The Auditor-General
Audit Report No.26 2008–09
Performance Audit

Rural and Remote Health Workforce Capacity- the contribution made by programs administered by the Department of Health and Ageing

Department of Health and Ageing

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
19 March 2009

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*. I present the report of this audit and the accompanying brochure to the Parliament. The report is titled *Rural and Remote Health Workforce Capacity - the contribution made by programs administered by the Department of Health and Ageing.*

Following its tabling in Parliament, 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

ABS	Australian Bureau of Statistics
AHCAs	Australian Health Care Agreements
ACNS	Aged Care Nurses Scholarship Scheme
AGPN	Australian General Practice Network
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
ATSI	Aboriginal and Torres Strait Islander
CCDs	Census Collection Districts
COAG	Council of Australian Governments
DEEWR	Department of Education, Employment and Workplace Relations
DoHA	Department of Health and Ageing
DoWS	District of Workforce Shortage
ERMP	Enterprise Risk Management Plan
ESPs	External Service Providers
Finance	Department of Finance and Deregulation

FMA Act	Financial Management and Accountability Act 1997
GP	General Practitioner
GPARIA	General Practitioner Accessibility and Remoteness Index of Australia
HA	Highly Accessible
KPIs	Key Performance Indicators
MBS	Medicare Benefits Schedule
MSOAP	Medical Specialists' Outreach Assistance Program
MHWD	Mental Health Workforce Division
NHHRC	National Health and Hospital Reform Commission
NHWSF	National Health Workforce Strategic Framework
NHWT	National Health Workforce Taskforce
NiGP	Nurses in General Practice Training and Support Program
NP	Nurse Practitioner
NRAS	National Registration and Accreditation Scheme
NRHA	National Rural Health Alliance
NSWRDN	New South Wales Rural Doctors Network
OECD	Organisation for Economic Co-operation and Development
OTDs	Support , Coordination and Assistance for Overseas Trained Doctors Program
PBS	Pharmaceutical Benefits Schedule
PB Statements	Portfolio Budget Statements

PACD	Primary and Ambulatory Care Division
PN	Practice Nurse
RAMUS	Rural Australia Medical Undergraduate Scholarship
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RCNA	Royal College of Nursing Australia
RDAA	Rural Doctors Association of Australia
RRMA	Rural Remote Metropolitan Area Classification
RRP	Rural Retention Program
RWAs	Rural Workforce Agencies
SBO	State Based Organisation
SLA	Statistical Local Area
SOLS	Specialist Obstetrician Locum Scheme
TRRPGPP	Training for Rural and Remote Procedural General Practitioners Program
VR	Very Remote
WHO	World Health Organisation

Glossary

Australian Standard Geographical Classification	The Australian Bureau of Statistics (ABS) uses the Australian Standard Geographical Classification (ASGC) for the purposes of collecting statistical geography. ASGC is a hierarchical classification system that provides a common framework of statistical geography and thereby enables the production of statistics which are comparable and can be spatially integrated.
Australian Statistical Geography Standard	In 2011, the ABS will use Australian Statistical Geographical Standard (ASGS), to create more stable and consistent statistical geography units than the ASGC. ASGS will include Mesh Blocks.
District of Workforce Shortage (DOWS)	DoWS are areas where the provision of medical services, based on Medicare data, are below the national average on a doctor to population ratio.
General Practitioner Accessibility and Remoteness Index of Australia	The General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) is used to define the locations eligible for assistance under the Rural Retention Program. GPARIA was developed specifically for the Rural Retention Program and classifies localities through the application of consistent criteria that reflect issues identified as important to rural doctors. These issues include general remoteness, local isolation and professional isolation.
Healthy Horizons	Healthy Horizons is the national strategy framework for rural health and outlines seven key goals for improving the health of rural and remote Australians, including 'maintain a skilled and responsive workforce'. It was endorsed by the Australian Health Ministers in 2003.
Mesh Blocks	Used within the ASGS, a mesh block is the smallest geographical unit which will generally contain between 30-60 dwellings.

Nurse Practitioner (NP)	Nurses who are specifically trained to work in specialised areas of medicine, for example, mental health.
Outcomes and Outputs Framework	The Outcomes and Outputs framework provides the basis of the Government's approach to budgeting and reporting for public sector agencies and the means by which the Parliament appropriates funds in the annual budget context.
Practice Nurse (PN)	Nurses who are specially trained to assume an expanded role in providing medical care under the supervision of a doctor.
Port Folio Budget Statements (PB Statements)	The statements inform Senators and Members of Parliament of the proposed allocation of resources, through the annual Budget process, to achieve government outcomes.
Rural Remote Metropolitan Area classification	The Rural, Remote and Metropolitan Areas (RRMA) classification was developed in 1994 as a remoteness classification based on 1991 population Census data and 1991 Statistical Local Aria (SLA) boundaries from the 1991 ASGC.
Statistical Geography	Statistical geography is the study and practice of collecting, analysing and presenting data that has a geographic or areal dimension, such as census or demographic data. It uses techniques from spatial analysis, but also encompasses geographical activities such as the defining and naming of geographical regions for statistical purposes.

Summary and Recommendations

Summary

Introduction

Australia's health system

1. The health system in Australia is a blend of Australian Government and State/Territory Government responsibilities with a mix of public and private funding. Constitutional powers identify the scope of Commonwealth responsibility and the residual powers that pertain to the States concerning health matters.[1]

2. The Australian Government has a leadership role in the development of health policy, particularly in relation to national issues such as public health, research and national information management. The Australian Government funds most out of hospital medical services through the Medicare Benefits Schedule (MBS), and most health research. The Australian Government also funds the Pharmaceutical Benefits Scheme (PBS), private health insurance rebates, residential aged care services, services for veterans and primary health care for Indigenous Australians.

3. The States and Territories are primarily responsible for the delivery and management of public acute and psychiatric hospital health services and a wide range of community and public health services including school health, dental health, maternal and child health and environmental health programs. The States and Territories are also responsible for maintaining direct relationships with most health care providers, including the regulation of health professionals.

4. Public hospitals and community care for aged and disabled persons are jointly funded by the Australian Government and the States and Territories.[2]

Health workforce roles and responsibilities

5. In common with the rest of the health care system and systems overseas, Australia's health workforce arrangements are complex and

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1 The Australian Constitution, s.51 (xxiiiA).

2 Department of Health and Aged Care, Financing and Analysis Branch, September 2000, *The Australian Health Care System: an outline*, p. 1-2.

interdependent. The most prominent entities that control or impact on workforce deployment and scopes of practice include: governments; bodies with delegated powers (including registration boards and some accreditation agencies); employers; educators and trainers; professional associations; industrial associations; and health insurers. State and Territory Governments play a particularly important role, so that even where national approaches are adopted, the ability to 'make things happen' often lies with those jurisdictions.[3]

Roles and responsibilities in rural and remote areas

6. In rural and remote Australia, the State and Territory Governments provide the majority of the health services infrastructure through rural health and hospital services.

7. The role of the Department of Health and Ageing (DoHA) in enhancing the rural and remote health workforce has been to increase the number of General Practitioners (GPs) working in rural and remote Australia through programs that focus on the use of Overseas Trained Doctors (OTDs); bonded medical places; scholarships for students from rural areas; and retaining GPs already working in rural and remote Australia through the provision of access to continuing education, locum services and retention payments. In addition, there are incentives to increase the number of nurses working in general practice in rural and remote Australia.

Health status of Australians living in rural and remote areas

8. While the general health level of Australians is quite high, the same is not true for those Australians living in rural and remote areas.[4] Around one–third of all Australians live outside of major metropolitan areas, yet the proportion of primary care health practitioners in these regions is notably lower. As geographic isolation becomes more pronounced, the numbers of Indigenous Australians living in these areas rise compared to other Australians, for example, 26 per cent of the Indigenous population lives in areas classified as 'remote or very remote' compared to 2 per cent of the non–Indigenous population.[5] The health status of Indigenous Australians, on average, is very poor compared to non–Indigenous Australians.

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3 Productivity Commission, 2005, *Australia's Health Workforce*, p. 51.

4 ibid.

5 Australian Bureau of Statistics (ABS), 2007, *Year Book Australia*.

9. Following a request from the Prime Minister in December 2007, the Minister for Health and Ageing requested DoHA to undertake an audit of the shortage of doctors, nurses and other health professionals in rural and regional Australia, and to describe the extent of these shortages by profession. The *Report on the Audit of the Health Workforce in Rural and Regional Australia* confirmed that the distribution of health professionals in relation to the distribution of the population in Australia was uneven, and particularly lacking in regional and remote Australia. Medical practitioners were in low supply relative to the population in the Northern Territory and Western Australia generally, compared to the rest of Australia. Other health professionals, particularly dentists and some allied health professionals were also unevenly distributed. Nurses, on the other hand, were relatively evenly distributed across Australia. The Rural, Remote and Metropolitan Areas (RRMA) classification structure is the current basis for the allocation of incentives to encourage doctors to practise in rural and remote Australia. RRMA is based on 1991 population Census data and is widely regarded by stakeholders as 'antiquated' and unsuitable.[6] The Minister for Health and Ageing announced in April 2008 that all geographical classification systems would be reviewed as part of an overall review of all rural health programs. The department is currently undertaking this review and will provide the outcomes to the Minister for consideration.

Supply of health professionals by geographic region

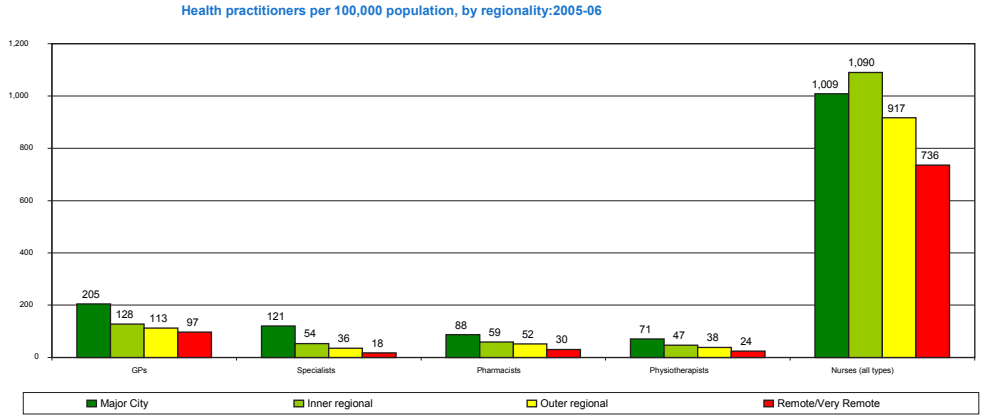
10. The Australian Bureau of Statistics (ABS) uses the Australian Standard Geographical Classification (ASGC) as the foundation for its spatial statistical collection. The ASGC consists of the following geographic regions—Major City, Inner Regional, Outer Regional and Remote/Very Remote. The ASGC is routinely updated to take account of population dispersion and the provision of services. One of ASGC's strengths is that it is the basis of many national statistical collections where geographical location is an important determinant.

11. Figure 1 illustrates the variation in health professional supply across Australia's geographic regions.

[6] Minister for Health and Ageing, April 2008, *Press Release—Report of the Audit of Health Workforce in Rural and Regional Australia* and the ANAO Stakeholder Survey.

Figure 1

Health professionals by remoteness category



Source: Most recent data on the distribution of health professionals provided by the Department of Health and Ageing to the 2020 Summit, 2008.

12. Since 1994, governments have responded to the challenges of health workforce shortages and their uneven distribution through the Council of Australian Governments (COAG). In particular, following COAG endorsement in 2006 of the Productivity Commission recommendations into Australia's health workforce, there was a renewed national effort through peak inter-governmental Ministerial Councils to resolve systemic supply and demand issues concerned with the adequate supply and distribution of health professionals, including in rural and remote Australia.

13. The Australian Government and its health and ageing administration agency, DoHA, have a substantial and pivotal leadership role in ensuring that Australians, including in rural and remote Australia, have access to a supply of adequately trained personnel to work in the health sector. DoHA administers around 60 programs directed at workforce distribution, health service delivery, and contributing to the education and training of health professionals in rural and remote Australia.

14. DoHA's programs directed at workforce distribution contribute to a number of Outcomes which are reported in the Health Portfolio Budget Statements, and which directly impact on the supply of adequately trained personnel to work in the health sector, including in rural and remote Australia. The principal Outcome group is Outcome 12: *Health Workforce Capacity*. DoHA's Mental Health and Workforce Division (MHWD) has responsibility for this outcome.

15. In 2007, the Minister for Finance and Deregulation announced a set of reforms to improve the transparency of government financial information. The reforms focus on improvements in agency Portfolio Budget Statements so that they are relevant, strategic and are performance oriented. The intention was to ensure that readers of Portfolio Budget Statements have a clear and transparent account of an agency's planned performance for the Budget year and the resources to be used.

16. It is against this background, that the Australian National Audit Office (ANAO) audited the effectiveness of DoHA's administration of health workforce initiatives in rural and remote Australia.

Audit scope and objective

Audit objective

17. The audit objective was to assess the effectiveness of the Department of Health and Ageing's administration of health workforce initiatives in rural and remote Australia.

Audit criteria

18. To form its opinion, the ANAO used the following criteria:

- DoHA has strategies in place to maximise its contribution to the Australian Government's specified Health Workforce Capacity outcome;
- DoHA has effectively implemented Australian Government programs addressing health workforce shortages in rural and remote Australia; and
- DoHA monitors and evaluates its health workforce programs for rural and remote Australia.

Audit scope

19. The audit focuses on the effectiveness of initiatives for the primary care health workforce in rural and remote areas. The audit scope concentrates on DOHA's responsibility for health workforce distribution and its limited responsibility for health workforce education and training. The audit scope did not include the administrative role of State and Territory Governments and the Indigenous health workforce.

Audit methodology

20. To gain a suitable understanding of the broader environment in which DoHA is delivering the Government's objective concerning health workforce capacity in rural and remote Australia and to identify the primary issues and evidence necessary to support an audit conclusion, the ANAO used the following evidence–gathering techniques: an analysis of key planning, policy and program documents; interviews with departmental staff and stakeholders; an in–depth analysis of eight rural and remote health workforce capacity programs; and a stakeholder survey.

Rural and remote health workforce capacity programs

21. In deciding which programs to examine in more detail, the ANAO, after consultation with the Mental Health and Workforce Division, the Primary and Ambulatory Care Division and the Aged Care Division, selected eight programs. The programs selected reflect the department's specific areas of responsibility for the health workforce in rural and remote Australia outlined above, and included:

- seven rural and remote health workforce capacity programs, almost all of which are distribution initiatives; and
- one health service delivery program with a health workforce capacity component—the Medical Specialists' Outreach Assistance Program (MSOAP).

22. While the programs represent a cross section of rural and remote activities and the results of the program analysis are indicative of DoHA's approach, the sample of programs was not designed to provide statistically significant results and the data obtained from the program analysis cannot be extrapolated to all health workforce capacity and health service delivery programs.

Stakeholder Survey

23. The delivery of the department's rural and remote health workforce capacity programs are outsourced to organisations in the health sector that have on-the-ground experience with health care arrangements in rural and remote areas of Australia.

24. The ANAO undertook a survey of external organisations, nominated by the MHWD as stakeholders. The ANAO invited 168 stakeholder organisations to participate in the on–line survey. Of the 168 stakeholder

organisations approached, 126 responded to the survey. This equates to a high response rate of 75 per cent.

25. As one of the key inputs to the audit, the ANAO obtained feedback from a broad range of stakeholders regarding their opinion of how well they considered that the department had:

- engaged with stakeholders to inform policy advice and program delivery;
- delivered programs addressing health workforce shortages in rural and remote Australia and managed the performance of service providers; and
- evaluated and improved rural and remote health workforce capacity programs.

26. The opinions of stakeholders are an important complementary input to the audit, as these stakeholder organisations are well placed to provide a perspective on DoHA's administrative performance and engagement of stakeholders. Of those stakeholders that responded to the ANAO survey, 71 per cent deliver rural and remote health workforce capacity programs under contract with DoHA.

Conclusion

27. The availability and quality of health care services across Australia is contingent upon the supply and distribution of health professionals. Over the last decade, Australia has experienced workforce shortages in a number of health professions, particularly in rural and remote regions. The ongoing shortage of doctors and nurses in these areas of the country has many characteristics in common with difficult social policy issues – it is multi-causal with many interdependencies, has no clear or definitive solution, is not the responsibility of any one jurisdiction and, ultimately, requires health professionals to move to, or work for a longer period in, a rural and remote area.

28. To ensure that Australia's health workforce has sufficient numbers of high quality doctors, nurses and allied health professionals to meet the health service needs of the community, the Australian Government created a specific Health Workforce Capacity outcome in DoHA in 2006. The health workforce statement adopted for DoHA's Outcome 12 is: *Australians have access to an enhanced health workforce*. Within this Outcome, the aim of the department's

health workforce programs in rural and remote Australia has been to increase the number of doctors and nurses working in general practice. The broader, aspirational nature of DoHA's Outcome 12 recognises that rural and remote health workforce capacity is a subset of a much larger health workforce capacity issue and while it is important to give attention to the issue of the rural and remote health workforce, it cannot be viewed in isolation from the broader context.

29. In pursuing Outcome 12, DoHA works in an environment where its programs provide only part of the total funding for health workforce initiatives. Its advice on policy options requires it to work with a range of entities, including the States and Territories, in order to maintain an overall picture of the national health workforce. In this challenging administrative environment, DoHA has key roles in influencing the achievement of the intended outcome, implementing policies and programs that take into account the operation and coverage of existing initiatives, measuring the progress being made via the Australian Government programs it administers, and providing advice to Ministers on any further measures or initiatives needed to improve access to an enhanced health workforce.

30. In this context, DoHA's approach to address health workforce issues in rural and remote Australia in a strategic way requires a clear appreciation of: the overall context, DoHA's particular role, and how the department's contribution to improving the situation will be measured and assessed. Such an approach would be expected to be underpinned and informed by: the identification, treatment and monitoring of the risks in DoHA's operating environment that affect the success of the department's programs; the measurement and tracking of the impact and ongoing relevance of the health workforce programs implemented by the department; and appropriate data on health care needs and health workforce capacity.

31. While DoHA has put in place structural arrangements to administer its direct program delivery responsibilities, the department has not yet developed a cohesive approach to inform its strategies and to report on its contribution to health workforce outcomes in rural and remote areas of Australia. The department's ability to set organisational strategies to achieve the outcome being sought: *Australians have access to an enhanced health workforce* in rural and remote areas of Australia has been hindered by:

- limited monitoring of key risks identified by DoHA, particularly: *insufficient supply of adequately trained personnel to work in the health sector*;

- DoHA's lack of a performance information strategy to inform government and the Parliament about the quality of the health workforce and its distribution across rural and remote Australia, and the level of access to health services by Australian citizens in rural and remote areas; and
- the use of old and unsuitable Census data and geographic classification systems as the basis for providing incentives to health professionals to work in rural and remote areas of Australia.

32. Over the past year there has been considerable activity in other jurisdictions and within DoHA directed at improving health workforce capacity in rural and remote Australia. In April 2008, the Minister for Health and Ageing announced that there would be a review of all targeted Australian Government programs in rural and remote Australia and that all geographic classification systems would be reviewed. In July 2008, DoHA re-established the Office of Rural Health. And in November 2008, COAG agreed to a significant health workforce package of $1.6 billion underwritten by the Commonwealth. These developments underline the importance of DoHA taking steps to improve its approach to managing and reporting on its contribution to health workforce outcomes in rural and remote areas of Australia.

Monitoring and managing key risks

33. The department has appropriately recognised the importance of performance information and identified *inadequate knowledge and information management* as a key risk affecting its ability to deliver against Outcome 12. This risk has materialised and there is a significant shortfall in information on the status and trends concerning the health workforce in rural and remote Australia. Until this risk is ameliorated, lack of information on the health workforce at the national level will continue to be a significant hindrance to the effective administration of rural and remote health workforce capacity programs managed by DoHA as well as the capacity of DoHA to provide evidence-based policy advice to government. DoHA's ability to manage this risk would benefit from a more active approach to monitoring the key risks identified by the department including at the program level.

Adopting a performance information strategy

34. DoHA manages many, relatively small health workforce programs and it is often difficult to monitor and assess their contribution to the broader outcome or gauge their relationship with similar or complementary programs both within the department and in other agencies. Performance monitoring and evaluation are complementary elements of a sound performance information strategy that can be used to provide a picture of program performance so that, over time, a better understanding of the critical success factors is developed.

35. Currently, DoHA's performance measures for Outcome 12 focus on outputs, and the department reports on the number of student scholarships provided and the number of nurses re-entering the workforce. These measures are not sufficient to capture the intended impact of this outcome. At the program level, the emphasis placed on evaluation varied across the rural and remote health workforce programs examined by the ANAO and the frequency and nature of the evaluations undertaken was not co-ordinated.

36. For DoHA to be in a position to determine its contribution to the outcome, it should develop and make use of appropriate effectiveness indicators and an evaluation strategy. A strategic approach to program evaluation would, in particular, enable DoHA to obtain a more in-depth understanding of the performance of its rural and remote health workforce programs, collect and analyse more comprehensive data, focus on key performance indicators and enable clearer identification of the causal links between program outputs and achieving the desired outcome. The combined use of effectiveness indicators and an evaluation strategy would assist DoHA, over time, to better assess the achievement of selected programs against a set of higher level outcomes, even when more than one agency is influencing the results, and to make judgements about the continued appropriateness of the programs the department administers or suitable amalgamations of programs.

37. When considering effectiveness, it is useful to take into account the perspectives of a range of stakeholders or to seek their views. Of the 126 organisations which responded to the ANAO Stakeholder Survey, 89 (71 per cent) deliver rural and remote health workforce capacity programs under contract to DoHA. While stakeholders are likely to make judgements based on their perceptions, the attitudes of stakeholders can also have a significant impact on the success of policy and program delivery. DoHA's capability to use and build on its experience in implementing health workforce

policy and programs in rural and remote Australia could be enhanced by improving the quality of the health workforce information gathered from stakeholders and by better using this information to inform policy and program approaches.

Use of appropriate and up-to-date data

38. DoHA relies on a number of data sets to inform its policy advising and program management responsibilities. Programs involving incentive payments to doctors to practise in rural and remote Australia are linked to two classification structures: the Rural, Remote and Metropolitan Areas (RRMA) classification structure, which uses 1991 Census data; and the General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) classification which was last updated in 2001. Because of their age, these classification structures have been increasingly questioned by stakeholders (including the current Minister for Health and Ageing) as suitable instruments to determine incentives for doctors who practise in rural and remote areas.

39. As these data sets become less relevant, the risk of producing outcomes which are inconsistent with the policy goal of *Australians have access to an enhanced health workforce* increases. DoHA recognised these anomalies when it conducted a review of RRMA for the then Minister for Health and Ageing in 2005. In April 2008, the Minister for Health and Ageing announced a review of all remoteness classification systems to ensure that incentives and rural health policies respond to current population figures and need.

Recommendations

40. The ANAO has made three recommendations designed to improve DoHA's capability to respond to the risks identified, especially the lack of accurate information on the status of health services across rural and remote Australia; to monitor and evaluate the department's relatively large number of small programs using a performance information strategy; and to obtain appropriate and up-to-date data to better inform program delivery and policy advice, including the use of feedback from key stakeholders that deliver the department's rural and remote programs. Adopting these recommendations will assist DoHA to guide, manage and report on its contribution to the Australian Government's health workforce capacity outcome.

Key findings by Chapter

Chapter 3—DoHA Strategies for Health Workforce Capacity in Rural and Remote Australia

41. The ANAO examined the strategies that DoHA has in place at the enterprise and Divisional levels to improve health workforce capacity in rural and remote Australia.

Strategies at the enterprise level

42. Key aspects of strategic planning include appropriate attention to:

- enterprise risks; and
- performance information.

43. DoHA's risk management framework includes an Enterprise Risk Management Plan (ERMP). The ERMP identifies those enterprise level risks that may have an adverse impact on the department's ability to achieve the outcomes set out in its Portfolio Budget Statements and/or other corporate objectives. The ERMP includes one of its key risks as: *insufficient supply of adequately trained personnel to work in the health sector*.

44. While this is a national risk, internally, DoHA allocated its treatment to the department's Mental Health and Workforce Division (MHWD). Notwithstanding DoHA's active approach to identifying the obstacles to a sufficient supply of adequately trained personnel in Australia's health sector, the ANAO found that the department had not monitored the effectiveness of the treatments put in place by the MHWD to ameliorate the inherent risks. There was, for example, no provision to monitor and report on progress being made over time and to provide DoHA's Executive with the information necessary to make informed decisions as to whether enterprise risk treatments were adequate and being appropriately progressed.

45. More broadly, the resolution of the health workforce risks identified by DoHA requires the department to work collaboratively with a range of bodies including departments of health in the States and Territories. While DoHA recognised this context, the department had not monitored the effectiveness of the treatments it put in place concerning collaboration with other jurisdictions. Given the complexity of the problem and the numerous stakeholders involved, a more rigorous approach to risk management is required. In particular, the use of oversight and monitoring arrangements to allow for regular assessments

of the status of the overall risk identified by DoHA, that is, *insufficient supply of adequately trained personnel to work in the health sector*, and whether the actions being taken by DoHA were effective or alternative approaches were needed, appropriate to the department's level of responsibility and control.

46. DoHA's Corporate Plan 2006–09 has a high level Performance Information Framework that was designed to guide the development of performance information management arrangements in lower level business plans. In the preamble to the Corporate Plan, DoHA's Secretary notes that to achieve the direction outlined in the Plan, team leaders and staff can only genuinely contribute when they have a direct 'line of sight' from their own work through to the department's priorities, values and responsibilities.

47. While DoHA has an overarching framework in place, through its Corporate Plan, to assist business groups to manage risks likely to impact on the achievement of business objectives, a challenge in any large organisation is maintaining ongoing alignment between corporate strategies, business plans and individual programs. Nevertheless, such alignment is influential in ensuring that the strategies adopted by an organisation to manage its risks, to undertake its planning, and to monitor and report on its performance are integrated at all levels.[7]

Strategies at the Divisional level

48. DoHA's Risk Management Policy advises that:

> risk management principles are to be applied and integrated into all the Department's strategic planning, business planning, policy development, program delivery, project management, grant management, procurement, service/product delivery, and all other decision making.[8]

49. DoHA's MHWD is responsible for Outcome 12 and is the risk owner of the high–level enterprise risk identified in the ERMP: *insufficient supply of adequately trained personnel to work in the health sector*.

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[7] This approach also helps to support integration between the outcomes being sought and the design and performance of individual programs. ANAO analysis, on the degree of integration between DoHA's corporate/ business level controls and their alignment with its rural and remote programs can be found at paragraph 71. Overall, the ANAO found that two of the eight programs that were examined in more detail as part of the audit were able to demonstrate clear links to higher level DoHA outcomes.

[8] Department of Health and Ageing, 2005, *Risk Management Policy*.

50. The MHWD's Risk Management Plan (incorporated in the Business Plan) identifies six risks, including the following three which relate to health workforce capacity:

- inability to deliver Government priorities and expected outcomes;
- inadequate knowledge and information management; and
- ineffective client/stakeholder management.[9]

51. MHWD manages a number of programs 'from a range of Outcomes in the Portfolio Budget Statements'. The department's current management strategies do not take into account the risks involved in designing, managing and reporting the department's cross portfolio activities in the area of rural and remote health workforce capacity. This increases the risk of program overlap and duplication and program objectives not being sufficiently aligned.

52. The MHWD has two program areas: Program 12.1—rural health workforce and Program 12.2—health workforce (general). In addition, the Division administers workforce distribution, and education and training programs 'from a range of Outcomes in the Portfolio Budget Statements'.[10] Each of these programs has an annual budget and there is clarity around the program description and objective. In a complex environment where a number of departmental Outcome groups are involved in achieving a stated government Outcome such as Outcome 12: *Australians have access to an enhanced health workforce*, a structured approach to managing performance across the relevant Outcome groups is required.

53. The ANAO reviewed performance information in the Health and Ageing 2008–09 Portfolio Budget Statements and found that there were no effectiveness indicators in place for Outcome 12 or for the other relevant Outcome groups—2, 3, 5, 6, and 8—where the MHWD has responsibility for co-ordinating, planning and managing rural and remote health workforce capacity programs. The performance measures that DoHA has in place focus on outputs, for example, the number of student scholarships provided and the number of nurses re-entering the workforce. These measures do not capture the intended impact of Outcome 12.

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9 Mental Health and Workforce Division, 2007–08, *Business Plan*.

10 These Outcome groups include: Outcome 2—*Access to Pharmaceutical Services*; Outcome 3—*Access to Medical Services*; Outcome 5—*Primary Care*; Outcome 6—*Rural Health*; and Outcome 8—*Indigenous Health*.

54. When determining an appropriate set of effectiveness indicators, an important contextual consideration is that Australia's health workforce environment is characterised by programs that cut across jurisdictions, departments and divisions within the department.

55. Useful contextual indicators would include information on trends over time that relate to the area targeted by DoHA's Outcome 12. These could include trends in the utilisation of Medicare benefits by geographic region (access), trends in the number and type of health professionals by region (workforce), and trends in diseases by region (need). Such 'gross' trends, however, will not necessarily represent DoHA's contribution to the outcome.

56. More specific indicators of 'net' effectiveness are required to draw out the positive contributions made by DoHA, filtering out the impact of other influences. Regular surveys could be used as an indicator of whether health professionals had moved to or practised longer in rural and remote areas and could identify the factors that influenced changes.

57. In this context, to report on the effectiveness of the contribution of its outputs and/or administered items to: *Australians have access to an enhanced health workforce*; DoHA could use or adapt the following measures, which enable stakeholders to understand DoHA's contribution within the context of the broader outcome.

Context/trend indicators

Access

- **Indicator 1**: Access to health and allied health services for people living in regional, rural and remote locations:
  - **Measure**: Could include numbers of health practitioners per head of population; measures of access to specified health facilities; and service utilisation rates under the Medicare Benefits and Pharmaceutical Benefits Schemes by geographic location.

Workforce

- **Indicator 2**: Number of health and allied health professionals practising in regional, rural and remote locations receiving education, training and support:
  - **Measure**: Measurement of numbers, by specified health worker type, receiving education, training and other support from Australian Government, State and Territory and professional association programs by geographic location.

Need

- **Indicator 3**: Positive change in health status for people living in regional, rural and remote locations over the longer term:
  - **Measure:** Measures such as death rates and life expectancy rates, injury prevention and control, cardiovascular and other health conditions by geographic location.

Specific DoHA effectiveness measure for rural and remote health workforce capacity

Workforce

- **Indicator**: Actions taken by health professionals in receipt of DoHA support:
  - **Measure/s**: Reporting on DoHA expenditure and trend changes in the number of health professionals in receipt of DoHA support moving to, or practising longer, in rural and remote locations.

58. Basic indicators and measures should be established, and refined and improved over time. This could include the use of health professional survey data collected by the Australian Institute of Health and Welfare (AIHW), supplemented with feedback from a range of stakeholders such as program deliverers and interest groups on the impact of DoHA's rural and remote health workforce capacity programs.

Chapter 4—Program Implementation

59. The department's MHWD manages around 35 rural and remote health workforce capacity programs. In addition to these programs, other divisions manage a number of health workforce capacity programs—such as the Office of Aged Care; and rural and remote health service delivery programs—such as the Primary and Ambulatory Care Division.

60. The ANAO selected, in consultation with DoHA, eight programs to examine in detail. The selection included health workforce education and training programs, workforce distribution programs and a health service delivery program with a workforce component.

61. Table 1 lists the eight programs (including one pilot) selected.

Table 1

Selected rural and remote health workforce capacity programs

Program name	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Specialist Obstetrician Locum Scheme (SOLS) (pilot)	659 110	12	MHWD	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Nurses in General Practice Training and Support Program (NiGP)	3 921 000	5	MHWD	Australian General Practice Network (AGPN) and State Based Organisations (SBOs)
Rural Australia Medical Undergraduate Scholarship (RAMUS)	6 194 959	12 & 5	MHWD	National Rural Health Alliance (NRHA)
Support, Coordination and Assistance for Overseas Trained Doctors Program (OTDs)	7 575 000	12	MHWD	Rural Workforce Agencies (RWAs), State and Territory Governments and Doctor Recruitment Agencies
Aged Care Nurses Scholarship Scheme (ACNS)	8 417 000	4	Office of Aged Care	Royal College of Nursing Australia (RCNA)
Medical Specialists' Outreach Assistance Program (MSOAP)	15 493 000	6	PACD	Rural Workforce Agencies (RWAs)
Rural Retention Program (RRP)	22 693 000	5	MHWD	Administered by Medicare Australia
Training for Rural and Remote Procedural GPs Program (TRRPGPP)	24 765 000	5	MHWD	Administered by Medicare Australia

Source: ANAO.

Note: Mental Health and Workforce Division (MHWD) and Primary and Ambulatory Care Division (PACD).

62. Successful program implementation is characterised by the following features:

- business planning processes to identify and treat program risks; and
- the planning and collection of program level performance information.

Risk management

63. Risk management is applicable to all levels in an organisation: at the enterprise level, the Divisional level, and at the program level. Alignment

between these levels helps to ensure that strategic and operational risks are managed consistently.

64. Integrating risk management into the governance, planning and management processes within an agency provides purpose in applying the risk management process and relates risk back to the agency's core business.[11] When integrating risk management, it is important to consider an agency's operating environment and, through deliberate planning, consider how risk management processes can be embedded into management activities such as business planning, decision making and reporting.[12]

Program level risks

65. As with any major departmental initiative, coordination of risk planning and management activities across a department is important. The involvement of staff from DoHA's program areas in identifying, monitoring and treating program risks that are important in managing broader exposures is vital to department-wide coordination and lays the foundation for effective risk management.

66. The ANAO assessed program risk management arrangements for each of the eight programs identified in Table 1. The risk management criteria were: link to Enterprise Risks; link to MHWD risks; risk context established; risks identified; risks analysed; risks evaluated; risks treated; risks monitored and reviewed.

67. ANAO analysis demonstrates that the eight rural and remote health workforce capacity programs do not place an equal emphasis on risk management. None of the eight programs demonstrated clear links to DoHA's enterprise risk concerning health workforce supply. As well, no clear links were articulated against MHWD risks. It needs to be noted that two programs—the Aged Care Nurses Scholarship Scheme (ACNS) and the Medical Specialists' Outreach Assistance Program (MSOAP) are delivered by other Divisions within DoHA.

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[11] Comcover, June 2008, Better Practice Guide, *Risk Management*, p. 20.

[12] ibid, p. 28.

Program performance information

68. Increasingly, performance information is being used to measure the success or otherwise of government programs. Performance measurement is characterised by ongoing and regular tracking of activities, outputs and while difficult, the contribution of the program to broader outcomes.

69. Performance information includes both quantitative and qualitative measurement and assessment. Such information is often readily available at the output level (i.e. the specific goods and services delivered by the program). However, as agencies seek to assess and track the impact of these goods and services being delivered to the community, information on the contribution of the program to intermediate and final outcomes becomes important.

70. The ANAO assessed program performance information management arrangements for each of the eight programs identified in Table 1. The program performance information management criteria were: link between programs and DoHA outcomes; link to similar or complementary programs; clear and measurable program objectives; mix of performance indicators; continuous improvement; monitoring and reporting systems; and quality data underpinning performance indicators.

71. ANAO analysis demonstrates that the eight rural and remote health workforce capacity programs do not place an equal emphasis on performance information management. While all programs were mentioned in recent Portfolio Budget Statements (PB Statements), not all programs were able to demonstrate clear links to these higher level outcomes. Two of the eight programs—RAMUS and NiGP—were able to demonstrate clear links to higher level DoHA outcomes. This was because these programs had effectiveness indicators in place which were able to demonstrate program contributions to the higher level outcome sought by government. However, no program was able to demonstrate clear links with similar or complementary programs.

72. Performance management should be a key feature underpinning all of DoHA's rural and remote health workforce capacity programs. The main findings in relation to DoHA's performance information management are:

- the lack of alignment between program performance information and higher level performance information required by DoHA to allow the department to track and report on the achievement of government outcomes; and

- there is little indication that rural and remote health workforce capacity programs are compared with similar or complementary programs within DoHA, other Australian Government departments or with other jurisdictions.

Chapter 5—Information for Policy and Program Advice

73. DoHA has a two fold responsibility. As the principal agency charged with achieving the Government's priorities (outcomes) concerning the health care and ageing needs of all Australians, one of its core activities is to provide quality, relevant and timely advice for Australian Government decision–making. Secondly, it is responsible for producing relevant and timely evidence–based policy research to support its advisory function.[13]

74. The department's MHWD Risk Management Plan identified six business risks including the risk most relevant to information for policy and program advice: *inadequate knowledge and information management*.

Health workforce data

75. To assess the appropriateness of representative[14] data for policy and program advising purposes, the ANAO examined the tertiary data sources used by DoHA, including the quality of the sourced data. The tertiary data sources examined include:

- Rural, Remote and Metropolitan Areas (RRMA) classification;
- General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) classification;
- the Australian Bureau of Statistics (ABS)—Australian Standard Geographical Classification (ASGC); and
- proposals for a National Registration and Accreditation Scheme (NRAS) for a number of health professions.

Rural, Remote and Metropolitan Areas (RRMA)

76. DoHA is currently reliant on the Rural, Remote and Metropolitan Areas (RRMA) classification as an eligibility criterion for many of its programs and

[13] Health and Ageing portfolio, 2008–09, *Portfolio Budget Statements*.

[14] Data that is deemed to be representative is accurate, reliable, reflects current realities and representations of real world facts.

related incentives. The RRMA classification was developed in 1994 as a remoteness classification based on 1991 population Census data.

77. DoHA recognised these anomalies when it conducted a review of RRMA for the then Minister for Health and Ageing in 2005:

> the accuracy and appropriateness of RRMA as a classification system has been increasingly questioned by stakeholders. The needs and characteristics of many regions throughout Australia have changed, and as RRMA has not been officially updated, it has not kept pace with these changes. It no longer accurately measures health or other need.[15]

General Practitioner Accessibility and Remoteness Index of Australia (GPARIA)

78. The General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) was developed specifically for the Rural Retention Program (RRP) which commenced in 1998. The objective of the RRP is to encourage GPs to stay longer in targeted rural and remote locations through the provision of financial incentives.

79. Because of their age, the suitability of the RRMA and GPARIA classification structures, as instruments on which to base the incentives that doctors who practise in rural and remote areas currently receive, is deteriorating.

80. In April 2008, the Minister for Health and Ageing announced a review of all remoteness classification systems as part of the overall review of all rural health programs. The review is currently being undertaken by the department.

The Australian Bureau of Statistics (ABS)—Australian Standard Geographical Classification (ASGC)

81. The ABS developed the Australian Standard Geographical Classification (ASGC) remoteness structure as a system that classifies Australia into five areas according to their relative remoteness and is now reported routinely by ABS, for many national collections, including in reports produced by the Australian Institute of Health and Welfare (AIHW).

[15] DoHA, 2005, Review of RRMA (unpublished).

82. It is important that DoHA uses sound evidence to inform its policy advising function concerning incentives for doctors in rural and remote Australia.[16]

Proposals for a National Registration and Accreditation Scheme

83. COAG signed an Intergovernmental Agreement in 2008 for a National Registration and Accreditation Scheme (NRAS) to register and accredit ten health professions: medical practitioners, nurses and midwives, pharmacists, physiotherapists, psychologists, osteopaths, chiropractors, optometrists and dentists.

84. NRAS will maintain a public health register for each health profession. A secondary benefit of the national scheme is the requirement for a national collection of health workforce data. The NRAS data will assist with national workforce planning and evaluation of national progress against health workforce priorities. However, this is subject to agreement by Health Ministers.

Opinion–based data sources

85. As one of the key inputs to the audit, the ANAO obtained feedback from a broad range of stakeholders regarding their opinion of how well they considered that DoHA has engaged with stakeholders to inform policy advice and program delivery. One hundred and twenty six stakeholder organisations[17] responded to the ANAO stakeholder survey. Of those that expressed an opinion on these particular issues[18]:

- one-third were of the view that, overall, DoHA effectively consults stakeholders in relation to policy issues; and
- approximately half (48 per cent) were of the opinion that, overall, DoHA effectively consults stakeholders in relation to program delivery issues.

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16 The Minister for Health and Ageing, *Media Release*, 30 April 2008.

17 The sample of stakeholder organisations included: deliverers of rural and remote health workforce programs on behalf of DoHA; Divisions of General Practice; education and/or training providers; peak/representative groups other than Divisions of General Practice; Medical Colleges or health professional associations; research organisations; and Rural Workforce Agencies (RWAs).

18 Stakeholders were excluded who did not respond to the particular question or who indicated that they 'neither agreed nor disagreed' with the statement. Less than 16 per cent of respondents were excluded on this basis.

86. When considering effectiveness, it is useful to take into account the perspectives of a range of stakeholders or to seek their views. While stakeholders are likely to make judgements based on their perceptions, the attitudes of stakeholders can have a significant impact on the success of policy and program delivery. DoHA's capability to use and build on its experience in implementing health workforce policy and programs in rural and remote Australia could be enhanced by:

- improving the quality of the health workforce information gathered; and
- better use of this information to inform policy and program approaches.

Chapter 6—Evaluation and Continuous Improvement

87. Program evaluation and performance information are complementary tools for program management. Evaluations can provide an invaluable perspective on program performance, especially over a number of years. In contrast, performance indicators provide information for day-to-day management.

88. While program evaluation is not a requirement of the Outcomes and Outputs framework, the Productivity Commission has identified the importance of evaluations in providing an evidence base to underpin reform processes. The Productivity Commission also suggests that the lack of evaluation activity makes it difficult to comment on the effectiveness or otherwise of government interventions.[19] Evaluations can assist managers and other decision–makers to: assess the continued relevance and priority of program objectives in the light of current circumstances, including government policy changes; test whether the program is achieving its stated objectives; ascertain whether there are better ways of achieving these objectives; assess the case for the establishment of new programs, or extensions to existing programs; and decide whether the resources for the program should be continued at current levels, be increased, reduced or discontinued. Evaluations also have the capacity to establish causal links. Over time, an evaluation strategy has the potential to provide credible, timely and objective findings,

[19] Gary Banks, Productivity Commission, February 2009, *Challenges of evidence-based Policy Making*.

conclusions and recommendations to aid in resource allocation, program improvement and program accountability.

89. The ANAO assessed program evaluation management arrangements for each of the eight programs identified in Table 1. The evaluation management criteria were: link to DoHA outcomes; link to an evaluation strategy; lessons learned; contribution to outcome achievement; clear contribution to higher level outcomes; prior evaluations; and robust and appropriate evaluation methodology.

90. ANAO analysis demonstrates that the eight rural and remote health workforce capacity programs do not place an equal emphasis on evaluation management.

91. While all programs were mentioned in recent Portfolio Budget Statements (PB Statements), not all programs were able to demonstrate clear links to these higher level outcomes. As discussed in Chapter 4 on program performance information management, two of the eight programs—RAMUS and NiGP—were able to demonstrate clear links to higher level DoHA outcomes. This was because these programs had effectiveness indicators in place which were able to demonstrate program contributions to the higher level outcome sought by Government. The lack of program effectiveness indicators also impacts on an agency's capacity to evaluate programs to provide assurance that programs remain relevant in the context of government outcomes.

92. None of the eight programs were able to demonstrate a clear link to an evaluation strategy. A strategy would assist DoHA to evaluate the contribution of its health workforce capacity programs to the department's Outcome 12: *Australians have access to an enhanced health workforce* and, where appropriate, other relevant DoHA outcomes.

93. DoHA administers around 60 programs directed at workforce distribution, health service delivery, and contributing to the education and training of health professionals in rural and remote Australia. In addition, there are a number of health workforce and health service programs being individually delivered by State and Territory Governments. In this context, an evaluation strategy would enable DoHA to identify program interdependencies and the contribution of individual programs (both internal and external) to the national health workforce objective. An evaluation strategy

would also ensure value for money by targeting DoHA evaluation work in this regard.

94. DoHA recognises the importance of program evaluation and advised the ANAO that during its review of all targeted, Australian Government funded rural health programs, the department will consider the parameters of evaluation strategies for existing rural and remote workforce initiatives.

Continuous improvement

95. DoHA operates in an environment of continuous improvement where the importance of using 'lessons learned' is well recognised within internal templates, strategies and accountability documents that guide staff within the organisation.[20] However, DoHA had not adopted a consistent approach to monitoring and improving its health workforce program performance through adopting 'lessons learned' from evaluations. A 'lessons learned' approach would allow program managers and the department to identify and consider the presumed causal links between health workforce capacity program inputs, activities, outputs, and outcomes, and to improve overall performance.

Summary of agency response

96. Health workforce capacity is complex with a range of organisations involved including:

- jurisdictions that are the major employers of the health workforce;
- State and Territory registration boards that register a number of professions;
- universities and the Technical and Further Education (TAFE) sector that educate health workers; and
- the department, whose main areas of focus have been on the distribution of general practitioners, funding of some specific rural and remote health services, and some training and education of the health workforce in respect of some known skills shortages.

97. The department works to improve health workforce capacity within the framework.

[20] DoHA, *Policy Formulation and advice* – advanced Version 3, p. 177.

98. The department agrees with and has undertaken activities that address the three recommendations made by the ANAO in this report. As stated in the report there is considerable activity already underway, much of which has been underway for some time directed at sustainable improvement in health workforce capacity in rural and remote Australia.

99. COAG announced a significant health workforce package underwritten by the Commonwealth including a National Health Workforce Statistical Register at its 29 November 2008 meeting. In addition, the Office of Rural Health has commenced a review of all targeted Commonwealth funded rural health programs. The review was announced by the Minister in April 2008 when she released the department's Report of the Audit of Health Workforce in Rural and Regional Australia.

100. The COAG package involves a fundamental change in the way clinical training for health professionals is provided, includes some significant investment in workforce planning data and includes measures that will have a positive impact on the number of health professionals. The Commonwealth took the lead with this package and the department undertook a significant piece of work over a long period of time in consultation with jurisdictions to make this happen.

101. The department is working with the Department of Finance and Deregulation to develop the Portfolio Budget Statements (PBS) under the reforms established by the Government to ensure that the PBS are relevant, strategic and performance focused. The ANAO have noted the complex environment the department operates in and has demonstrated how this impacts on the ability to develop performance measures that take out all other influences. The department will review its performance indicators for health workforce in that context.

Recommendations

There is considerable activity, underway and planned, which is directed at sustainable improvements in health workforce capacity in rural and remote Australia. This is at the intergovernmental COAG level, and also through the review processes announced by the Minister for Health and Ageing in April 2008. At the same time, the Australian Government has set in train a series of reforms to improve the transparency of government financial information, focussing on improvements in agency Portfolio Budget Statements so that they are relevant, strategic and performance oriented. In this context, the ANAO has made three recommendations to support DoHA in its approach to risk management, performance information and data management concerning future rural and remote health workforce capacity arrangements.

Recommendation No. 1 Para 3.70

To better co-ordinate the Department of Health and Ageing's workforce education and training, and distribution initiatives, the ANAO recommends that DoHA:

(a) monitors its treatments of the enterprise risks associated with insufficient supply of adequately trained personnel to work in the health sector; and

(b) where applicable, identifies and acknowledges in its planning processes the activities and potential impacts of other programs and initiatives, concerned with Australia's health workforce.

DoHA response: *Agreed*

Recommendation No. 2 Para 3.105

To better inform decision–making on the Department of Health and Ageing's contribution to the Government's health workforce outcomes, the ANAO recommends that DoHA:

(a) establishes performance information management arrangements, including effectiveness indicators for monitoring progress towards health workforce outcomes; and

(b) develops an evaluation strategy for the rural and remote health workforce capacity programs that it administers.

DoHA response: *Agreed*

Recommendation No. 3 Para 5.65

To ensure the currency, quality, relevance, and timeliness of the information and policy advice provided to the Australian Government concerning rural and remote health workforce capacity issues, the ANAO recommends that the Department of Health and Ageing develops a process to:

(a) ensure that its health workforce data is accurate and current; and

(b) access opinion–based information sources, both within and outside of the department.

DoHA response: *Agreed*

Audit Findings and Conclusions

1. Introduction

This chapter provides information on the background and context of Australia's rural and remote health workforce capacity, including the role of government. The chapter concludes with the objective, criteria, scope and methodology of the audit.

The Global Context

1.1 Health workforce shortages are a global phenomenon. In 2006, the World Health Organisation (WHO) identified widespread shortages of health professionals, including 57 countries with critical shortages. The WHO estimated that the number of additional health professionals currently needed to reach a satisfactory global supply of health workers is around 4.3 million.[21] In its *World Health Report 2006*, the WHO considered that Australia, compared to other countries, did not have a critical shortage of health service providers—doctors, nurses and midwives.[22]

1.2 The WHO forecasts that the international health workforce crisis will worsen in future years, for both developed and developing countries. Developed countries will see demand for health professionals rise due to an ageing population and an increase in chronic conditions requiring higher levels of care. Developed countries are also predicted to face increasing concentrations of health professionals in urban and metropolitan areas.[23] By contrast, developing countries will continue to face workforce shortages owing to the international relocation of locally trained doctors to better resourced nations, limited health resourcing capacity, and limited ability to manage infectious disease.[24]

Health workforce capacity challenges for Australia

1.3 Health workforce capacity in Australia is complex with a range of organisations involved including:

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[21] World Health Organisation (WHO), 2006, *The World Health Report 2006: Working Together for Health*, Geneva, p. 12.

[22] World Health Organization. *Global Atlas of the Health Workforce* <http://www.who.int/globalatlas/default.asp> [accessed 11 December 2008].

[23] World Health Organisation (WHO), 2006, op cit.

[24] ibid.

- jurisdictions that are the major employers of the health workforce;
- State and Territory registration boards that register a number of professions[25]; and
- universities and the Technical and Further Education (TAFE) sector that educate health workers.

1.4 In this environment, the main areas of focus of the Australian Government's Department of Health and Ageing have been on the distribution of general practitioners, funding of some specific rural and remote health services, and some training and education of the health workforce in respect of some known skills shortages.

1.5 State and Territory governments have a significant role in health workforce, including in rural and remote areas. These governments employ the majority of the health workforce, and provide a significant proportion of clinical training.

1.6 Australia now trains and recruits health professionals in a competitive international market and is a signatory to the Code of Practice for the International Recruitment of Health Care Professionals.[26] Australia is a net importer of health professionals with more than 36 per cent of Australia's doctors being overseas trained.[27] The Australian Government's Department of Health and Ageing (DoHA) has contracts with recruitment agencies to actively recruit trained health professionals. The State and Territories also have active recruitment programs in place to recruit health professionals from overseas.

1.7 An effective, sufficient and reliable health workforce is essential for addressing the healthcare needs of all Australians. Australians rely on health professionals, health systems, providers and governments for equitable access to primary and acute health care services.

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[25] The Council of Australian Governments (COAG) signed an Intergovernmental Agreement in 2008 for the national registration and accreditation of ten health professions.

[26] Otherwise known as the "Melbourne Manifesto", adopted at the 5th Wonca World Rural Health Conference, 3 May 2002. Source: Wonca, 2002, <http://www.globalfamilydoctor.com/aboutWonca/working_groups/rural_training/melbourne_manifesto.htm> [accessed 11 December 2008].

[27] Commonwealth of Australia, 2008, Medicare data quoted in: *Report of the Audit of Health Workforce in Rural and Regional Australia*. p. 27.

1.8 Shortages of qualified health professionals are increasingly common and are of considerable concern to governments and citizens. In addition to challenges raised by Australia's ageing population and tight labour market, the distribution of Australia's population presents an additional challenge to securing an effective and accessible health workforce outside of major cities.

1.9 Australia's ageing population will be a significant driver of demand for health workers for the next few decades. The Australian Bureau of Statistics (ABS) predicted in 2004 that by 2051 there will be a much greater proportion of people aged 65 years and over, and a lower proportion of people aged under 15 years. More than one in five Australians will be aged 65 or over, with ageing effects stronger in rural areas.[28] Australia's capacity to plan, supply and maintain a sufficient rural and remote health workforce capacity for current and future needs is a substantial challenge. This challenge is exacerbated by an ageing health workforce.

1.10 For these reasons, the Australian National Audit Office (ANAO) examined the effectiveness of DoHA's administration of health workforce initiatives in rural and remote Australia.

Composition of the Australian Health Workforce

1.11 In 2005, the Australian health workforce consisted of around 569 700 professionals or around 5.7 per cent of the total workforce.[29] Enrolled and Registered Nurses made up approximately half the total health workforce, at 285 619.[30] Medical professionals (that is, doctors and specialists) accounted for 59 900 workers, or just over 10 per cent of the total health workforce.[31] Figure 1.1 provides aggregate information on health professionals in Australia.

[28] Australian Bureau of Statistics, 2004, *Population Projections Australia 2004–2101*, Cat. No. 3222.0.

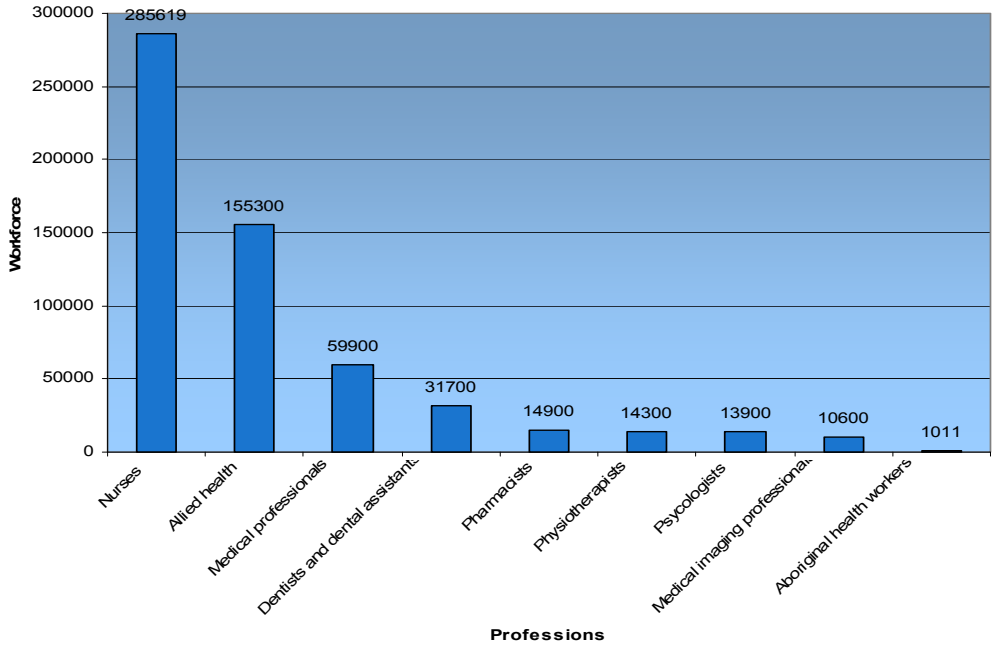
[29] Australian Institute of Health and Welfare (AIHW), 2007, *Australia's Health 2006*, p. 315.

[30] AIHW, 2008, *Nursing and midwifery labour force 2005*, National health labour force series No. 39. Cat. No. 40, p. 5.

[31] AIHW, op. cit.

Figure 1.1

Numbers of Health Professionals, 2005



Source: AIHW, 2007, *Australia's Health 2006*.

Note: Allied health professions include chiropractors, optometrists, and podiatrists amongst others.

Health Workforce Shortages

1.12 Although the absolute numbers of health professionals in Australia has increased over time, these increases have not always kept pace with Australia's growing population. Workforce shortages of health professionals, particularly in rural and remote areas, have become more pronounced in recent years.[32]

Medical Workforce Shortages

1.13 The current medical workforce shortage has developed over many years. Following a period of international concern over rising medical workforce expenditures, the Australian Government capped the number of

[32] Productivity Commission, 2005, *Australia's Health Workforce*, p. 337.

places in medical schools in the mid 1990s to reduce the, then, perceived risk of a doctor oversupply.[33]

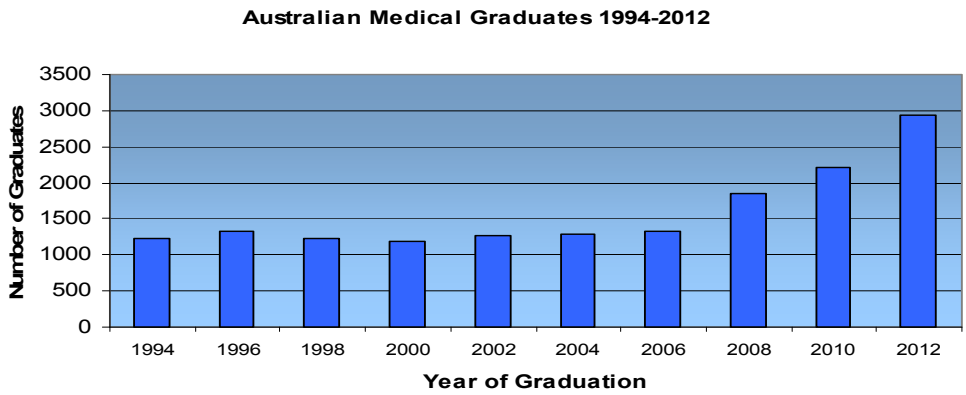
1.14 The cap remained in place until 2004 and, during this period, Australia fell within the bottom third of all Organisation for Economic Cooperation and Development (OECD) countries in the number of medical graduates per capita.[34] At 2.8 practising physicians per 1 000 people in 2005, Australia was just below the average of all OECD countries (3.1).[35]

1.15 The Department of Education, Employment and Workplace Relations (DEEWR) has responsibility for the education of the health workforce and the establishment of the number of medical places, for example, is undertaken by DEEWR. The Department of Health and Ageing liaises with DEEWR in this regard.

1.16 Figure 1.2 shows the earlier limit on graduate numbers and the projected increase towards the Australian Government's target of 3 000 medical graduates per annum by 2012.

Figure 1.2

Medical Graduate Numbers—values actual and projected



Source: Department of Health and Ageing, Medical Training Review Panel, Eleventh Report, 2007.

Note: Values between 1994 and 2006 are actual, from 2007 to 2012, numbers are projected.

[33] Department of Health and Aged Care, August 2001, *The Australian Medical Workforce*, Occasional Papers: New Series No. 12.

[34] OECD, 2008, *Health Workforce and International Migration: Can New Zealand Compete?* Health Workforce Paper No. 33, p. 27.

[35] OECD, *Health Data* 2008, *How does Australia Compare?* p. 2.

Australian Government response to medical workforce shortages

1.17 During the late 1980s to early 1990s, the Australian Government focused efforts on improving the geographical distribution of doctors, intervening as the market was no longer delivering equitable access.[36] The first Commonwealth/State National Rural Health Strategy began in 1991, with the Commonwealth launching the first rural health workforce program, the General Practitioner (GP) Rural Incentives Program (GPRIP) in 1993.[37] Now renamed as the Rural Retention Program (RRP), the program aims to improve the uptake of rural and remote medical practice, via relocation and incentive grants related to length of stay.

1.18 The national strategic framework for rural health, *Healthy Horizons: A framework for Improving the Health of Rural, Regional and Remote Australians Outlook 2003–07*, (Australian Health Ministers' Advisory Council (AHMAC) National Rural Health Policy Subcommittee and the National Rural Health Alliance, 2003), was endorsed by Australian Health Ministers in 2003. *Healthy Horizons* outlines seven key goals for improving the health of rural and remote Australians, including 'maintain a skilled and responsive workforce'.[38] Healthy Horizons was reviewed by the AHMAC Rural Health Standing Committee in 2007–08. While the future of Healthy Horizons has not been determined, the goals outlined remain relevant and continue to be used as a guiding framework for governments.

Health status of rural and remote populations

1.19 Although the general health level of Australians is quite high, the same is not true of those living in rural and remote areas.[39] Around one third of all Australians live outside of major metropolitan areas, yet the proportion of primary care health practitioners in these regions is notably lower.

1.20 Australians living in rural and remote Australia, on average, have higher levels of morbidity and mortality than those in metropolitan areas, and

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36 Department of Health and Aged Care, op. cit.

37 McEwin, K and Cameron, I, 2007, *The 1987 NSW Rural Doctor's Dispute*, published by the New South Wales Rural Doctors Network.

38 National Rural Health Alliance, 1999, *Healthy Horizons*.

39 ibid.

the distinction generally becomes more marked as rurality or remoteness increases.

Key factors driving poorer health outcomes for rural and remote Australia are:

- increased health risk factors (including riskier occupational hazards);
- poorer socio-economic precedents for good health (including poorer education and workforce participation);
- poorer access to health services and particularly specialist medical services, resulting from both workforce shortages and large travelling distances; and
- higher proportions of Indigenous Australians, with generally poorer health outcomes, in these areas.[40]

1.21 Health status for Indigenous Australians, on average, is extremely poor by comparison to non-Indigenous Australians. Health status is a product of many interdependent variables, however, there is value in highlighting difficulties of health workforce access in remote areas. In 2006, 31 per cent of discrete Indigenous communities were located more than 100 kilometres from the nearest Aboriginal primary health care service, and more than 64 per cent were more than 100 kilometres from the nearest hospital.[41]

Collecting and analysing health statistics

1.22 The Australian Institute of Health and Welfare (AIHW) releases a biennial health report—*Australia's Health*—which provides information about the health status of Australians and the health services they receive.

1.23 *Australia's Health 2008* reaffirms that Australians living in rural and remote areas generally have poorer health than their major city counterparts. This is combined with less access to primary health–care services. The AIHW also comments that a major problem in understanding the health of people in rural and remote Australia is the limited availability, representativeness and quality of data to allow meaningful comparisons between populations from different areas.[42]

[40] AIHW, *Australia's Health 2006*, pps. 239-240.

[41] ABS, 2006, CHINS Survey, reported in Productivity Commission, *Indigenous Compendium 2008*, p. 100.

[42] AIHW, 2008, *Australia's Health*, p. 97.

The composition of the health workforce in rural and remote Australia

1.24 The most notable difference in the makeup of medical practitioners working in rural and remote Australia is the prevalence of Overseas Trained Doctors (OTDs). OTDs make up 36 per cent of Australia's total population of doctors, rising to 41 per cent in rural and remote areas.[43]

1.25 Most rural and remote areas are classified as Districts of Workforce Shortage (DoWS). DoWS are areas where the provision of medical services, based on Medicare data[44], are below the national average on a doctor to population ratio.

1.26 Following a request from the Prime Minister in December 2007, the Minister for Health and Ageing requested the department to undertake an audit of the shortage of doctors, nurses and other health professionals in rural and regional Australia, and to describe the extent of these shortages by profession. The *Report on the Audit of the Health Workforce in Rural and Regional Australia* confirmed that the distribution of health professions in relation to the distribution of the population in Australia was uneven, and particularly lacking in regional and remote Australia. Medical practitioners were in low supply relative to the population in the Northern Territory and Western Australia generally, compared to the rest of Australia. Other health professions, particularly dentists and some allied health professionals were also unevenly distributed. Nurses, on the other hand, were relatively evenly distributed across Australia.

1.27 Figure 1.3 illustrates the variation in health professional supply across geographical region types, for example, there are around 205 General Practitioners (GPs) per 100 000 population in Australia's major cities compared with less than half that number of GPs per 100 000 population in Remote/Very Remote areas of Australia.

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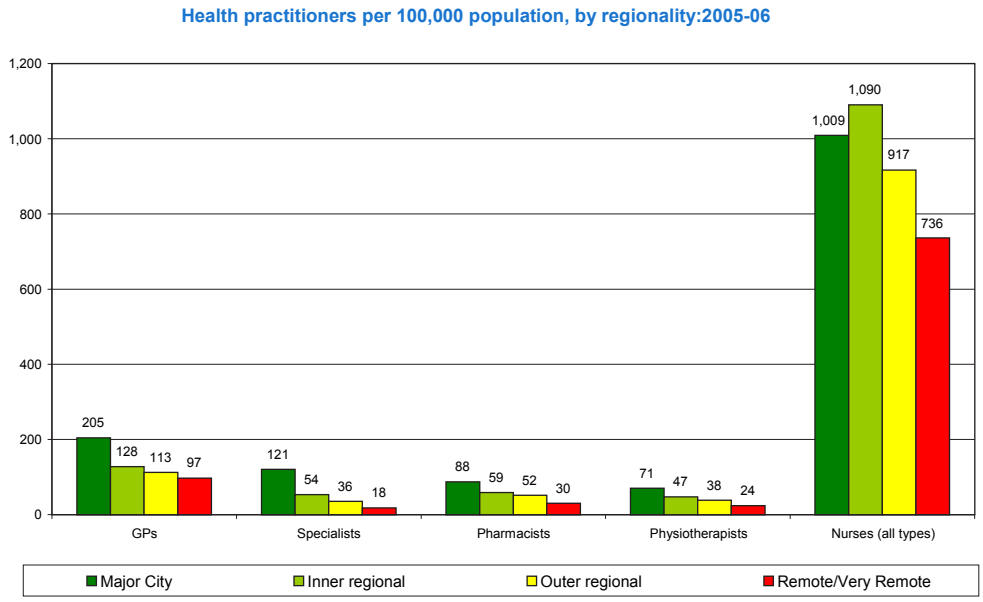
[43] Minister for Health and Ageing, 30 April 2008, *Workforce Audit Reveals Challenges for Rural Health*, media release.

[44] Medicare Provider Number restrictions apply to all OTDs, such that they only receive a restricted Medicare Provider Number when they work in a DoWS.

Figure 1.3

Health professionals by remoteness category



Source: Most recent data on health professionals provided by the Department of Health and Ageing to the 2020 Summit, 2008.

Key barriers identified by stakeholders to an adequate supply of health professionals in rural and remote Australia

1.28 The ANAO asked stakeholder organisations what, in their opinion, are the key barriers to ensuring adequate health workforce capacity in rural and remote Australia. In a number of instances, the barriers identified by stakeholders are outside of DoHA's control. The most commonly cited barriers included:

- the **perceived and real difficulties of living in rural and remote Australia**, including:
  - lack of job and educational opportunities for the spouse and children of health professionals,
  - the high cost of living in rural and remote Australia, including transport and housing costs, and education costs (especially where private education is required), and

- negative lifestyle perceptions related to: harsh climate; social and cultural isolation; and after-hour work demands;

- **a national and global under-supply of qualified health professionals**: stakeholders considered that this partly reflected cuts in graduate medical positions in previous years and the increased demand for health services;
- **lack of rural and remote loadings:** under the Medicare Benefits Schedule (MBS) and/or current requirements for access to MBS payments: a number of stakeholder argued for rural and remote MBS loadings to reflect the higher cost of services in rural and remote areas;
- **inadequate salaries and conditions:** some stakeholders considered that inadequate salaries and conditions were preventing health professionals from taking up positions in rural and remote Australia; and
- **inadequate evaluation and review**: some organisations considered there was a need for more evidence-based review of the effectiveness of the range of DoHA programs to ensure that limited resources were well directed.

1.29 In addition to the barriers identified above, stakeholders identified a very broad range of other factors impacting on rural and remote health workforce capacity, including: a lack of succession planning; the deterioration in public health infrastructure in many rural and remote communities; a lack of procedural skills training (a key element of rural health practice) for medical graduates; inadequate maternity care provisions; the high cost of professional indemnity insurance; and inadequate medical graduate intakes, especially amongst Indigenous students.

Recent Key Reports

1.30 Information on recent key reports, of relevance to the audit topic—health workforce capacity in rural and remote Australia—can be found in Appendix 1. The recent key reports are:

- the Productivity Commission's Report on the Health Workforce;
- The Blame Game; and
- 2020 Summit.

1.31 There was considerable alignment between the recommendations and suggestions of each of the three reports concerning growing workforce shortages across a number of health professions. Overall, this suggests that health workforce shortages are of interest to health consumers, providers and governments.

Peak Government Arrangements

1.32 Information on peak government arrangements can be found in Appendix 2. The peak government arrangements outlined are:

- Council of Australian Governments (COAG); and
- Australian Health Ministers' Conference (AHMC).

1.33 COAG is the peak forum of heads of government in Australia. COAG noted health workforce supply and demand issues in June 2004, and accepted, in part, the 20 recommendations of the Productivity Commission's report on 13 April 2007.

1.34 COAG has a number of related structures to assist it in determining national approaches to critical issues. These are Commonwealth–State Ministerial Councils. For health, the Australian Health Ministers' Conference (AHMC) is the appropriate forum comprising the Health Ministers of the various jurisdictions.

1.35 The COAG meeting on 29 November 2008 committed to:

> an unprecedented reform package of $1.6 billion for Australia's health workforce. The commitment by governments seeks to meet the future challenges of the health system through workforce reform by providing additional funds for undergraduate clinical training; increasing the number of postgraduate training places (including GP places); and establishing a national health workforce agency and health workforce statistical register to drive a more strategic long–term plan for the health workforce.[45]

Overlap of responsibilities

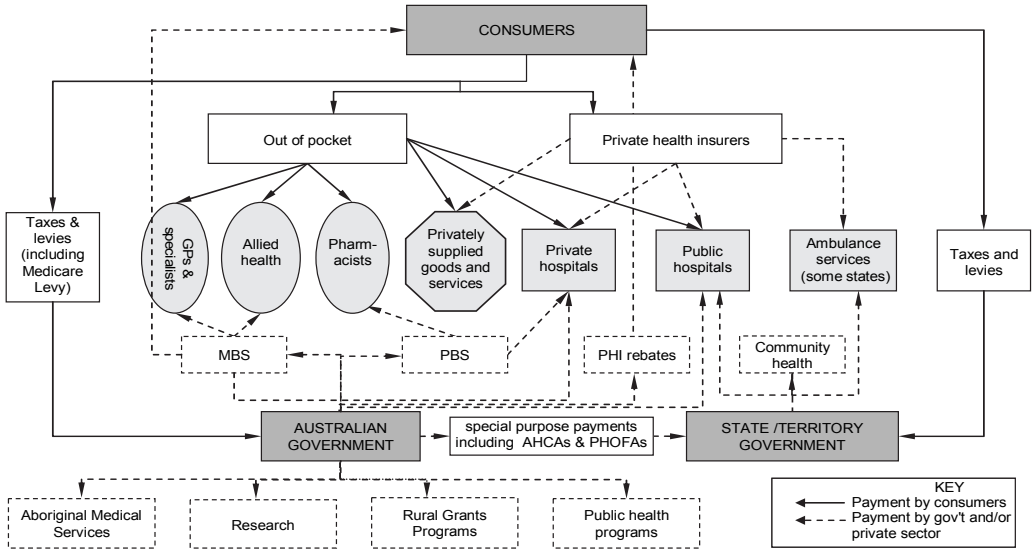
1.36 Figure 1.4 presents the Australian Health System. It is a blend of Australian and State Government responsibilities and a mix of public and

[45] <http://www.coag.gov.au/coag_meeting_outcomes/2008-11-29/attachmnets.cfm> [accessed 12 January 2009].

private funding. This gives rise to a model where responsibility and accountability for health service provision is not always transparent.

Figure 1.4

The Australian Health System



Source: A Department of Health and Ageing schema provided for the 2020 Summit.

The role of government

1.37 Governments within Australia have a primary role concerning the health workforce as employers; regulators; and providers of payments and incentives. The Australian, State and Territory Governments have constitutional ability to provide health benefits and services.[46] The Constitutional Powers, outlined in Table 1.1, identify the scope of Commonwealth responsibility and the residual powers that pertain to the States concerning the authority to make laws concerning health matters.

[46] The Australian Constitution, s.51 (xxiiiA).

Table 1.1

Division of Health Powers

Constitutional Division of Health Powers	
s. 51 (xxiiiA)	**Commonwealth has power in relation to medical and dental services** "The Parliament shall, subject to this Constitution, have power to make laws for the peace, order, and good government of the Commonwealth with respect to:- (xxiiiA.) The provision of maternity allowances, widow's pensions, child endowment, unemployment, *pharmaceutical*, *sickness and hospital benefits, medical and dental services* (but not so as to authorise any form of civil conscription), benefits to students and family allowances:" (emphasis added)
s. 107	**States retain other powers not exclusively vested in the Commonwealth** *"Every power of* the Parliament of a Colony which has become or becomes *a State, shall, unless it is by this Constitution exclusively vested in the Parliament of the Commonwealth* or withdrawn from the Parliament of the State, *continue* as at the establishment of the Commonwealth, or as at the admission or establishment of the State, as the case may be." (emphasis added)

Source: The Australian Constitution.

1.38 The sharing of responsibility for the health of Australian citizens extends to local governments which may also engage in health care provision and workforce attraction and maintenance, particularly in rural and remote areas.[47]

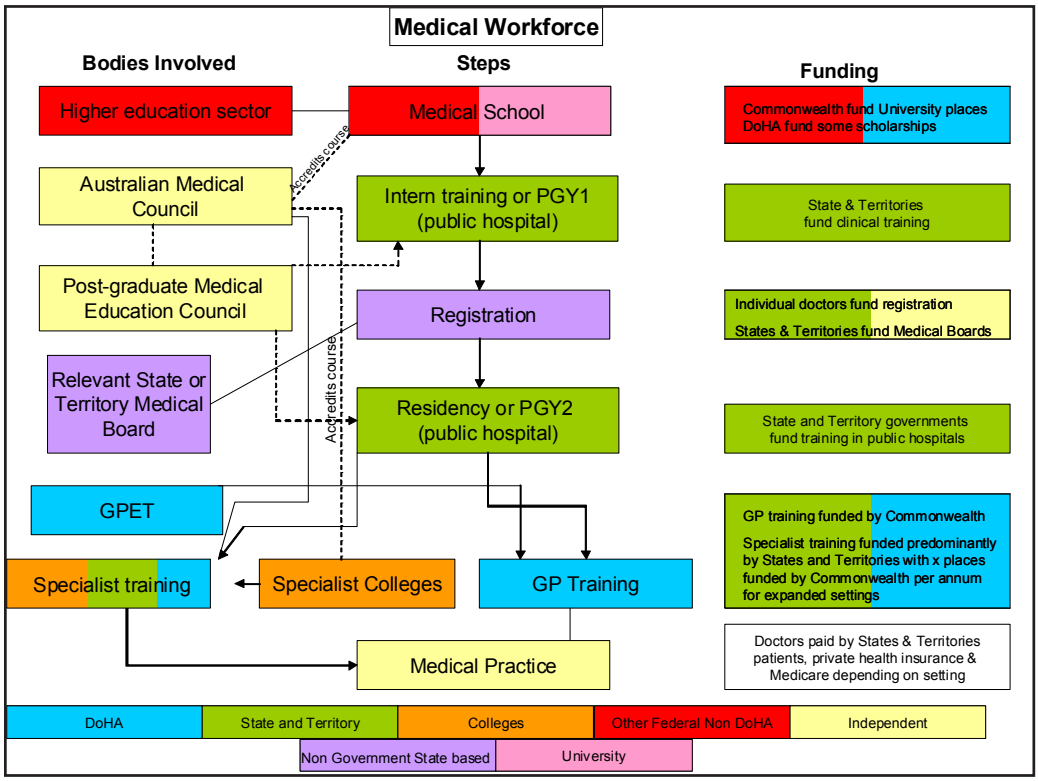
1.39 In the area of health workforce planning and implementation, governments, at all levels, share the ability to manage health workforce issues with key stakeholders including: health workforce professionals; professional associations and regulatory bodies; service providers; health industry organisations and insurers; health lobbyists; and health consumer organisations.

1.40 An example of the complexity and interdependency of current training arrangements for the health workforce is provided in Figure 1.5 which sets out the training pathway for the medical workforce. Figure 1.5 identifies the organisations involved in the training pathway as well as funding responsibilities.

[47] DoHAC, 2000, *The Australian Health Care System: an outline*.

Figure 1.5

Arrangements for medical workforce training



Source: DoHA.

1.41 The Australian Government has a leadership role in policy making for national priority issues, including health. The Australian Government has traditionally influenced the health workforce through primary care health services. This is especially through the Medicare Benefits Schedule which funds GPs and specialists.[48] The Australian Government co–funds State and Territory public hospital services and related provisions through Australian Health Care Agreements (AHCAs).[49]

[48] The major elements of Medicare are contained in the *Health Insurance Act 1973* and include: free treatment of public patients in public hospitals; a patient rebate of 85 per cent of the Schedule fee for services provided by a GP; or for services provided on behalf of a GP; and for health services provided by some other health professionals.

[49] The Australian Government also funds the Pharmaceutical Benefits Scheme (PBS), private health insurance rebates, residential aged care services, services for veterans and primary health care for Indigenous Australians. Recent additions are extensions of Medicare funding for chronic care conditions, health assessments and certain services by nurses, dentists and some allied health professions.

1.42 State and Territory governments directly fund and deliver most hospital and acute care health services and public and community health services, including dental, maternal and child health.[50] State and Territory governments are also responsible for regulation, inspection and licensing of premises and health professionals, patient transport, and specialist palliative care.[51]

1.43 Local governments vary in extent of their health service delivery, but typically provide community-based and home care services.[52]

1.44 The overlap of these areas of responsibility between the tiers of government has been identified as an impediment to rational and effective health workforce planning.[53]

The investment role of government

1.45 Australia has a large and increasing investment in health services. Australian governments and citizens spent a total of $86.9 billion on health in 2005–06, equivalent to 9.6 per cent of the national Gross Domestic Product (GDP).[54] This is marginally above the 2005 average (9 per cent) for OECD countries.[55]

1.46 In 2005–06, around two–thirds of funding for health care was by governments (67.8 per cent—$59 billion), of which the largest contribution comes from the Australian Government—$37 billion.[56]

1.47 Appendix 3 provides additional details on investment in the Australian Health System.

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50 Australian Institute of Health and Welfare, op. cit.

51 ibid.

52 ibid.

53 Productivity Commission, 2005, *Australia's Health Workforce.* p. 350.

54 Australian Institute of Health and Welfare, 2007, *Health Expenditure Australia 2005–06*, Health and Welfare Expenditure Series, no. 30.

55 OECD, OECD Factbook 2008 [internet], available from <http://puck.sourceoecd.org/vl=2073011/cl=19/nw=1/rpsv/factbook> [accessed 12 January 2009].

56 Australian Institute of Health and Welfare, op. cit.

The Role of the Department of Health and Ageing

1.48 The role of the department in enhancing the rural and remote health workforce has been to increase the number of GPs working in rural and remote Australia through programs that focus on the use of Overseas Trained Doctors (OTDs); bonded medical places; scholarships for students from rural areas; and retaining GPs already working in rural and remote Australia through the provision of access to continuing education, locum services and retention payments. In addition, there are incentives to increase the number of nurses working in general practice in rural and remote Australia.

1.49 In 2006, the COAG decisions that flowed from the recommendations of the 2005 Productivity Commission report on the Health Workforce in Australia increased the role of the department. Following this, the department took steps to ensure that health workforce capacity was given an increased focus and established the Mental Health and Workforce Division (MHWD).

1.50 The department's 2006–07 Portfolio Budget Statements included Outcome 12, Health Workforce Capacity, to further increase the focus of health workforce. The goal of DoHA's Outcome 12, Health Workforce Capacity, is that: *Australians have access to an enhanced health workforce*. Outcome 12 is managed within DoHA by the MHWD.

1.51 DoHA administers around 60 programs directed at workforce distribution, education and training, and service delivery in rural and remote Australia. The MHWD is responsible for the majority of Australian Government health workforce capacity programs. The MHWD has two programs areas: Program 12.1—rural health workforce and Program 12.2—health workforce (general).

1.52 In addition, the Division administers workforce distribution, and education and training programs on behalf of other Outcome groups. These Outcome groups include: Outcome 2—*Access to Pharmaceutical Services*; Outcome 3—*Access to Medical Services*; Outcome 5—*Primary Care*; Outcome 6—*Rural Health*; and Outcome 8—*Indigenous Health*.

1.53 In the late 1990s and early 2000s, DoHA had an Office of Rural Health which managed Outcome 5 (Rural Health) programs and other program areas across the Portfolio which contributed to achieving the outcome.[57] DoHA's

[57] Department of Health and Ageing, *2001–02 Annual Report*, p. 181.

Portfolio Budget Statements for 2000–01 indicated that a national set of rural health performance indicators would be developed on a collaborative Commonwealth and State and Territory basis. It would include indicators of access to health services for people living in regional, rural and remote locations; the number of health professionals practising in these areas and positive changes in the health status of people living in these areas.[58] DoHA's 2000–01 Annual Report noted that:

> the task was highly complex, and problematic, particularly in the areas of health status change where it would take some considerable years to show changes. Such a national approach would not necessarily assist the Commonwealth in determining the impact of its own rural health programs.[59]

An agenda for reform

1.54 Shortly after taking office in December 2007, the Government announced a reform agenda for the health system, which included addressing health workforce shortages in rural and remote areas.

1.55 The Minister for Health and Ageing, the Hon Nicola Roxon MP, released results of an audit of health professionals in rural and remote Australia on 30 April 2008. This audit confirmed significant workforce shortages, in addition to Australia's heavy reliance on OTDs and found marked weaknesses in population data used to fund programs.

1.56 The Minister established an Office for Rural Health within DoHA in July 2008 to drive rural health reform, and committed to a review of geographical classification systems including the Rural, Remote and Metropolitan Areas (RRMA) and of all targeted Commonwealth health workforce programs over the following 12 months.[60]

1.57 A new body, the National Health and Hospital Reform Commission (NHHRC), was established by the Australian Government in February 2008. The NHHRC is commissioned with developing a long-term health reform plan by June 2009. Two of the eight elements they are to address are health service

[58] Health and Ageing Portfolio, *2000–01 Portfolio Budget Statements*.

[59] Department of Health and Ageing, *2000–01 Annual Report*, p. 145.

[60] Minister for Health and Ageing, 2008, op. cit.

provision in rural areas and provision of a sustainable health workforce into the future.[61]

Relevant Previous ANAO Audits

1.58 Recent related performance audits include:

- ANAO Audit Report No.40 2003–04, *Management of the Multipurpose Services Program and the Regional Health Services Program*, Department of Health and Ageing;
- ANAO Audit Report No.41 2005–06, *Administration of Primary Care Funding Agreements*, Department of Health and Ageing;
- ANAO Audit Report No.19 2006–07, *Administration of State and Territory Compliance with the Australian Health Care Agreements (AHCAs)*, Department of Health and Ageing; and
- ANAO Audit Report No.25 2007–08, *Administering Round the Clock Medicare Grants,* Department of Health and Ageing.

1.59 The ANAO also publishes Better Practice Guides. The following are relevant for this audit:

- ANAO Better Practice Guide—*Planning for the Workforce of the Future,* March 2001;
- ANAO Better Practice Guide—*Some Better Practice Principles for Developing Policy Advice,* November 2001; and
- Department of the Prime Minister and Cabinet and ANAO Better Practice Guide, October 2006, *Implementation of Programme and Policy Initiatives*.

1.60 The Department of Finance and Deregulation (Finance) manages the Comcover fund which provides risk management and insurance services to a range of public sector agencies. Through the Comcover fund, Finance is responsible for promoting better practice risk management across the Australian Government sector and to support this responsibility, has published the Comcover, June 2008, *Better Practice Guide—Risk Management*.

[61] NHHRC, Terms of Reference, <http://www.health.gov.au/internet/main/publishing.nsf/Content/nhrc-1> [accessed 12 January 2009].

Audit Objectives, Criteria, Scope and Methodology

Audit objectives

1.61 The audit objective is to assess the effectiveness of the Department of Health and Ageing's administration of health workforce initiatives in rural and remote Australia.

Audit criteria

1.62 To form its opinion, the ANAO used the following criteria:

- DoHA has strategies in place to maximise its contribution to the Australian Government's specified Health Workforce Capacity outcome;
- DoHA has effectively implemented Australian Government programs addressing health workforce shortages in rural and remote Australia; and
- DoHA monitors and evaluates its health workforce programs in rural and remote Australia.

Audit scope

1.63 The audit focuses on the effectiveness of initiatives for the primary care health workforce in rural and remote areas. The audit scope concentrates on the Department of Health and Ageing's responsibility for health workforce distribution initiatives and its limited responsibility for health workforce education and training. The audit scope did not include the administrative role of State and Territory Governments and the Indigenous health workforce.

Audit methodology

1.64 To gain a suitable understanding of the broader environment in which DoHA is delivering the Government's objective concerning health workforce capacity in rural and remote Australia and to identify the primary issues and evidence necessary to support an audit conclusion, the ANAO used the following evidence–gathering techniques: an analysis of key planning, policy and program documents; interviews with departmental staff and stakeholders; an in–depth analysis of eight rural and remote health workforce capacity programs; and a stakeholder survey.

Rural and remote health workforce capacity programs

1.65 As part of the audit, the ANAO, in consultation with DoHA, selected eight programs to examine in more detail. The programs selected reflect the department's specific areas of responsibility for the health workforce in rural and remote Australia outlined in paragraph 1.48. They included:

- seven rural and remote health workforce capacity programs, almost all of which are distribution initiatives; and
- one health service delivery program with a health workforce capacity component—the Medical Specialists' Outreach Assistance Program (MSOAP).

1.66 Table 1.2 includes the eight programs (including one pilot) selected.

Table 1. 2

Selected rural and remote health workforce capacity programs

Program name	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Specialist Obstetrician Locum Scheme (SOLS) (Pilot)	659 110	12	MHWD	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Nurses in General Practice Training and Support Program (NiGP)	3 921 000	5	MHWD	Australian General Practice Network (AGPN) and State Based Organisations (SBOs)
Rural Australia Medical Undergraduate Scholarship (RAMUS)	6 194 959	12 & 5	MHWD	National Rural Health Alliance (NRHA)
Support, Coordination and Assistance for Overseas Trained Doctors Program (OTDs)	7 575 000	12	MHWD	Rural Workforce Agencies (RWAs), State and Territory Governments and Doctor Recruitment Agencies
Aged Care Nurses Scholarship Scheme (ACNS)	8 417 000	4	Office of Aged Care	Royal College of Nursing Australia (RCNA)
Medical Specialists' Outreach Assistance Program (MSOAP)	15 493 000	6	PACD	Rural Workforce Agencies (RWAs)
Rural Retention Program (RRP)	22 693 000	5	MHWD	Administered by Medicare Australia
Training for rural and remote Procedural GPs Program (TRRPGPP)	24 765 000	5	MHWD	Administered by Medicare Australia

Source: ANAO.

Note: Mental Health and Workforce Division (MHWD) and Primary and Ambulatory Care Division (PACD).

1.67 While the programs represent a cross section of rural and remote activities and the results of the program analysis are indicative of DoHA's approach, the sample of programs was not designed to provide statistically significant results and the data obtained from the program analysis cannot be extrapolated to all health workforce capacity and health service delivery programs.

1.68 Appendix 4 provides an overview of the eight programs the ANAO examined.

ANAO Stakeholder Survey

1.69 The delivery of the department's rural and remote health workforce capacity programs are outsourced to organisations in the health sector that have on-the-ground experience with health care arrangements in rural and remote areas of Australia.

1.70 The ANAO undertook a survey of external organisations, nominated by the MHWD as stakeholders. Out of a total of 168 stakeholder organisations invited to participate in the ANAO on–line stakeholder survey, 126 responded—a high response rate of 75 per cent. These 126 organisations included: Divisions of General Practice[62]; education and/or training providers; peak/representative groups other than Divisions of General Practice; Medical Colleges or health professional associations; research organisations; and Rural Workforce Agencies (RWAs).[63] [64]

1.71 These 126 stakeholder organisations are well placed to provide a perspective on DoHA's administrative performance and engagement of stakeholders:

- most are in regular contact with DoHA – 85 per cent of these organisations indicated that they typically contact DoHA at least once a month and 56 per cent indicated that they typically contact DoHA at least once a week; and
- 80 per cent of these organisations indicated that they have provided program delivery advice to DoHA and 66 per cent indicated that they have provided policy advice to DoHA.

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62 The Australian General Practice Network (AGPN) represents 111 Divisions of General Practice, which are local State/Territory based organisations. Only Divisions designated by AGPN as either rural or remote were invited to participate in the ANAO stakeholder survey. AGPN estimates that more than 90 per cent of GPs and an increasing number of practice nurses and allied health professionals are members of their local Division.

63 There are seven RWAs that operate in each State and the Northern Territory. The RWAs directly recruit (including from overseas) and support GPs in rural and remote communities through a range of services to GPs and their families.

64 The ANAO analysed the extent to which stakeholder views varied across these stakeholder groups. These disaggregated results are not presented in this report to ensure that the views of individual organisations are not disclosed or that the confidentiality of the survey process is in no way compromised.

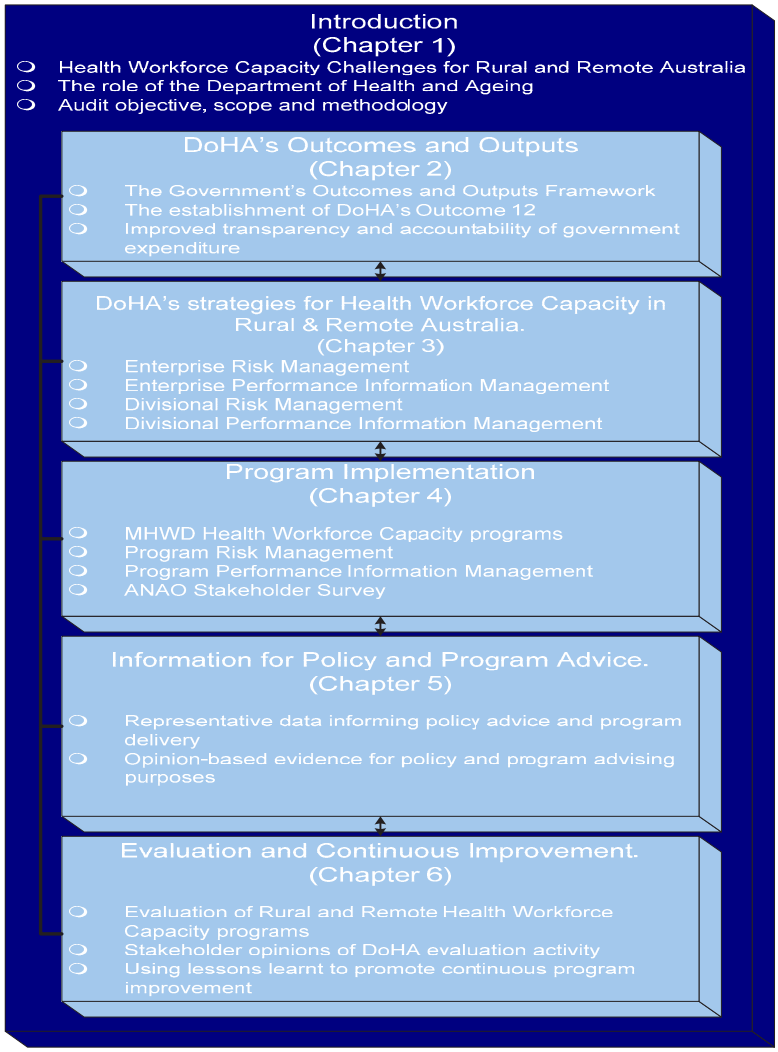
1.72 The audit was conducted in accordance with ANAO Auditing Standards at a cost of $622 000. Allanson Consulting Pty Ltd and Orima Research assisted with the conduct of the audit.

Structure of this Report

1.73 The report is presented in six chapters, as outlined below.

Figure 1.6

Structure of the audit report



Source: ANAO.

2. DoHA's Outcomes and Outputs

This chapter provides information on the Government's Outcomes and Outputs accountability framework. It also describes the evolution of DoHA's Outcome structure and the establishment of Outcome 12—Health Workforce Capacity.

The Government's Outcomes and Outputs framework

2.1 The Outcomes and Outputs framework provides the basis of the Government's approach to budgeting and reporting for public sector agencies and the means by which the Parliament appropriates funds in the annual budget context. It is central to the legal and regulatory framework set out in the *Financial Management and Accountability Act 1997* (FMA Act).[65]

2.2 The key elements of the Outcomes and Outputs framework are:

- specification of what government is seeking to achieve (outcomes);
- specification of how the actual deliverables will assist in achieving the outcomes (outputs);
- identification of expenses, revenues, assets or liabilities managed by agencies on behalf of the Government (administered items);
- establishment of a performance management regime that includes indicators of effectiveness and efficiency; and
- annual performance reporting of agencies' contributions to the achievement of outcomes and the delivery of outputs.[66]

2.3 Outcomes play a specific role in the Outcomes and Outputs framework. Outcomes are defined by the Department of Finance and Deregulation (Finance) as:

> the impact sought or expected by government in a given policy arena. The focus is on change and consequence: what effect can government have on the community, economy and/or national interest? Outcome statements also

---

65 The enactment of the FMA Act significantly changed the legal and regulatory basis for the governance and management of Australian Government organisations. To support the appropriate levels of governance required by the FMA Act, it is advisable that Australian Government agencies establish sound arrangements to plan and manage activities to achieve Government objectives.

66 ANAO Audit Report No.23 2006–07, *Application of the Outcomes and Outputs Framework*, p.15.

perform a specific legal function by describing the purposes of appropriated funds.[67]

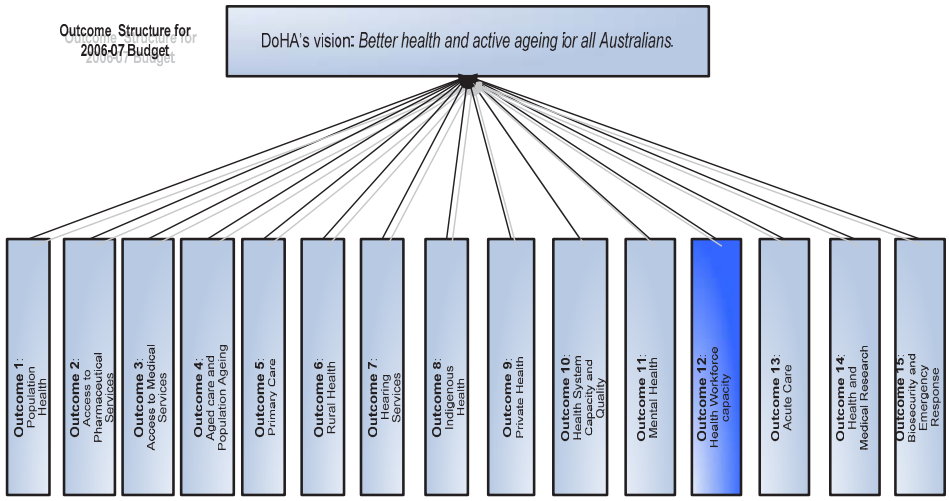
2.4 Outcomes are often long–term in nature and performance information in this area should focus on effectiveness.

The establishment of DoHA's Outcome 12

2.5 DoHA's Outcome structure was revised for 2006–07 to reflect the Government's priorities for health and ageing and established a number of new Outcomes, including Outcome 12: *Health Workforce Capacity*. Figure 2.1 is the structure against which funds were appropriated in the 2006–07 Budget.

Figure 2.1

Outcome structure for the 2006–07 Budget



Source: ANAO, based on Portfolio Budget Statements.

2.6 In reference to Outcome 12, Health and Ageing's 2006–07 Portfolio Budget Statements (PB Statements) noted:

> through this Budget, the Government also addresses Australia's need for more and better skilled health professionals to be effectively distributed across Australia. The Government has already made significant investments in developing and expanding the health workforce to address areas of workforce shortage. This budget builds on these initiatives. Reform of the health

[67] <http://www.finance.gov.au/budgetgroup/CommonwealthBudget_Overview/structuring_outcomes> [accessed 18 November 2008].

workforce is subject to ongoing consideration by the Council of Australian Governments (COAG), expected in mid 2006. Meeting the Government's workforce objectives will require working collaboratively with a range of bodies and the States and Territories.[68]

2.7 Following the COAG decisions, DoHA suggested the following revision to the portfolio Outcome structure:

> that Outcome 9: Health System Capacity and Quality be separated into the following Outcomes to properly reflect the Government's priorities in the 2006–07 Portfolio Budget Statements and Budget Bills:
>
> - Health System Capacity and Quality (Outcome 10);
> - Mental Health (Outcome 11); and
> - Health Workforce Capacity (Outcome 12).

2.8 Finance specifies the process agencies should undertake when changing Outcome structures and related performance information:

> To change an existing outcome structure, agencies must, in this order:
>
> - consult with the Department of Finance and Deregulation;
> - obtain legal advice to confirm that the new outcomes form 'valid appropriations' under Section 81 and 83 of the Constitution;
> - obtain approval from the Minister; and
> - obtain approval from the Minister for Finance and Deregulation.[69]

2.9 DoHA followed the process set out by Finance to revise agencies' Outcome structure. However, the Outcome statement for Outcome 12 contained in the correspondence between the two relevant Ministers is: *the capacity and quality of the health care system meets the needs of Australians*, whereas the Outcome statement for Outcome 12 contained in DoHA's 2006–07 PB Statements is: *Australians have access to an enhanced health workforce*.[70]

2.10 Outcome statements serve several purposes, including:

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[68] Health and Ageing Portfolio, *Portfolio Budget Statements 2006–07*, Budget Related paper No. 1.11.

[69] <http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/specifyingoutcomes.> [accessed 18 November 2008].

[70] Health and Ageing portfolio, *Portfolio Budget Statements 2006–07*, Budget related paper 1.11.

- defining the impacts government expects from both the work of the agency (outputs) and the administered items the agency manages;
- articulating the purpose of the relevant appropriations under the Appropriations Acts of the Australian Budget; and
- providing the Parliament, external accountability bodies, agency clients, interest groups and the general public with a clear statement of the broad goals of Government and its agencies.[71]

2.11 For these reasons, Outcome statements form a key component of the Government's accountability framework.

2.12 Concerning the inconsistency between the Outcome statement agreed to by the relevant Ministers and that which appeared in DoHA's PB Statements, the department advised:

> there was a breakdown in the administration process with documenting the development of the Outcome 12 statement in 2006–07 within the Department of Health and Ageing. However, it is clear that agreement from the then Minister of Finance and Administration was obtained, as the correct wording was published in the 2006–07 Appropriation Bill (No.1) and Budget Paper No.4.[72]

Improved transparency and accountability of government expenditure

2.13 The Minister for Finance and Deregulation, the Hon Lindsay Tanner MP announced a set of reforms (Operation Sunlight) to improve the transparency of government financial information. The key objectives of Operation Sunlight are to:

- tighten the Outcomes and Outputs framework;
- change Budget papers to improve their readability and usefulness;
- improve the transparency of Estimates;
- expand the reach of Budget reporting;
- improve inter–generational reporting; and

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71 <http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/specifyingoutcomes> [accessed 18 November 2008].

72 Departmental email, 25 November 2008.

- improve the financial framework.[73]

2.14 Finance has commenced a review of all outcomes to improve the specificity of outcomes and their consistency across government with the aim of restoring an appropriate focus on tangible and measurable outcomes. This is for consideration in the 2009–10 Budget.

2.15 DoHA is currently reviewing its outcome statements with Finance and considers that the review will enable the department to better reflect its role.

2.16 The review will focus on improvements in agency PB Statements so that they are relevant, strategic and are performance oriented. The intention is to ensure that readers of PB Statements have a clear and transparent account of an agency's planned performance for the Budget year and the resources to be used. The Government's financial information reform process provides DoHA with an opportunity to more closely align its publically reported performance information with its contribution to the Government's Health Workforce Capacity outcome.

[73] <http://www.finance.gov.au/financial-framework/financial-management-policy-guidance/operation-sunlight/index.html> [accessed 9 January 2009].

3. DoHA Strategies for Health Workforce Capacity in Rural and Remote Australia

This chapter assesses DoHA's risk management, business planning and performance information management strategies, concerned with the achievement of Outcome 12.

3.1 Strategic management is the systematic process of analysis by which a department aligns itself to its operating environment and makes decisions about the most appropriate options, or strategies, for achieving the outcomes required by government. If departmental strategies are not properly focused, organisational directions and priorities may have a poor relationship to important factors for the achievement of the desired outcomes, and critical aspects of responsibility and accountability.

3.2 Systems and processes are an important part of a strategic approach as they assist organisations identify risks to the achievement of the planned outcome; develop business plans in this context and through performance information arrangements monitor whether or not the strategy is working.

3.3 It is important that there is alignment between the high–level strategy articulated at the enterprise level and business operations so that they remain consistent with the overall purpose of the agency.[74]

3.4 Most public sector organisations have in place desirable elements of good governance including: corporate plans setting out corporate objectives and strategies; public sector and/or agency values; business planning incorporating control structures such as risk management; and performance monitoring arrangements (including evaluation and review).

3.5 However, in 2003, the then Auditor–General noted that:

> what many agencies seem to lack is a credible way to integrate these elements into a unified, mutually reinforcing complete structure. This involves a consistent, strategic approach to good governance so that good governance

[74] Department of Finance and Deregulation, November 2000, *Specification of Outcomes and Outputs Guidance Document*, p. 31.

practice is successfully integrated with, and supports the way Commonwealth departments and agencies do business.[75]

3.6 Aspects of DoHA's internal arrangements that influence its approach to health workforce capacity issues, include:

- the department's approach to risk management;
- DoHA's Corporate Plan;
- Divisional risk and business planning; and
- performance information arrangements.

3.7 In this chapter, the ANAO examined the strategies—risk and business planning and performance information—that DoHA has in place at the enterprise and divisional levels concerning health workforce capacity in rural and remote Australia. Future directions concerning the re-establishment of the Office of Rural Health are also considered. Chapter 4 examines how these high–level strategies transfer and are aligned with strategies adopted at the program level. This examination is conducted through an assessment of eight health workforce capacity programs in rural and remote Australia.

The department's approach to risk management

3.8 Risk identification, assessment and treatment are a critical part of an agency's strategy to deliver the Government's objective. Risk management should be part of the strategy and planning processes, rather than a back-end control.[76]

3.9 Risk is defined as 'the chance of something happening that will have an impact on objectives'.[77] The Australian Standard defines the Risk Management Process as 'the systematic application of management policies, procedures and practices to the tasks of communicating, establishing the context, identifying, analysing, evaluating, treating, monitoring and reviewing risk'.[78]

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[75] Pat Barrett, Auditor–General of Australia, August 2003, speech to the National Institute for Governance, *Better Practice Public Sector Governance*, p. 10.

[76] ANAO *Better Practice Guide – Public Sector Governance*, 2003, p. 20.

[77] Standards Australia, *Risk Management*—AS/NZS 4360:2004.

[78] ibid.

DoHA's Risk Management Framework

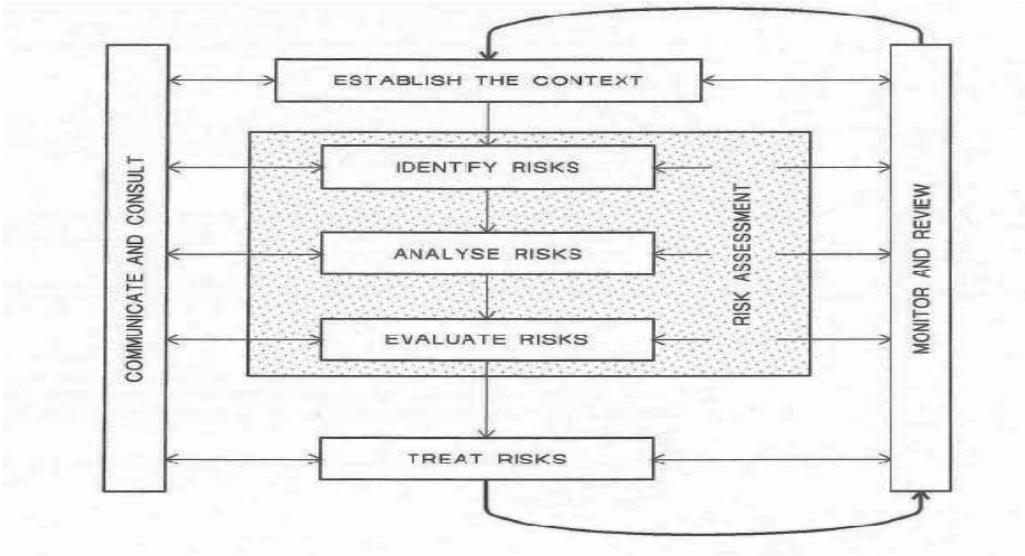
3.10 The department's Risk Management Framework, as approved by the Secretary, is aligned with the Australian/New Zealand Risk Management Standard (AS/NZS 4360:2004). AS/NZS 4360:2004 is a generic guide for managing risk. The standard sets out the key elements of the risk management process and acknowledges that the design and implementation of a risk management system will be influenced by the needs of an organisation, its objectives, its products and services, and the processes and specific practices employed.[79]

3.11 One of the objectives of the standard is to provide guidance to assist organisations achieve a more confident and rigorous basis for decision–making and planning.[80]

3.12 Figure 3.1 presents the risk management process set out in AS/NZS 4360:2004.

Figure 3.1

AS/NZS 4360:2004 Risk Management Process - Overview



Source: Standards Australia.

[79] ibid.

[80] ibid.

3.13 The main elements of the risk management process set out in the standard are:

- *communicate and consult*—with internal and external stakeholders;
- *establish the context*—sets basic parameters in which the risk will be managed and sets the scope for the remainder of the risk management process;
- *identify risks*—source where, when, why, how events could impact on achievement of the objective;
- *analyse risks*—identify existing controls and where gaps exist;
- *evaluate risks*—the rating of risks enables decisions to be made about extent and nature of treatment required;
- *treat risks*—develop and implement cost effective strategies to mitigate risks; and
- *monitor and review*—monitor the effectiveness of all steps of the risk management process.[81]

Enterprise Risk Management Plan

3.14 An Enterprise–wide Risk Management approach is a structured and disciplined alignment of strategy, processes, people, technology and knowledge to evaluate and manage the risks/uncertainties that may prevent an agency from achieving its business objectives.[82] Risk management is core to effective public administration, with high-level risks normally monitored and managed at executive levels.

3.15 In the 2007 Enterprise Risk Management Plan (ERMP), DoHA identifies as a challenge:

> the need to predict and analyse future health trends in terms of both the level of demand for services and the ever increasing number of potential supply options (and their associated costs). The Department needs to predict these trends accurately, and then advise the Australian Government on the best distribution of available resources to meet overall health and ageing objectives.[83]

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81 ibid.

82 Adapted from Arthur Anderson, 2000, *Managing risk, managing value*.

83 Department of Health and Ageing, October 2007, *Enterprise Risk Management Plan*.

3.16 DoHA's ERMP identifies those enterprise level risks that may have an adverse impact on the Department's ability to achieve its Portfolio Budget Statements (PB Statements) Outcomes and/or other corporate objectives. The ERMP includes one of its key risks as: *insufficient supply of adequately trained personnel to work in the health sector*. This is a national risk that has been made the responsibility of the Mental Health and Workforce Division (MHWD).

Establish the context

3.17 Establishing the context is fundamental to the risk management process as this step enables the definition of the agency's external and internal environment and the purpose of the risk management activity. This step also includes consideration of the interface between the external and internal environments and their capacity to affect agency risks.[84]

3.18 While the ERMP identifies the sources[85] of the risk and the consequences of the risk eventuating (see paragraph 3.22), little preliminary work has been undertaken within the department to establish the context of the risk thereby facilitating the development of appropriate risk management actions.

3.19 When Outcome 12 was established in the 2006–07 Budget, DoHA's PB Statements acknowledged the potential challenge to achieving the Outcome when it stated: 'meeting the Government's workforce objectives will require working collaboratively with a range of bodies and the States and Territories.' While the importance of elaborating this external context was recognised, it was not evident that further work was undertaken by the department to identify its area of responsibility and define a treatment regime for the enterprise–wide risk appropriate to its level of responsibility and control.

3.20 The ERMP identifies four controls to mitigate the likelihood of the risk eventuating:

- mapping and analysis unit created to collect and analyse information (workforce size, sectors, and geographical presence) to improve evidence–based policy making;

[84] Standards Australia, op cit, p. 12.

[85] Sources of the risk are identified as a shortage of appropriately skilled health sector workforce – Doctors, Nurses and Dentists; a lack of data on doctors' distribution (all sectors) and population shifts to adequately inform decision–making on health workforce policy; and responsibility and funding uncertainties between Commonwealth and State Governments.

- protocols in place for out-posting staff and/or external advisors to relevant health workforce program areas/locations;
- active participation in COAG and the Australian Health Ministers' Advisory Committee (AHMAC), the Australian Health Care Agreements and the Public Health Funding Agreement; and
- utilising DoHA's communication and media unit to target the Health Sector Workforce.

3.21 Monitoring and reviewing the effectiveness of all steps of the risk management process is a key feature of AS/NZS 4360:2004. Two reports were provided to DoHA management in 2007–08 on this enterprise-wide risk. However, the second ERMP report gives no indication whether the treatments applied by DoHA have been progressed and are having the desired impact.

3.22 DoHA has acted to manage an enterprise level risk that may have an adverse impact on the Department's ability to achieve its PB Statements Outcomes and/or other corporate objectives and the department recognises the significant, adverse consequences of having an *insufficient supply of adequately trained personnel to work in the health sector,* in particular:

- the public is not provided with adequate health care, particularly rural and Indigenous sectors; and
- DoHA is unable to achieve PB Statements Outcomes, particularly 12.1 which aims to increase the number of health care professionals and ensure they are well trained to practise in rural areas.

3.23 While the department has a high level framework in place to manage its strategic risks including: *insufficient supply of adequately trained personnel to work in the health sector*, there are aspects of the department's management of this risk that could be improved including:

- a renewed effort on establishing the context for the risk so that DoHA is able to identify which aspects of the enterprise-wide risk it is able to manage and which are under the control of external parties; and
- specific attention to monitoring and reviewing the effectiveness of treatment measures and regular reporting to management.

DoHA's Risk Management Policy

3.24 The department's 2005 Risk Management Policy recognises the importance of alignment between the key elements of a governance

framework, including risk management and planning to moderate enterprise risks. The Policy states that:

- risk management is an essential element of sound business planning and decision making in the current public sector environment;
- risk management principles are to be applied and integrated into all the Department's strategic planning, business planning, policy development, program delivery, project management, grant management, procurement, service/product delivery, and all other decision making; and
- enterprise risks are strategic in nature and may impact upon the achievement of the Department's objectives (as stated in the Corporate Plan).[86]

DoHA's Corporate Plan

3.25 In the 2006–09 Corporate Plan, the Secretary sets out how DoHA will succeed in its vision: *better health and active ageing for all Australians*. This includes: 'anticipating opportunities and what might go wrong, and managing risk'.[87]

3.26 DoHA's Corporate Plan 2006–09 includes a focus on health workforce issues:

> working together with the States and Territories to reduce duplication and gaps, and to deliver efficient, value-for-money health and aged care services through an adaptable and sustainable health and aged care workforce.

3.27 In the preamble to the Corporate Plan, DoHA's Secretary notes that to achieve the direction outlined in the Plan, team leaders and staff can only genuinely contribute when they have a direct 'line of sight' from their own work through to the department's priorities, values and responsibilities.

3.28 While DoHA has an overarching framework in place, through its Corporate Plan, to assist business groups to manage risks likely to impact on the achievement of business objectives, a challenge in any large organisation is maintaining ongoing alignment between corporate strategies, business plans and individual programs. This approach is influential in ensuring that the

[86] Department of Health and Ageing, 2005, *Risk Management Policy*.

[87] Department of Health and Ageing, 2006–09, *Corporate Plan*.

strategies adopted by an organisation to manage its risks, to undertake its planning, and to monitor and report on its performance are integrated at all levels.

Performance information management arrangements

3.29 Performance information management refers to an integrated system of performance information, evaluation, performance monitoring, assessment, and performance reporting. Key components of performance are effectiveness, efficiency and service quality. Performance management in the Australian Public Service has the primary concern of aligning individual, program, and divisional performance with corporate plans and outcomes.

3.30 The public sector is reliant on explicit performance measures not only for its own operations, but in contracting arrangements with third party service deliverers. These measures are, in part, a substitute for the price signals that operate in a competitive market.[88]

3.31 This section examines DoHA's performance framework, including:

- the departmental performance framework; and
- the structure of performance information.

Departmental performance framework

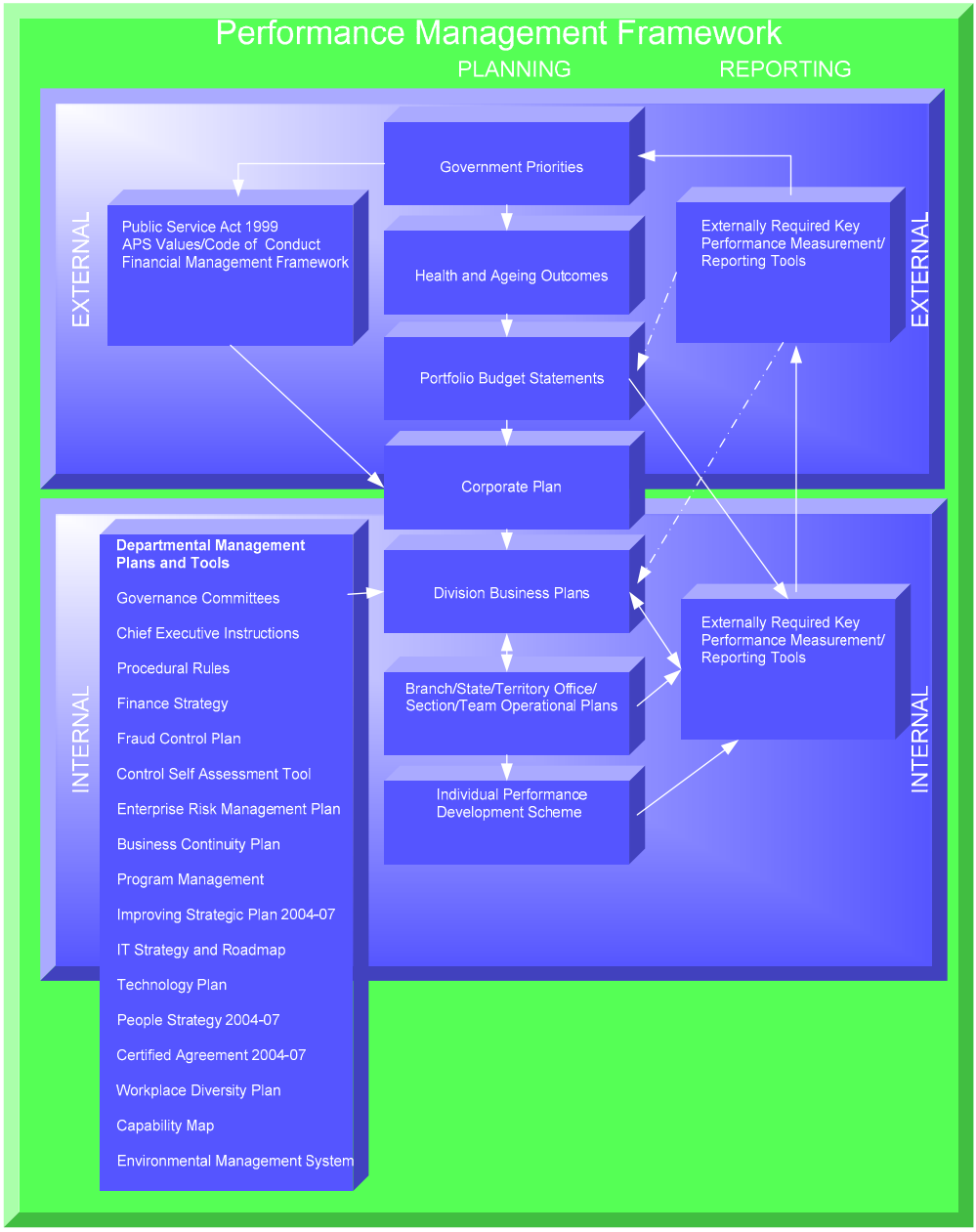
3.32 DoHA's activities, resourcing and performance reporting are organised under a structure of 15 Outcomes including Outcome 12—Health Workforce Capacity. DoHA has adopted the practice of describing its core activities by generic Output groups across its Outcome structure. These Output groups are: Program Management and Policy Advice.

3.33 Figure 3.2 illustrates DoHA's performance framework. This framework guides the department's planning and resource management, assists it to meet its obligations as an Australian Government agency, and promotes continuous improvement through evaluation.

[88] Chris Aulich, John Halligan and Sandra Nutley (eds), 2001, *Australian Handbook of Public Sector Management*, Allen & Unwin, Sydney, p. 125.

Figure 3.2

DoHA's Performance Management Framework



Source: Department of Health and Ageing, *2006–09 Corporate Plan*.

The structure of performance information

3.34 Government policy details for agencies the dual purpose of performance information in the Outcomes and Outputs framework.[89] Firstly, it provides timely feedback on the performance of agency outputs and administered items so that agencies can take action, if required, over the course of the budget year to ensure that the expectations of government and the agency can be met. In this context, performance information makes a valuable contribution to well–informed agency decision–making.

3.35 Secondly, the purpose of performance information is to assist stakeholders, principally Parliament, to draw informed conclusions about performance in published documentation—performance for a particular year is foreshadowed in agency PB Statements and actual performance for that year is reported through agency annual reports. In this context, it is important that performance information is structured in ways which clearly demonstrate how an agency's outputs and administered items contribute to the achievement of the outcomes sought by the Government and for which agencies are responsible.[90]

3.36 The 2008–09 Health and Ageing PB Statements describe performance information for DoHA:

> the Department measures its success in achieving the Australian Government's objective for health and ageing by setting performance indicators for each outcome. These performance indicators are directly aligned with the programs managed by the Department. They are also pitched at a high level to allow for meaningful reporting of outcomes and achievements in the annual report.[91]

Performance information is about results and impacts not processes and activities

3.37 Finance requirements include that agencies' PB Statements are to ensure that information, specifically in articulating contributions to outcomes, is focused on the results and impacts planned by the agency and not on the

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89 <http://www.finance.gov.au/financial-framework/financial-management-policy-guidance> [accessed 9 January 2009].

90 Mark Nizette, 2001, *Program performance reporting and evaluating in Australia*, p. 5.

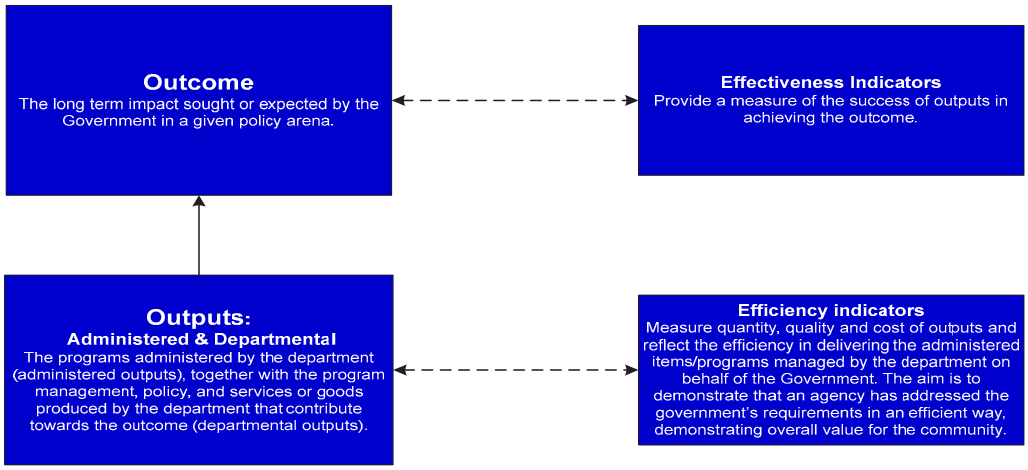
91 Health and Ageing Portfolio, *Portfolio Budget Statements 2008–09*, Budget Related Paper No. 1.10.

processes which are facilitating the results. Performance information needs to show the impacts of outputs and administered items on outcomes.[92]

3.38 Figure 3.3 illustrates how departmental and administered outputs in combination contribute to the achievement of an Outcome, with effectiveness indicators providing a measure of the success of outputs in achieving the Outcome.

Figure 3.3

Measuring performance



Source: ANAO.

Outcome statements

3.39 Finance policy guidance advises that outcome statements:

> should, amongst other things, be specific, measurable, stated in such a way as to allow the relevant target group(s) to be identified and enable the formulation of sound effectiveness indicators to measure the impact of departmental outputs and administered items on the desired outcome and be free of vague, value–laden or inspirational language.[93]

3.40 The ANAO recognises the challenges departments face to accurately demonstrate their contribution to high-level and long-term outcomes. An ANAO survey of a number of agency PB Statements, conducted in 2005–06,

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92 Department of Finance and Deregulation, March 2008, *Portfolio Budget Statements Constructors Kit*, p. 7.

93 <http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/specifyingoutcomes> [accessed 9 January 2009].

found that outcome statements were expressed in broad terms and did not specify the result or impact to be achieved and included terms such as 'enhance, advance, contribute to or benefit' with no indication of the degree of enhancement, advancement, contribution or benefit to be achieved.[94]

3.41 Nevertheless, to inform the Parliament that funds that are appropriated for a specific purpose are actually being spent on activities to achieve that purpose, departments need to develop comprehensive performance information management arrangements, including effectiveness indicators.

Performance reporting documentation

3.42 Agencies' PB Statements and Annual Reports are the two principal documents by which agencies identify and report on their accountability responsibilities.

3.43 One of the principles underpinning Finance's revised guidelines for PB Statements for 2008–09 is the inclusion of a Strategic Outlook. As a result, performance information would include discussion on the department's short, mid and long-term strategies for delivering on Australian Government objectives. In stating the planned contributions to outcomes and in setting performance targets, a tangible link is made between Australian Government objectives and resources, and setting the benchmarks by which their performance can be measured.[95]

3.44 A key feature of annual appropriations under the Appropriation Acts is that appropriations, for administered items, are tied to a particular agency Outcome, that is, there is a clear indication from Parliament that it is authorising expenditure for a particular purpose.[96]

3.45 A mechanism to ensure the accurate reporting of this requirement is through agencies' annual reports.

3.46 Previous ANAO audit reports have identified areas for improvement in the specification, measurement and reporting of outcomes:

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[94] ANAO Audit Report No.23 2006–07, *Application of the Outcomes and Outputs Framework*, pps. 45-46.

[95] Department of Health and Ageing, Internal Guidance—Instructions for producing Outcome Chapters.

[96] ANAO submission to the Senate Finance and Public Administration References Committee, 2006, *Inquiry into the Transparency and Accountability of Commonwealth Public Funding and Expenditure*.

in order to provide accountability and transparency to Parliamentarians and other stakeholders, agencies' annual reporting frameworks need to be improved, particularly in relation to:

- the specification of agencies influence on, and contribution to, shared outcomes;
- performance measures relating to quality and effectiveness/impact;
- the efficiency of agency operations and the cost effectiveness of outputs delivered; and
- targets or other basis for comparison.[97]

3.47 ANAO findings concerning the implementation of the department's performance management framework for Outcome 12 are discussed at paragraph 3.81.

Divisional risk management and business planning

3.48 This section examines:

- DoHA's Mental Health and Workforce Divisional (MHWD) risk and business planning processes and alignment between these and higher-level planning processes; and
- MHWD planning and risk processes for health workforce capacity programs managed and delivered on behalf of other Outcome groups.

MHWD risk management

3.49 The implementation of a risk management framework is a necessary part of ensuring the consistency of risk identification and risk treatment decisions made by an agency. Risk management can be applied at many levels within an organisation, for example, at the strategic level through an Enterprise Risk Management Plan and at the operational level through Division and Branch risk management plans. Alignment between these levels will help to ensure that strategic and operational risks are managed consistently.

[97] ANAO Audit Report No.11 2003–04, *Annual Performance Reporting*.

3.50 DoHA's Risk Management Policy advises that:

> risk management principles are to be applied and integrated into all the Department's strategic planning, business planning, policy development, program delivery, project management, grant management, procurement, service/product delivery, and all other decision making.[98]

3.51 When integrating risk management, it is important to consider an agency's operating environment and, through deliberate planning, consider how risk management processes can be embedded into management activities such as business planning, decision making and reporting.[99]

3.52 DoHA's Risk Management Policy sets out the preferred departmental approach to managing risks at the business group level:

> Division risk management involves consideration of risk(s) that may impact upon the achievement of Division business activities (as stated in respective business plans derived from the Corporate Plan). As such, enterprise risk management and Division risk management are inherently linked. Consequently, enterprise risks are managed at the Division level (where appropriate).[100]

MHWD business planning

3.53 As required by departmental policy set out in the 2005 Risk Management Policy, lower level planning documents, such as Divisional Business Plans, should be aligned with overarching strategic priority areas, including risk management.

3.54 The MHWD Business Plan was developed in September 2007. In November 2007, the department conducted a Review of Divisional Planning processes. A key finding of the Review was: *the lack of incentive for rigorous planning, given the lack of a clear relationship between plans, budgets and priorities.*[101]

3.55 The internal review also highlighted areas for improvement in Divisional Planning processes, including:

- better links between planning and performance;

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98 Department of Health and Ageing, 2005, *Risk Management Policy*.

99 Comcover, June 2008, Better Practice Guide, *Risk Management*, p. 28.

100 Department of Health and Ageing, 2005, op cit.

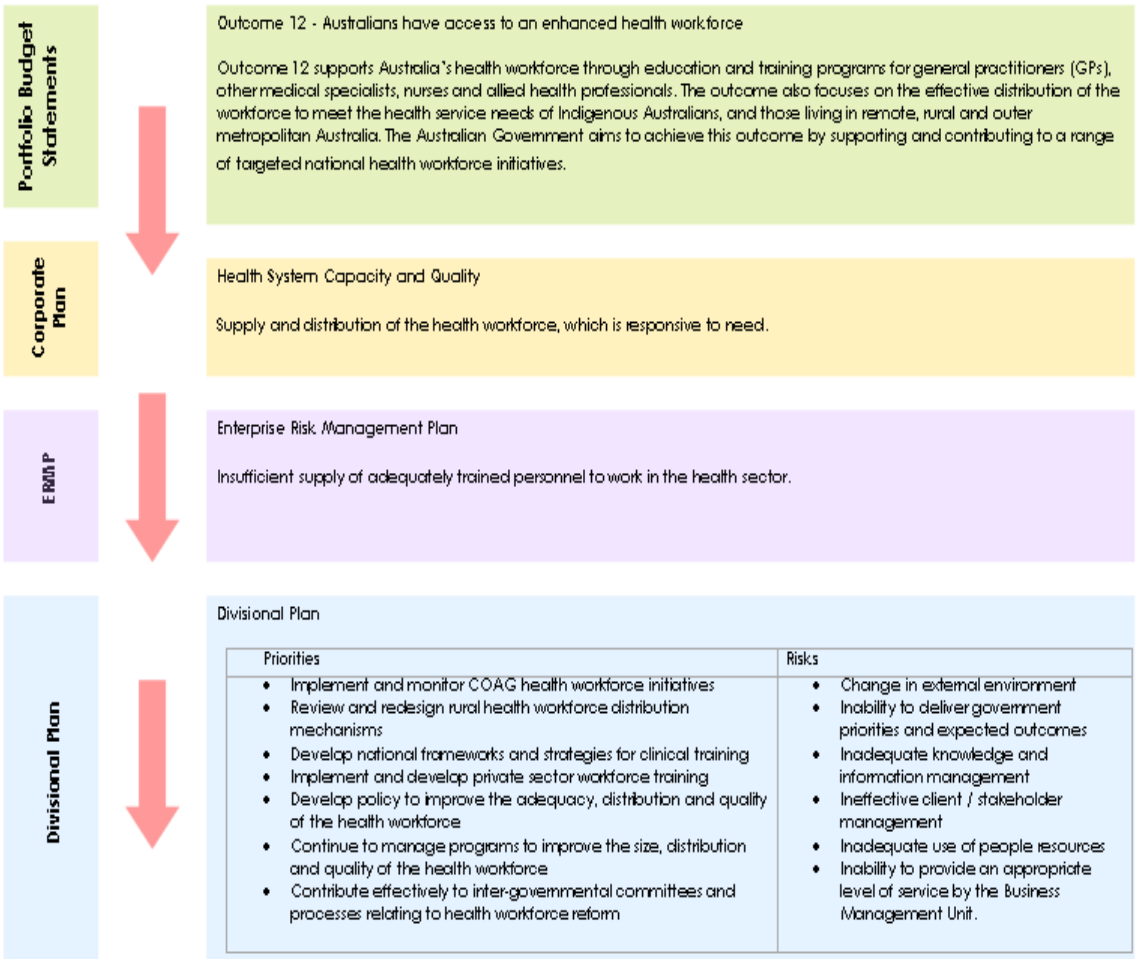
101 Department of Health and Ageing, 2007, *A Review of Divisional Planning Processes*.

- better links, in 'line of sight' between PDS (Personal Development Scheme), branch operational plans, divisional plans, the corporate plan and departmental and government priorities, as spelled out in Annual Reports and Portfolio Budget Statements (PB Statements);
- better links between business and workforce planning and budgeting; and
- better integration of risk management and implementation issues.

3.56 Figure 3.4 sets out MHWD's approach to risk and business planning and alignment with higher level risk and corporate planning.

Figure 3.4

MHWD approach to risk and business planning



Source: Mental Health and Workforce Division, DoHA.

3.57 Table 3.1 lists three of the six risks identified in the MHWD business plan, the treatments applied and the actions supporting these treatments. These three risks are specifically related to health workforce capacity issues.

Table 3.1

MHWD's approach to risk management

Risk	Treatment	DoHA Actions
Change in the external environment	• Better sharing of knowledge and information. • Development of better business cases, including risk management.	• Program management meetings held regularly to discuss health workforce, develop strategy papers and share information on current issues. • Comprehensive feedback on Secretary's meeting provided to MHWD Executive Group each week. • Round tables held on workforce matters.
Inability to deliver government priorities and expected outcomes	• Increase emphasis on staff training and development. • Maintain optimal resource levels. • Ensure a consistent message is provided to the Department and to stakeholders regarding the agenda and activities of the Division. • Improve the quality of forecast program budgets and funding/spending profiles. • Early attention to areas of anticipated policy consideration. • Priority given to issues raised by the Minister, the Minister's Office and the Departmental Executive.	• Workforce policy training provided to a number of staff. • Quality of budget forecasts improved as evidenced by a reduced program underspend in 2007–08. Reports discussed once a month at the MHWD Executive meeting. • A stakeholder database was developed and implemented to inform staff of issues and messages before they meet with stakeholders. • Program management meetings held regularly to discuss health workforce, develop strategy papers and share information on current issues. • Program Fact Sheets developed to provide consistent information on each program, including information regarding the current status of the programs.
Inadequate knowledge and information management	• Increased focus on staff development and retention, and better succession planning. • Increased staff training and development in the use of available information management systems and tools. • Better sharing of knowledge and information. • Further consideration of part-time employment.	• Workforce policy training provided. • Response to the Staff Survey includes the establishment of a working group with staff from across MHWD with a focus on retention of staff. • Trialled use of the program database that contains the program fact sheets. Staff now being trained for a full roll out to all Directors. • Program Fact Sheets provide a guide to the programs that has proved useful in handing over programs. • Workforce program meetings, round tables and MHWD executive meetings sharing information. • Establishment of the Mapping and Analysis Unit to improve data and information management.

Source: Mental Health and Workforce Division, DoHA.

MHWD manages health workforce capacity programs for other Outcome groups

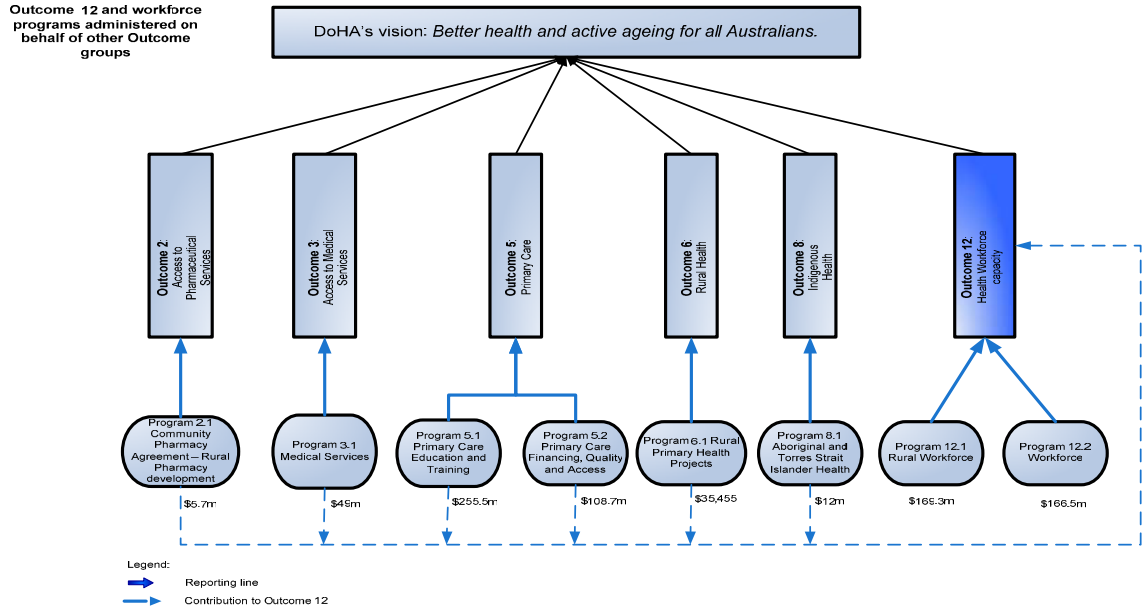
3.58 Figure 3.5 identifies health workforce capacity program areas managed and delivered by the MHWD. These include those focussed on the rural health workforce—Outcome 12—Program 12.1 and the health workforce (in general), Outcome 12—Program 12.2. As illustrated in Figure 3.5, MHWD administers workforce programs for a number of other DoHA Outcome groups: Outcome 2—*Access to Pharmaceutical Services*; Outcome 3—*Access to Medical Services*; Outcome 5—*Primary Care*; Outcome 6—*Rural Health;* and Outcome 8—*Indigenous Health*.

3.59 Total administered expenditure for 2007–08 for all programs managed by MHWD was around $756 858 030, including administered expenditure for Outcome 12 programs of around $333 772 000.

3.60 Figure 3.5 provides details on administered expenditure for Outcome 12 programs and related programs from other Outcome groups.

Figure 3.5

Outcome 12 health workforce programs and contributing programs from other Outcome groups



Source: ANAO, based on DoHA information.

3.61 The MHWD's Business Plan sets out a number of priorities/objectives for Outcome 12 and related health workforce capacity programs it manages for other Outcome groups, including Outcome 5—*Primary Care* and Outcome 8—*Indigenous Health*. Priority/objectives have not been set for programs managed for other Outcome groups: Outcome 2—*Access to pharmaceutical services*, Outcome 3—*Access to medical services* and *Outcome 6—Rural Health*.

3.62 One of the priorities/objectives for Outcome 5 programs is:

- implement and manage programs to improve the size, distribution and quality of the primary care health workforce.[102]

3.63 This priority/objective has characteristics similar to an Outcome 12 priority/objective:

- continue to manage programs to improve the size, distribution and quality of the health workforce.[103]

3.64 MHWD manages programs 'from a range of Outcomes within the Portfolio Budget Statements'. In 2006–07, administered expenditure for these programs totalled $423 086 030. The department's current management strategies do not take into account the risks involved in designing, managing and reporting the department's cross–portfolio activities in the area of rural and remote health workforce capacity. This increases the risk of program overlap and duplication and program objectives not being sufficiently aligned. The risk of inefficient program administration also increases.

3.65 To moderate these risks, MHWD's business planning needs to identify and treat the risks associated with managing programs 'from a range of Outcomes within the Portfolio Budget Statements' so that programs are delivered in an effective and coordinated manner to ensure that: *Australians have access to an enhanced health workforce* in rural and remote communities.

Reporting against business plans

3.66 MHWD reports on a quarterly basis to the department's Planning and Performance Committee on progress against its Business Plan. This includes information on performance against targets, and identifies emerging risks,

[102] Mental Health and Workforce Division, 2007, op cit.

[103] ibid.

including instances of expenditure slippage. Proposed risk treatments are not developed.

Financial reporting

3.67 MHWD's Financial Services Unit reports each month to the Departmental Executive on administered and departmental expenditure and compares expenditure against budget and whether there is a variance of plus or minus 10 per cent. These reports are presented and discussed at the MHWD's executive meetings in the context of strategic directions. In addition, where the MHWD manages programs 'from a range of Outcomes within the Portfolio Budget Statements', the Financial Services Unit provides the Outcome groups with monthly financial reporting on expenditure.

3.68 The Minister for Health and Ageing established an Office of Rural Health in 2008. The Office has commenced a review of all targeted Australian Government funded rural health programs and will provide advice to Government on the ongoing management, coordination and monitoring of these programs.

3.69 The ANAO has made the following recommendation to assist DoHA's management, co-ordination and monitoring of its health workforce education and training, and distribution initiatives.

Recommendation No.1

3.70 To better co-ordinate the Department of Health and Ageing's workforce education and training, and distribution initiatives, the ANAO recommends that DoHA:

- monitors its treatments of the enterprise risks associated with *insufficient supply of adequately trained personnel to work in the health sector*; and
- where applicable, identifies and acknowledges in its planning processes the activities and potential impacts of other programs and initiatives, concerned with Australia's health workforce.

DoHA response: *Agreed*

Departmental response

3.71 The department agrees with this recommendation noting that it already undertakes these activities and will continue to do so.

Divisional performance information management

3.72 This section examines:

- DoHA's Mental Health and Workforce Division's (MHWD) performance information management arrangements; and
- links between MHWD performance information management for rural and remote health workforce capacity programs and programs that MHWD managed and delivered on behalf of other Outcome groups.

Effectiveness indicators at the Outcome level

3.73 The Government's policy setting for agency performance information requires indicators of effectiveness in terms of the contributions of relevant departmental outputs and administered items to the achievement of the outcome.[104]

3.74 The purpose of effectiveness indicators is to allow an assessment of the extent of the contribution agency outputs/ or administered item outputs makes to specified outcomes and the impact that is achieved. The Department of Finance and Deregulation provides the following guidance on effectiveness measures. Indicators of outcome performance should focus on the effectiveness of government activity in contributing to specified outcomes. There are two types:

- those that relate to the *overall* outcome; and
- those that relate to the *effectiveness* of government's contribution to that overall result, principally through its administered items and the agencies' outputs.[105]

3.75 Reporting on the general trends in the area targeted by the outcome is a useful 'contextual' indicator. Contextual information is helpful in describing the broad environment in which the agency is operating and in developing and communicating policy options. Such indicators, however, should not purport to necessarily represent the agency's contribution to the outcome. That information should be contained in effectiveness indicators.

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[104] <http://www.finance.gov.au/financial-framework/financial-management-policy-guidance> [accessed 9 January 2009].

[105] Department of Finance and Deregulation, November 2000, *The Outcomes and Outputs Framework Guidance Document*.

3.76 Effectiveness indicators require careful design and specification. They do not lend themselves to be as easily characterised as output or administered item indicators. For long term planning and policy purposes, it is important that the best available effectiveness indicators are indentified and reported against. It is therefore up to agencies, in close consultation with their Ministers and stakeholders, to identify realistic, useful and relevant effectiveness indicators to help those interested in the agency and/or the administered items it manages to better understand their value in terms of specific policy outcomes.[106] Indicators of effectiveness seek to draw out the specific effects caused by agencies and filter out the impact of other influences.[107]

Finance policy guidance

3.77 Table 3.2 sets outs Finance policy guidance which suggests criteria agencies can use to develop relevant effectiveness indicators.

Table 3.2

Criteria to identify relevant effectiveness indicators

Criteria	Elements of relevant effectiveness indicators
Criterion 1	the degree to which they reflect the terms of the specified outcome
Criterion 2	the degree to which they relate to the appropriateness of the specified output(s) or administered item(s) in contributing to the specified outcome
Criterion 3	the degree to which they encompass contributions to the outcome by all relevant outputs and/or administered items
Criterion 4	the degree to which they account for factors outside the direct or indirect influence or control of the agency and/or government policy mechanisms (i.e. in relation to administered items)

Source: Department of Finance and Deregulation, November 2000, *The Outcomes and Outputs framework Guidance Document*.

3.78 Finance advises that none of these criteria is an absolute. There are few (if any) effectiveness indicators which will always entirely reveal the appropriateness of the output or administered item as well as measure *all* its contributions—and *only* its contributions—to the outcome. The intention, however, is to come as close as possible to this ideal.

[106] ANAO Audit Report No.23, 2006–07, op cit.

[107] Department of Finance and Deregulation, March 2008, *Portfolio Budget Statements Constructors Kit*, p. 88.

3.79 The ANAO reviewed performance information in the Health and Ageing 2008–09 PB Statements and found that there were no effectiveness indicators in place for Outcome 12 or for the other relevant Outcome groups—2, 3, 5, 6, and 8—where the MHWD has responsibility for co-ordinating, planning and managing rural and remote health workforce capacity programs.

3.80 The performance measures that DoHA has in place focus on outputs, for example, the number of student scholarships provided and the number of nurses re-entering the workforce.

3.81 These measures do not capture the intended impact of Outcome 12. For DoHA to be in a position to determine whether Outcome 12 is delivering as planned, it needs to develop and make use of appropriate effectiveness indicators. Such indicators should be designed to inform Parliament, and DoHA about:

- the quality of the health workforce and its distribution across Australia; and
- the level of access to health services by Australian citizens including those in rural and remote areas.

Contextual/trend indicators

3.82 In DoHA's PB Statements for 2000–01, the department included in its discussion on performance information for Outcome 5: *Rural Health* that a national set of rural health performance indicators would be developed cooperatively with State and Territory counterparts. It was planned that during 2000–01 the following data sets would be collected.

Access

- **Indicator 1**: Access to health and allied health services for people living in regional, rural and remote locations:
  - **Measure**: Could include numbers of health practitioners per head of population; measures of access to specified health facilities; and service utilisation rates under the Medicare Benefits and Pharmaceutical Benefits Schemes by geographic location.

Workforce

- **Indicator 2**: Number of health and allied health professionals practising in regional, rural and remote locations receiving education, training and support:
  - **Measure**: Measurement of numbers, by specified health worker type, receiving education, training and other support from Australian Government, State and Territory and professional association programs by geographic location.

Need

- **Indicator 3**: Positive change in health status for people living in regional, rural and remote locations over the longer term:
  - **Measure:** Measures such as death rates and life expectancy rates, injury prevention and control, cardiovascular and other health conditions by geographic location.

Indicator 1: Access to health and allied health services for people living in regional, rural and remote locations

3.83 The ANAO notes that DoHA reported trend data in its Annual Reports against this effectiveness indicator. Table 3.3 provides an analysis of Medicare Benefits Schedule (MBS) outlays per capita in rural and remote Australia compared with other geographic locations over a five year period.

Table 3.3

Medicare Benefits Schedule (MBS) Outlays by regional category per capita, 1998–99 to 2002–03

	Total Benefits per Capita, in dollars (2002-03 prices)				
Region	**1998-99**	**1999-2000**	**2000-01**	**2001-02**	**2002-03**
Capital City	425.68	427.50	425.21	437.39	431.98
Other Metro Centre	407.94	409.50	406.87	420.79	417.14
Rural and Remote	319.33	323.16	329.15	345.82	349.87
Australia-wide	**394.03**	**396.47**	**396.58**	**410.22**	**407.71**

1. Non Farm GDP implicit price deflator used for earlier years for meaningful comparison.
2. Population figures as provided by the Australian Bureau of Statistics (ABS) to 30 June 2001.
3. The figures underlying this table are based on cash not accrual numbers in order to preserve the time series.
4. For MBS the numbers are based on claims processed during the year.
5. The allocation to regional category is based on postcode of patient enrolment.

Source: Department of Health and Ageing, *2002–03 Annual Report*, p. 87.

3.84 In subsequent Annual Reports, the department reported Medicare outlays by State and Territory rather than by geographic location.

3.85 Data collection agencies, such as the Australian Bureau of Statistics (ABS) and the Australian Institute of Health and Welfare (AIHW), often hold well–documented data providing trend information. This can be useful for reporting improvements over the longer term for outcomes such as: *Australians have access to an enhanced health workforce*.

3.86 The AIHW periodically publishes statistics on the medical labour force[108], the nursing and midwifery labour force[109] as well as occasional workforce publications on allied health professions. The primary source of information for these publications is derived from voluntary surveys which are completed by health professionals annually. Labour force aspects include employment characteristics, work activity and geographic work locations. These data sets, especially for the medical and nursing work force have been collected since the mid 1990s. The collections can be analysed over time and as such would provide DoHA with a source of information to illustrate the challenges associated with health workforce capacity in rural and remote Australia.

Indicator 2: Number of health professionals practising in regional, rural and remote locations receiving education, training and support

3.87 Given the lack of integration between the health workforce planning processes of the Australian Government and State and Territory Governments, DoHA could use these AIHW data for dual purposes:

- to portray the larger problem which Outcome 12—*Australians have access to an enhanced health workforce* (including in rural and remote Australia) is seeking to address; and
- to enable DoHA to report specific, planned achievements in line with current targets against the Government's objective.

Indicator 3: Positive change in health status for people living in regional, rural and remote locations over the longer term

3.88 The AIHW also produces a range of publications including a rural health series which provides indictors of health status and determinants of

[108] AIHW, 2004, *Medical Labour Force 2002*.

[109] AIHW, 2005, *Nursing and Midwifery Labour Force 2003*.

health for people living in rural, regional and remote Australia. These statistics could be used to provide a backdrop for DoHA to identify and report on its contribution to: *Australians have access to an enhanced health workforce* (including in rural and remote Australia).

Specific DoHA effectiveness measure/s for rural and remote health workforce capacity

3.89 The use of the above contextual indicators would be beneficial in describing the broad environment in which DoHA is operating. Trends in access, need, and health workforce by region would, however, reflect the combined efforts of Commonwealth, State and Territory Governments. Such 'gross' trends will not necessarily represent DoHA's particular contribution to the outcomes.

3.90 Currently, the degree of administrative control exercised by DoHA on rural and remote health workforce outcomes is relatively limited. DoHA is one of several responsible agencies and if government and community expectations are not being met, it does not necessarily mean that the department is not performing. However, effective accountability requires DoHA to be able to demonstrate the impact of its rural and remote health workforce capacity programs and, while difficult, to assess the specific contribution the department's programs are making towards the achievement of the intended broader outcome.

3.91 More specific indicators of 'net' effectiveness are required to draw out the particular contributions made by DoHA, filtering out the impact of other influences. DoHA could, for instance, obtain an indication as to whether its administration of rural and remote health workforce capacity initiatives was both appropriate and well-performing by surveying and reporting whether the health professionals the department supported had, in fact, changed their

behaviour and moved to or practised longer in a rural area. The following is an example of such an indicator.

Workforce

- **Indicator**: Actions taken by health professionals in receipt of DoHA support:
  - **Measure/s**: Reporting on DoHA expenditure and trend changes in the number of health professionals in receipt of DoHA support moving to, or practising longer, in rural and remote locations.

Measuring the contribution of outputs that contribute to more than one outcome

3.92 Under the financial framework, outputs should be specified in such a way that their contribution to an outcome is measurable. However, there are situations where an output may influence a second outcome. In addition to managing Outcome 12, the MHWD manages a number of outputs/program 'from a range of Outcomes within the Portfolio Budget Statements'. In this circumstance, it is advisable to develop appropriate performance management arrangements which enable the contribution to the achievement of both outcomes to be measured and reported. This includes the development of performance information, including effectiveness indicators, which are capable of measuring the output's contribution to dual outcomes and reporting on this contribution for both Outcomes.

3.93 DoHA's PB Statements does not provide information on the department's strategic approach to co-ordinating, planning and managing program activity across Outcome groups to ensure the successful achievement of the Outcome that: *Australians have access to an enhanced health workforce* (including rural and remote Australia).

3.94 DoHA's 2008–09 PB Statements contains no reference in the Outcome Summaries or related performance information of the contributions of Outcome groups 2—*Access to Pharmaceutical Services*, 3—*Access to Medical Services* or 8—*Indigenous Health* to Outcome 12—*Australians have access to an enhanced health workforce* (including rural and remote Australia). The Summary Statement for Outcome 5—*Primary Care* indicates that the achievement of Outcome 5—*Australians have access to high quality, well-integrated and cost effective primary care*—is jointly managed by the Primary and Ambulatory Care Division (PACD) and the MHWD. Outcome 6—*Rural Heath* is the responsibility of the PACD.

Reporting the contribution of outputs to outcome achievement

3.95 One of the key requirements of agencies' annual reporting functions is to provide a review of performance in relation to the efficiency of the outputs and their effectiveness in terms of achieving planned outcomes.[110]

3.96 In circumstances where a number of Outcome groups are contributing to the achievement of a shared outcome—such as Outcome 12, a reporting mechanism needs to be developed to enable the specification, and the measurement, of the contribution of each Outcome group to the shared Outcome. This would assist stakeholders to gain an appreciation of how government activities are managed and co-ordinated across Outcome groups to achieve a cross-departmental Outcome.

3.97 The lack of effectiveness indicators in DoHA's accountability documents impedes the department's ability to report on the effectiveness of Departmental outputs and administered items to achieving government Outcomes.

The Office of Rural Health

3.98 DoHA's 2008–09 PB Statements notes that:

> the Government will establish an Office of Rural Health to drive the Government's reform agenda in Rural Health. The establishment of this Office represents the first step in the Government's response to the audit of Australia's rural and regional health workforce. Over the next year, the Government will continue to respond to this report through reforms of current geographic classification systems, and review all programs that support rural health professionals and rural health services.[111]

3.99 On 25 June 2008, DoHA's Secretary announced the re-establishment of the Office of Rural Health, within the PACD, effective from 1 July 2008:

> this Office will provide the focal point in the Department both for rural health programs and for initiatives aimed at better aligning distribution of the health workforce with community needs. Responsibility for workforce distribution will therefore transfer from the MHWD to the new Office of Rural Health.

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[110] The Department of the Prime Minister and Cabinet, 2006, *Requirements for Annual Reports for Departments, Executive Agencies and FMA Act Bodies*.

[111] Health and Ageing Portfolio, *Portfolio Budget Statements 2008–09*, op cit.

3.100 The Secretary went on to announce that a senior officer from MHWD would head up the new Office, whilst also maintaining a role with MHWD to ensure ***effective co-ordination of all workforce distribution, education and training initiatives***.

3.101 This announcement reinforces the importance of establishing effective and integrated arrangements across relevant DoHA Outcome groups to achieve the Government's stated Outcome 12: *Australians have access to an enhanced health workforce* (including in rural and remote Australia).

Rural and remote health workforce capacity strategy

3.102 In a complex operating environment where a number of departmental Outcome groups are involved in achieving a stated government outcome, careful management, co-ordination, planning and performance monitoring is required. A department-wide strategy would enable a common approach to be developed across relevant Outcome groups concerning the achievement of Outcome 12. This would include putting in place systems and processes to enable the identification and allocation of responsibilities for the management, planning, coordination, monitoring and reporting of the activities of each contributing Outcome group. Such a strategy would enable DoHA to:

- undertake a comprehensive risk assessment enabling the oversight and monitoring of risks, relating to rural and remote health workforce capacity, at various levels within the department;
- articulate the contribution of each of its relevant Outcome groups to improving health workforce capacity in rural and remote Australia;
- where applicable, identify and acknowledge in its planning processes the activities and potential impacts of other programs and initiatives, concerned with Australia's health workforce;
- establish performance information management arrangements (including effectiveness indicators) for monitoring progress towards health workforce outcomes; and
- develop an evaluation strategy for rural and remote health workforce capacity programs that it administers. (Chapter 6 outlines the value of robust evaluation as a component of an overall strategy to inform decision–makers about the effectiveness of their programs and to inform stakeholders on the contribution of these programs to a long-term government objective.)

3.103 This approach would enable DoHA to maximise the contributions made by the various Outcome groups to improve health workforce capacity in rural and remote Australia and report to Parliament and other stakeholders on progress being made against this shared objective.

3.104 As discussed previously, the Minister for Health and Ageing established an Office of Rural Health in 2008. The Office has commenced a review of all targeted Australian Government funded rural health programs and will provide advice to Government on the ongoing management, coordination and monitoring of these programs. Arising from the review, the department will consider the parameters of evaluation strategies for existing rural and remote workforce initiatives.

Recommendation No.2

3.105 To better inform decision–making on the Department of Health and Ageing's contribution to the Government's health workforce outcomes, the ANAO recommends that DoHA:

- establishes performance information management arrangements, including effectiveness indicators for monitoring progress towards health workforce outcomes; and
- develops an evaluation strategy for the rural and remote health workforce capacity programs that it administers.

DoHA response: *Agreed*

Departmental response

3.106 The department is currently working with the Department of Finance and Deregulation regarding new arrangements for the Portfolio Budget Statements. This will change the structure and format of performance indicators.

3.107 In respect of health workforce data, the Commonwealth has undertaken, as a component of the COAG decision of 29 November 2008, to fund and participate in a National Health Workforce Statistical Register which will improve health workforce information. The National Registration and Accreditation Scheme agreed by COAG is also expected to contribute to improved data. The department notes the ANAO recognition that the Commonwealth's capacity to apply performance indicators to workforce

program outcomes is restricted by the influence of other activities in an environment where the Commonwealth has a limited role.

3.108 The Minister for Health and Ageing announced a review of all rural health programs including workforce programs in April 2008, which will serve the same purpose as an evaluation. The Office of Rural Health has commenced this review of all targeted Commonwealth funded rural health programs.

4. Program Implementation

The Department of Health and Ageing (DoHA) administers around 60 programs directed at workforce distribution, education and training, and health service delivery in rural and remote Australia. This chapter examines the implementation of eight of these programs by assessing the risk and performance information management arrangements in place. The views of stakeholders were also obtained on performance information in their contractual arrangements with DoHA as well as their perception of the effectiveness of DoHA's overall package of rural and remote health workforce capacity programs.

MHWD health workforce capacity programs

4.1 DoHA administers around 60 programs directed at workforce distribution, education and training, and health service delivery in rural and remote Australia 'from a range of Outcomes within the Portfolio Budget Statements'. Outcome 12 includes the majority of workforce distribution, and education and training programs (listed at Appendix 5).

4.2 After consultation with the Mental Health and Workforce Division (MHWD), the ANAO selected six rural and remote health workforce capacity programs to examine in more detail as part of the audit. Health workforce capacity programs are also administered by other Divisions within the department. Because of this, after consultation with the Primary and Ambulatory Care Division (PACD) and the Office of Aged Care, the ANAO selected two further workforce programs for more detailed examination.

4.3 Table 4.1 includes the eight programs (including one pilot) selected.

Table 4.1

Selected rural and remote health workforce capacity programs

Program name	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Specialist Obstetrician Locum Scheme (SOLS)	659 110	12	MHWD	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Nurses in General Practice Training and Support Program (NiGP)	3 921 000	5	MHWD	Australian General Practice Network (AGPN) and State Based Organisations (SBOs)
Rural Australia Medical Undergraduate Scholarship (RAMUS)	6 194 959	12 & 5	MHWD	National Rural Health Alliance (NRHA)
Support, Coordination and Assistance for Overseas Trained Doctors Program (OTDs)	7 575 000	12	MHWD	Rural Workforce Agencies (RWAs), State and Territory Governments and Doctor Recruitment Agencies
Aged Care Nurses Scholarship Scheme (ACNS)	8 417 000	4	Office of Aged Care	Royal College of Nursing Australia (RCNA)
Medical Specialists' Outreach Assistance Program (MSOAP)	15 493 000	6	PACD	Rural Workforce Agencies (RWAs)
Rural Retention Program (RRP)	22 693 000	5	MHWD	Administered by Medicare Australia
Training for Rural and Remote Procedural GPs Program (TRRPGPP)	24 765 000	5	MHWD	Administered by Medicare Australia

Source: ANAO.

Note: Mental Health and Workforce Division (MHWD) and Primary and Ambulatory Care Division (PACD).

4.4 As is common with the majority of health workforce capacity programs, these programs are contracted out to a range of third party organisations involved in either health delivery or health promotion advocacy work.

The key elements of a program

4.5 A program consists of a group of government–mandated activities that contribute to a common strategic objective. A program has several key elements, including:

- clear objectives that are stated in terms of intended outcomes in relation to identified need;
- specified resources, strategies, activities, and processes;
- clearly identifiable management (including attention to program risk) and accountability arrangements; and
- performance information.

4.6 The collection of program level performance information complements the information aggregated at the outcome level.

4.7 In this chapter, two key elements of program implementation were assessed across the eight health workforce capacity programs. They are: risk management and performance information management.

Program risk management

4.8 In Chapter 3, the ANAO examined the high level risk management framework in place at the corporate and Divisional levels and the alignment between these two levels.

4.9 This section assesses how the MHWD treats risk at the program level and alignment with elements of the higher level framework.

4.10 There are many levels of risk management during the program cycle, including:

- program design and implementation;
- assessment of applications from service providers; and
- administration of funding arrangements with service providers.

4.11 It is important to examine the relationship between program areas and an agency's overarching risk management framework to ensure consistency in the approach to risk management process and practice.[112] Alignment between the identification of program level risks, Divisional risks and departmental strategic risks is a key feature of a risk management approach. Departmental guidance and advice should assist program managers to have an appropriate

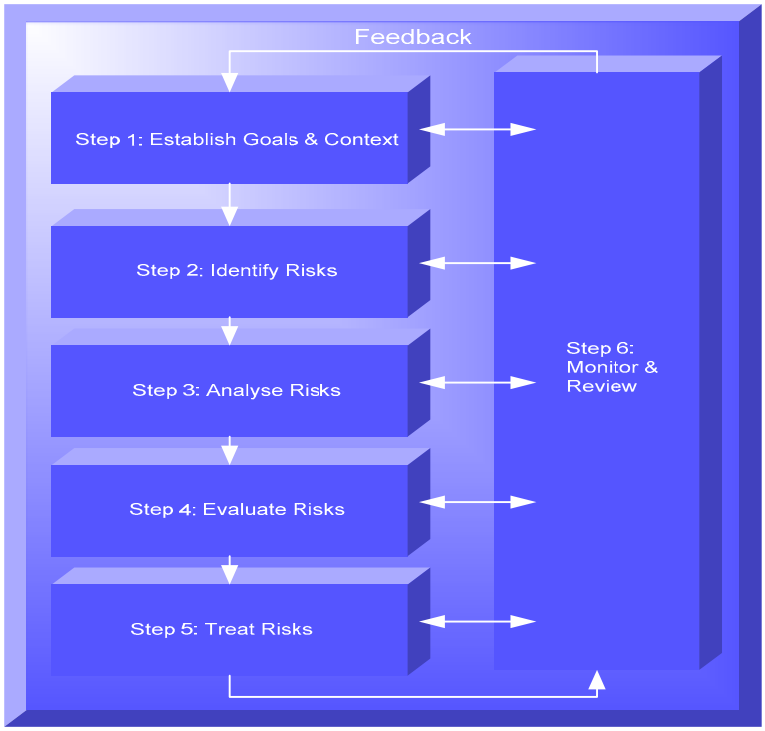
[112] Comcover, op cit, p. 29.

risk management strategy in place to identify, analyse and treat program level risks that relate to DoHA's core business.

4.12 Individual program risk management plans were assessed against the department's internal guidance on risk assessment and management, which is outlined in the DoHA *Risk Management Toolkit*. Figure 4.1 illustrates the steps to managing risk provided in the DoHA guidance. These steps are derived from the AS/NZS 4360:2004 Standard on Risk Management.

Figure 4.1

DoHA steps to managing risk



Source: Department of Health and Ageing, *Risk Management Toolkit*.

Program risk assessment criteria

4.13 The ANAO adapted the steps set out in the Risk Management Toolkit as program level risk management criteria. In addition to these six criteria, two additional audit criteria were included in the assessment to determine if there were clear links between high-level enterprise wide risks, Divisional risks and program level risks. These risk management audit criteria are:

- is there a link between the program level risks and the DoHA enterprise risk: *insufficient supply of adequately trained personnel to work in the health sector*? and
- is there a link between the program level risks and MHWD risks?

ANAO analysis

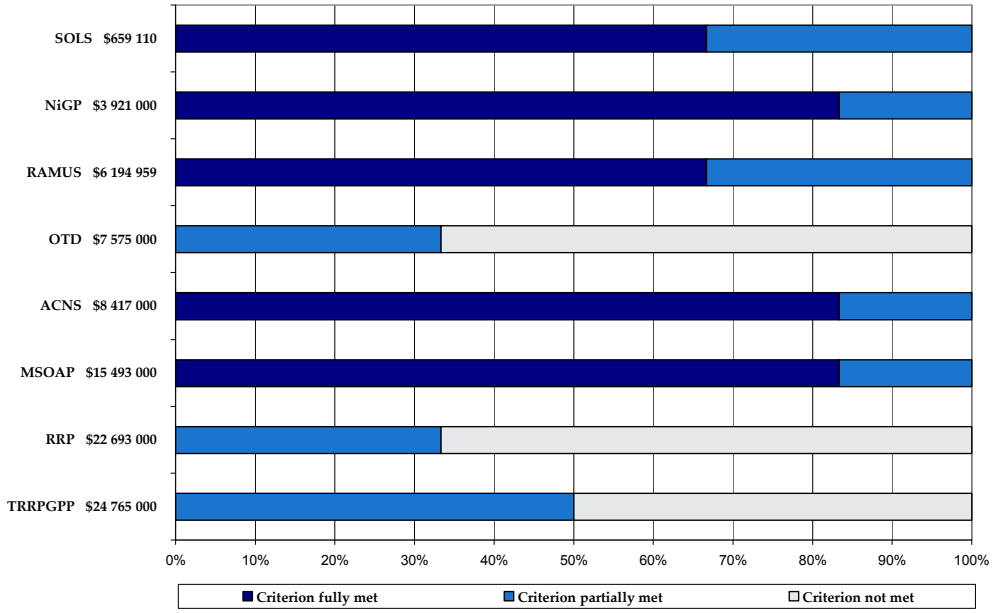
4.14 The analysis indicates that the eight rural and remote health workforce capacity programs do not place an equal emphasis on risk management. None of the eight programs demonstrated clear links to DoHA's enterprise risk concerning health workforce supply. As well, no clear links were demonstrated with MHWD risks (two programs—ACNS and MSOAP—are delivered by other Divisions within DoHA).

4.15 Six of the eight criteria related to risk management at the program level. These six criteria were adapted from internal DoHA program management guidance developed for program managers. Three of the eight programs performed well against internal program guidance concerning risk management—ACNS, MSOAP and NiGP—fully met five of the six criteria, while SOLS and RAMUS fully met four of the six criteria. The remaining programs—TRRPGPP, RRP and OTDs—performed poorly against internal program guidance concerning risk management as these programs met none of the six criteria fully.

4.16 The ANAO assessment results against the program level risk management criteria are displayed in Figure 4.2. The full assessment of each program against the eight ANAO criteria is in Appendix 6.

Figure 4.2

Program risk management



Source: ANAO analysis.

Good practice examples of program risk management

4.17 Over the course of the audit, the ANAO identified a number of good practices concerning program risk management. These are detailed in Table 4.2.

Table 4.2

Good practice program risk management

Good practice examples
C3 - are the goals and context of program risk management established? The Aged Care Nurses Scholarship Scheme followed the guidelines and template set out in the *Risk Management Toolkit* to clearly define the business objectives of the program. This provided a focus for the development of the risk management plan. The risk management plan for the Scholarship Scheme identifies the outcome of the program as well as the outputs. With the outcome and outputs clarified, risks of the program are more easily identified, analysed, evaluated, and treated.
C4 - are program risks identified? The Rural Australia Medical Undergraduate Scholarship (RAMUS) program has identified a number of internal risks to the program including the capability of the auspicing agency to effectively deliver the program. It also identified external risks such as the risk of not being able to attract sufficient eligible medical students for the scholarships and insufficient rural mentors to support the RAMUS scheme. Identification of these external risks increases the likelihood of developing a successful treatment.
C5 - are program risks analysed? The Nurses in General Practice Training and Support Program (NiGP) has successfully analysed and assigned risks a pre-treatment risk rating. Firstly, the risk treatment plan analyses the likelihood and the consequence of a risk occurring. It is then possible to analyse these risks and give an overall level risk rating on a scale from "Severe Risk" to "Trivial Risk". The plan further allows an analysis of risks by prioritising them and assigning responsibility to the relevant staff member. Overall, the program's analysis of risks adheres to guidance set out in the *Risk Management Toolkit* and effectively gives the risks a pre-treatment risk rating.
C6 - are program risks evaluated? Medical Specialists' Outreach Assistance Program (MSOAP) is a good practice example of a risk assessment plan indicating whether the level of risk is deemed acceptable or unacceptable, and if any additional treatments should be developed. Of the seven risks assessed for the program, two were considered to be acceptable, with the remaining five considered to be unacceptable. The risks were evaluated correctly, with the five risks being appropriately judged unacceptable and suitable treatments developed as a result of the evaluation.
C7 - are program risks treated? The treatment of risks is perhaps the most crucial aspect of a risk management plan. The Rural Australia Medical Undergraduate Scholarship Program (RAMUS) is a good practice example of a program that has successful and cost effective treatments in place for those risks that have been considered as unacceptable. RAMUS has a variety of treatments in place depending on the risk, and has multiple treatments in place for some of the higher level risks. Importantly, with the successful treatments in place, all risks are regarded as acceptable.
C8 - are program risks monitored and reviewed? Ongoing monitoring and review of identified risks and their respective treatments is the final component of a robust risk assessment plan. The Specialist Obstetrician Locum Scheme (SOLS) is considered a good practice example for monitoring and review of risk management because of the monitoring and review function of the Advisory Committee and Management Group. These two groups provide policy advice and program administration. The Advisory Committee consists of representatives from key stakeholder groups and provides external guidance on SOLS to the department. The Management Group is made up of staff from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), the Rural Doctors Association of Australia (RDAA), and the NSW Rural Doctors Network (NSWRDN). This group manages the SOLS pilot. The Advisory Committee and the Management Group meet regularly and have a variety of roles and duties, including identifying, treating and reporting on SOLS risks to the department.

Source: ANAO.

Note: The program risk management criteria and rationale are presented in Appendix 6.

Overall assessment of health workforce capacity programs against risk management criteria

4.18 Attention needs to be given to aligning enterprise level risks, Divisional level risks and program level risks. At the program level there is an additional requirement to ensure that the risks to achieving business objectives are routinely managed across programs in accordance with internal DoHA guidance.

Program performance information management

4.19 In Chapter 3, the ANAO reported on the high-level performance management framework in place at the corporate and Divisional levels and the alignment between these two levels.

4.20 In this chapter, the ANAO examined the performance information management arrangements that DoHA has at the program level which contribute to Outcome 12: *Australians have access to an enhanced health workforce* and alignment with higher level performance information requirements.

4.21 Stakeholder opinions[113] of performance information in rural and remote health workforce capacity programs are also taken into account. This focuses on performance information contained in contractual arrangements with health service providers.[114]

Management of performance information at the program level

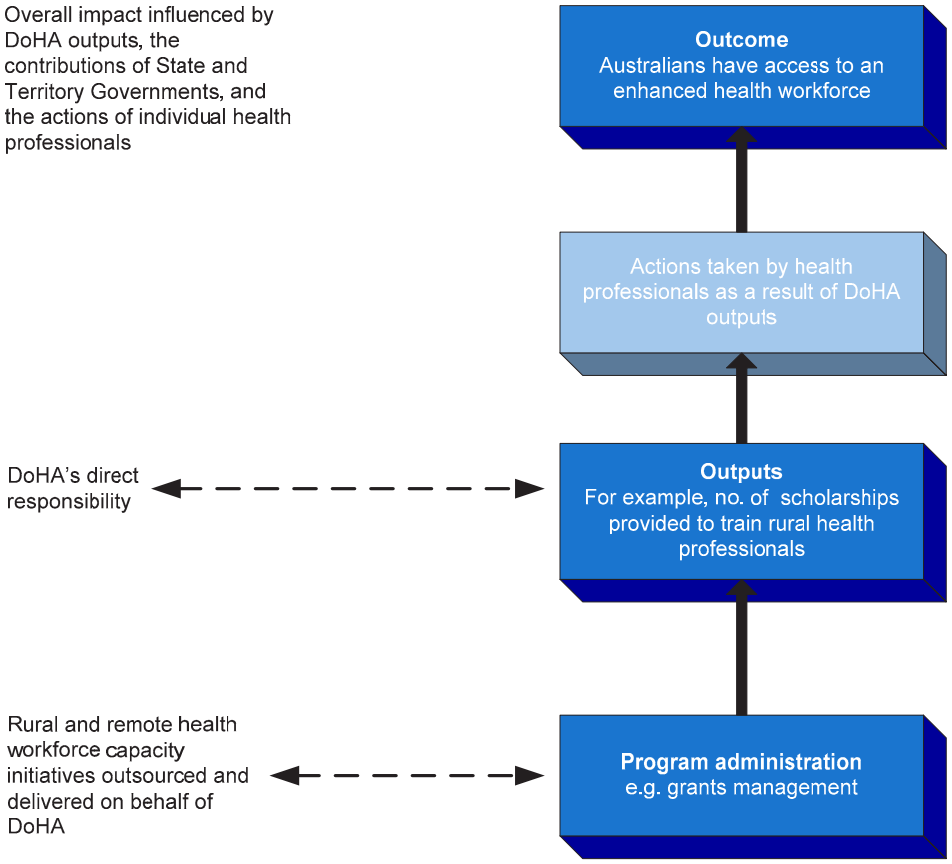
4.22 This section reports how performance information is captured and used at the program level. As indicated in Figure 4.3, performance information is often readily available at the output level (i.e. the specific goods and services delivered by the program). However, as agencies try to measure or track the impact of these goods and services, information on the contribution of the program to final outcomes becomes important.

[113] The ANAO undertook a statistically valid survey of external organisations, nominated by the MHWD as stakeholders.

[114] 71 per cent of respondents identified themselves as health service delivery providers - ANAO Stakeholder Survey.

Figure 4.3

Contribution of programs to final outcomes



Source: ANAO analysis.

4.23 The ANAO developed an assessment criterion to test the linkage:

- is there a clear link between program performance indicators and higher level DoHA outcomes?

4.24 To examine DoHA attempts to identify potential rural and remote health workforce capacity program duplication and overlap with similar or complementary programs within DoHA, with other Australian Government departments, and with other jurisdictions, the ANAO developed a further criterion:

- are links with similar and complementary programs identified?

4.25 In addition to the two high-level criteria outlined above, the program examinations used the additional following criteria, adapted from DoHA's internal guidance, to assess performance information:

- are objectives clear and measureable?
- is there an appropriate mix of performance indicators?
- is performance information continually improved?
- are regular monitoring and reporting systems in place?
- does DoHA provide assurance around the quality of the data that underpins the performance indicators?

DoHA's internal guidance for program managers

4.26 DoHA's internal guidance for program managers includes: a training package –*Policy Formulation and Advice*—Advanced Version 3 and the *Program Managers Manual*.

4.27 Advice included in the training package—*Policy Formulation and Advice* suggests that performance information should have balance and clarity:

- performance information will be useful where it is pitched to provide a comprehensive and balanced coverage of a particular outcome, output or administered item through a concise basket of performance indicators which can be understood, are well-defined, and are cost-effective to collect, store and manage; and
- performance information is most effective and meaningful where it is integrated with internal management processes and accountabilities within an agency, and can be utilised to meet external requirements.[115]

4.28 DoHA has its own guidelines for performance information used in its administered programs: the *Program Managers Manual*. The purpose of the *Program Managers Manual* is to:

- provide detailed procedures for the standard funding process;
- describe the principles underpinning program management and administration; and

[115] DoHA, *Policy Formulation and Advice* – Advanced Version 3, p. 175.

- assist officers to develop, manage, administer and evaluate programs.[116]

4.29 In regards to performance information in contractual arrangements with health service delivery providers, the manual sets out the procedures and appropriate arrangements needed for a funding agreement and a successful program:

- appropriate arrangements need to be in place to enable the performance of participants to be assessed periodically against the purposes for which the funding is given. This can be achieved in a variety of ways such as through progress reports, inspections and peer assessments. The preferred method will vary depending on the size of the funding arrangement, perceived risk and sensitivity, and the availability of adequate monitoring resources. Progress reports of the project activity should be required at least every six months during the course of the project. Some funded projects (e.g. short-term projects, conferences) may require more frequent reporting.[117]

ANAO analysis

4.30 The analysis demonstrates that the eight rural and remote health workforce capacity programs do not place an equal emphasis on performance information management. Two of the eight programs—RAMUS and NiGP—were able to demonstrate clear links to higher-level DoHA outcomes. However, no program was able to demonstrate clear links with similar or complementary programs.

4.31 Five of the seven criteria related to performance information management at the program level. One of eight programs—NiGP—performed strongly against internal program guidance concerning performance information management and fully met four of the five criteria; followed by—ACNS and MSOAP—both of which fully met three program performance information management criteria. SOLS and RAMUS each fully met two criteria, while TRRPGPP fully met one criterion. The remaining programs—RRP and OTDs—performed poorly against internal program guidance concerning performance information management and met none of the criteria fully.

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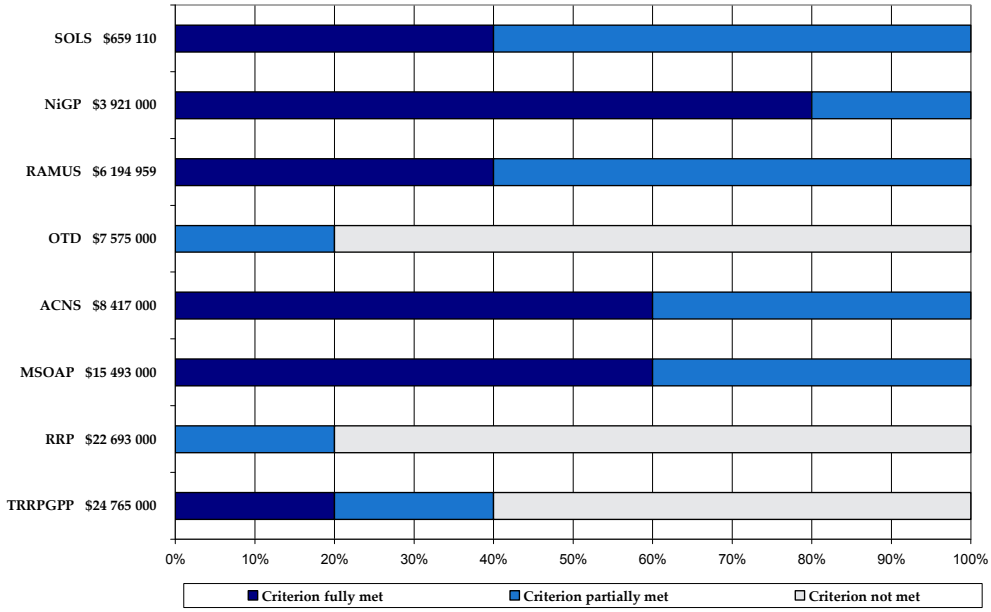
[116] DoHA, *Program Managers Manual.*

[117] ibid.

4.32 The ANAO assessment results against the program level performance information management criteria are displayed in Figure 4.4. The full assessment of each program against the seven ANAO criteria is found in Appendix 6.

Figure 4.4

Program performance information management



Source: ANAO analysis.

Good practice examples of program performance information management

4.33 During the course of the audit, the ANAO identified a number of good practice examples of program performance information management. These are presented in Table 4.3.

Table 4.3

Good practice program performance information management

Good practice examples
C1 - is there a clear link between program performance information and higher level DoHA outcomes? The Rural Australia Medical Undergraduate Scholarship Program (RAMUS) is owned by both Outcome 5 and Outcome 12. RAMUS has an effectiveness indicator in place that clearly links it to Outcome 5 – Primary Care (*Australians have access to high quality, well integrated and cost effective primary care*) and to Outcome 12 – Health Workforce Capacity (*Australians have access to an enhanced health workforce*). With an effectiveness indicator in place, the program's tracking project allows DoHA to track medical graduate placements over time. This provides DoHA's program managers with the capacity to assess whether or not scholarship holders are practising in rural and remote areas.
C2 - are links with similar and complementary programs identified? Of the eight programs assessed against this criterion, four had links with other similar DoHA administered programs. However, these programs did not clearly identify links with other Australian Government programs or with programs administered in other jurisdictions. However, one program—MSOAP—has a program advisory structure, the Advisory Forum. One of the functions of the Forum is to examine links (when appropriate) with the planning processes of other programs to explore possibilities for integrated program implementation.
C3 - are program objectives clear and measureable? A good practice example of clear and measurable objectives is the Aged Care Nurses Scholarship program. The program was introduced in the 2002-03 Budget, with the aim of increasing the number of students entering aged care nursing, especially in rural and regional areas, at either the undergraduate or postgraduate level and to provide assistance in continuing education. Scholarships are awarded against the following criteria: financial need, previous experience in aged care, and length of time spent in a rural area. The objective of providing scholarships is to increase the number of students entering aged care nursing, especially in rural and regional areas. This is a very clear objective. Similarly, because the number of scholarships is capped and student numbers closely monitored, program results can be measured.
C4 - is there an appropriate mix of performance indicators? The Nurses in General Practice Training and Support Program (NiGP) has an effectiveness indicator and a good mix of qualitative and quantitative performance indicators. NiGP has effectiveness indicators which relate directly to Outcome 5 – Primary Care (*Australians have access to high quality, well-integrated and cost-effective primary care*), including: • improvements are measured over time of the performance of State Based Organisations (SBOs) to facilitate access to education and professional development options for rural and remote Practice Nurses that are central to their role; and • SBOs collaborate with other relevant organisations and professional bodies to facilitate support external to the Divisions of General Practice Network for nurses working in general practice. Along with having these effectiveness indicators, the program has a mix of output and process indicators. Examples include: • number of general practices contracting the services of one or more Practice Nurses; • proportion of eligible practices accessing the Practice Nursing Practice Incentive Payments; and • number of nurses attending education/professional development opportunities funded by the SBOs.

Good practice examples
C5 - is performance information continually improved? Nurses in General Practice Training and Support Program (NiGP) is an example of good practice for continuously improving performance information. For the NiGP 2008-09 Annual Plan, DoHA consulted with the SBOs of the Australian General Practice Network (AGPN). The parties decided to update and reduce performance information to make it clearer and simpler. Performance indicators were reduced from nine to five, with only key indicators now in place.
C6 - are regular monitoring and reporting systems in place? Medical Specialists' Outreach Assistance Program (MSOAP) is a good practice example in relation to performance reporting. The program has monitoring and reporting systems in place to measure program performance. In 2007, MSOAP developed a central database and transferred program data from 2005 onwards to the database. With the introduction of the database, program performance and program risks are now regularly monitored through the interrogation of the database.

Source: ANAO.

Note: The program performance information management criteria and rationale are presented in Appendix 6.

Overall assessment of health workforce capacity programs against program performance information management

4.34 Performance information management should be a key feature underpinning all of DoHA's rural and remote health workforce capacity programs. The main findings of the chapter in relation to performance information management are:

- stronger vertical alignment between program performance information and higher–level performance information concerning the achievement of government Outcomes requires attention; and
- there is little indication that rural and remote health workforce capacity programs are compared with similar or complementary programs within DoHA, other Australian Government departments or with other jurisdictions.

ANAO Stakeholder Survey

4.35 The ANAO Stakeholder Survey sought stakeholders' opinions of the performance information requirements contained in their contracts with DoHA. Their views were limited to the health workforce capacity programs that they delivered on behalf of DoHA.

4.36 DoHA internal guidance indicates that stakeholder involvement in the development of performance indicators is an important element of funding agreements:

it is important to negotiate and settle with the participant the performance indicators against which the participant's performance will be measured.[118]

Stakeholder Opinions

4.37 Of the 126 stakeholder organisations that responded to the ANAO survey, 89 (71 per cent) deliver rural and remote health workforce capacity programs under contract to DoHA. These 89 External Service Providers (ESPs) were asked to respond to a group of questions relating to their funding agreement(s) with DoHA and DoHA's monitoring, evaluation and support of ESPs. A number of questions focussed on program accountability and performance monitoring.

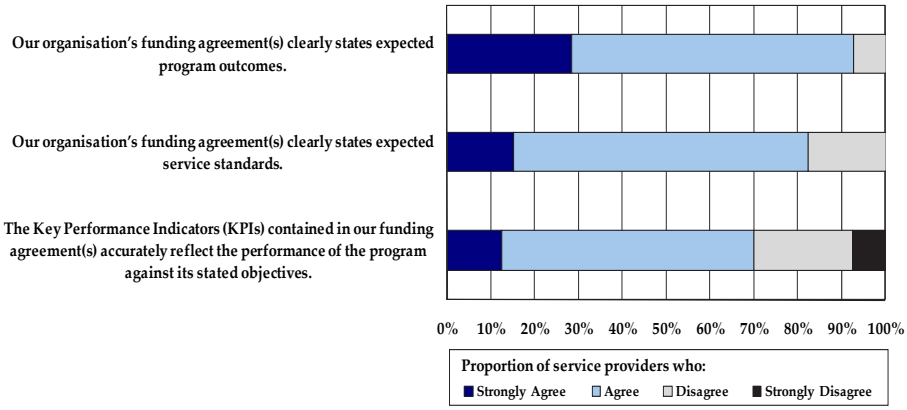
4.38 Figure 4.5 shows that:

- 93 per cent of external service providers (ESPs) that responded to the ANAO stakeholder survey were of the opinion that their funding agreement clearly stated expected program outcomes;
- 82 per cent of ESPs were of the opinion that their funding agreement clearly stated expected service standards; and
- 70 per cent of ESPs were of the opinion that the Key Performance Indicators (KPIs) contained in their funding agreement(s) accurately reflected the performance of the program against its stated objectives.

[118] DoHA, *Tips for Successful Project Monitoring*.

Figure 4.5

Stakeholder views on performance information included in funding agreements



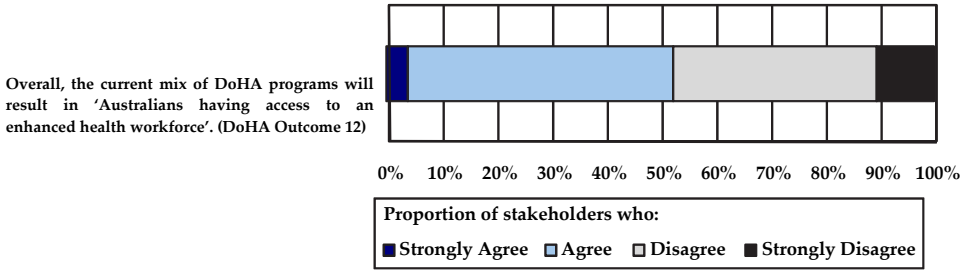
Source: ANAO Stakeholder Survey Report.

Stakeholder assessment of the effectiveness of DoHA's overall package of rural and remote health workforce capacity programs

4.39 The ANAO asked stakeholders whether they considered that the current mix of DoHA programs will result in 'Australians having access to an enhanced health workforce' (DoHA Outcome 12). Figure 4.6 shows that around one half (53 per cent) of stakeholders agreed that the current mix of DoHA programs would result in 'Australians having access to an enhanced health workforce'.

Figure 4.6

Overall, the current mix of DoHA programs will result in 'Australians having access to an enhanced health workforce', extent of stakeholder agreement.



Source: ANAO Stakeholder Survey Report.

4.40 Stakeholder comments indicated that there was broad support for the range of rural and remote health workforce capacity programs currently in place. As well, responses indicated that stakeholders were of the opinion that the level of resourcing was a key influence in achieving an adequate health workforce in rural and remote Australia (see comments below).

Key barriers identified by stakeholders to improved health workforce capacity performance in rural and remote Australia

4.41 The ANAO asked stakeholder organisations what, in their opinion, were the key barriers to ensuring adequate health workforce capacity in rural and remote Australia. In a number of instances, the barriers identified by stakeholders are outside of DoHA's control. Commonly cited barriers included:

- **the perceived and real difficulties of living in rural and remote Australia**, including:
  - the lack of job and educational opportunities for the spouse and children of health professionals,
  - the high cost of living in rural and remote Australia, including transport and housing costs, and education costs (especially where private education is required), and
  - negative lifestyle perceptions related to: harsh climate, social and cultural isolation, and after-hour work demands;
- **complex/conflicting policies**: a number of stakeholders expressed the view that the current range of rural and remote health workforce programs was fragmented and overly complex and that coordination and integration with other government policies would be useful. An example cited concerned the interplay between immigration policies and policies directed at attracting health professionals to outer metropolitan areas which sometimes made it more difficult to attract health professionals to rural and remote areas. Others noted that management and administrative approaches varied across agencies and that this hampered the achievement of long-term outcomes;
- **professional isolation**: many stakeholders cited a lack of professional support and development opportunities and a defined career path in rural health as key barriers to attracting and retaining rural and remote health professionals;

- **inadequate training infrastructure in rural and remote Australia:** although stakeholders acknowledged the positive impact of DoHA infrastructure funding (including the Rural Clinical Schools and University Departments of Rural Health programs), many considered that the capacity to support training placements in rural and remote Australia remained inadequate, particularly in view of anticipated increased training placements over coming years; and
- **a national and global under-supply of qualified health professionals**: stakeholders considered that this partly reflected cuts in graduate medical positions in previous years and the increased demand for health services.

5. Information for Policy and Program Advice

This chapter reviews DoHA's use of evidence to inform the development of policy and program advice for health workforce capacity in rural and remote Australia.

5.1 A core function of DoHA is to develop evidence–based policy advice pertaining to health workforce capacity in rural and remote Australia for Ministerial and Government consideration.

5.2 In this chapter, the ANAO examined DoHA's use of evidence including:

- the extent to which DoHA uses representative data to inform policy advice and program delivery; and
- opinion–based evidence for policy and program advising purposes.

What is representative data?

5.3 Data that is deemed to be representative is accurate, reliable, reflects current realities[119] and representations of real world facts.[120]

Why is having representative data to inform policy advice important?

5.4 Australian Public Service departments and agencies provide policy advice as an output to Ministers to help ensure that government decisions are appropriately informed and supported.

5.5 The Australian Institute of Health and Welfare (AIHW) considers that:

> a major problem in understanding the health of people in rural and remote Australia is the limited availability, representativeness and quality of data to allow meaningful comparisons between populations from different areas.[121]

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[119] Department of Finance and Deregulation, November 2000, *The Outcomes and Outputs Framework-Guidance Document.*

[120] Standards Australia 2005, AS 5021*, The language of health concept representation*.

[121] AIHW, 2008, *Australia's Health*, p. 97.

5.6 Policy advice is one of two outputs for the Mental Health and Workforce Division (MHWD) which manages Outcome 12: Health Workforce Capacity, including in rural and remote Australia.

5.7 Output group 1—**Policy advice** refers to:

- *the provision of a policy advice service*: including monitoring, analysing and reporting to Ministers on specific issues. It spans new policy proposals, Budget packages, Cabinet submissions, and the preparation of legislation and coordination comments; and
- *the provision of Ministerial services*: including ministerial correspondence, minutes to the Minister, Question Time Briefs, Parliamentary Questions on Notice, ministerial speeches, media releases, ministerial launches, briefings, Portfolio Budget Statements (PB Statements) and annual reports.

5.8 Table 5.1 sets out the performance information required for the MHWD Output Group – Policy Advice.[122]

Table 5.1

Performance information for Output Group – Policy advice

Indicator	2008–09 reference point or target
Quality, relevant and timely advice for Australian government decision–making measured by Ministerial satisfaction.	Ministerial satisfaction.
Production of relevant and timely evidence–based policy research.	Relevant evidence–based policy research produced in a timely manner.

Source: Health and Ageing Portfolio, 2008–09, *Portfolio Budget Statements – Budget Paper No. 1.10*.

5.9 Aligning with its PB Statements, DoHA's Corporate Plan states that:

> we will help to achieve improved health and wellbeing through strengthening evidence–based policy advising, improving program management, research, regulation, and partnerships with other government agencies, consumers and stakeholders.[123]

[122] Health and Ageing Portfolio, *2008–09 Portfolio Budget Statements*, Budget Related Paper No. 1.10.

[123] DoHA, *2006–09 Corporate Plan.*

5.10 The MHWD risk management plan identified business risks pertinent to providing information for policy and program advice: *inadequate knowledge and information management*.

The extent to which DoHA uses representative data to inform policy advice and program delivery

5.11 To assess the appropriateness of representative data for policy and program advising purposes, the ANAO examined the tertiary data sources used by DoHA, including the quality of the sourced data. In particular, the ANAO examined:

- Rural, Remote and Metropolitan Areas (RRMA) classification;
- General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) classification;
- the Australian Bureau of Statistics (ABS)—Australian Standard Geographical Classification (ASGC); and
- proposals for a National Registration and Accreditation Scheme (NRAS) for a number of health professions.

5.12 This examination was undertaken with a view to assessing the extent to which these data sources are used as representative evidentiary bases.

Rural, Remote and Metropolitan Areas (RRMA) classification

5.13 The Rural, Remote and Metropolitan Areas (RRMA) classification was developed in 1994 as a remoteness classification based on 1991 population Census data and 1991 Statistical Local Aria (SLA) boundaries from the 1991 Australian Standard Geographical Classification (ASGC).

5.14 The RRMA Classification consists of three zones (Metropolitan, Rural and Remote) and seven classes. RRMA combines a distance measure with a population density measure. The latter measure is subject to change owing to trends in urbanisation.

5.15 DoHA advised the ANAO that the vast majority of its programs currently rely on the RRMA classification as a basis for the allocation of program funding.

5.16 Table 5.2 outlines the structure of the RRMA classification.

Table 5.2

Structure of the RRMA classification

Zone	Class	Abbreviation
Metropolitan Zone	Capital Cities Other Metropolitan Centres	RRMA 1 RRMA 2
Rural Zone	Large Rural Centres Small Rural Centres Other Rural Areas	RRMA 3 RRMA 4 RRMA 5
Remote Zone	Remote Centres Other Remote Areas	RRMA 6 RRMA 7

Source: DoHA.

5.17 Since the adoption of RRMA in 1994, significant changes in urbanisation between these towns have resulted in anomalies in RRMA allocations and incentives.[124]

5.18 The following is an example of a discrepancy that arises when RRMA is relied upon in 2008 to determine allocations and incentives:

- there is little nuance, with relatively well-off areas (such as Bowral in NSW) afforded the same classification as poorer areas (such as Walgett); or little ability to differentiate between wealthy inner city suburbs (such as Toorak), and lower socio-economic metropolitan/suburban areas (such as Frankston).[125]

5.19 As a result, a General Practitioner (GP) practising in Bowral—Central Highlands, NSW would receive similar retention benefits to a GP practising in Walgett—Western NSW.

5.20 DoHA recognised these anomalies when it conducted a review of RRMA for the then Minister for Health and Ageing in 2005:

> the accuracy and appropriateness of RRMA as a classification system has been increasingly questioned by stakeholders. The needs and characteristics of many regions throughout Australia have changed, and as RRMA has not been

[124] Minister for Health and Ageing, 2008, *Report of the Audit of Health Workforce in Rural and Regional Australia*, p. 6.

[125] DoHA Correspondence.

officially updated, it has not kept pace with these changes. It no longer accurately measures health or other need.[126]

Ministerial commentary concerning RRMA

5.21 The Minister for Health and Ageing recently stated, when releasing the *Report of the Audit of Health Workforce in Rural and Regional Australia*, that:

- the Government relied on 17 year old population figures—from 1991 Census data—in developing incentives for doctors and other rural workforce policies; and
- these figures dictate the incentives that doctors who practise in rural and remote areas receive. It is ridiculous that incentives for doctors are based on antiquated data, and an antiquated system.[127]

ANAO analysis of the distribution of DoHA funds by geographic area classification

5.22 The ANAO reviewed the classification basis for the allocation of incentives for GPs in rural and remote Australia. DoHA is currently reliant on the RRMA classification as the eligibility criterion for many of its programs (Table 5.3). DoHA makes little use of the current ASGC remoteness structure to determine incentive payments.

Table 5.3

Distribution of select program funds by geographic area classification as at 2004–05

Geographic Area Classification	Budget	Distribution
ASGC	$610 609.25	0.1%
OTHER	$9 769 747.97	1.6%
ARIA	$76 936 765.25	12.6%
RRMA	$523 292 125.54	85.7%
TOTAL	**$610 609 248.00**	**100%**

Source: ANAO analysis based on DoHA data.

[126] DoHA, 2005, Review of RRMA (unpublished).

[127] Minister for Health and Ageing, 30 April 2008, *Press Release*.

ANAO Stakeholder Survey results concerning RRMA

5.23 As part of the ANAO stakeholder survey, stakeholders were asked to provide any comments or suggested improvements in relation to the delivery of DoHA's rural and remote health workforce capacity programs.

5.24 There were a number of responses which identified the RRMA classification as a significant impediment to program delivery. Comments included:

> *the RRMA Classification is the most significant factor that works against us attracting new GPs to our area and without changes to it we are locked out of a lot of the rural and remote programs;*
>
> *regional centres miss out badly and this could become worse if the already inequitable RRMA system is replaced by ARIA* (see discussion below*);*
>
> *RRMA classification is rarely an accurate indicator in identifying workforce capacity; and*
>
> *need to review current RRMA classification which is based on 1990s dataset which impacts on our funding structure severely and our capacity to service the community.*

5.25 The Minister announced in April 2008 that all geographical classification systems would be reviewed as part of an overall review of all rural health programs. The department is currently undertaking this review and will provide the outcomes to the Minister for consideration.

General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) classification

5.26 The General Practitioner Accessibility and Remoteness Index of Australia (GPARIA) was developed specifically for the Rural Retention Program (RRP) which was first funded in the 1999–2000 Budget. DoHA confirmed that GPARIA was last updated in 2001.

5.27 The objective of the RRP is to encourage GPs to stay longer in targeted rural and remote locations through the provision of financial incentives.

5.28 The GPARIA classification consists of five categories of eligible locations, which range from Highly Accessible (HA) to Very Remote (VR), with VR representing locations that have been identified as potentially most in need of retention support.

5.29 The RRP uses GPARIA to allocate retention grants of between $5 000 and $25 000 per annum to GPs in eligible locations—Categories HA - VR.

5.30 ARIA defines five categories of remoteness based on road distance to service centres, and is available for a variety of geographical units including localities, Census Collection Districts (CCDs), Statistical Local Areas (SLAs) and postcodes. The five categories are:

- Highly Accessible (ARIA score 0 - 1.84) - relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction;
- Accessible (ARIA score >1.84 - 3.51) - some restrictions to accessibility of some goods, services and opportunities for social interaction;
- Moderately Accessible (ARIA score >3.51 - 5.80) - significantly restricted accessibility of goods, services and opportunities for social interaction;
- Remote (ARIA score >5.80 - 9.08) - very restricted accessibility of goods, services and opportunities for social interaction; and
- Very Remote (ARIA score >9.08 - 12) - very little accessibility of goods, services and opportunities for social interaction.[128]

5.31 The five variables have been developed to provide a relative index of need where retention support is required. This is used as a basis for applying different qualifying periods and payment rates for doctors working in different locations and who receive incentives under the RRP program.

ANAO analysis

5.32 Table 5.4 outlines the structure of the GPARIA classification.

5.33 Table 5.4 suggests that 81 per cent of the population exhibit a Highly Accessible ARIA score (between 0-1.84) where they have relatively unrestricted access to a wide range of goods and services and opportunities for social interaction. Comparatively, only 1 per cent of the population exhibits a Very Remote score (9.08 – 12) where they have very little access to goods, services and opportunities for social interaction.

[128] Australian Institute of Health and Welfare, 2002, *Australia's Health*.

Table 5.4

GPARIA categories

DoHA ARIA		
Category	**Population (000,000)**	%
Highly Accessible	14.9	81
Accessible	2.2	12
Moderately Accessible	0.8	4
Remote	0.2	1
Very Remote	0.2	1

Source: AIHW Population Estimates; AIHW, 2002, *Australia's Health*.

5.34 DoHA acknowledges that there has been increasing criticism of how GPARIA divides Australia into eligible areas for RRP incentives.

5.35 The 2006 DoHA Review of RRP recommended:

- the GPARIA classification to be reviewed and updated in light of the most recent 2006 census data;
- a routine review of the GPARIA classification; and
- a wider review of the inclusiveness of GPARIA classification.[129]

5.36 The objective of the RRP is to retain GPs in rural and remote locations through the use of retention payments. The RRP is delivered by Medicare Australia and in budget year 2007–08 retention payments totalled $22 693 000. DoHA tracks RRP expenditure from Medicare data.

5.37 DoHA needs assurance that the retention payments it provides through the RRP go towards achieving the RRP retention objective, that is, that DoHA analysis of the Medicare data is able to show that the retention payments contribute to retaining GPs in rural and remote Australia rather than just payments are being made. A time series analysis would assist DoHA in this regard.

[129] DoHA, 2006, *Review of the Rural Retention Program*.

Australian Standard Geographical Classification (ASGC)

5.38 The Australian Standard Geographical Classification (ASGC) was developed in 1984 to form the foundation of the statistical geography[130] used by the Australian Bureau of Statistics (ABS).

5.39 The ABS intends to replace the current ASGC with the new Australian Statistical Geography Standard (ASGS) through an implementation strategy commencing in 2011.

5.40 The Australian Statistician recently stated, when releasing the *Outcome from the Review of the Australian Standard Geographical Classification,* that:

> the ASGS will be based upon mesh blocks creating more stable and consistent units than the ASGC. It will be the new basis for the publication of the complete range of ABS spatial statistics. The ASGS will become the essential reference for understanding and interpreting the geographical context of ABS statistics.[131]

5.41 In 2011 ASGS will be based upon mesh blocks[132] creating more stable and consistent units than the ASGC. At this stage of the audit, DoHA is aware that there are a range of issues regarding the implementation of the approach adopted by the Australian Statistician.

5.42 ASGS will be the new basis for the publication of the complete range of ABS spatial statistics. The ABS anticipates that ASGS will be widely adopted outside the ABS to facilitate the cross comparison of spatial statistics.

5.43 Until this time, the Australian Statistician encourages the adoption of the ASGC to facilitate the cross comparison of spatial statistics.

5.44 ASGC has been routinely updated, and has formed the basis of the complete range of ABS spatial statistics for many national collections including statistics produced by the Australian Institute of Health and Welfare (AIHW). ASGC 1991 forms the basis of RRMA. This represents an exception to the routine update of many national collections which are currently based on ASGC 2006, as RRMA remains tied to SLAs from ASGC 1991.

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[130] Statistical Geography is the various geographical areas, or spatial units, which build the different classification structures across Australia.

[131] ABS, 2008, *Outcome from the Review of the Australian Standard Geographical Classification.*

[132] The new ASGS will be built from Mesh Blocks, the smallest geographical unit, which will generally contain between 30-60 dwellings.

5.45 According to the AIHW, some advantages of the ASGC remoteness structure over other classification structures include:

- as it was developed by the ABS, it is likely to be adopted in a wide range of disciplines; and
- as a result, it is likely to be of use to a greater number of users and compatible with other future analyses.[133]

5.46 The *Report of the Audit of Health Workforce in Rural and Regional Australia* commented that the ASGC is currently the most accurate method for measuring remoteness. The Minister for Health and Ageing stated:

> ASGC is updated to take account of factors such as new road networks, new area boundaries and actual services provided through centres. It is used as a basis for state planning and provides a better basis for understanding workforce projections as it reflects changes in population distribution and urbanisation.[134]

5.47 DoHA recognises the significance of *an insufficient evidence base, including lack of data, to support rural health policy development and program implementation and evaluation* and has proposed to: *develop a performance monitoring framework and tools to enable the outcomes of rural health programs and initiatives to be evaluated*. [135]

5.48 DoHA needs to use sound evidence to inform its policy advising function concerning incentives for doctors in rural and remote Australia.[136] To do this adequately, DoHA requires the most representative data to assist in determining the incentives that doctors who practise in rural and remote communities receive.

5.49 The review of geographical classification systems which was requested by the Minister in April 2008 provides the opportunity to base the retention payments received by health professionals in rural and remote Australia on a more equitable basis.

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[133] AIHW, 2007, *ASGC Technical Notes*.

[134] Minister for Health and Ageing, 2008, op cit.

[135] DoHA, September 2008, ministerial correspondence.

[136] ibid.

Proposals for a National Registration and Accreditation Scheme

5.50 The Council of Australian Governments (COAG) signed an Intergovernmental Agreement in 2008 for the National Registration and Accreditation Scheme (NRAS) of ten health professions: medical practitioners, nurses and midwives, pharmacists, physiotherapists, psychologists, osteopaths, chiropractors, optometrists and dentists.

5.51 NRAS will maintain a public health register for each health profession. A secondary benefit of the national scheme is the requirement for a national collection of health workforce data. The NRAS data will assist with national workforce planning and evaluation of national progress against health workforce priorities. However, this is subject to agreement by Health Ministers.

Opinion–based evidence for policy and program advising purposes

5.52 Evidence-based public policy advising concerns the use of reliable and relevant knowledge to help address and resolve problems. It is also congruent with important modern strategic concerns with risk analysis and appropriate mitigation responses.[137]

5.53 The provision of quality, relevant and timely advice for Australian Government decision–making is a core function of DoHA. To do this in an efficient and effective manner, it is important that the risks associated with this core function are identified, analysed, treated and monitored.

5.54 Integral to managing risk is communicating and consulting with stakeholders. The AS/NZS 4360:2004 risk management standard suggests that:

- an important consideration is actively consulting stakeholders rather than a one way flow of information from the decision maker to the stakeholder;
- stakeholders are likely to make judgements about risk based on perceptions. Since the view of stakeholders can have a significant impact on the decisions made, it is important that their perceptions of

[137] Brian Head, 2008, The Australian Journal of Public Administration vol. 67, no. 1, *Three lenses of evidence based policy*, p. 2.

risk be identified, recorded and integrated into the decision making process; and

- stakeholder involvement in the policy advising function also allows stakeholders to appreciate the benefits of particular controls and the need to endorse and support a treatment plan.[138]

5.55 DoHA's Corporate Plan states that:

> we will help to achieve improved health and wellbeing through strengthening evidence–based policy advising, improving program management, research, regulation, and partnerships with other government agencies, consumers and stakeholders.[139]

DoHA's engagement of stakeholders on policy and program delivery issues

5.56 An important element of DoHA's policy advising and implementation function is stakeholder consultation in relation to policy and program delivery issues, set out in Table 5.5.[140]

Table 5.5

Output Group 2 – Program management

Indicator	2008–09 reference point or target
Stakeholders participate in program development through a range of avenues, such as conferences and regular meetings.	Stakeholders participated in program development.

Source: Health and Ageing Portfolio, 2008–09, Portfolio Budget Statements – Budget Related Paper No. 1.10.

5.57 As one of the key inputs to the audit, the ANAO obtained feedback from a broad range of stakeholders regarding their opinion of how well they considered that DoHA has engaged with stakeholders to inform policy advice and program delivery.

5.58 When considering effectiveness, it is useful to take into account the perspectives of a range of stakeholders or to seek their views. While stakeholders are likely to make judgements based on their perceptions, the

[138] Standards Australia, *Australian/New Zealand Standard—Risk Management*: AS/NZS 4360:2004.

[139] DoHA, 2006–09 *Corporate Plan.*

[140] DoHA, 2007–08 *PB Statement- Output Group 12.2.*

attitudes of stakeholders can have a significant impact on the success of policy and program delivery.

5.59 One hundred and twenty six stakeholder organisations responded to the ANAO stakeholder survey. Of those that expressed an opinion on these particular issues[141], Figure 5.1 shows that:

- one-third were of the opinion that, overall, DoHA effectively consulted stakeholders in relation to policy issues; and
- approximately half (48 per cent) were of the opinion that, overall, DoHA effectively consulted stakeholders in relation to program delivery issues.

Figure 5.1

Stakeholder views on DoHA consultation in relation to policy and program delivery issues

Source: ANAO Stakeholder Survey Report.

[141] Stakeholders were excluded who did not respond to the particular question or who indicated that they 'neither agreed nor disagreed' with the statement. Less than 16 per cent of respondents were excluded on this basis.

5.60 The ANAO invited stakeholders to comment about DoHA's engagement of stakeholders. In relation to DoHA's engagement of stakeholders on policy issues, a number of stakeholders were of the opinion that:

> *there was a need for more stakeholder consultation in relation to policy development;*
>
> *DoHA should generally provide more time for structured and regular stakeholder consultation, although some stakeholders noted that the political environment did not always allow for this;*
>
> *the quality of DoHA's stakeholder engagement varied considerably across programs and this sometimes reflected high staff turnover in particular program areas;*
>
> *DoHA State Offices generally had more positive working relationships with stakeholders than the DoHA National Office; and*
>
> *the DoHA National Office should consult a broader range of stakeholders and adopt a less unilateral or 'top down' approach to policy development.*

5.61 In relation to DoHA's engagement of stakeholders on program issues, a number of stakeholders were of the opinion that:

> *we have always found the Department to be a collaborative partner with us in delivering the programs they fund us for. Very pragmatic and supportive;*
>
> *the department is very helpful in advising us and helping us deliver the programs;*
>
> *DoHA are responsive to delivery issues, interested in mutual problem-solving and Gresolution of problems; and*
>
> *clearly there is some capacity for rationalisation of some of the programs and reconfiguration of the mix. Easy to say but difficult to achieve. Nevertheless we believe that DoHA is listening, there have been significant changes, and we expect that refinement will continue.*

5.62 As noted in previous chapters, about 71 per cent of respondents[142] indicated that they deliver at least one rural and remote health workforce

[142] ANAO Stakeholder Survey.

capacity program under contract to DoHA. In relation to DoHA's engagement of stakeholders on program delivery issues, respondents presented mixed views, with a number of stakeholders of the opinion that:

> *DoHA is generally responsive to stakeholders when they raise program delivery issues, although some stakeholders indicated that DoHA was not always timely in responding to the issues they had raised;*
>
> *a lack of timely consultation had adversely impacted on the implementation of some programs; and*
>
> *DoHA was collaborative and supportive of external service providers, providing helpful advice on program delivery and seeking to resolve any program delivery issues as they arose.*

5.63 Communication and consultation with stakeholders is an important consideration in the policy advising context and the aim of using representative data and opinion–based evidence for policy advising is well established at DoHA. However, the availability of both types of evidence for health workforce capacity was often underutilised within the department.

5.64 Modern governments require sound evidence of both the effectiveness of implementation and delivery of policies, programs and projects and the effectiveness of outcomes. DoHA's capability to use and build on its experience in implementing health workforce policy and programs in rural and remote Australia could be enhanced by:

- improving the quality of the health workforce information gathered from stakeholders; and
- better use of this information to inform policy and program approaches.

Recommendation No. 3

5.65 To ensure the currency, quality, relevance, and timeliness of the information and policy advice provided to the Australian Government concerning rural and remote health workforce capacity issues, the ANAO recommends that the Department of Health and Ageing develops a process to:

- ensure that its health workforce data is accurate and current; and
- access opinion based information sources, both within and outside of the department.

DoHA response: *Agreed*

Departmental response

5.66 Significant work is already underway in the department and both the National Health Workforce Statistical Register announced by COAG on 29 November 2008 and the National Registration and Accreditation Scheme will now be significant providers of national health workforce data. The department already accesses opinion–based information sources through a range of committees and stakeholder forums. It will continue to do this.

6. Evaluation and Continuous Improvement

This chapter examines DoHA's approach to evaluating the programs it administers concerned with rural and remote health workforce capacity. It also assesses DoHA's use of 'lessons learned', through evaluating the rural and remote health workforce capacity programs it manages, to promote continuous program improvement.

6.1 In the context of the Outcomes and Outputs Framework, agencies are responsible for their own performance information management including their evaluation strategy.

6.2 While program evaluation is not a requirement of the Outcomes and Outputs framework, the Productivity Commission has identified the importance of evaluations in providing an evidence base to underpin reform processes. The Productivity Commission also suggests that the lack of evaluation activity makes it difficult to comment on the effectiveness or otherwise of government interventions.[143]

6.3 Evaluations assist managers and other decision makers to: assess the continued relevance and priority of program objectives in the light of current circumstances, including government policy changes; test whether the program is achieving its stated objectives; ascertain whether there are better ways of achieving these objectives; assess the case for the establishment of new programs, or extensions to existing programs; and decide whether the resources for the program should be continued at current levels, be increased, reduced or discontinued. Evaluations also have the capacity to establish causal links. Over time, an evaluation strategy has the potential to provide credible, timely and objective findings, conclusions and recommendations to aid in resource allocation, program improvement and program accountability.

6.4 This chapter examines DoHA's approach to:

- evaluating its rural and remote health workforce capacity programs;
- utilising stakeholder opinions; and
- using 'lessons learned' to promote continuous program improvement.

[143] Gary Banks, Productivity Commission, February 2009, *Challenges of evidence-based Policy Making*.

Evaluation of rural and remote health workforce capacity programs

6.5 In Chapter 4, the ANAO examined DoHA's approach to the identification and collection of rural and remote health workforce capacity program information and the performance management framework that DoHA has in place to assess the performance of its rural and remote health workforce capacity programs.

6.6 DoHA's *Program Manager's Toolkit* provides managers with a range of guidance on program evaluation:

> funding programs should be evaluated periodically to determine how effective they are in achieving government policies. Data collected for an evaluation will provide managers with information about whether:
>
> - the aims and objectives of the program are still relevant;
> - the funding program is the most efficient and effective way of achieving the desired outcome;
> - there is a continuing need for the funding scheme; and
> - whether any changes need to be made to the conduct of the program.

What programs should be evaluated and when

6.7 Finance suggests that all program and program elements within a portfolio should be evaluated on a regular and systematic basis. This would involve a rolling schedule of evaluations which includes major effectiveness evaluations of each program (or major parts of programs) once every three to five years. Efficiency evaluations should be undertaken more frequently and appropriateness should be reassessed periodically, especially when there are changes in the political, economic and/or social contexts of the program.

6.8 The following considerations will determine the frequency and nature of the evaluations to be undertaken:

- whether the program absorbs substantial resources, has considerable policy significance, or is significant in achieving Government objectives;
- whether there are Cabinet or ministerial directives to undertake the evaluation;
- whether the program has high public visibility or has an important relationship to other program areas;

- whether termination, extension or change in the program has been proposed; and
- the time since the program was last reviewed.

6.9 Evaluations should be additional to, and complement, the regular and ongoing monitoring of programs by program managers against performance information.[144]

6.10 In consultation with DoHA, the ANAO selected eight rural and remote health workforce capacity programs for more detailed examination. Table 6.1 includes the eight programs (including one pilot) selected for assessment against program evaluation management criteria.

Table 6.1

Selected rural and remote health workforce capacity programs

Program name	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Specialist Obstetrician Locum Scheme (SOLS)	659 110	12	MHWD	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Nurses in General Practice Training and Support Program (NiGP)	3 921 000	5	MHWD	Australian General Practice Network (AGPN) and State Based Organisations (SBOs)
Rural Australia Medical Undergraduate Scholarship (RAMUS)	6 194 959	12 & 5	MHWD	National Rural Health Alliance (NRHA)
Support, Coordination and Assistance for Overseas Trained Doctors Program (OTDs)	7 575 000	12	MHWD	Rural Workforce Agencies (RWAs), State and Territory Governments and Doctor Recruitment Agencies
Aged Care Nurses Scholarship Scheme (ACNS)	8 417 000	4	Office of Aged Care	Royal College of Nursing Australia (RCNA)
Medical Specialists' Outreach Assistance Program (MSOAP)	15 493 000	6	PACD	Rural Workforce Agencies (RWAs)
Rural Retention Program (RRP)	22 693 000	5	MHWD	Administered by Medicare Australia

[144] DoFA, 1994, *Doing Evaluations a Practical Guide.* p. 6.

Program name	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Training for Rural and Remote Procedural GPs Program (TRRPGPP)	24 765 000	5	MHWD	Administered by Medicare Australia

Source: ANAO.

Note: Mental Health and Workforce Division (MHWD) and Primary and Ambulatory Care Division (PACD).

Evaluation assessment criteria

6.11 The ANAO adopted the following high level evaluation management criteria:

- is there a clear program link to higher level DoHA outcomes?
- is there a link to an evaluation strategy?

6.12 The following program level evaluation management criteria were adapted from internal and external evaluation guidance:

- are lessons learned adopted?
- is it clear what contribution the program makes to achieving outcomes?
- is it clear what contribution the program makes to achieving higher level outcomes?
- has the program been evaluated?
- is the evaluation methodology clear? and
- is the evaluation robust and appropriate for long term program improvement?

ANAO analysis

6.13 The analysis demonstrates that the eight rural and remote health workforce capacity programs do not place an equal emphasis on evaluation management.

6.14 While all programs were mentioned in recent Portfolio Budget Statements (PB Statements), not all programs were able to demonstrate clear links to these higher level outcomes. As discussed in Chapter 4 on program performance information management, two of the eight programs—RAMUS and NiGP—were able to demonstrate clear links to higher level DoHA outcomes. This was because these programs had effectiveness indicators in place which were able to demonstrate program contributions to the higher level outcomes sought by Government. The lack of program effectiveness

indicators also impacts on an agency's capacity to evaluate programs to provide assurance that programs remain relevant in the context of government outcomes.

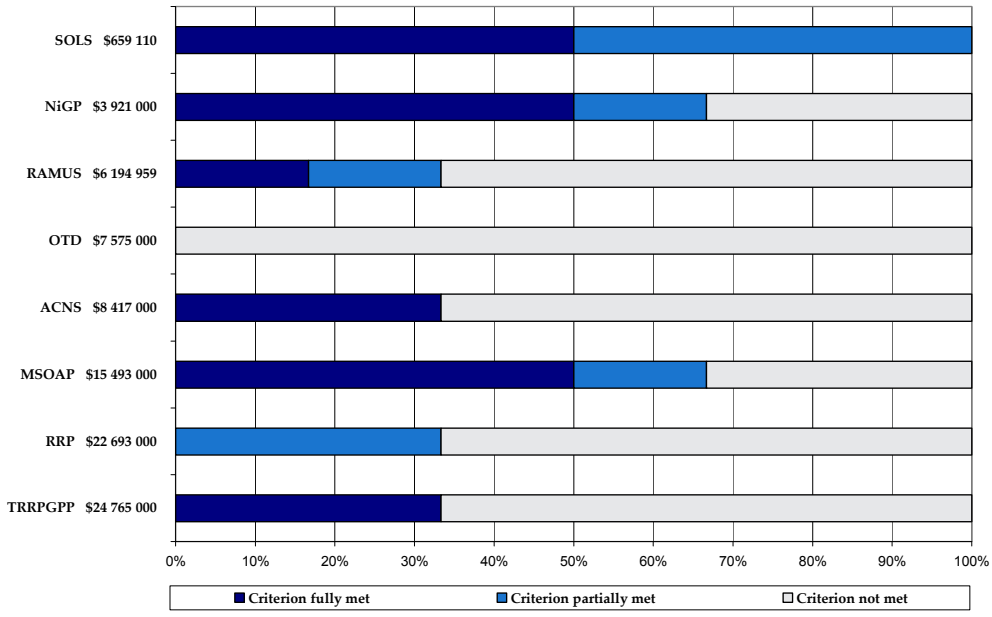
6.15 None of the eight programs were able to demonstrate a clear link to an evaluation strategy.

6.16 Six of the eight criteria related to evaluation management at the program level. Two programs—MSOAP and NiGP—fully met three criteria concerning program evaluation management while TRRPGPP and ACNS fully met two criteria. RAMUS fully met one criterion. RRP and OTDs performed poorly against program evaluation management and met none of the criteria fully. SOLS was not assessed against the majority of the program evaluation management criteria, as it is still in pilot phase.

6.17 The ANAO assessment results against the program level evaluation management criteria are displayed in Figure 6.1. The full assessment of each program against the eight ANAO criteria can be found in Appendix 6.

Figure 6.1

Program evaluation management



Source: ANAO analysis.

Good practice examples of program evaluation management

6.18 During the course of the audit, the ANAO identified a number of good practice examples of program evaluation management. These are presented in Table 6.2.

Table 6.2

Good practice program evaluation management

Good practice examples
C1 - Is there a clear link to higher level DoHA outcomes? All programs were mentioned in recent Portfolio Budget Statements (PB Statements); however, not all programs were able to demonstrate clear links to these higher level outcomes.
C3 - Are 'lessons learned' adopted? The Aged Care Nurses Scholarship Scheme was involved in a pilot to use Nurse Practitioners (NPs) within the aged care sector. A review of the pilot found that there were several benefits from allowing the NP role to have limited access to the Pharmaceutical Benefits Schedule (PBS) and Medicare Benefits Schedule (MBS) within primary care. DoHA set up an intra departmental working group which included the Aged Care Division. The group collaborated to develop a draft policy for the more effective use of the NP role in primary care.
C4 - Is it clear what contribution the program is making to achieving outcomes? The objective of the Nurses in General Practice Training and Support Program (NiGP) is to build the capacity of Divisions within the Australian General Practice Network (AGPN) to deliver support services for nursing in general practice, in particular to recruit and retain nurses in general practice. A Lapsing Program Review in 2004 found that the program was making an effective contribution to supporting Practice Nurses in general practice.
C5 - Is it clear what contribution the program is making to achieving higher level outcomes? The Nurses in General Practice Training and Support Program (NiGP) is owned by Outcome 5 and is managed by the Mental Health and Workforce Division (MHWD) which is responsible for Outcome 12. The final report of the Evaluation of the 2001 Nursing in General Practice Initiative identified the contribution made by the NiGP to support Practice Nurses in general practice as a mechanism to recruit and retain Practice Nurses. This contribution directly links to Outcome 5: *Australians have access to high quality, well integrated and cost effective primary care* and to Outcome 12 *Australians have access to an enhanced health workforce (*including in rural and remote Australia).

Good practice examples
C6 - Has the program been evaluated? In lieu of periodic evaluations, program managers for the Medical Specialists' Outreach Assistance program (MSOAP) conduct an annual mini review of fundholder performance. This annual review provides a good opportunity to refine and improve program performance. The first annual review in 2007 identified that one fundholder was not adequately performing and steps were taken to identify and contract with a more appropriate agency.

Source: ANAO.

Note: The program evaluation management criteria and rationale are presented in Appendix 6.

Overall assessment of health workforce capacity programs against program evaluation management criteria

6.19 An evaluation strategy is a key mechanism to assure stakeholders and decision–makers that programs are achieving against their stated objective and contributing effectively to the outcome sought by government.

6.20 The absence of an evaluation strategy for rural and remote health workforce capacity programs limits DoHA's ability to better inform decision–making on the effectiveness of the contribution of its programs to the Government's health workforce capacity outcome.

6.21 Where there are multiple jurisdictions involved in workforce distribution, education and training and service delivery programs, a comprehensive evaluation strategy provides an opportunity to identify program interdependencies, including duplication, overlap and gaps.

6.22 DoHA recognises the importance of program evaluations and advised the ANAO that during its review of all targeted Australian Government funded rural health programs, it will consider the parameters of evaluation strategies for existing rural and remote workforce initiatives. An evaluation strategy would assist DoHA to evaluate a range of health workforce capacity programs against a set of higher level outcomes.

Stakeholder opinions of DoHA evaluation activity

6.23 The ANAO Stakeholder Survey asked whether stakeholder organisations have been involved in evaluations and/or reviews of rural and remote health workforce capacity programs, the nature of their involvement and their overall assessment of:

- the rigor of these evaluations/reviews;

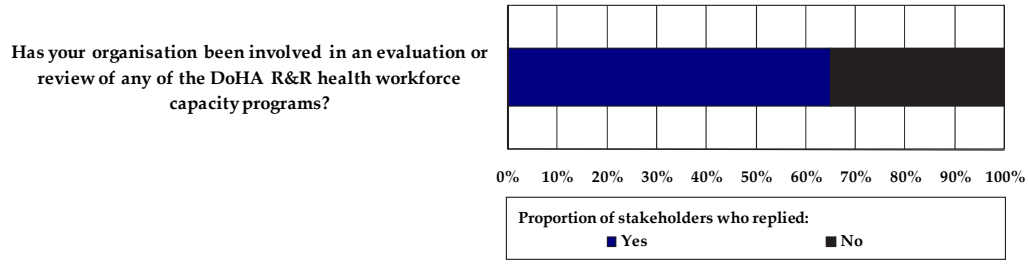
- whether evaluation/reviews had resulted in program improvements; and
- whether stakeholders were adequately informed about the results of these program evaluations/reviews.

6.24 Figure 6.2 shows that around two-thirds (65 per cent) of stakeholder organisations that participated in the ANAO survey indicated that they had been involved in an evaluation or review of a DoHA rural and remote health workforce capacity program. The nature of stakeholder involvement included:

- providing (or contributing to) submissions, information and/or advice to evaluation teams;
- being involved in consultation processes;
- engaging external consultants to independently evaluate programs; and
- being the subject of an evaluation as an external service provider.

Figure 6.2

Has your organisation been involved in an evaluation or review of any DoHA rural and remote health workforce capacity programs?



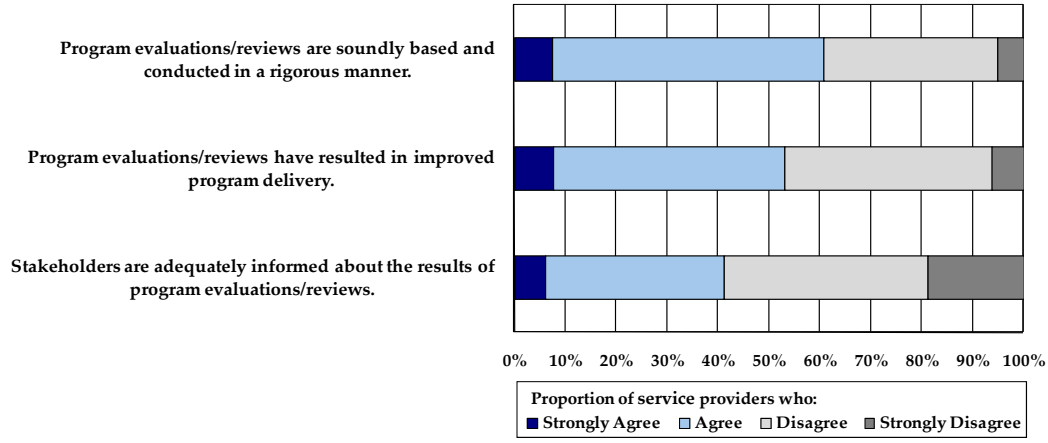
Source: ANAO Stakeholder Survey Report.

6.25 Figure 6.3 shows that for those stakeholder organisations which participated in the survey that:

- 62 per cent of stakeholders were of the opinion that program evaluations/reviews were soundly based and conducted in a rigorous manner;
- 54 per cent of stakeholders were of the opinion that program evaluations/reviews had resulted in improved program delivery; and
- 42 per cent of stakeholders were of the opinion that stakeholders were adequately informed about the results of program evaluations/reviews.

Figure 6.3

Stakeholder views on program evaluation/reviews of rural and remote health workforce capacity programs



Source: ANAO Stakeholder Survey Report.

6.26 The ANAO survey invited stakeholders to comment about evaluations/reviews of rural and remote health workforce capacity programs. Consistent with the above findings, many stakeholders expressed concerns about program evaluations/reviews. The main stakeholder concerns were that:

> *a number of DoHA program reviews had never been released publicly or to stakeholders. A number of stakeholders commented that this represented a considerable waste of time and effort. It appeared that little by way of program delivery improvements had been achieved as a result of these program reviews;*
>
> *although program reviews are often conducted in very tight timeframes (limiting the opportunity for considered input by stakeholders), it can take DoHA years to provide stakeholders with feedback from these reviews;*
>
> *program evaluations/reviews are not always conducted in a rigorous manner, but tended to be 'tick and flick' or tokenistic exercises;*
>
> *the narrow scope and/or review consultations processes, which excluded key stakeholders, had biased review outcomes; and*
>
> *it was not evident to some stakeholders that DoHA was effectively utilising review or performance information to adjust program administration or manage the performance of external service providers.*

6.27 Some stakeholders made positive comments about DoHA support and advice during review processes and the importance of effective review processes. Suggested improvements included: distributing program review reports via the internet, and including outcome measures for Indigenous Australians in future reviews.

Using lessons learned to promote continuous program improvement

6.28 DoHA operates in an environment of continuous improvement where the importance of using 'lessons learned' is well recognised within internal templates, strategies and accountability documents to guide staff within the organisation.[145]

What are lessons learned?

6.29 Lessons learned is the capacity of an organisation to obtain insight from its own experience, and modify the way it operates according to these learnings.

6.30 DoHA's Corporate Plan states that:

- our Performance outlines how we will plan, manage and evaluate our day-to-day business, as well as the tools we use to promote the smart use of resources and continuous improvement; and
- the Department's performance framework guides our planning and resource management, assists us to meet our obligations as an Australian Government agency, and promotes continuous improvement through evaluation.[146]

6.31 Evaluations provide the means of informing program managers and senior departmental officers whether the program they are responsible for is achieving the desired results. Evaluations are also a useful mechanism to assist managers make decisions about how effectively their program is performing and finding options to improve that performance.

[145] DoHA, *Policy Formulation and advice* – advanced Version 3, p. 177.

[146] DoHA, 2006–2009, *Corporate Plan.*

6.32 Concerning the importance of evaluation as a means to identify incremental success in achieving a longer term government objective, Finance guidance comments:

> Outcomes are often long term in nature and performance information in this area must focus on effectiveness. It needs to achieve a balance between addressing progress against milestones, intermediate targets and ultimate long-term impacts. According to these circumstances, outcome reporting can be complemented by identifying the results of performance audits, reviews or evaluations.[147]

6.33 In an accountability sense, evaluation is also a useful adjunct to performance management arrangements as it enables Parliament and stakeholders to form their own judgement about how well programs are achieving the objectives that were set for them and the contributions they make to achieve the Government's longer term objectives.

6.34 Robust program evaluation is heavily dependant on the quality and availability of program information.

6.35 During the audit, the ANAO found that five of the eight health workforce capacity programs that were examined had been evaluated. There was no clear basis as to why certain programs were selected for evaluation as opposed to others. It was difficult to ascertain whether or not the level of funding was a key consideration or whether possible overlap with other Australian Government programs or health workforce capacity programs managed in other jurisdictions was a key determinant. To optimise evaluation resources there needs to be clarity around decisions to evaluate programs.

National data sets

6.36 As discussed in Chapter 5, the National Registration Accreditation Scheme (NRAS), when it becomes operational in 2010, will maintain a public health register for ten health professions. Depending on Ministerial agreement, NRAS data sets will also potentially provide DoHA with an accurate data source to continuously improve rural and remote health workforce capacity programs. These data sets could underpin evaluation methodology and assist in identifying areas for improvement and provide the opportunity to assess program achievements over the long term.

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[147] Department of Finance and Deregulation, 2008, *Financial Management Policy Guidance - Specification of Outcomes and Outputs*.

6.37 DoHA administers around 60 programs directed at workforce distribution, health service delivery, and contributing to the education and training of health professionals in rural and remote Australia. In addition, there are a number of health workforce and health service programs being individually delivered by State and Territory Governments. In this context, an evaluation strategy would enable DoHA to identify program interdependencies and the contribution of individual programs (both internal and external) to the national health workforce objective. An evaluation strategy would also ensure value for money by targeting DoHA evaluation work in this regard.

6.38 DoHA conducts rural and remote health workforce capacity program evaluations. However, the department's evaluation practices can be improved through a more systematic approach focusing on:

- the level of program significance in achieving government objectives;
- the level of visibility/importance of the program to stakeholders;
- program materiality; and
- time lapsed since previous evaluations.

6.39 The development and adoption of an evaluation strategy by Outcome 12 management incorporating the above points would assist DoHA managers to assess the performance of their rural and remote health workforce capacity programs and support accountability to external stakeholders.

Ian McPhee
Auditor-General

Canberra ACT
19 March 2009

Appendices

Appendix 1: Recent Key Reports

The Productivity Commission's Report on the Health Workforce

In March 2005, the Council of Australian Governments (COAG) commissioned the Productivity Commission to examine Australia's health workforce, including supply and demand factors for health professionals, and to propose solutions to ensure continuity of quality health care provision over the next 10 years.[148] The Productivity Commission found evidence of growing workforce shortages across a number of health professions, and an increasing reliance on overseas trained professionals. These shortages are particularly acute in rural and remote Australia.

Productivity Commission findings:

- Australia's demand for health workforce services will continue to increase, driven primarily by population ageing, technological advancements and increasing community expectations;
- to satisfy this increased demand, new models of care will be needed;
- additional health workers will need to be trained, and retention and re-entry for qualified health workers to be improved; and
- the effectiveness, efficiency and distribution of Australia's current health workforce will need to be improved.

To address Australia's worsening health workforce shortages, the Commission recommended a range of measures designed to:

- support local innovations in work redesign and service delivery, and to evaluate such innovations, and to promote those of significance into national models of primary care;
- improve health education and training arrangements;
- coordinate state and profession-based accreditation and registration of professionals under a unified national scheme, with uniform national standards for registrations;
- further consider the impact of payment mechanisms, including for provision of services by suitably qualified health professionals other than doctors;
- rationalise planning structures and improve workforce projections;

[148] The Productivity Commission, 2005, *Australia's Health Workforce*. p. 4.

- undertake a cross program evaluation exercise to determine which mix of policies and programs are most cost-effective for rural and remote workforce matters; and
- make explicit provisions in health workforce planning for rural and remote areas, and for special needs communities.[149]

The Blame Game

In November 2006, the House of Representatives Standing Committee on Health and Ageing published its findings on health care funding— *The Blame Game*.

***The Blame Game* found:**

- evidence of widespread shortages of many types of health professionals, with these shortages being acute in outer suburban areas, regional and rural areas; and that
- the cause of these shortages was partly attributable to underinvestment in health training places over the last 15 years, and that shortages have been exacerbated by weaknesses in current health funding arrangements.[150]

The Committee made several recommendations, including that:

- the Department of Health and Ageing take a lead role in coordinating recruitment of overseas trained health professionals (Recommendation 4);
- the Australian Government implement a strategy for self-sufficiency by producing adequate numbers of health graduates to meet projected demand by 2021 (Recommendation 5); and
- the Australian Government ensure that changes in models of care arising from task substitution are also reflected in funding arrangements (Recommendation 9).[151]

2020 Summit

The Prime Minister of Australia convened an Australia 2020 Summit at Parliament House on 19 and 20 April 2008 to help shape a long term strategy for the nation's future. The Summit brought together a group of Australians from across the country to tackle the long term challenges confronting

[149] ibid.

[150] House of Representatives Standing Committee on Health and Ageing, 2006, *The Blame Game: Report on the Inquiry into Health Funding*. p. 80.

[151] ibid.

Australia's future, challenges which require long-term responses from the nation beyond the usual three year electoral cycle.

Health was one of the key priority areas that the 2020 Summit participants considered. The Health stream initially discussed what ambitions were necessary in order for Australia to consider a long–term health strategy. Ambitions were grouped into five main themes—healthy lifestyles; health promotion and disease prevention; the health workforce and service provision; addressing health inequalities; future challenges and opportunities in health; and health research, research translation and research training.

Summit participants suggested that by 2020 Australia should be self-sufficient in producing Australia's workforce and assisting in enhancing health throughout the region. To facilitate this ambition, the following strategies were put forward:

- less hierarchy and a workforce that is collaborative, integrated, flexible and cooperative;
- the best use of innovation in health technologies to revolutionise health care and delivery;
- a future focus: convergence of genetics, robotics and nano-technology will revolutionise the way Australia treats and manages health care;
- better alignment so the best provider provides the support needed by the individual at the lowest cost and with less demarcation and better use of allied health professionals; and
- better retention: employers need to be employers of choice, which calls for a more respectful approach to employment.[152]

There is considerable alignment between the recommendations and suggestions of each of the three reports discussed above indicating that, overall, health workforce shortages are of interest to health consumers, providers and governments.[153] This is consistent with the views expressed by stakeholders in the ANAO Stakeholder Survey.

[152] Australia 2020 Summit, May 2008, *Final Health Report*.

[153] This is further substantiated by the number of media articles on local or national health workforce shortages appearing in the press on a near daily basis.

Appendix 2: Peak Government Arrangements

Council of Australian Governments (COAG)

The Council of Australian Governments (COAG) is the peak forum of heads of government in Australia. COAG noted health workforce supply and demand issues in June 2004, and accepted, in part, the 20 recommendations of the Productivity Commission's report on 13 April 2007.[154]

COAG also endorsed the *National Health Workforce Strategic Framework* (NHWSF), furthering the earlier endorsement by the Australian Health Ministers' Conference (AHMC).[155] This framework sets out a vision, seven guiding principles and strategies for effective health workforce policy and planning through coordinated actions of government.[156] The Framework's seven guiding principles are set out in Table A2.1.

[154] Council of Australian Governments, 25 June 2004 and 13 April 2007, *Communiqué*.

[155] ibid.

[156] Australian Health Ministers' Conference, 2004, *National Health Workforce Strategic Framework*.

Table A2.1

National Health Workforce Strategic Principles

	The Seven National Health Workforce Strategic Principles
1.	Australia should focus on achieving, at a minimum, national self sufficiency in health workforce supply, whilst acknowledging it is a part of a global market.
2.	Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.
3.	All health care environments regardless of role, function, size or locations should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.
4.	Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.
5.	To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.
6.	Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.
7.	Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require: cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors; stakeholder commitment to the vision, principles and strategies outlined in this framework; a nationally consistent approach; best use of resources to respond to the strategies proposed in this framework; and a monitoring, evaluation and reporting process.

Source: National Health Workforce Strategic Framework.

Importantly, at the 14 July 2006 meeting, COAG agreed to ensure that health education and training is better aligned with workforce needs. To facilitate this, the Commonwealth and the States and Territory Governments signed a

Memorandum of Understanding for better consultation on health-related university places.[157]

Subsequent COAG decisions on health workforce matters

10 February 2006 COAG agreement:

- to address the national health workforce shortage Senior Officials are to provide COAG in June 2006 with detailed information on the number of additional Commonwealth medical student places required along with related measures needed to ameliorate the situation (i.e. the shortfall); and
- to develop a national assessment process for overseas qualified doctors to ensure appropriate standards in qualifications and training as well as increase the efficiency of the assessment process.[158]

14 July 2006 COAG agreement:

- joint Commonwealth and Victorian Government capital funding of $46 million for medical schools at Deakin and Monash Universities;
- the Commonwealth offered to provide further capital funding of about $26 million for New England, Queensland and James Cook Universities, subject to matching funding from the States;
- the Commonwealth will also provide about $120 million over four years to fund the 605 new medical places and $93 million over four years to fund additional nursing places; and
- States and Territories are playing their part in systematically addressing health workforce needs, and support the Commonwealth in its responsibility for university education of health students by providing clinical placements and for many, pre-registration employment. States and Territories also committed to introducing a raft of health workforce attraction, retention and development measures.[159]

COAG also agreed to establish a taskforce on the national health workforce, reporting to the Australian Health Ministers' Conference through the Australian Health Ministers Advisory Council, to undertake project-based work and advise on workforce innovation and reform.[160]

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[157] COAG agreed that the responsibilities of the Ministerial Council on Education, Employment, Training and Youth Affairs (MCEETYA) would be expanded to include annual agreement on national workforce priorities and advice on education and training that addresses current and emerging national skills shortages.

[158] <http://www.coag.gov.au/meetings/100206/index.htm> [accessed 9 January 2009].

[159] ibid.

[160] ibid.

At the November 2008 meeting, the Commonwealth and the States committed to an unprecedented reform package of $1.6 billion – the single largest investment in the health workforce ever made by Australian governments – comprising $1.1 billion of Commonwealth funding and $540 million in State funding.

29 November 2008 COAG agreement:

- $500 million in additional Commonwealth funding for undergraduate clinical training, including increasing the clinical training subsidy to 30 per cent for all health undergraduate places;
- an increase of 605 postgraduate training places, including 212 GP places; and
- the establishment of a national health workforce agency and health workforce statistical register to drive a more strategic long-term plan for the health workforce.
- Investment of $175.6 million over four years in capital infrastructure will also be provided to expand teaching and training, especially at major regional hospitals to improve clinical training in rural Australia. This is vital because students who train in rural areas are more likely to practice in rural Australia.
- The 212 additional ongoing GP training places will boost the total number of GP training places to over 800 from 2011 onwards, and 73 additional specialist training places in the private sector. Funding will also be provided to train approximately 18,000 nurse supervisors, 5,000 allied health and other supervisors, and 7,000 medical supervisors.[161]

Australian Health Ministers' Conference

COAG has a number of related structures to assist it in determining national approaches to critical issues. These are Commonwealth–State Ministerial Councils. For health, the Australian Health Ministers' Conference (AHMC) is the appropriate forum comprising the Health Ministers of the various jurisdictions.

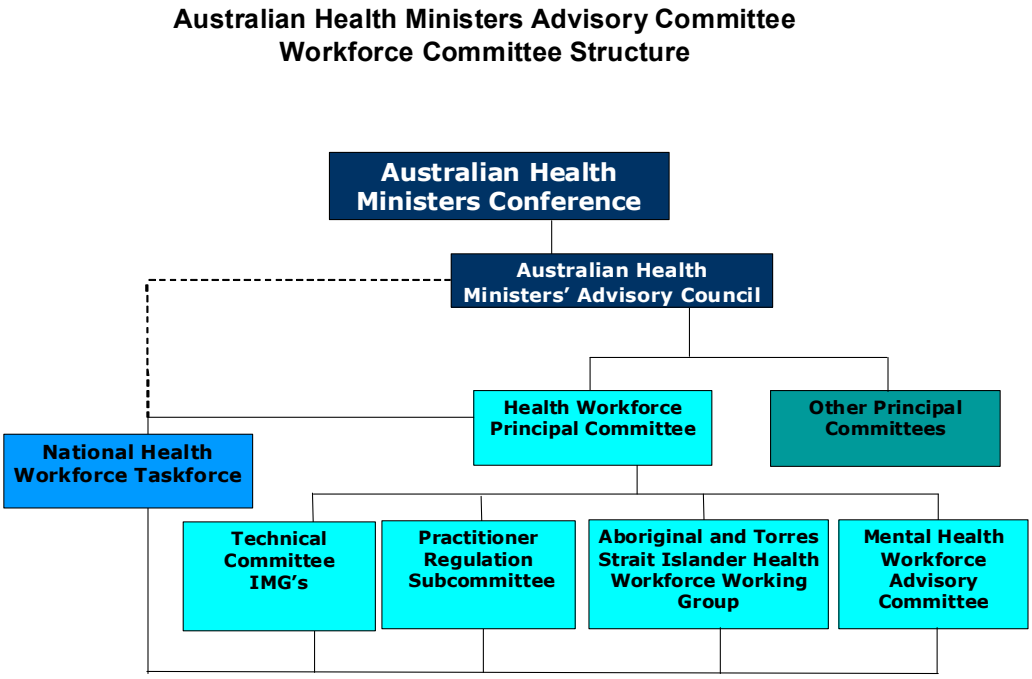
AHMC is supported by the Australian Health Ministers Advisory Committee (AHMAC) which consists of high-level officials from the various Australian Government, State and Territory Health Departments. In turn, AHMAC is supported by the Health Workforce Principal Committee and the National Health Workforce Taskforce.

These relationships are set out in Figure A2.1.

[161] ibid.

Figure A2.1

Health Workforce Advisory Structure



Source: National Health Workforce Taskforce.

National Health Workforce Taskforce

The National Health Workforce Taskforce (NHWT) was established in December 2007 to implement key elements of the COAG health workforce agenda, and commenced work under an AHMAC approved Work Program in April 2008. NHWT commenced projects in 2008 in the following fields:

- evaluation of the National Health Workforce Strategic Framework;
- projects in Research, Planning and Data;
- projects in Education and Training; and
- implementation of National Registration and Accreditation.[162]

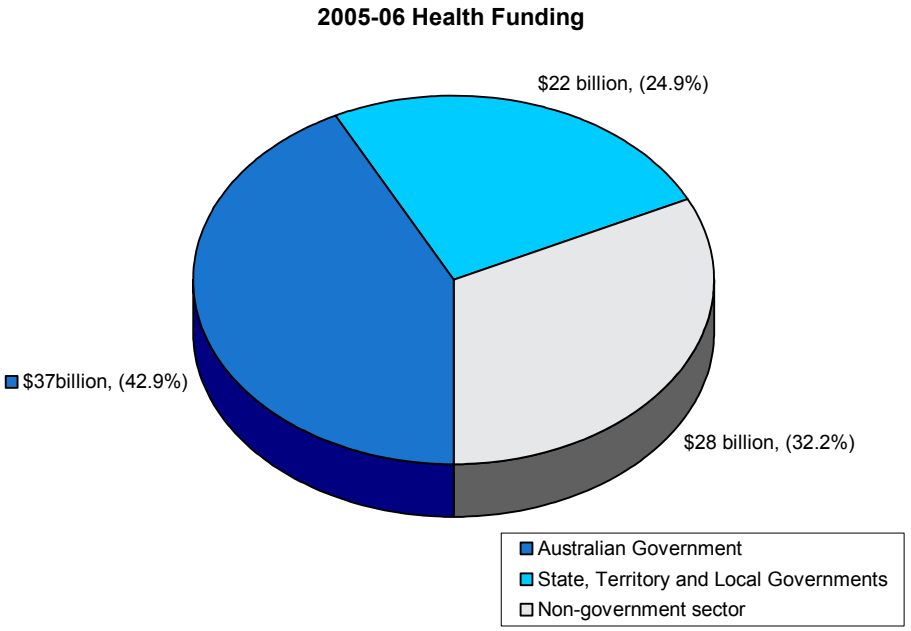
[162] National Health Workforce Taskforce, 2008, *National Health Workforce Program*.

Appendix 3: Health System Investment

Figure A3.1 shows the level of investment by the Australian Government, the State and Territory and Local Governments and the non-government sector in health funding.

Figure A3.1

Sources of Health Funding



Source: Australian Institute of Health and Welfare, 2005–06, *Health Expenditure Australia*.

In 2006-07, the Australian Government spent 3.8 per cent of Gross Domestic Product (GDP) on health services (including Medicare and the PBS). Australian Government health expenditure is expected to rise over coming years, with Treasury predicting a near-doubling to 7.3 per cent of GDP by 2046-47.[163] This is slightly higher than projections for OECD countries, which suggest health expenditures will increase to around 6 per cent of GDP by the year 2050.[164]

[163] The Commonwealth Treasury, *The Intergenerational Report 2007*, Canberra, Appendix 1.

[164] OECD, 2008, *Factbook*.

Appendix 4: Overview of rural and remote health workforce capacity programs assessed by the ANAO

Table A4.1

The eight rural and remote health workforce capacity programs assessed by the ANAO

Program name	Program Objective	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Specialist Obstetrician Locum Scheme (SOLS)	The program aims to: i) maintain and improve the access of rural women to quality local obstetric care by providing the rural specialist obstetrician workforce with efficient and cost-effective locum support; ii) sustain safety and quality in rural practice by facilitating access to personal leave, professional development, and breaks from on-call commitments for rural obstetricians; and iii) use better locum services to encourage the current workforce to maintain services and others to begin a career in rural and regional areas.	659 110	12	MHWD	Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
Nurses in General Practice Training and Support Program (NiGP)	The program aims to: i) build the capacity of Divisions within the Australian General Practice Network (AGPN) to deliver support services for nursing in general practice, in particular to recruit and retain nurses in general practice; and ii) broker, coordinate and fund education and professional development opportunities for nurses in general practice in collaboration with Divisions.	3 921 000	5	MHWD	Australian General Practice Network (AGPN) and State Based Organisations (SBOs)

Program name	Program Objective	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Rural Australia Medical Undergraduate Scholarship (RAMUS)	The program aims to: maintain 550 scholarships worth $10 000 per year to students from a rural background and that have a demonstrated financial need. The scholarship is to assist with their travel and accommodation costs while studying for a medical degree. RAMUS is one of a number of long term strategies that aim to increase the general practice workforce in rural and remote communities.	6 194 959	12 & 5	MHWD	National Rural Health Alliance (NRHA)
Support, Coordination and Assistance for Overseas Trained Doctors Program	The Strengthening Medicare Package contains a number of measures that will increase opportunities for appropriately qualified overseas trained doctors to enter the Australian medical workforce. These measures include: i) international recruitment strategies; ii) opportunities for doctors to stay longer or obtain permanent residency through changes to immigration arrangements; iii) improved training arrangements and additional support programs; iv) reduced “red tape” in approval processes; and v) assistance for employers and overseas trained doctors in arranging placements.	7 575 000	12	MHWD	Rural Workforce Agencies (RWAs), State and Territory Governments and Doctor Recruitment Agencies
Aged Care Nurses Scholarship Scheme	The program aims to increase the number of students entering aged care nursing, especially in rural and regional areas at either the undergraduate or postgraduate level and to provide assistance in continuing education.	8 417 000	4	Office of Aged Care	Royal College of Nursing Australia (RCNA)

Program name	Program Objective	07–08 Budget $	Outcome group	Managed by Division	Fund holder arrangements
Medical Specialists' Outreach Assistance Program (MSOAP)	The program aims to: i) increase visiting specialist services in areas of identified need; ii) support medical specialists to provide outreach medical services in rural and remote areas; iii) facilitate visiting specialist and local health professional communication about ongoing patient care; and iv) increase and maintain the skills of regional, rural and remote health professionals in accordance with local need.	15 493 000	6	PACD	Rural Workforce Agencies (RWAs)
Rural Retention Program (RRP)	The program supports targeted financial incentives for long serving doctors in rural and remote areas which are experiencing difficulties in retaining GP services. Eligibility and payment amounts are based on the length of service of individual doctors, the remoteness of the area they are practising in, and the level of services they provide.	22 693 000	5	MHWD	Administered by Medicare Australia
Training for Rural and Remote Procedural GPs Program	The objective of the program is to support procedural GPs in rural and remote areas to access a grant to attend relevant training, up skilling and skills maintenance activities.	24 765 000	5	MHWD	Administered by Medicare Australia

Source: ANAO, based on DoHA information.

Appendix 5: List of rural and remote health workforce capacity programs

Table A5.1

Program list and description

Program Name	Description
A. Non-bonded scholarships to medical students from rural backgrounds	
Rural Australia Medical Undergraduate Scholarship (RAMUS) program	Provides funding for a range of measures to support general practice infrastructure and training.
GP Infrastructure, Training & Support (GPITS) – John Flynn Scholarship Scheme (JFSS)	Supports medical students while they undertake a placement in the same rural or remote community for a minimum of two weeks per year, usually over a 4 year period, with the expectation that many will consider rural practice upon graduation.
B. Bonded scholarships that require recipients to practice in rural and remote communities	
Medical Rural Bonded Scholarships	Addresses the shortage of doctors in outer metropolitan, rural and remote areas of Australia.
Bonded Medical Places (BMP) Scheme	Provides additional first year medical school places for students willing to work in a District of Workforce Shortage for a period of time equal to the length of their medical degree.
C. Financial incentives for medical graduates to practice in rural and remote communities	
HECS Reimbursement Scheme	Reimburses one fifth of the HECS fees of eligible medical graduates for each year of training undertaken or services provided in rural and remote locations.
D. Scholarships and support for nurses and nursing students	
Rural Nurses Initiative	Provides scholarships and support mechanisms for undergraduate nursing students and nurses wishing to undertake continuing professional education or re-enter the workforce.
Nurses in General Practice (NiGP) program	Provides training and professional support to nurses in general practice and ensures their effective contribution to safe and quality patient care.
E. Scholarships and support for allied health professionals	
ATSI Health Services	Provides funding for National workforce coordination and implementation of the National Workforce Strategic Framework for Aboriginal and Torres Strait Health.

Aged Care Nurses Scholarship scheme	Encourages people to enter (or re-enter) aged care nursing and increases the skills of nurses working in the aged care sector, particularly in rural and regional areas.
COAG Mental Health – Improving the capacity of Health Workers in Indigenous Communities	Provides 25 Puggy Hunter Scholarships over 5 years that target mental health professionals.
F. Support for GPs and medical specialists in rural and remote areas	
Medicare Plus Rural and Remote Procedural GPs	Enables procedural GPs in rural and remote areas to access a grant to attend relevant training, up-skilling and skills maintenance activities under the Strengthening Medicare Package.
GPITS – Workforce (RWAs & ARRWAG)	Promotes and facilitates the recruitment, retention, education, support and distribution of GPs in rural and remote areas. RWAs are funded under the rural and remote GP Program in each state and the Northern Territory to provide a range of activities and support to improve the attraction, recruitment and retention of GPs to rural and remote areas.
National Rural and Remote Health	Provides rural and remote communities with appropriate access to health services targeting innovative service delivery arrangements and the recruitment and retention of a skilled rural health workforce.
GP Infrastructure Training and support (RAMUS RUSC & JFSS)	Provides funding for a range of measures to support general practice infrastructure and training.
GPITS – Rural Undergraduate Support & Coordination Program (RUSC)	Funds participating Australian medical schools to perform three key functions: promoting the selection of rural applicants; developing support systems for Program medical students with an interest in rural medicine; and providing short-term rural placements for all Australian medical students.
Workforce Support for Rural GPs (WSRGP)	Provides funding to support newly arrived and existing general practice workforce (including registrars and medical students in rural areas). WSRGP is administered by 66 Divisions of General Practice with at least 5% of their population living in rural and remote (RRMA 4-7) areas. WSRGP develops the capacity of the general practitioner workforce in rural and remote areas, and the accessibility of the general practitioner workforce to rural and remote communities.
Support Scheme for Rural Specialists (SSRS)	Improves access to Continuing Professional Development (CPD) activities for rural and remote based specialists. The scheme aims to ameliorate factors that contribute to medical specialists moving away from rural based practice, including isolation and difficulties in accessing CPD available to specialists in large centres.
Specialist Obstetrician Locum Scheme (SOLS)	Improves the access for rural women to quality local obstetric care by providing the rural specialist obstetrician workforce with efficient and cost effective locum support.

Rural Advanced Specialist Trainee Support (RASTS)	Provides training programs and support network for advanced specialist trainees in rural Australia.
Providing Remote Onsite Skills, Procedural Education and clinical Training (PROSPECT)	Increase the procedural skills and knowledge of doctors working in Katherine and Gove Hospitals in NT.
G. Infrastructure funding for Rural Clinical Schools and University Departments of Rural Health	
Rural Medical Training Clinical Schools	Encourages medical professionals to take up a career in rural clinical practice by providing education and training for medical students in a rural and remote setting, and support for rural health professionals who are currently working in rural areas.
University Departments of Rural Health	Aims to increase the recruitment and retention of rural health professionals by providing medical, nursing and allied health students opportunities to practice clinical skills in a rural environment.
Advanced Specialist Training Posts in Rural Areas	Supports the establishment of accredited advanced specialist training posts in rural and remote locations to provide trainees with exposure to rural specialist practice.
H. Financial incentives for GPs in private practice in rural and remote Australia.	
Rural Retention Program	Encourages more doctors to remain in those rural and remote areas experiencing the most difficulty retaining the services of general practitioners by offering targeted financial incentives. Eligibility and payment amounts are based on the length of service of individual doctors, the remoteness of the area they are practising in and the level of services they provide.
I. Recruitment, support and retention of Overseas Trained Doctors in rural and remote communities	
Support, Co-ordination and Assistance for Overseas Trained Doctors (OTDs)	A package of measures to attract and assist overseas trained doctors in their efforts to work in Australia as medical practitioners.
J. Financial incentives for health professionals in private practice in rural and remote Australia	
GPITS – Workforce GP Training: GP Education & Training (GPET) and Rural Vocational Training Scheme (RVTS)	GPET manages the delivery of regionally provided and controlled vocational education and training to general practice registrars enrolled in the Australian General Practice Training program. The RVTS provides an alternative route to vocational recognition for remote practitioners.

New General Practitioner registrars	Provides funds for an additional 50 places on the Australian General Practice Training program. They were specifically for rural areas. The rural emphasis in training places is complemented by financial incentives that encourage medical practitioners to undertake their vocational training in rural and remote locations. Under the Registrars Rural Incentives Payment Scheme (RRIPS) registrars who join the Rural Training Pathway were eligible for incentives of up to $60,000 over three years of general practice training.
Dental Training - Expanding Rural Placements	Supports clinical placements for metropolitan dentistry students in established rural training settings. Funding through this measure includes capital funding, student support, new teaching appointments and administration costs.
Community Pharmacy Agreement - Rural Pharmacy Development	RPWP comprises of various initiatives designed to recruit, train and retain pharmacists for rural and remote areas, including undergraduate and graduate pharmacy scholarships, and an emergency locum scheme.
K. Additional Medicare Payments for General Practitioners in rural and remote communities	
Medicare Benefits Schedule (MBS) – Rural Other Medical Practitioners (ROMPS) Program	Encourages non-vocationally recognised medical practitioners to provide general practice services in eligible rural locations by providing access to the higher A1 Medicare rebate.
MBS – Medicare Plus for Other Medical (MOMPs) Program	Encourages certain medical practitioners who are currently in adequately supplied workforce areas to relocate to Areas of Workforce Shortage (AOW) for a period of time. The MOMPs Program provides access to the A1 Medicare rebate for GP services provided in AOWs by eligible pre-1996 non-vocationally registered medical practitioners. Normally non-vocationally recognised medical practitioners would access the lower A2 Medicare rebate.
MBS – Temporary Resident & Other Medical Practitioners (TROMPs) Program	The TROMPs Program was created to overcome an unintended consequence of amendments to the 1996 Medicare Provider Number legislation, which would have seen a number of long term temporary resident doctors lose access to the Medicare Benefits Schedule.
Medical Specialists' Outreach Assistance Program (MSOAP)	Improves access to specialist health services in rural and remote areas by addressing some of the disincentives for specialists to provide outreach services.

Appendix 6: Technical appendix

This Appendix includes the criteria that the ANAO used to assess eight rural and remote health workforce capacity programs in three key program areas: risk management, performance information management and evaluation management. The results of the assessments are also provided.

Risk Management criteria and rationale

The risk management criteria that the ANAO used were:

- C1 - is there a link to the DoHA enterprise risk: *insufficient supply of adequately trained personnel to work in the health sector?*
  - this criterion was used to determine if direct links could be made between program level risks and risks identified at the enterprise level;
- C2 - is there a link to MHWD risks?
  - this criterion was used to determine if directs links could be made between program level risks and the risks identified in the MHWD Risk Management Plan;
- C3 - are the goals and context of program risk management established?
  - this criterion was used to determine if the context in which the program operates was fully articulated and its business goals clearly defined. Business objectives will vary depending on the nature of the activity, for example, policy advising or program management. Identifying the specific business objectives will inform the focus of the risk assessment.[165]
- C4 - are program risks identified?
  - the identification of risks is a critical step in the risk management process. A successful process ensures that all risks to the identified business objectives are considered and clearly defined.[166]

[165] Department of Health and Ageing, *Risk Management Toolkit*. p.4.

[166] ibid.

- C5 - are program risks analysed?
  - this step involves considering the 'likelihood' and 'impact' of an identified risk occurring in light of treatments currently in place. Each identified risk is given a 'current risk rating' to determine if this risk requires any additional or other treatment(s) to be developed and implemented.[167]
- C6 - are program risks evaluated?
  - the purpose of a risk evaluation is to identify which risks (if any) require additional or other treatment(s). For each identified risk it is necessary to determine if the risk to achieving the business objective(s) is acceptable or unacceptable. This can assist in deciding whether or not to commit additional resources to any additional or other risk treatment(s).
- C7 - are program risks treated?
  - treatment strategies are used to mitigate an identified risk and can include:
    - avoid the risk—not proceeding with the component of an activity that underlies the risk;
    - reduce the likelihood of the risk—developing treatments to reduce the likelihood of the risk occurring;
    - reduce the impact—developing treatments to reduce the consequences should the risk occur; and
    - transfer the risk—transferring the risk to another party to manage.[168]

[167] ibid.

[168] ibid, p. 9.

- C8 - are program risks monitored and reviewed?
  - operational risks should be reviewed via quarterly operational risk owner status reports. Risk owners, as identified during the risk assessment process, should prepare a status report for the respective Division Head regarding the progress of operational risk mitigation treatments (against agreed timeframes).[169]

Table A6.1 includes the raw data for each risk management criterion that each of the eight rural and remote health workforce capacity programs was assessed against.

[169] ibid, p.10.

Table A6.1

ANAO assessment of program risk management

	link to DoHA enterprise risk?	link to MHWD risks?	goals and context of program risk management established?	program risks identified?	program risks analysed?	program risks evaluated?	program risks treated?	program risks monitored and reviewed?
Specialist Obstetrician Locum Scheme (SOLS)	×	×	✓	✓	P	P	✓	✓
Nurses in General Practice Training and Support Program (NiGP)	×	×	✓	✓	✓	✓	✓	P
Rural Australia Medical Undergraduate Scholarship Program (RAMUS)	×	×	✓	✓	✓	P	✓	P
Support, Coordination and Assistance for Overseas Trained Doctors (OTD)	×	×	P	P	×	×	×	×
Aged Care Nurses Scholarship Scheme (ACNS)	×	N/A	✓	P	✓	✓	✓	✓
Medical Specialists' Outreach Assistance Program (MSOAP)	×	N/A	✓	✓	✓	✓	P	✓
Rural Retention Program (RRP)	×	×	×	P	×	×	×	P
Training for Rural and Remote Procedural GPs (TRRPGPP)	×	×	×	P	×	×	P	P

Source: ANAO analysis.

✓ Criterion fully met. P Criterion partially met. X Criterion not met.

Performance Information Management criteria and rationale

The program information management criteria that the ANAO used were:

- C1 - is there a clear link between program performance information and higher level DoHA outcomes?
  - to be useful for decision-making, program performance information should link to higher level outcome performance information, so there is alignment between departmental outcomes and program aims and objectives. This ensures consistency and promotes accountability between the levels of performance information.
- C2 - are links with similar and complementary programs identified?
  - to support program effectiveness, it is important that rural and remote health workforce capacity programs can demonstrate links with similar or complementary programs funded by other Australian Government departments and those funded by other jurisdictions. This goes towards limiting program duplication and overlap.
- C3 - are program objectives clear and measureable?
  - program objectives are statements concerning the expected program outputs and outcomes. Objectives must be clear so that stakeholders can determine what the program is attempting to achieve. Objectives must be measurable so that performance information can be collected, recorded and reported.
- C4 - is there an appropriate mix of performance indicators?
  - performance information will be useful where it is pitched to provide a comprehensive and balanced coverage of a particular program, through a mix of qualitative and quantitative performance indicators which can be understood and are well-defined.[170]
  - performance information should enable a judgement as to whether the program is actually working. This is defined as

[170] Nizette, M., October 2001, *Program performance reporting and evaluation in Australia.*

effectiveness and is the extent to which the activities and goods and services provided are achieving the stated objectives. An effectiveness indicator can be used to measure the outputs of the program in relation to higher level outcomes. An effectiveness indicator illustrates whether a program is directly contributing to the Outcome sought by government.

- C5 - is performance information continually improved?
  - performance reporting is most effective where trends can be compared over time.
    - the reporting of agency outcomes and outputs, and performance information structures, can be expected to evolve with experience, changing needs, and the availability of more relevant or more reliable information; and
    - performance information should be regularly assessed for appropriateness, including through systematic review and evaluation of agency outputs and administered items and, where necessary, of the Government outcomes they support.[171]
- C6 - are regular monitoring and reporting systems in place?
  - monitoring should be undertaken by agencies throughout the year so that their performance against indicators and targets can be assessed. Outcomes are often achieved over a long period of time and agencies need to monitor milestones to ensure that intended results are likely to be delivered.
  - monitoring against targets for each indicator assists performance improvement, for example through:
    - progress reports;
    - inspections; and
    - assessments by external peers.[172]

[171] DoHA, *Policy Formulation and Advice* – Advanced Version 3.

[172] DoHA, *Tips for Successful Project Monitoring*.

- reporting is the final product of monitoring:
  - the frequency of reports depends upon the complexity of the project and the level of risk involved. Progress performance and financial reports should be provided on a basis that is consistent with the activity being funded. Reporting can be required either regularly or intermittently depending upon the critical points in particular projects.[173]

- C7 - does DoHA provide assurance around the quality of the data that underpins the performance indicators?
  - data quality underpins performance information. The quality of data is important because stakeholders (including Parliament) need to know the extent to which they can rely on the performance information being reported.
  - data quality standards, procedures, and data quality assurance processes assist with ensuring that the appropriate level of data quality is met. Agencies need to assess the risks associated with the collection and use of data and develop standards and procedures to improve data quality:
    - systems should be established early to capture relevant information as it becomes available. The type of data collected for monitoring purposes should allow comparisons between similar projects over time and provide sufficient information to identify ineffective, inefficient or fraudulent use of funds.[174]

Table A6.2 includes the raw data for each performance information management criterion that each of the eight rural and remote health workforce capacity programs was assessed against.

[173] ibid.

[174] DoHA, *Program Managers Manual.*

Table A6.2

ANAO assessment of program performance information management

	clear link to higher level DoHA outcomes?	links with similar and complementary programs identified?	objectives clear and measurable ?	appropriate mix of performance indicators?	performance information continually improved?	regular monitoring and reporting systems in place?	DoHA provides assurance around the quality of the data that underpins the Performance indicators (PIs)?
Specialist Obstetrician Locum Scheme (SOLS)	P	P	P	P	✓	✓	P
Nurses in General Practice Training and Support Program (NiGP)	✓	P	✓	✓	✓	✓	P
Rural Australia Medical Undergraduate Scholarship Program (RAMUS)	✓	P	✓	P	P	✓	P
Support, Coordination and Assistance for Overseas Trained Doctors (OTD)	P	×	×	P	×	×	×
Aged Care Nurses Scholarship Scheme (ACNS)	P	P	✓	P	✓	✓	P
Medical Specialists' Outreach Assistance Program (MSOAP)	P	P	✓	P	✓	✓	P
Rural Retention Program (RRP)	P	×	×	P	×	×	×
Training for Rural and Remote Procedural GPs (TRRPGPP)	P	×	✓	P	×	×	×

Source: ANAO analysis.

✓ Criterion fully met. P Criterion partially met. X Criterion not met.

Evaluation Management criteria and rationale

The evaluation management criteria that the ANAO used were:

- C1 - Is there a clear link to higher level DoHA outcomes?
  - evaluations provide assurance that programs remain relevant and contribute to higher level outcomes and provide insights into how programs can be modified to ensure a better chance of success.[175]
- C2 - Is there a link to an evaluation strategy?
  - where there are a large number of programs contributing to the achievement of an outcome and where these programs are sourced from a number of Outcome groups, an evaluation strategy is essential to determine whether a program is still performing against its stated objectives and whether resources could be used more effectively elsewhere to achieve the overall objective.
- C3 - Are lessons learned adopted?
  - a key benefit of evaluation is to provide a better information base to assist managers to continuously improve program performance. Evaluation also provides an opportunity to share the lessons learned through program management.
- C4 - Is it clear what contribution the program is making to achieving outcomes?
  - evaluations provide the means of satisfying program managers and senior departmental officers that the program they are responsible for is achieving the desired results.
- C5 - Is it clear what contribution the program is making to achieving higher level outcomes?
  - the Government's Outcomes and Outputs framework focuses on measuring progress towards the results that it is seeking for the Australian community. In this context, it is important that

[175] Sedgwick, Steve, 1993, *The Role of Evaluation in the Budget*.

agencies are able to clearly identify their contribution to the higher level outcomes sought by government.

- C6 - Has the program been evaluated?
  - regular evaluations are important as a management tool aiding continuous program improvement.
- C7 - Is the evaluation methodology clear?
  - the usefulness of program evaluations for program improvement purposes is very much dependent upon quality issues. A key quality feature is the clarity of the evaluation methodology so that program managers are able to follow the reasoning behind any recommendations that the evaluator might make concerning areas for improvement.
- C8 - Is the evaluation methodology robust and appropriate for long term program improvement?
  - it is important that agencies have in place a robust evaluation methodology that it applies across its programs. This is to ensure that program evaluations are regular and systematic. Without such a requirement, it is not possible to compare program arrangements and core activities over time, which in turn impacts on the ability of program managers to reflect and keep abreast of the long term success or otherwise of the program/s they manage.

Table A6.3 includes the raw data for each evaluation management criterion that each of the eight rural and remote health workforce capacity programs was assessed against.

Table A6.3

ANAO assessment of program evaluation management

	clear link to higher level DoHA outcomes?	link to an evaluation strategy?	lessons learned adopted?	program makes clear contribution to achieving Outcomes?	program makes clear contribution to achieving higher level Outcomes?	program been evaluated?	evaluation methodology clear?	evaluation methodology robust and appropriate for long term program improvement?
Specialist Obstetrician Locum Scheme (SOLS)	P	×	✓	P	N/A	N/A	N/A	N/A
Nurses in General Practice Training and Support Program (NiGP)	✓	×	P	✓	✓	✓	×	×
Rural Australia Medical Undergraduate Scholarship Program (RAMUS)	✓	×	×	×	P	✓	×	×
Support, Coordination and Assistance for Overseas Trained Doctors (OTD)	P	×	×	×	×	×	×	×

	clear link to higher level DoHA outcomes?	link to an evaluation strategy?	lessons learned adopted?	program makes clear contribution to achieving Outcomes?	program makes clear contribution to achieving higher level Outcomes?	program been evaluated?	evaluation methodology clear?	evaluation methodology robust and appropriate for long term program improvement?
Aged Care Nurses Scholarship Scheme (ACNS)	P	×	✓	×	×	✓	×	×
Medical Specialists' Outreach Assistance Program (MSOAP)	P	×	✓	✓	P	✓	×	×
Rural Retention Program (RRP)	P	×	P	×	×	P	×	×
Training for Rural and Remote Procedural GPs (TRRPGPP)	P	×	×	✓	×	✓	×	×

Source: ANAO analysis.

✓ Criterion fully met . P Criterion partially met X Criterion not met.

Index

P

R

S

W

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