The Auditor-General
Audit Report No.2 2013–14
Performance Audit

Administration of the Agreements for the Management, Operation and Funding of the Mersey Community Hospital

Department of Health and Ageing

Department of Health and Human Services, Tasmania

Tasmanian Health Organisation – North West

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
14 August 2013

Dear Mr President
Dear Madam Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and Ageing, the Department of Health and Human Services (Tasmania) and the Tasmanian Health Organisation – North West in accordance with the authority contained in the *Auditor-General Act 1997*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit to the Parliament. The report is titled *Administration of the Agreements for the Management, Operation and Funding of the Mersey Community Hospital*.

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

Yours sincerely

Ian McPhee
Auditor-General

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

AUDITING FOR AUSTRALIA

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Abbreviations

ACHS	Australian Council of Healthcare Standards
ACSQHC	Australian Commission on Safety and Quality in Health Care
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANAO	Australian National Audit Office
CDI	clostridium difficile infection
CEO	Chief Executive Officer
CGC	Commonwealth Grants Commission
DHHS	Department of Health and Human Services
DoHA	Department of Health and Ageing
DRGs	Diagnosis Related Groups
EDIS	Emergency Department Information System
EIMS	Electronic Incident Management System
FAR	Fixed Asset Register
FMA Act	*Financial Management and Accountability Act 1997*
FTE	Full-time Equivalent
GP	General Practice
GST	Goods and Services Tax
HDU	High Dependency Unit
HHF	Health and Hospitals Fund

HoA	Heads of Agreement
JCPAA	Joint Committee of Public Accounts and Audit
LGAs	Local Government Areas
LGH	Launceston General Hospital
MCH	Mersey Community Hospital
NEAT	National Emergency Access Target
NEST	National Elective Surgery Target
NHPA	National Health Performance Authority
NHRA	National Health Reform Agreement
NPA	National Partnership Agreement
NPA IPHS	National Partnership Agreement on Improving Public Hospital Services
NWAHS	North West Area Health Service
NWRH	North West Regional Hospital
PAF	Performance and Accountability Framework
PBS	Portfolio Budget Statements
PHE	Public Hospital Establishment
PwC	PricewaterhouseCoopers
RACS	Royal Australian College of Surgeons
SAB	staphylococcus aureus bacteraemia
SPP	Specific Purpose Payment

Tasmania	State of Tasmania
THO Act	*Tasmanian Health Organisations Act 2011*
THO-NW	Tasmanian Health Organisation–North West
THOs	Tasmanian Health Organisations
VMOs	Visiting Medical Officers

Glossary

Access block	Access block occurs when a patient has finished their emergency care and needs to be admitted as an inpatient but a bed is not available for them, meaning the patient continues to wait in the emergency department.
Acute care	Clinical services provided to admitted or non-admitted patients, including managing childbirth, curing illness or treating injury, performing surgery, relieving symptoms and/or reducing the severity of illness or injury, and performing diagnostic and therapeutic procedures. Most episodes involve a relatively short hospital stay.
Admitted patient	A patient who has undergone a formal admission process in a public hospital to begin an episode of care. Admitted patients can receive acute, subacute or non-acute care services.
Australian-refined Diagnosis Related Group	A patient classification system used to classify hospital admissions into groups with similar clinical conditions (related diagnoses) and similar resource usage (hospital services).
Casemix	The range and types of episodes of care (the mix of cases) treated by a hospital.
Clinical effectiveness	Patients receive the right care at the right time, by a clinician with appropriate skills and qualifications who is informed and involved in their care.
Clinical governance	The system by which the governing body, managers, clinicians and staff share responsibility and are held accountable for patient care, minimising risks to consumers and for continuously monitoring and improving the quality of clinical care.

Non-admitted patient	A patient who has not undergone a formal admission process, but who may receive care through an emergency department, outpatient or other non-admitted service.
Raw separation	An episode of admitted patient care that is not adjusted for the complexity of the care required.
Weighted separation	An episode of admitted patient care that incorporates the level and complexity of the treatment provided.

Summary and Recommendations

Summary

Introduction

1. The Mersey Community Hospital (MCH) is located in Latrobe, 10 kilometres south-east of Devonport, Tasmania. The MCH provides hospital services to around 62 000 people in a catchment area that is characterised by population growth over recent years, an ageing population, socio-economic disadvantage and significant chronic disease, particularly cardiovascular disease, diabetes and cancer.

2. The MCH has approximately 100 beds and provides medical services, including emergency, general adult and paediatric medicine, general surgery, ophthalmological, some oncology, limited rehabilitation and allied health support. There are approximately 500 staff members employed at the MCH.[1]

3. First opened in 1961, the MCH has been operated at various times in its history by the Tasmanian Government and by private providers. In November 2007, the Commonwealth purchased the MCH from the Tasmanian Government in response to local community concern over proposed service changes at the hospital. The MCH is the only hospital in Australia both owned and directly funded by the Commonwealth. Since 1 September 2008, the Tasmanian Government has managed and operated the MCH under successive Heads of Agreement (HoA) with the Commonwealth, endorsed in 2008 and 2011, which have provided Commonwealth funding of $169.8 million and $197.5 million respectively for this purpose.[2]

4. Over the period in which the Tasmanian Government has managed and operated the MCH under the HoA, the Australian health care system has undergone significant reform. This includes: the 2011 National Health Reform Agreement (NHRA), which established independent Local Hospital Networks as the management model for public hospitals, with states and territories funded as system administrators; and the National Health Performance Authority, supported by a Performance and Accountability Framework (PAF), to improve transparency and accountability for hospital performance.

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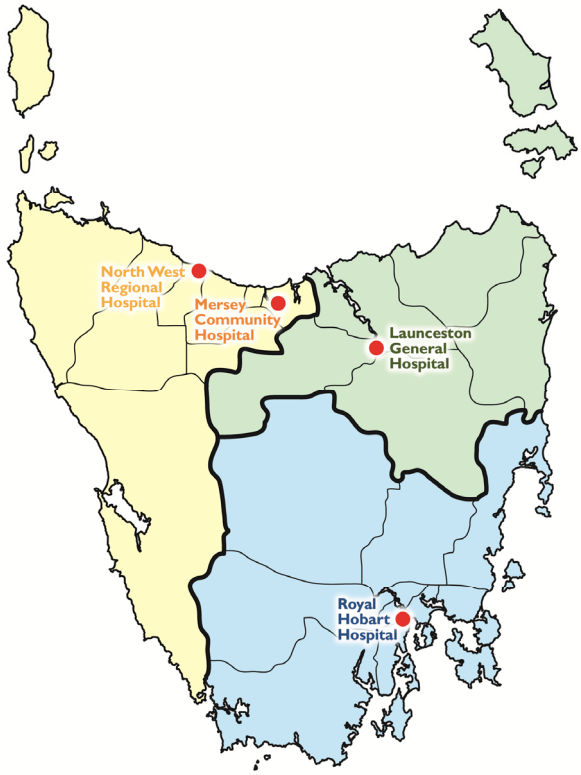
1 The full-time equivalent (FTE) staffing level was 300. Department of Health and Human Services, *Achieving Results in the NWAHS*, April 2012.

2 The 2008 and 2011 Heads of Agreement are available on the Department of Health and Ageing's website, at <http://www.health.gov.au/internet/main/publishing.nsf/Content/mersey-community-hospital-HOA>.

5. Until 30 June 2012, the MCH was managed as part of Tasmania's North West Area Health Service (NWAHS), a division of the Tasmanian Government Department of Health and Human Services (DHHS). On 1 July 2012, in accordance with the NHRA's requirement that states and territories establish Local Hospital Networks, the three Area Health Services in Tasmania—North West, North and South—became Tasmanian Health Organisations.[3] The MCH has been managed by the Tasmanian Health Organisation-North West (THO-NW) since 1 July 2012. However, the current HoA remains an agreement between the Commonwealth and Tasmania, and continues to be administered by the Australian Government Department of Health and Ageing (DoHA) and DHHS. The THO areas and Tasmania's acute hospitals are shown in Figure S1.

Figure S.1: Tasmanian Health Organisation areas and acute hospital locations



Source: DHHS.

[3] Tasmanian Health Organisations are independent statutory authorities managed by a Chief Executive Officer, and each is responsible to a Governing Council, which in turn reports to the Tasmanian Minister for Health and the Treasurer.

Commonwealth acquisition of the Mersey Community Hospital

6. Under the Tasmanian Government's ownership and operation of the then Mersey Hospital prior to November 2007, the hospital formed one campus of a single North West Regional Hospital (NWRH), with the other campus at Burnie, 56 kilometres north-west of Latrobe.

7. The Tasmanian Government's *Tasmania's Health Plan*, which was released in May 2007, announced a strategy to address issues of sustainability, service duplication, costs and health care quality in North West Tasmania by consolidating high acuity inpatient, intensive care and emergency services at the Burnie campus of the NWRH. The Mersey campus would focus on lower risk and sub-acute services, short stay services, including day surgery, and specialist outpatient services.

8. In response to the local community's concerns regarding the proposed service changes, the then Prime Minister, the Hon John Howard MP, announced on 1 August 2007 that the Commonwealth would directly fund a Community Trust to operate the MCH, which it would seek to lease from Tasmania. The Tasmanian Government did not agree to lease the hospital to the Commonwealth, but offered to sell it for $1, subject to conditions.

9. Following negotiations between the two governments, the Commonwealth assumed ownership of the MCH from the Tasmanian Government on 23 November 2007, for a purchase price of $1.10 (GST inclusive), the day before the 2007 Federal election. In summary, the Australian Government's key policy objectives in assuming ownership of the MCH were to:

- restore and maintain the full range of services provided at the MCH prior to the Tasmanian Government's announcement of service changes in *Tasmania's Health Plan 2007*; and
- introduce community-based operation of the hospital through a Trust, funded by the Commonwealth, and test this as a model for other regional hospitals.

10. During the 2007 election campaign, the Australian Labor Party committed to honour the agreement made between the Howard Government and the Tasmanian Government.[4] Following the change of government, in March 2008, the Australian Government decided:

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[4] Australian Labor Party, 'Investment in Tasmanian Health', 25 September 2007.

- not to proceed with the Community Trust model announced by the previous Government;
- that it was not practical or cost-effective for DoHA to have direct operational responsibility for the MCH beyond 30 June 2008; and
- to commence a tender process to identify a private sector service provider to operate the MCH from that date.

11. The subsequent tender process did not result in a concluding bid, and the Government opted to enter into a negotiation process with the Tasmanian Government, represented by DHHS, to resume operating and managing the MCH under Commonwealth ownership. Subsequently, a HoA was signed by the Australian and Tasmanian governments on 27 August 2008 establishing the terms and conditions for the Commonwealth owned and funded MCH to be managed and operated by Tasmania until 30 June 2011.

12. The services required to be delivered at the MCH were set out in the Schedule to the HoA as the core clinical activities of the hospital, with the Commonwealth's objective as owner of the MCH set out in Recital A as follows:

> As the owner of the Mersey Community Hospital at Latrobe in the North West region of Tasmania, the Commonwealth seeks to ensure that the people in its catchment area have appropriate access within clinically appropriate times to a range of safe health care services based on clinical need.[5]

Management and operation of the Mersey Community Hospital by Tasmania

13. The Tasmanian Government resumed managing and operating the MCH on 1 September 2008. A second HoA was signed on 23 June 2011 continuing the arrangement for a further three years, expiring on 30 June 2014. Key provisions of both HoA included the quantum of funding and the clinical services required to be delivered at the MCH.

Funding

14. The funding agreed between the Commonwealth and Tasmania for the management and operation of the MCH under the two HoA is outlined in Table S1. The 2008 HoA did not provide for an annual indexation factor to be

[5] This objective was retained in the 2011 HoA with two minor modifications to reflect the continuity of the arrangement.

applied to the funding, however, an indexation factor of 3.5 per cent was included in the 2011 HoA, to apply after the first year.

Table S.1: Commonwealth funding for the MCH under the HoA

Heads of Agreement	Funding period	Funding provided (GST exclusive)	Total
2008	1 Sep 08 to 30 Jun 09	$49.8 million[1]	$169.8 million[2]
	1 Jul 09 to 30 Jun 10	$60.0 million	
	1 Jul 10 to 30 Jun 11	$60.0 million	
2011	1 Jul 11 to 30 Jun 12	$63.6 million	$197.5 million[3]
	1 Jul 12 to 30 Jun 13	$65.8 million	
	1 Jul 13 to 30 Jun 14	$68.1 million	
			$367.3 million

Source: Heads of Agreement for the Management, Operation and Funding of the Mersey Community Hospital, 2008 and 2011.

Notes: 1 Less than a full year's funding due to timing of the Agreement.

2 Funding not subject to indexation.

3 Funding has been adjusted for indexation.

15. Under both HoA, the funding for the MCH is quarantined from:

- the Commonwealth Grants Commission assessment for the distribution of the Goods and Services Tax (GST) revenue pool to states and territories; and
- funding provided to Tasmania under national health funding arrangements.

16. The Tasmanian Government has accordingly remained eligible for its full entitlement of Commonwealth health-specific and other general funding streams.[6] In addition to the Australian Government's direct funding to the MCH under the HoA of $367 million, the MCH received $0.9 million under the National Partnership Agreement on Improving Public Hospital Services from 2011–12 to 2013–14. The Government has also allocated a total of $14 million to DoHA for the administration of the two HoA.

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[6] Health-specific funding to Tasmania includes: $265 million in 2010–11 under the National Health Care Specific Purpose Payments; eligibility for up to $89.2 million through to 2016–17 under the National Partnership Agreement on Improving Public Hospital Services; and $325 million over four years under the Commonwealth's emergency rescue package for the Tasmanian health system announced on 15 June 2012.

Clinical services delivery

17. The 2008 and 2011 HoA require Tasmania to 'carry on the hospital diligently, honestly and in a professional and competent manner'[7] and to comply with 'responsible public hospital practice in respect of the hospital and in relation to any medical, clinical, surgical or other service' provided at the hospital.[8] The Schedule to the Agreements sets out 12 core clinical activities (see Appendix 2) that are to be 'carried on by Tasmania' at the MCH, without further specifying individual or relative activity levels.

18. The 12 core clinical activities specified in the 2008 and 2011 HoA were largely determined by the service profile of the hospital existing prior to the proposals for change set out in *Tasmania's Health Plan 2007*. While there is flexibility for MCH management to develop and refine services outside the core clinical activities, changes to the core clinical activities can only be made with the agreement of the Commonwealth. There were no changes made to the core clinical activities during the life of the 2008 HoA. Under the 2011 HoA, the Australian Government Minister for Health agreed, on 18 October 2012, to changes in general surgery and paediatric inpatient services. These changes were sought by MCH surgeons to enable the safe delivery of the services.[9]

Differences between the 2008 and 2011 Heads of Agreement

19. While both HoA are set out in a similar way with a number of common terms and conditions, some key changes were introduced into the 2011 HoA, including:

- a limit of $250 000 on the use of Commonwealth funding for minor capital works to the hospital or its facilities, in contrast to the 2008 HoA, which specified that funding could be used for all upgrades and expansions to the hospital;
- the inclusion of annual indexation for the funding of 3.5 per cent;
- provision to 'move towards' activity based costing of services to allow for greater transparency of costs and benefits;

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7 *Heads of Agreement for the continued management, operation and funding of the Mersey Community Hospital*, 2011, Clause 8.2(b).

8 ibid., Clause 8.2(e).

9 The changes to surgery agreed on 18 October 2012 limit the surgery performed at the MCH to weekdays between 9am to 5pm, and outside of these hours where clinically necessary, rather than continuing to make surgery available 24 hours a day, seven days a week.

- expenditure reports to be provided monthly by Tasmania rather than quarterly, and an explanation for any variances of more than 10 per cent from the average expenditure for the previous three months; and
- recognition of the MCH's position within the then NWAHS, providing for the involvement of the hospital and its facilities in Tasmania's strategy for health service delivery in the state's North West region.[10] This addition formally reflects both parties' acknowledgement that the MCH could not operate in isolation from other health services in its region.

Request for an audit

20. On 20 December 2011, the Senator for Tasmania, Senator the Hon Richard Colbeck, wrote to the Auditor-General informing him of allegations concerning the misuse of Commonwealth funding for the MCH in contravention of the HoA, and requested an investigation of those allegations.

21. After initial enquiries with DoHA, as the responsible Australian Government department, the Auditor-General drew Senator Colbeck's request to the attention of the Joint Committee of Public Accounts and Audit (JCPAA) in February 2012, noting that the concerns raised by Senator Colbeck had also been aired in the national and Tasmanian media. The Auditor-General advised the JCPAA that an audit of the administration of the HoA would provide assurance to the Parliament on the use of Commonwealth funding at the MCH and the administrative effectiveness of the HoA, and potentially inform any further agreement between the Commonwealth and Tasmania on the operation of the hospital. The Auditor-General also advised that section 18B of the *Auditor-General Act 1997* (the Act) allowed the ANAO to conduct, at the request of the JCPAA, a performance audit of a Commonwealth partner where the Commonwealth has provided money to the partner for a Commonwealth purpose.

22. The Chair of the JCPAA wrote to the Auditor-General on 28 March 2012, advising that the JCPAA had resolved to request the Auditor-General to undertake a performance audit of the administration of the 2008 and 2011 HoA for the management, operation and funding of the MCH. In

[10] *Heads of Agreement for the continued management, operation and funding of the Mersey Community Hospital*, 2011, Clause 23.

response to this request, the Auditor-General decided to undertake the audit. It is the first performance audit conducted by the ANAO pursuant to section 18B of the Act. The audit was formally designated and commenced in July 2012.

Audit objectives and criteria

23. The objective of the audit was to assess the effectiveness of the administration, by DoHA and the Commonwealth partners, of the 2008 and 2011 Heads of Agreement for the management, operation and funding of the Mersey Community Hospital.

24. To conclude against the audit objective, the audit assessed whether:

- DoHA effectively established and administered the HoA for the MCH; and
- DHHS and the THO-NW are managing and operating the MCH in accordance with the HoA.

25. There were three organisations involved in the audit: DoHA and DHHS, the departments representing the Commonwealth and Tasmania as parties to the HoA, and the THO-NW, in recognition of its assumption of management responsibility for the MCH from 1 July 2012.

26. The scope of the audit had regard to the terms of the JCPAA request under section 18B(1) of the *Auditor-General Act 1997*, specifically the administration of both HoA, covering the period from 1 September 2008. Emphasis was given to whether Commonwealth funds were used in accordance with the HoA, and included consideration of whether the Commonwealth's objectives for acquiring the hospital have been achieved. The audit did not examine operational decision-making within the hospital, such as decisions regarding appointments to clinical positions. The ANAO engaged an external firm with health sector expertise to provide technical assistance in analysing MCH expenditure transactions, performance and costs.

27. While this audit focuses on assessing the effective implementation of the arrangements for the management, operation and funding of the MCH, including the achievement of program objectives, the ANAO does not have a mandate to examine and report on the appropriateness of government policy. As such, this audit does not comment on the merits of the Australian Government's decision to acquire the MCH from the Tasmanian Government in 2007 or its ongoing ownership.

Overall conclusion

28. In November 2007, the Australian Government purchased the MCH from the Tasmanian Government in response to local community concern over proposed service changes at the hospital. Since 1 September 2008, the Tasmanian Government has managed and operated the MCH under two HoA with the Commonwealth, established in 2008 and 2011. Under the two HoA over the six years from 2008 to 2014, direct Commonwealth funding to Tasmania for the management and operation of the MCH totals $367.3 million.

29. As the only Australian Government owned and funded hospital within a health care system where the delivery of public hospital services falls within the responsibilities of the states and territories, the MCH is uniquely placed. As such, the operation of the MCH necessitates arrangements that sit outside the general approaches adopted by the Australian Government to fund the delivery of health services by state and territory owned public hospitals. The establishment and ongoing management of these arrangements have presented a range of additional costs and challenges for DoHA, representing the Australian Government as the hospital owner, and the two state government entities—DHHS and the THO-NW—which have responsibility to operate the hospital within the broader Tasmanian health care system.

30. The recently expanded mandate of the Auditor-General, which provides for performance audits of Commonwealth partners under s18B of the *Auditor-General Act 1997*, has facilitated the ANAO's examination of these unique arrangements. As the first performance audit involving a Commonwealth Partner, this report provides the governments and legislatures in both the Commonwealth and Tasmanian jurisdictions with our assessment of the administration of the arrangements governing the operation of the MCH. The audit does not, however, extend to commenting on the merits of the Australian Government's decision to acquire the MCH from the Tasmanian Government in 2007 and its ongoing ownership as this decision reflects government policy.

31. In general, the administration of the 2008 and 2011 HoA by DoHA and DHHS has been effective in facilitating delivery, at the Commonwealth-owned MCH, of a range of agreed clinical services, including those specified under the HoA. Under the day-to-day management of DHHS, and more recently, the THO-NW, MCH clinical services have generally been delivered within an effective clinical governance framework. In addition, the majority of these services met or exceeded established national targets and benchmarks,

particularly for the emergency department, elective surgery, inpatient management and the High Dependency Unit.[11] Notwithstanding these achievements, the cost of service delivery at the MCH, while better than other Tasmanian acute hospitals, is significantly higher than comparable mainland hospitals—primarily driven by higher staff counts per units of weighted activity, more costly medical and surgical supplies, dependence on locum medical staff and higher administrative overheads.

32. The decision to assume ownership and continue existing service delivery at the MCH has come at an additional direct cost to the Commonwealth of $367.3 million over the six years to 30 June 2014[12] and resulted in greater risk exposure as hospital owner. These additional costs and risks, which arise from the unique arrangements adopted for the MCH, underline the need for effective and ongoing monitoring. At present, system limitations make it difficult for DHHS to readily provide assurance regarding the use of some Commonwealth funds, while weaknesses in the MCH performance framework mean that DoHA is not well positioned to assess whether its ownership and funding of the MCH is effective and whether the Commonwealth is receiving value for money from the arrangements. There remains scope for:

- DHHS, in conjunction with the THO-NW, to improve existing systems to provide greater assurance regarding the use of Commonwealth funds; and
- DoHA to expand its existing performance measurement framework for the MCH program and to strengthen its analysis of reported performance information collected under the framework to better demonstrate the extent to which the program is achieving its objectives.

33. While DoHA's and DHHS' administration of the HoA has facilitated the continuation of service delivery at the MCH, the differing objectives for the hospital held by the Commonwealth and Tasmania have not been fully reconciled: the Commonwealth's objective primarily relates to the delivery of a

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[11] The cost and performance of the MCH across key areas of clinical activity is discussed in detail in Chapter 6 of the report. For example, in relation to the performance of the emergency department in 2012, the MCH reported a National Emergency Access Target performance level of 77 per cent, against a target of 72 per cent. The NEAT is a key performance indicator (KPI) used to assess the performance of emergency departments under the National Partnership Agreement on Improving Public Hospital Services.

[12] See Table S1, which provides details of annual funding levels under each HoA. A further $14 million has been allocated to cover the cost of administration of the two HoA by DoHA.

set of core clinical services in place at the time the hospital was acquired, while Tasmania has sought to rationalise the delivery of hospital services in the state's North West between the MCH and the NWRH at Burnie in line with the state's health plan. To support the achievement of its objective, the Commonwealth has invested a substantial amount of direct funding, with the benefits to Tasmania extending beyond this amount, as it also receives a range of indirect financial benefits.[13] Although the Commonwealth has retained the range of clinical services at the MCH outlined in the HoA, where it is safe to do so, Tasmania has also advanced the implementation of its health plan objectives for the state's North West, with the MCH moving during 2012–13 from a 24 hour/seven day a week surgery facility to a mixed day and short stay surgery facility.

34. Notwithstanding a generally sound working relationship, which has supported the ongoing administration of the arrangements governing the operation of the MCH, the differing government objectives has meant that DoHA and DHHS have expended significant time and resources revisiting issues relating to service changes and hospital costs. In particular, the mechanism specified in the HoA for changing its provisions—a Clinical and Financial Services Plan—has not been effective. In addition, while the HoA recognise the need to manage the MCH as part of Tasmania's health network in the North West, how this principle should apply in practice to the integration of services between the MCH at the NWRH at Burnie has not been settled between the parties. There also continues to be disagreement between the Commonwealth and Tasmania over responsibility for funding capital works at the hospital above the threshold of $250 000, and a compromise on this issue struck to enable the 2011 HoA to be agreed has not resolved this disagreement. The negotiation of any new HoA from July 2014 presents an opportunity to address these issues and establish a clear and agreed strategic direction for the MCH.[14]

35. Over the period that the Commonwealth has owned and funded the MCH, there have been persistent allegations reported in the Tasmanian and national media that Commonwealth funds for the MCH have been used

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[13] These indirect benefits include: the retention of $34 million in annual recurrent savings (in 2008 prices) from its funding of the hospital prior to the Commonwealth's purchase; the exemption of MCH funding from Commonwealth Grants Commission assessments of GST distribution to the states and territories, and from the calculation of funding levels provided under national health initiatives; and the retention of MCH revenue.

[14] The Tasmanian Government Minister for Health wrote to the Australian Government Minister for Health and Ageing on 27 June 2013 to commence negotiations for the management, administration and operation of the MCH beyond the expiry of the 2011 HoA on 30 June 2014.

outside the MCH contrary to the terms of the HoA. With regard to these allegations, the Tasmanian Government has stated that 'the MCH operates its funding in accordance with the detailed and publicly available Heads of Agreement'.[15] Further, DHHS informed the ANAO that it has 'only used Commonwealth funds for the performance of this project [the MCH program]'. The ANAO's testing of expenditure transaction samples over a four year period found no evidence to indicate that the MCH was using Commonwealth funds outside the HoA requirements in the categories of employee, supplies and pharmaceuticals expenditure, which have been the subject of such allegations.

36. Nevertheless, the inability of DHHS and MCH systems to readily provide the ANAO with complete transaction listings for MCH expenditure on shared corporate services and cross-charging between the MCH and other hospitals meant that it was not possible during the audit to form an overall judgement on the appropriateness of the use of funds in these categories. There is, therefore, scope for DHHS and the MCH to improve existing systems to better inform hospital management and oversight, provide greater assurance to respective governments, and to more efficiently demonstrate adherence to DHHS' obligations arising from the HoA.

37. While the MCH performs well in comparison to other Tasmanian hospitals with regard to the cost of delivered services, it does not perform as well against comparable mainland hospitals. For example, while the MCH's average cost per weighted separation[16] of $5125 was $1550, or 43 per cent, higher than the average cost for its peer group of mainland hospitals[17], it was $729, or 12 per cent, lower than the other Tasmanian hospitals. As outlined earlier, the higher cost of MCH clinical services in comparison to its peer group is primarily driven by higher staff counts per units of weighted activity, medical and surgical supplies, dependence on locum medical staff and administrative overheads. Some of these costs reflect structural factors within

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[15] Similarly, the Tasmanian Government has also been publicly reported as rejecting allegations of this type, stating that 'funding and resourcing of the Mersey Hospital is strictly in accordance with the three-year federal agreement' ['Hospital funding inquiry urged', *ABC News,* 22 December 2011].

[16] A weighted separation is an episode of admitted patient care that incorporates the level and complexity of the treatment provided. These figures are for acute admitted care in 2009–10, the latest data from the National Hospital Cost Data Collection available at the time of the audit's analysis.

[17] The MCH was compared to 10 mainland hospitals classified as medium inner regional hospitals that displayed a very similar casemix to the MCH.

Tasmania that contribute, in part, to the higher cost of service delivery.[18] However, there would be benefit in further exploring options to improve the efficiency of service delivery at the MCH by reviewing costs in particular areas, such as for locum medical staff.[19]

38. The Commonwealth's objectives for ownership of the MCH, which DoHA terms the 'core outcome' of the HoA, have been narrowly defined as the continuing provision of the core clinical activities, with existing performance measures not directly addressing the impact of those activities on the community serviced by the MCH. Furthermore, the Commonwealth preferred that the HoA not define the performance or service quality standards—of a kind that would normally be included in a services contract with a private sector provider—that Tasmania is required to meet as the operator of the MCH.[20]

39. The categories of operational and clinical information reporting that Tasmania is required to provide have not been updated since 2008 and, while there have been some recent improvements in DoHA's approach to its scrutiny of MCH performance information, the department's analysis of data reported under the two HoA has not been undertaken in a consistent and structured manner. These factors limit the Commonwealth's ability to assess whether the MCH is performing effectively, and whether it is receiving value for the significant amount of direct and indirect funding provided for the MCH program.

40. Commonwealth ownership has resulted in the need to establish unique arrangements for the management and operation of the MCH, which have come at additional cost and complexity as compared to the standard model of providing Commonwealth funding for public hospitals through health care agreements. A range of direct and indirect costs have been borne primarily by the Commonwealth, with the quarantining of funding for the MCH from the CGC's assessment for the distribution of the GST revenue pool also affecting the funds available for distribution to other states and territories. The ongoing administration of the HoA also necessitates a substantial commitment from

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[18] These factors include Tasmanian's capacity to achieve savings in medical and surgical supply costs given the size of the health system in comparison to other jurisdictions.

[19] MCH locum costs in 2010–11 represented 15.3 per cent of the hospital's expenditure on salary and wages, which was significantly (88 per cent) higher than the next highest Tasmanian hospital.

[20] DoHA considered that this high level approach provided Tasmania with clear responsibility and the necessary flexibility for day-to-day hospital management, reduced the Commonwealth's risk exposure in respect to hospital management and minimised departmental administration.

administering agencies, relating to ongoing administration and periodic negotiation. Further, the Commonwealth continues to shoulder risk as the owner of the MCH, notwithstanding its day-to-day management and operation by Tasmanian Government entities. In recognition of the additional costs, risks and complexity arising from ad hoc arrangements of this type, it is to be expected that responsible agencies will continue to monitor and keep under review the implementation of desired objectives in order to be in a position to advise governments on the benefits of the current arrangements over alternative options.

41. While the HoA support the continued delivery of a range of clinical services by the MCH to patients in its catchment, the strengthening of elements of the agreement and improvements in aspects of the responsible entities' administration have the potential to improve overall hospital performance and contribute to enhanced accountability. In this respect, the ANAO has made five recommendations—two directed to DoHA, one directed to DHHS and two directed jointly to both agencies. These recommendations are designed to enhance the utility of the HoA, provide greater assurance regarding the use of Commonwealth funds and strengthen the measurement of achievements against the MCH program objectives. There are also a number of suggestions made in the report to enhance the administration of the HoA, most notably: resolving the issue of responsibility for funding of capital works at the MCH; clarifying the extent of community engagement necessary to underpin decision-making on the MCH's service profile; and strengthening arrangements for the management of MCH assets.

Key findings

Effectiveness of the Heads of Agreement

42. Negotiations between the Commonwealth and Tasmania to establish both the 2008 and 2011 HoA, and agree the quantum of Commonwealth funding to the MCH under both, delivered HoA that have generally been effective in supporting the operation of the hospital. However, some aspects of the form and content of the HoA as negotiated between the parties have not supported the effective administration of the MCH arrangements.

43. In particular, the HoA specify a Clinical and Financial Services Plan as the mechanism to amend the agreements, but this has not been effective as a means for agreeing changes to the HoA or for negotiating changes to the MCH's service profile. On the occasions when a Plan has been agreed, the

timing of that agreement late in the year[21] has not allowed that Plan to be used effectively by the hospital to guide operational activities, and often its finalisation has come at the expense of the timely development of the following year's Plan. This is undesirable in a dynamic hospital environment. In the context of negotiating any new HoA from 1 July 2014, there would be merit in the parties examining the role of the Clinical and Financial Services Plan, in particular its status as an annual plan and whether an alternative process should be established for negotiating and agreeing 'supplementation and amendment' to the HoA.[22]

44. The form of the two HoA for the management, operation and funding of the MCH is a hybrid between a funding agreement and a services contract. The HoA do not contain any requirement for Tasmania, as the operator of the MCH, to meet performance or service quality standards of the kind that would normally be included in a services contract with a private sector operator.[23] Further, the categories of operational and clinical information reports that Tasmania is required to provide to the Commonwealth under the Schedule to the HoA have not been reviewed or amended since 2008. There would be benefit in reviewing these categories to ensure that they align with contemporary measures of hospital performance. Moreover, DoHA's analysis of the data reported has not been undertaken in a consistent or structured manner over the life of the two HoA. These issues inhibit the Commonwealth's ability to assess whether the hospital is performing effectively in meeting the Commonwealth's objectives.

45. There is ongoing disagreement between the parties over the responsibility for capital funding for the MCH. In the negotiation of the 2011 HoA, a compromise was agreed that limited use of Commonwealth funding for any minor capital works to an amount of $250 000 and allowed

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21 A Clinical and Financial Services Plan was not agreed for 2009–10. The Plan for 2010–11 was agreed on 17 February 2011. The Plan for 2011–12 was agreed on 29 June 2012.

22 In the context of the Clinical and Financial Services Plan, the term 'supplementation' refers to any additions to the HoA, while the term 'amendment' refers to changes to existing clauses.

23 The information available to the Commonwealth under the HoA relating to the performance of the MCH is relatively limited, is not described as 'performance' information, and does not include measurable performance indicators or standards.

Tasmania to apply to the Health and Hospitals Fund (HHF)[24] for capital funding above that limit. However, Tasmania's subsequent application to the HHF for $22.8 million in capital funding for the MCH was unsuccessful. It is apparent that the compromise that was agreed to enable the 2011 HoA to be signed was understood differently by the parties. DHHS considers that the terms of the 2011 HoA removed any obligation from Tasmania to fund capital works above $250 000, and placed that obligation on the Commonwealth as the owner of the facility. In response, the Commonwealth has noted that there is no provision in the 2011 HoA for it to fund additional capital works above $250 000. Given the potential impact on the quality of hospital facilities and the delivery of clinically safe services, resolution of the issue of responsibility for capital funding, including an appropriate process for considering specific requirements, should be addressed in the context of negotiating any new HoA from 1 July 2014.

Expenditure of Commonwealth funds for the MCH

46. The Commonwealth's direct funding for the MCH under the HoA is the subject of financial reporting requirements and subsequent scrutiny by DoHA and DHHS. While areas of concern have been identified through this scrutiny, these concerns have been resolved in consultation between the parties. For example, in 2009 and 2010, the Commonwealth questioned Tasmania's management of orthopaedic services in the North West region by treating patients from the MCH's catchment area at the NWRH and charging the MCH for that service. As Tasmania advised that it met those costs from MCH revenue, rather than from direct Commonwealth funding, this approach was not considered by DoHA to be contrary to Tasmania's HoA obligations.

47. The media has reported claims about the use of Commonwealth funds allocated to operate the MCH for expenses associated with employees, pharmaceuticals and supplies at the NWRH at Burnie.[25] The ANAO's

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[24] The Health and Hospitals Fund (HHF) was established by the Australian Government in the 2008–09 Budget to fund capital investment in health facilities, including renewal and refurbishment of hospitals, medical technology equipment and major medical research facilities and projects. Applications for funding from the HHF are assessed by an Advisory Board against evaluation criteria agreed by the Australian Government Minister for Health. The ANAO recently completed a performance audit of the administration of the HHF (ANAO Performance Audit No. 45 of 2011–12), available at <www.anao.gov.au>.

[25] See, for example, Tingle, L 'Claims funds bypassed Mersey', *The Australian Financial Review*, 1 December 2011, p. 12; Kempton, H 'Hospital cash switch storm', *The Mercury*, 22 December 2011; and 'Hospital funding inquiry urged', *ABC News*, 22 December 2011.

substantive testing of MCH and DHHS accounting records, covering transactions randomly sampled over the four years from 2008–09 to 2011–12, found no evidence to indicate that the MCH was using Commonwealth funds outside the HoA requirements in the categories of employee, supplies and pharmaceuticals expenditure. In the area of expenditure on patient transport, a number of transactions were identified in the accounts analysed where patient travel could not be separated from staff travel, meaning that the ANAO could not form an overall conclusion for the patient transport category. However, the transactions examined did not show that funds were used inconsistently with the HoA, and broader analysis indicates that the MCH's patient transport costs are not inconsistent with those of other Tasmanian hospitals.

48. While Tasmania is required, under the HoA, to maintain complete and current financial records relating to all aspects of the operation of the MCH, DHHS could not provide the ANAO with complete transaction listings for expenditure on shared corporate services provided to the MCH, and cross-charging between the MCH and other hospitals. This meant that the transaction samples tested by the ANAO did not represent a full population of transactions in these categories and, therefore, it was not possible to form an overall judgement on the appropriateness of the use of funds for these categories. While DHHS has since advised that it has developed an IT solution to provide a full population of cross-charging expenditure transactions, there remains scope to address systems limitations to better inform hospital management and oversight, provide greater assurance to respective governments, and to more efficiently demonstrate adherence to DHHS' obligations arising from the HoA. Such systems improvements include aligning reporting and conducting periodic system reconciliations, to better position DHHS to fulfil Tasmania's obligations under the HoA, as well as provide greater transparency around the use of Commonwealth funds.

49. With regard to expenditure on assets, the ANAO examined the controls in place at the MCH to manage the purchase, transfer, repair and disposal of assets at the hospital. These assets are owned by the Commonwealth. The ANAO found that there was scope for the MCH to strengthen its asset control systems, including implementing a regular asset stocktake program, to provide greater assurance regarding the management of hospital assets purchased with Commonwealth funds.

MCH management and performance

50. The MCH's corporate and clinical governance arrangements align with national standards and are consistent with the requirement under the HoA that Tasmania carry on the hospital in a professional and competent manner and comply with responsible public hospital practice. The ANAO's analysis of the MCH's clinical services indicated a number of well-performing areas. Performance results for inpatient management, High Dependency Unit demand and elective surgery wait times under the National Elective Surgery Target[26] were all positive. The MCH's emergency department is performing strongly against national benchmarks for patients to be seen within minimum times for their category of care (triage category), although there is some scope to improve the treatment times for patients in triage categories 3, 4 and 5, to bring these up to the performance levels recorded across the other acute care hospitals in Tasmania.[27] The MCH also comfortably achieved the state target in 2012, under the National Emergency Access Target[28], for patients being discharged from the emergency department within four hours.

51. The MCH recorded less positive performance results for aspects of its obstetrics service and for infection rates. Obstetrics data showed a higher rate of first birth (primipara) caesareans at the MCH than its peer group hospitals (48 per cent of first time mothers had caesareans at the MCH compared with 22 per cent at peer group hospitals), and a lower percentage compared with its peers of emergency caesareans commenced within the recommended 30 minutes (37 per cent compared to 73 per cent at peer group hospitals). A proposed review of obstetrics at the MCH is likely to assist with identifying practical changes that can improve these performance results. With regard to infection rates, the MCH did not meet the national target for the staphylococcus aureus bacteraemia (SAB)[29] infection rate in 2010–11 and 2011–

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[26] The 2011 National Partnership Agreement on Improving Public Hospital Services commits participating states and territories to targets relating to elective surgery and emergency department care. The National Elective Surgery Target (NEST) sets progressive targets for each state and territory for patients waiting for elective surgery to be treated within the clinically recommended time for their category of urgency.

[27] The NWRH at Burnie, the Royal Hobart Hospital and the Launceston General Hospital.

[28] The National Emergency Access Target (NEAT) sets progressive targets for each state and territory to achieve, by 2015, 90 per cent of all patients presenting to a public hospital emergency department either ready to leave the emergency department for admission to hospital, referred to another hospital for treatment, or discharged within four hours.

[29] Staphylococcus aureus bacteraemia (SAB) is a bloodstream infection with an estimated mortality rate of approximately 25-30 per cent of infected patients.

12[30], and its rate of clostridium difficile infection (CDI)[31] has progressively worsened since 2008–09, to be the highest CDI rate among Tasmanian hospitals in 2011–12. While a proportion of such infections may have been contracted before patients present to the hospital, there would be benefit in the THO-NW investigating potential causes for these infection rate results to inform remedial action.

MCH efficiency

52. The ANAO examined the MCH's weighted costs[32] for acute care and all care types against a national peer group of 10 medium sized inner regional hospitals and against the three other acute care hospitals in Tasmania. The MCH's average weighted costs for acute care and for all care types were significantly more expensive than its peer group by, respectively, 43 per cent and 23 per cent. However, the MCH is less costly on these weighted measures than the other Tasmanian hospitals, being 12 per cent lower per unit of weighted activity for acute care and seven per cent lower for all care types. While the characteristics of the MCH as a lower acuity hospital, with significant amounts of lower cost activity in day surgery, outpatient care and emergency department presentations, contribute to this result, it broadly indicates that the MCH is operating more efficiently than other Tasmanian hospitals.

53. Two of the key expenditure categories contributing to higher costs at the MCH compared to its peer group were identified as a high staff-to-patient ratio[33] and high medical and surgical supply costs[34]. High costs in these areas are common to the other Tasmanian hospitals, and the ANAO has been

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30 The MCH recorded an SAB infection rate of 2.3 case per 10 000 occupied bed days in 2010–11 and 2.1 cases in 2011–12, which exceeded the National Healthcare Agreement target of 2.0.

31 Clostridium difficile infection (CDI) is an infection of the bowel and affects patients in a similar way to SAB in increasing the risk of mortality, and often resulting in longer hospital stays.

32 As public hospitals have differing profiles in relation to the types of care provided and the mix of patients serviced, which vary in cost, the accepted approach to comparing costs between hospitals involves applying agreed weightings to these variables to produce a standard unit of activity on which comparisons can be made.

33 In 2010–11, the MCH had 37.8 full-time equivalent (FTE) staff per 1000 units of weighted activity compared with 29.0 FTE for the MCH's peer group and 39.8 FTE for the other Tasmanian hospitals. Further, the MCH's average salary and wage cost of $3195 per unit of weighted activity in 2010–11 was 19 per cent higher than the average cost per unit of $2668 for the medium inner regional hospital peer group. However, the MCH's cost on this measure is five per cent lower than for the other Tasmanian hospitals ($3367).

34 Expenditure on medical and surgical supplies was 72 per cent higher for the MCH ($717) compared with its peer group of hospitals ($416).

informed that work is underway within DHHS to examine options to improve Tasmania's performance with regard to the cost of supplies. The other drivers of higher costs at the MCH are expenditure on locum medical staff[35] and general administration costs[36], and it would be timely for the THO-NW and the MCH to review the factors influencing these costs and put in place effective strategies to improve efficiency in those areas of expenditure. The ANAO notes that the Commission on Delivery of Health Services in Tasmania[37] has a mandate from the Australian and Tasmanian governments to make recommendations with respect to remediating identified inefficiencies in the delivery of public health services in Tasmania, and recommending improvements to hospital system performance, and will produce a detailed report later in 2013.

Achievement of Commonwealth objectives in owning and funding the MCH

54. There was a high degree of congruence between successive Australian Governments' objectives in owning and funding the MCH, which emphasised the importance of maintaining, for the benefit of the local community, the clinical services at the hospital that were subject to change under *Tasmania's Health Plan 2007*, and ensuring local community engagement in decision-making on the MCH's service profile.

55. However, measures of performance, including the Key Performance Indicators (KPIs) in DoHA's Portfolio Budget Statements (PBS), have defined effectiveness narrowly as the continuing provision, at the MCH, of the core clinical activities specified in the HoA. That measure of effectiveness has been achieved. However, the impact of providing those activities—at the MCH—on the health needs of the local community, which was at the heart of the Commonwealth's intervention, has not been adequately represented in measures of performance and effectiveness for the program.

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35 MCH locum costs in 2010–11 represented 15.3 per cent of the hospital's expenditure on salary and wages, which was significantly (88 per cent) higher than the next highest Tasmanian hospital.

36 Expenditure on administration was 82 per cent higher at the MCH ($466) than the average for its peer group of hospitals ($255).

37 The Commission was established as part of a $325 million package of assistance to Tasmania's health system announced by the Australian Government on 15 June 2012. It presented an interim report to the Commonwealth and Tasmanian Health Ministers in December 2012.

56. Notwithstanding the inclusion, in Recital A of both HoA, of a statement of objective that contains broader dimensions than that in the PBS, the absence of an adequate performance framework in the HoA to measure these dimensions hampers the Commonwealth's ability to assess the standard and quality of service provision at the MCH. In addition, until recently, DoHA has not fully utilised the operational and clinical information reported to it under the HoA to evaluate the performance of the MCH. The lack of KPIs addressing the impact and cost-effectiveness of the MCH program means that the Commonwealth is not well placed to assess whether its ownership and funding of the MCH is effective.

57. With regard to whether the Commonwealth has received value for money from its ownership and funding of the MCH, the MCH program has not been subject to value for money analysis by the Commonwealth in either a policy advising context or in the performance management process associated with the establishment and administration of the HoA. There are some positive indicators in relation to the cost component of a value for money judgement, insofar as the quantum of funding agreed for the two HoA conformed closely to the funding envelopes for negotiation agreed by the Australian Government. Further, as previously mentioned, the MCH is a relatively efficiently run hospital compared with the other Tasmanian acute hospitals. However, a robust assessment of the value achieved from funding the MCH's operations, particularly the core clinical services the Commonwealth requires it to provide, necessitates a focus on the outcomes from the provision of those services, particularly the impact on the health needs of the local community. At present, the Commonwealth's performance measurement framework for the MCH program, with its focus on the provision of the core clinical activities rather than on their impact, is not capable of supporting an assessment of value for money achieved from the substantial direct and indirect funding provided for the MCH program. Enhancements to the monitoring of the performance of the MCH program would better position DoHA to advise government on the merits and operational benefits of various options for the delivery of the hospital services to the Latrobe region.

Summary of agency responses

58. Summary responses to the proposed report from each of the organisations involved in the audit are provided below, with the full responses provided at Appendix 1 to this report.

Australian Government Department of Health and Ageing

In delivering the Mersey Community Hospital program, the Department's focus is at all times on the current Australian Government's established policy priority for the Mersey Community Hospital: the availability to the local community of North West Tasmania of hospital services which are safe, high quality and based on clinical need. As noted in the report, the Department has made enhancements to its administration of the program over time. The Department will continue its efforts in these areas, both as part of normal business practice and in the context of any future agreement with Tasmania. The Department agrees with the ANAO's recommendations.

Tasmanian Government Department of Health and Human Services

The audit has provided an opportunity for the Department, with Tasmanian Health Organisation – North West, to review current systems and practices at the Mersey Community Hospital (the Mersey), but also systems at a broader state-wide level. In addition to the recommendations, the audit has made a number of observations with regard to shared services and systems that the Department is actively considering, and responding to internally.

The conclusion of the audit is timely, ahead of negotiating the arrangements for the continued management, funding and operation of the Mersey. The findings of the ANAO will inform these negotiations, particularly regarding working towards a mutually agreeable resolution to capital funding for the Mersey and considering the purpose of the clinical and financial services plans in the context of negotiating service change.

Tasmanian Health Organisation–North West

[The Chief Executive Officer of the Tasmanian Health Organisation – North West] concurs with the Secretary of DHSS that the findings of the audit provide direction to the THO-NW, together with DHHS, regarding key improvements that can be made to systems associated with management of the MCH; work has commenced to this end.

With the physical condition of the MCH likely to come under scrutiny through the next accreditation process, [the Chief Executive Officer] is keen to resolve the outstanding ambiguity regarding responsibility for funding of capital works. It is also important that there is a clear mechanism for agreeing service change. Successful resolution of these matters will impact on the extent to which [the Chief Executive Officer] is able to ensure the delivery of quality, safe hospital services at the MCH within the available budget.

Recommendations

Recommendation No.1

Paragraph 3.25

To assist with the timely finalisation and effective implementation of the Clinical and Financial Services Plan for the MCH, the ANAO recommends that DoHA and DHHS:

- clarify the function of the Plan, in particular its status as an annual plan and whether it should continue to be used as the designated means to vary the HoA;
- consider alternative processes to the Plan for negotiating changes to the MCH's service profile under the HoA; and
- develop appropriate processes and timeframes to enable the Plan to be finalised prior to the commencement of the financial year, so that it can be effectively used to guide hospital operations.

DoHA response: *Agreed.*

DHHS response: *Agreed.*

Recommendation No.2

Paragraph 3.46

To improve the Commonwealth's ability to monitor and assess the performance of the MCH under any future HoA, particularly the quality and safety of the services being delivered, the ANAO recommends that DoHA review the categories of operational and clinical information required to be reported under the HoA, with a view to:

- drawing on the best contemporary practice contained in the performance and accountability framework established under the national health reform process; and
- facilitating better utilisation of the information provided in assessing MCH performance.

DoHA response: *Agreed.*

Recommendation No.3

Paragraph 5.69

To improve the transparency of expenditure reporting for the MCH and to provide greater assurance that Commonwealth funds are being used in accordance with the HoA, the ANAO recommends that DHHS:

- address system limitations that prevent assurance being provided in relation to MCH expenditure under the HoA, specifically shared services, cross-charging and patient transport expenditure, and subsequently, in consultation with DoHA, undertake an audit of those expenditure categories;
- review, following consultation with DoHA, the alignment of the monthly and annual financial reports it provides under the HoA with its financial systems;
- undertake periodic reconciliations between its finance system and other systems, such as payroll, asset and pharmaceutical management systems; and
- review its management of MCH records, including employee files, to help ensure that relevant records are available in a timely manner.

DHHS response: *Agreed.*

Recommendation No.4

Paragraph 6.97

To support the efficient delivery of health care services at the MCH, the ANAO recommends that DoHA and DHHS initiate a targeted review by the THO-NW of the MCH's use of locums to determine whether there are any additional measures that can be taken by the hospital to better manage these costs.

DoHA response: *Agreed.*

DHHS response: *Agreed.*

Recommendation No.5

Paragraph 7.63

To better assess the effectiveness of the Commonwealth's ownership and funding of the MCH, and whether the Commonwealth is receiving value for money from the MCH arrangements, the ANAO recommends that DoHA expand its performance measurement framework for the MCH program to:

- incorporate existing MCH reporting required under the National Health Reform Agreements; and
- better inform an assessment of the extent to which the program objectives, established under Recital A of the HoA, are being achieved, with specific reference to service safety, clinical needs and community access.

DoHA response: *Agreed.*

Audit Findings

1. Background and Context

This chapter provides an overview of the recent history of the Mersey Community Hospital, the Heads of Agreement between the Commonwealth and Tasmanian governments governing the management and operation of the hospital, and the request for the Auditor-General to conduct an audit.

Introduction

The Mersey Community Hospital

1.1 The Mersey Community Hospital (MCH) is located in Latrobe, 10 kilometres south-east of Devonport, Tasmania (Figure 1.1). It has approximately 100 beds and provides medical services including emergency, general adult and paediatric medicine, general surgery, ophthalmological, some oncology, limited rehabilitation and allied health support. There are approximately 500 staff members employed at the MCH.[38]

Figure 1.1: Mersey Community Hospital

Source: ANAO, October 2012.

[38] The full-time equivalent (FTE) staffing level was 300. Department of Health and Human Services, *Achieving Results in the NWAHS*, April 2012.

1.2 First opened in 1961, the MCH has been operated at various times in its history by the Tasmanian Government and by private providers. In November 2007, the Commonwealth purchased the MCH from the Tasmanian Government in response to local community concern over proposed service changes at the hospital. The MCH is the only hospital in Australia both owned and directly funded by the Commonwealth. Since 1 September 2008, the Tasmanian Government has managed and operated the MCH under two successive Heads of Agreement (HoA) with the Commonwealth.

Health profile of the Latrobe region

1.3 The MCH provides hospital services to around 62 000 people in a catchment area comprising four North West Local Government Areas (LGAs): Devonport, Central Coast, Latrobe, and Kentish. All of these areas experienced population growth in the five years between 2005 and 2010, with Latrobe, where the MCH is located, achieving 15 per cent growth in population, making it one of the fastest residential growth areas in Tasmania.

1.4 Tasmania has the oldest population of all the states and territories with a median age of 39.9 years as at 30 June 2010, compared with the national median age of 36.9 years. Of the four LGAs serviced by the MCH, three have median ages higher than the Tasmanian average—Latrobe, at 44 years and Central Coast and Kentish, both at 43 years. Devonport's median age is equal to the Tasmanian average. The number of people aged 65 years and over in Tasmania is projected to continue to grow, from one person in every six in 2012 to one in every four people by 2032.[39] The implications of an ageing population include a rise in the incidence of illness and disability requiring medical treatment, thereby placing increased demand on medical and hospital services.

1.5 In addition to the oldest population, compared with the national average Tasmania also has:

- a higher proportion of the population aged 18 years and above who smoke (Australia: 16.3 per cent, Tasmania: 23.2 per cent); and

[39] Department of Health and Human Services, *Building Better Communities – a companion document to the DHHS Service and Community Profiles*, 2010, p. 1.

- a higher proportion of the population who are overweight or obese (Australia: 63.4 per cent, Tasmania: 65.6 per cent).[40]

1.6 These risk factors, when combined with an ageing population, are likely to result in an increased incidence of chronic disease, adding to the burden on health services. There is significant chronic disease in the North West, particularly cardiovascular disease, diabetes and cancer. There is also a high rate of teenage pregnancy.

1.7 Household income affects access to food, housing, health services and other factors that influence an individual's health status. The median weekly household income for Tasmania is $948, approximately 23 per cent lower than the national median of $1234. Tasmania's North West region contains significant areas of socio-economic disadvantage, and all four LGAs in the MCH's catchment have a lower median weekly household income than the median for Tasmania as a whole.

Commonwealth acquisition of the Mersey Community Hospital

Tasmania's 2007 Health Plan

1.8 Under the Tasmanian Government's ownership and operation of the then Mersey Hospital prior to 2007, the hospital formed one campus of a single North West Regional Hospital (NWRH), with the other campus at Burnie, 56 kilometres west of Latrobe.

1.9 In 2004, a review of the Tasmanian health system was conducted by an expert advisory group chaired by Professor Jeff Richardson[41], which recommended the consolidation of various services, including specialist services, to the Burnie campus of the NWRH. This was due to its facilities, location, existing capacity, and capability to handle more complex medical and surgical cases.

1.10 This recommendation was accepted and incorporated in the Tasmanian Government's *Tasmania's Health Plan*, which was released in May 2007. The Plan sought to reform Tasmania's health services through better integration of

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[40] Australian Bureau of Statistics, *Australian Health Survey: First Results 2011–12*, available from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/4364.0.55.0012011-12?OpenDocument> [accessed 25 January 2013].

[41] The review report was titled *The Tasmanian Hospital System: Reforms for the 21st Century*.

primary and acute health care, and guiding the future development of service design and delivery throughout Tasmania.[42] The Plan examined the delivery of health services in the North West region and concluded that the NWRH had not been able to achieve service sustainability across both campuses[43]—Burnie and Mersey—due to a range of factors, including:

- a lack of clinicians to cover on-call rosters at the two sites;
- high cost of services;
- a heavy reliance on overseas trained doctors, with inadequate support and supervision, particularly at the Mersey campus;
- a lack of suitably trained nurses to provide the full range of acute services at the two sites;
- a lack of adequate facilities, particularly at the Mersey campus;
- worsening workforce issues with the pending retirement of key clinicians and lack of succession planning strategies;
- compromising of capacity to achieve accreditation of training posts due to low volumes of activity at both sites; and
- difficulty sustaining the volumes needed to meet minimum accepted standards for safe practice.[44]

1.11 To address issues of sustainability, service duplication, costs and health care quality, the Plan announced a new strategy for the North West involving the consolidation of high acuity inpatient, intensive care and emergency services at the Burnie campus of the NWRH. The Mersey campus would focus on lower risk and sub-acute services, short stay services, including day surgery, and specialist outpatient services.

1.12 *Tasmania's Health Plan* had the support of both government and opposition parties in Tasmania and general clinical support. However, some members of the local community, as well as some doctors and other staff employed at the Mersey campus, did not support the planned service changes

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42 *Tasmania's Health Plan* comprised two elements: a *Primary Health Services Plan*, which focused on strengthening the primary health care system, and a *Clinical Services Plan*, which focused on services delivered in the major hospitals and by the Tasmanian ambulance service.

43 Department of Health and Human Services, *Tasmania's Health Plan: Summary*, May 2007, p. 49.

44 Department of Health and Human Services, *Clinical Services Plan*, May 2007, p. 89.

at the hospital. A 'Mersey Hospital Supporters Group' was formed to lobby against the service changes, which included canvassing for Commonwealth intervention.

Commonwealth intervention

1.13 In response to the local community's concerns, the then Prime Minister, the Hon John Howard MP, announced on 1 August 2007 that the Commonwealth would take over funding of the Mersey Hospital. In his letter of that date to the Premier of Tasmania, the Prime Minister advised of the Commonwealth's intention to:

- guarantee the continued funding of a wide range of inpatient, outpatient, accident and emergency and day procedure services, as well as appropriate surgical and high-dependency capacity at the Mersey Hospital;
- support the establishment of a Mersey Community Hospital Trust, comprising local government, business and health profession leaders, to run the renamed Mersey Community Hospital (MCH) on behalf of the community;
- underwrite the Trust's recurrent and capital funding of the hospital, including arrangements to lease the hospital buildings, infrastructure and medical equipment from the Tasmanian Government; and
- have the Trust assume full control of the hospital by 1 July 2008.

1.14 The Tasmanian Government responded on 20 August 2007, requesting that the Commonwealth take immediate control of the hospital. Further, it advised it would not agree to leasing the MCH to the Commonwealth, but offered to sell it for $1, subject to 15 conditions, including that:

- from the date of transfer all responsibility for the hospital rested with the Commonwealth or an organisation appointed by the Commonwealth to operate the hospital;
- the Commonwealth provided assurance that it would meet all capital and recurrent costs of the MCH;
- the Commonwealth would lease back to Tasmania, at no cost, parts of the MCH that were required for ongoing service delivery, including the ambulance station, the equipment and technology library and the stores; and

- any funding associated with the MCH should be quarantined from any assessments of the Commonwealth Grants Commission, and from funding received by the Tasmanian Government under the Australian Health Care Agreement or any other Commonwealth-state agreement.

1.15 Following further negotiations, the then Commonwealth and Tasmanian Health Ministers agreed that the Commonwealth would acquire the hospital and the Tasmanian Government would continue to operate it until the date of its transfer to the Commonwealth. An interim HoA dated 20 September 2007 was signed between the two parties outlining the conditions for the transfer of the hospital to the Commonwealth on 1 November 2007. While the Commonwealth would own and operate the MCH after that date, the HoA specified that the Tasmanian Government would continue to provide the hospital's administrative services, on a reimbursement basis, until 30 June 2008.

1.16 In the event, the sale could not be completed by 1 November 2007 due to delays in settling various administrative issues, including the transfer of contracts, state licensing arrangements for the Commonwealth to operate a public hospital in Tasmania, employment arrangements for staff, and the contracted services to be provided by Tasmania (such as payroll and IT services). The Commonwealth finally assumed ownership of the MCH from the Tasmanian Government on 23 November 2007, for a purchase price of $1.10 (GST inclusive), the day before the 2007 Federal election.

1.17 During the 2007 election campaign, the Australian Labor Party committed to honour the agreement made between the Howard Government and the Tasmanian Government.[45] Following its election win, the Australian Labor Party formed government on 3 December 2007.

Commonwealth operation of the Mersey Community Hospital

1.18 Following its acquisition by the Commonwealth, the MCH was operated by the Australian Government Department of Health and Ageing (DoHA) while the Government decided on its preferred approach to longer-term arrangements for the hospital's operation. In March 2008, the Government decided that it was not practical or cost-effective for DoHA to have direct operational responsibility for the MCH beyond 30 June 2008, and a

[45] Australian Labor Party, 'Investment in Tasmanian Health', 25 September 2007.

process to identify a private sector service provider to operate the hospital was commenced. The previous Government's plan to establish a Community Trust was not adopted. On 7 March 2008, DoHA announced that a request for tender would be conducted to select a not-for-profit provider to manage the MCH as a public hospital. From the expressions of interest received, one organisation was determined as meeting the criteria. During the course of subsequent negotiations with that organisation, it informed the Commonwealth on 30 May 2008 that it was withdrawing its tender.[46]

1.19 Following the unsuccessful tender process, the Australian Government decided to enter into a negotiation process with the Tasmanian Government, represented by DHHS, to resume operating and managing the MCH under the ownership of the Commonwealth. Subsequently, a HoA was signed by the Commonwealth and Tasmania on 27 August 2008 for the management, operation and funding of the MCH until 30 June 2011. The HoA established the terms and conditions for the Commonwealth owned and funded MCH to be managed and operated by Tasmania.

Revised Tasmanian Health Plan

1.20 During the period in which the Commonwealth operated the MCH, the Tasmanian Government updated the Clinical Services Plan component of its 2007 Health Plan to reflect the MCH's changed ownership and funding. The updated Clinical Services Plan, released in May 2008, presented two potential models for services in the North West, pending confirmation of the Commonwealth's arrangements to run the MCH from 1 July 2008.

1.21 The first model, which was Tasmania's preferred model, was similar to the original 2007 Clinical Services Plan, in that the MCH would become a centre for day surgery and specialist aged care rehabilitation, low risk obstetrics and emergency services. The second model involved the MCH operating as a full service community hospital in accordance with the commitments made by the Australian Government, providing a full range of community hospital-type services, including low to medium complexity medical and surgical inpatients, supported by a High Dependency Unit. The updated Clinical Services Plan stated that:

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[46] The Hon Nicola Roxon MP (then Minister for Health and Ageing), *Mersey Hospital*, media release, Parliament House, Canberra, 6 June 2008.

> The Tasmanian Government believes that a full service profile as provided for in Model 2 is unlikely to be sustainable. If the new operators are unable to deliver health care services of an acceptable range and quality, the Tasmanian Government would only consider resuming responsibility for the hospital on the basis that Model 1 was implemented.[47]

Management and operation of the Mersey Community Hospital by Tasmania

1.22 The Tasmanian Government resumed managing and operating the MCH on 1 September 2008 under a HoA signed on 27 August 2008. A second HoA was signed on 23 June 2011 continuing the arrangement for a further three years, expiring on 30 June 2014.[48] Key provisions of both HoA included the quantum of funding, the clinical services required to be delivered at the MCH and reporting requirements.

Funding

1.23 The funding agreed between the Commonwealth and Tasmania for the management and operation of the MCH under the two HoA is outlined in Table 1.1. The 2008 HoA did not provide for an annual indexation factor to be applied to the funding, however, an indexation factor of 3.5 per cent was included in the 2011 HoA, to apply after the first year.

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47 DHHS, *Clinical Services Plan*, May 2008, p. 6.

48 The Tasmanian Government Minister for Health wrote to the Australian Government Minister for Health and Ageing on 27 June 2013 to commence negotiations for the management, administration and operation of the MCH beyond the expiry of the 2011 HoA on 30 June 2014.

Table 1.1: Funding under the Heads of Agreement

Heads of Agreements	Funding period	Funding received (GST exclusive)	Total
2008–11	1 Sep 08 to 30 Jun 09	$49.8 million[1]	$169.8 million[2]
	1 Jul 09 to 30 Jun 10	$60.0 million	
	1 Jul 10 to 30 Jun 11	$60.0 million	
2011–14	1 Jul 11 to 30 Jun 12	$63.6 million	$197.5 million[3]
	1 Jul 12 to 30 Jun 13	$65.8 million	
	1 Jul 13 to 30 Jun 14	$68.1 million	
			$367.3 million

Source: ANAO analysis.

Note 1: Less than a full year's funding was provided due to the timing of the commencement of the HoA.

Note 2: Funding was not subject to an indexation factor.

Note 3: Increased funding reflects the agreed indexation factor applying in 2012–13 and 2013–14.

1.24 With regard to the use of the funding, Clause 4.1 in both the 2008 and 2011 HoA states that Tasmania must use the funds only for the performance of the project. The project is defined in the Schedule to the HoA as comprising:

(a) the management and operation (including the repair and maintenance) of the hospital; and

(b) carrying on the business and operations of the hospital, which includes managing, administering, delivering and performing, at a minimum, the core clinical activities (see paragraph 1.29).

Relationship to other Commonwealth funding

1.25 Under both HoA, the funding for the MCH is quarantined from:

- the Commonwealth Grants Commission (CGC) assessment for the distribution of the Goods and Services Tax (GST) revenue pool to states and territories; and
- funding provided to Tasmania under the National Healthcare Specific Purpose Payment (SPP)[49] or any other health funding arrangement.

[49] The National Healthcare SPP expired on 1 July 2012 and was replaced by the National Health Reform Agreement (NHRA). The NHRA is a nation-wide agreement aimed at improving the transparency, governance and financing of Australia's health care system.

1.26 The Tasmanian Government has accordingly remained eligible for its full entitlement of Commonwealth health-specific and other general funding streams. In 2010–11, these streams included $265 million in funding to Tasmania from the $12 billion available under the National Healthcare SPP. Tasmania can also receive a maximum of $89.2 million as its share of the $3.4 billion available over the life of the National Partnership Agreement on Improving Public Hospital Services, which incorporates funding from 2009–10 until 2016–17.[50]

1.27 On 15 June 2012, the Australian Government Minister for Health announced an 'emergency rescue package' for Tasmania's health system, providing $325 million over four years, covering eight separate components.[51] The ANAO has been advised that, at the time of this audit, MCH has not been allocated direct funding from this package.

Clinical services delivery

1.28 The 2008 and 2011 HoA require Tasmania to 'carry on the hospital diligently, honestly and in a professional and competent manner'[52] and to comply with 'responsible public hospital practice in respect of the hospital and in relation to any medical, clinical, surgical or other service' provided at the hospital.[53] The Agreements set out 12 core clinical activities that are to be 'carried on by Tasmania' at the MCH, without further specifying individual or relative activity levels.

1.29 The core clinical activities are set out at Item A in both HoA, as follows:

(a) a High Dependency Unit;

(b) a 24 hour/7 day emergency department;

(c) general and specialist medical services (including paediatric care);

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50 The funding figures are the base figures included in the *National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services*, July 2011.

51 These components are: an increased number of elective surgeries; establishment of Walk-in Clinics in Hobart and Launceston; support for community activities aimed at preventing and managing chronic disease; better post-treatment and palliative care; more medical specialists; addressing mental health services gaps; implementation of an electronic record keeping initiative; and support for clinical services research and development.

52 *Heads of Agreement for the continued management, operation and funding of the Mersey Community Hospital*, 2011, Clause 8.2(b).

53 ibid., Clause 8.2(e).

(d) oncology services;

(e) low risk obstetrics and gynaecological care;

(f) surgery and surgical specialities (other than planned complex surgery) that can be safely performed at the Hospital, including overnight planned and unplanned surgery and related post surgical care;

(g) clinical support services such as pathology, radiology and pharmacy;

(h) outpatient services;

(i) palliative care;

(j) geriatric support;

(k) community and outreach services; and

(l) such other services as the Commonwealth and Tasmania agree, having regard (amongst other things) to the professional support that progressively becomes available to the Hospital through the clinical networks developed under Tasmania's Clinical Services Plan.

Changes to clinical services

1.30 The core clinical activities of the MCH specified in the 2008 and 2011 HoA were largely determined by the service profile of the hospital prior to the proposals for change set out in *Tasmania's Health Plan 2007*. While there is flexibility for MCH management to develop and refine services outside the core clinical activities, changes to the core clinical activities can only be made with the agreement of the Commonwealth. There were no changes made to the core clinical activities during the life of the 2008 HoA.

1.31 During and subsequent to negotiation of the 2011 HoA, Tasmania indicated to the Commonwealth that it was seeking to make adjustments to general surgery and paediatric inpatient services at the MCH. Specifically, the roster for general surgery at the MCH was a one-in-two on call rotation, whereas the Royal Australian College of Surgeons (RACS) recommendation to ensure safe provision of surgical services was an on-call roster no more frequent than a one-in-four rotation. Tasmania sought the Commonwealth's agreement to move to the RACS recommended roster, which would entail the MCH ceasing the provision of out-of-hours surgery, with such surgery to be conducted at the NWRH in Burnie.

1.32 In relation to inpatient paediatric care, Tasmania noted the very low proportion (5 per cent) of paediatric emergency department presentations that were admitted to the hospital. Tasmania proposed closing the MCH paediatric ward, given that a new short stay unit, built as part of the emergency department renovations in 2011, would be available to be used to treat low acuity paediatric cases.

1.33 Following discussions between the Commonwealth and Tasmania, the Tasmanian Minister for Health wrote to the Australian Government Minister for Health on 25 September 2012 proposing the changes to general surgery rostering and paediatric services at the MCH in order to preserve the safe provision of these services across both hospitals in the North West region. The RACS and the Australian Medical Association (AMA) supported the service changes, as did the Governing Council of the Tasmanian Health Organisation–North West (THO-NW), which has been the MCH's regional governing authority since 1 July 2012.[54] The Australian Government Minister for Health agreed to the proposed service changes on 18 October 2012.

Reporting requirements

1.34 The 2011 HoA requires various performance and financial reporting to be provided by Tasmania to the Commonwealth (see Table 1.2).

Table 1.2: Reporting requirements under the 2011 Heads of Agreement

Period	Type of report
Monthly	Revenue and expenditure for the hospital for the relevant month.
Quarterly	Performance of the operation and management of the hospital, including information about the number of emergency department presentations, monthly bed occupancy rates, elective surgery activity and waiting times, and serious incidents by volume and service type.
Annually	Independently audited financial statements. Information about the hospital's utilisation, emergency department and outpatient services, elective surgery waiting times and clinical training commencements and completions. [A]

Source: ANAO analysis.

Note A: This information must be provided in accordance with the established National Minimum Data Set to enable it to be reported at a national level.

[54] Governance arrangements for the MCH are summarised in paragraphs 1.40-1.43, and examined in detail in Chapter 4.

1.35 As indicated in Table 1.2, the HoA require Tasmania to report quarterly and annually on aspects of the hospital's clinical and other activities, including: bed occupancy rates; number of outpatients; the number of emergency presentations and waiting times; elective surgery activity and waiting times; and serious incidents by volume and service type. There are, however, no performance standards or measures attached to these activity reports.

Differences between the 2008 and 2011 Heads of Agreement

1.36 While both HoA are set out in a similar way with a number of common terms and conditions, some key changes were introduced into the 2011 HoA, which included:

- a limit of $250 000 for any minor capital works to the hospital, in contrast to the 2008 HoA, which specified that funding could be used for all upgrades and expansions to the hospital;
- the inclusion of annual indexation for the funding;
- the ability to introduce other priorities and/or services as agreed by the two parties, which the Tasmanian Government is responsible for delivering;
- provision to 'move towards' activity-based costing of services to allow for greater transparency of costs and benefits; and
- expenditure reports to be provided monthly by Tasmania rather than quarterly, and an explanation for any variances of more than 10 per cent from the average expenditure for the previous three months.

1.37 One of the more significant changes to the 2011 HoA was the inclusion of an explicit reference to the MCH's position within the Tasmanian health system, which states that:

- Tasmania will continue to involve the hospital and its facilities in Tasmania's strategy for health service delivery in the state's North West region; and
- if Tasmania wishes to use the funds to provide services other than the core clinical activities in the state's North West region, the parties agree

to discuss in good faith how such services could be provided and implemented.[55]

1.38 This addition reflects both parties' acknowledgement that the MCH cannot operate in isolation from other health services in its region, and formally recognises the MCH's integration as a public hospital within Tasmania's health network in the North West region.

National health reform

1.39 Over the period in which the Tasmanian Government has managed and operated the MCH under successive HoA with the Commonwealth, the Australian health care system has undergone significant reform. This includes: the 2011 National Health Reform Agreement (NHRA), which established independent Local Hospital Networks as the management model for public hospitals, with states and territories funded as system administrators; and the National Health Performance Authority, supported by a Performance and Accountability Framework (PAF), to improve transparency and accountability for hospital performance.

Tasmania's health network

1.40 Until 30 June 2012, the MCH formed part of Tasmania's NWAHS, a division of DHHS. In addition to the MCH, the NWAHS was responsible for the NWRH at Burnie, three district hospitals and seven community health centres. Under this model, the Chief Executive Officer (CEO) of the NWAHS was responsible for determining resource allocations within its geographic area of responsibility, using a flexible model that allowed resources to be used across the area as required.

1.41 On 1 July 2012, in accordance with the NHRA's requirement that states and territories establish Local Hospital Networks, the three Area Health Services in Tasmania—North West, North and South—became Tasmanian Health Organisations (THOs). While the THOs are independent statutory authorities managed by a CEO, each is responsible to a Governing Council, which in turn reports to the Tasmanian Minister for Health and the Treasurer.

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[55] *Heads of Agreement for the continued management, operation and funding of the Mersey Community Hospital*, 2011, Clause 23.

1.42 THOs are responsible for managing:

- public hospitals and other health services in their control; and
- area budgets to deliver efficient and economic health services.

1.43 While the THO-NW has been responsible for the day-to-day management of the MCH since 1 July 2012, the HoA governing the operation of the hospital remains an agreement between the Commonwealth and Tasmania. As such, the agreement continues to be administered by DOHA and DHHS.

Request for an audit

1.44 On 20 December 2011, the Senator for Tasmania, Senator the Hon Richard Colbeck, wrote to the Auditor-General informing him of allegations concerning the misuse of Commonwealth funding for the MCH in contravention of the HoA, and requested an investigation of those allegations.

1.45 Following initial background enquiries with DoHA, as the responsible Australian Government department, the Auditor-General drew Senator Colbeck's request to the attention of the Joint Committee of Public Accounts and Audit (JCPAA) in February 2012, noting that the concerns raised by Senator Colbeck had also been aired in the national and Tasmanian media. The Auditor-General advised the JCPAA that an audit of the administration of the HoA would provide assurance to the Parliament on the use of Commonwealth funding at the MCH and the administrative effectiveness of the HoA, and potentially inform any further agreement between the Commonwealth and Tasmania on the operation of the hospital. The Auditor-General also advised that section 18B of the *Auditor-General Act 1997* (the Act) allowed the ANAO to conduct, at the request of the JCPAA, a performance audit of a Commonwealth partner where the Commonwealth has provided money to the partner for a Commonwealth purpose.

1.46 The Chair of the JCPAA wrote to the Auditor-General on 28 March 2012, advising that the JCPAA had resolved to request the Auditor-General to undertake a performance audit of the administration of the 2008 and 2011 HoA for the management, operation and funding of the MCH. In response to this request, the Auditor-General decided to undertake the audit. It is the first performance audit conducted by the ANAO pursuant to section 18B of the Act. The audit was formally designated and commenced in July 2012.

Audit objective, criteria and methodology

1.47 The objective of the audit was to assess the effectiveness of the administration, by DoHA and the Commonwealth partners, of the 2008 and 2011 Heads of Agreement for the management, operation and funding of the Mersey Community Hospital.

1.48 To conclude against the audit objective, the audit assessed whether:

- DoHA effectively established and administered the HoA for the MCH; and
- DHHS and the THO-NW are managing and operating the MCH in accordance with the HoA.

1.49 Three organisations were designated: DoHA and DHHS, the departments representing the Commonwealth and Tasmania as parties to the HoA, and the THO-NW, in recognition of its assumption of management responsibility for the MCH from 1 July 2012.

1.50 The scope of the audit had regard to the terms of the JCPAA request under section 18B(1) of the *Auditor-General Act 1997*, specifically the administration of both HoA, covering the period from 1 September 2008. Emphasis was given to whether Commonwealth funds were used in accordance with the HoA, and included consideration of whether the Commonwealth's objectives for acquiring the hospital have been achieved. The audit did not examine operational decision-making within the hospital, such as decisions regarding appointments to clinical positions.

1.51 While this audit focuses on assessing the effective implementation of the arrangements for the management, operation and funding of the MCH, including the achievement of program objectives, the ANAO does not have a mandate to examine and report on the appropriateness of government policy. As such, this audit does not comment on the merits of the Australian Government's decision to acquire the MCH from the Tasmanian Government in 2007 or its ongoing ownership.

1.52 The audit methodology included:

- interviews with DoHA, DHHS, THO-NW and MCH staff;
- interviews with non-government stakeholders;
- consideration of contributions from members of the public lodged via the citizen's input facility on the ANAO's website;

- review of documents held by DoHA and DHHS relevant to the development, negotiation and administration of the HoA;
- analysis of MCH performance data; and
- analysis of MCH financial processes and accounts, with particular emphasis on employees, hospital supplies, pharmaceutical supplies, corporate and shared services, cross-charging arrangements and asset management.

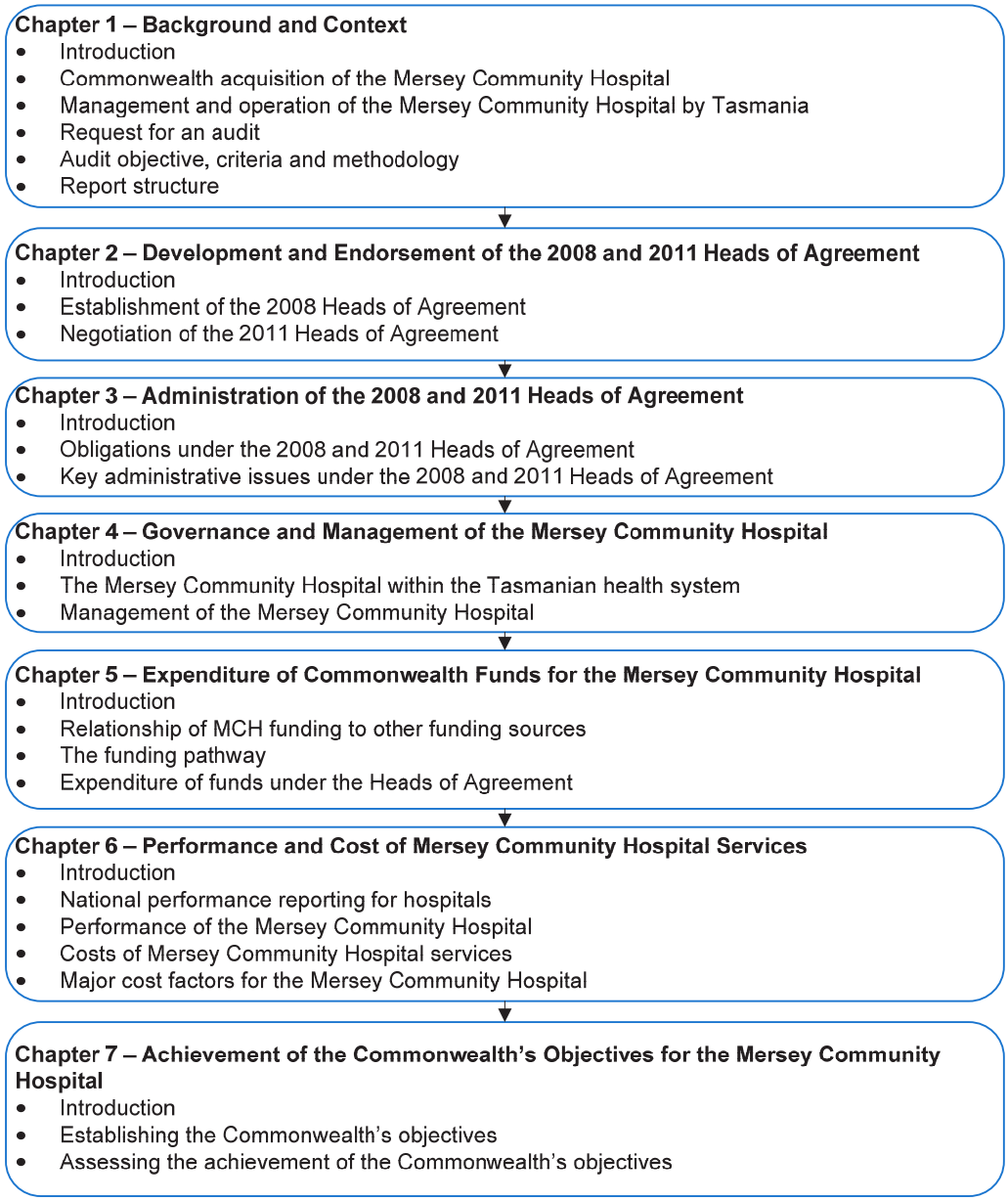
1.53 Given the extent and complexity of recent developments in hospital performance measurement under relevant national health agreements, and the particular characteristics of public hospital operations, the ANAO engaged an external firm with health sector expertise to provide technical assistance in undertaking performance and expenditure analysis at the MCH. The ANAO sought quotations from four professional services firms sourced from existing panel arrangements. Following formal evaluation of those quotations, PricewaterhouseCoopers was selected as the preferred respondent and was engaged to provide the relevant technical services to the ANAO.

1.54 The audit was conducted in accordance with ANAO Auditing Standards at an estimated cost of $925 000.

Report structure

1.55 The structure of the report is set out in Figure 1.2.

Figure 1.2: Report structure



2. Development and Endorsement of the 2008 and 2011 Heads of Agreement

This chapter examines the negotiation and establishment of the 2008 and 2011 Heads of Agreement for the management, operation and funding of the Mersey Community Hospital.

Introduction

2.1 As described in Chapter 1, the arrangements through which the Mersey Community Hospital (MCH) is operated by the State of Tasmania (Tasmania) for its owner, the Commonwealth of Australia (the Commonwealth), are set out in a Heads of Agreement (HoA) for the management, operation and funding of the MCH. The first HoA was signed on 27 August 2008[56] by the Commonwealth and Tasmania (the parties) and applied from 1 September 2008 until 30 June 2011. A second HoA, for the continued management, operation and funding of the MCH was signed by the parties on 23 June 2011 for the period 1 July 2011 until 30 June 2014.

2.2 The first of the following two sections of this chapter examines the establishment of the 2008 HoA, focusing on the determination of key terms and conditions, particularly those that have had ongoing importance throughout the life of both HoA. Other issues that were significant in the 2008 HoA negotiations, such as the employment status and conditions of MCH staff, are not covered, as they were settled at the time.

2.3 The second section examines the negotiation of the 2011 HoA. Given that the form and the majority of the content of the 2008 HoA was retained for the 2011 HoA, this examination focuses on the principal changes from the 2008 HoA.

Establishment of the 2008 Heads of Agreement

2.4 The Commonwealth initially sought to have an agreement in place with Tasmania by 30 June 2008, which is when the HoA of 20 September 2007,

[56] There was an earlier interim HoA signed on 20 September 2007 setting out the terms of the sale of the MCH to the Commonwealth and providing for Tasmania to provide ongoing administrative support until 30 June 2008.

providing for transitional administrative support to the MCH, expired. Recognising that this timeframe was not going to be achievable, the parties agreed to extend the transitional HoA until 31 August 2008.

2.5 When negotiations commenced, Tasmania's preferred position was that the hospital be returned to its ownership with ongoing funding provided by the Commonwealth. This position was not accepted by the Commonwealth. Negotiations between the parties consequently focused on Tasmania operating the hospital on behalf of the Commonwealth.

Form of the agreement

2.6 The form that an agreement takes necessarily influences its content. The Commonwealth and Tasmania concurred that an agreement between them governing the management arrangements for the MCH would be broad and over-arching rather than a detailed legal instrument. This approach was also expected to facilitate a timely conclusion to negotiations.

2.7 The form of the HoA was essentially a hybrid between a funding agreement and a services agreement, insofar as it drew on the content of the services agreement that had been prepared by the Commonwealth for a potential private operator. A services agreement with a private provider typically incorporates standards of performance that the provider is required to meet. However, in the case of the draft HoA being negotiated by the Commonwealth and Tasmania, references to an independent review of the operator's performance; performance indicators; insurance, clinic licence and accreditation requirements; and applicable hospital operation standards, were not included.

2.8 The Commonwealth preferred a HoA that was not prescriptive about service levels or performance because it would:

- give Tasmania clear responsibility and appropriate flexibility in the day-to-day management of the MCH;
- reduce the risk that problems that may arise in relation to the MCH's operational performance could be attributed to compliance with specific conditions determined by the Commonwealth, and attract criticism to the Commonwealth as a result; and
- minimise the level of resources required by the Commonwealth to administer the arrangement.

Negotiating the agreement

2.9 Officials of the Australian Government Department of Health and Ageing (DoHA) and the Tasmanian Government Department of Health and Human Services (DHHS) commenced negotiations on 18 June 2008 over the broad management arrangements for Tasmania's operation of the MCH that would ultimately be reflected in the HoA. By 3 July 2008, a number of key issues had been negotiated and supported in principle at officials level, including:

- funding of $180 million over three years to be used for the recurrent operating costs of the hospital and capital requirements. Funding could only be used for the MCH, including to expand the services at the hospital;
- Tasmania would provide regular financial and service reports to the Commonwealth, including full acquittal of the Commonwealth funding and audited financial statements;
- a Clinical Services and Financial Plan would be agreed for the hospital;
- the existing range of services would continue to be delivered at the hospital, with the range of services to be agreed, and to be within safe and contemporary clinical practice;
- the MCH would be part of the broader health service network for the North West of Tasmania;
- permanent positions for a General Manager, Clinical Director, Human Resources Manager and Finance Director would be established at the MCH; and
- Tasmania would establish a Community Regional Advisory Body, and provide a licensing arrangement which would accommodate the conditions of the HoA.

2.10 On 14 July 2008, the Tasmanian Government agreed to accept the offer of Commonwealth funding of $60 million per year under a three-year agreement. The then Australian Government Minister for Health and Ageing announced on 18 July 2008 that agreement had been reached between the two governments for the state to manage the MCH, and that detailed operational arrangements would be negotiated as quickly as possible. The Minister confirmed that the services that would continue at the MCH included a High Dependency Unit (HDU), day surgery and inpatient medical and surgical

services, low risk obstetric services, low risk inpatient paediatrics and low complexity inpatient acute medical services.[57]

2.11 The first draft of the HoA was provided to DHHS by DoHA on 23 July 2008. This initial draft underwent several iterations over the following two months as technical details were negotiated between the parties, which were informed by consultation with their respective finance and legal departments. The HoA was signed by the Commonwealth and Tasmania on 27 August 2008. The key elements of the HoA established through the negotiations were the quantum of funding, the core clinical services, performance measurement and reporting arrangements, the integration of the MCH into the Tasmanian health and hospital network, and the consultation mechanisms. These are examined in more detail below.

Quantum of funding

2.12 Establishing the quantum of funding for the MCH involved both parties making calculations of the running costs of the hospital and assessing the impact of various other factors, including capital expenditure requirements, economies available from operating the MCH within the Tasmanian health network rather than as a stand-alone entity, and various inclusions and exclusions agreed as part of the Commonwealth's acquisition of the MCH in 2007.

2.13 Accurately estimating actual costs was difficult for the Commonwealth given that it had operated the MCH for less than a full year, and, while it had been reimbursing DHHS for the provision of particular administrative services to the hospital, there was uncertainty around the totality and value of such services.

2.14 In preparation for the engagement of a private sector provider to operate the MCH, DoHA had received approval from the Government for funding of $64 million per annum for the hospital. This figure was based on estimates of direct operational costs of $45 million plus $19 million per annum for overhead costs, and an assumption that the MCH would operate as a stand-alone hospital, with the overheads covering the cost of the administrative services then being delivered by DHHS, such as finance and IT support.

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[57] The Hon Nicola Roxon MP (then Minister for Health and Ageing), *Future of Mersey Community Hospital Assured*, media release, Parliament House, Canberra, 18 July 2008.

2.15 In developing the Commonwealth's funding offer to Tasmania, DoHA estimated that the annual cost of Tasmania operating the MCH would be $55 million, taking into account that Tasmania would operate the hospital as part of its hospital network rather than as a stand-alone hospital. With the inclusion of capital upgrades and an expansion of services, DoHA estimated that $60 million per annum would be appropriate to meet the hospital's operating costs. DoHA also considered that the savings available to Tasmania from no longer having to fund the MCH would be retained in the North West and used to assist with meeting the demand for services.

2.16 Based on its estimate, the Commonwealth offered Tasmania $60 million a year for three years to operate the hospital. In addition to this, the Commonwealth agreed that Tasmania could retain all hospital revenue, including Commonwealth payments for Department of Veterans' Affairs patients, and continue to access funding under Commonwealth health programs. The offer excluded annual increases in funding through indexation, which the Commonwealth perceived as beneficial because it:

- placed the responsibility for meeting any cost increases in health care on Tasmania; and
- provided an incentive to the Tasmanian Government to improve the hospital's efficiency so that the cost of any additional services could be met within the Commonwealth's funding envelope.

2.17 DHHS advised DoHA that it estimated the operating costs of the hospital would be between $64 million to $80 million. Its initial response to DoHA's offer of $60 million a year was that it was unacceptable. DHHS also queried DoHA about the difference between the Commonwealth's offer and the expected hospital budget of $64 million cited in the Expression of Interest documentation for a private operator. DoHA explained to DHHS that the hospital's operating costs would have been higher for a private operator because it would be operated as a stand-alone hospital. In particular, compliance costs would also have been higher for a private operator, as the Commonwealth intended to impose more stringent performance requirements and greater reporting responsibilities than those being imposed on Tasmania.

2.18 On the basis of further negotiation, Tasmania decided to agree to the Commonwealth's offer of $60 million a year in direct funding, taking into consideration:

- the Commonwealth's indication that it had no capacity to negotiate above $60 million;
- that total revenue for the MCH, including the Commonwealth's funding, was estimated to be between $65 million to $70 million a year, within which Tasmania expected it could accommodate indexation and capital requirements;
- the substantial recurrent savings to Tasmania of $34 million a year from the amount it had previously spent to operate the MCH; and
- the exclusion of the MCH funding from the per capita calculations used by the Commonwealth Grants Commission to distribute to each state or territory its share of GST revenue (refer Chapter 1, paragraphs 1.14 and 1.25).

2.19 The Tasmanian Government also recognised that implementation of its updated Health Plan would not be possible with the MCH operating outside the Tasmanian health system. Its agreement to the Commonwealth's offer would enable the Plan to be implemented, with the Commonwealth covering the cost of the MCH component.

Core clinical services

2.20 In negotiating the 2008 HoA, the Commonwealth's position was to continue all services available at the hospital prior to the release of *Tasmania's Health Plan 2007*, and it sought agreement from Tasmania to the following services: a High Dependency Unit (HDU); a 24 hour emergency department; overnight medical, surgical and paediatric care; low risk obstetrics; and some surgery requiring overnight stay.

2.21 Tasmania was prepared to agree to the continuation of existing services, provided they could be safely and sustainably delivered. It perceived that existing services were aligned with its preferred model under the updated Clinical Services Plan of *Tasmania's Health Plan 2007* (see Chapter 1, paragraph 1.20). However, over the term of the HoA, Tasmania intended to pursue Commonwealth support for the implementation of *Tasmania's Health Plan 2007* with respect to services at the MCH, and planned for the service profile to be adjusted early in the new arrangement to appropriately delineate services between the MCH and the NWRH.

2.22 The parties agreed that a Services and Financial Plan would be agreed for the MCH. Provisions were included in the 2008 HoA for the Plan to be the mechanism for any supplementation or amendment to the HoA that the

parties agreed to make, to 'reflect changes in the circumstances in which the Project is being delivered'. Once a Services and Financial Plan was agreed, the HoA would be read subject to it; that is, its terms would prevail over any terms of the HoA inconsistent with it.[58] The HoA did not specify whether the Plan should be prepared annually or periodically as required.

2.23 The services that the parties agreed to be delivered at the hospital were set out in Item A of the Schedule of the HoA. Surgery and surgical specialties was the only service listed in the HoA Schedule that included specific reference to it continuing on the basis that it could be safely delivered.

2.24 The level of services to be delivered was not specified in the HoA, which was in contrast to the draft services agreement prepared by DoHA for a private operator. The HoA included a more generic requirement that Tasmania's use of Commonwealth funding was to provide the patients in the MCH catchment with access to a range of safe and cost effective services within clinically appropriate timeframes.

2.25 Beyond the services listed in the HoA Schedule, recital D(c) in the HoA recorded the parties' agreement to move to expand the range of services over the agreement period, subject to both parties' budgetary constraints, affording priority to renal dialysis, rehabilitation and expanded outpatient services.

Performance measurement and reporting

2.26 The Commonwealth required Tasmania to provide, under the Schedule to the HoA, quarterly and annual operational and clinical information (refer Appendix 2), and quarterly and annual financial reporting and acquittal of funding. During negotiations, Tasmania characterised these reporting requirements as 'extraordinary and onerous'. The Commonwealth declined to substantially revise the performance reporting requirements, noting that the majority of information required under the HoA was already provided under the reporting requirements in the existing *Australian Health Care Agreements.* However, the Commonwealth conceded that the quarterly financial reporting requirements under Item C3 of the Schedule to the HoA could be fulfilled using Tasmania's existing internal monthly financial reporting process.

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[58] See clauses 1.5, 3.2, 4.1(a), 4.1(b) and 4.2 of the 2008 *Heads of Agreement for the management, operation and funding of the Mersey Community Hospital*.

2.27 The Commonwealth viewed the performance and financial reporting requirements as going 'to the heart of the Agreement'. Notwithstanding this view, the requirements in the HoA were less detailed than those that had been set out in the draft services agreement the Commonwealth had prepared for a potential private operator of the MCH. That draft services agreement had contained 39 performance indicators, representing a richer set of data than that required of Tasmania under the HoA, grouped under three high level themes:

- quantitative: including number of weighted separations, number of day only cases and number of presentations to the emergency department by triage category;
- qualitative: including re-admission and infection rates, staffing ratio standards and accreditation status; and
- access: including waiting time for outpatients, average length of stay for inpatients and time between decision to discharge/transfer and actual time of discharge/transfer.

2.28 Information required by the Commonwealth in the HoA with Tasmania about the quality and safety of services delivered at the hospital was limited to the inclusion, in the quarterly operational and clinical information reports, of serious incidents by volume and service type.

Integration into the Tasmanian health and hospital network

2.29 During and subsequent to the negotiation of the Commonwealth's acquisition of the MCH in November 2007, both the Commonwealth and Tasmania regularly acknowledged the benefits of the MCH operating as part of Tasmania's broader hospital network. Despite this being an inclusion in the broad management arrangements agreed prior to the drafting of the HoA (refer paragraph 2.9), no specific reference was included in the 2008 HoA to the MCH operating within Tasmania's broader health and hospital network. It may have been difficult to frame an appropriate provision, given that the previous regional arrangement, with the MCH constituting one campus of the NWRH, could no longer exist, and a new regional authority—in the form of the North West Area Health Service (NWAHS)—was yet to be established.[59]

[59] The establishment of the North West Area Health Service in October 2008 is described in Chapter 4, paragraph 4.3.

Consultation mechanisms

2.30 The HoA set out communication mechanisms between: DoHA and DHHS; the MCH and the Devonport community; and the MCH clinicians and hospital management.

DoHA and DHHS

2.31 The HoA outlined a dispute resolution process between the Commonwealth and Tasmania. It also included requirements for Tasmania to notify the Commonwealth of specific incidents should they arise, for example:

- if there was a delay in engaging key hospital personnel, including a General Manager, Clinical Director, Finance Manager and Human Resource Manager; and
- any actual or threatened circumstance that had or could have had an adverse impact on the Tasmanian Government's management of Commonwealth funding.

2.32 Section 9 of the HoA provides for each party to appoint a liaison officer, with responsibility for operational coordination and management between the parties of their respective HoA obligations. However, outside the regular performance and financial reporting requirements, the HoA did not specify a requirement for regular contact between the Commonwealth and Tasmania.

MCH and the Devonport community

2.33 While the Commonwealth decided not to proceed with the Community Trust governance model for operating the hospital (refer Chapter 1, paragraph 1.18), community consultation remained a priority. The HoA required Tasmania to establish a community regional advisory body to provide key stakeholder engagement with, and guidance to, the direction and development of health and community services in the North West.

MCH clinicians and hospital management

2.34 The HoA also required Tasmania to establish a Clinical Services Advisory Group consisting of physicians and other health practitioners. The role of the group was to consider the range and location of services to be delivered in the North West. Tasmania was also required to advise the Commonwealth of any recommendations made by the group.

Variations to the 2008 HoA

2.35 During the life of the 2008 HoA, two variations were made to the agreement, which were executed through formal agreement variations. The first of these variations related to the requirement in clauses 6.1 and 6.2 of the HoA that Tasmania recruit and retain a General Manager for the MCH, and to advise the Commonwealth of any delays in filling the position. By November 2009, Tasmania was experiencing delays in recruiting a permanent General Manager. Noting the creation of the NWAHS in October 2008, Tasmania sought Commonwealth agreement for the position to be integrated, and have an extended role, within the NWAHS structure. The Commonwealth agreed to the request and an agreement variation was signed on 17 December 2009, documenting the parties' agreement that the project included the participation of the MCH in the collaborative arrangements constituting the NWAHS, and that the duties of the General Manager position involved additional NWAHS duties.

2.36 The second variation related to the negotiation of the 2011 HoA, in that clause 19.1 of the 2008 HoA required that the two parties meet to discuss the future management, administration and operation of the hospital no later than six months prior to the expiry date of the HoA. The Australian Government Minister for Health wrote to the Tasmanian Minister for Health on 25 October 2010 proposing that the requirement be changed to require the parties to meet no later than three months before the expiry of the HoA. This was to allow more time to reach agreement on the terms of a new HoA, particularly in relation to future funding. Tasmania agreed, and the variation was signed on 14 January 2011.

Conclusion

2.37 Reaching agreement on the management arrangements for the MCH was in both the Commonwealth's and Tasmania's interests. The Commonwealth did not have an alternative operator for the hospital, and there were benefits for the Tasmanian Government in accepting the agreement, including the retention as savings of the recurrent annual expenditure on the MCH prior to its acquisition by the Commonwealth.

2.38 The 2008 HoA included key high level principles important to each party. In particular, the Commonwealth secured the maintenance of the core clinical activities at the MCH that were central to its decision to acquire the hospital in 2007. Timing pressure and the absence of an alternative operator meant that the Tasmanian Government was in a stronger negotiating position

than the Commonwealth, with the Commonwealth making several concessions to Tasmania's position in negotiating the final details of the HoA.

2.39 The funding of $180 million over three years, without indexation, offered by the Commonwealth was based on the information available to DoHA at the time, and conformed with the funding envelope agreed by the Australian Government. While DoHA was successful in securing Tasmania's agreement to direct funding of $180 million, the real cost to the Commonwealth was higher than this sum given its agreement that Tasmania could count other Commonwealth payments, such as for Department of Veterans' Affairs patients, in hospital revenue, and the continuing quarantining of the MCH funding from funding provided to Tasmania under national health agreements. The availability of those funding sources was an important consideration in Tasmania's acceptance of the Commonwealth's funding offer.

2.40 Significant in its absence from the HoA was any explicit provision for the MCH to operate within the Tasmanian health and hospital network in the North West, particularly given the statements on both sides acknowledging the importance of this aspect of the hospital's operation and its inclusion in the agreed broad management arrangements.

2.41 The Commonwealth also secured its preferred reporting requirements included in the Schedule to the HoA. However, those reporting requirements were significantly less detailed than the range of quality and safety performance indicators proposed for a private sector provider. As a consequence, the information available to the Commonwealth under the HoA about the performance of the MCH is relatively limited, is not described as 'performance' information, and does not include measurable performance indicators or standards.

Negotiation of the 2011 Heads of Agreement

2.42 Tasmania initiated negotiations in relation to the 2011 HoA through a letter from the Premier to the Prime Minister on 27 April 2010. In the letter, the Premier advised that Tasmania was prepared to enter into a new HoA over five years dependent on the Commonwealth meeting the following four conditions:

- annual funding of $65 million indexed at 7.2 per cent a year;
- the MCH to operate as part of the Tasmanian health and hospital network, with the governance framework that applies to that network;

- the Commonwealth to be responsible for an appropriate level of capital maintenance and funding of any agreed capital upgrades required during the contract period; and
- continued quarantining of MCH funding from Commonwealth Grants Commission fiscal equalisation assessments.

2.43 The Prime Minister responded to the Premier on 28 June 2010 agreeing that discussions commence in a timely fashion and advising that the Australian Government Health Minister had been asked to contact her Tasmanian counterpart to commence discussions. Following the intervening 2010 Federal election, the Australian Government Minister for Health's letter of 25 October 2010 to the Tasmanian Minister for Health sought the variation to the HoA noted earlier to provide a longer period for negotiation, and advised that Tasmania's funding proposal was under consideration. The Tasmanian Minister for Health replied on 20 December 2010 agreeing the additional time for negotiation. However, the Minister advised that Tasmania required a new arrangement to be finalised by 31 March 2011, otherwise it would have no choice but to issue a licence to enable the Commonwealth to assume operation of the MCH.

2.44 The Commonwealth's negotiating position was considered by the Australian Government early in February 2011. The two Tasmanian conditions that were essentially a continuation of existing arrangements were agreed, including the quarantining of MCH funding from the Commonwealth Grants Commission's fiscal equalisation assessment of the redistribution of GST revenue. The Commonwealth also agreed to the MCH operating as part of the Tasmanian health and hospital network. As noted in paragraph 2.35, the Commonwealth had already agreed to the MCH participating in the NWAHS under the variation to the HoA agreed in December 2009.

2.45 While the Commonwealth agreed to these two Tasmanian conditions, the quantum of funding, the inclusion of an indexation factor in the funding and responsibility for capital funding required further negotiation. The following two sections outline, first, the progress of the two parties' positions in moving towards the outcomes agreed on these issues and, second, the key issues for the Commonwealth and Tasmania in the negotiation process.

Quantum of funding

2.46 During the Australian Government's consideration of its negotiating position in February 2011, it noted that rolling over the existing HoA at the

same level of funding would likely be rejected by Tasmania given the rising cost of health service delivery. It agreed an increased funding envelope for the negotiation, to be fully offset from savings within the Health and Ageing portfolio. It did not agree with Tasmania's condition that the Commonwealth be responsible for capital maintenance and any agreed capital upgrades.

2.47 On the basis of the Government's decision, the Minister for Health wrote to her Tasmanian counterpart on 1 March 2011 advising the Commonwealth's agreement to two of the four conditions and acknowledging that some increase in funding would be appropriate to recognise increased costs. The Minister offered Commonwealth funding of $183.24 million over three years, or $61.08 million a year. Indexation was not raised in the letter. The Minister also advised the Commonwealth's preference that arrangements under the 2008 HoA for capital funding continue, whereby the costs of upgrades to the hospital and its facilities, replacement of worn and damaged items and general repairs and maintenance were provided from within the Commonwealth's funding for the hospital.[60]

2.48 With the agreement of Ministers, negotiations between DoHA and DHHS officials commenced on 7 March 2011. Tasmania formally rejected the Commonwealth's funding offer on 28 March 2011. The Commonwealth made a second offer of $187 million over three years on 30 March 2011. This was also rejected, and a third offer of $190.8 million was made on 21 April 2011. Tasmania formally responded on 1 June 2011, noting this offer, but insisting on the inclusion of an indexation factor. To avoid an impasse, Tasmania offered to reduce this factor from 7.2 per cent to 3.5 per cent a year, commencing in the second year, resulting in a three-year total funding envelope of $197.56 million. The Commonwealth advised Tasmania of its agreement on 23 June 2011. The progress of the negotiation of the quantum of funding is summarised in Table 2.1.

[60] Clause 4.1(c) of the 2008 *Heads of Agreement for the management, operation and funding of the Mersey Community Hospital*.

Table 2.1: MCH funding requests and offers during 2011 HoA negotiations

Tasmania		Commonwealth	
Date	Funding sought over three years $ million	Date	Funding offered over three years $ million
27 April 2010	209.37[1]	1 March 2011	183.24
28 March 2011	209.37	30 March 2011	187.00
13 April 2011	209.37	21 April 2011	190.80[2]
1 June 2011	197.56[3]	23 June 2011	197.56

Source: ANAO analysis of DoHA and DHHS information.

Notes: 1 Equates to $65.0 million a year plus 7.2 per cent indexation.

2 Equates to $63.6 million a year without indexation.

3 Equates to $63.6 million a year plus 3.5 per cent indexation in the final two years.

2.49 With respect to capital funding, the Australian Government Minister for Health in her letter of 21 April 2011 advised that there was scope for flexibility in apportioning the offered increase of $10.8 million (to $190.8 million) across the three years, and that capital upgrades could be met within this flexible apportionment. In subsequent discussions, Tasmania rejected this approach. In order to break the deadlock over capital funding, the Commonwealth indicated that Tasmania could apply for funding for major capital upgrades to the hospital, above $250 000, through the Health and Hospitals Fund (HHF).[61] Tasmania accepted this compromise.[62] The Tasmanian Minister for Health noted in her letter of 1 June 2011 to the Australian Government Minister that this 'concession' by the Commonwealth contributed to Tasmania's preparedness to reduce its requirement for annual indexation from 7.2 per cent to 3.5 per cent.

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61 The Health and Hospitals Fund (HHF) was established by the Australian Government in the 2008–09 Budget to fund capital investment in health facilities, including renewal and refurbishment of hospitals, medical technology equipment and major medical research facilities and projects. Applications for funding from the HHF are assessed by an Advisory Board against evaluation criteria agreed by the Australian Government Minister for Health. The ANAO recently completed a performance audit of the administration of the HHF (ANAO Performance Audit No. 45 of 2011–12), available at <http://www.anao.gov.au/>.

62 The outcome of Tasmania's application to the HHF and subsequent discussions between the parties regarding responsibility for capital funding are described in Chapter 3 at paragraphs 3.28-3.35.

Key issues in the negotiations

2.50 As in 2008, Tasmania held a potential advantage in negotiations as alternative options available to the Commonwealth to operate the hospital were limited. During the negotiations, Tasmania emphasised this position by regularly reminding the Commonwealth that the clock was ticking towards the expiry of the HoA on 30 June 2011, and that there were minimum timeframes in advance of that date for the Commonwealth to acquire the licence necessary to operate the hospital. Tasmania also initiated the negotiation process and was the first of the parties to set out its conditions, which then largely determined the negotiating agenda.

2.51 In considering its position when entering the negotiations, the Australian Government maintained the view that it was not practical or cost-effective for DoHA to have direct operational responsibility for the MCH. The Government considered that, on patient safety grounds, it was preferable for the MCH to remain integrated with the Tasmanian public hospital system and, therefore, continue to be operated by Tasmania. Accordingly, while the option of re-testing the market to find a private operator was canvassed, it was considered to be a fall-back option if a continuation of the arrangement with Tasmania was unable to be settled. Handing ownership of the MCH back to Tasmania was not considered by the Australian Government as an option at the time of negotiations.

2.52 In its approach to the negotiation over funding for the MCH. Tasmania's negotiating position was based on the following:

- current MCH costs were exceeding $65 million a year;
- MCH costs beyond the funding of $60 million a year under the 2008 HoA were being covered by the state government, despite the fact it was operating the hospital on behalf of the Commonwealth owner on a fee for management service basis;
- acceptance of a Commonwealth funding offer of base funding below $65 million would require the cessation and reconfiguration of services, including core clinical services, such as the emergency department; and
- while Tasmania had funded major capital improvements at the MCH during the life of the 2008 HoA at a cost of $6.1 million, further improvements were required that could not be met from within the existing hospital funding level, and Tasmania was not in a position,

and should not be required, to continue to fund improvements to a Commonwealth-owned facility.

2.53 For its part, the Commonwealth:

- pointed out that the MCH had been operating effectively, including expanding non-core services, within the existing funding amount;
- made consistent efforts—through queries, information requests and a site visit—to verify Tasmania's estimation that current MCH costs were running at $65 million a year;
- refused to agree to any reduction in core clinical activities;
- sought to identify in consultation with Tasmania areas of potential efficiency improvements outside the core clinical activities; and
- emphasised the totality of Commonwealth health funding assistance to Tasmania, and the Tasmanian Premier's agreement in June 2008 that $34 million—identified by the Premier as the annual recurrent savings component of Tasmania's funding of the Mersey hospital prior to its take-over by the Commonwealth—would be allocated to health services in the North and North West regions of Tasmania.

2.54 As shown in Table 2.1, despite ongoing communication and information exchanges between DoHA and DHHS officials during March and April 2011, and increases in the Commonwealth's funding offer, agreement could not be reached on a quantum of funding at that time. However, negotiations were effective in exposing the core issues that any compromise would need to address. These included Tasmania's firm belief that it had been exposed financially by the lack of an indexation provision and the absence of a reference to responsibility for capital funding in the 2008 HoA, with DHHS advising that it supplemented the MCH's budget by $3.8 million in 2010–11. Tasmania was also concerned at the lack of flexibility experienced under the 2008 HoA to adjust clinical services to achieve efficiencies. The Commonwealth also wanted the contribution that hospital revenue made to the totality of funds available to the MCH appropriately taken into account in settling the amount of direct Commonwealth funding.

2.55 A compromise was ultimately struck around these key issues, with Tasmania agreeing to the Commonwealth's offer of access to a new avenue of capital funding through the HHF, above a limit of $250 000 for minor capital works from Commonwealth funding to be set out in the new HoA. Subsequent developments in 2012 (addressed in Chapter 3, paragraphs 3.28–3.35), made it

clear that the Commonwealth and Tasmania held different understandings of the import of this compromise approach, and the issue of responsibility for capital funding is yet to be settled, more than two years after the HoA was signed.

2.56 In relation to the revenue generated by the hospital, Tasmania initially offered to contribute the MCH's own-source revenue to meet the hospital's operational costs for the first year of the new agreement. Through an exchange of letters outside the terms of the HoA, the Commonwealth sought a commitment from Tasmania that this arrangement should apply for the life of the agreement, and Tasmania agreed.[63]

2.57 With regard to clinical services, Tasmania agreed that existing core services specified in the schedule to the 2008 HoA would be maintained, but advised that it would need to maintain flexibility in the provision of non-core services. In her letter of 23 June 2011 confirming the terms of the agreement, the Australian Government Minister for Health acknowledged that advice, and noted her expectation that any changes to non-core services proposed by Tasmania would be implemented in close consultation with DoHA, as well as local stakeholders, including the community.

2.58 Meeting Tasmania's revised request for a 3.5 per cent indexation factor required additional Commonwealth funding of $6.76 million over three years—above the increased funding already offered of $10.8 million—to a total of $197.56 million. Given the short timeframe before the expiry of the HoA, the Prime Minister agreed to this total funding amount on 11 June 2011. The period between the Prime Minister's decision and the Minister for Health's letter to the Tasmanian Minister for Health on 23 June 2011 was utilised by officials to finalise and agree the text of the HoA, so that a signature-ready copy could be provided with the Minister's letter. The HoA was signed by the Ministers on 23 June 2011 and announced on 28 June 2011.[64]

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63 The Tasmanian Minister for Health wrote to the Australian Government Minister for Health on 18 December 2012, advising that, because the MCH was no longer required to pay payroll tax to the state, Tasmania would invest MCH own-source revenue across the THO-NW, rather than reserving it exclusively for the MCH.

64 The Hon Nicola Roxon MP (then Minister for Health and Ageing), *New Mersey Community Hospital Funding Agreement Signed*, media release, Parliament House, Canberra, 28 June 2011.

Additional issues

2.59 The conditions sought by Tasmania set the agenda for the negotiation between the parties, and the principal changes to the 2011 HoA from the 2008 HoA reflected the agreements reached on those conditions during the negotiations. For example, the agreement that the MCH would operate as part of the Tasmanian health and hospital network was given effect by the inclusion of clause 23 in the 2011 HoA and also recognised in the Schedule to the HoA.[65]

2.60 With respect to the capital funding issue, the wording of clause 4.1(c) in the 2011 HoA was varied from the 2008 HoA by stating that the use of Commonwealth funds included any minor capital works to the hospital or its facilities with a value up to $250 000. The 2011 HoA contains no provisions concerning capital funding for the MCH above that amount. The agreement for Tasmania to make submissions for capital funding through the HHF was recorded in the Ministerial correspondence, but not included in the HoA.

2.61 While there were some areas of technical amendment of the HoA negotiated between officials, these were relatively minor. The only significant new issue introduced by the Commonwealth into the negotiations was its proposal to recognise the move, under the National Health Reform Agreement, to activity based funding for hospitals from 1 July 2012. In her letter to the Tasmanian Minister of 1 March 2011, the Australian Government Minister suggested that a three-year agreement, rather than Tasmania's preference for a five-year agreement, would suitably allow for the implications of activity based funding for the MCH to be considered within one to two years. In her subsequent letter of 30 March 2011, the Minister advised that the Commonwealth's increased offer of $7.0 million over three years was conditional upon Tasmania agreeing to activity based costing of services being introduced into the hospital by 2012–13, to provide increased transparency of the drivers of hospital costs. This was reiterated in the Minister's further letter of 21 April 2011, but was no longer stated as a condition of Tasmania's agreement to the funding offered.

2.62 The Tasmanian Minister's correspondence to the Australian Government Minister during the negotiations did not respond, or make

[65] The Schedule to the 2011 HoA states that 'Tasmania must ensure that the Hospital operates as part of the Tasmanian Health and Hospital Network, and Tasmania must comply with any governance framework that applies to the Tasmanian Health and Hospital Network.'

reference, to the proposed move to activity based funding or costing. However, Tasmania agreed to the inclusion of Part E (d) of the Recitals at the beginning of the 2011 HoA, which states that the parties 'will move towards activity based costing of the services being delivered to allow for greater transparency of costs and benefits at the MCH'.

2.63 Beyond the issues outlined earlier, the remaining changes to the HoA were relatively minor. Reporting requirements under the Schedule to the HoA were changed to increase the frequency of financial reporting and acquittal of funding from quarterly to monthly reporting. In conjunction with this change, a requirement was introduced for a detailed explanation to be provided by Tasmania where monthly expenditure varied by more than 10 per cent from the three-monthly average. No changes were made to the requirements for the quarterly and annual reports of operational and clinical information.

Conclusion

2.64 The negotiation of the 2011 HoA was a lengthy and detailed process. DoHA and DHHS officials conducted the negotiations professionally, and advised their Ministers appropriately in supporting their governments' policy positions and jurisdictional interests. Both parties made concessions to achieve an agreement in time to secure the continuity of management arrangements at the MCH without major disruption to the operation of the hospital.

2.65 In terms of the financial outcome and the agreement to $197.56 million in Commonwealth funding over three years, this sum was slightly above the mid-point between the parties' positions at the commencement of the negotiations, reflecting the Commonwealth moving further towards Tasmania's position in order to accommodate the compromise on indexation of funding necessary to achieve agreement. This was an acceptable outcome for the Commonwealth from a government perspective. However, Tasmania maintained the significant financial advantages resulting from retaining the recurrent savings made in 2008 from the transfer of MCH ownership to the Commonwealth, and from the continued quarantining of MCH funding from Commonwealth Grants Commission assessments and from Commonwealth financial assistance under other intergovernmental agreements. Further, there was the possibility of securing additional funding under the HHF.

2.66 Tasmania's early statement of its conditions set the agenda for the negotiations. While it was open for the Commonwealth to raise additional matters, it essentially responded to Tasmania's statement throughout the

negotiations. As a consequence, some aspects of the HoA that might usefully have been reviewed and updated remained unchanged, including the performance reporting requirements under the Schedule to the HoA, and the role of the Clinical and Financial Services Plan.

2.67 While a compromise was reached on a new approach to capital funding arrangements, subsequent events revealed that the parties' understanding of the meaning of that compromise are at variance, and the issue remains unresolved.

3. Administration of the 2008 and 2011 Heads of Agreement

This chapter examines the key provisions of the Heads of Agreement that have affected the administration of the arrangements between the Commonwealth and Tasmania.

Introduction

3.1 As outlined in Chapter 2, the two HoA were the products of complex negotiations between the Commonwealth and Tasmania, reflecting the parties' respective policy objectives and positions. The ANAO examined the administration of both HoA by DoHA and DHHS, focusing on the effectiveness of the HoA as instruments to govern the delivery of hospital services at the MCH and the compliance of the parties with their terms. The following sections broadly examine the obligations established under the HoA the key administrative issues that have arisen in the administration of both agreements. More detailed analysis of management, financial and performance obligations is covered in Chapters 4-6.

Obligations under the 2008 and 2011 Heads of Agreement

3.2 The overwhelming majority of obligations contained in the HoA are placed on Tasmania as the manager and operator of the hospital. The current HoA agreed in 2011 contains 54 individual obligations directed to Tasmania, with a further nine obligations activated by particular circumstances.

3.3 In response to a formal ANAO request, DHHS advised in August 2012 that, of the 54 obligations, Tasmania was compliant with 51, non-compliant with two and partially compliant with one. Following further examination by DHHS of the coverage of its assets and contract registers for the MCH, DHHS provided additional information and evidence to the ANAO in July 2013 supporting a finding of partial compliance rather than non-compliance in those areas, as shown in Table 3.1.

Table 3.1: HoA obligations with which Tasmania is partially compliant

HoA clause	Obligation	Compliance status and reason
12.6(a)	Tasmania must maintain a register of all Hospital Assets recording the date of acquisition or lease, the purchase price, their description, the amount of the Funds used to acquire them, the extent remaining of their economic life and (where relevant) details of their disposal (including the sale price).	Partially compliant. DHHS maintains a fixed assets register for tangible assets greater than $10 000. This was confirmed by the ANAO's testing of MCH asset controls during the course of the audit.
13.4	Tasmania must continue to maintain and keep current a register of all those contracts in connection with the Hospital to which it is a party or of which it has the benefit. Tasmania must provide the Commonwealth with a copy of that register from time to time during the Agreement period on request and promptly (without request) after this Agreement ends.	Partially compliant. DHHS keeps a register of all contracts over $50 000. In addition, the Business Manager at the MCH has kept a register of all contracts managed by the MCH since September 2012, regardless of value. A copy of this register was provided to the ANAO by DHHS in July 2013.
7.7	Tasmania must implement and maintain electronic data processing and transmission systems in respect of the hospital such that it can: a. use electronic claiming channels through Medicare Australia, including Medicare Online, Medicare Easyclaim and Medicare Australia's Electronic Claim Lodgement and Information Processing Service Environment; and b. integrate with and utilise private health insurers' electronic claims systems, as appropriate.	Partially compliant. There are electronic data processing and transmission systems with Medicare available at the MCH. Consistent with other hospitals in Tasmania, the MCH does not have an electronic processing system for private health insurance claims. DHHS advised that it is considering implementing an electronic processing system for private health insurers, although it is not a current budget priority. This would occur in accordance with DHHS's management of this for all hospitals across the state.

Source: DHHS advice to the ANAO, 17 August 2012 and 4 July 2013.

3.4 These areas of partial compliance reported to the ANAO by DHHS are consistent with those identified in an earlier external audit of Tasmania's compliance with 19 specific conditions[66] set out in the 2008 HoA, commissioned by DHHS from a private accounting firm in 2009–10. A draft report[67] outlining the findings of this audit was presented to DHHS in

[66] DHHS was unable to provide the ANAO with the Terms of Reference for this engagement. Consequently, the basis on which the 19 conditions were selected for review is unclear.

[67] The draft report was titled *Audit of the compliance with the Heads of Agreement for the Management, Operation and Funding of the Mersey Community Hospital*.

February 2010, but DHHS was unable to provide the ANAO with a copy of its response to the draft report or confirm that the report was finalised.

3.5 With respect to the HoA obligations with which Tasmania indicated it was compliant, the ANAO's analysis of the MCH's governance, expenditure and performance (see Chapters 4, 5 and 6) largely confirmed DHHS' advice in relation to Tasmania's obligations in those areas. However, the current arrangements to manage financial data within DHHS systems means that the department is not well placed to meet the record-keeping obligations, which support accountability for MCH expenditure, under clause 7.2(a) of the HoA (this matter is examined in Chapter 5). DHHS advised the ANAO in July 2013 that work was underway within its Shared Services unit to ensure that DHHS is better placed to meet these obligations, noting that any changes would need to be statewide and consistent with state policy. The ANAO's examination of the MCH's assets management systems also found that a complete listing of asset disposals was not maintained (see Chapter 5, paragraph 5.57–5.63), which is an area of non-compliance with the obligations under clause 12.6(a) of the HoA.

3.6 A number of the more technical obligations under the HoA were not independently examined during the audit, but the ANAO's review of records of correspondence and liaison meetings between DoHA and DHHS during the life of both HoA did not identify issues in relation to these obligations, other than minor exceptions. For example, documentation is not available to demonstrate that Tasmania submitted quarterly reports to DoHA of critical incidents at the MCH for six quarters between January 2010 and June 2011, as required under Item C1(g) of the Schedule to the HoA.

Conclusion

3.7 Overall, the ANAO did not observe material non-compliance by Tasmania with its obligations under the HoA. In relation to the obligations to maintain registers of all assets and contracts, with which Tasmania is partially compliant, the ANAO recognises the difficulties associated with maintaining such registers for all items, including lower value items, in a hospital environment. The negotiation of the 2011 HoA provided an opportunity to review the appropriateness and practicality of these obligations, but this opportunity was not taken. The ANAO suggests that DoHA and DHHS review the obligations under clauses 12.6 (a) and 13.4 in the context of the negotiation of any new HoA beyond 2014.

Key administrative issues under the 2008 and 2011 Heads of Agreement

3.8 The treatment of some issues in both HoA, particularly the function of a Clinical and Financial Services Plan, responsibility for capital funding and performance information requirements, have had practical implications for the administration of the HoA and for the relationship between the Commonwealth and Tasmania. The following sections examine these areas.

Clinical and Financial Services Plans

3.9 As noted in paragraph 2.22, the 2008 HoA provided for a Services and Financial Plan to be the vehicle for agreed amendments to the HoA.[68] Beyond its function in that respect, the HoA gave no guidance as to any other function of the Plan or the type of information to be included in the Plan. While the HoA did not specify a timing requirement for the Plan, Tasmania positioned its draft Services and Financial Plan for 2009–10 and 2010–11 as an annual plan.

3.10 For the first two and a half years of the life of the 2008 HoA, the Commonwealth and Tasmania were unable to finalise a Clinical and Financial Services Plan for the MCH. There was, therefore, no high-level planning document in place for the hospital for 2008–09 and 2009–10 and by the time the Plan for 2010–11 was agreed on 17 February 2011, only four months of that year remained. Over that period of two and half years, both parties were at times responsible for significant delays in the process of preparing, commenting on and clearing draft Plans, and these delays largely stemmed from the lack of clarity in the HoA about the purpose and the information requirements of the Plan. During that period, the parties considered it more effective to use specific agreements to execute variations to the HoA in December 2009 and January 2011 (see paragraphs 2.35–2.36), notwithstanding that a Services and Financial Plan was specified in the HoA as the mechanism to amend or supplement the Agreement.

[68] Tasmania adopted the term Clinical and Financial Service Plan for its first draft of the Plan prepared in June 2009, and thenceforth. The term Clinical and Financial Services Plan formally replaced Services and Financial Plan in the 2011 HoA.

Varying the core clinical activities through the Clinical and Financial Services Plan

3.11 As noted in paragraph 2.21, Tasmania planned to review and seek appropriate adjustments to the MCH's core clinical activities early in the life of the 2008 Agreement, with the vehicle for this being the Services and Financial Plan. The inability of the parties to agree a Clinical and Financial Service Plan until four months before the expiry of the 2008 HoA meant that Tasmania was unable to fulfil its intentions in this regard. Instead, the finalised 2010–11 Clinical and Financial Service Plan, and the draft Plans leading up to it, recorded changes to the MCH's service profile outside the core clinical activities, such as the initiatives taken by Tasmania to expand particular day-surgery services at the hospital, such as endoscopy and cataract surgery.

3.12 DHHS approached the preparation of the Clinical and Financial Services Plan for 2011–12 as an opportunity to address issues it had raised during the negotiation of the 2011 HoA. In particular, DHHS maintained the position it had taken into the HoA negotiations that Commonwealth funding of less than $65 million a year was insufficient for the continuation of hospital services at the existing level, and that operating within the agreed base funding of $63.6 million a year would require efficiency gains. It, therefore, sought to use the Clinical and Financial Services Plan to explore with the Commonwealth the potential to re-profile MCH services to ensure their sustainable delivery within available funds. DHHS understood this strategy had been agreed, consistent with the letter from the Tasmanian Minister for Health to the Australian Government Minister for Health on 27 June 2011, which advised of Tasmania's endorsement of the HoA and stated that negotiations between DHHS and DoHA 'have provided for sufficient flexibility within the HoA to allow the re-profiling of services over time.'

3.13 In accordance with this strategy, the draft of the Clinical and Financial Services Plan provided by DHHS to DoHA on 18 November 2011 identified potential opportunities to adjust the service profile at the MCH. Most of these changes focused on advancing the role of the MCH as a day-surgery, sub-acute hospital by consolidating services between the NWRH and the MCH, including:

- discontinuing 24/7 surgery[69] at the MCH and consolidating more complex, higher acuity surgery at the NWRH;
- transferring birthing services to the NWRH and providing antenatal and postnatal services at the MCH; and
- transferring inpatient paediatric services to the NWRH and providing outpatient paediatric services at the MCH.

3.14 The draft Plan noted that in the area of inpatient surgery, the MCH was operating on a 1:2 on call roster, which did not meet recommended guidelines from the Royal Australian College of Surgeons (RACS), and that it was imperative to move to a 1:4 on call roster for surgical consultants. The proposed consolidation of services between the two hospitals, outlined above, was designed to facilitate this move.

3.15 DoHA met with DHHS and clinicians at the MCH in March 2012 to discuss the proposed changes. At this meeting, DHHS and DoHA agreed that, to facilitate settlement of the Plan, references to prospective future service changes would be removed from it and discussion of these issues would be deferred to the 2012–13 Clinical and Financial Services Plan process. A further draft of the 2011–12 Plan was provided to DoHA in April 2012, with sections referring to potential service changes deleted. However, the Plan remained unacceptable to DoHA because it continued to refer to the MCH becoming the sub-acute hub for the North West. Further amendment to address this meant that the Clinical and Financial Services Plan for 2011–12 was approved by the Australian Government Minister for Health on 29 June 2012. The Plan was, therefore, signed one day before the end of the year to which it related.

Service changes in 2012–13

3.16 Following the agreement that discussion of potential service changes would be removed from the 2011–12 Clinical and Financial Services Plan, DoHA invited DHHS to provide separate proposals regarding those changes. An overview paper provided by DHHS in June 2012 proposed a series of discussion papers to be developed during 2012–13, as the basis for consultation with the Commonwealth. These papers were to cover the following issues, in sequence: general surgery; paediatric services; capital planning; community consultation; obstetrics and gynaecological services; and anaesthetics.

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[69] This refers to having surgery available 24 hours a day, seven days a week.

3.17 Before the first of these papers could be prepared, general surgeons in the Department of Surgery at the Tasmanian Health Organisation-North West (THO-NW) wrote to the THO-NW CEO on 2 August 2012. The surgeons were pursuing the changes to on-call rostering that had been raised previously by DHHS in the draft 2011–12 Clinical and Financial Services Plan and discussed with DoHA at the meeting in March 2012. The surgeons advised that the change was necessary due to safety and accreditation reasons, financial constraints and to provide safe working hours for the surgeons. Implementation of the roster would require limiting the surgery performed at the MCH to weekdays between 9am to 5pm and outside of these hours where clinically necessary, rather than continuing to make surgery available 24 hours a day, seven days a week.

3.18 Following a meeting between DoHA and DHHS officials and clinicians at the MCH on 3 September 2012 to discuss the issue, the Tasmanian Minister for Health wrote to the Australian Government Minister on 25 September 2012. In her letter, the Tasmanian Minister recommended agreement to the change to the on-call roster, and the consequential changes to surgery hours at the MCH, in order to ensure the safe provision of general surgery services at the MCH and across the North West. The Minister noted that Item A(f) of the Core Clinical Activities in the Schedule to the HoA referred to surgery and surgical specialties 'that can be safely performed at the Hospital', and that continuation of an unsafe rostering arrangement would, therefore, contravene the Agreement. The Minister noted the support of both RACS and the Australian Medical Association for the proposed change.

3.19 The Minister also advised that the change to general surgery hours would enable the opening of a Short Stay Unit in the MCH's Emergency Department. The Minister sought agreement to the closure of the inpatient paediatrics ward at the MCH—as had been previously proposed and supported in-principle by DoHA—with the new Unit providing support to the majority of paediatric admissions to the MCH requiring only observation and stabilisation, and more complex cases being transferred to the NWRH.

3.20 The Australian Government Minister for Health responded on 8 October 2012 agreeing to the changes, in order to ensure the safe delivery of general surgery services at the MCH, and noting that the establishment of the Short Stay Unit would enable more appropriate care for children presenting to the emergency department at the MCH.

3.21 Both Ministers in their letters referred to the need to reflect the agreed changes in the 2012–13 Clinical and Financial Services Plan. It is significant, however, that while the service changes were initiated by DHHS, and responded to by DoHA, in the context of the 2011–12 Plan, their negotiation could not be accommodated in that process and they were subsequently progressed and agreed in advance of the preparation of the 2012–13 Plan. The Australian Government Minister for Health noted that the exchange of Ministerial letters 'formalises the changes to the core clinical services', pending finalisation of the 2012–13 Clinical and Financial Services Plan. The Tasmanian Minister provided the 2012–13 Plan to the Australian Government Minister for agreement on 17 January 2013, and the Plan was agreed by the Minister on 14 March 2013.

Conclusion

3.22 The lack of clarity in the 2008 HoA regarding the purpose and content of the Clinical and Financial Services Plan, particularly its status as an annual plan, meant that the timing of the first Plan slipped from 2009–10 to 2010–11, and agreement to it was not obtained until February 2011, well into the year to which it was intended to apply. This was just over four months before the expiry of the 2008 HoA. Tasmania's subsequent attempt to utilise the 2011–12 Clinical and Financial Services Plan to set out future service changes foundered on the differing understandings between the parties of the scope of changes to MCH services, and the Commonwealth's requirements for implementation details. As a result, the 2011–12 Clinical and Financial Services Plan ultimately did not address service change and was agreed at the end of the financial year to which it applied. Service changes were subsequently negotiated between DoHA and DHHS, and approved by Ministers, in advance and outside of the preparation of the 2012–13 Clinical and Financial Services Plan, which was finalised in March 2013.

3.23 Against this background, the Clinical and Financial Services Plan has not been an effective mechanism for making changes to the HoA, particularly changes to the MCH's service profile. On the occasions when a Plan has been agreed, the timing of that agreement late in the year has not allowed that Plan to be used effectively by the hospital to guide operational planning, and often its finalisation has come at the expense of the timely development of the following year's Plan.

3.24 The parties have demonstrated the ability to successfully negotiate variations to the HoA, and agree changes to the service profile of the MCH,

outside the process of preparing a Clinical and Financial Services Plan. In the context of negotiating any new HoA from 1 July 2014, there would be merit in the parties examining the role of the Clinical and Financial Services Plan, in particular whether an alternative process should be established for negotiating and agreeing supplementation and amendment to the HoA. To the extent that provision for a Clinical and Financial Services Plan is maintained in any future HoA, its function as an annual planning document should be clarified and processes set out for it to be prepared and agreed in a timely manner, before the commencement of the year to which it is intended to apply.

Recommendation No.1

3.25 To assist with the timely finalisation and effective implementation of the Clinical and Financial Services Plan for the MCH, the ANAO recommends that DoHA and DHHS:

- clarify the function of the Plan, in particular its status as an annual plan and whether it should continue to be used as the designated means to vary the HoA;
- consider alternative processes to the Plan for negotiating changes to the MCH's service profile under the HoA; and
- develop appropriate processes and timeframes to enable the Plan to be finalised prior to the commencement of the financial year, so that it can be effectively used to guide hospital operations.

DoHA response:

3.26 *DoHA agrees with the recommendation.*

DHHS response:

3.27 *DHHS supports this recommendation. It is agreed that the Clinical and Financial Services Plan has not been an effective means of agreeing changes to the Heads of Agreement, nor for negotiating changes to the MCH's service profile. Both DHHS and the THO-NW are eager to address this to ensure that processes for change and negotiation are more streamlined and take into account safety and sustainability in a timely manner. This is extremely important to the overall operational effectiveness of the MCH over time.*

Responsibility for capital funding

3.28 During the negotiations of the 2011 HoA, DHHS identified an immediate requirement of $740 000 for necessary capital upgrades and

improvements to the hospital. As described in paragraph 2.49, the compromise agreed between the Commonwealth and Tasmania in relation to responsibility for capital funding was that Tasmania would not be required to meet the cost of any significant capital upgrades (above $250 000) to the MCH from within the annual funding provided by the Commonwealth, but applications could be made to the Health and Hospitals Fund (HHF) for consideration.

3.29 In October 2011, Tasmania applied to the HHF for funding of $22.8 million under its 2011 Regional Priority Round, with an additional $1.9 million contribution from Tasmania, to provide for:

- relocation and expansion of the MCH Supply Department, to meet Australian Council on Healthcare Standards recommendations, and support the role of the Supply Department as a regional and state supply facility;
- expansion of the Pharmacy Department to meet Tasmanian Pharmacy Authority Requirements for registration as a pharmacy premises and to meet increased demand for pharmacy services;
- expansion of the third operating theatre to make it suitable for specialist laparoscopic day surgery and add two day surgery recovery beds;
- expansion of the Outpatient Department to accommodate increased demand and ensure capacity for centralising ambulatory care services;
- relocation of the Medical Procedure Unit to be collocated with the Outpatient Department, to accommodate increased demand; and
- expansion of the Day Surgery Unit to include a second endoscopy suite and an additional eight day surgery beds.

3.30 The results of the HHF round were announced in the 2012 Federal Budget on 8 May 2012. Tasmania's application was unsuccessful. Feedback from the independent HHF Advisory Board to DHHS was that the application was assessed as not fully meeting the HHF evaluation criteria.

3.31 The Tasmanian Minister for Health wrote to the Australian Government Minister for Health on 3 July 2012 expressing surprise at this outcome and referring to the HHF application as the initial process for the Australian Government funding works above the $250 000 limit. Noting that the capital requirements were necessary for the MCH to meet accreditation standards and increased patient throughput, the Minister sought the

Australian Government Minister's advice on how the Australian Government intended to meet its capital liability in respect of the requirements.

3.32 The Australian Government Minister for Health responded on 2 August 2012 summarising the HHF process, and noting the Commonwealth's funding contributions to the Tasmanian health system, including the announcement of a funding package of $325 million over four years. With regard to the MCH, the Minister advised that 'there is no provision under the current Heads of Agreement ... for Commonwealth funded additional capital works.'

3.33 Further correspondence from the Tasmanian Health Minister on 5 February 2013 noted that the HHF Advisory Board did not specify against which criteria the MCH application was unsuccessful and that the reason provided did not clearly align with the criteria. The Minister re-emphasised Tasmania's view of the importance of the capital upgrades to meet standards and accreditation requirements for the MCH, and noted an increasingly urgent need to resolve the interpretation of the HoA. There was subsequent correspondence on the issue from the Australian Government Minister on 19 March 2013 and from the Tasmanian Minister on 28 June 2013. Concurrent discussions between the Commonwealth and Tasmania have focused on assessing the particular capital expenditure needs identified by Tasmania on a case-by-case basis, and these discussions were continuing at the conclusion of the audit.

Conclusion

3.34 The compromise agreed in the exchange of Ministerial letters during 2011 HoA negotiations was understood differently by the parties, and its execution in the wording of the HoA, while enabling the Agreement to be signed, has not proved effective in resolving the issue of responsibility for capital funding. From the Commonwealth's perspective, Tasmania's application to the HHF—a competitive grant program—was 'for consideration', subject to the independent assessment of the HHF Advisory Board, and did not represent a guarantee of funding. From Tasmania's perspective, the agreement between Ministers and the terms of clause 4.1(c) of the 2011 HoA, removed any obligation from Tasmania to fund capital works above $250 000, and placed that obligation on the Commonwealth as the owner of the facility. In Tasmania's view, the HHF avenue for funding was one option for the Commonwealth to provide capital funding, not the only option. As expressed in the Australian Government Minister's letter of 2 August 2012, the

Commonwealth considers that there is no provision in the 2011 HoA for it to fund additional capital works above $250 000.

3.35 While discussions between the Commonwealth and Tasmania to address the MCH's specific capital funding requirements were continuing at the time of preparation of this report, there is scope for the parties to resolve the issue of responsibility for capital funding, including an appropriate process for considering specific requirements, in the context of negotiating any new HoA from 1 July 2014.

Performance reporting and evaluation

3.36 The Commonwealth chose not to seek the inclusion, in the body of the 2008 HoA, of performance or service quality standards to which Tasmania, as the operator of the MCH, would be required to meet. In the absence of such standards, which would generally be expected in such service agreements, DoHA advised the ANAO that it considers the MCH's achievement of accreditation as a form of assurance that the hospital is being appropriately managed.

3.37 Items C1 and C2 of the Schedule to the HoA set out requirements for quarterly and annual reporting of operational and clinical information (refer paragraphs 2.26–2.28 and Appendix 2). These requirements were not reviewed or amended in the negotiation of the 2011 HoA. Given the absence of performance requirements in the body of the HoA, Tasmania's reporting under the Schedule is the primary means through which the Commonwealth can assess and gain insights into the performance of the MCH.

3.38 DoHA's website, which contains a 'questions and answers' section about the MCH, includes the question: 'How will performance of the Mersey Community Hospital be measured?' The answer given notes that Tasmania is required to provide quarterly and annual audited financial data, and clinical operation information and reports. It states that 'Tasmania will also provide specific unit record data on hospital utilisation so that the Commonwealth is able to measure performance based on both admitted and/or non-admitted patient services.'[70]

[70] See <www.health.gov.au/internet/main/publishing.nsf/Content/mersey-community-hospital> [accessed 20 June 2012].

3.39 The primary mechanism currently used by DoHA to follow up on quarterly operational reports is through the monthly liaison meetings and teleconferences with DHHS. The reporting requirements are a standing item on the agenda for these meetings. The ANAO observed a significant difference in the level of DoHA's engagement with DHHS and MCH management regarding clinical reporting between the period from 2008 to 2012 and 2012–13. Up until 2012, discussion under this agenda item predominantly focused on the timeliness of reporting (which has significantly improved in 2012–13), with DoHA recorded as querying the MCH's performance on only two occasions. Those queries, in October and November 2011, related to patient waiting and treatment times and the infection rate for staphylococcus aureus bacteraemia (SAB) at the MCH, which was higher than the national benchmark.[71]

3.40 In contrast, records of monthly liaison meetings in 2012–13 show DoHA querying the clinical reports and seeking additional information on a range of clinical performance measures, including bed numbers, surgery patient care days, operating theatre utilisation, occasions of service for oncology and chemotherapy, patient throughput rates, bed occupancy, and infection rates. Further, two additional quarterly reports were requested by DoHA and added in 2012–13, covering surgery and paediatric transfers from the MCH to the NWRH and other hospitals, and workplace health and safety. This increased level of engagement by DoHA reflects its interest in monitoring the impact of the service changes at the MCH agreed in October 2012.

3.41 DoHA advised the ANAO that its consideration of MCH performance also draws on the range of performance information reported to relevant national bodies that is becoming available under the Performance and Accountability Framework (PAF) of the National Health Reform Agreement. However, DoHA acknowledged that its use of reports provided under the HoA and the performance data reported under the PAF is not incorporated into a consolidated performance measurement framework for the MCH program.

3.42 A further avenue of MCH performance reporting was introduced with the establishment of the THO-NW on 1 July 2012. The Service Agreement for

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[71] The national benchmark for SAB infections is no more than two cases per 10 000 days of patient care. This is set out in the National Healthcare Agreement 2011, p. A-10. In 2010–11, the *MyHospitals* website reported the MCH as having 2.3 cases per 10 000 days of patient care. Available from: <http://www.myhospitals.gov.au/hospital/mersey-community-hospital/safety-and-quality/sab> [accessed 17 October 2012].

the THO-NW, between its Governing Council and the Tasmanian Minister for Health (refer Chapter 4, paragraph 4.8), states that the THO-NW must ensure that the MCH delivers services in accordance with the performance standards set out in the Agreement. The Quality and Service Standards Schedule to the Service Agreement contains key performance indicators (KPIs) and assigns performance levels for each KPI.

Conclusion

3.43 In relation to the Commonwealth's ability to assess and measure the performance of the MCH, the HoA do not contain performance or service quality standards that Tasmania is required to meet as the operator of the hospital. As a consequence, the HoA have not included an adequate framework for the Commonwealth to assess and evaluate the performance of the MCH, particularly in terms of service standards and quality.

3.44 DoHA has acted to ensure that Tasmania meets its obligation to provide operational and clinical information reports under Item C1 of the Schedule to the HoA. Notwithstanding recent improvements in its scrutiny of those reports and its consideration of performance information relevant to the MCH provided more recently under the PAF, DoHA's analysis of MCH performance data has not been undertaken in a consistent and structured manner over the life of the HoA, and has fallen short of its stated commitment to measure MCH performance based on both admitted and/or non-admitted patient services. These issues have inhibited the Commonwealth's ability to assess whether the hospital is performing effectively in meeting the Commonwealth's objectives.

3.45 The categories of operational and clinical information reporting under the Schedule to the HoA were not reviewed or amended in the 2011 HoA and remain as they were in 2008. Given the passage of time and national progress in establishing measures of health and hospital performance since 2008, there would be benefit in a review of the HoA reporting categories, drawing on the best contemporary practice contained in the performance and accountability framework, and having regard to the principle of 'single provision, multiple use' of information[72], established under the national health reform process.

[72] The 'single provision, multiple use' of information principle is stated in Clause B86d of the National Health Reform Agreement.

Recommendation No.2

3.46 To improve the Commonwealth's ability to monitor and assess the performance of the MCH under any future HoA, particularly the quality and safety of the services being delivered, the ANAO recommends that DoHA review the categories of operational and clinical information required to be reported under the HoA, with a view to:

- drawing on the best contemporary practice contained in the performance and accountability framework established under the national health reform process; and
- facilitating better utilisation of the information provided in assessing MCH performance.

DoHA response:

3.47 *DoHA agrees with the recommendation.*

Consultation requirements

3.48 The 2008 HoA set out requirements for consultation with key stakeholders in the local community and with clinicians working at the hospital (see paragraphs 2.30–2.34). The ANAO examined how these requirements had been implemented and administered under both HoA.

Liaison meetings between the parties

3.49 As noted in paragraph 2.32, the HoA have not contained provisions requiring regular contact between the parties, though provision for the appointment of liaison officers was included. In practice, the Commonwealth and Tasmania considered it desirable to continue the regular consultations that had been established in negotiating the 2008 HoA beyond the date of the commencement of the Agreement. In October 2008, it was agreed that teleconferences would be held on a monthly basis between representatives from the MCH, DHHS and DoHA.

3.50 During the life of the 2008 HoA, 15 liaison meetings were held between November 2008 and February 2011. These meetings were generally held every second month from August 2009, with varying degrees of formality regarding agendas, papers and meeting records. The period after February 2011 was concurrent with increased consultation between the parties during the negotiation of the 2011 HoA, so specific liaison meeting were not considered necessary. Liaison meetings resumed in October 2011, with the parties making

greater efforts to standardise meeting timings and administration. Both parties commented to the ANAO that this approach has been beneficial for the relationship.

Community consultation

3.51 The 2008 HoA (Clause 8.2(d)) required Tasmania to establish a community regional advisory body to provide key stakeholder engagement with, and guidance to, the direction and development of health and community services in the North West region. In December 2008, Tasmania implemented this requirement by establishing a North West Area Health Service Network Advisory Group (the Group), with broad local community and health sector membership. The main purpose of the Group was to operate as a communication forum and as an opportunity for key stakeholders to provide input to project development in the region.

3.52 The HoA require Commonwealth representation on the Group (Clause 9.3). DoHA's expectation was that the Group's meetings would deliver outcomes that ensured:

- the integration of the MCH into the broader North West health system;
- the people of the North West region would be provided with the most appropriate, clinically safe and cost-effective service and care options;
- the identification of hospital services that enhance services across the North West region; and
- guidance on the direction of health and community services in the North West.

3.53 DoHA was represented at the meetings of the Group by its Tasmanian Office State Manager. DoHA was unable to provide documents to the ANAO relating to its participation in Group meetings, particularly any guidance and feedback between its State Manager and central office, after the second meeting in March 2009. DHHS informed the ANAO that, since July 2010, meetings of the Group have generally occurred on a six-monthly basis and that DoHA has not been represented at the meetings since 2010.

Clinical Services Advisory Group

3.54 The 2008 HoA (Clause 8.3) required Tasmania to establish a Clinical Services Advisory Group as a clinical network of physicians and other health practitioners. The Group's role was defined in the HoA as considering matters referred to it by Tasmania, including the nature, extent and location of clinical

services in the region. In March 2009, the CEO of the NWAHS advised DoHA that the Clinical Services Advisory Group would become part of the established Medical Advisory Group.[73] These clinicians meet on an ad hoc basis.

3.55 The HoA requires that Tasmania keep the Commonwealth fully informed of recommendations it receives from this Group. The HoA further states that nothing in the clause requires the Commonwealth to accept or implement those recommendations. Records of the DoHA/DHHS liaison meetings indicate that clinicians discussed changes to rostering arrangements twice in 2010, and that their recommendations were provided to DoHA. Clinicians also met with DoHA during the March 2012 meeting (refer paragraph 3.15) to discuss rostering and service profile changes at the MCH.

3.56 Notwithstanding the discussion of the rostering issue over a two year period by clinicians, no adjustments were made until the clinicians raised the matter formally with the THO-NW CEO in August 2012 (as described in paragraph 3.17) their intention to share rostering across the MCH and NWRH due to safety and other concerns. This episode suggests that the utility and purpose of the Clinical Services Advisory Group model, as an instrument under the HoA for involving clinicians in the definition of clinical services at the MCH, would benefit from re-consideration and clarification.

Conclusion

3.57 DoHA and DHHS have generally maintained a sound working relationship, which underpins the ongoing administration of the arrangements governing the operation of the MCH. The liaison meetings between DoHA and DHHS have provided a useful platform to raise and manage issues relating to the operation of the MCH, with parties making greater efforts more recently to standardise meeting timings and administration.

3.58 In accordance with the HoA, a community regional advisory body and a clinical services advisory group have both been established. While the obligation to establish the community regional advisory group rests with DHHS, the HoA established a membership role for DoHA. DoHA has also established a range of outcomes to be achieved by the body. The department

[73] The Medical Advisory Committee's prime responsibility is to provide advice on all general medical and related clinical issues to the CEO and the Hospital executive to assist with their deliberations on clinical service planning, delivery, assessment and quality assurance issues.

was not, however, well placed to demonstrate the level of interaction it has had with the body due to a lack of documentation regarding its involvement in meetings. In relation to the Clinical Services Advisory Group, advice has been provided to DoHA, as required under the HoA, regarding the delivery of clinical services at the MCH. Given the need for clinicians to step outside this process in 2012 and write directly to the THO-NW CEO regarding rostering concerns, there would be merit in further clarifying the role of the group in contributing to the clinical settings at the MCH.

4. Governance and Management of the Mersey Community Hospital

This chapter examines the governance and management arrangements at the Mersey Community Hospital.

Introduction

4.1 The Heads of Agreement (HoA) stipulate the terms and conditions by which the Mersey Community Hospital (MCH) is to be managed. Under Clause 8.2(b) of both the 2008 and 2011 HoA, the Tasmanian Government must '...manage the Hospital diligently, honestly and, in a professional and competent manner.' In order to assess this, the ANAO initially reviewed the governance and management structures of the MCH under both HoA. The audit did not examine operational decision-making within the hospital, such as decisions regarding appointments to clinical positions. In subsequent chapters, the ANAO examined the use of Commonwealth funding for operating the hospital (Chapter 5), and the performance and cost of hospital services (Chapter 6).

The Mersey Community Hospital within the Tasmanian health system

The Department of Health and Human Services' role

4.2 DHHS oversees the management of the MCH as a public hospital within the broader Tasmanian health network, and in particular, within the North West region, which is governed by a regional health body. Between 2008 and 2012, the body—the North West Area Health Service (NWAHS)—was an operational unit within DHHS. In accordance with the provisions of the National Health Reform Agreement regarding the establishment of Local Hospital Networks, on 1 July 2012 the Tasmanian Health Organisation–North West (THO-NW) was established. The THO-NW is an independent body with responsibility for the allocation and expenditure of the health budget in the North West region. However, DHHS retains ultimate responsibility for monitoring the operations of the MCH under the HoA and for liaising with DoHA.

North West Area Health Service 2008–12

4.3 In October 2008, DHHS established the NWAHS to improve integration between primary and secondary health care services in the North West region and increase local management through public participation in community networks.[74] The following year, this model was replicated across the state, creating the North Area Health Service and South Area Health Service.[75]

4.4 Each area health service was managed by a Chief Executive Officer (CEO) who held overall responsibility for health service delivery in the region. A General Manager was appointed for the MCH and the North West Regional Hospital (NWRH). Under this management structure, corporate and clinical governance responsibilities were managed on a regional basis, rather than by individual health operators.

4.5 As a matter of principle, it was acknowledged by the Howard Government during negotiations for the Commonwealth's purchase of the MCH in 2007 that it could not be effectively operated in isolation from the Tasmanian health and hospital network. This was similarly acknowledged during the Rudd Government's consideration of management arrangements for the hospital in 2008. However, the 2008 HoA did not include a specific reference to the MCH operating within a wider health and hospital network. While in practice, DoHA recognised and worked with the NWAHS after its establishment[76], the lack of formal recognition in the 2008 HoA created uncertainty around the management of the MCH in a regional context. When negotiations on the 2011 HoA commenced, a key condition identified by the Tasmanian Premier was that the MCH 'operate as part of the Tasmanian Health and Hospital Network with the governance framework that applies to that network.'[77] The Commonwealth agreed to this condition, and Clause 23 was included in the 2011 HoA, recognising that the management and

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74 Department of Health and Human Services, *Annual Report 2008–09*, DHHS, Hobart, p. 2.

75 ibid., p. 2.

76 A variation to the HoA agreed by the parties in December 2009 to expand the role of the MCH's General Manager to include the duties of the General Manager for Elective Services for the North West, included reference to the NWAHS.

77 Letter from the then Premier of Tasmania, the Hon David Bartlett MHA to the Prime Minister, the Hon Kevin Rudd MP, dated 27 April 2010.

operation of the MCH includes its participation in the broader arrangements of the NWAHS.[78]

Tasmanian Health Organisation–North West

4.6 As outlined earlier, the Area Health Services were superseded on 1 July 2012 by the Tasmanian Health Organisations (THO) introduced under the National Health Reform Agreement.[79] Establishment of the THOs fulfilled Tasmania's responsibility to create independent Local Hospital Networks as separate legal entities from 1 July 2012.[80] The objective of the Local Hospital Networks is to decentralise public hospital management by increasing local decision-making and community involvement. Under the *Tasmanian Health Organisations Act 2011* (THO Act), enacted on 24 November 2011, the THOs are independent statutory bodies.

4.7 The primary accountability mechanism for the THOs is the Governing Councils, which are made up of local community members appointed by the Tasmanian Minister for Health and the Treasurer with a common Chairperson across all three THOs.[81] The main responsibility of the Governing Councils is to set an appropriate strategic direction of the THOs in each region. The THO-NW Governing Council has been involved in the management of the MCH since the Council came into effect in July 2012. The Tasmanian Minister for Health and DHHS are responsible for monitoring the performance of the THOs and the Governing Councils.[82]

4.8 Each THO has a Service Agreement between the Governing Council and the Minister for Health. The Service Agreement contains details specific to

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78 Clause 23 acknowledges that Tasmania will manage and operate the MCH in line with its strategy for the North West of Tasmania and provides for consultation between the Commonwealth and Tasmania in those cases where Tasmania wishes to use funding to deliver services other than the core clinical activities specified in the HoA.

79 The National Health Reform Agreement is the overarching health policy on improving health outcomes (refer Chapter 6, paragraph 6.4).

80 Council of Australian Governments, *National Health Reform Agreement 2011*, COAG, Canberra, 2011, pp. 46-50.

81 *Tasmanian Health Organisations Act 2011*, part 3.

82 Tasmanian Government, *Tasmanian Health Organisations Performance Management* [Internet], Tasmanian Government, available from <http://www.dhhs.tas.gov.au/__data/assets/pdffile/0017/101906/20120622-vf-Fact_Sheet_-_Performance_Management_2.pdf> [accessed 6 November 2012].

each region, such as the regional service profile and service planning.[83] Each THO is also responsible for managing the regional health budget and making sure that funding is used to achieve efficient and economical delivery of health and hospital services.[84]

4.9 During the development of the THO-NW Service Agreement, DoHA and DHHS officials discussed the impact the THO Act and Service Agreement would have on the management of the MCH. It was agreed that DHHS would continue to oversee the THO-NW's management of the MCH. The THO-NW Service Agreement includes an explicit recognition of the Tasmanian Government's responsibility to manage the MCH according to the HoA, stating that '[w]here a discrepancy arises between the HoA and this Service Agreement, the HoA is to take precedence.'[85] DoHA was satisfied that this arrangement is consistent with the intent of the HoA.

4.10 Notwithstanding the transfer of responsibility for the MCH from the NWAHS to the THO-NW, appropriate governance oversight of the MCH has been maintained. In relation to the service changes negotiated between the Commonwealth and Tasmania affecting general surgery rostering and paediatric care at the MCH, the THO-NW Governing Council was advised of the proposal by the THO-NW in August 2012, and its endorsement of the changes was sought. The submission to the Governing Council included a risk management plan and communication strategy.

4.11 While it was appropriate to brief the Governing Council on the proposed service changes and gain its endorsement, the Chair[86] and the Tasmanian Minister for Health subsequently described the Governing Council's endorsement as 'approving' the changes. Caution needs to be exercised in using 'approval' terminology given that the THO-NW's authority to adjust the core clinical activities at the MCH is subject to the HoA. The Chief

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83 The THO-NW Service Agreement specifies that it is responsible for overseeing and coordinating the delivery of a wide range of health services to the North West region. This includes: achieving and maintaining standards of patient care; working with other THO's to coordinate services; providing training and education; undertaking research; and collecting health data to contribute to state and national reporting and research.

84 Tasmanian Government, *Purpose, Functions and Powers of Tasmanian Health Organisations* [Internet], Tasmanian Government, available from <http://www.dhhs.tas.gov.au/__data/assets/pdffile/0019/101908/20120622-vf-Fact_Sheet_-_Purpose_Functions_Power.pdf> [accessed 1 November 2012].

85 Tasmanian Government, *2012–13 Service Agreement between Minister for Health and the Governing Council of the Tasmanian Health Organisation – North West*, internal document, 2012, p. 9.

86 J. Rheinberger, 'Mornings on Demand', *ABC Radio Hobart,* 24 October 2012.

Executive Officer of the THO-NW wrote to the Chair of the Governing Council on 21 March 2013 drawing attention to this issue, and also included a footnote in the MCH Clinical and Financial Services Plan 2012–13 stating that Governing Council approval is subject to meeting the requirements of the HoA. Given the role of the THO-NW in the management of the MCH, there would be benefit in the parties giving consideration, in the negotiation of any future HoA, to including appropriate recognition of the THO-NW.

Management of the Mersey Community Hospital

4.12 In addition to its responsibility to manage the MCH diligently, professionally and competently, Clause 8.2(e) of the HoA also requires Tasmania to comply with responsible public hospital practice in respect of the hospital and its medical, clinical and surgical services. The following section examines key elements of the hospital's governance, including clinical governance arrangements, accreditation status, risk management and credentialing.

Governance

4.13 Under the regional governance structure of the former NWAHS and the current THO-NW, internal policies and guidelines are consistent across the region. However, the Commonwealth's ownership of the hospital adds an additional level to the governance arrangements for the MCH, as the hospital's management is accountable to the THO-NW, DHHS and DoHA.

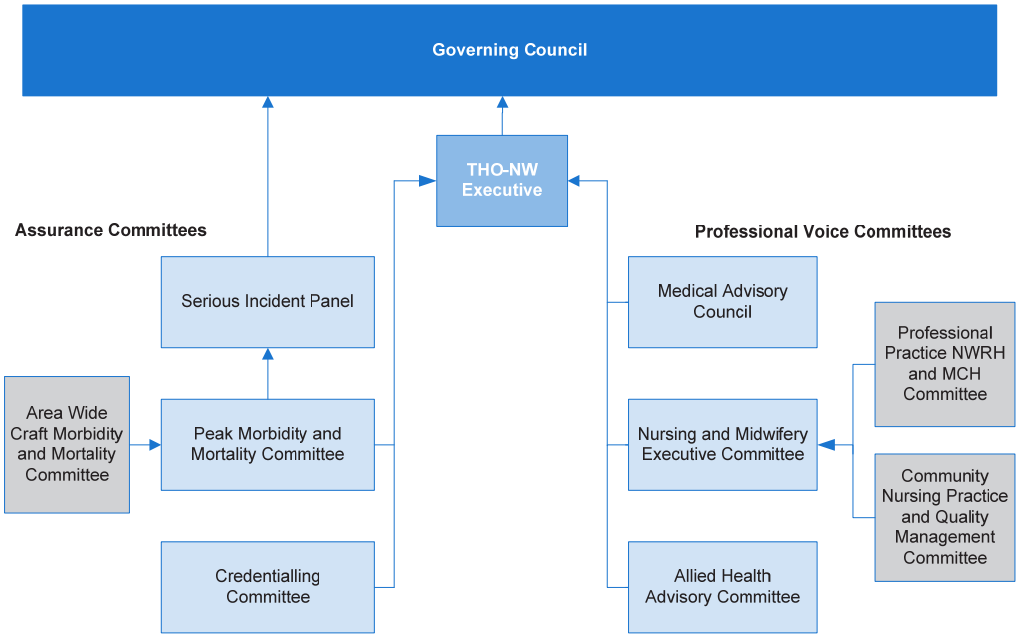
4.14 The THO-NW manages a regional quality framework that establishes clinical and corporate governance. Many of these policies were put in place by the NWAHS and have been adopted by the THO-NW. Appendix 3 shows the organisational structure of the THO-NW.

4.15 The THO-NW monitors the effectiveness of its clinical and corporate governance requirements through the quality framework, specifically through:

- audits of medical and administrative records, and mortality and morbidity reviews;
- clinical indicators set by the Australian Council of Healthcare Standards (ACHS);
- complaint and incident investigations and trends;

- external reviews and audits as part of the ACHS accreditation process and relevant medical colleges, performance reviews conducted through medical credentialing and scope of practice requirements;
- surveys of patient satisfaction and surveys of staff safety; and
- maintaining a panel to review serious incidents that have been recorded at hospitals and consider recommendations made by the mortality and morbidity committee (refer Figure 4.1), with a view to making recommendations to the THO-NW Executive about potential improvements.

Figure 4.1: Assurance and Professional Voice Committees in the THO-NW



Source: THO-NW.

Clinical governance

4.16 Clinical (or professional) governance is a key area of hospital management. It is the system by which the governing body, managers, clinicians and staff share responsibility and are held accountable for: the

delivery of appropriate patient care; minimising risks to consumers; and for continuously monitoring and improving the quality of clinical care.[87] The model implemented by the THO-NW incorporates the monitoring, review and accreditation roles of the key healthcare industry regulation bodies, the Australian Commission on Safety and Quality in Health Care (ACSQHC), and the ACHS.

4.17 The THO-NW quality framework is supported by two categories of clinical governance committees: assurance committees and professional voice committees. The clinical governance framework for these committees is shown in Figure 4.1. The professional voice and the credentialing committees report to the THO-NW Executive. The Morbidity and Mortality Committee reports to the Serious Incidents Panel, which in turn reports to the Governing Council.

4.18 Under Clause 8.3 of both HoA, Tasmania is required to establish a clinical network of physicians and other health practitioners. This group is referred to as the 'Clinical Services Advisory Group' in the HoA, but in a monthly meeting[88] held in December 2008, it was agreed that the MCH's existing Medical Advisory Council would serve this function.

4.19 The Medical Advisory Council is a key element of the clinical governance framework of the MCH. The Council comprises Head Clinicians and the Director of Medical Services. Its principal role is to provide advice on all general medical and related clinical issues to the CEO and the hospital executive to assist with their deliberations on clinical service planning, delivery, assessment and quality assurance issues. Under the HoA, Tasmania must keep the Commonwealth informed of any recommendations it receives from the Medical Advisory Council. However, the Commonwealth is not obliged to accept or act on any of the recommendations. All senior clinicians interviewed by the ANAO confirmed their roles and active participation in the clinical governance framework.

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87 Australian Council of Healthcare Standards, *ACHS News*, Vol 12, 2004, p. 4.

88 In October 2008, it was agreed that teleconferences would be held on a monthly basis between representatives from the MCH, DHHS and DoHA (refer Chapter 3).

Accreditation

4.20 Accreditation provides public recognition of the achievement by a healthcare organisation of requirements of national healthcare standards.[89] To be effective, accreditation should be considered as part of a broader continuous quality improvement framework to ensure that safety and quality issues are appropriately addressed in a timely manner.[90] In the case of the MCH and NWRH, they are considered one entity for the accreditation process. Accreditation is undertaken across three areas of hospital operations—corporate, clinical and support functions.

4.21 Although there is no specific reference to accreditation in the HoA, DoHA advised the ANAO that it considers achieving accreditation as one of the mechanisms in place to provide assurance that the hospital is appropriately managed in accordance with the requirements of the HoA. Accreditation for the North West region hospitals from the ACHS was most recently received in July 2011. While accreditation is valid for four years, there are scheduled periodic reviews after the second year.

4.22 At the time the NWAHS received accreditation, an overall rating of 'moderate achievement' was provided by the ACHS. The accreditation process identified that the capacity of the NWAHS to plan, develop and deliver services in accordance with the goal set out in *Tasmania's Health Plan 2007* of 'one service on two sites' was impacted by the HoA, resulting in a number of services being provided that are not as effective as they could be.[91] One of the major recommendations related to service planning at MCH:

> Following finalisation of the Commonwealth Heads of Agreement with respect to MCH, service planning be reviewed to ensure that services are delivered in the most effective and efficient way, with particular reference to the provision of medical staff coverage, on call rosters and safe working hours.[92]

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89 Australian Council of Healthcare Standards, 'Report of the Organisation-Wide Survey for the ACHS Evaluation and Quality Program', *North West Area Health Service – Acute Services*, ACHS, Ultimo, 2011, p. 1.

90 Australian Commission on Safety and Quality in Health Care, *Fact Sheet – National Safety and Quality Health Service Standards – Overview* [Internet], ACSQHC, available from <http://www.safetyandquality.gov.au/our-work/accreditation/nsqhss/nsqhs-standards-fact-sheets/> [accessed 7 November 2012].

91 Australian Council of Healthcare Standards, 'Report of the Organisation-Wide Survey for the ACHS Evaluation and Quality Program', *North West Area Health Service – Acute Services*, ACHS, Ultimo, 2011, p. 15.

92 ibid.

4.23 To some extent, these issues have been addressed by the clinician-led changes to the inpatient paediatrics unit and general surgery rostering agreed in October 2012.

4.24 A further recommendation from the ACHS that affects the MCH related to the appropriateness of storage and control of stock items within the Regional Supply Department at the MCH, with the NWAHS required to review the 'cramped conditions.' DHHS advised the ANAO in July 2013 that progress on this issue is subject to the resolution of the ongoing issue of responsibility for the funding of capital works at the MCH above the limit of $250 000 set in the HoA.[93]

4.25 The THO-NW has demonstrated that it monitors and addresses accreditation requirements on an ongoing basis. For example, the ACSQHC is overseeing the implementation of 10 new National Safety and Quality Health Service Standards against which a new accreditation model will assess health service providers from 1 January 2013. The THO-NW has incorporated compliance with these new Standards as a requirement in its Continual Quality Improvement Framework 2012–15.

4.26 With regard to the MCH's ability to meet these future accreditation standards, Tasmania has advised the Commonwealth that the outstanding issue of responsibility for capital funding potentially compromises future accreditation for the MCH. In particular, Tasmania noted that the Supply Department, Pharmacy Department and theatre recovery area were identified through various reviews, including one by the ACHS, as requiring upgrading. As previously outlined, responsibility for providing capital funding for the MCH above the limit of $250 000 set in the HoA is the subject of ongoing negotiations between the Commonwealth and Tasmania (refer Chapter 3).

Risk management

4.27 Good clinical governance requires well-designed systems for identifying and managing risks to patients, employees, volunteers, visitors and the institution.[94] The most recent review of the risk management framework

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93 ibid., p. 42. There were also concerns raised about the ventilation system to the room holding chemicals in the MCH theatre. DHHS has advised that work is progressing to rectify this issue through the installation of a larger exhaust fan in the room.

94 Australian Commission on Safety and Quality in Healthcare, *Standard 1: Governance for safety and Quality in Health Service Organisations: Safety and Quality Improvement Guide*, Commonwealth of Australia, Sydney, 2012, pp. 6 and 8.

was completed by the NWAHS in May 2012. The revised framework was carried over through the transition to the THO-NW and is in effect from 1 July 2012 to 1 July 2015.

4.28 The THO-NW risk management framework uses the principles and guidelines set out by the Australian Standard on risk management.[95] The Quality and Safety Unit within the THO-NW maintains a risk register that records relevant risks, the controls in place to manage them, the risk rating and ongoing monitoring and review processes. The THO-NW's Risk Management Framework requires high or very high risks to be reviewed at least quarterly, or as determined by senior management and medium to low risks are to be reviewed at least annually by either the relevant committee or manager.

Credentialing

4.29 Credentialing is the process used to verify the qualifications and experience of medical practitioners to determine their ability to provide safe, high quality health care services within a specific health care setting. THO-NW has a formal policy in place that requires all healthcare practitioners (including locums) to be assessed for credentialing and defining the scope of their work. Any performance issues with medical staff are dealt with by the Credentialing Committee (refer Figure 4.1). Tasmania is currently investigating options for state-wide credentialing, rather than the current regional approach.

Conclusion

4.30 The MCH's corporate and clinical governance arrangements align with national standards. In those aspects of hospital management, it is consistent with the requirement under the HoA that Tasmania carry on the hospital in a professional and competent manner and comply with responsible public hospital practice. The MCH operates within the North West regional governance structure and policies are generally consistent across the two acute hospitals within the region.

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[95] Standards Australia, *AS/NZS ISO 31000:2009 Risk Management-Principles and Guidelines*, Standards Australia, Australian and New Zealand, 2009.

5. Expenditure of Commonwealth Funds for the Mersey Community Hospital

This chapter examines the basis on which the Mersey Community Hospital is funded under the Heads of Agreement and the mechanisms used by the Commonwealth Department of Health and Ageing to monitor Tasmania's compliance with agreement terms and conditions. It also outlines the results of the ANAO's testing of selected Mersey Community Hospital expenditure categories.

Introduction

5.1 The Commonwealth provides funding to Tasmania for the management and operation of the Mersey Community Hospital (MCH). The amount of funding is agreed between the Commonwealth and Tasmania during the negotiation of each Heads of Agreement (HoA). The funding for the MCH, provided under the 2008 and 2011 HoA, was $169.8 million and $197.5 million respectively.

5.2 The 2008 and 2011 HoA set the parameters within which Commonwealth funding is to be used. Clause 4.1 in both the 2008 and 2011 HoA states that Tasmania must use the funds only for the performance of the project. The project is defined in the Schedule to the HoA as comprising:

(a) the management and operation of the hospital (including repair and maintenance); and

(b) carrying on the business and operations of the hospital, which includes managing, administering, delivering and performing, at a minimum, the core clinical activities.

5.3 To determine whether funds for the MCH were approved by DoHA in accordance with the Commonwealth financial framework and were being managed by the parties in line with the requirements of the HoA, the ANAO examined the:

- relationship of MCH funding to other funding sources;
- funding pathway, including payment arrangements and accountability mechanisms; and
- expenditure of funds under the HoA.

Relationship of MCH funding to other funding sources

5.4 The Commonwealth's direct funding under the HoA provides the majority of revenue for the operation of the MCH. In general, Commonwealth payments to the states are taken into account when the distribution of Goods and Services Tax (GST) revenue is being calculated by the Commonwealth Grants Commission (CGC).[96] However, the direct funding received from the Commonwealth for the MCH does not result in a reduction in other Commonwealth funding streams, as it was agreed that the funding would be quarantined.[97]

5.5 Specifically, the successive HoA have provided that the Commonwealth take steps to ensure that its funding for the MCH is excluded or 'quarantined' from the CGC's calculation of the Tasmanian share of GST revenue. Tasmania requested this exclusion as one of conditions on which it agreed to sell the hospital to the Commonwealth in 2007, to avoid a reduction in the overall level of GST funding Tasmania received from the Commonwealth as a consequence of the Commonwealth acquiring the hospital. Having been agreed as part of the sale of the MCH, this exclusion was maintained in both the 2008 and 2011 HoA. As a result, the funding that Tasmania receives under the HoA to operate the MCH is in addition to the funding that it would otherwise receive from the Commonwealth.

5.6 In addition to the direct funding from the Commonwealth under the HoA, the MCH receives funding through:

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96 The CGC is a statutory authority, the functions of which include providing advice to the Commonwealth on the allocation of revenue from the GST to states and territories. GST revenue is distributed to the states and territories at different per capita amounts, a process known as 'fiscal equalisation.' This process is designed to address the different economic and social conditions that have affected the revenue that states and territories can collect from taxes and charges, and the costs of delivering services. Those Commonwealth payments that are not taken into account by the CGC when calculating the distribution of GST revenue fall into two groups: those that do not provide budgetary support and those where the objective of a Commonwealth payment is in conflict with fiscal equalisation. In the latter case, terms of reference to the Commission specify those payments that should not have an effect on the distribution of the GST.

97 The Commission has reported that its terms of reference require that the Commonwealth's ongoing operation of the Mersey Community Hospital through the Tasmanian Government should not influence Tasmania's fiscal capacity. Refer Commonwealth Grants Commission, *Report on GST Revenue Sharing Relativities–2010 Review, Volume 2–Assessments of State Fiscal Capacities, Appendix 2B Treatment of Commonwealth Payments in the 2010 Review*. Available from: <http://www.cgc.gov.au/attachments/article/27/2010_REVIEW_FINAL_REPORT_VOLUME_2.pdf> [accessed 10 July 2013].

- national health initiatives ($0.9 million from 2011–12 to 2013–14 under the National Partnership Agreement on Improving Public Hospital Services);
- the Tasmanian Government for capital improvements ($6.1 million during the life of the 2008 HoA) and building maintenance ($170 000 from 2001–12 to 2012–13);
- the hospital's own-source revenue ($5.985 million in 2011–12); and
- a variety of other sources (less than $1 million).

This funding is detailed in Appendix 4.

The funding pathway

5.7 Commonwealth funding for the MCH is appropriated to DoHA and is subject to internal Commonwealth reporting and approval requirements. The expenditure of the funds by DHHS is subject to separate reporting and acquittal requirements under the HoA, which are designed to provide assurance to DoHA that the funds are being spent in accordance with the agreement. These arrangements are examined in the following sections.

Appropriation and approval of MCH funding

5.8 Commonwealth funding to the MCH is sourced from DoHA's Budget Outcome 13—*Acute Care*. Outcome 13 aims to improve the efficiency of, and access to, public hospitals and acute care services through the delivery of major reforms. In 2012–13, the total estimated expense for Outcome 13 is $991.3 million.[98] There are three programs under Outcome 13, with the MCH initiative funded under Program 13.3: *Public Hospitals and Information*.

Financial management framework approvals

5.9 The Commonwealth financial management framework, established by the *Financial Management and Accountability Act 1997* (FMA Act), FMA Regulations and FMA Orders, places obligations on FMA Act agencies for the management of public money and public property.[99] DoHA, as a department

[98] Commonwealth of Australia, *Portfolio Budget Statements 2012–13*, Commonwealth of Australia, Canberra, 2012, p. 224.

[99] Public money and public property are broadly defined in the FMA Act as money and property in the custody or control of the Commonwealth.

subject to the FMA Act, is required to comply with the obligations set out under the framework.[100]

5.10 FMA Regulation 9 sets out specific legislative requirements that must be satisfied in order for an approver, in the case of the MCH a senior DoHA officer, to properly approve a spending proposal under an arrangement such as the HoA. Arrangements involving the commitment of public money without an existing appropriation, generally over future financial years, also require approval under FMA Regulation 10. Consistent with these requirements, DoHA sought and recorded the appropriate approvals under FMA Act Regulations 9 and 10 for the commitment of Commonwealth funds for the initial purchase of the hospital and, subsequently, for the commitment of Commonwealth funding under the 2008 and 2011 HoA.[101]

5.11 It is important that a Commonwealth approver's consideration of the proper use of resources, and their decisions in relation to spending proposals are recorded in a manner that promotes transparency and accountability and which is capable of demonstrating compliance with financial framework and policy obligations. This includes any inquiries undertaken, or caused to be undertaken, that would be considered reasonable in the context of assessing spending proposals for the MCH initiative.

5.12 In relation to the four Regulation 9 approvals by the delegate (a senior DoHA officer) for the spending proposals to commit Commonwealth funding for the MCH, the approvers did not record that further inquiries were undertaken or requested. The approval was given on the basis of information provided in the department's submission. The information provided to the approver by the department was particularly important in the context of the MCH initiative, as the quantum of funding was not determined on the basis of a competitive process.

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[100] The FMA Act applies to DoHA in so far as the funds for the MCH are committed, appropriated and transferred to Tasmania. Clause 1.6 of the HoA states that the agreement is to be governed by the laws in force in the State of Tasmania. Expenditure of Commonwealth funding at the MCH is managed in accordance with the Tasmanian *Financial Management and Audit Act 1990* and relevant Treasurer's instructions.

[101] The Regulation 9 and 10 approvals were provided in advance of the endorsement of each of the two HoA, as required by the financial framework. In total, there were three Regulation 9 approvals provided for the 2008 HoA to cover additional expenditure. These approvals were for the total revised funding envelope for the MCH. Regulation 9 approval relating to the 2011 HoA was provided on the same day as the HoA was signed by the Australian Government Minister for Health.

5.13 As outlined in Chapter 2, in preparation for the negotiations for each HoA, DoHA prepared calculations to estimate hospital running costs and assessed a range of factors that had the potential to affect these calculations. The department also obtained the Government's approval for the funding envelope for the negotiations. However, the departmental Regulation 9 submissions covering both the 2008 and 2011 spending proposals did not include specific information on the work that the department had undertaken to determine that the spending proposal represented a proper use of Commonwealth resources.[102]

5.14 While DoHA had taken steps to accurately cost the operations of the hospital in preparation for the 2008 HoA negotiations, the Regulation 9 submission relating to the 2008 HoA provided very limited information for the approver to make a decision on the merits of the spending proposal. For example, it did not reference value for money considerations and detailed arrangements for the management of risks, the assessment of agreement deliverables, financial acquittal and reporting arrangements. DoHA was better placed to advise on costs for the 2011 HoA given the knowledge and experience gained from the operation of the hospital under the earlier HoA.[103] As a result, the Regulation 9 submission relating to the 2011 HoA included additional information, such as value for money considerations and arrangements for monitoring the hospital's performance and expenditure, but still contained relatively limited information to support a determination that the spending proposal represented a proper use of Commonwealth resources. In both the 2008 and 2011 Regulation 9 approvals, the department could have drawn more fully, in its advice to the approver, on information available to it from the policy process it was engaged in to settle operating and funding arrangements for the MCH.

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[102] Proper use is defined in section 44 of the FMA Act as 'efficient, effective, economical and ethical use that is not inconsistent with the policies of the Commonwealth'. While amendments to the FMA Act, which came into effect on 1 March 2011, added 'economical' to the definition of proper use, the Department of Finance and Deregulation has advised that the concepts of efficient and effective already encompassed the concept of economical, which was added to emphasise the requirement to avoid waste and increase the focus on the level of resources that the Commonwealth applied to achieve outcomes. (See Finance Circular No. 2011/01 Commitments to spend public money (FMA Regulations 7 to 12), available at <http://www.finance.gov.au/publications/finance-circulars/2011/docs/Finance-Circular-2011-01-FMA-Regulations-7-12.pdf> [accessed 11 April 2013]).

[103] As outlined at paragraph 5.26 of this chapter, DoHA also specifically examined the MCH's expenditure and costs in April 2011, and conducted a site visit for this purpose, in the context of negotiations with Tasmania on the quantum of funding to be included in the 2011 HoA.

MCH payment arrangements

5.15 The payment of Commonwealth funds to the MCH occurs on a monthly basis, with MCH finance staff invoicing DoHA at the commencement of each month, one month in advance. DoHA then electronically transfers the funds to DHHS and they are receipted directly to the MCH. The amount of funding provided to the MCH each month is calculated by dividing the total annual funding amount by 12. The Tasmanian Health Organisation-North West (THO-NW) is legislatively responsible for managing the hospital services, including the funding provided by the Commonwealth through DHHS.

Accountability and assurance

Monthly reporting

5.16 Under the HoA, DHHS prepares monthly Finance and Activity Reports for the MCH. These reports are provided to DoHA and are also analysed by the MCH management to identify any budgetary or operational matters, which are then discussed at monthly departmental meetings.

5.17 Financial matters involving the MCH are also discussed during monthly teleconferences between DoHA, DHHS and MCH management. In general, the matters discussed relate to financial reporting obligations specified in the HoA, specific compliance issues, and any necessary follow-up action. These monthly teleconferences provide a useful mechanism to share information and resolve operational issues.

Audited annual financial statements

5.18 The HoA require DHHS to provide annual audited financial statements to DoHA. Further, the Tasmanian Audit Office undertakes an audit of MCH's financial statements as part of a larger audit of DHHS. This audit work provides assurance that the MCH's financial statements:

- present fairly, in all material respects, the financial position and performance, cash flows and changes in equity of the hospital; and
- are in accordance with the HoA and Australian Accounting Standards.

5.19 The assurance provided in relation to the financial statements being in accordance with the HoA does not extend to providing assurance that the expenditure is consistent with the specific terms and conditions of the HoA. Rather, it is the responsibility of DHHS' Chief Financial Officer to provide an annual acquittal statement to DoHA confirming that the funds were used in

accordance with the specific requirements of the HoA. This responsibility has been fulfilled since the commencement of the HoA.

Expenditure of funds under the Heads of Agreement

5.20 Since the Commonwealth's acquisition of the MCH, a number of public claims have been made relating to the possible use of Commonwealth funding intended for the MCH to support other hospitals in the region. In particular, the media has reported claims in relation to the use of Commonwealth funds for staffing expenses and for the purchase of supplies and pharmaceuticals at the NWRH in Burnie.[104] With regard to these claims, the Tasmanian Government has stated that 'the MCH operates its funding in accordance with the detailed and publicly available Heads of Agreement'.[105] Further, DHHS informed the ANAO that it has 'only used Commonwealth funds for the performance of this project [the MCH program]'.

5.21 In assessing these claims, and considering whether the expenditure of Commonwealth funding for the MCH complies with the HoA, the ANAO reviewed documents relating to DoHA's monitoring of expenditure reporting under both the 2008 and 2011 HoA. The ANAO also conducted an examination of MCH expenditure transactions, drawing samples from the MCH's accounts from 2008–09 to 2011–12. The ANAO engaged PricewaterhouseCoopers (PwC) to assist it in this examination. Samples were taken from areas of hospital activity that had either been subject to claims of misuse of funds or, in the ANAO's view, represented a potential area of risk. The areas included staffing expenses, the purchase of supplies and pharmaceuticals, patient transport shared services and cross-charging. The ANAO also reviewed the MCH's asset management system.

DoHA's monitoring of expenditure reporting

5.22 Upon receipt of MCH's monthly expenditure reports, DoHA uses the reported data to compile Mersey Monthly Reports, comprising cumulative summaries of MCH's profit and loss on a cash basis, and a month-by-month breakdown of the balance sheet and income statement.

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[104] Tingle, L. 'Claims funds bypassed Mersey', *The Australian Financial Review*, 1 December 2011, p. 12; Kempton, H. 'Hospital cash switch storm', *The Mercury*, 22 December 2011; and, 'Hospital funding inquiry urged', *ABC News*, 22 December 2011.

[105] Similarly, the Tasmanian Government has also been publicly reported as rejecting allegations of this type, stating that 'funding and resourcing of the Mersey Hospital is strictly in accordance with the three-year federal agreement' ['Hospital funding inquiry urged', *ABC News,* 22 December 2011].

5.23 The ANAO's analysis of DoHA records indicated that the department reviews each Mersey Monthly Report and, where necessary, queries DHHS on expenditure. Under Clause 7.3 in both HoA, Tasmania must maintain financial records sufficient for it to substantiate to the Commonwealth's reasonable satisfaction that the funding has been expended or committed according to the HoA.

5.24 From time-to-time, DoHA has raised issues with DHHS in relation to concerns arising from its analysis of the monthly expenditure reports. In April 2009, DoHA identified an increase in expenditure on the 'Purchase of Specialist Services' category. DHHS subsequently advised DoHA that $2 million had been used to purchase clinical services (the large majority of this expenditure was for orthopaedic services) from the NWRH and Launceston General Hospital (LGH) for patients from the Mersey catchment area. DoHA deemed that this expenditure was outside the provisions of the 2008 HoA and advised DHHS that no further payments of this nature were to be made from Commonwealth funds. The department obtained advice indicating that, while the approach adopted by DHHS was not in keeping with the intent of the HoA, it did not represent a breach. On this basis, action to recover the funding was not pursued.

5.25 In June 2010, DoHA again queried DHHS on an overall increase in monthly expenditure compared with previous months. In its query to DHHS, DoHA reiterated the Commonwealth's requirement for the funding to be used exclusively on the MCH. DHHS advised that the increase was due to the occurrence of annual expenses including: $785 000 for the purchase of orthopaedic services for patients from the MCH catchment area to be treated at the NWRH; $1.6 million on interstate charging; and $321 000 for the redevelopment of the High Dependency Unit (HDU) at the MCH, which was funded by Tasmania.

Ongoing DoHA scrutiny

5.26 Apart from its regular review of MCH financial reports, DoHA specifically examined the MCH's expenditure and costs in April 2011, and conducted a site visit for this purpose, in the context of negotiations with Tasmania on the quantum of funding to be included in the 2011 HoA. The purpose of the examination was to verify the basis of Tasmania's estimate for the amount of funding required to operate the hospital, rather than to test the appropriateness of expenditure against the HoA. During 2012, DoHA tasked an official to undertake more detailed analysis of the MCH's financial reports,

and this generated a number of queries and requests for clarification. For example, DoHA asked for explanations of the types of items recorded in specific expense and revenue categories, and queried trends in these categories. DoHA advised the ANAO that these queries were answered to its satisfaction.

Conclusion

5.27 DoHA has scrutinised the MCH expenditure reports provided by DHHS and queried expenditure where there were concerns regarding compliance with the HoA. It also had available to it the audits of the MCH's financial statements conducted by the Tasmanian Audit Office. However, DoHA's scrutiny has not extended to conducting a review or audit of MCH expenditure against the terms of the HoA. While DoHA examined the MCH's financial records in April 2011, this examination was undertaken for the purpose of clarifying MCH costs in the context of the negotiation of the 2011 HoA not as a means of validating expenditure. The periodic review by DoHA of MCH expenditure would provide additional assurance regarding the appropriate use of Commonwealth funds under the HoA.

Analysis of expenditure transactions

5.28 To gain assurance that Commonwealth funding for the MCH has been used in accordance with the HoA, the ANAO analysed the following categories of expenditure: employees, supplies, pharmaceuticals, patient transport, shared services costs and cross-charging. As outlined earlier, these categories were selected because they had either been subject to claims of misuse or represented an area of potential risk. The ANAO sought the cooperation of DHHS and the THO-NW in accessing relevant staff and information and this cooperation was agreed and provided.

5.29 The first step in testing[106] was to confirm the total value of transactions recorded for each expense type in DHHS' financial management system, used by the MCH, to the value reported in DHHS' annual acquittal statement to DoHA and in the annual financial statements. This was necessary because there is a lack of alignment between the expense categories in DHHS' system and the expense categories set out in the monthly and annual acquittal

[106] The ANAO's testing involved confirming the details of transactions selected as part of the sampling process with the documentation supporting the transaction, for example invoices and timesheets.

statements in the Annexures to the HoA and in the MCH's annual financial statements.

5.30 The ANAO selected a sample of transactions from the total population of transactions recorded for each selected expenditure category, to assess whether the funding has been used in accordance with the requirements of the HoA. This assessment does not constitute a financial statement audit, but was a targeted analysis of expenditure categories identified as potential risks to the appropriate use of Commonwealth funds. Nevertheless, the sample size selected for three expense categories—employee expenses, supplies and pharmaceuticals expenses—would support a high level of assurance in the conduct of a financial statement audit.

5.31 The financial management system maintained by DHHS, and used at the MCH, did not have the functionality to produce a complete list of transactions between the MCH, DHHS and other Tasmanian hospitals. Consequently, in the case of two expense categories—payments for shared services and cross-charging expenses[107]—the total population of transactions could not be confirmed. While the ANAO was able to test transactions from these expenditure categories, a conclusion could not be drawn as the total populations for these categories could not be confirmed and the sample tested cannot be considered to be representative. DHHS advised the ANAO in July 2013 that, subsequent to the completion of audit fieldwork, it has now developed an IT solution to identify a complete population of shared services and cross-charging transactions. DHHS advised that this solution will enable a full set of these transactions to be populated for any future audit of these expense categories.

Access to financial records

5.32 As outlined earlier, under the HoA Tasmania must maintain financial records sufficient for it to substantiate, to the Commonwealth's reasonable satisfaction, that the funding has been expensed or committed according to the HoA. To meet its obligations under the HoA, DHHS requires appropriate systems to capture, analyse and report financial information. However, following the Commonwealth's acquisition of the hospital, DHHS did not adjust financial management systems to reflect the MCH as a separate entity within Tasmania's health system. DHHS advised the ANAO in July 2013 that it

[107] Cross-charging expenses refers to payments between the MCH and other Tasmanian hospitals.

considered that the MCH is easily distinguished from the rest of the department because it has its own group, cost centres, fund source and location, and DHHS uses this information to provide the annual acquittal statement to DoHA for MCH funding. Nevertheless, in the testing of MCH expenditure difficulties were experienced in distinguishing MCH financial data from other hospital data within DHHS systems, and in reconciling the transaction listing extracted from DHHS's finance system to the hospital's annual financial statements and the annual acquittal statement. Further, as noted above, DHHS's systems at the time of testing did not support the preparation of a complete cross-charging transaction listing for the MCH, meaning that DHHS was not well placed at that time to meet its accountability obligations under the HoA.

5.33 Notwithstanding the preparedness of DHHS and the THO-NW to cooperate with the audit, and the efforts of their staff to assist, some of the financial information required to support the ANAO's testing of individual transaction samples could not be provided within the timeframe for audit fieldwork and was, therefore, unable to be tested. In particular, following initial difficulties and delays in selecting employee samples for testing from the relevant DHHS system, there were subsequent difficulties in locating some employee files and information to support testing of samples that would generally be expected to be retained in these files.[108]

5.34 The issues encountered by the ANAO in testing these expenditure categories indicates there is scope for improvement in the management of the MCH's records, in particular records of financial transactions. Improvement in these areas would better position DHHS to meet its accountability obligations under the HoA and provide greater assurance regarding the appropriate use of Commonwealth funds in managing the hospital.

Results of expenditure analysis

5.35 Within the limitations of DHHS' systems and the availability of records, the ANAO analysed samples taken from selected expenditure categories. The ANAO applied an exception threshold of two per cent to these

[108] DHHS advised the ANAO in July 2013 that a contributing factor to the difficulties in accessing employee records was the relocation of a small amount of archived or former MCH employee records away from the MCH as an interim measure following the closure of a storage facility and pending electronic scanning of those records. In this context, the ANAO noted that there was no mechanism to keep track of personnel files that were transferred to other locations.

samples. This means that if the proportion of transactions that could not be verified or were incorrect represented more than two per cent of the value of the sample population, the ANAO was unable to obtain sufficient assurance to form a conclusion regarding the appropriateness of expenditure in those categories.

5.36 The test results for employees, supplies and pharmaceuticals were within this exception threshold, and conclusions were therefore able to be formed for these categories of expenditure. However, the results for the patient transport transactions testing significantly exceeded the allowable threshold, as outlined below (refer paragraph 5.46). Further, no conclusion could be drawn about shared services and cross-charging transactions as the total populations for these categories could not be confirmed and a representative sample of transactions could not be selected and tested.

Shared staff

5.37 Preceding the Commonwealth's takeover, the MCH, together with the NWRH, formed one entity with two separate campuses. In discussions with clinicians and the MCH management, the ANAO was informed that staff regularly work at both the MCH and NWRH. Where staff work between the MCH and other hospitals, their salary costs are required to be apportioned between the hospitals accordingly. Consultants, Registrars and nursing staff from NWRH often provide medical support for the MCH, and vice versa, when the staff roster needs to be filled or specialist medical expertise is required. For instance:

- prior to the change in general surgery services at the MCH, which was implemented in October 2012, three general surgeons employed at the NWRH were rostered for two or more days a week at the MCH;
- prior to the change to paediatrics services at the MCH, there was a regional on-call roster, with the Registrar at the MCH and the Registrar at the NWRH being rostered on alternate weekends; and
- two anaesthetists, who are employed permanently at the NWRH, are rostered individually at the MCH every second day.

5.38 The media has reported claims that Commonwealth funds provided for the MCH are being used to pay for staff at the NWRH.[109] To assess these

[109] Tingle, L. 'Claims funds bypassed Mersey', *The Australian Financial Review*, 1 December 2011, p. 12.

claims, the ANAO tested a sample of 153 transactions, including salary and wage payments to permanent staff, payments of invoices for locum medical practitioners and recognition of employee leave and other benefits. Of these 153 transactions, valued at $753 834, nine transactions could not be tested because DHHS was unable to provide the necessary supporting documentation. On the basis of the testing undertaken, the ANAO did not find evidence that Commonwealth funds were used to meet expenditure associated with staff employed at the NWRH or any other Tasmanian hospitals.

Regional stores function

5.39 Hospital stores, such as bandages and syringes, for the THO-NW (including the MCH) are held on site at the MCH.[110] The Supply Department at the MCH operates as a central storage facility, receiving, distributing and storing medical equipment and supplies. Medical supplies and equipment are initially purchased by DHHS from suppliers and are then transferred to the MCH to be stored and further distributed to all hospitals in the North West, including King Island. The warehousing facility at the MCH holds over 2600 regularly used medical, surgical and general hospital products.

5.40 While the Supply Department is located at the MCH, it is managed and operated by DHHS staff. These staff visit each ward and department on a weekly or bi-weekly schedule to record stock levels then replenish stock to agreed holding levels. Costs are charged to the ward or department when the supplies are dispensed.

5.41 The MCH is invoiced monthly by the NWRH, with invoiced amounts inclusive of a 15 per cent administration levy—capped at a maximum of $50 000 per month. The MCH is the only Tasmanian hospital that is charged this fee because it is the only public hospital not owned by the Tasmanian Government. As DHHS employs the Supply Department staff, this fee is to allow DHHS to recoup the costs associated with the MCH's use of the stores function.

5.42 The media has also reported claims that Commonwealth funding is being used inappropriately to purchase Commonwealth funded goods from the Supply Department at the MCH for the NWRH. To assess these claims, the ANAO analysed 150 transactions valued at $843 096, which included

[110] Pharmaceuticals are stored and dispensed from the NWRH (refer paragraph 5.43).

transactions relating to the purchase of pharmaceuticals (refer paragraphs 5.43 to 5.45). Of the 150 transactions in the sample, five transactions, valued at $3763 could not be verified because either DHHS was unable to provide the necessary information or the transactions were not supported by the related documentation. Notwithstanding the lack of supporting documentation for five transactions, the ANAO did not find evidence of Commonwealth funds being used to purchase supplies used at the NWRH or any other Tasmanian hospital.

Regional pharmaceuticals function

5.43 The MCH obtains its pharmaceutical supplies from the NWRH, which functions as the central pharmaceuticals storage facility for Tasmania's North West region. Pharmaceuticals are managed using an electronic pharmaceutical management system, which is linked with DHHS' financial management system. Pharmaceuticals are dispatched from the NWRH daily. The linking of the pharmaceutical management and finance systems enables the cost centre of the MCH and other receiving hospitals to be automatically debited once the order is dispatched, rather than being invoiced.

5.44 Similar to the Supply Department outlined earlier, the MCH is charged a 15 per cent administration levy by DHHS for pharmaceutical dispensing services. To recoup the cost associated with the MCH utilising this DHHS service, this fee was introduced when the Commonwealth acquired the hospital. Previously the MCH was also charged an additional $8000 per month for a specialised dispensing service. In 2011, pharmacist numbers at the MCH pharmacy increased, meaning that the MCH was able to undertake its own specialist dispensing and no longer required the services provided by the NWRH. The monthly fee was subsequently discontinued.

5.45 Testing was undertaken—in conjunction with the testing of transactions relating to hospital supplies—to assess claims made in the media of inappropriate use of Commonwealth funds provided to the MCH to purchase pharmaceuticals for the NWRH.[111] The ANAO's testing did not find evidence of Commonwealth funds being used to purchase pharmaceuticals for the NWRH or any other Tasmanian hospital.

[111] Kempton, H. 'Hospital cash switch storm', *The Mercury*, 22 December 2011.

Patient transport

5.46 The ANAO reviewed patient transport expenditure, including taxi fares for patients and reimbursement of ambulance costs to the Tasmanian Government. The ANAO selected 50 transactions from two accounts, valued at $220 102. Of these 50 transactions, 25 related to ambulance transport, valued at $186 839, and were verified. The remaining 25 transactions, valued at $33 263[112], included cab charges used by both patients and staff members, but there was no means in the accounts and supporting documents to identify the type of user, or identify the travel purpose. Accordingly, these transactions could not be verified as patient transport, and therefore represented an exception rate in the testing of 15.1 per cent, well above the two per cent exception threshold.

5.47 DHHS noted in advice to the ANAO in July 2013 the existence of an alternative cost centre to the accounts tested in which staff member travel would not have been included. Nevertheless, the accounts tested by the ANAO included patient travel expenditure covering the period for examination over four years from 2008–09 to 2011–12. There may be benefit in DHHS reviewing the current organisation of its account structures, post 1 July 2012, to confirm that travel categories are appropriately recorded. DHHS further advised that the inability to trace cab charges back to a user category (patient or staff member) had been identified and that a system had been in place since 2012 to record instances of use against the type of user. The ANAO's testing covered transactions for the four financial years to the end of 2011–12, prior to the introduction of this system.

5.48 More broadly, the ANAO notes that hospitals often cover the travel and accommodation costs for visiting medical practitioners, such as locums, and that such expenditure is not inconsistent with the HoA. Broader analysis of cost comparisons between the MCH and other Tasmanian hospitals, shows the MCH's patient transport costs, on a weighted comparison, are similar to those of Royal Hobart and Launceston General hospitals, and substantially below those of the NWRH.

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[112] Taxi vouchers are processed in batches. Therefore, each one of the 25 transactions represents a batch of taxi vouchers.

Shared services

5.49 DHHS provides a range of shared services and support to the MCH, comprising: finance; human resources; and information technology. These shared services include direct (accounts payable, debt management, employee pay and conditions processing and IT support) and indirect activities (finance and IT system hosting and personnel functions). DHHS also provides acute hospital services support, which assists the MCH in treating patients. These services include: medical retrieval; clinical data and clinical costing; electronic incident management system (EIMS); and the emergency department information system (EDIS). Further, DHHS provides 'Other Services' consisting of motor vehicle fleet/non-urgent patient transport services to the MCH.

5.50 Subsequent to the Commonwealth assuming full ownership of the MCH on 23 November 2007, DHHS appointed a consultant to determine and report on the costs associated with the transfer of the MCH from Tasmania to the Commonwealth, including the provision of ongoing support. This review determined that the cost for the provision of shared, acute and other services was $186 075 per month (GST exclusive), equating to an annual cost of $2 232 900 (GST exclusive). On the basis of the review, DHHS adopted the recommended fee structure, with the service fee automatically deducted from the MCH funding on a monthly basis.

5.51 DHHS and DoHA hold differing views on the reasonableness of the amount of the monthly fee. The cost to DHHS of providing shared, acute and other services at the MCH has not been revised since 2007. DHHS informed the ANAO that the costs would now most likely be greater than the amount originally calculated, as there has been no indexation applied over time and a number of cost drivers have increased, including in the areas of staffing, systems and computer hardware and support costs. However, in the context of its April 2011 examination of MCH costs, DoHA observed that the monthly fee appeared to be excessive, and suggested that an independent review be conducted.

5.52 DHHS advised the ANAO in July 2013 that it is in the process of developing a more structured and transparent approach to the shared services provided to THOs. As part of that process, it will review the arrangements for sharing the cost of delivering those services over the coming year. The early completion of this review would be beneficial in providing clarity around the

actual and reasonable cost of shared services support to the MCH, and would inform negotiations for any future HoA.

5.53 The ANAO identified and tested the monthly service fee for support services made from the MCH to DHHS. This testing found that the 2008–09 financial statements recorded that the MCH paid a full year of service fees to DHHS, even though the 2008 HoA did not come into effect until September 2008. DHHS was aware of this recording error and the ANAO confirmed that only a partial year of Commonwealth payments was made to DHHS under the HoA.[113] Aside from this error, no other errors were identified in the shared services payments. The ANAO's testing confirmed that the fees paid by the MCH to DHHS were in accordance with the established annual service fee.

5.54 In addition to the shared services payments, regular charges between Tasmanian hospitals and DHHS occur for a range of items, including: supplies and consumables; pharmaceuticals; motor vehicle costs; and workers compensation costs. However, DHHS could not produce, from its financial management system, a comprehensive list of payments between the MCH and DHHS for testing during audit fieldwork. As a direct result, the ANAO could not select and test a representative sample of these payments, and cannot conclude more broadly about the appropriateness of payments made by the MCH to DHHS.

Cross-charging

5.55 Cross-charging expenses are payments made between the MCH and other Tasmanian hospitals. There are two accounts at the MCH established to record these types of transactions. However, the THO-NW advised that these accounts do not record all cross-charging transactions, which can also be recorded in other accounts. The ANAO tested a sample of 11 transactions from the 81 transactions recorded in the two cross-charging accounts. No inappropriate transactions, such as unsubstantiated payments, were identified in this testing.

5.56 In relation to the cross-charging expenses recorded outside of the dedicated accounts, DHHS was unable to produce a comprehensive list of

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[113] In the 2008–09 financial statements for the MCH, a full year of service fee payments, amounting to $2 232 900, was recorded despite only nine monthly payments totalling $1 674 675 being made, which was consistent with the commencement of the agreement. This was a recording error in the financial statements, not a payment error, which DHHS had previously identified.

transactions between the MCH and other Tasmanian hospitals. As a result, the ANAO could not identify and test a representative sample of cross-charging transactions. Therefore, notwithstanding the results of the 11 transactions tested, the ANAO is unable to form a conclusion on whether payments made from the MCH to other Tasmanian hospitals are in accordance with the conditions set out in the HoA. As noted in paragraph 5.31, DHHS advised the ANAO that it has now developed an IT solution to identify a complete population of shared services and cross-charging transactions. This solution is designed to enable a full set of these transactions to be populated for any future audit of these expense categories.

Asset management

5.57 The ANAO identified the purchase and transfer of assets to the NWRH and other Tasmanian hospitals as a potential risk relating to the use of Commonwealth funds under the HoA, as hospital assets can be high value, portable items that can be readily used at other hospitals. The ANAO's examination focused on the controls in place at the MCH to manage the purchase, transfer, repair and disposal of assets at the hospital. The ANAO did not sight or account for specific assets.

5.58 The MCH uses an electronic asset management system to manage hospital assets. It records assets worth more than $1000 from the date of their intended purchase. There is a four-step approval process for purchasing an asset at the MCH, including approval from the Head of Department that is requesting the purchase, the Business Unit Manager and the Product Evaluation Committee.[114] Once approval at these levels has been received, a purchase order for the asset is entered into the electronic asset management system and the financial delegate is required to provide the final approval for its purchase in the system. Tasmania's financial management system records the purchase of the asset and uses these details to update a fixed assets register (FAR). The FAR is used to record the asset purchase price and depreciation for accounting purposes. Assets worth more than $10 000 are recorded in FAR, however, the electronic asset management system records assets worth $1000 or more. Consequently, there is a discrepancy between the number and type of assets recorded in the two systems. This results in the MCH's financial records

[114] It is the role of the Product Evaluation Committee to approve assets that may require a trial prior to being purchased.

accounting for a lower value of assets than is recorded in its electronic asset management system, and leads to difficulties in reconciling the two systems.

5.59 When the asset is received by the MCH, a barcode is assigned to it, which is also recorded in the electronic asset management system, and is used to track the asset during its life. The electronic asset management system is also used to track the repair, maintenance, transfer and disposal of assets. It is the responsibility of the hospital department that has custody of the asset to record its repair and/or maintenance. The ANAO's assessment found that asset disposals and repairs and/or maintenance are inconsistently recorded in the electronic asset management system. For example, a complete listing of assets that had been disposed of was not maintained, which makes it difficult to confirm those assets that are no longer in use.

5.60 Theft, misuse and unlawful use or acquisition of assets are common fraud risks.[115] DHHS has a fraud control plan and policy in place that applies to the three Tasmanian THOs. The fraud control plan promotes the implementation of fraud risk assessment programs. The THO-NW maintains a risk register, however, it does not identify the risk of fraud as a separate risk or as a component of other risks. For example, fraud is not described in the context of the risk to asset management.

5.61 Stocktakes can be used to address the risk of fraud, especially where small, attractive and high cost items can be readily accessed. Stocktakes can be used to test whether the information in an asset management system is correct and current by confirming the condition of an asset, as well as its location and existence. While DHHS advised the ANAO in July 2013 that, as part of its annual preparation of departmental financial statements, it requests departmental entities to undertake stocktakes of assets, the MCH does not have an asset stocktake schedule and does not periodically undertake stocktakes of its assets.

5.62 There is scope for the MCH's management of assets to be significantly strengthened to provide greater assurance regarding the use of Commonwealth funds in managing hospital assets. In particular, the ANAO suggests that DHHS and the THO-NW consider:

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[115] Australian Government, *Commonwealth Fraud Control Guidelines*, Australian Government, Canberra, 2011, p 5.

- aligning the minimum value recording thresholds for assets between the finance system and the asset management system so assets are consistently recorded in both systems;
- introducing and promoting policies regarding the consistent and complete recording of asset additions, disposals, repairs and maintenance at the MCH; and
- planning and implementing a regular asset stocktake program at the MCH.

5.63 DHHS advised the ANAO in July 2013 that it is in the process of improving its processes for identifying and managing risk across the portfolio and this will include ensuring that THOs implement risk minimisation strategies at the local level. DHHS advised that it will strengthen its asset management practices in line with the ANAO's suggestions.

Conclusion

5.64 The MCH receives funding from a range of sources, the majority of which is direct funding from the Commonwealth under the HoA. Tasmania contributes funding to the operation of the MCH, including through the allocation of funds from Commonwealth health initiatives and reinvesting any own-source revenue into the operation of the hospital.

5.65 The Commonwealth's direct funding is the subject of financial reporting requirements and subsequent scrutiny by DoHA and DHHS. While areas of concern have been identified through this scrutiny, these concerns have been resolved in consultation between the parties. For example, in 2009 and 2010, Tasmania managed orthopaedic services in the North West region by treating patients at the NWRH and charging the MCH for that service. Tasmania met those costs from MCH revenue, rather than from direct Commonwealth funding, and was therefore not considered by DoHA to be in breach of its HoA obligations.

5.66 The media has reported claims about the misuse of Commonwealth funds for expenses associated with employees, pharmaceuticals and supplies at the NWRH. The ANAO's substantive testing found no evidence to indicate that the MCH was using Commonwealth funds outside the HoA requirement in the categories of employee, supplies and pharmaceuticals expenditure. In the case of patient transport testing, the combination of patient and staff transport records by DHHS meant that the ANAO could not form an overall conclusion for the patient transport category. However, the evidence examined

did not show that funds were used inconsistently with the HoA, and broader analysis indicates that the MCH's patient transport costs are not inconsistent with those of other Tasmanian hospitals.

5.67 While limited testing was able to be undertaken, the ANAO cannot form a judgement on the appropriateness of the use of funds for shared services and cross-charging expenses, as DHHS could not provide complete transaction listings and representative samples could not be identified and tested. The shared services transactions tested identified a recording error in the 2008–09 financial statements, which was already known to DHHS. No errors were identified in the testing of cross-charging transactions. DoHA and DHHS have differing views on the appropriateness of the cost of providing shared services, and for this reason, it is important that DHHS complete its planned review of these costs. Further, by addressing shortcomings in the MCH's asset management processes and controls, DHHS can address a potential risk to the appropriate use of Commonwealth funds.

5.68 Tasmania is required under the HoA to maintain complete and current financial records. However, DHHS's systems were unable to provide some key information required for the ANAO's expenditure testing, including employee information and comprehensive lists of transactions between the MCH and other Tasmanian entities. As a result, the ANAO could not form conclusions on the compliance of expenditure on shared services, cross-charging and patient transport with the terms of the HoA. DHHS has since advised that it has developed a means to produce a total population of cross-charging transactions, and has also put in place a means to provide for the clearer attribution of cab charges to patients or staff members. However, it will be important to address any residual system constraints and gain assurance regarding the appropriateness of expenditure under those categories not able to be tested as part of this audit. Other systems improvements, such as aligning reporting and conducting periodic system reconciliations, would better position DHHS to fulfil Tasmania's obligations under the HoA, as well as provide greater transparency around the use of Commonwealth funds.

Recommendation No.3

5.69 To improve the transparency of expenditure reporting for the MCH and to provide greater assurance that Commonwealth funds are being used in accordance with the HoA, the ANAO recommends that DHHS:

- address system limitations that prevent assurance being provided in relation to MCH expenditure under the HoA, specifically shared services, cross-charging and patient transport expenditure, and subsequently, in consultation with DoHA, undertake an audit of those expenditure categories;
- review, following consultation with DoHA, the alignment of the monthly and annual financial reports it provides under the HoA with its financial systems;
- undertake periodic reconciliations between its finance system and other systems, such as payroll, asset and pharmaceutical management systems; and
- review its management of MCH records, including employee files, to help ensure that relevant records are available in a timely manner.

DHHS response:

5.70 *DHHS supports this recommendation. In respect to element one, DHHS acknowledges the ANAO's findings with regard to system limitations and advises that, based on feedback received during the audit, steps have been taken to resolve these issues. For example, a script has been developed which can now identify a complete population of shared services and cross-charging transactions.*

5.71 *Work is underway to address elements two and three of this recommendation. In respect to the fourth element, DHHS notes that a minority of employee records took an unsatisfactory amount of time to locate due to an interim storage measure; this will be rectified by scanning these documents electronically.*

6. Performance and Cost of Mersey Community Hospital Services

This chapter examines the performance of the Mersey Community Hospital in key areas of clinical activity and the cost of the hospital's services compared with its national peers and other Tasmanian hospitals.

Introduction

6.1 In order to complete its assessment of Tasmania's responsibilities under clause 8.2 of the Heads of Agreement (HoA), with regard to the diligent, professional and competent management of the hospital, the ANAO examined the clinical service performance of the MCH against established standards and benchmarks. The following sections: provide an overview of the national performance reporting framework for hospitals; assess the MCH's performance reporting systems; and analyse the MCH's performance in key areas of hospital activity, having regard to the hospital's service profile.

6.2 To assess whether the MCH is managed efficiently by Tasmania, the second section of this chapter examines the costs of acute care and of all care types at the MCH compared with a national peer group of 10 medium sized inner regional hospitals, and with the other three acute care hospitals in Tasmania. The major factors contributing to the MCH's costs are then examined.

National performance reporting for hospitals

6.3 Hospital performance reporting is required under various national agreements, including the National Healthcare Agreement 2012[116] and the National Partnership Agreement on Improving Public Hospital Services.[117] The Tasmanian State Government, through DHHS, is responsible for reporting performance information for the MCH under these agreements.

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[116] The National Healthcare Agreement 2012 is an agreement between the Commonwealth and the state and territory governments on the priority areas requiring improvement in Australia's health system, including identifying long-term objectives.

[117] The National Partnership Agreement on Improving Public Hospital Services sets out, amongst other things, the performance targets through the National Emergency Access Target (NEAT) and the National Elective Surgery Target (NEST). It ties reward funding to states' and territories' achievement of these targets.

6.4 The National Health Reform Agreement (NHRA)[118] is the overarching health policy on improving health outcomes. It focuses on: public hospital funding; performance reporting; local governance of elements of the health system; policy planning for primary health care; and responsibilities for aged care.[119] The NHRA also establishes the information agreed for mandatory collection and reporting at a national level. The MCH contributes to this data collection, which is compiled at a state level and is provided to DoHA and the Australian Institute of Health and Welfare (AIHW).[120]

6.5 The NHRA introduced a Performance and Accountability Framework (PAF) to improve transparency and accountability for hospital performance. The PAF requires states and territories to provide performance information on hospitals, local hospital networks and Medicare Locals[121] across three areas: equity; effectiveness; and efficiency of service delivery. The information provided by states and territories is used in reports prepared by the National Health Performance Authority (NHPA).[122]

6.6 The PAF outlines performance reporting for hospitals against 17 performance indicators in four categories: Effectiveness – safety and quality; Effectiveness – patient experience; Equity and Effectiveness – access; and Efficiency – efficiency and financial performance. These are based on indicators specified in other national agreements, such as the National Healthcare Agreement. Tasmania reports performance information about the MCH as part of its reporting obligations under relevant agreements.

MCH performance reporting systems

6.7 The quality and integrity of hospital performance information is becoming increasingly important in Australia given the financial incentives for

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[118] The NHRA is an agreement between the Commonwealth and the state and territory governments to improve health outcomes for Australians and develop a sustainable health system. It also outlines new financial and governance arrangements for public hospitals, and new governance arrangements for primary healthcare and aged care.

[119] Council of Australian Governments, *National Health Reform Agreement 2012*, COAG, Canberra, 2012, p. A-3.

[120] The Australian Institute of Health and Welfare is an independent statutory body, established to provide reliable and relevant information on Australia's health and welfare, on a regular basis.

[121] Medicare Locals were established under the National Health Reform Agreement. Their purpose is to coordinate primary healthcare delivery and identify and address gaps in health care services.

[122] The NHPA is an independent body established under the *National Health Reform Act 2011* that monitors and reports on the performance of local health care organisations, including Local Hospital Networks, public and private hospitals, and primary health care organisations.

state and territory governments if they achieve performance benchmarks under the National Partnership Agreement on Improving Public Hospital Services. These incentives increase the risk of tampering with data to improve performance results, as in the well-publicised case of the Canberra Hospital's manipulation of emergency department statistics in 2012.[123]

6.8 While there has been no suggestion of any similar manipulation of performance data occurring at the MCH, the ANAO assessed the controls in three key electronic performance information systems, maintained by DHHS and used at the MCH to capture and report hospital performance, to review the potential risks to data quality and integrity in these systems. A comprehensive examination of the integrity of MCH performance data was not within the scope of this audit. The systems assessed were the:

- Inpatient Management (IPM) system, which records information about hospital wards, including bed availability and the admission of patients;
- Electronic Incident Management System (EIMS), which records clinical and patient incidents, such as incorrect medication dosages; and
- Emergency Department Information System (EDIS), which records operational information about the emergency department, for example patient waiting times.

6.9 The strengths and shortcomings in controls were relatively consistent across the IPM system, EIMS and EDIS. The strengths are that all three systems have restricted access and an audit log facility. However, weaknesses exist in supporting these security features, including that:

- passwords to access the systems are relatively weak eight character passwords, required to be changed every 90 days, and EIMS has a generic password that can be used by all staff;
- regular reviews of audit logs for each system are generally not undertaken, although DHHS has advised that, in relation to EIMS, the system administrator receives regular login data for review; and

[123] ACT Auditor-General, *Emergency Department Performance Information: Report No. 6/2012*, ACT Auditor-General's Office, Canberra, 2012.

- reviews are not undertaken when users' profiles are added or changed in all three systems, except when a new user is added to the IPM system.

6.10 The findings indicate that there is scope to improve system controls to minimise the risk to data quality and integrity at the MCH. In order to enhance the integrity and quality of the information recorded in these systems, the ANAO suggests that DHHS and the THO-NW: strengthen password requirements, including removing generic passwords; review additions and changes to users' profiles; and review audit logs to identify and address any unusual system access activity.

6.11 DHHS advised the ANAO in July 2013 that the THO-NW is in the process of developing a policy regarding the use of generic passwords, in order to reduce their use. It also advised that EIMS is about to be replaced with a software solution that contains a more sophisticated audit facility and further rigour in relation to user access and security. This new system will be supported by a state-wide policy designed to ensure integrity of performance data, including audit and review requirements.

Performance of the Mersey Community Hospital

6.12 As discussed in Chapter 2, the HoA does not include a performance measurement framework; rather it sets out the requirements for quarterly and annual financial and operational reporting to DoHA. Consequently, to assess the performance of the MCH, the ANAO selected for analysis key performance indicators outlined in national agreements, such as the PAF and National Partnership Agreement on Improving Public Hospital Services, having regard to the MCH's service profile.

MCH service profile

6.13 The core clinical activities set out in Item A of the Schedule to the HoA are the major determinant of the service profile of the MCH. There is some flexibility to manage clinical activities within the terms of Item A by agreement between the parties, such as the changes to general surgery rostering and paediatric care agreed in October 2012. There is also flexibility to provide services outside the core clinical activities.

6.14 Since the Commonwealth's acquisition of the MCH, the range of elective day surgery available has expanded to include:

- endoscopy intervention services;

- urology outpatient and surgical services;
- short stay orthopaedic surgery;
- cataract surgery;
- dental surgery; and
- ear, nose and throat surgery.

6.15 The introduction of these additional services has increased the overall activity of the hospital. Surgical activity at the MCH grew six per cent from 2009–10 to 2011–12. In 2011–12, 92 per cent of surgery was elective and the remaining surgery was emergency surgery.

6.16 As acknowledged in the 2012–13 Clinical and Financial Services Plan, the service profile of the MCH is moving towards the provision of low-acuity, day surgery procedures, while the NRWH is treating higher-acuity patients. This shift in the MCH's service profile is in the direction of the objective set out in *Tasmania's Health Plan 2007*.

Performance in key areas of clinical activity

6.17 The following sections examine the MCH's performance in key areas: inpatient management; the emergency department, elective surgery; the High Dependency Unit, obstetrics; and infection rates.

Inpatient management

6.18 Measuring inpatient management can highlight potential cost efficiencies and service-mix improvements. Average length of stay and bed occupancy are two performance measures to inform inpatient management.

Average length of stay

6.19 The average length of stay can be used to measure efficiency as a shorter hospital stay reduces the cost of a patient's treatment. The two measures of the average length of stay, including and excluding same day separations, have decreased by 11 per cent at the MCH over the three-year period from 2009–10 to 2011–12. Table 6.1 shows that, in 2010–11, the MCH's average length of stay, both including and excluding same day separations, was lower than the Tasmanian and national averages for public acute hospitals.

Table 6.1: Average length of stay comparisons (2010–11)

	MCH	Tasmania	National
Average length of stay including same day separations	2.7 days	3.4 days	3.7 days
Average length of stay excluding same day separations	4.4 days	5.9 days	6.5 days

Source: ANAO analysis and Australian Institute of Health and Welfare, *Australian Hospital Statistics 2010–11*, AIHW, Canberra, 2011, p. 178.

6.20 The lower average length of stay at the MCH should also contribute to a lower cost per patient separation than the Tasmanian and national averages. However, while this is true for the Tasmanian average, it is not true in comparison with the national average. The higher costs at the MCH compared to the national average are due in part to high staffing, medical and supplies, and administration costs, which are examined later in this chapter (see paragraphs 6.72-6.93).

Bed occupancy

6.21 Bed occupancy levels are a measure of the utilisation of available beds and are usually measured at midnight to reflect the overnight occupancy of inpatient beds. Occupancy rates for the Medical, Surgery, High Dependency and the Women's and Children' Health Units at the MCH were examined by the ANAO.

6.22 The bed occupancy levels for the MCH fluctuate from month to month, for example, bed occupancy was 77.4 per cent in August 2011, but only 57.9 per cent in January 2012. Bed occupancy over the full 2011–12 year for the four units examined at the MCH averaged 70 per cent, which represents a 10 per cent decrease on the levels for 2010–11. This declining trend may relate to the increase in same day surgery activity at the MCH over the same period resulting in a reduction to the number of patients requiring overnight care.

Emergency Department

6.23 The emergency department at the MCH was upgraded in 2011 and 2012. This upgrade cost $5.3 million and was funded by Tasmania.[124] The Tasmanian Government considered the upgrade necessary to accommodate

[124] The total funding amount included retained MCH revenue and direct state government funding.

the large number of annual attendances to the MCH emergency department and provide capacity to manage patients requiring short-term observation (less than 24 hours). In 2011–12, there were 25 852 attendances at the MCH emergency department. This level of attendance is consistent with previous years' figures of 26 151 in 2010–11 and 24 876 in 2009–10. DHHS anticipates that emergency department attendances in 2012–13, when available, will show an increase over the 2011–12 figure.

6.24 Patients who attend an emergency department are assessed for their ability to wait for care and are allocated a triage category, as defined by the Australasian College of Emergency Medicine, which indicates the time within which they should be seen, as follows:

- Resuscitation (Category 1): immediate;
- Emergency (Category 2): within 10 minutes;
- Urgent (Category 3): within 30 minutes;
- Semi-urgent (Category 4): within 60 minutes; and
- Non-urgent (Category 5): within 120 minutes.

6.25 Of the 25 852 presentations to the MCH emergency department in 2011–12, 68.6 per cent were semi-urgent or non-urgent. The 2012–13 Clinical and Financial Services Plan partly attributes these high numbers of presentations in the lower level triage categories to the limited availability of after-hours and bulk-billing general practice (GP) services in the North West region. The North West region is also less well serviced by GPs than the rest of Tasmania. In 2011, the North West region had 64.2 full-time equivalent GPs per 100 000 population, which was less than the two other health regions and less than the Tasmanian state figure of 72.5.[125]

6.26 Organisations such as the AIHW[126] and the Productivity Commission[127] also use these triage categories to report on emergency department performance. Table 6.2 shows the benchmarked waiting times against triage

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[125] The Commission on Delivery of Health Services in Tasmania, *Preliminary Report to the Australian Government and Tasmanian Government Health Ministers*, 21 December 2012, p. 61.

[126] Australian Institute of Health and Welfare, *Australia's Hospitals at a Glance 2010–11*, AIHW, Canberra, 2012.

[127] Productivity Commission, *Public and Private Hospitals*, Productivity Commission, Canberra, 2009.

category. The MCH achieved the targets for four of the five triage categories, and its performance significantly exceeded the national benchmark in three of these, but did not achieve the target for Category 1.[128] In comparison with other Tasmanian hospitals, the MCH performed between 5–7 per cent lower for Categories 2, 3 and 4, and at a comparable level for Category 5. There would be benefit in the THO-NW reviewing the MCH's processes for treating Category 2, 3 and 4 emergency department patients to identify potential improvements. DHHS advised the ANAO in July 2013 that the MCH Director of Emergency Medicine has introduced initiatives designed to improve Category 2 and 3 wait times.

Table 6.2: Emergency department waiting time benchmark

Triage category	Target	MCH result 2011–12	Target achieved
Category 1 – resuscitation	100 per cent of patients should be seen immediately	98 per cent	✗
Category 2 – emergency	80 per cent of patients should be seen within 10 minutes	84 per cent	✓
Category 3 – urgent	75 per cent of patients should be seen within 30 minutes	75 per cent	✓
Category 4 – semi-urgent	70 per cent of patients should be seen within 1 hour	79 per cent	✓
Category 5 – non-urgent	70 per cent should be seen within 2 hours	93 per cent	✓

Source: Australasian College of Emergency Medicine.

6.27 A key performance indicator used to assess the performance of emergency departments, as specified in the National Partnership Agreement on Improving Public Hospital Services, is the National Emergency Access Target (NEAT). Under this agreement, reward funding to states and territories is tied to achieving this target.

6.28 The NEAT is 90 per cent of all patients presenting to a public hospital emergency department either ready to leave the emergency department for

[128] The failure to meet the 100 per cent target resulted from a single case, in a total of 44 Category 1 presentations, not being seen immediately. Further examination of this case by MCH management found that the patient was examined within three minutes. The patient was subsequently discharged just over an hour from their initial presentation. Given these circumstances, DHHS considers that there is a possibility that the patient was incorrectly assessed as a Category 1 presentation.

admission to hospital, referred to another hospital for treatment, or discharged within four hours.[129] Each state is benchmarked against 2009–10 data, meaning that the targets differ across each state and territory. Table 6.3 shows Tasmania's state-wide targets by calendar year against its benchmark according to the NEAT.

Table 6.3: Tasmania's NEAT baseline and targets for patients to leave the emergency department within four hours

2009–10 Baseline (per cent)	2012 (per cent)	2013 (per cent)	2014 (per cent)	2015 (per cent)
66.0	72.0	78.0	84.0	90.0

Source: National Partnership Agreement on Improving Public Hospital Services, Schedule C.

6.29 In 2012, the MCH reported a NEAT performance of 77 per cent, thus exceeding its target. However, for patients leaving the emergency department through admission to the hospital, the proportion of presentations admitted in under four hours at the MCH was reported at 21 per cent, which was considerably lower than peer group hospitals across Australia and Tasmania (32 per cent and 41 per cent, respectively).[130] There is, therefore, scope to further improve the MCH's NEAT performance by increasing the number of emergency patients who are admitted within four hours.

Elective surgery

6.30 As noted in paragraph 6.16, the MCH is moving towards being a sub-acute, mostly day surgery facility with 92 per cent of surgery being elective surgery. This is reflected in the type of elective surgery being undertaken at the MCH. In 2011–12 hospital data showed:

- 89 per cent of patients were admitted, treated and discharged on the same day; and

[129] Council of Australian Governments, *National Partnership Agreement on Improving Public Hospital Services*, COAG, Canberra, 2011, pp. 30-38.

[130] DHHS advised the ANAO in July 2013 that the opening of the Short Stay Unit in the emergency department in January 2013 was having a positive impact on the proportion of presentations admitted within four hours, reporting that indicative data suggested the figure had increased to 43 per cent.

- nine per cent of patients were admitted on the same day as their treatment, but stayed for one or more nights.[131]

6.31 Improving elective surgery performance in Australia has been the focus of several intergovernmental agreements. In particular, the National Partnership Agreement on Improving Public Hospital Services ties achievement of the National Elective Surgery Target (NEST) to financial incentives for states and territories, and the National Partnership Agreement on the Elective Surgery Waiting List Reduction Plan (which expired on 31 December 2011) included median wait times for surgery as a performance indicator.

National Elective Surgery Target (NEST)

6.32 The primary objective of the NEST is to increase the percentage of elective surgery patients treated within clinically recommended timeframes. The goal is 100 per cent of all category one patients waiting for surgery to be treated within the clinically recommended time (30 days), and to reduce the waiting time for patients who have waited longer than clinically recommended.[132] Table 6.4 shows the three elective surgery categories and the target waiting times.

Table 6.4: Elective surgery waiting time benchmarks

Category	Target
Category 1 – urgent	Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly and become an emergency
Category 2 – semi-urgent	Admission within 90 days is desirable for a condition which is likely to deteriorate if left untreated beyond 90 days
Category 3 – non-urgent	Admission beyond 90 days is acceptable for a condition which is unlikely to deteriorate

Source: DHHS, *Progress Chart September 2012*, p. 11.

6.33 To achieve the NEST, two stages have been identified:

[131] The remaining two per cent of patients were not planned to be admitted on the day of their treatment either because they were admitted the day before or they were existing inpatients who were subsequently added to the elective surgery waiting list.

[132] Council of Australian Governments, *National Partnership Agreement on Improving Public Hospital Services*, COAG, Canberra, 2011, pp. 14-26.

- Stage 1 is aimed at stepped improvements in the number of patients treated within the clinically recommended times; and
- Stage 2 is a progressive reduction in the number of patients who are overdue for surgery, particularly patients who have waited the longest beyond the clinically recommended time.

6.34 Commonwealth incentive payments are available to state and territory governments for each stage. The performance indicators for NEST are retained from the previous National Partnership Agreement on Elective Surgery Waiting List Reduction Plan. Table 6.5 shows Tasmania's reported baseline and targets across each calendar year, and indicates that the MCH comfortably achieved its 2012 target.

Table 6.5: Tasmania's baseline and targets under NEST

	Baseline 2010 (per cent)	2012 (per cent)		2013 (per cent)	2014 (per cent)	2015 (per cent)	2016 (per cent)
		Target	MCH Actual	Target	Target	Target	Target
Category 1	75.4	84.0	89.0	92.0	100.0	100.0	100.0
Category 2	59.3	67.0	81.0	76.0	84.0	92.0	100.0
Category 3	76.8	81.0	98.0	86.0	91.0	95.0	100.0

Source: National Partnership Agreement on Improving Public Hospital Services, Schedule A.

Median wait time

6.35 Of the elective activity undertaken at the MCH in 2011–12, 38 per cent was surgical and 62 per cent was non-surgical activity. Average elective surgery waiting times at the MCH are shorter than the Tasmanian and national averages.

6.36 Table 6.6 shows that, comparatively, MCH has a lower average median wait time for elective surgical activity than the Tasmanian and national average median wait times. It also shows that the MCH had a lower proportion of its elective surgery patients waiting more than 365 days for treatment compared with Tasmania and nationally. The small proportion of emergency surgery undertaken at the MCH contributes to its superior elective surgery performance, since elective surgery schedules and operating theatre availability are less disrupted by emergency surgery demands.

Table 6.6: Average median waiting times for elective surgery

	Average median wait time			Proportion of patients who waited more than 365 days		
	MCH	Tasmania	National	MCH	Tasmania	National
Surgical	29 days	38 days	36 days	0.6 per cent	9.4 per cent[1]	2.7 per cent

Source: ANAO analysis of MCH records provided by DHHS and Australian Institute of Health and Welfare Elective Surgery Reporting.

Note 1: In 2011–12, Tasmania had the largest percentage of patients, among all the states and territories, waiting for more than one year for elective surgery. It is an area of focus in the National Partnership Agreement on Improving Health Services in Tasmania, between the Commonwealth and Tasmanian Governments, signed in September 2012.

High Dependency Unit

6.37 In the 2008 and 2011 HoA, the Commonwealth listed a High Dependency Unit (HDU) as a required core clinical service to be delivered at the MCH. The then Mersey Hospital's Intensive Care Unit was one of the services to be discontinued under *Tasmania's Health Plan 2007* and, therefore, was one of the services that the Commonwealth indicated would be reinstated following its intervention. In early 2008, the Commonwealth engaged a consulting firm to outline the options for critical care models at the MCH. The report recommended that an HDU was a safer and more sustainable care option than retaining an Intensive Care Unit.[133]

6.38 The HDU currently has four beds and treats patients who require a high level of monitoring and management. In the period from 2009–10 to 2011–12, there was a reported 34 per cent increase in the number of patients treated in the HDU (214 to 287 patients), with an average bed occupancy of 80 per cent. The growth in separations is larger than the four per cent growth in general separations over the same period, indicating strong demand and high utilisation for this service.

Obstetrics

6.39 Tasmania's 2007 Health Plan outlined Tasmania's intention to limit the obstetrics services available at the MCH to low-risk births and consolidate medium-risk births to the NWRH. However, consistent with the Commonwealth's intention to maintain existing services at the MCH, it

[133] SpencerSmith and Associates, *Options for Inpatient Critical Care Services at the Mersey Community Hospital: Final Report*, March 2008.

continued to provide a full range of birthing services following the Commonwealth's acquisition. In 2011–12, there were 413 births recorded at the MCH. This was a decline from the number of births in the two prior years (423 births in 2009–10 and 432 births in 2010–11).

6.40 Performance indicators used to measure obstetrics services include: primipara[134] caesarean rates and the proportion of emergency caesareans commenced within 30 minutes of an unplanned surgery request.

Primipara caesarean rate

6.41 Primipara pregnancies are generally uncomplicated, and consequently, the level of intervention associated with these types of births is generally low.[135] Primipara caesarean rates are used to compare inter-hospital maternity care controls.

6.42 Figure 6.1 illustrates that over the three-year period of 2009–10 to 2011–12, the proportion of first time mothers who had a caesarean was larger at the MCH than its peer reporting group.[136] The most notable difference was from January to June 2012, when 48 per cent of first time mothers had caesareans at the MCH compared with 22 per cent at peer hospitals.

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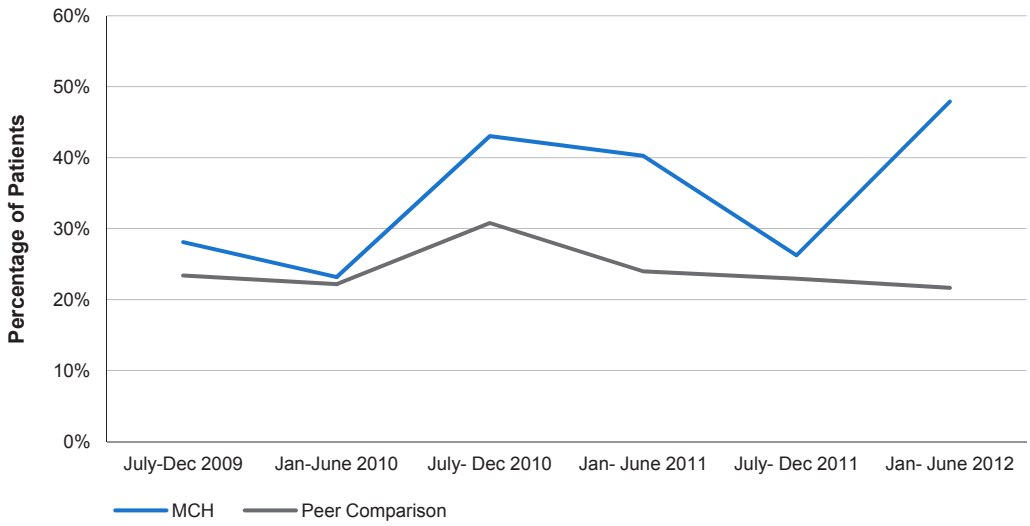
[134] Primipara means a woman who is giving birth for the first time.

[135] Department of Human Services (Victoria), *Victorian Maternity Services Performance Indicators: Complete set for 2004–05: January 2006*, DHS, Melbourne, 2006, p. 5.

[136] The ACHS determined the peer group comparison for this analysis.

Figure 6.1: Primipara caesarean rates



Source: ANAO analysis of MCH records provided by DHHS.

6.43 While primipara pregnancies are generally uncomplicated, conditions such as obesity and diabetes increase the risk factors involved and can significantly increase caesarean rates. As noted in Chapter 1 (paragraph 1.7) the North West region contains significant areas of socio-economic disadvantage, and one of the consequences of this is that the MCH's catchment population has higher than average levels of obesity, diabetes, hypertension and poor nutrition. DHHS advised the ANAO that this is likely to be contributing to the higher rate of primipara caesareans at the MCH. A higher primipara caesarean rate can also reflect a clinician-led obstetrics model, as opposed to a midwife-led model. DHHS acknowledged that such a model may be an unintended consequence of the current service design (staff composition and workload) of the MCH's obstetrics department.

Emergency caesarean

6.44 The ACHS identifies the proportion of patients whose emergency caesarean was commenced within 30 minutes of the request of unplanned surgery as an Anaesthesia Safety Indicator. In the period from July 2009 to June 2012, 37 per cent of emergency caesareans at the MCH were commenced within 30 minutes, compared with 73 per cent for peer comparison hospitals. While the MCH's performance improved during 2011–12, it remained below the peer comparison group. In response to this result, DHHS has advised that the Head of the Department for Obstetrics and Gynaecology for the THO-NW has initiated:

- a weekly education session where staff discuss clinical governance matters, induction and caesarean rates, and any causal factors;
- measures to ensure the accurate categorisation of emergency (Category 1) caesareans; and
- monthly audits of Category 1 births, to ensure that any delays in the system are identified and addressed.

6.45 The 2012–13 Clinical and Financial Services Plan identifies key challenges to the obstetrics and gynaecology services at the MCH and the North West, including: recruitment, retention and skilling of staff; and high operational costs. In response to these challenges, the Plan proposed a review of Obstetrics and Gynaecology services to:

- confirm the optimal service level and staffing arrangements; and
- consider existing government arrangements with a view to identifying potential improvements.

Infection rates

6.46 Infection rates are used as a measure of the quality of hospital services being delivered. The two infection types included in the PAF (refer paragraphs 6.5 and 6.6) are staphylococcus aureus bacteraemia (SAB) and clostridium difficile infection (CDI). Hand hygiene is recognised as a measure to help reduce incidences of these types of infections.

Staphylococcus aureus bacteraemia

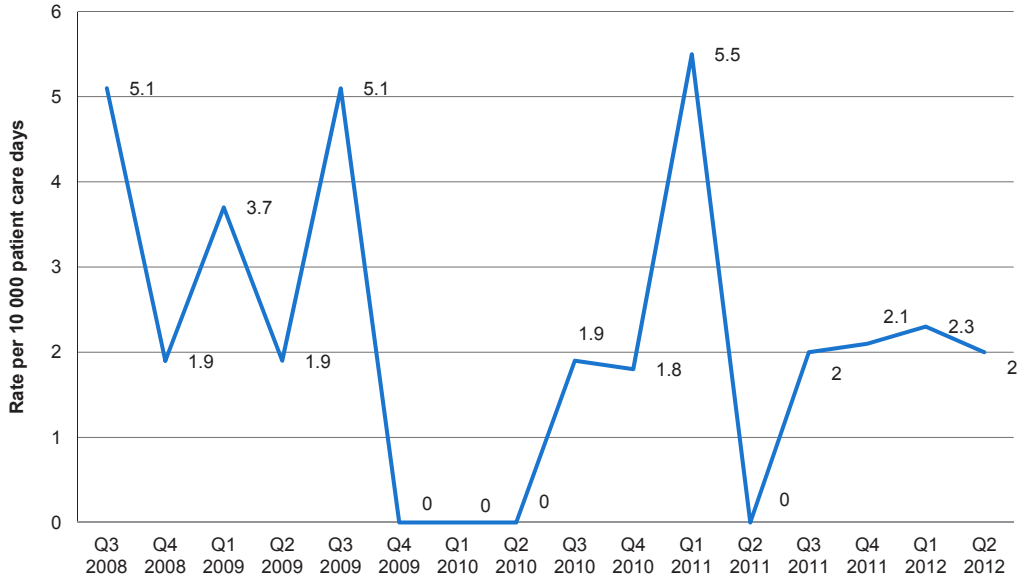
6.47 SAB is a bloodstream infection with an estimated mortality rate of approximately 25-30 per cent of infected patients. Patients with a SAB infection are more likely to require a longer hospital stay, thus increasing the cost of their treatment. States and territories report on SAB infections to the AIHW, and in turn, this is reported by the National Health Performance Authority on the *MyHospitals* website.[137]

6.48 The National Healthcare Agreement requires the rate of SAB to be no higher than 2.0 cases per 10 000 occupied bed days. The reported average SAB rate for the MCH was 2.3 cases per 10 000 occupied bed days in 2010–11 and 2.1 cases in 2011–12, exceeding the National Healthcare Agreement target. In

[137] The *MyHospitals* website reports performance information on all public hospitals and some private hospitals in Australia.

both those years, the SAB rates at the MCH were also higher than other Tasmanian hospitals and almost double the Tasmanian average. Figure 6.2 shows several 'spikes' in the rate in particular quarters over the period from 1 October 2008 to 30 June 2012, which illustrates the potentially distorting impact on the annual average of individual SAB cases in a small inpatient population.

Figure 6.2: Number of SAB infection cases per 10 000 bed days at the MCH, 2008–12



Source: ANAO analysis of MCH records provided by DHHS.

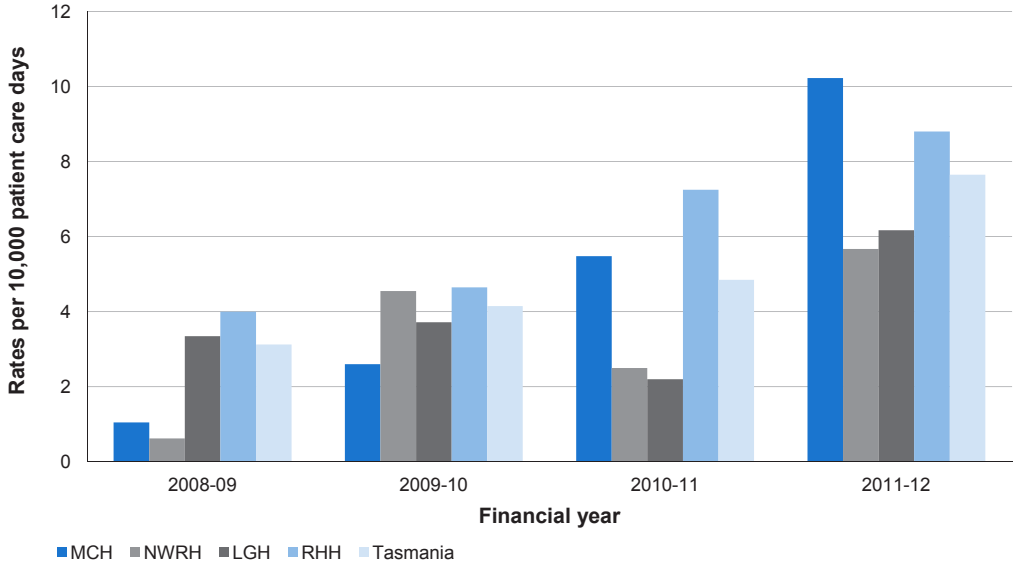
6.49 DoHA queried the high rates of SAB during the regular monthly liaison meeting in November 2011. At that time, the MCH indicated the rates were not representative due to the high number of outpatients who attend the MCH. DHHS advised that a proportion of these outpatients may already have SAB, which is then detected during treatment of the patient and reflected in the MCH's infection rates, even though the infection was not contracted at the MCH.

Clostridium difficile infection

6.50 CDI is an infection of the bowel and affects patients in a similar way to SAB; that is, it increases the risk of mortality, and often results in longer hospital stays resulting in higher treatment costs. CDI can be caused by overuse of antibiotics, suboptimal cleanliness and ineffective infection control processes.

6.51 In 2008–09 and 2009–10, the MCH reported the second lowest and lowest rates, respectively, of CDI among the four acute Tasmanian hospitals. However, as shown in Figure 6.3, in 2010–11 and 2011–12 the MCH had the second highest and highest rates, respectively, of CDI among these hospitals.

Figure 6.3: CDI infection rates



Source: ANAO analysis of MCH records provided by DHHS.

Note: Launceston General Hospital (LGH) and Royal Hobart Hospital (RHH).

6.52 As with SAB, a contributing factor to the CDI rate at the MCH may be the high rate of community onset CDI cases, where patients have acquired CDI before being hospitalised. DHHS advised that an increase in community onset CDI cases has been observed both locally and nationally, and that further work is required to investigate the factors behind this increase.

Hand hygiene

6.53 Hand hygiene among healthcare workers, that is washing their hands or cleaning them with alcohol based rubs regularly, can assist to minimise incidences of SAB and CDI. Hand hygiene audits at the MCH are conducted up to three times a year. They involve: observing healthcare workers; recording the number of times they wash or clean their hands; and estimating a compliance rate based on observations. The high rates of SAB and CDI in 2010–11 do not appear to correlate with the hand hygiene compliance rates reported for the MCH, which have been close to the national benchmark (70 per cent) since 2010.

6.54 Between the second and third hand hygiene audits in 2012, however, compliance rates declined at the MCH. To address this decline, the MCH conducted education sessions for staff, nominated two senior consultants to 'role model' good hand hygiene behaviour, and erected improved signage around the hospital to remind workers of their hand hygiene responsibilities. DHHS advised the ANAO in July 2013 that these initiatives have had a positive impact, with the MCH reporting an overall hand hygiene compliance rate in the first period of 2013 of 83.4 per cent.

6.55 While the most recent data shows a decline in the SAB rate at the MCH early in 2012–13, given the high rates of SAB and CDI in 2011–12, the ANAO suggests that the MCH continue to review all the factors contributing to these rates and adjust its infection control strategies accordingly.

Serious clinical incidents

6.56 A clinical incident is an unplanned event which causes, or has the potential to cause, harm to a patient. Under the 2008 and 2011 HoA, Tasmania is required to provide quarterly reporting of serious incidents by service type and volume. Serious incidents are assigned a Severity Assessment Code between one (extreme risk) and four (low risk).

6.57 Tasmania's reporting to DoHA includes Severity Assessment Code 1 and 2 incidents. The MCH's serious incident record since its acquisition by the Commonwealth is shown in Table 6.7. The discrepancy between the number of incidents recorded and reported is due to some incidents being reclassified as of lower severity following incident reviews undertaken subsequent to the quarterly report. This review process and its effect on the quarterly statistics has been made explicit in the quarterly reports to DoHA since 2011–12.

Table 6.7: Serious clinical incidents recorded at the MCH and reported to DoHA

Year	Serious incidents recorded at the MCH	Serious incidents reported to DoHA
2008–09	2	2
2009–10	3	8
2010–11	5	No data reported
2011–12	3	16
2012–13 (to 31 December)	1	4

Source: MCH data and reports to DoHA under Item C1(g) of the Schedule to the HoA.

6.58 As there are no national benchmarks for serious incidents, the ANAO is unable to draw a conclusion regarding the MCH's comparative performance with respect to the level of serious incidents.

Conclusion

6.59 Analysis of the services profile at the MCH indicates a number of well-performing areas. Performance results for inpatient management, High Dependency Unit demand and elective surgery wait times under the NEST are all positive. The MCH's emergency department is also performing strongly against national NEAT benchmarks, although there is scope to improve the treatment times for categories 3, 4 and 5 patients, to be consistent with results across other Tasmanian hospitals.

6.60 The performance results for the obstetrics service at the MCH are not as positive. Tasmania has identified the service as requiring improvement and the proposed review of obstetrics at the MCH is likely to assist with identifying practical changes that can impact on performance results. Infection rates are another area requiring attention. There would be benefit in the MCH management investigating other potential causes for these higher infection rates.

Cost of Mersey Community Hospital services

6.61 The ANAO engaged PricewaterhouseCoopers (PwC) to undertake an analysis of the MCH's costs and how these compared to other Tasmanian hospitals and to similar hospitals nationally. The results of this analysis are a broad indication of whether the Commonwealth is receiving value for its expenditure on the MCH, and how efficiently Tasmania is operating the hospital for the Commonwealth owner.

Cost analysis methodology

6.62 There is a significant variation in factors that influence costs incurred by a hospital. These factors include: the volume of patients treated; the complexity of patient treatments (the patient 'casemix'); the types of care provided (for example, admitted patient care, emergency care, outpatients); and the structural features of a hospital, such as the specialties available and its geographic location. A simple comparison based on dividing costs by the number of patient separations (raw separations) for different hospitals would be misleading, as it would not take these variable factors into account.

Establishing reasonable comparisons requires applying a method of standardisation to the variables.

6.63 There is an accepted approach in the health sector when benchmarking costs between hospitals, which applies weights to derive an average cost per unit of weighted activity. The unit of weighted activity standardises the counts of the different types of care (acute admitted care, emergency department, outpatient and other non-admitted care) and patient casemix (highly complex and costly versus very simple and low cost) into a single unit on which comparisons can be made.

6.64 With regard to acute admitted care, this method is well established—weights are applied to different diagnosis related groups (DRGs) to recognise the differing complexity and expense of patient treatment, and the resulting calculation of the average cost per weighted patient separation is available from the National Hospital Cost Data Collection. The existence of these national data recognises that acute admitted care is the largest component (approximately 65 per cent) of hospital expenditure on a national basis, and represents 93 per cent of patient separations.

6.65 For types of hospital activity other than acute care, a figure on the average cost per weighted unit of activity is not as readily available. The audit therefore drew on the national Public Hospital Establishment (PHE) dataset[138], supplemented from other relevant sources, for data on units of activity for emergency departments (number of presentations), outpatient and other non-admitted care (number of occasions of service), and non-acute admitted care (number of patient days). Cost weights for these activity types relative to the average cost of an acute admitted separation were then estimated to establish a unit of weighted activity for all care types. By applying the same system of weights to each individual hospital, the proportion of a hospital's resources consumed in delivering different services was able to be estimated.

6.66 The second part of the benchmarking methodology identified suitable comparator hospitals to the MCH. The starting point for selecting such hospitals was the nationally-accepted classification of public hospitals by size and location

[138] The national Public Hospital Establishment (PHE) dataset consists of data supplied by the state and territory health authorities. Information is collected on a financial year basis from almost all public acute and public psychiatric hospitals in Australia.

developed by the AIHW.[139] The MCH sits in the C1 Medium group of 31 hospitals classified by the AIHW as medium acute hospitals with 5000 to 10 000 weighted separations per year. This potential peer group for the MCH was further refined, using a remoteness index, to a group of 10 hospitals classified as medium inner regional hospitals. Analysis of a number of variables for these hospitals, including the number of cost-weighted separations, the average number of DRG's treated and the patient age profile, confirmed that the MCH is very similar in casemix and is comparable to this peer group.

Cost analysis results

6.67 The comparison between the MCH, other Tasmanian hospitals[140] and the medium inner regional hospitals peer group for the average cost per weighted separation of acute admitted care in 2009–10 is shown in Table 6.8. The MCH's average cost per weighted separation of $5125 was $1550, or 43 per cent, higher than the average cost for its peer group. However, the MCH's cost was $729, or 12 per cent, lower than the other Tasmanian hospitals.

Table 6.8: MCH cost comparisons: acute admitted care (2009–10)

	MCH	Tasmanian hospitals, excluding MCH	Peer group hospitals
Direct costs per weighted separation (A)	$3647	$4468	$2582
Overhead costs per weighted separation (B)	$1478	$1386	$993
Total cost per weighted separation (A + B)	**$5125**	**$5854**	**$3575**
Average number of cost-weighted separations	7196	30 590	6271
Average complexity (cost weighted separations ÷ raw separations)	0.82	1.05	1.01

Source: PwC from the National Hospital Cost Data Collection.

[139] The public hospital classification was developed by the AIHW, together with the National Health Ministers Benchmarking Working Group and the National Health Performance Committee, for use in presenting and comparing data on cost per weighted separation. Acute care hospitals are classified into eight groups, from largest to smallest.

[140] The Tasmanian hospitals included in all cost comparisons in this section of the report are the three other acute care hospitals—Royal Hobart Hospital, Launceston General Hospital and the NWRH at Burnie.

6.68 The cost comparison for all care types in 2009–10 is shown in Table 6.9, based on the unit of weighted activity calculated through the approach described in paragraph 6.64. As data was drawn in this case from the PHE dataset, total costs comprise salary and non-salary expenditure. Although the differences in the source datasets means that the costs shown in Tables 6.8 and 6.9 are not directly comparable, the figures for all care types show the same relative positions between the MCH and the two comparator groups, albeit with smaller differentials. The MCH's total average expenditure per unit of activity for all care types of $5253 was $980, or 23 per cent, higher than its peer group, and was $386, or seven per cent, lower than other Tasmanian hospitals.

Table 6.9: MCH cost comparisons: all care types (2010–11)

	MCH	Tasmanian hospitals, excluding MCH	Peer group hospitals
Non-salary average expenditure per unit of weighted activity (A)	$2088	$2272	$1909
Salary average expenditure per unit of weighted activity (B)	$3165	$3367	$2364
Total average expenditure per unit of weighted activity (A + B)	**$5253**	**$5639**	**$4273**
Average units of weighted activity	12 260	46 208	10 010

Source: PwC from the Public Hospitals Establishment dataset and clinical data supplied by MCH.

6.69 The results from both of the comparisons above show that the MCH operates more efficiently than other Tasmanian hospitals. The fact that the MCH is a less complex hospital, with fewer specialties than the other Tasmanian hospitals contributes, in part, to this outcome. National data show that hospitals with activity profiles similar to the MCH incur lower weighted costs than large and complex hospitals with a high number of specialties and services. However, the relative cost difference incurred by the MCH compared to other Tasmanian hospitals is greater than that seen in national data, where the average difference between medium and large hospitals is in the order of two per cent.

6.70 The comparisons do, however, show that the costs incurred by the MCH are significantly higher than those of its national peers in the medium inner regional hospital group. Nonetheless, cost comparisons between the

other Tasmanian hospitals and their corresponding peer groups show similar and even larger cost differences, indicating that there is likely to be state-based factors influencing the cost profile of the MCH and the other Tasmanian hospitals relative to hospitals in other jurisdictions.

Major cost factors for the Mersey Community Hospital

6.71 Having established the relative overall position, in terms of costs, of the MCH against its medium inner regional hospitals peer group, the ANAO drew on analysis of MCH expenditure to identify factors contributing to the difference in costs between the MCH and its peer group. The analysis covered expenditure on employee costs and particular non-employee costs, such as expenditure on medical and surgical supplies and administration.

Employee costs[141]

6.72 The proportion of salaries and wages as a component of total expenditure at the MCH is generally consistent with the other Tasmanian hospitals. In 2010–11, 60 per cent of the MCH's expenditure related to staff salaries and wages, similar to the Launceston General Hospital (60 per cent) and Royal Hobart Hospital (62 per cent), but higher than the NWRH (52 per cent). For the medium inner regional hospitals peer group, salaries and wages represented 55 per cent of expenditure, and this figure increased to 62 per cent when the costs of Visiting Medical Officers (VMOs) were included, which is broadly similar to the MCH.[142]

6.73 Analysis of salary and wages expenditure by type of employee also showed that the distribution of employee costs at the MCH is very similar to other Tasmanian hospitals and its national peer group. The variations between the hospitals were two per cent or less in the proportions of expenditure for the major employee types, including salaried and visiting medical officers, nurses, administrative and clerical staff and domestic staff.

6.74 Although the proportion of costs by employee type is similar for the MCH and its peer group, significant differences appear when employee costs

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[141] Cost analysis in this section draws on data from the PHE dataset reported for 2010–11.

[142] Tasmanian hospitals report very low levels of expenditure on VMOs compared with hospitals in non-metropolitan regions in other jurisdictions. Inclusion of VMOs in the MCH's employee expenditure adds only one per cent to the 60 per cent represented by such expenditure, compared with the addition of seven per cent when VMOs are added to employee expenditure in the MCH's national peer group.

are analysed as average costs per unit of weighted activity. The MCH's average salary and wage cost, including VMOs, of $3195 per unit of weighted activity in 2010–11 was 19 per cent higher than the average cost per unit of $2668 for the medium inner regional hospital peer group. However, the MCH's cost on this measure is five per cent lower than for the other Tasmanian hospitals ($3367). The cost differences between the MCH and other hospitals on this measure for particular employee types include:

- administration and clerical: the MCH was 29 per cent higher than its peer group, but 11 per cent lower than other Tasmanian hospitals;
- salaried medical officers and visiting medical officers combined: the MCH was 16 per cent higher than its peer group and the same as other Tasmanian hospitals; and
- nurses: the MCH was 23 per cent higher than its peer group, and six per cent higher than other Tasmanian hospitals.

6.75 The MCH's higher average salary and wage costs compared to its peer group could derive either from higher average wages paid per employee, or higher staff counts, or a combination. However the average salary or wage at the MCH in 2010–11 across all employee types was $84 000, which was $3000 less than the average for its peer group of $87 000.[143] This indicates that higher wages are not a factor, and that the higher costs at the MCH are due to a higher average number of staff.

6.76 In 2010–11, the MCH had 37.8 full-time equivalent (FTE) staff per 1000 units of weighted activity compared with 29.0 FTE for the MCH's peer group and 39.8 FTE for the other Tasmanian hospitals. Table 6.10 shows the average FTE comparisons between the MCH and its peer group and the other Tasmanian hospitals for the principal employee types.

[143] These average salary figures are sourced from the PHE dataset 2010–11, rounded to the nearest thousand.

Table 6.10: Average FTE per 1000 weighted units of activity (2010–11)

Employee type	MCH (average FTE)	Tasmanian hospitals, excluding MCH (average FTE)	Peer group hospitals (average FTE)
Administration and clerical	6.1	7.0	4.1
Domestic	5.9	5.8	4.1
Salaried medical officers and VMOs	6.8	6.3	4.6
Nurses	17.7	16.9	14.1
Diagnostic and health professionals	1.4	3.9	2.0

Source: PwC analysis of the PHE and APC datasets 201–11, the NHCDC Round 13 and 14, and Australian Hospital Statistics 2010–11.

6.77 The comparisons in Table 6.10 show that the MCH's ratios of staff to patients are, in general, similar to those of the other Tasmanian hospitals. The diagnostics and health professionals category is an exception to this, reflecting the fact that the MCH has a smaller number of specialty units than the larger Tasmanian hospitals.

6.78 Although not shown in Table 6.10, comparison data between the other Tasmanian hospitals and their respective national peer groups also highlight that Tasmania as a whole has significantly higher staff to patient ratios than hospitals in other jurisdictions. While analysing the reasons for this state-wide characteristic was outside the scope of the audit, the ANAO notes that the Preliminary Report of The Commission on Delivery of Health Services in Tasmania also identified a higher ratio of staff per hospital separation in Tasmania than elsewhere in Australia. The Commission has indicated that further work, leading to a detailed report later in 2013, will examine this and other cost drivers contributing to higher-than-average costs per hospital separation in Tasmania.[144]

6.79 In relation to the MCH, there is evidence to indicate that operating in smaller and remote regions has an effect on staff to patient ratios, due to the need to maintain staffing levels without the volume of patients to achieve efficiencies available in the larger, more populated regions. There is also a

[144] The Commission on Delivery of Health Services in Tasmania, *Preliminary Report to the Australian Government and Tasmanian Government Health Ministers*, 21 December 2012, p. 11.

structural contribution to this effect at the MCH, due to the core clinical activities that it is required to maintain under the HoA, and the requirement for some of these activities, such as obstetrics, to be supported by on-call nurses and clinicians.

6.80 Maintenance of a 24/7 general and emergency surgery service was, until recently, one of those required activities. The changes agreed to surgical rostering at the MCH in October 2012, resulting in the cessation of out of hours surgery, will reduce the number of FTE required to support the surgery roster and is anticipated by DHHS to produce savings of $715 000 a year as a result.

6.81 It is too early to assess the impact of this change on the FTE to patient ratio at the MCH, particularly as the savings have been reallocated to enable the opening, in January 2013, of a six-bed short stay unit in the emergency department, including funding nursing FTE to support the unit. This strategy has, however, the potential to deliver efficiency benefits in terms of the MCH's ability to better meet demands in the emergency department.

Locum costs

6.82 The MCH has experienced difficulties over many years, both before and after Commonwealth acquisition, in attracting and retaining permanent medical staff. This has meant that it has had to rely on employing locum medical staff, who are generally more costly to employ than salaried staff. The MCH Clinical and Financial Services Plan 2009–10 noted that funding locums was a major cost driver for the hospital. The cost of contracting locums to fill vacant positions or gaps in rosters was again noted as a longstanding concern in the 2012–13 Plan.

6.83 The Tasmanian Government published figures in September 2012 on locum costs at the major Tasmanian hospitals for 2010–11 and 2011–12, in response to a parliamentary Question on Notice. These are shown in Table 6.11. The MCH spent $5 932 663 on locums in 2010–11. This represented 15.3 per cent of the MCH expenditure on salary and wages and was significantly (88 per cent) higher than the next highest Tasmanian hospital. In 2011–12, the MCH's locum costs increased to $7 341 405, whereas locum costs at the other Tasmanian hospitals decreased, meaning that the MCH's locum costs in 2011–12 were 196 per cent higher than the next highest hospital.

Table 6.11: Locum costs at the MCH and other Tasmanian hospitals

Hospital	Locum costs 2010–11 $	Locum costs 2011–12 $	Percentage change
MCH	5 932 663	7 341 405	+23.7
NWRH Burnie	2 676 454	2 173 022	-18.8
Launceston General	3 144 280	2 477 494	-21.2
Royal Hobart	1 989 020	131 089	-93.4

Source: ANAO analysis of figures provided in *Hansard*, House of Assembly, Tasmania, Question upon Notice 174, 27 September 2012.

6.84 In terms of the total average cost per unit of weighted activity of $5253 at the MCH in 2010–11 (see Table 6.9), locum costs represented $484, or nine per cent, of that cost. This was significantly higher than the NWRH ($150 per unit of weighted activity), Launceston ($70) and Royal Hobart ($26).

6.85 As there is no publicly available data on locum expenditure in the MCH's medium inner regional hospital peer group, a direct comparison is not possible. However, national data on costs for hospitals in that peer group indicates that they spend relatively more than major hospitals on VMOs, which are in a similar category to locums as non-permanent or non-salaried medical staff. In 2010–11, VMO costs in the peer group hospitals represented $303, or seven per cent, of the total average cost per unit of weighted activity. This suggests that the MCH is not as divergent in its locum costs compared with similar hospitals than with other Tasmanian hospitals, but still spends proportionally more on locums than its peer group spends on comparable non-salaried medical staff.

6.86 DoHA, DHHS and the THO-NW are aware of the MCH's dependence on locums, and its impact on MCH costs, and regularly monitor locum expenditure. Recruitment is a standing item on the agenda of the monthly liaison meeting. Successive MCH Clinical and Financial Services Plans have also recognised both the cost impact of the hospital's reliance on locums and the difficulty of attracting permanent staff to the North West, due to the comparatively small caseload of the hospitals in the North West, which presents a challenge to practitioners' ability to maintain skills. While strategies have been formulated to improve the recruitment and retention of medical staff, in order to reduce the dependence on locums, there has been no structured review of the effectiveness of those strategies. The 23 per cent increase in locum costs at the MCH from 2010–11 to 2011–12 suggests that there is scope for the parties to consider further options to manage these costs.

6.87 The MCH Clinical and Financial Services Plan 2012–13 reports that locums will move from being paid directly or through an agency to being considered 'on-staff,' and that this could result in up to a 20 per cent increase in locum costs through the payment of superannuation and workers compensation.[145] This development further emphasises the role of locums as a major cost driver at the MCH. In view of this development, and the potential efficiency benefits in reducing reliance on locums, it would be timely for the parties to request the THO-NW to review the factors determining the MCH's reliance on locums and its current approaches to reducing that reliance.

Non-salary costs

6.88 In addition to higher salary costs, the MCH also incurs higher non-salary costs per unit of weighted activity than its peer group. In 2010–11, the MCH incurred non-salary expenditure of $2059 per unit of weighted activity, 28 per cent higher than its peer group ($1606). However, this was nine per cent lower than the other Tasmanian hospitals ($2272), indicating that the MCH is more efficient in this area.

6.89 Differentials between the MCH and its peer group were more notable in the following expenditure categories:

- expenditure on medical and surgical supplies was 72 per cent higher for the MCH ($717) compared with its peer group ($416); and
- expenditure on administration was 82 per cent higher at the MCH ($466) than the average for its peer group ($255).

6.90 The differential in medical and surgical supplies, which is the largest non-salary expenditure category, accounts for a large proportion of the total difference in non-salary expenditure between the MCH and its peer group. The high costs for medical and surgical supplies are not unique to the MCH, but appear to be characteristic of all Tasmanian hospitals. The figures for the other hospitals compared to the MCH's cost of $717 per unit of weighted activity in 2010–11 were $1288 at the NWRH, $757 at Launceston General, and $671 at Royal Hobart. Limitations on Tasmania's ability to leverage economies of scale in negotiating prices for medical and surgical supplies have been suggested as

[145] The THO-NW decided to employ locum medical staff as hospital employees in order to provide consistent liability protection for those employees and to ensure compliance with Commonwealth taxation, superannuation, Fringe Benefit Tax and GST obligations.

a contributing factor to this situation. DHHS has acknowledged that there is significant opportunity to improve Tasmania's performance in managing these costs, and is currently undertaking a review of procurement functions across the portfolio to improve procurement practices and processes. Any improvement from this state-wide initiative would also have a positive effect on the MCH's costs and efficiency.

6.91 In terms of administration expenditure, this was the only non-salary expense category where the MCH incurred a higher average cost per weighted unit of activity ($466) than the other Tasmanian hospitals ($234), and was almost twice as expensive as those hospitals. A proportion of this difference is likely to be a function of hospital size, a factor observed nationally in smaller hospitals, where a level of administrative support has to be maintained notwithstanding a smaller caseload. The requirement under the HoA to maintain senior executive positions at the MCH would also contribute to this effect.

6.92 A review of the reasons contributing to the MCH's higher average administration cost per unit of weighted unit of activity relative to both its peer group and the other Tasmanian hospitals, and whether there is scope to achieve efficiencies in this category of expenditure, would place the MCH in a better position to manage administration costs.

Conclusion

6.93 Historically, there have been a number of challenges to operating the MCH efficiently. Some of these challenges are structural and ongoing, including the hospital's regional location and close proximity to the NWRH. For example, the difficulty of attracting permanent medical staff to the North West means that MCH continues to rely on locums to deliver services, which is generally a higher-cost model.

6.94 Compared with a peer group of 10 other medium sized inner regional hospitals, the MCH's average weighted costs for acute care and for all care types were more expensive than that peer group by, respectively, 43 per cent and 23 per cent. However, the three other major hospitals in Tasmania are also significantly more expensive than their respective national peer groups. Importantly, however, the MCH is less costly on these weighted measures than the other Tasmanian hospitals, being 12 per cent lower per unit of weighted activity for acute care and seven per cent lower for all care types. While the characteristics of the MCH as a lower acuity hospital, with significant amounts

of lower cost activity in day surgery, outpatient care and emergency department presentations, contribute to this result, it broadly indicates that the MCH is operating more efficiently than other Tasmanian hospitals.

6.95 An examination of statewide characteristics that contribute to Tasmanian hospitals being more expensive to operate than hospitals interstate was outside the scope of this audit. However, two of the key expenditure categories contributing to higher costs at the MCH compared to its peer group—a higher staff to patient ratio and higher medical and surgical supply costs—are common to the other Tasmanian hospitals. Work is underway within DHHS to examine options to improve Tasmania's performance with regard to the cost of supplies. In addition, the Commission on Delivery of Health Services in Tasmania has a mandate to make recommendations with respect to remediating identified inefficiencies in the delivery of public health services in Tasmania, and recommending improvements to hospital system performance, and is scheduled to produce a detailed report later in 2013.

6.96 The other drivers of higher costs at the MCH are expenditure on locum medical staff and general administration costs, and it is timely that the THO-NW and the MCH review the factors influencing these costs and determine whether there are any additional measures that can be taken by the hospital to better manage these costs.

Recommendation No.4

6.97 To support the efficient delivery of health care services at the MCH, the ANAO recommends that DoHA and DHHS initiate a targeted review by the THO-NW of the MCH's use of locums to determine whether there are any additional measures that can be taken by the hospital to better manage these costs.

DoHA response:

6.98 *DoHA agrees with the recommendation.*

DHHS response:

6.99 *DHHS supports this recommendation. The reliance on locums to staff the MCH is a recognised issue, and recruitment is a standing agenda item at the Mersey Monthly meetings between DHHS, DoHA and the THO-NW. In an attempt to address this issue, the MCH has a full time resource dedicated to attracting and recruiting staff. Both DHHS and the THO-NW are open to considering any additional measures which can be taken to better manage these costs.*

7. Achievement of the Commonwealth's Objectives for the Mersey Community Hospital

This chapter examines the establishment of the Commonwealth's objectives in assuming and maintaining ownership of the Mersey Community Hospital and the extent to which these objectives have been achieved. It also considers whether the Commonwealth has received value for money from the arrangements established with Tasmania to manage and operate the hospital.

Introduction

7.1 The Mersey Community Hospital (MCH) is unique among public hospitals as the only hospital owned and directly funded by the Commonwealth. At the time of its acquisition by the Commonwealth in 2007, the arrangement was suggested as a possible model for future Commonwealth intervention in the provision of regional hospital services. The unique status of the MCH arrangement adds to the importance of defining clear objectives for the arrangement and measuring their achievement.

7.2 The ANAO initially examined the various means used to establish the Commonwealth's objectives in acquiring and maintaining its ownership of the MCH, including public announcements, Ministerial statements and correspondence, the Portfolio Budget Statements (PBS) for the Department of Health and Ageing (DoHA) and the two HoA agreed with the Tasmanian Government.

7.3 The ANAO subsequently assessed how effectively the Commonwealth measures the extent to which the MCH program objectives are being achieved, including value for money considerations.

Establishing the Commonwealth's objectives

7.4 The Commonwealth's objectives were outlined by the Australian Government at the time of the acquisition of the MCH in 2007, and were subsequently refined over the period covered by the two HoA—from September 2008 to the present.

Acquisition of the MCH in 2007

7.5 The Australian Government's decision to intervene in the operation of the MCH was announced by the then Prime Minister on 1 August 2007 in response to local community concerns about the Tasmanian Government's plans to downgrade or close many of the services delivered at the hospital.[146] The decision was expressed in terms of the Government being 'prepared to underwrite a community-based proposal to keep the Mersey Hospital in North West Tasmania providing a full range of hospital services and treating public and private patients.' The Government's intention, at the time of its purchase of the hospital, was that a community-based MCH Trust would be established to take full control of the hospital from 1 July 2008.[147]

7.6 The services to be provided by the MCH were identified in the Prime Minister's announcement as 'a comprehensive range of inpatient, outpatient, accident and emergency and day procedure services, as well as appropriate surgery and high-dependency capacity'. With respect to any additional services that the MCH might provide, the Government's position was that this would be a matter for the MCH Trust, following consultation with the local community regarding its expectations of the range of services that could be feasibly and safely provided at the hospital.

7.7 The then Prime Minister described the Australian Government's plan to fund a community-controlled hospital as a project of national significance on the basis that, if the initiative worked, 'it could be a model for keeping viable hospital facilities in other parts of regional Australia'.[148]

7.8 In summary, the Australian Government's key policy objectives in assuming ownership of the MCH in 2007 were to:

- restore and maintain the full range of services provided at the MCH prior to the Tasmanian Government's announcement of service changes in *Tasmania's Health Plan 2007*; and

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[146] The Hon John Howard MP (then Prime Minister), *Mersey Hospital Tasmania: A Commonwealth-funded and community controlled public hospital*, media release, Parliament House, Canberra, 1 August 2007. The Tasmanian Government's 2007 Health Plan and its impact on the MCH were discussed in Chapter 1.

[147] The Government established a Mersey Interim Community Advisory Committee in September 2008 to assist in implementing the transition to the Trust.

[148] The Hon John Howard MP (then Prime Minister), *Mersey Hospital Tasmania: A Commonwealth-funded and community controlled public hospital*, media release, Parliament House, Canberra, 1 August 2007.

- introduce community-based operation of the hospital through a Trust, funded by the Commonwealth, and test this as a model for other regional hospitals.

Refinement of the Commonwealth's objectives

7.9 Use of the MCH arrangement as a model for future Commonwealth interventions in respect to regional hospitals has not been referred to in decisions or announcements on the MCH by the current Australian Government. However, advice provided by DoHA to the Government early in 2008 noted the benefit to the Commonwealth from MCH ownership in allowing it to develop expertise in, and better understand, potential hospital funding models. Since that time, the 2011 National Health Reform Agreement (NHRA) has established independent Local Hospital Networks as the management model for public hospitals, with states and territories funded as system administrators.

Heads of Agreement

7.10 In negotiating the 2008 HoA, the incoming Australian Government's position was similar to that of its predecessor in seeking to continue the range of services available at the MCH prior to the release of *Tasmania's Health Plan*. These services were set out in the Schedule to the HoA as the core clinical activities of the hospital.

7.11 The Commonwealth objective as owner of the MCH was set out in Recital A in the 2008 HoA. This objective was retained in the 2011 HoA with only minor modifications to reflect the continuity of the arrangement (shown in square brackets) as follows:

> As the owner of the Mersey Community Hospital at Latrobe in the North West region of Tasmania, the Commonwealth seeks to [continue to] ensure that the people in its catchment area have appropriate access within clinically appropriate times to a[n appropriate] range of safe health care services based on clinical need.

7.12 This objective encompasses a number of dimensions—including some that by their nature are dynamic and may change over time—as follows:

- local community access to health care services;
- appropriate access to services within clinically appropriate times; and
- an appropriate range of services demonstrating:
  - service safety; and
  - clinical need.

7.13 In terms of the Australian Government's requirement for a mechanism for community engagement, it was agreed in the HoA that Tasmania would establish a community regional advisory body to provide key stakeholder engagement with, and guidance to, the direction and development of health and community services in the North West.

7.14 With regard to the delivery of services additional to the core clinical activities, Item D(c) in the Recitals in the 2008 HoA stated that the parties would move, subject to their budgetary constraints, to expand the range of services over the period of the HoA, affording priority to renal dialysis, rehabilitation and expanded outpatient services. Both the Australian Government and Tasmanian Ministers referred to the potential to deliver these additional services in their statements announcing the signing of the 2008 HoA.[149] This expanded range of services was also included in Recital E(c) in the 2011 HoA.

7.15 As noted in Chapter 2 (see paragraph 2.62), at the initiation of the Australian Government, an additional objective was added to the Recital E for the 2011 HoA, stating that the parties 'will move towards activity based costing of the services being delivered to allow for greater transparency of costs and benefits at the MCH'.

DoHA Portfolio Budget Statements

7.16 The Commonwealth's objectives in acquiring the MCH in 2007 have also been refined through DOHA's successive Portfolio Budget Statements (PBS).[150] Commonwealth funding for the MCH is provided under DoHA's Program 13.3: *Public Hospitals and Information* within Outcome 13: *Acute Care*. For the past two years, the overall objective for Outcome 13 has been stated in DoHA's PBS as: 'Improved access to public hospitals, acute care services and public dental services, including through targeted strategies, and payment to state and territory governments.'

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[149] The Hon Nicola Roxon MP (then Australian Government Minister for Health and Ageing), *Agreement for management of Mersey Community Hospital signed*, media release, Parliament House, Canberra, 28 August 2008. The Hon Lara Giddings MHA (then Tasmanian Minister for Health and Human Services), *Mersey Handover Assures a Bright Future*, media release, Parliament House, Hobart, 28 August 2008.

[150] Portfolio Budget Statements (PBS) and annual reports are the principal mechanisms for monitoring and reporting program performance to external stakeholders. The PBS set out agency-level outcomes and programs, and agency resourcing, deliverables and performance information, including Key Performance Indicators (KPIs), which demonstrate progress against agencies' program objectives. Performance against the deliverables and KPIs outlined in the PBS are reported in the agency's annual report.

7.17 The form and focus of the objectives, performance targets and performance indicators and measures for Program 13.3 have been varied by DoHA in the PBS during the life of the MCH arrangements. Each year, a selection of activities and initiatives are described in the PBS. As a $60 million a year program within a multi-billion dollar portfolio budget, MCH funding does not necessarily require the inclusion of specific program objectives and measures in the PBS. Indeed, the 2012–13 and 2013–14 PBS do not include any reference to the MCH under Program 13.3. However, the MCH was included in the PBS from 2008–09 to 2011–12.

7.18 In the 2008–09 PBS, the MCH was included as a separate activity. The program information included for this activity outlined the Commonwealth's purchase of the hospital, and its intention to engage a private sector organisation to operate the hospital, provide high quality clinical services and consult the community regularly. The MCH was also included in the major activities described under Program 13.3 in the PBS for 2009–10, 2010–11 and 2011–12, under the heading of improving health care services in, variously, Tasmania or North West Tasmania. The Australian Government's objective was stated in each PBS as improving health care services for people in North West Tasmania, by ensuring access to safe, appropriate and sustainable health care services at the MCH, including a High Dependency Unit, a 24 hour emergency service, medical and surgical services, and low risk obstetric and paediatric services. Community engagement has not featured in the program objectives for the MCH in the PBS and has only been referred to on one occasion, in the PBS for 2009–10.[151]

Assessing the achievement of the Commonwealth's objectives

7.19 The references to the Commonwealth's objectives for its acquisition of the MCH in government policy announcements and Ministerial statements have informed the content of DoHA's PBS, which places performance measurement and reporting obligations on the department in line with the Australian Government's Outcomes and Programs Framework. In the case of the MCH, Commonwealth objectives are also encompassed in the terms of the two HoA,

[151] The 2009–10 PBS recorded, as a qualitative deliverable, the establishment by Tasmania of the North West Health Services Network Advisory Group to meet its obligations under the HoA.

but the nature of any performance measures and reporting obligations attached to those objectives is determined by the parties to the HoA.

7.20 The Commonwealth's objectives outlined in the PBS have primarily focused on ensuring access to a set of core clinical activities provided by the MCH. The HoA specify those core clinical activities but, in contrast, also encompass a wider range of objectives, including the additional dimensions to service provision included in Recital A. In addition, the HoA reflect the parties' shared intention to expand services and move towards activity based costing of services, and the requirement for community engagement. The following sections examine performance reporting against the Commonwealth's objectives stated in both the PBS and the HoA, and assess the adequacy of the performance measurement and reporting framework for the MCH.

Performance measurement and reporting under the PBS

7.21 Within the PBS, KPIs are expected to inform agencies, government and stakeholders about the performance of programs, including their impact and cost-effectiveness, and signal opportunities for improvement.[152] The KPIs applying to the MCH in the PBS from 2008–09 to 2011–12[153] are summarised as follows:

- in 2008–09, the KPI for the MCH was 'enhanced, safe and sustainable hospital services for the people in the North West region of Tasmania', measured by the implementation of effective governance arrangements for the MCH to enable achievement of this KPI;
- in 2009–10, the KPI for improved health care services in North West Tasmania was the ongoing effective management and operation of the MCH by Tasmania, measured by 'the ongoing provision of the services[154] specified in the agreement'; and
- in 2010–11 and 2011–12, the KPI for the same objective as in 2009–10 was the continued provision by the MCH of the core clinical services

[152] Australian National Audit Office, *The Australian Government Performance Measurement and Reporting Framework*, Audit Report No. 28, ANAO, Canberra, 2012–13, p. 11.

[153] As noted in paragraph 7.17, no objectives or KPIs for the MCH were included in the 2012–13 and 2013–14 PBS.

[154] The references in the PBS to 'services' under the HoA is a reference to the core clinical activities set out in the Schedule to the HoA. The terms 'services' and 'activities' are often used interchangeably in references to the core clinical activities in official documents relating to the MCH and the HoA.

specified in the HoA, measured by analysis of data provided under the HoA to demonstrate that the agreed services were being provided.

7.22 In line with the PBS, the department has monitored Tasmania's ongoing provision of the core clinical activities specified under the HoA, and subsequently reported on performance against the KPIs in its annual reports. DoHA has reported in each of its annual reports for the relevant years that the KPIs outlined above were met.

7.23 The KPIs included in the PBS were limited to confirming that Tasmania was providing the core clinical activities required under the HoA. As such, they were, essentially, indicators of activity, and did not include a balanced set of both qualitative and quantitative measures. DoHA advised the ANAO that it also has regard to MCH performance reporting to national bodies[155] under the NHRA's Performance and Accountability Framework (PAF). However, there is no consolidated performance measurement framework for the MCH program incorporating the relevant KPIs from the PAF. The lack of such a framework, and the limitations of the KPIs included in the PBS, inhibits the Commonwealth's ability to assess the impact of the MCH program and the cost-effectiveness of its funding.

Performance measurement against objectives in the HoA

7.24 As outlined in paragraph 7.12, Recital A of the HoA contains a more detailed statement of the Commonwealth's objective than DoHA's PBS. However, the HoA do not include a performance measurement framework that incorporates an assessment of the standard and quality of the MCH's services. Further, the categories of operational and clinical information reported to DoHA under the HoA have not been reviewed since their establishment in 2008, and DoHA's use of that information over the life of the two HoA has been inconsistent and is not structured.

7.25 As a consequence, the Commonwealth is not well positioned to assess whether its objectives under Recital A are being achieved. Further, the weaknesses in the current performance measurement framework limit the insights available to DoHA to inform any future HoA for the MCH or future arrangements of the same type.

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[155] These bodies include the National Health Performance Authority, the Independent Hospital Pricing Authority and the Australian Institute of Health and Welfare.

Provision of clinical services

7.26 DoHA's monitoring and oversight of the implementation of both HoA have focused primarily on ensuring that the core clinical activities continue to be provided. To that end:

- the core clinical activities were not varied during the life of the 2008 HoA;
- the Commonwealth would not agree to any change to the core clinical activities in negotiating the 2011 HoA; and
- DoHA would not agree to the inclusion of proposals for changes to core clinical activities in the draft Clinical and Financial Services Plan for 2011–12.

7.27 The changes to surgical services at the MCH that were agreed by the Commonwealth in October 2012 conformed to the terms of the core clinical activities, which specify that surgical services must be provided safely. The changes to paediatric services agreed by the Commonwealth at the same time also conformed to the terms of the core clinical activities under the HoA, in that paediatric care would continue to be provided, albeit in the new Short Stay Unit rather than in a dedicated ward.

7.28 With regard to the shared intention of the parties, stated in the Recitals in both HoA (refer paragraph 7.14), to expand the range of services provided at the MCH, services have been expanded in a number of areas, including endoscopy, elective cataract surgery and urology.[156] However, the service areas identified in Recital E(c) of the HoA as priorities have generally not been expanded. Average monthly attendances in the outpatients department grew by 8.4 per cent in 2009–10 and by 0.96 per cent 2010–11, but declined by 6.28 per cent in 2011–12, consistent with a reduction in activity levels to achieve budget targets. Renal dialysis services have not been expanded and the regional rehabilitation unit foreshadowed by the Australian Government Minister for Health and Ageing in 2008[157] has not been established. In this context, the ANAO acknowledges that decisions to change and expand services at the MCH are complex, require

[156] Department of Health and Ageing, *Annual Report 2009–10*, Canberra, 2010, p. 324.

[157] The Hon Nicola Roxon MP (then Minister for Health and Ageing), *Agreement for management of Mersey Community Hospital signed*, media release, Parliament House, Canberra, 28 August 2008.

detailed consultation and must have regard to the MCH operating, under the THO-NW, as part of Tasmania's health network in the North West.

7.29 With respect to the parties' shared intention to move to activity based costing of services at the MCH, DoHA advised the ANAO that it has used the National Hospital Cost Data Collection to review activity based costings of the MCH, and expects to use this to inform costings of the hospital going forward, taking into consideration the MCH's unique circumstances.

Community engagement

7.30 DoHA's activity to engage with the local community in the operation of the MCH has been limited. The 2009–10 PBS recorded the establishment of the North West Health Services Network Advisory Group, with DoHA membership, as required by the HoA. As outlined in Chapter 3 (refer paragraphs 3.51-3.53), from the second meeting of that Advisory Group early in 2009, DoHA devolved its representation to its State Office and has not been recorded as attending an Advisory Group meeting since 2010.

7.31 As noted earlier (paragraph 7.9) and in Chapter 4 (refer paragraph 4.6), the objective of the creation of Local Hospital Networks under the NHRA was to increase local decision-making and community involvement in hospital management. In line with this development, DoHA advised the ANAO that it is the role of the THO-NW to engage with the local community. However, the requirement in the HoA for DoHA to engage with the local community through a community regional advisory board mechanism has not been amended. Reports on community engagement activities remain a standing item on the agenda of the monthly liaison meeting between DoHA, DHHS and the THO-NW.

7.32 In rejecting DHHS's proposals for change to core clinical activities in the context of the 2011–2012 Clinical and Financial Services Plan, one of the reasons given by DoHA was that DHHS would require a strategy for engaging the local community about the changes. While the nature of community engagement in the consideration of service changes is not defined in the HoA, DoHA advised the ANAO that it considered that the changes in 2012 to surgery and paediatric services at the MCH provide an example of appropriate and targeted community consultation.

Assessing the impact of the MCH arrangements

7.33 Meeting the needs of the local community, in terms of the community's access to hospital services at the MCH, was at the heart of the Commonwealth's motivation and objective in assuming ownership of the

hospital in 2007. That objective was achieved primarily through the preservation of hospital services, which were defined as the core clinical activities in the 2008 HoA. The KPIs that subsequently appeared in the PBS focused on the continuing provision of that set of core clinical activities, which has not changed since 2008.

7.34 The nature of the MCH arrangements is that the Commonwealth provides funding to Tasmania as the hospital operator to guarantee the provision of a set of core clinical activities. How those activities are provided is essentially a matter for the operator. To the extent that these arrangements are similar to a purchaser/provider model, the ANAO has previously observed that the provider's responsibility for the delivery of services makes it better suited to measuring deliverables. However, the responsibility of the purchaser—in this case, the Commonwealth—to oversee the initiative makes it better suited to measuring the impact through KPIs.[158]

7.35 Notwithstanding the continuing importance to the Commonwealth of maintaining community access to the core clinical activities, the ANAO notes that the current performance measurement framework for the MCH program does not include any measures to assess the impact of those clinical activities on the contemporary and evolving health needs of the local community in North West Tasmania.

Assessing value for money

7.36 Value for money can be broadly defined as optimising the use of resources to achieve intended outcomes. The elements of a performance measurement framework—linking objectives, outcomes, resources and performance measures—provides governments with the means to assess value for money. Furthermore, Commonwealth agencies have particular responsibilities under the *Financial Management and Accountability Act 1997* (the FMA Act), section 44 of which requires that agency chief executives promote the proper use of Commonwealth resources. 'Proper use' in this context means efficient, effective, economical and ethical use that is not inconsistent with the policies of the Commonwealth. This is often referred to as the value for money test.

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[158] Australian National Audit Office, *The Australian Government Performance Measurement and Reporting Framework*, Audit Report No. 28, ANAO, Canberra, 2012–13, p. 19.

7.37 While the decision to acquire and maintain ownership of the MCH was a matter for government, the ANAO examined whether value for money was explicitly considered by the Commonwealth in the course of negotiating and agreeing the two HoA for the management, operation and funding of the MCH. DoHA records examined by the ANAO did not include advice to the Australian Government containing explicit reference to value for money considerations in the context of the negotiation of the 2008 or 2011 HoA.

7.38 With regard to internal DoHA documents, an internal submission, dated 22 June 2011, to the departmental delegate, recommending FMA Regulation 9 approval of the final Commonwealth funding offer to Tasmania in the negotiation of the 2011 HoA, included a section titled 'Achieving Value with Public Money'. The advice to the delegate in this section referred to the following considerations:

- it is not practical or cost-effective for the Commonwealth to operate the MCH itself;
- continuation of the MCH arrangements with Tasmania will provide certainty to the community that hospital services will continue to be available locally; and
- the amount of funding negotiated with Tasmania is commensurate with maintaining the level of services that the Commonwealth expects Tasmania to provide to the people of the MCH catchment area in operating and managing the hospital, and recognises cost pressures since the HoA was negotiated in 2008.

7.39 This internal advice represents the basic components of a value for money assessment by linking the level of funding with the outcome sought (the level of hospital services provided), and concluding that they are commensurate. However, no analysis supporting that conclusion was provided to the delegate, notwithstanding information available to DoHA from its administration of the MCH arrangements over the previous three years, and the advice fell short of a robust analysis of whether a value for money outcome would be achieved. Further, as noted earlier, KPIs applying to the MCH program in DoHA's PBS do not refer to cost-effectiveness and are limited in measuring the effectiveness of the Commonwealth's ownership and funding of the MCH. Therefore, the Commonwealth's performance framework does not provide for or support an assessment of value for money.

Cost considerations

7.40 In relation to the cost to the Commonwealth of the MCH program, there is substantial documentary evidence of DoHA's efforts, in the course of both HoA negotiations, to estimate the cost of operating the MCH as accurately as possible. In 2008, within the limitations of the available information, the Commonwealth estimated $64 million per year as the cost of engaging a private provider to operate the hospital. When that tender process was unable to be concluded, the Commonwealth successfully negotiated with Tasmania an annual funding amount of $60 million, which conformed with the funding envelope agreed by the Australian Government.

7.41 During the 2011 HoA negotiations, DoHA worked to verify estimates of MCH costs provided by Tasmania to support its request for a substantial increase in funding. In reaching agreement with Tasmania to funding of $197.56 million over three years, the Commonwealth achieved an acceptable outcome, considering the respective negotiating positions of the parties and that Tasmania had made concessions, including reducing the amount of indexation requested from 7.2 per cent to 3.5 per cent per year.

7.42 While the Commonwealth's direct funding to the MCH under the HoA is the predominant cost of the arrangement, DoHA is also funded for the costs of administering the MCH program. This amount represents approximately 3.8 per cent of the cost of the Commonwealth's direct funding under the HoA. The quarantining of the Commonwealth's MCH funding from National Partnership Agreement (NPA) funding means that the MCH also continues to be eligible for funding over and above the direct funding provided by the Commonwealth through the HoA (see Table 7.1 and Appendix 4).[159]

[159] For example, the Tasmanian Government applied in 2011 for grant funding for the MCH under the HHF. As noted in Chapter 3, this application was unsuccessful.

Table 7.1: MCH-related Commonwealth funding

Funding type	2008–09 ($m)	2009–10 ($m)	2010–11 ($m)	2011–12 ($m)	2012–13 ($m)	2013–14 ($m)	Total
Direct funding under HoA (ex GST)	49.8	60.0	60.0	63.6	65.8	68.1	**367.3**
DoHA administration	2.6	1.7	1.8	2.5	2.7	2.7	**14.0**
NPA IPHS funding	-	-	-	0.5	0.2	0.2	**0.9**
Total	**52.4**	**61.7**	**61.8**	**66.6**	**68.7**	**71.0**	**382.2**

Source: ANAO analysis.

7.43 Table 7.1 does not include the financial impact of the quarantining of the MCH funding under the HoA from Commonwealth Grants Commission (CGC) assessments of the allocation of GST revenue. The impact of this exemption is that the total GST allocation to Tasmania of $1.7 billion would have been reduced had the MCH funding been incorporated in the CGC's fiscal equalisation calculations. While exemptions of this type do not represent an additional cost to the Commonwealth, they do affect the amount of the GST funding pool that would otherwise have been available for allocation to other states and territories.

Cost efficiency

7.44 The likelihood of optimising the use of resources, and therefore value for money, is improved by increasing efficiency in administration and operations. Efficiency results from either optimising outputs for a given set of resource inputs, or minimising resource inputs for a given quantity and quality of output.

7.45 The Commonwealth is not well placed to assess the efficiency of the services it funds at the MCH. As noted in Chapter 2, the form of the HoA is not a full service agreement in that it does not set standards of performance that are required to be met by the operator of the hospital. Similarly, there is no reference to efficiency in the HoA, particularly any requirement for the operator to achieve more efficient outcomes in the provision of hospital services. However, and as noted in Chapter 2 (refer paragraph 2.16), the Commonwealth regarded the exclusion of an annual indexation increase in the 2008 HoA as an incentive to Tasmania to improve efficiency in order to meet the cost of additional services from within Commonwealth funding.

7.46 One approach to assessing value for money involves comparing activity costs to established benchmarks and to comparable activities. As outlined earlier in Chapter 6, the ANAO analysed the efficiency of the MCH in comparison to a national peer group of hospitals and to other Tasmanian hospitals, measured by the cost per weighted separation for acute admitted care, and costs per unit of weighted activity for all care types.

7.47 The ANAO's analysis found that, on those measures, the MCH was more costly than its national peer group. However, there are particular factors applying in Tasmania that mean that all public hospitals there are more costly to run than their mainland peers. When compared with other Tasmanian hospitals, the MCH was less costly for both acute admitted care and all care types. These results indicate that, in the Tasmanian context, the MCH is a relatively efficiently run hospital. This may, in part, be a result of the case mix delivered by the MCH compared to other public hospitals.

7.48 Further analysis in Chapter 6 of expenditure categories contributing to the high costs of Tasmanian hospitals and the MCH compared to their national peer groups, identified factors specific to the MCH as the cost of locum medical staff and general administrative costs. Reducing costs in these areas would improve overall MCH efficiency and the value the Commonwealth receives for its funding. The ANAO has made a recommendation regarding a review of the factors contributing to the MCH approach to the use of locum medical staff.

Achieving intended outcomes

7.49 The ANAO's examination of the performance measurement framework applying to the MCH program indicates that DoHA has, over the life of the HoA, focused on confirming Tasmania's provision of the set of core clinical activities specified in the HoA.

7.50 A value for money perspective is useful in highlighting the weaknesses in DoHA's performance measures, in that 'value' in the MCH context cannot be fully assessed by confirming the provision of the core clinical activities. A robust assessment of the value produced by those activities, against the current funding of $197.56 million over three years provided by the Commonwealth, must have regard to the outcomes from the provision of those activities, particularly issues of service safety, clinical needs and community access encompassed in the objective in Recital A of the HoA. Desirably, an assessment of value would also consider the impact of the core clinical activities on the health needs of the local community. Consequently, a full value for money

assessment is not capable of being supported by the current performance measurement framework applied by DoHA to the MCH program and the supporting arrangements.

Conclusion

7.51 The MCH program has not been subject to value for money analysis in either the policy advising phases supporting the negotiation of the two HoA or in the context of the performance management process. While there was some internal departmental consideration of aspects of value for money in the context of the financial approval process for the 2011 HoA, there would have been merit in drawing on the information and experience accumulated in administering the 2008 HoA to prepare a more robust analysis. The Commonwealth's performance framework for the MCH program, with its focus on the provision of the core clinical activities rather than on their impact, is not capable of supporting a full assessment of value for money from the program.

The relationship between the Commonwealth's and Tasmania's objectives for the MCH

7.52 The Commonwealth's objectives for its acquisition of the MCH are reflected in the content of the HoA—including Recital A, the list of core clinical activities in the Schedule, and the requirement to establish a community regional advisory body—and have, therefore, been agreed by Tasmania.

7.53 However, the parties have differing perspectives over the future role and service profile of the MCH, particularly in relation to the Tasmanian Government's ongoing commitment to its 2007 Health Plan, which remain unresolved. The purpose of the Commonwealth's intervention to assume ownership of the hospital was to maintain services at the MCH that the Tasmanian Government had planned to cease or reduce as part of its consolidation strategy for the hospitals in North West Tasmania set out in the 2007 Health Plan. That strategy involved the consolidation of acute care services at the North West Regional Hospital in Burnie, with the MCH focusing on lower risk and sub-acute services, particularly day surgery.

7.54 While the Tasmanian Government revised the Clinical Services Plan under the Health Plan in 2008 (refer Chapter 1, paragraph 1.20) to recognise Commonwealth ownership of the MCH, it has not resiled from the service consolidation strategy for the North West hospitals or from its commitment to implement the 2007 Health Plan. A strong consideration in the Tasmanian

Government's decision to agree the 2008 HoA was that it could not implement the Health Plan with the MCH operating outside of Tasmania's health system. In announcing that agreement, the then Tasmanian Minister for Health and Human Services stated that: 'The Mersey will be managed in line with Tasmania's Health Plan.'[160]

7.55 Tasmania continues to see the consolidation of hospital services in the North West as justified on clinical safety grounds and as a means of achieving long-term strategic policy objectives, specifically, efficiencies in integrating the services of two hospitals operating 56 kilometres apart and under the same regional management authority in the THO-NW. Tasmania pursued, unsuccessfully, changes to the hospital's service profile consistent with its Health Plan in the negotiation of the 2011 HoA, and in the subsequent preparation of the 2011–12 Clinical and Financial Services Plan.[161] While the Commonwealth agreed to the service changes to surgery and paediatric care proposed by Tasmania in 2012 on clinical safety grounds, its position on service integration in the North West is viewed through a more immediate policy prism—its requirement that the MCH maintain the core clinical activities specified in the HoA.

7.56 Although there have been areas of policy disagreement between the parties over the service profile at the MCH, they have also commented positively about the arrangements governing the ownership and operation of the hospital. The Chief Executive Officer of the North West Area Health Service stated in the Executive Summary to the 2010–11 Clinical and Financial Services Plan that: 'There seems little doubt at the end of the first 24 months of this arrangement that the partnership between the Commonwealth and the DHHS is working positively.' Further, the then Prime Minister advised the Premier of Tasmania at the commencement of the 2011 HoA negotiations that she was keen to see the benefit of the arrangement for the people in the Mersey region continue into the future. The Tasmanian Minister for Health also noted in internal correspondence, following the signing of the 2011 HoA, that the existing HoA had worked well for the Mersey and the community of the North West coast.

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[160] The Hon Lara Giddings MHA (then Tasmanian Minister for Health and Human Services), *Mersey Handover Assures a Bright Future*, media release, Parliament House, Hobart, 28 August 2008.

[161] As outlined in Chapter 3, Tasmania viewed the Clinical and Financial Services Plan as the agreed mechanism under the HoA to achieve service changes at the MCH.

7.57 Notwithstanding those positive sentiments, the Commonwealth and Tasmania have differing positions on the future role of the MCH, the core clinical activities to be delivered by the hospital, and related issues of hospital costs and sustainability of services. While specific outcomes under the HoA will be informed by the respective policy positions of the two governments, the ANAO's proposed recommendation (see Chapter 3, paragraph 3.25) that the parties clarify the role of the Clinical and Financial Services Plan would assist in the future management and implementation of agreed initiatives under the HoA.

Conclusion

7.58 There was a high degree of congruence between successive Australian Governments' policy objectives in owning and funding the MCH. These objectives emphasised the importance of maintaining, for the benefit of the local community, access to the clinical services at the hospital that were subject to change under *Tasmania's Health Plan 2007*, and ensuring local community engagement in decision-making on the MCH's service profile.

7.59 However, measures of performance, including the KPIs in DoHA's PBS, have defined effectiveness narrowly as the continuing provision, at the MCH, of the core clinical activities specified in the HoA, and have not included a balanced set of both qualitative and quantitative measures. While DoHA also has regard to hospital performance reporting for KPIs developed under the National Health Reform Agreement, these sit outside the PBS and the HoA, and have not been integrated into a consolidated performance measurement framework for the MCH program.

7.60 Notwithstanding the inclusion, in Recital A of both HoA, of a statement of objective that contains broader dimensions than that in the PBS, the absence of an adequate performance framework in the HoA inhibits the Commonwealth's ability to assess whether this objective is being achieved. In addition, notwithstanding recent improvements to its scrutiny of MCH operational and clinical information reports provided under the HoA, DoHA has not fully utilised this information to evaluate the performance of the MCH. Overall, the lack of a consolidated performance measurement framework, and the absence in the current framework of measures addressing impact and cost-effectiveness, means that the Commonwealth is not well placed to assess the effectiveness of its ownership and funding of the MCH.

7.61 The definition of the core clinical activities required to be delivered by Tasmania under the HoA has not changed since 2008. The impact of providing those activities—at the MCH—on the health needs of the local community, which was at the heart of the Commonwealth's intervention, is not represented in measures of performance and effectiveness for the program.

7.62 Such an assessment is also a critical element in assessing whether the Commonwealth is receiving value for the $382 million it will have spent on MCH related costs over the six years from the commencement of the arrangement in 2008–09. While DoHA appropriately took steps to calculate the total funding envelope for operating the MCH in the context of negotiating the two HoA, the department is not well placed to assess or promote service efficiency at the hospital. The Commonwealth's performance framework for the MCH program, with its current focus on the provision of the core clinical activities rather than on their cost-effectiveness and impact, is not able to support a full assessment of value for money from the program.

Recommendation No.5

7.63 To better assess the effectiveness of the Commonwealth's ownership and funding of the MCH, and whether the Commonwealth is receiving value for money from the MCH arrangements, the ANAO recommends that DoHA expand its performance measurement framework for the MCH program to:

- incorporate existing MCH reporting required under the National Health Reform Agreements; and
- better inform an assessment of the extent to which the program objectives, established under Recital A of the HoA, are being achieved, with specific reference to service safety, clinical needs and community access.

DoHA response:

7.64 *DoHA agrees with the recommendation.*

Ian McPhee
Auditor-General

Canberra ACT
14 August 2013

Appendices

Appendix 1: Agency responses

Australian Government Department of Health and Ageing

Australian Government
Department of Health and Ageing

SECRETARY

Dr Tom Ioannou
Group Executive Director
Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

Dear Dr Ioannou

PERFORMANCE AUDIT: ADMINISTRATION OF THE MERSEY COMMUNITY HOSPITAL AGREEMENTS

Thank you for your letter of 10 July 2013 providing an opportunity for the Department to comment on the proposed Australian National Audit Office (ANAO) report of the above audit.

I understand that at the exit interview of 27 June 2013 Ms Kerry Flanagan, Deputy Secretary, provided comments and editorial suggestions on the five Issues Papers to the ANAO.

I further understand that subsequent to the exit interview, revisions to recommendations directed to the Department (recommendations 1, 2, 4, and 5) have been made in the proposed audit report.

As requested in your letter of 10 July 2013, please find attached the Department's comments on the proposed audit report (**Attachment A**).

If you have any questions about this matter, please contact Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control Branch, on (02) 6289 7877.

Yours sincerely

Jane Halton PSM
Secretary

August 2013

Enclosed: Department response to audit recommendations

MDP 84 GPO Box 9848 Canberra ACT 2601
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Attachment A

DEPARTMENT RESPONSE TO AUDIT RECOMMENDATIONS

1. PROPOSED SUMMARY RESPONSE

In delivering the Mersey Community Hospital program, the Department's focus is at all times on the current Australian Government's established policy priority for the Mersey Community Hospital: the availability to the local community of North West Tasmania of hospital services which are safe, high quality and based on clinical need. As noted in the report, the Department has made enhancements to its administration of the program over time. The Department will continue its efforts in these areas, both as part of normal business practice and in the context of any future agreement with Tasmania. The Department agrees with the ANAO's recommendations.

2. RECOMMENDATIONS

Recommendation No. 1

To assist with the timely finalisation and effective implementation of the Clinical and Financial Services Plan for the MCH, the ANAO recommends that DoHA and DHHS:

- clarify the function of the Plan, in particular its status as an annual plan and whether it should continue to be used as the designated means to vary the HoA;
- consider alternative processes to the Plan for negotiating changes to the MCH's service profile under the HoA; and
- develop appropriate processes and timeframes to enable the Plan to be finalised prior to the commencement of the financial year, so that it can be effectively used to guide hospital operations.

Department Response: The Department of Health and Ageing agrees with this recommendation.

Recommendation No. 2

To improve the Commonwealth's ability to monitor and assess the performance of the MCH under any future HoA, particularly the quality and safety of the services being delivered, the ANAO recommends that DoHA review the categories of operational and clinical information required to be reported under the HoA, with a view to:

- drawing on the best contemporary practice contained in the performance and accountability framework established under the national health reform process; and
- facilitating better utilisation of the information provided in assessing MCH performance.

Department Response: The Department of Health and Ageing agrees with this recommendation.

Recommendation No. 3

To improve the transparency of expenditure reporting for the MCH and to provide greater assurance that Commonwealth funds are being used in accordance with the HOA, the ANAO recommends that DHHS:

- address system limitations that prevent assurance being provided in relation to MCH expenditure under the HoA, specifically shared services, cross-charging and patient transport expenditure, and subsequently, in consultation with DoHA, undertake an audit of those expenditure categories;
- review, following consultation with DoHA, the alignment of the monthly and annual financial reports it provides under the HoA with its financial systems;
- undertake periodic reconciliations between its financial system and other systems, such as payroll, assets and pharmaceutical management systems; and
- review its management of MCH records, including employee files, to help ensure that relevant records are available in a timely manner.

This recommendation is for Tasmania only - no response required.

Recommendation No. 4

To support the efficient delivery of health care services at the MCH, the ANAO recommends that DoHA and DHHS initiate a targeted review by the THO-NW of the MCH's use of locums to determine whether there are any additional measures that can be taken by the hospital to better manage these costs.

Department Response: The Department of Health and Ageing agrees with this recommendation.

Recommendation No. 5

To better assess the effectiveness of the Commonwealth's ownership and funding of the MCH, and whether the Commonwealth is receiving value for money from the MCH arrangements, the ANAO recommends that DoHA expand its performance measurement framework for the MCH program to:

- incorporate existing MCH reporting required under the National Health Reform Agreements; and
- better inform an assessment of the extent to which the program objectives, established under Recital A of the HoA, are being achieved, with specific reference to service safety, clinical needs and community access.

Department Response: The Department of Health and Ageing agrees with this recommendation.

Tasmanian Government Department of Health and Human Services

Department of Health and Human Services
OFFICE OF THE SECRETARY

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Tasmanian Government

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Dr Tom Ioannou
Group Executive Director, Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

Dear Dr Ioannou

Subject: Proposed Audit Report on the Administration of the Agreements for the Management, Operation and Funding of the Mersey Community Hospital

I refer to your letter of 10 July 2013 and the proposed audit report on the *Administration of the Agreements for the Management, Operation and Funding of the Mersey Community Hospital.*

I am aware that officers from the Department of Health and Human Services (DHHS) have liaised with Mr Peter Jones regarding a number of editorial and minor contextual matters within the proposed report. I am grateful for the collaborative approach that the Australian National Audit Office (ANAO) has taken towards the audit, noting that this was the first to be conducted under the provisions of section 18B of the *Auditor-General Act 1997* and thus new territory for a state government.

The audit has provided an opportunity for DHHS, with Tasmanian Health Organisation – North West (THO – North West), to review current systems and practices at the Mersey Community Hospital (the Mersey), but also systems at a broader statewide level. In addition to the recommendations, the audit has made a number of observations with regards to shared services and systems that DHHS is actively considering, and responding to internally.

The conclusion of the audit is timely, ahead of negotiating the arrangements for the continued management, funding and operation of the Mersey. The findings of the ANAO will inform these negotiations, particularly regarding working towards a mutually agreeable resolution to capital funding for the Mersey and considering the purpose of the clinical and financial services plans in the context of negotiating service change.

Attached is a summary response to the audit, together with a response to the three recommendations made to DHHS.

I thank you for the professional and sensitive manner in which your staff have conducted the audit, and I look forward to provision of your Final Report.

Yours sincerely

Matthew Daly
Secretary

7 August 2013

Enc: Summary Response
Response to Recommendations

Attachment 1

Summary Response

The audit has provided an opportunity for the Department, with Tasmanian Health Organisation – North West, to review current systems and practices at the Mersey Community Hospital (the Mersey), but also systems at a broader state-wide level. In addition to the recommendations, the audit has made a number of observations with regard to shared services and systems that the Department is actively considering, and responding to internally.

The conclusion of the audit is timely, ahead of negotiating the arrangements for the continued management, funding and operation of the Mersey. The findings of the ANAO will inform these negotiations, particularly regarding working towards a mutually agreeable resolution to capital funding for the Mersey and considering the purpose of the clinical and financial services plans in the context of negotiating service change.

Attachment 2

Response to Recommendations

Recommendation No.1

DHHS supports this recommendation.

It is agreed that the Clinical and Financial Services Plan has not been an effective means of agreeing changes to the Heads of Agreement, nor for negotiating changes to the MCH's service profile.

Both DHHS and THO-North West are eager to address this to ensure that processes for change and negotiation are more streamlined and take into account safety and sustainability in a timely manner.

This is extremely important to the overall operational effectiveness of the MCH over time.

Recommendation No. 3

DHHS supports this recommendation.

In respect to element one, DHHS acknowledges the ANAO's findings with regard to system limitations and advises that, based on feedback received during the audit, steps have been taking to resolve these issues. For example, a script has been developed which can now identify a complete population of shared services and cross-charging transactions.

Work is underway to address elements two and three of this recommendation.

In respect to the fourth element, DHHS notes that a minority of employee records took an unsatisfactory amount of time to locate due to an interim storage measure; this will be rectified by scanning these documents electronically.

Recommendation No. 4

DHHS supports this recommendation.

The reliance on locums to staff the MCH is a recognised issue, and recruitment is a standing agenda item at the Mersey Monthly meetings between DHHS, DoHA and THO-North West. In an attempt to address this issue, the MCH has a full time resource dedicated to attracting and recruiting staff.

Both DHHS and THO-North West are open to considering any additional measures which can be taken to better manage these costs.

Tasmanian Health Organisation–North West

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Dr Tom Ioannou
Group Executive Director, Performance Audit Services Group
Australian National Audit Office
GPO Box 707
CANBERRA ACT 2601

Dear Tom

Subject: Proposed Audit Report on the Administration of the Agreements for the Management, Operation and Funding of the Mersey Community Hospital

I refer to your letter of 10 July 2013 and the enclosed audit report on *Administration of the Agreements for the Management, Operation and Funding of the Mersey Community Hospital.*

As you are aware, the Tasmanian Health Organisation – North West (THO-North West) has worked closely with the Department of Health and Human Services (DHHS) for the duration of the audit. I have discussed the findings as presented in the proposed report with DHHS, and support their position in full. A summary of THO-North West's response is appended.

I concur with the Secretary, that the findings of the audit provide direction to the THO-North West, together with DHHS, regarding key improvements that can be made to systems associated with management of the Mersey Community Hospital (the Mersey); work has commenced to this end.

With the physical condition of the Mersey likely to come under scrutiny through the next accreditation process, I am keen to resolve the outstanding ambiguity regarding responsibility for funding of capital works. It is also important that there is a clear mechanism for agreeing service change. Successful resolution of these matters will impact on the extent to which I am able to ensure the delivery of quality, safe hospital services at the Mersey within the available budget.

The audit has been a positive process for THO-North West to engage in, and I appreciate the collegial approach of your team during the past twelve months.

Yours sincerely

Gavin Austin
Chief Executive Officer
Tasmanian Health Organisation - North West

August 2013

Att: THO-North West Summary Response
Cc: Mr Mark Simpson, Mr Peter Jones

Attachment 1

Summary Response

I concur with the Secretary, that the findings of the audit provide direction to the THO-North West, together with DHHS, regarding key improvements that can be made to systems associated with management of the Mersey Community Hospital (the Mersey); work has commenced to this end.

With the physical condition of the Mersey likely to come under scrutiny through the next accreditation process, I am keen to resolve the outstanding ambiguity regarding responsibility for funding of capital works. It is also important that there is a clear mechanism for agreeing service change. Successful resolution of these matters will impact on the extent to which I am able to ensure the delivery of quality, safe hospital services at the Mersey within the available budget.

Appendix 2: Operational and clinical information reporting required under Item C of the Schedule to the Heads of Agreement

C1 Quarterly operational and clinical information and reports

Tasmania will report to the Commonwealth promptly after each 31 March, 30 June, 30 September and 31 December during the Agreement Period (in respect of calendar quarters ending on those dates), and at the End of the Agreement (in respect of the period since the last calendar quarter end date) on:

(a) unit record (as specified in the Admitted Patient Care National Minimum Data Set (NMDS)) Australian Refined Diagnosis-related Groups (AR-DRG) admitted data by medical, surgical and other, by funding source;

(b) the number of outpatient by type of service;

(c) all activity and counts of allied health services by type;

(d) the number of presentations at the emergency department and waiting time;

(e) elective surgery activity and waiting time;

(f) bed occupancy rates per month; and

(g) serious incidents by volume and service type.

C2 Annual operational and clinical information and reports

At the end of each financial year during the Agreement Period in either case (and in respect of the financial year then ended) and at the End of the Agreement (and in respect of the period since the end of the previous financial year), Tasmania will promptly report to the Commonwealth on:

(a) unit record data on hospital utilisation, including all items in the Admitted Patient Care NMDS, Elective Surgery Waiting Times Admissions and Removals NMDS, Elective Surgery Waiting Times Census NMDS, and Non-admitted Patient Emergency Department Care NMDS;

(b) all items in the Public Hospital Establishment NMDS;

(c) non-admitted NMDS, which includes emergency department and outpatient department services data;

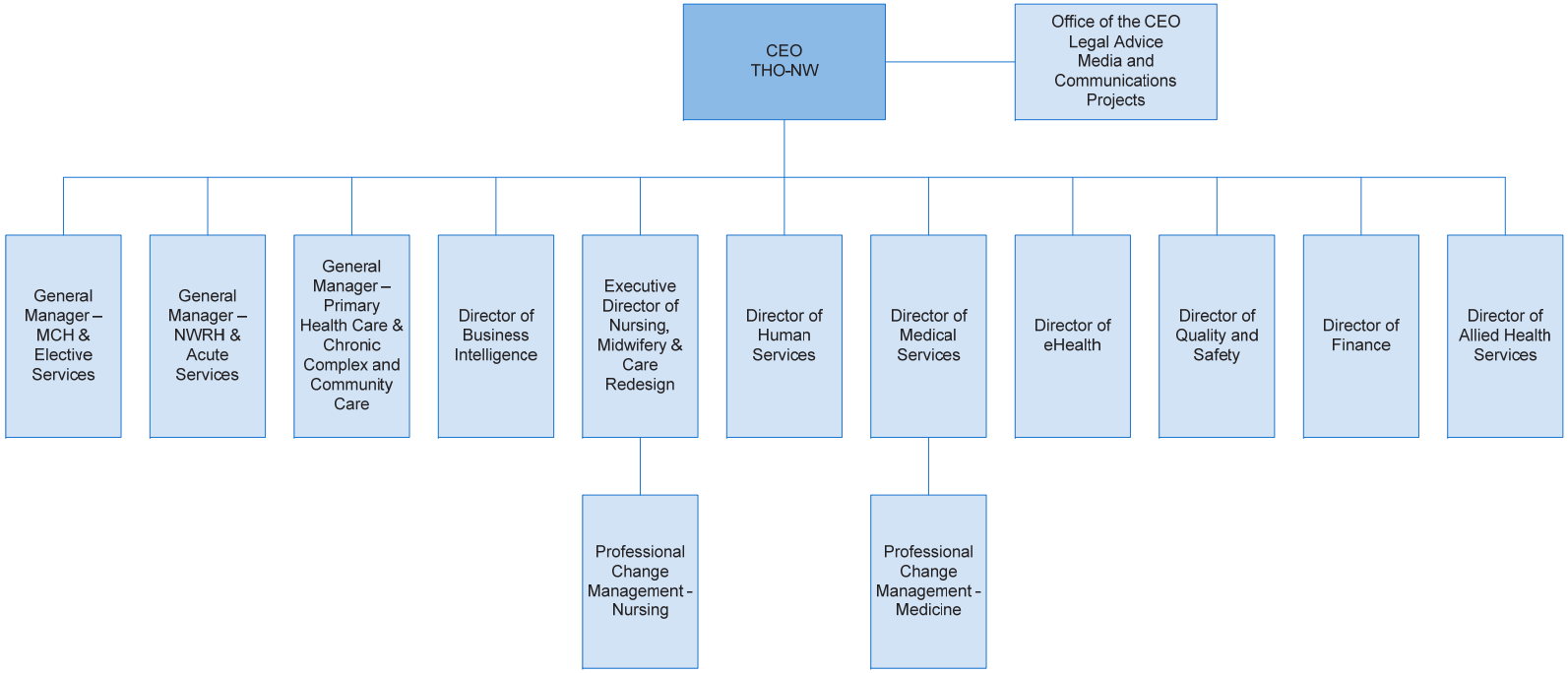
(d) integrated information relevant to Elective Surgery Waiting Times Admissions and Removals NMDS and Elective Surgery Waiting Times Census NMDS, in a format which can be linked to the unit record data provided in accordance with the Admitted Patient Care NMDS; and

(e) training:

i. the number of clinical placements commenced by specialty type; and

ii. the number of clinical placements completed by specialty type.

Appendix 3: THO-NW governance structure



Source: 2011–12 Clinical and Financial Services Plan, p. 9.

Appendix 4: Funding sources other than direct Commonwealth funding to the MCH

In addition to the direct funding from the Commonwealth under the HoA, the MCH receives funding through national health initiatives, own-source revenue and other sources, including some Tasmanian Government funding. This funding is outlined below.

National Partnership Agreement on Improving Public Hospital Services

In 2011, the Commonwealth entered into the $3.4 billion National Partnership Agreement on Improving Public Hospital Services (NPA IPHS) with the states and territories, to improve public hospital service delivery, including elective surgery, emergency department services, and sub-acute care.

The NPA IPHS aims to achieve improved health outcomes by increasing public hospital efficiency and capacity through the delivery of six initiatives to be implemented over eight years from 2009–10 to 2016–17, including capital funding for emergency departments and elective surgery, and funding for additional hospital beds.[162]

Under the NPA IPHS, Tasmania can receive a maximum of $88.9 million for elective surgery, emergency department and sub-acute care. The funding, detailed in Table A1, comprises $80.2 million in facilitation and capital funding and $8.7 million in reward funding, which is contingent on the achievement of elective surgery and emergency department targets.

[162] Council of Australian Governments (COAG), *The National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services*, p. 3.

Table A1: NPA IPHS funding allocation for Tasmania (excluding reward funding)

Funding Type	2009–10 ($m)	2010–11 ($m)	2011–12 ($m)	2012–13 ($m)	2013–14 ($m)	Total ($m)
Facilitation Funding						
Elective Surgery	-	-	8.1	-	2.3	**10.4**
Emergency Department	-	-	4.0	1.1	1.7	**6.8**
Flexible Funding	2.7	2.7	1.1	1.1	1.1	**8.7**
Facilitation Total	**2.7**	**2.7**	**13.2**	**2.2**	**5.1**	**25.9**
Capital Funding						
Elective Surgery	1.9	1.9	2.5	-	1.2	7.5
Emergency Department	1.9	1.9	1.9	1.9	1.9	9.5
Capital Total	**3.8**	**3.8**	**4.4**	**1.9**	**3.1**	**17.0**
Sub-acute Funding Total	**-**	**-**	**5.7**	**10.6**	**21.0**	**37.3**
Total	**6.5**	**6.5**	**23.3**	**14.7**	**29.2**	**80.2**

Source: *National Partnership Agreement on Improving Public Hospital Services: Interim Implementation Plan - Tasmania 2011–12 to 2013–14*, 19 April 2011. Updated figures for each year, within the agreed totals, provided by DHHS on 4 July 2013.

The $80.2 million in facilitation and capital funding has been allocated to 43 projects across Tasmania, relating to the six funding types under the agreement (refer Table A1). The MCH has been provided with $700 000 under the NPA IPHS to date to fund ophthalmology services, and will receive a further $200 000 for this purpose in 2013-14.

Tasmanian Cancer Initiative

In 2009–10, the Commonwealth committed to provide Tasmania with $2.4 million over three years to fund health infrastructure projects across the state.[163] As part of this funding, $1.4 million was allocated to upgrading chemotherapy and cancer facilities in North West Tasmania. DoHA and DHSS have agreed that the $343 000 allocated under this initiative for upgrading the chemotherapy unit at the MCH will be paid via the HoA rather than via the

[163] Commonwealth of Australia, *Budget Paper No. 2 Budget Measures 2009–10* [Internet], Commonwealth of Australia, Canberra, 2009, available from <http://www.budget.gov.au/2009-10/content/bp2/html/bp2_expense-16.htm> [accessed November 2012].

Tasmanian Cancer Care Project. DHHS advised the ANAO that further discussions with DoHA will take place on the arrangements for progressing this payment.

Tasmanian Government capital funding

The HoA provide for Commonwealth funding to be used for capital works at the MCH, limited to a maximum value of $250 000 in the 2011 HoA. In addition to the Commonwealth's contribution, the Tasmanian Government has provided capital funding to upgrade facilities at the MCH. This funding included $0.8 million to relocate the High Dependency Unit, which was completed in 2010, and $5.3 million to expand the MCH's Emergency Department, which was completed in 2012. DHHS advised the ANAO that its Asset Management Services provided a total of $170 000 in Capital Investment Program funding in 2011-12 and 2012–13 for the essential maintenance of buildings at the MCH.

Other funding sources

The MCH receives relatively small amounts of additional funding from other sources, as follows:

- $390 000 from Health Workforce Australia, a Commonwealth agency, to provide a nurse endoscopist from October 2011 to May 2014;
- $360 000 over three years from 2012–13 from the Australasian College for Emergency Medicine (ACEM) for education, training and support to emergency medical staff, primarily for Certificate/Diploma Supervisors to supervise candidates who are undertaking the College's Emergency Medicine Certificate and Diploma Programs; and
- a total of $106 528 in 2011–12 and 2012–13 for one midwife, from Australian Government funding under the Indigenous Early Childhood Development project, provided to MCH through the Population Health Unit of DHHS.

MCH revenue

The MCH generates a small proportion of own-source revenue, as shown in Table A2. As agreed by the Commonwealth during negotiations over the 2008 HoA, this funding is retained by the MCH and is used to meet operational expenditure. While the amount of own-source revenue generated by the MCH has fluctuated, it has increased 86.5 per cent over the period of the HoA.

Table A2: MCH own-source revenue

Revenue and Other Income from Transactions	2008–09 $'000	2009–10 $'000	2010–11 $'000	2011–12 $'000
Sales of goods and services				
Inpatient fees	2 183	1 896	1 854	2 118[1]
Outpatient fees	60	108	122	See note 1
Rental revenue	221	260	253	222
Other user charges	125	1 257	59	1 646
PBS revenue	-	-	168	467
Total sales of goods and services	**2 589**	**3 521**	**2 456**	**4 453**
Other revenue				
Salaries and wages recoveries	72	74	44	26
Worker's compensation recoveries	56	130	91	983
Food recoveries	125	167	236	197
Operating recoveries	337	1 988	3 867	303
Donations	31	58	34	23
Total other revenue	**621**	**2 417**	**4 272**	**1 532**
Total own-source revenue	**3 210**	**5 938**	**6 728**	**5 985**

Source: Mersey Community Hospital Financial Statements, 2008–09, 2009–10, 2010–11 and 2011–12.

Note 1: In the 2011–12 financial statements, inpatient and outpatient revenue was reported as a combined amount.

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