to assessing and approving project reports. For example, the responsibility for project report assessment could be fully devolved to STOs with CO retaining an oversight role, reviewing a selection of STO assessments to maintain consistency and quality of the assessment process.

4.3 CO provides a spreadsheet of project report due dates to the STOs. However, STO personnel did not consider this spreadsheet to be helpful or user-friendly. In each of the three STOs the ANAO visited, program staff had developed and maintained their own up-to-date spreadsheets that tracked, inter alia, project report due dates.

4.4 When STOs receive project reports, they are assessed against a standard assessment template. The assessment template is the same for all three grant types. The template has been reviewed at least twice, and the current version was provided to STOs in early May 2007. However, STOs remain critical of the assessment template. STO staff claimed that the form is repetitive and that it could be better tailored for supplementary grants as some of the questions are unnecessary and the amount of information required excessive for the small size of the grants.[42] STOs are responsible for clarifying any ambiguity in project reports, requesting missing or additional information, and negotiating changes where necessary. STOs and several services agreed that it was often necessary to clarify reports or request outstanding information.

4.5 STO personnel reported that the majority of time assessing project reports was spent on the financial reporting section. One STO, for example, estimated that it devotes 75 per cent of the assessment process to this one section.

4.6 Services interviewed by the ANAO were generally positive about the reporting requirements, saying that they were not too onerous and that the project report template was useful. Some grant recipients have also commented to DoHA that collection of the data for their project reports has proved valuable for their own quality assurance and planning purposes. However, two services informed the ANAO that completing the reports was time consuming. Also, all services interviewed reported the need to tailor existing information systems or create new systems to capture the data required by the project reports.

Verifying data

4.7 In its 2005–06 report, *Administration of Primary Care Funding Agreements*, the ANAO examined DoHA's monitoring of funding agreement compliance and found that:

> The system used by Health to monitor primary care funding agreements relies primarily on self-reporting, with limited activity to verify the accuracy or quality of information within reports submitted by funded organisations.[43]

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[42] In December 2007, DoHA advised the ANAO that an CO/STO working group was established to revise assessment templates. New templates were developed and distributed in December 2007.

[43] ANAO, *Administration of Primary Care Funding Agreements*, *Department of Health and Ageing*, Audit Report No.41 2005-06, p. 71.

4.8 The ANAO's findings in this audit were similar. DoHA monitors compliance with the terms, conditions and requirements of funding agreements via the project reporting system. It requires confirmation on elements such as business status (for example, Australian Business Number), insurance and accreditation status and recipients of operating subsidies and start-up grants are required to provide audited financial statements annually. However, DoHA does not verify important data provided by services in project reports. For example, DoHA does not generally require that services substantiate data provided on such service details as opening times, number of consultations, number of home visits, and staffing levels. Nor does it request evidence about the qualitative data provided in project reports such as quality assurance arrangements and how community needs were met. Unless there is an apparent anomaly in the project reports, the information provided is accepted at face value.

4.9 DoHA requires these data to assist it to determine whether services are complying with the conditions of their funding agreements and, in turn, whether the program is achieving its objective. Also, project reports are the basis upon which grant payments are made. Therefore, it is important that DoHA gains adequate assurance that the data provided accurately reflects the service's progress. DoHA does not need to routinely verify all data provided by grant recipients. However, a level of review encourages accuracy of reporting and increases the confidence in the quality of information reported by funded organisations.

Recommendation No.3

4.10 The ANAO recommends that DoHA develop and implement a cost-effective, systematic, risk-based approach to verifying data provided by funded after hours services, which is key to measuring compliance with funding agreements and assessing progress against the RTCM's objective.

DoHA's response:

4.11 Agreed. Whilst DoHA currently employs a risk-based approach to verifying the data provided by RTCM grant funding recipients, this is undertaken on an ad hoc basis. The Department acknowledges the need to develop and implement a systematic process for verifying the data provided by funding recipients.

4.12 However, given the number of grants administered by the Department, this data verification will need to continue to be undertaken on a risk basis and

in a cost effective manner. For example, grant recipients are required to provide DoHA with the provider numbers of GPs working in their service. This means that the Department has the capacity to check service data received from funding recipients against MBS activity if there is a reason to believe that it would be useful to perform such a check given individual circumstances. Also, as a new requirement, Round 3 Supplementary Grant recipients will be required to provide the Department with an audited financial statement at the end of the project period. Previously, the provision of audited financial statements was only a requirement of Operating Subsidy and Start Up Grant recipients.

Analysing program trends

4.13 DoHA's monitoring and analysis was focussed on individual grants. DoHA does track some issues between reporting periods, such as unresolved issues from previous reports. However, the extent and quality of this tracking largely depends on the initiative of individual program officers. DoHA does not systematically chart the progress of grants over reporting periods, or analyse the available data by grant type or at a whole-of-program level. Indeed, data is examined in isolation; it is not captured in a centralised database which would allow analysis. Therefore, trends or issues that may emerge over time, or that are common across grant types or the whole program, are not systematically identified. Any lessons learned from the program are identified on an ad hoc basis, and are based on the knowledge and experience of program staff.

4.14 The ANAO suggests that DoHA make greater use of the information collected in project reports. Such data can assist DoHA to identify trends or issues in the program, appreciate the lessons learned from each funding round, and inform improvements to its processes and documentation.

Grant payments

4.15 The amount and timing of grant payments is specified in the funding agreements. In the 2004–05 to 2006–07 financial years, DoHA's grant payments to services amounted to $9.12 million, as shown in Figure 4.2. This is significantly less than the RTCM budget.

Figure 4.2

RTCM grant payments

Financial year	Payments ($)	Budget ($)
2004–05	80 000	2 000 000
2005–06	2 411 501	10 500 000
2006–07	6 624 433	16 000 000
Total	6 115 934	28 500 000

Note: The payment amounts above are inclusive of Goods and Services Tax (GST). Grants are budgeted exclusive of GST; GST is then included as a component of the total payment to the service. For example, if the supplementary grant to a service is $50 000 (the maximum available), the total payment to the service will be $55 000 (the $50 000 grant plus 10 per cent GST).

Source: ANAO analysis of DoHA data.

4.16 The underspend is a result of the number of grants being less than available, and the grant amount requested by some applicants being less than the maximum available. Therefore, the amount budgeted for each grant type was not allocated. The underspend is also a result of an assumption that the grants would be executed on 1 July of each year and would, therefore, require a full year of funding. This assumption did not allow time to advertise the funding round, receive and assess applications, and negotiate funding agreements. Also, the entire allocation for the 2004–05 start-up grants was provided in the first year. Therefore, some of the budgeted amounts have not been paid in the budgeted period, resulting in an underspend for that period.

4.17 In February 2007, DoHA was granted approval to reallocate funding within the RTCM grants program, subject to the number and quality of applications received. This means that, for Round 3: 2007–08 and subsequent rounds, unallocated funding can be reallocated from one grant type to another if DoHA receives sufficient quality applications. For example, if DoHA receives more applications for supplementary grants than anticipated, but fewer applications for operating subsidies, the excess amount budgeted for operating subsidies can be used to fund additional supplementary grants.

4.18 DoHA has established an effective invoicing and payments system, with payments triggered by DoHA accepting the project reports. The ANAO also found that payments were made in a timely manner following acceptance of project reports. Only one service interviewed by the ANAO stated that the period between submitting project reports and receiving grant payments was not timely. The payments system includes procedures to reduce, withhold or

recover payments if necessary. DoHA has reduced the payment to four services on a total of five occasions.[44]

4.19 However, as previously stated, DoHA does not verify the data provided in project reports, including the financial data provided by supplementary grant recipients who were not required to submit audited financial statements.[45]

Lessons learned

4.20 While DoHA does not have systematic procedures to capture lessons learned from its staff or from grant recipients, it has occasionally made changes to its processes and to program documents based on lessons learned in previous funding rounds. For example, the second RTCM staff workshop in January 2006 included a discussion of lessons learned from Round 1: 2005–06, and a CO staff meeting was held in January 2007 to discuss lessons from Round 2: 2006–07 and resulting changes to Round 3: 2007–08 documents. In addition, following each round CO managers discuss the assessment process with the assessment panel.

4.21 Aside from the project report monitoring system, DoHA does not have a system to capture feedback from services about stages of the grants process, RTCM documents, or the effectiveness or efficiency of the program. Also, services were not aware of any means available to them to provide feedback to DoHA. None of the CO and STO staff interviewed by the ANAO reported receiving comments from services. As such, DoHA is not drawing on a valuable source of observations about the program, which could be used to inform appropriate changes to its processes.

4.22 At the RTCM workshop in January 2006, DoHA staff identified the need to foster contact between services. Establishing networks between services that wish to be involved would assist those services to share common issues, seek advice from their peers and, perhaps, enhance after hours delivery by services in the same or adjacent areas. However, DoHA informed the ANAO that this has been a low priority and, consequently, has not occurred. DoHA further stated that some STOs have disseminated better practice progress reports on ad hoc occasions, primarily in an attempt to educate and assist new grant recipients. However, it has not systematically identified or

[44] During 2004–05 to 2006–07.

[45] DoHA has informed the ANAO that it intends to require audited financial statements from Round 3: 2007–08 supplementary grant recipients at the end of the project period.

disseminated better practice service delivery models and/or reports. Providing staff and services with examples of good practice, particularly in project reporting, would assist services to understand DoHA's expectations and may offer ideas for improving after hours services.

Ian McPhee
Auditor-General

Canberra ACT
27 February 2008

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