The Auditor-General

Planning for Rural Health

Department of Health and Family Services

Australian National Audit Office

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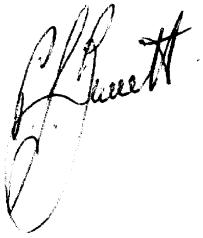
Australian National
Audit Office

Canberra ACT
28 May 1998

Dear Madam President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit of the Department of Health and Family Services in accordance with the authority contained in the *Auditor-General Act 1997.* I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *Planning for Rural Health.*

Yours sincerely



P. J. Barrett
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

AHMAC	Australian Health Ministers' Advisory Committee
AHMC	Australian Health Ministers' Conference
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
COAG	Council of Australian Governments
DEETYA	Department of Employment, Education, Training and Youth Affairs
DHFS	Department of Health and Family Services
DoFA	Department of Finance and Administration
GAO	United States General Accounting Office
HIC	Health Insurance Commission
HSSD	Health Services Development Division
JCPA	Joint Committee of Public Accounts
LG	Local Government
MOU	Memorandum of Understanding
NPHP	National Public Health Partnership
NRHS	National Rural Health Strategy
DOPIE	Department of Primary Industries and Energy
RHSET	Rural Health Support Education and Training program

Part One

Summary and Recommendations

Audit Summary

National Rural Health Strategy

1. The momentum for a national strategy focusing on the health needs of rural and remote communities grew from the inaugural National Rural Health Conference held in Toowoomba in 1991. The then Commonwealth Minister for Health, Housing and Community Services and the Rural Doctors Association of Australia co-convened the meeting of over 350 rural health professionals, administrators and consumers to consider, discuss and debate a variety of issues in rural health care and service delivery as part of the development of a National Rural Health Strategy.

2. Participants at the Conference expressed concern about the difficulties associated with access to health services in rural and remote areas of Australia. They noted that national surveys undertaken by the Australian Institute of Health and Welfare had shown that people living in rural and remote areas of Australian had poorer health status than those living in urban areas.

3. With around 27 per cent[1] or 4.8 million Australians living outside metropolitan areas in either a rural or remote part of the country, there was pressure to place the issues of health in rural and remote areas higher on the national health agenda.

4. In 1994 Australian Health Ministers acknowledged that there was a need for a specific and unique strategy in order to meet the health care needs of rural and remote communities. Accordingly, they endorsed the National Rural Health Strategy (NRHS) with the goal of providing a framework and policy to:

- guide the provision of appropriate rural health services and equitable access to them;
- provide a mechanism for addressing agreed rural health priorities;
- encourage the adoption of approaches to service delivery which are tailored to meet the special circumstances of rural Australia; and
- measure progress towards meeting key rural health goals.

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1 *National Rural Health Strategy,* Australian Health Ministers' Conference, March 1994, AGPS.

5. In 1996, the Australian Health Ministers' Conference approved a comprehensive review of the Strategy to follow a 1997 National Rural Health Conference. To achieve this objective, the Department of Health and Family Services (DHFS) commenced a review of the existing Strategy for rural health with a view to presenting proposals for revision to the Health Ministers' Conference in October 1998. The review will consider progress, achievements and the shape of future programs in the area.

Audit objectives

6. The objective of the audit was to determine whether the DHFS had managed its coordinating role and implemented its responsibilities under the National Rural Health Strategy efficiently and effectively.

Conclusions

7. The audit found that DHFS' National Rural Health Strategy coordination was well-managed. While there was no extensive central coordination for delivery of rural health programs in DHFS, the informal coordination appeared to be effective. However, DHFS will need to monitor that co-ordination to see if it continues to be effective over time or whether more efficient arrangements are needed.

8. The National Rural Health Strategy identified thirteen priority concerns and activities for achieving National Health Goals and Targets and listed proposals to address these. DHFS had sole or partial responsibility for action on eleven. DHFS had fully implemented two proposals and partially implemented seven, while two had not been implemented. The two proposals that were not implemented related to establishing an Office of Rural Health and developing performance indicators to measure outcomes. This last proposal is significant because, in its absence, DHFS does not know if the progress it has made in implementing the National Rural Health Strategy has improved the health status of rural and remote Australians.

9. While DHFS meets its annual reporting requirements in the broad, it should enhance the quality of information it provides to enable stakeholders to obtain a more informed view of the programs' efficiency and effectiveness.

Key Findings

Managing the National Rural Health Strategy

1. There is a diverse range of health programs operating in the Department. While none has specific or sole responsibility for rural health, each has a role in implementing the National Rural Health Strategy.

2. DHFS' rural health programs are delivered in a disaggregated way through a number of departmental Divisions and Branches, without extensive central coordination. However, avenues exist within DHFS for the exchange of information between program managers involved in service delivery to rural residents. Those avenues of communication appeared to be effective in their operation.

3. Some of these programs involve the allocation of financial resources directly to rural health. These are identifiable in DHFS' Budget funding. In 1997-98 they amounted to approximately $73 million. Other programs do not involve identifiable allocations of funds, but incorporate rural health elements as part of a wider approach to improvement of community health.

4. Since DHFS had not been able to develop outcome measures for its activities in rural health, it was unable to determine if its implementation of the 1994 NRHS had improved the health status of rural residents.

5. There is evidence of a clear policy commitment to addressing the health needs of rural and remote Australians by DHFS. However, neither DHFS' 1997-98 Corporate Plan or its 1996-97 Annual Report make specific reference to a health objective for rural and remote Australians. Further, rural health does not appear amongst DHFS' key priorities within its range of programs.

6. The ANAO found that there is a substantial program of national rural health forums and conferences involving coordination and joint funding with other agencies. For example, the Department of Primary Industries and Energy and the DHFS partly co-sponsored a National Rural Public Health Forum in Adelaide in October 1997. The Department of Employment, Education, Training and Youth Affairs (DEETYA) is involved in rural health through its responsibility for university funding and activities in universities providing education for the medical workforce and allied health professionals.

7. In general, DHFS' programs chiefly deal with issues associated with the medical workforce. While most programs preceeded the

Commonwealth's endorsement of NRHS, they are generally consistent with the NRHS. They do not, however, specifically address NRHS proposals, but are aimed at consistent outcomes. It was noted, however, that DHFS had not established a Commonwealth Office of Rural Health as proposed in the 1994 NRHS.

8. The ANAO observed that there was no significant duplication of rural health elements in program management within the DHFS. We also found that program managers were aware of the extent of State activities in areas where there was a likely overlap between Commonwealth and State programs.

9. While there is a degree of cooperation between the Commonwealth and State and Territories authorities, rural health stakeholders at the National Rural Public Health Conference in Adelaide, in October 1997, commented on a lack of consultation by governments generally. There is little apparent Local Government (LG) involvement in the determination of community health needs and in implementing initiatives that form part of DHFS' rural health program elements.

Accountability for the National Rural Health Strategy

10. The ANAO found that DHFS' reporting on its rural health programs meets the requirements of the Annual Reporting Guidelines issued by the Department of Prime Minister and Cabinet and the Guidelines for the preparation of Portfolio Budget Statements issued by the Department of Finance and Administration.

11. Notwithstanding such reporting, and largely because of the relatively small size of rural health expenditure within the DHFS Budget, there is little or no aggregate information available to Parliament or stakeholders on:

- the cost to the Commonwealth of its participation in the NRHS;
- contributions to NRHS by participating governments and the levels of resources, costs and Budget impacts of rural health programs;
- program outputs and achievements by the various levels of government; and
- the aggregate performance of NRHS in progressing the agreed proposals.

12. As the national health agency, DHFS does not take steps to obtain, collate or report on aggregate national expenditure or program achievements dealing with health in rural and remote communities. Also, its support of performance and outcome measurement (under Proposal 13 of the Strategy) has not yet given rise to useful results.

13. DHFS' Departmental Management Committee has recognised the importance of reporting performance information by seeking endorsement of a strategic approach to issues arising from the introduction of an output budgeting and accrual accounting framework. The ANAO notes DHFS' steps to develop a structure appropriate for its future obligations in accrual budgeting and outcomes reporting.

14. The limited information currently collected and reported is insufficient to allow external reviewers and stakeholders to assess:

- how much effort and resources the Department applies to rural health;
- what practical outputs are derived from relevant programs;
- how actively DHFS is progressing Commonwealth obligations under NRHS; and
- the extent to which DHFS conducts its rural health programs effectively or efficiently.

15. Commonwealth agencies that deliver health services to rural and remote Australians should determine clear objectives, strategies and targets. These various elements of program management should recognise the inherent difference between the target population and the population at large as well as the cost implications of any strategy determined.

16. The DHFS should determine, in the context of current resource priorities and constraints, the level of resources necessary to achieve DHFS' and the Government's rural health objectives. That recognition can only occur as the process of defining health needs comes to fruition, including the health status of rural populations compared to other Australians.

17. The current status of the health of rural and remote Australians needs to be benchmarked against the health of the rest of the population before program targets can be set. The second element in assessing resource requirements is the extent to which the rural and remote population influences general (ie, broad public health) program costs for the rest of the population.

Revision of the National Rural Health Strategy

18. The 1994 NRHS was established as a framework and means to address the health status of Australians living outside metropolitan areas. The principal goal of the revision of the Strategy is to ensure the NRHS' continued relevance as an operational framework for the further development of rural and remote health services. In contributing to the revision of the Strategy, the DHFS should promote changes that will outline its responsibilities for the delivery of the NRHS. Furthermore, the DHFS should seek to have the Strategy evolve from a framework for action into

an operational outline. This could be significantly progressed through greater attention to the importance of performance information in the revised NRHS. This would allow the DHFS to provide feedback on key aspects of performance, such as how efficient and effective is agency expenditure in achieving its desired outputs and outcomes.

Recommendations

Set out below are the ANAO's recommendations with report paragraph reference and DFAT's abbreviated responses. More detailed responses and any ANAO comments are shown in the body of the report.

Recommendation No. 1 Para. 2.15

The ANAO recommends that DHFS:

- advise the Minister on the costs and benefits of establishing an Office of Rural Health; and
- advise the Australian Health Ministers' Advisory Committee (AHMAC) of the Minister's decision on this matter.

DHFS response: Agreed.

Recommendation No. 2 Para. 2.24

The ANAO recommends that DHFS establish a clear portfolio objective and key priorities for rural health.

DHFS response: Agreed.

Recommendation No. 3 Para. 2.34

The ANAO recommends that DHFS estimates Commonwealth and national expenditure on rural health services, so as to enable it to analyse the relative significance of its expenditure on the health status of those communities, and to support its planning, monitoring and evaluation of its health programs.

DHFS response: Agreed.

Recommendation No. 4 Para. 2.59

The ANAO recommends that the DHFS:

- differentiate rural health elements within its program structure to assist in identifying the relationship between program costs, outputs and health outcomes; and
- review the extent to which it needs to identify rural health as a focus of information collection for accrual budgetary and reporting purposes.

DHFS response: Agreed.

Recommendation No. 5 Para. 3.23

In order to better implement the NRHS, the ANAO recommends that DHFS:

- review the extent to which its reporting practices provide information on the resource costs and outputs of its programs related to rural health;
- develop an information base on those factors so that it can more effectively report Commonwealth efforts towards the objectives of the National Rural Health Strategy; and
- seek, through the revision of the NRHS, to establish whether information on resources and outputs could be collated and incorporated into national statements of activity, investment and achievement.

DHFS response: Agreed.

Recommendation No. 6 Para. 4.19

The ANAO recommends that DHFS:

- focus on the development of a basic definition of health status as a means of defining the problem that the National Rural Health Strategy aims to address;
- take steps to evaluate the progress achieved in the Rural Health Support Education and Training program contract for the study of rural health performance indicators;
- in conjunction with its State counterparts, develop a timetable for the completion of the remaining steps in its contract study; and
- consider whether the overseas approach involving the use of premature death statistics could provide a simpler way of measuring the health status of rural and remote communities in Australia.

DHFS response: Agreed.

Part Two

Audit Findings and Conclusions

1. Introduction

This Chapter explains why the audit was undertaken, its objectives and methodology. The criteria used to reach the audit conclusions are summarised at the end of the Chapter.

Background

1.1 In its 1997-98 Corporate Plan, the Department of Health and Family Services stated its vision to be:

> *"The leader in promoting, developing and funding world class health and family services for all Australians."*

1.2 To achieve this objective, the DHFS directly and indirectly funds health programs which cover, amongst other target groups, those living in rural areas. Programs with a rural health component which are readily identifiable in DHFS' Budget total approximately $73 million in 1997-98. The rural component of most other programs with elements of rural health, such as Medicare, is not as readily identifiable.

National Rural Health Strategy

1.3 The momentum for a national strategy focusing on the health needs of rural and remote communities emanated from the first National Rural Health Conference held in Toowoomba in 1991. Participants included the Minister for Health, Housing and Community Services and officials from his Department as well as 350 rural health professionals, administrators and consumers. The conference outcomes expressed concern about the difficulties associated with access to health services in rural and remote areas of Australia. They noted that national surveys undertaken by the Australian Institute of Health and Welfare had shown that people living in rural and remote areas of Australia had poorer health outcomes than those living in urban areas.

1.4 With approximately 27 per cent[2] or 4.8 million Australians living outside metropolitan areas in either a rural or remote part of the country, there was pressure to place the rural and remote areas health issues higher on the national health agenda.

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[2] *National Rural Health Strategy,* Australian Health Ministers' Conference, March 1994, AGPS.

1.5 In 1994 Australian Health Ministers recognised that there was a need for a specific and unique strategy in order to meet the health care needs of rural and remote communities. Accordingly, they endorsed the National Rural Health Strategy (NRHS) developed by Commonwealth and State/Territory officials on the Australian Health Ministers' Advisory Committee. This had the broad goals[3] of providing a framework and policy to:[4]

- guide the provision of appropriate rural health services and equitable access to them;
- provide a mechanism for addressing agreed rural health priorities;
- encourage the adoption of approaches to service delivery which are tailored to meet the special circumstances of rural Australia; and
- measure progress towards meeting key rural health goals.

1.6 In July 1996 the Australian Health Ministers issued a National Rural Health Strategy Update. In endorsing this report the Australian Health Ministers' Conference approved a comprehensive review of the Strategy to follow a 1997 National Rural Health Conference. To achieve this objective, the DHFS is reviewing the existing strategy for rural health with a view to presenting a revision to the Health Ministers' Conference in October 1998. The review will consider progress, achievements and the shape of future programs in the area.

The role of the Department of Health and Family Services

1.7 The Commonwealth's endorsement of the NRHS involves DHFS as the leading national health agency in developing a full understanding of, and supporting, a range of health policies and programs that all Australian governments will implement. In areas where Commonwealth activity is the most appropriate way to address the agreed proposals, the Commonwealth is also committed to providing resources and taking steps, through its portfolio programs, to address the health needs of rural and remote communities. Ministerial endorsement of NRHS is evidence of acceptance by the Commonwealth that some rural health issues can only be addressed by actions in State/Territory jurisdictions that go beyond the direct reach of programs delivered by the Commonwealth through DHFS.

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3 *National Rural Health Strategy*, Australian Health Ministers' Conference, March 1994, AGPS.

4 *ibid*, p. 1.

1.8 Within its agreed framework, NRHS leaves to the Commonwealth, State/Territory and other health jurisdictions the nature of program responses that they adopt, how program planning and implementation will be carried out, and how program outcomes will be measured. There are no specific requirements within the Strategy for agreed methods of implementation or for performance information. Each health administration is free to develop implementation and performance information arrangements appropriate to its circumstances including its mandated responsibilities.

1.9 Similarly, NRHS does not include specific references to the resource costs of programs to address the agreed proposals. It does not address the likely total resource costs of meeting the NRHS aims. It makes no reference to expected or promised levels of funding by the Commonwealth and other governments to establish or maintain the programs needed to implement the agreed aims. Specifically, NRHS does not include specific requirements that governments maintain program funding levels or match funding efforts.

Reasons for the audit

1.10 This audit commenced following ANAO's consideration of previous audit coverage of DHFS' rural health programs, the risk to program management, materiality aspects and Parliamentary and public interest. The audit was also undertaken to assist DHFS in the administration of rural health activities.

Audit objectives

1.11 The objective of the audit was to determine whether DHFS had managed its coordinating role and implemented its responsibilities under the National Rural Health Strategy efficiently and effectively.

Audit methodology

1.12 A preliminary study was undertaken to identify aspects of rural health within the DHFS, and to develop an approach to the audit. The audit focussed on DHFS' participation in the National Rural Health Strategy. It did not consider rural health elements that affect Aboriginal and Torres Strait Islanders because those elements are the subject of another ANAO audit, whose results will be reported separately. The audit involved fieldwork with DHFS, largely in Canberra, and consultation with stakeholders.

Audit criteria

1.13 Audit criteria were developed to allow the audit the means of reaching an opinion on the progress achieved by DHFS in the various elements of the National Rural Health Strategy. Criteria were developed to consider if:

- DHFS had clear and attainable objectives for the NRHS, determined priorities for rural health and applied resources accordingly;
- implementation of the Strategy was coordinated between DHFS' Divisions and other Commonwealth agencies, including the Health Insurance Commission;
- there were cooperative arrangements with other levels of government to implement NRHS to the extent possible;
- DHFS had defined the outputs and outcomes it sought from rural health programs and measured performance against those outputs and outcomes;
- program targets were met;
- DHFS' NRHS reporting met the requirements of the Parliament; and
- DHFS management of rural health programs encouraged consistency in outputs and outcomes in Commonwealth and State programs and avoided duplication of services.

1.14 The audit was conducted in conformity with ANAO Auditing Standards and cost $187 000.

Audit conclusions

1.15 The audit found that DHFS' National Rural Health Strategy coordination was well-managed. While there was no extensive central coordination for delivery of rural health programs in DHFS, the informal coordination appeared to be effective. However, DHFS will need to monitor that co-ordination to see that it continues to be effective over time. Of the thirteen proposals in the National Rural Health Strategy, DHFS had sole or partial responsibility for action on eleven. DHFS had fully implemented two proposals and partially implemented seven, while two had not been implemented. The two proposals that were not implemented related to establishing an Office of Rural Health and developing performance indicators to measure outcomes. This last proposal is significant because, as a result, DHFS does not know if the progress it has made in implementing the National Rural Health Strategy has improved the health status of rural and remote Australians. DHFS' published information on its rural health programs was insufficient for stakeholders to form a view on those programs' efficiency and effectiveness.

2. DHFS Rural Health Policies and Programs

This Chapter provides an outline of DHFS' policies to improve the health of rural and remote Australia, and it identifies DHFS' programs which have a level of involvement in rural health.

Policy background

2.1 The Government's health policy for the 1996 election included a commitment to a strategy to deal with a perceived crisis in rural health, through continuation of existing programs and implementation of new programs. The principal element of this commitment was directed at what the policy called a crisis in health workforce numbers, principally (but not solely) among medical practitioners, that impeded access to appropriate health services by communities in rural and remote areas of Australia. This commitment was reinforced in the 1996-97 and 1997-98 Budgets through the provision of funding to existing programs. The funding was directed at rural health improvement and at the implementation of new activities.

2.2 The objectives of current DHFS policy settings are connected with reducing the impact of the perceived crisis in rural health workforce numbers, identified in the Government's health policy, and with improving access to services in rural and remote communities. However, these objectives are not clearly stated in any of the Department's policy pronouncements.

2.3 Another perspective on the Commonwealth's rural health objectives is indicated by the endorsement by successive Ministers for Health of a National Rural Health Strategy (NRHS). A detailed discussion of the NRHS is in Chapter 3. Under the NRHS the Commonwealth, through the Minister for Health, has endorsed a framework and set of priorities. These encompass, as well as access to services, the identification of and documentation of the extent of rural health needs, initiating measures to address these needs and measuring improvements in health outcomes in rural and remote communities.

DHFS' corporate plan

2.4 The Department's 1997-98 Corporate Plan includes generic aims. These aims include:

- increasing the health status of disadvantaged population groups;
- providing a nationally coherent health system which allows regional and state variations; and
- using targeted approaches to gain improved outcomes for individuals, communities and the whole population.

2.5 In other respects, however, the Corporate Plan makes no specific reference to any objectives DHFS may have for its program activities dealing with rural health. Rural health does not, for example, appear amongst DHFS' key priorities within its range of programs. A comparison is DHFS' objective in relation to indigenous health, which is

> *"To raise the health status of Aboriginal and Torres Strait Islander peoples by improving access to culturally appropriate high quality health care."*

2.6 There are three possible reasons for this situation. First, rural health policy and programs do not align with the major functional structures on which the DHFS organisation is based. There are rural health elements in many of the Department's broad public health policies and programs. In addition, few rural health programs are directly delivered by DHFS. Those that it delivers are small relative to the scale of many DHFS programs, and not material in terms of financial and other resources. Second, many of the key elements of improving rural health in Australia are more closely related to the programs and activities of State health authorities, which take direct decisions concerning the allocation of resources to rural area health services. DHFS activities are more closely related to limited areas of Commonwealth direct interest, such as workforce issues in the medical profession and broad public health improvement programs. Third, DHFS rural health activities are not the subject of specific Commonwealth legislation. This is a situation similar to many other areas in which DHFS has policy interests and programs.

DHFS rural health programs

2.7 A list of the directly identifiable rural health activities funded under the 1997-98 DHFS Budget is at Table 1.

Table 1
DHFS Rural Health Programs, 1997-98

Rural Health Program activity	DHFS organisational responsibility	1997-98 Budget estimate and description of activity	Nature of program and services funded
Medical Workforce Financial Assistance	Health Services Development Division State Financing Branch	$20.2m. Part of Program 2.1 *Medicare Benefits and General Practice Development*	Funding is provided for a range of activities, such as research and development, infrastructure support, rural doctor training and employment of non specialist hospital doctors. It should be noted however, that not all the programs are for rural health.
Royal Flying Doctor Service	as above	$16.4m. Part of Program 2.3 *Acute Care*	DHFS provides a grant in aid to support the Service. Other funding is by States and through donations.
Rural Health Support Education and Training Program (RHSET)	as above	$7.3m. Part of Program 2.3 *Acute Care*	Grants funding of projects to improve education training and support for rural health care providers, based on applications submitted in accordance with guidelines. Two application rounds per annum; around 700 applications in each. 435 grants approved since 1991. Examples: *Uni. of New England - review tertiary education opportunities for rural and remote health workers; Tas. Logging Assn. - funds community support network for forest industry families in N Tasmania, dealing with fatalities and debilitating injuries.* A Departmental evaluation of RHSET was completed in March 1996.
University Departments of Rural Health	as above	$6m. Part of Program 2.3 *Acute Care*	Annual grants of $1.5m. paid to universities to establish health education and training centres in non-metropolitan localities. Currently four approved of a planned six.
Rural Obstetrics	as above	$5m. Part of Program 2.3 *Acute Care*	Specific purpose grants to States for pilot studies, funded by expected savings from Medicare.
Specialist Posts	as above	$2m. Part of Program 2.3 *Acute Care*	Funds specialist training positions in non-metropolitan hospitals.

Rural Health Program activity	DHFS organisational responsibility	1997-98 Budget estimate and description of activity	Nature of program and services funded
John Flynn medical student vacation scholarships	Health Benefits Division General Practice Branch	$0.8m. Part of Program 2.1 *Medicare Benefits and General Practice Development*	New program - introduced in 1997. Up to 150 scholarships to be provided annually.
General Practice Rural Incentive Program (GPRIP)	Health Benefits Division General Practice Branch	$15.2m. Part of Program 2.1 *Medicare Benefits and General Practice Development* (Alternative General Practice funding arrangements)	Incentive payments of $20 000 to GPs to encourage relocation to rural/remote areas. Grants (up to $78 000) for GP training. Around 360 relocation/training grants to date. Payments also cover continuing medical education and locum support relief, incentives $50 000 (up to three yrs) to GPs in 60 remote area communities, funding of medical student rural exposure and family support grants. Some program management by State Rural Division Coordinating Units.
Total identifiable rural health funding		**$72.9m**	

2.8 The Department also considers rural health in the context of most of its major public health programs. In addition to the identifiable elements listed in Table 1, there are rural health elements in the following major programs:

- **Public Health - Program 1** **1997-98 Budget $462.0 million**

  The objective of this program is to promote and protect the health of all Australians and minimise the incidence and severity of preventable illness, injury and disability.

- **Medicare Benefits and General Practice Development - Sub-program 2.1** **1997-98 Budget $6984.0 million**

  A strategy under this program is to increase the recruitment and retention of general practitioners in undersupplied rural and remote areas.

- **Mental Health - Sub-program 2.4** **1997-98 Budget $69.7 million**

  The objective is to improve mental health outcomes in Australia and reduce the rate of youth suicide through direct programs and cooperation with States and Territories.

- **Aboriginal and Torres Strait Islander Health - Program 3**
  1997-98 Budget $136.0 million

  This program is currently the subject of a separate audit by ANAO.

- **Aged and Community Care - Program 5**
  1997-98 Budget $3730 million

  The program aims to enhance the quality of life of older Australians, through high quality cost effective care services.

- **Disability Programs - Program 6** **1997-98 Budget $785.8 million**

  The program aims to enable disabled persons to participate equally in community life.

Other activities in the DHFS portfolio

2.9 In addition to DHFS programs identifiable as connected with rural health in the DHFS portfolio, there are other activities and programs in rural health.

- **Medicare** - the Health Insurance Commission (HIC) pays health benefits in respect of services rendered by medical practitioners in areas of Australia defined as rural and remote. HIC is involved in reviews and data collection concerning these payments and uses Medicare data to derive information concerning changes in the numbers of and types of medical practitioners in rural and remote areas. Projected savings through changes to the delivery of obstetric services in rural and remote areas have been used to fund a trial of new methods of service delivery.
- **Pharmaceutical benefits** are paid in respect of pharmaceutical items dispensed to residents in rural and remote areas.
- **Expenditure** on Medicare and pharmaceutical benefits in respect of services rendered to residents of rural and remote areas are not included in Table 1. There are no firm statistics concerning the total amounts paid and the distribution of these payments. It is likely, however, that such payments would account for a substantial proportion of total Commonwealth expenditure in relation to health in rural and remote communities.
- **The Australian Institute of Health and Welfare (AIHW)** is closely involved in the development of health benchmarks and performance measures for rural and remote Australia, principally under a contract funded through the DHFS Rural Health Support Education and Training (RHSET) program involving the health authority of a major State.
- **National Health and Medical Research Council (NHMRC)** forms a part of Sub-program 1.3, Health Research and Information and assists in

contributing to the pool of health knowledge which may be used to develop better strategies to improve the well-being of Australians, including rural residents.

Coordination of activities within DHFS

2.10 DHFS has no formal Committee structure or designated work group responsible for coordinating the management of rural health program elements conducted throughout DHFS' Divisions and Branches.

2.11 The audit found through interviews that DHFS program managers demonstrated a sound, if (in some cases) generalised, knowledge of the breadth of rural health activities throughout the Department, and were aware of the program responsibilities of their colleagues and the directions and aims of rural health activities conducted elsewhere. Avenues exist within DHFS for the exchange of information between program managers where there is actual or potential commonality between program elements, and these appeared to be effective in their operation. RHSET applications, for example, are referred to other management groups if the grant requested is more appropriately funded by another program. No instances were noticed of duplication of common activity in the development or delivery of programs by the DHFS Branches concerned with rural health elements.

The Commonwealth Office of Rural Health

2.12 Proposal 4 of the National Rural Health Strategy (referred to in more detail in the next Chapter) calls for the establishment within DHFS of a Commonwealth Office of Rural Health to promote the integration and coordination of the funding and provision of rural health related services. The Strategy, including this Proposal, was endorsed by Commonwealth and State/Territory Health Ministers in 1994. DHFS considered the cost of establishing a formal Office against the benefits and concluded that the resources could be better utilised elsewhere within the Portfolio. DHFS indicated, in its response to ANAO Recommendation No.1 (paragraph 2.16) that the Minister has accepted its proposal not to create a separate Office of Rural Health but rather the role to be undertaken within its existing structure.

2.13 Without the central focus that an Office of Rural Health could provide, there is a risk that DHFS-managed rural health program elements may lack coordination. The risk is, however, reduced by current informal consultative arrangements. Notwithstanding, there are a number of aspects of rural health common to DHFS programs that could be better addressed

if a central coordinating body, such as the proposed Office, were established. These aspects are as follows:

- The Commonwealth has endorsed the development of a set of measures of health status in rural and remote Australia. This task involves the measurement of differences in health outcomes in different parts of Australia, and measures of performance by which the success of rural health initiatives can be gauged. It is currently conducted through RHSET program funding of a study involving AIHW. A more detailed discussion of this project is in Chapter 3. The measures likely to result from the project will play a significant role in outcomes measurement for all rural health related activities in the DHFS Portfolio. In general the development of this project has been the sole responsibility of the managers of the RHSET program, and selected State health authorities. In view of the importance of outcomes measurement, there is scope for a wider involvement of program element managers throughout DHFS in the direction of this project.
- ANAO discussions with other stakeholders, including State health authorities and health service organisations, suggested that confusion exists in some quarters concerning the availability of information on Commonwealth funded activity in rural health. As a result, there is a potential for wasted effort by some organisations in, for example, seeking funds for educational and developmental projects that may parallel existing efforts, such as the projects funded under the Rural Health Support and Education Training (RHSET) program. A central presence such as the proposed Office of Rural Health could function as a repository of information, a source of reporting to the many stakeholders in this field on current activities and a point of contact for persons seeking assistance for rural health projects and initiatives.

2.14 Chapter 3 discusses the NRHS in more detail, including the fact that a review of the Strategy is taking place with a view to revision during 1998. The current review provides an opportunity for DHFS to consider whether it continues to support the concept of an Office of Rural Health, which has not been implemented. After four years of involvement with the other stakeholders in rural health (including States and Territories as parties to NRHS), it would be timely for DHFS to consider whether the largely informal coordination that has taken place in the past four years has met its needs in this area. The matter of provision of information to stakeholders and the advantages of a central information and contact point should also form part of DHFS' consideration prior to finalising a revised Strategy.

Recommendation No.1

2.15 The ANAO recommended to DHFS that it:

- advise the Minister on the costs and benefits of establishing an Office of Rural Health; and
- advise the Australian Health Ministers' Advisory Committee (AHMAC) of the Minister's decision on this matter.

DHFS Response

2.16 The DHFS agreed with the ANAO recommendation, and advised that the Minister has accepted that the Department operate a "matrix management" approach whereby a Branch in the Health Services Development Division (HSDD) acts as a lead agency, hub and overall co-ordinator of rural issues, whilst "line" branches continue to deal with rural issues applying to their principal business.

Coordination with other Commonwealth agencies

2.17 Other Commonwealth agencies outside the DHFS Portfolio have policy and program interests in the health of rural and remote communities, and interests in programs affecting the provision of services to those communities. There is a substantial program of forums and conferences involving coordination and joint funding with other agencies, particularly the Department of Primary Industry and Energy (DOPIE). The most recent such activity was a Public Health Forum held in Adelaide in October 1997 sponsored in part by DHFS and DOPIE.

2.18 The Department of Employment, Education, Training and Youth Affairs (DEETYA) is also involved in rural health - through its responsibility for university funding and activities in universities and other institutions providing education for the medical workforce and allied health professionals. DHFS' program aims include the introduction of changes in curricula to ensure that medical undergraduates are exposed to the conduct of medical practice in rural and remote communities. The objective is to assist graduates to enter practice or to work in rural areas, thereby improving rural residents' access to services. In discussion with stakeholders, it was evident that elements of curriculum development and rural exposure in training are being successfully developed and implemented in Australian medical schools, through DEETYA supported changes in admission and curriculum practices and DHFS' direct funding of some activities such as the establishment of university departments of rural medicine.

Conclusion

2.19 There are indications that, due to current coordination efforts between other Commonwealth departments with programs that relate to the health status of rural and remote Australians, there is no obvious duplication of service delivery.

Cooperative arrangements with other governments

2.20 DHFS has a number of separate agreements with States on public health issues, some of which deal with elements of rural health. Under current DHFS policy, it is intended to combine many of these separate agreements into a single public health agreement within which funds are provided to each State for programs aimed at specific health outcomes. These arrangements are yet to be fully accepted by the States through the machinery of COAG. To date, only Queensland and the Northern Territory have signed public health agreements. The DHFS should ensure that the wide acceptance of general public health agreements will not reduce program activities and resources dedicated to rural health.

2.21 While there is cooperation between the Commonwealth and State and Territories authorities, some rural health stakeholders have commented on a lack of consultation by governments generally. At the National Forum on Public Health in Adelaide in October 1997, there were numerous calls for more involvement of Local Government (LG) in the determination of community health needs and in implementing initiatives that form part of DHFS' rural health program elements.

2.22 The NRHS is a cooperative arrangement between the Commonwealth and State and Territory governments. State health authorities participate in a number of rural health elements through specific arrangements for delivery of relevant services, such as provision of hospital and nursing services. While many of these elements are essential to the achievement of the aims of the Strategy, they go beyond the immediate aims of DHFS in those programs for which it is directly responsible.

Conclusion

2.23 DHFS' rural health programs are relative small when compared to other services being delivered by the Department and as such are delivered in a disaggregated way through a number of departmental Divisions and Branches, without extensive central coordination. Rural health does not appear amongst DHFS' key priorities within its range of programs. Nevertheless, there is evidence of a clear policy commitment to addressing the health needs of rural and remote Australians.

Recommendation No.2

2.24 The ANAO recommends that DHFS establish a clear portfolio objective and key priorities for rural health.

DHFS response

2.25 Agreed. This will be reflected in the Department's 1998-99 Corporate Plan.

Resources for rural health

2.26 As mentioned in Chapter 1, approximately 27 per cent of the Australian population or 4.8 million people reside in areas defined as rural and remote. However, there is little information to indicate the proportion of DHFS' national health Budget that is expended on this section of the population. The total Budget impact of rural health is comprised of expenditure in rural communities on programs and benefits in which all Australian communities participate, together with expenditure on programs specifically aimed at improving health in rural and remote communities.

2.27 Commonwealth agencies that deliver health services to rural and remote Australians need to determine clear objectives and targets. These objectives and targets should recognise the inherent difference between the target population and the population at large as well as the cost implications of any strategy. The DHFS should determine, in the context of current resource priorities and constraints, the level of resources necessary to achieve DHFS rural health objectives. That recognition can only occur as the process of defining health needs (referred to in Chapter 3) comes to fruition, and defines the health status of rural populations compared to other Australians. The current status of the health of rural and remote Australians needs to be measured for more effective performance before targets can be set. The second element in resource determination is the extent to which the rural and remote population influences general (ie, broad public health) program costs for the rest of the population.

2.28 These factors, when established, could provide a basis for decision making about the level of national health resources that should be directed at the rural and remote population. DHFS should develop means of analysing the impact of the rural and remote population on the costs of their programs, including costs such as Medicare and pharmaceutical benefits, and on the broad programs of public health improvement that DHFS funds. There was no evidence that DHFS had conducted any such analysis in respect of its portfolio programs.

2.29 On a broader basis, financial analysis should recognise that most direct health services are not provided by the Commonwealth but are the responsibility of State and Territory health authorities.

2.30 Also, DHFS had no consolidated information about the costs to State and Territory health authorities of the general health services they provide to rural and remote populations, or the level of expenditure in special purpose programs they conduct. DHFS is unlikely currently to receive this information from the States and Territories.

2.31 It was noted that a DHFS commissioned report on *Expenditures on Health Services for Aboriginal and Torres Straight Islander People*[5] canvassed an approach to the aggregation of health expenditure by the Commonwealth and other governments on health services used by indigenous people, similar to the approach proposed here for all rural residents. The analysis showed that the target population derived little benefit from many health programs. It derived two estimates of expenditure, the net government expenditure on the health of Aboriginal and Torres Strait Islander people and the gross expenditure on those services subject to government provision or subsidy. It also commented on how the compilation of such data could be continued on a regular basis.

2.32 The project report includes tables which establish some previously uncertain values: for example, these values include the indigenous share of public expenditure on health, and the ratio of indigenous to non-indigenous expenditures per person.

2.33 Collation of financial data such as these on Commonwealth and all-government expenditure on health programs in rural and remote areas of Australia would assist DHFS to balance its allocation of health resources in accordance with its mission of providing health services to all Australians. Data collection for these purposes could be achieved through the resources of the Australian Institute of Health and Welfare, in conjunction with the Australian Bureau of Statistics.

Recommendation No.3

2.34 The ANAO recommends that DHFS estimates Commonwealth and national expenditure on rural health services, so as to enable it to analyse the relative significance of its expenditure on the health status of those communities, and to support its planning, monitoring and evaluation of its health programs.

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[5] *Expenditures on Health Services for Aboriginal and Torres Strait Islander People*, The National Centre for Epidemiology and Population Health and the Australian Institute of Health and Welfare, January 1998, Canberra.

DHFS response

2.35 Agreed.

Accountability and reporting

2.36 Commonwealth annual reporting requirements for portfolio programs are designed to disclose the resource costs of programs, to provide information on program performance, to comment on the achievement of program objectives and, increasingly, to measure the outcomes that programs achieve.

2.37 The Annual Reporting Guidelines, issued by the Department of Prime Minister and Cabinet and approved by the Parliamentary Joint Committee of Public Accounts, state that the principal formal accountability mechanisms to the Parliament are:

- annual reports;
- Portfolio Budget Statements; and
- Portfolio Additional Estimates Statements.

2.38 These elements of DHFS' Portfolio reporting were reviewed during the audit. DHFS reporting of its rural health programs meets Parliamentary and other accountability requirements. The review of DHFS' Portfolio Budget Statements for 1997-98 and the Department's Annual Report for 1996-97 identified input costs (Budget expenditure impacts) only for some elements of the DHFS rural health program. These are cited in Table 1. Generally there was only limited reporting of program outcomes and outputs for program elements.

2.39 The guidelines on reporting only require that information in relation to programs be reported. Because rural health is not a separate funded program, by not reporting aspects of rural health the Department is not falling down on its formal reporting obligations. Notwithstanding, as a means of public disclosure and of reporting resources and results to the large number of stakeholders involved in rural health, including rural residents, DHFS reporting could be enhanced. Notwithstanding, the ANAO is conscious of the need to form a balance between reporting and the transaction costs of that reporting. The level of public disclosure of related costs, specific outcomes and outputs is not high, and those items on which reports are made are incomplete and difficult to locate. An example of inadequate reporting is that the Parliament or stakeholders cannot obtain a reasonable estimate of rural health expenditure. Nor is it possible for the Parliament to know the effects of public expenditure on rural health programs. The principal reason for the low level of reporting observed is the relatively low level of financial materiality of rural health program elements compared to the much larger mainstream health programs managed by DHFS.

Outputs

2.40 While the Department complies with the reporting guidelines, very little performance information on rural health program outputs was reported by DHFS to the Parliament in either its 1996-97 Annual Report or in its Program Performance Statements for the 1997-98 Budget. The only identifiable output report was a summary in the 1996-97 Annual Report of information on the numbers of general practitioners and specialists in rural and remote areas. This is set out in Table 2.

Table 2
Percent of general practitioners and specialists in rural and remote areas

Year	1992-93	1993-94	1994-95	1995-96	1996-97
GPs	21.7	21.6	21.7	22.2	22.6
Specialists	12.8	12.7	12.6	12.8	13.1

2.41 The Table indicates that there were changes in the percentages of GPs and Specialists practising in rural and remote areas of Australia. Generally the percentages of the profession in practice in these areas have increased. It was not clear, however, whether this change meant that more medical practitioners were available to meet the needs of rural and remote communities, health needs had changed or were not met or there was a shift in population. Without additional information on the numbers of health professionals in practice in comparison with health needs, the data does not provide sufficient information to indicate whether the situation is moving towards a higher level of service to rural and remote communities.

2.42 DHFS' Annual Report for 1996-97 includes information on other aspects of its programs affecting rural and remote communities. It includes data on:

- distribution of Australian pharmacies by urban and rural areas 1997 (reference Sub-program 2.2 Pharmaceutical Benefits);
- numbers of people per pharmacy in rural and remote areas compared to urban and regional 1997 (reference Sub-program 2.2 Pharmaceutical Benefits);
- aged care accommodation compared to the proportion in the population of persons aged 70 and over, as at 30 June 1997, including information on persons residing in rural and remote areas (reference Sub-program 5.1 Policy and Planning); and

- level of Aged Care Assessment Team service to older people in rural and remote areas, as at 30 June 1995 (Sub-program 5.2 Assessment).

2.43 There is scope for a substantial increase in activity in the measurement of outputs from rural health programs conducted by DHFS as well as in its reporting of the information to Parliament and stakeholders. The outputs of most DHFS programs in Table 1 can be quantified using features such as the numbers of:

- grants provided to practitioners;
- practitioner relocations achieved;
- communities served by DHFS incentive programs; and
- posts and activities funded, and types of grants for training and support.

2.44 Many program managers consulted had such information available, but it did not form part of DHFS' reports to the public, health professionals or to Parliament.

2.45 A major issue raised at the National Rural Public Health Forum in Adelaide in 1997 was that there was a need for policy makers to be more accountable to rural and remote people, the level of interest in DHFS program outputs was high, but the lack of published material was regarded as a defect in DHFS' management of its programs. Consideration should be given to an approach to reporting whereby the Department regularly collects output information on these significant programs and makes it available to State and Territory governments and other stakeholders through periodic publication. Such an approach could be undertaken at relatively low cost and it would enable a better informed community of stakeholders. In particular, regular publication of information about the number and nature of RHSET grants, and the conclusion of the relevant studies and information available, would substantially increase stakeholder awareness of the effectiveness of Commonwealth activities in rural health.

Conclusion

2.46 The level of reporting on rural health matters was neither extensive nor comprehensive. Its scope was limited and frequency of reporting was low. The result suggests that, under its current reporting framework, DHFS applies little effort to the reporting of information concerning services, programs and activities provided to persons in rural and remote areas. On the other hand, however, the evidence of DHFS' Corporate Plan and its general structures and program resource levels suggest that tracking and reporting costs and progress for rural health elements is not a high priority for DHFS. The information currently reported is neither comprehensive nor detailed enough to enable any judgement about the extent to which DHFS conducts its rural health programs effectively or efficiently.

2.47 The limited information currently collected and reported is insufficient to allow external reviewers and stakeholders to assess how much effort and resources the Department applies to rural health, what practical outputs are derived from relevant programs, and how actively DHFS is progressing Commonwealth obligations under NRHS.

Performance indicators and outcome measures

2.48 Although, it is not expressed in DHFS' policy statements or in its Corporate Plan the outcomes sought by DHFS through its rural health activities relate to improved health among rural and remote communities. The Department is involved in the development of performance indicators for rural health, against which progress in the implementation of the NRHS can be measured. At the time of this audit, these indicators were still being developed. The process involves collection of data specific to rural and remote Australia by the Australian Institute of Health and Welfare. A working group chaired by the South Australian Health Commission will then analyse the data and seek agreement to a set of performance indicators. Until the indicators have been developed, it will not be possible to determine health outcomes for the target populations. Further discussion on the development of performance indicators for the NRHS can be found in Chapter 4.

2.49 It is essential for the DHFS to develop a regime to measure outcomes for those elements for which it is responsible - otherwise it will not be able to determine if progress against targets is being achieved. The development of measures of health differential and associated outcomes appears to be a reasonable step for DHFS to take. An example would be by measurement of a reduction in deaths resulting from coronary heart disease in rural and remote areas compared to the metropolitan areas of Australia. By means of such measurements, the Department will derive the benefit of measurable outcomes for its own programs as well as making a major contribution to the effectiveness of implementation of NRHS by all participating governments.

2.50 Performance information should also relate to demonstrating that DHFS has been active and effective in its work towards the objectives of NRHS, which is a significant obligation evidenced by Commonwealth endorsement of the Strategy. A more detailed discussion on this is in Chapter 4. These objectives, some outside the scope of programs directly conducted by DHFS, relate to the identification of the nature and extent of rural health needs, equitable access to health services, recruitment, training and support of rural health care providers. The need for such performance information needs to be balanced against the wider overall mission of DHFS to provide policy advice and implement Government policies on public

health, health care, health care funding, and family services for all Australians.

Towards accrual budgeting

2.51 JCPA Report 338 "Accrual Accounting - A Cultural Change" (August 1995) recognised the importance of performance information in the following terms:

> *Perhaps the most powerful aid in assessing agency or program performance will be to compare ratios of financial performance, financial position and cash flows. A comparison of such ratios over time could be an important way of highlighting best practice or trends and calling agencies to account for departures from these marks.*

2.52 In April 1997 the Government decided to implement an accrual-based outcomes and outputs framework for the Commonwealth. The first full accrual Budget is due in 1999-2000.

2.53 The new framework will provide more useful information to the Parliament and stakeholders on both financial and non-financial performance, and will assist decision making in agencies and at the whole-of-government level. Its underlying objective is to increase the efficiency and effectiveness of delivery of government services, through contestability based on visibility of full costs for purchasable outputs.

2.54 The DHFS Departmental Management Committee has recognised the importance of reporting performance information by seeking endorsement of a strategic approach to issues arising from the introduction of the output budgeting and the accrual framework. The main benefit of the accrual framework will be achieved through the provision of better financial information that will assist in applying three efficiency principles set out in the Report of the National Commission of Audit (June 1996). These deal with:

- *Best practice delivery*: Program delivery arrangements must compare favourably with best practice benchmarks of performance (wherever comparable benchmarks of this type can be obtained);
- *Transparency and accountability*: Program requirements must specify that the policy and funding functions are clearly separated from the service delivery functions and that cost outcomes are transparent;
- *Accessibility*: Programs must be as simple and accessible as possible; and

- *Contestability*: Mechanisms must be introduced to ensure competitive or contestable program delivery.[6]

2.55 The Department of Finance and Administration (DoFA) recently issued an exposure draft on the development of outputs and outcomes frameworks for appropriate reporting in an accrual budgeting context. DHFS reporting in respect of rural health does not meet the standards expressed in that draft. To meet the standards, reporting in respect of rural health should:

- describe and cost the outputs produced and the outcomes to which the outputs contribute;
- specify the performance information required to monitor the production of outputs and the achievement of planned outcomes; and
- report performance accordingly.

2.56 DHFS is currently considering the possible shape and content of a Health portfolio outputs and outcomes structure to start the process of restructuring management in accordance with accrual budgeting requirements. This process will continue with the aim of implementing output budgeting in the 1999-2000 budget cycle.

2.57 In developing a structure appropriate for its future obligations in accrual budgeting and outcomes reporting, DHFS should take into account the extent to which it needs to identify rural health as a focus of information collection for these purposes. The current level of reporting suggests that, in view of the low relative materiality of rural health program elements, the topic may not achieve a high visibility in the accrual budgetary structure.

2.58 On the other hand, DHFS' endorsement of the NRHS appears to impose some obligation to incorporate rural health more obviously into its organisational structure at a sufficient level of recognition to enable the Department to report at some level on achievements in the area. As DHFS proceeds to develop an accounting and reporting structure, there is scope for highlighting rural health as a sub-element of the larger programs within which many activities are currently conducted. More visibility for rural health would be essential for the purpose of separate reporting of outputs and outcomes, to the extent to which this is practicable. Without some steps to incorporate such a structural approach to rural health, there is a risk that insufficient information will be collected to enable measurement of outputs and outcomes in relation to this sector.

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[6] *National Commission of Audit, Report to the Commonwealth Government*, June 1996, AGPS, Canberra 1996, p. 14.

Recommendation No.4

2.59 The ANAO recommends that the DHFS:

- differentiate rural health elements within its program structure to assist in identifying the relationship between program costs, outputs and health outcomes; and
- review the extent to which it needs to identify rural health as a focus of information collection for accrual budgetary and reporting purposes.

DHFS response

2.60 Agreed. Such elements can be differentiated, subject to reasonable limits such as cost-effectiveness.

3. DHFS Participation in the National Rural Health Strategy

This Chapter discusses DHFS' participation in the National Rural Health Strategy, the nature of the Strategy and its provisions for accountability reporting.

The role and status of the National Rural Health Strategy — a Commonwealth - State program framework

3.1 The Australian Health Ministers' Conference (AHMC) in March 1994[7] endorsed and issued the NRHS. It provides an agreed national focus for efforts by all governments to improve rural health. Commonwealth, State and Territory Health portfolio agencies worked together to develop the Strategy. There is no Commonwealth legislation specifically dealing with the Strategy, and Commonwealth participation (through DHFS), and the terms of the Strategy itself, were not the subject of specific consideration by the Commonwealth Cabinet.

3.2 It is important to note that NRHS is not a Commonwealth-State agreement for the delivery of a specific health program. Rather, it is a framework for action. Within the NRHS framework, all Commonwealth, State and Territory governments agreed on a set of national principles within which they would develop and implement their separate policies on rural health. The agreed principles would also guide the management by their health authorities of programs for rural health improvement and the delivery of health services to rural and remote communities.

3.3 NRHS sets out national principles and priorities for all government programs concerned with improving rural health. All governments endorsed the NRHS framework and the specific proposals it contains. NRHS also provides a broad mechanism to address agreed priorities. It emphasises the measurement of program outcomes and progress towards meeting key rural health goals. Commonwealth, State and Territory governments agreed that NRHS would provide a series of agreed common goals that each would address in their respective health administrations.

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[7] *National Rural Health Strategy*, Australian Health Ministers' Conference, March 1994, AGPS.

Rural health national goals

3.4 The NRHS includes details of a number of agreed key goals, aimed at ensuring that the Strategy is directed towards achieving optimal health for rural Australia. These goals include:

- identifying and documenting the nature and extent of rural health needs;
- reviewing how existing services are provided to identify their appropriateness and effectiveness in meeting rural health needs;
- fostering measures for the recruitment and retention of rural health care providers;
- training and supporting rural health care providers;
- providing equitable access to services and increasing community and provider awareness of available services;
- systematically evaluating rural health care programs, measuring health outcomes achieved and making the results available to users; and
- maximising the integration and coordination of rural health services.

3.5 Other NRHS goals relate to participative planning and other community involvement, provision of services to Aboriginal and Torres Strait Islander communities, and reducing impediments to effective health care delivery.

The NRHS proposals

3.6 Reflecting its broad strategic approach, at the core of the NRHS are thirteen proposals. These express concerns and issues that governments agreed must be addressed if the NRHS goals are to be achieved. The full text of the proposals is in Appendix A. In summary, the proposals deal with a broad range of matters affecting the development of health services appropriate to rural and remote Australia and how services are to be delivered by government health authorities. A summary of the proposals, who was responsible for their implementation and what was achieved by DHFS is set out in Table 3.

Table 3
National Rural Health Strategy 1994
NRHS proposals and their implementation

Proposal	Description of proposal	Responsibility for implementation	Implemented by DHFS
1	Frameworks and regional plans for rural health	State and Territory governments	Not applicable
2	Models of service delivery reflecting special needs of rural Australia	Principal responsibility - State and Territory governments National coordination through the Commonwealth; DHFS and RHSET funding for some innovative models	Implemented
3	Flexibility in the funding and management of aged care and health services	Commonwealth, States and Territories responsible for flexible approaches to funding; Commonwealth may trial new funding methods	Partially implemented
4	Establishing a Commonwealth Office of Rural Health	Commonwealth responsibility	Not implemented
5	Recruitment and retention of the rural health workforce	Commonwealth responsible for GP Rural Incentive Scheme, supporting Divisions of General Practice, GP locum support; States and Territories responsible for rural health training, support networks, infrastructure, incentives and practice support for nursing and allied health professions	Implemented
6	Student selection and entry standards to tertiary health care provider education, developing appropriate curricula and exposing students to rural health issues and practices	Principally Commonwealth responsibility; States and Territories liaise with educational institutions to facilitate	Partially implemented
7	Availability of medical specialist services and allied health personnel	All parties have some responsibility; Commonwealth funds specialist pilot projects, technology enhancement, and training of different types; States and Territories support outreach and visiting specialist services	Partially implemented
8	A special focus on resources and training of ATSI health workers	Commonwealth responsibility	Partially implemented
9	Multi skilling health care workers and multi disciplinary activities	State and Territory responsibility	Not applicable
10	Priority in 1994-95 for ATSI health services and rural mental health	Commonwealth responsibility; principally dealt with from 1995 by the Office of Aboriginal and Torres Strait Islander Health Services	Partially implemented

Proposal	Description of proposal	Responsibility for implementation	Implemented by DHFS
11	A primary health care approach for isolated communities and changes in service funding and delivery	Commonwealth, State and Territory responsibility	Partially implemented
12	Priority in 1994-95 for primary health care and public health programs and funding review	Joint responsibility; Commonwealth to review Medicare arrangements as applied in rural Australia; States and Territories to implement primary health care approach	Partially implemented
13	National and local indicators to measure health, monitor program outcomes and measure performance	Joint responsibility; funding responsibility is with the Commonwealth	Funding provided but indicators not developed

3.7 The Table indicates that of the thirteen proposals in the National Rural Health Strategy, DHFS had sole or partial responsibility for action on eleven. DHFS had fully implemented two proposals and partially implemented seven, while two had not been implemented.

Implementing the Strategy

3.8 As indicated above, these proposals were endorsed by health ministers. How they are implemented is a matter for the governments and their health administrations, while the extent to which a government can address them is related to the range of health programs that government can and do undertake. Some, for example, can only be implemented through State and Territory health policies and programs.

3.9 DHFS' health programs are principally concerned with programs dealing with the medical profession, through payment of medical benefits and regulation of practitioners, and broader issues of national public health. Therefore, those elements of the NRHS proposals that deal with these topics are for the Commonwealth to implement through DHFS programs. In addition, DHFS programs such as RHSET provide the opportunity for the Commonwealth to provide funding to support State initiatives for innovation in service delivery.

3.10 Many of the proposals require action by State and Territory governments, and some require joint action between the Commonwealth and States. Table 3 comments on the responsibilities of the respective governments for each NRHS proposal. The range of specific programs that DHFS conducts in respect of rural health was described in Chapter 2.

The role of the Department of Health and Family Services

3.11 As mentioned in Chapter 1, the Commonwealth's endorsement of the NRHS involves DHFS as the leading national health agency in developing a full understanding of, and supporting a range of health policies and programs that all Australian governments will implement.

3.12 The Strategy provides for performance information. It broadly acknowledges the importance of developing suitable health outcomes measures, and stresses that providing effective health services can be ensured only by linking health service intervention with improved health outcomes. The NRHS' outcomes focus suggests that all participating governments agree on the importance of measuring outcomes and adopting processes by which the effectiveness of health interventions, taken in accordance with NRHS directions, would be measured. In other respects, however, NRHS is silent on the possibility of national performance information on programs affecting rural health.

3.13 As individual programs are conducted by each of the governments involved, they operate quite independently and focus mainly on their individual program processes, including program resource requirements (costs and Budget impact), program outputs (services and functions provided to the community) and program outcomes (the effects on health among communities and groups at which the programs are directed).

3.14 These individual program processes, resources, outputs and outcomes provide a basis on which information can be developed on program performance. As described earlier, the extent to which such information is actually developed and reported in respect of these programs is a matter for each government responsible for the implementation and management of the programs.

3.15 At the national level, the level at which NRHS was agreed between governments, there is no specific provision for exchange between governments of program performance information and no requirement for developing and reporting performance information for the Strategy overall.

3.16 NRHS does not directly impose accountability or information requirements on participating governments. It leaves these features to the accountability and reporting arrangements that each has in place.

3.17 As noted in the previous Chapter, DHFS' activities in rural health are not extensively reported by that Department. Both resource costs and program outputs related to rural health are difficult to identify in published DHFS reports and Budget documentation.

3.18 From a broader perspective, DHFS is the participating health agency with broad national responsibilities, but it does not obtain details from the other participants of their expenditures on rural health programs. Consequently there is no information available on the level of total expenditure on rural health services throughout Australia. Recommendation No.4 in Chapter 2 has been designed to address this issue.

3.19 The situation with output measures is similar. There is no regular reporting between States/Territories and the Commonwealth on program results in terms of outputs achieved. There is no provision in NRHS for sharing information and reporting to other participating governments either the costs of the basic health services they provide to rural and remote populations, or the costs of specific programs that are implemented under NRHS. Consequently, there is no aggregate information available concerning practical aspects such as numbers of persons trained, numbers of health professionals placed and usage of services in rural and remote communities. Some reliable and regular reporting of information would be desirable to provide an overview of the national effort being made to meet what NRHS identifies as national goals.

3.20 As mentioned in Chapter 2 the NRHS is a framework for addressing the health needs of rural and remote Australians. It is not an agreed management process. With the support of the DHFS, the NRHS could evolve through the current revision process into a Strategy with agreed management processes. The ANAO noted that the NRHS is silent on whether there is to be reporting to governments, parliaments or other stakeholders on its effect on the management of programs and the extent to which progress is made towards NRHS' broad goals. It does, however, call for an annual review by AHMC of progress in rural health. The AHMC advisory council in 1995 approved a review of NRHS. This was completed and in June 1996 AHMC reviewed progress on NRHS and identified issues and priorities requiring particular attention.[8] The AHMC report canvassed stakeholder views and considered progress against each of the 13 original NRHS proposals. It also sought to identify benefits derived since 1994 and impediments to future progress.

3.21 The lack of agreed detailed information on the cost of rural and remote health activities is a weakness that does not assist decision making on appropriate levels of resources for rural health programs, either on a national basis or in each health jurisdiction. As the national health agency, DHFS does not take steps to obtain, collate or report on aggregate national

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[8] *National Rural Health Strategy Update*, Australian Health Ministers' Conference, July 1996, AGPS.

expenditure or program achievements dealing with health in rural and remote communities.

3.22 The ANAO found that the following aggregate information is not required to be reported under the NRHS:

- contributions to NRHS by participating governments and the levels of resources and expenditures on rural health programs;
- program outputs and achievements by governments; and
- the aggregate performance of NRHS in progressing the agreed proposals.

Recommendation No.5

3.23 In order to better implement the NRHS, the ANAO recommends that DHFS:

- review the extent to which its reporting practices provide information on the resource costs and outputs of its programs related to rural health;
- develop an information base on those factors so that it can more effectively report Commonwealth efforts towards the objectives of the National Rural Health Strategy; and
- seek, through the revision of the NRHS, to establish whether information on resources and outputs could be collated and incorporated into national statements of activity, investment and achievement.

DHFS response

3.24 Agreed. These activities will be undertaken by the Branch in the Health Services Development Division identified as the rural hub.

4. Progress since 1994 and an Approach to a New National Rural Health Strategy

This Chapter comments on the measurement of rural health program outcomes, and ways in which the DHFS can contribute to the review of the National Rural Health Strategy. It suggests how the DHFS could contribute to the revision of the NRHS.

Measuring NRHS health outcomes

4.1 The Strategy refers in detail to the need for effective outcomes measurement as a significant feature of NRHS. It is reasonable that the AHMC and governments would expect to see a structure in which parties could agree that progress had been made, the proposals against which progress had occurred, and the amount of progress made. Without regular measurements of this type, there is no basis on which an assessment can be made of the success of the Strategy in addressing agreed issues and priorities in rural health.

4.2 In the 1994 NRHS, governments agreed that two key strategic goals were:

- identification of the nature and extent of rural health needs; and
- evaluation of rural health care programs and measurement of health outcomes.

4.3 The importance of measurement is emphasised by the extensive reference made to it in the March 1994 Strategy. A specific NRHS proposal (Proposal 13) singles out measurement as a vital part of the Strategy. Under this proposal it was suggested that the AHMAC supports the development and adoption of national and local indicators for rural and remote Australia in order to:

- measure performance in the development and delivery of services;
- measure the health status of rural and remote populations;
- monitor health outcomes for rural and remote populations, including those for specifically targeted groups; and
- provide communities with information about their health status.

4.4 It further proposed that, pending the development of indicators, an interim set of outcome measures be adopted to monitor the progress of health service performance in rural and remote areas.

4.5 The AHMC Advisory Council agreed to support this approach. However there has been only limited success in developing a basis on which this proposal can be implemented in accordance with the Strategy's intentions. The proposal requires not only the Commonwealth but also State/Territory governments to report to AHMAC. If each government reported its performance information, the latter could be coordinated and collated by the AHMAC.

Identifying rural health needs

4.6 There appears to be general agreement among stakeholders that a differential exists between health outcomes for persons living in rural and remote areas of Australia and others living in metropolitan areas. As mentioned in Chapter 2 there also appears to be significant difficulty in establishing a measure of this differential, or a series of measures, that could be used as a baseline for measuring changes in rural health outcomes over time. A baseline measure would appear to be essential in defining the problem at which the Strategy was principally directed and the extent of the health disadvantages that rural and remote communities experience.

4.7 Despite the importance accorded by Proposal 13 to measuring health status, practical steps to develop appropriate measures have been late in starting and progress in this direction has been very slow.

4.8 The principal vehicle for developing measures for health status was a research project dealing with the development of performance measures for rural health, for which funding was provided by DHFS through its RHSET program. The project first took the form of a grant to the Victorian Department of Health and Community Services in 1995. After a period of little apparent progress, approval was given in April 1996 to transfer the grant to the South Australian Health Commission. The project involved a joint effort by the recipient organisation and the Australian Institute of Health and Welfare (AIHW) to develop benchmarks for health service delivery through a set of national and local performance indicators for rural and remote Australia.

4.9 By late 1997 some progress was made and two reports on the subject were drawn up by AIHW. A report in November 1996 provided details of a framework to be used for indicator development and data collection. In October 1997 AIHW prepared a further report, in draft, discussing a number of observed differentials in health. The report was based on comparison of statistical data on health status in metropolitan and other centres. The

information was based on statistics dealing with mortality, morbidity and health risk factors.

4.10 In discussions with ANAO, the Working Group with responsibilities for this aspect of NRHS advised that the information in the October 1997 draft report, while useful, did not go far enough. The Group sought a series of 'Sentinel Indicators', each reflecting an identified illness or health risk factor, that could provide a suite of benchmarks of health status differentials, and baselines for measuring changes in health status over time. It considered that the information available was not sufficiently comprehensive to support such indicators.

4.11 On review by the ANAO, however, it appeared that at least some of the Group's concern reflect perceived shortcomings in the reported data on health outcomes as a basis for cross comparisons. In other words, they consider that the indicators may not be suitable for comparisons between communities within rural and remote Australia. It should be borne in mind, however, that comparisons, while useful, are not the principal aim of the baseline health indicators under NRHS. The focus should be on appropriate indicators of health differences between rural and remote communities and the rest of Australia.

4.12 It is noted that in early 1998, nearly four years after the endorsement of NRHS, there is no agreement on a health status baseline measuring the differences in health outcomes at which the Strategy is directed. A key part of NRHS Proposal 13 has not yet, therefore, been implemented to date. The development of such a measurement is central to defining the problem that the Strategy was developed to solve.

An overseas comparison

4.13 ANAO research disclosed an overseas precedent that merits consideration in the determination of comparative national baselines for health. US Federal Government assistance to States for health purposes is partly based on comparative measures of population health. For this purpose, the US General Accounting Office (GAO) has reviewed two major multi-factor indices of public health available for this purpose. Its study of the process[9] disclosed that an available statistical measure of *premature death* among a defined population provided a sound proxy for more complex measures of health differentials. The measure accounted, more easily and efficiently, for most of the changes that took place in a wide

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[9] *Public Health - A Health Status Indicator for Targeting Federal Aid to States, Report to the Chairman*, Committee on Labor and Human Resources, US Senate, United States General Accounting Office Report GAO/HEHS-97-13, November 1996, Washington, DC.

range of variables. In GAO's view, the relatively simple measure available through State statistics on premature death was an efficient way to allocate funding between States with varied health needs.

4.14 The AIHW report of October 1997 (referred to above) included extensive statistics on mortality rates in metropolitan and rural populations on which a measure of premature deaths could be based. Such an approach could lead to early determination of the broad measure of health differential at which NRHS is expressly directed.

4.15 The measure may have imperfections, particularly for comparison between rural and regional localities. However, for the purpose of establishing the primary baseline of health status, it would provide for a quicker response than the present process under which no baseline has yet been determined - despite the importance placed on this step by the terms of the 1994 Strategy.

4.16 It is possible that such a measure could be adopted on a trial basis while the investigation of 'Sentinel Indicators' continues under the RHSET contract. The apparent failure to agree a measured baseline for health status has also affected the prospects of meeting the other objectives set out in Proposal 13, including monitoring health outcomes, developing and reporting outcomes to monitor health service performance, and the possible setting of targets for health status of rural and remote populations.

4.17 Similar comments apply to the development of continuing performance measures for improved health in rural and remote populations. AIHW's reports indicate that the measures eventually adopted for this purpose must be based on an appropriate regimen of statistical collections to establish appropriate time series useful for measuring progress. While this process continues, a trial based on changes in data on premature deaths (as mentioned above) could be a useful way of determining whether this factor represents a good proxy for more complex measurements, as reported in the United States.

4.18 ANAO acknowledges that there may be needs, on the part of some stakeholders, to obtain highly detailed regional differential data for comparisons between States or between regions for planning purposes and to allow comparisons to be made across all rural and remote communities. From the national point of view, however, and reflecting the focus of NRHS, there should be more attention paid to the development of broad national indicators that are useful in measuring in national terms the success of a national strategy.

Recommendation No.6

4.19 The ANAO recommends that DHFS:

- focus on the development of a basic definition of health status as a means of defining the problem that the National Rural Health Strategy aims to address;
- take steps to evaluate the progress achieved in the Rural Health Support Education and Training program contract for the study of rural health performance indicators;
- in conjunction with its State counterparts, develop a timetable for the completion of the remaining steps in its contract study; and
- consider whether the overseas approach involving the use of premature death statistics could provide a simpler way of measuring the health status of rural and remote communities in Australia.

DHFS response

4.20 Agreed.

1998 revision of NRHS

4.21 In endorsing its 1996 NRHS report, AHMC approved a comprehensive review of NRHS to follow a 1997 National Rural Health Conference. The intention of the Ministers is to develop a new NRHS that will similarly guide the provision of rural health services by all governments for the period 1998 to 2002. The current timetable calls for submission of a new NRHS in mid-1998 for the approval of health ministers.

4.22 The framework currently emerging for a new (1998) NRHS contemplates introducing some different approaches to coordinating relations between stakeholders (principally, the Commonwealth and other governments). Early indications are that the new strategy should include guidelines and directions for action, and state clearly the nature of action to be taken by the Commonwealth, States and Territories to implement the Strategy.

4.23 The new Strategy may also introduce accountability by all government health authorities for actions taken to implement the agreed priorities and achieve the agreed outcomes. The increased focus on accountability will be accompanied by wider reporting on the implementation of the new Strategy and its outcomes.

Accountability regime

4.24 It is important that Commonwealth Government agencies report on program inputs, outputs and their resultant outcomes in order to demonstrate that they have used funds for the purposes intended.

4.25 The ANAO/DoF Better Practice Guide on Performance Information Principles[10] defines performance information as evidence about performance that is collected and used systematically as a manifestation of the accountability of government agencies to Ministers, the Parliament, the general public and to other key stakeholders. Performance information is the currency of accountability. The development and reporting of performance information is needed to provide Commonwealth and State/Territory Governments and stakeholders with the means of identifying the direction a program is heading and whether resources are being used in the most cost effective manner.

4.26 In order to better implement the Government's rural health priorities, the Department could negotiate during the revision process such that the NRHS be developed to:

- define program objectives which will allow better planning, setting of targets, allocation of resources and establishment of milestones for Departments;
- better inform the Parliaments about rural health issues;
- better inform the general public and stakeholders on the performance of government's contributions to health care for rural and remote Australians; and
- facilitate the provision of reports which support the operation of programs and public accountability.

DHFS leadership

4.27 The DHFS could provide leadership to this process by, firstly, defining its own role more clearly in the National Rural Health Strategy's implementation; secondly, by improving its rural health program reporting and by encouraging States/Territories to do the same; and, thirdly by helping to develop a national periodic report on government rural health activity.

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[10] *Performance Information Principles, Better Practice Guide*, November 1996, Australian National Audit Office and the Department of Finance, ANAO 1997.

4.28 Ownership of the Strategy clearly rests with the Commonwealth and State/Territory Governments, by virtue of its endorsement by Health Ministers in 1994. DHFS has the opportunity to contribute to the revision of the NRHS and to make suggestions that could enhance the responsibilities of each party, particularly that of the Commonwealth. The DHFS should promote the establishment of clear lines of responsibilities in the impending revision to the Strategy, otherwise there is a danger that governments will duplicate efforts unnecessarily, apply resources inefficiently, and not identify all areas of health needs.

National reporting

4.29 The DHFS sees itself as becoming the leader in promoting, developing and funding world class health and family services for all Australians. The ANAO sees the DHFS as having a role in encouraging State/Territory Governments to participate in wider reporting of the numerous aspects of their activities and expenditures on rural health. Developing a national report will need to be a consultative process between Commonwealth and State Governments. During the audit, the ANAO discussed rural health issues with a number of State government officials, and found that each had objectives and goals for contributing to the NRHS. They are not necessarily the same in each State/Territory and are different again for the Commonwealth. Despite having different goals and objectives, the Commonwealth and the States/Territories could report information that would permit comparisons between and across governments. For example, collecting and reporting information on the following aspects would provide a certain degree of accountability for each reporting entity and for the overall rural health strategy:

- resources, costs, Budget impacts, expenditure. This would demonstrate State/Commonwealth commitment to the strategy and the level of the investment of resources nationally in trying to address rural health problems; aggregated expenditure or Budget tables could assist in compiling these details;
- as mentioned throughout this report, there is a need to report outputs; and
- Governments could agree on a framework of outputs associated with the major elements of NRHS, for example, medical training, practice, allied health professionals and services provided.

Reporting health differentials

4.30 The 1994 NRHS observed that there is evidence that indicates significant health differentials between rural and urban populations in areas such as:

- mental illness;
- youth suicide;
- injuries;
- road trauma; and
- alcohol and substance abuse.

4.31 The evidence suggests that the health problems listed above are apparently most acute in rural areas. The Strategy was developed to not only reduce the effects of these problems, but to reduce amongst other things the inequities experienced by many rural residents in respect of access to and provision of health care services. To determine where the significant health status differentials exist, it will be necessary to gather and report information on a regular basis. Given the long-term nature of the health outcomes sought, any changes that might occur may not be detected by program managers for some time. However, unless the data is compiled it will not be possible to determine if the approaches being used by governments are working. While it is essential to develop a process whereby data can be collated to measure performance, it is important that a system be developed that does not divert resources from service provision because it is cumbersome and complex.

Public Health Agreements

4.32 Recently the DHFS and some State and Territory health departments signed a memo of understanding to establish a National Public Health Partnership (NPHP) for Australia. The proposal for a NPHP was endorsed by Health Ministers on 4 July 1996. It was noted as a significant step in the reform of Commonwealth and State/Territory relations in health finance. The preamble to the MOU says that it establishes for the first time a multilateral inter-governmental framework between the Commonwealth and State/Territory Health Authorities to protect and improve the health of Australians.

4.33 The ANAO noted that rural health was not specifically mentioned in the NPHP MOU. The latter's goal to improve the health status of Australians, in particular population groups most at risk, could be interpreted as being directed at Australians living in rural and remote communities as much as at Australians living in urban areas. A number of national public health priority areas will form the basis for the joint

development by Commonwealth and State/Territory health departments of a Work Program. It is interesting to note that there are similarities between the priorities in the work program and proposals in the NRHS. For example, the priority to develop public health information systems to enable more effective national monitoring of the health of the Australian population correlates closely to Proposal 13 in the Strategy. That proposal suggests endorsement of national and local indicators for rural and remote Australians in order to measure performance in the development and delivery of services, and to monitor health outcomes for rural and remote populations. The opportunity exists now, at a time when the NRHS is being revised and in the early stages of the NPHP, to form a partnership between the NRHS and the NPHP that will serve the dual purpose of raising the profile of the needs of rural and remote communities and addressing the health needs of all Australians. This would mean enhancing the complementarity of the National Rural Health Strategy and the National Public Health Partnerships.

Conclusion

4.34 The ANAO has identified a number of areas where the Department can better implement its responsibilities under the 1994 NRHS. Its involvement in the revision process can ensure that any new Strategy becomes more than a framework for action, but rather becomes a document that will define the roles of governments agencies, including the DHFS.

Canberra ACT
28 May 1998

P.J. Barrett
Auditor-General

Part Three

Appendices

Appendix A

Proposals made under the National Rural Health Strategy

National Rural Health Strategy

Proposal 1

State and Territory Health Authorities should facilitate the development of strategic frameworks or regional plans for each of their rural regions incorporating National and State wide policies and guidelines with informed community participation.

Proposal 2

Health Authorities, in conjunction with the community and non-government agencies, should further pursue the development of frameworks, such as model health plans, as examples of how services might best be delivered to rural communities. Initial attention should focus on developing models that identify the level and mix of health services appropriate for different sizes and types of rural communities.

Among the factors such models will reflect are health status, the social and economic composition of the resident population, the nature of population change, geographic location and the distance of the community from major service centres.

Model health plans should be sufficiently flexible to cover the broad range of needs which characterise rural communities, and should maximise community participation and involvement in the planning process. A priority should be given to meeting the needs of people in remote areas.

Funding for this activity should be sought under the RHSET program with the Commonwealth establishing a steering group, including representatives of State Health Authorities, to commission and oversight the progress of activities.

Proposal 3

The flexible approaches to funding and management arrangements between the Commonwealth and States for aged care and health services in rural communities should be accelerated and expanded. This is the subject of the current Australian Health Ministers' Advisory Council working party initiatives in relation to multipurpose services and nursing home type patients.

Proposal 4

A Commonwealth Office of Rural Health should be established in the Department of Human Services and Health to promote the integration and coordination of the funding and provision of rural health-related services.

Proposal 5

As well as supporting action in the priority areas proposed in this strategy, Health Authorities should continue initiatives aimed at improving the recruitment and retention of the rural health workforce.

Proposal 6

The Commonwealth, through the Minister for Health and the Minister for Employment, Education and Training should introduce:

(a) arrangements which provide for tertiary institutions, on advice of AHMAC, to base decisions about health science course intake numbers and curricula that reflect workforce and workplace requirements;

(b) the adoption by tertiary education institutions conducting health science courses targets of:

  (i) a minimum of intakes of students from rural backgrounds in undergraduate courses no less than the proportion that rural communities represent of each State's population; and

  (ii) an increase in the number of undergraduate clinical placements being in rural locations;

(c) arrangements to undertake a comprehensive evaluation of undergraduate selection and rural clinical practice initiatives in order to assess their impact and effectiveness on the recruitment and retention of rural health care providers;

(d) curricula for health care provider courses of core units incorporating a primary health care approach to practice and cross-cultural training with an emphasis on Aborigines and Torres Strait Islanders where appropriate; and

(e) additional courses providing preparation for rural practice and options for reducing the costs to people undertaking those courses.

Proposal 7

In conjunction with ongoing programs designed to recruit and retain health care providers in rural areas, all Health Authorities should identify and implement specific initiatives directed towards:

(a) developing ways in which specialist medical support for rural GPs can be improved;

(b) increasing the availability of both resident and visiting specialist medical services in rural areas;

(c) increasing the availability of allied health personnel and managers in rural areas; and

(d) encouraging specialist medical colleges to take positive steps to improve:

  (i) the supply of suitably trained medical specialists in rural areas;

  (ii) training for generalists particularly in surgery; and

  (iii) training in mental health for general Practitioners.

Proposal 8

In relation to health care providers practising in rural Australia:

(a) action should be taken to formalise and legitimise existing roles of rural nurses and Aboriginal and Torres Strait Islander health workers and to provide more resources to accelerate Aboriginal and Torres Strait Islander health worker education programs;

(b) pilot projects should be undertaken to evaluate alternative models for the practice roles of nurses and Aboriginal and Torres Strait Islander health workers in rural regions undersupplied with medical services; and

(c) An education and training strategy for remote area health care providers should be developed. This strategy should take account of:

  (i) training needs according to the circumstances of practice;

  (ii) the special needs of remote area nurses;

  (iii) the development of core curricula;

  (iv) arrangements for providing the training; and

  (v) arrangements to enable health care providers to undertake the training.

This activity should be undertaken by AHMAC.

Proposal 9

Action should be taken by all Health Authorities to develop and implement innovative best practice models in order to maximise the opportunities for multi skilling of health workers and the expansion of multi disciplinary activities.

Proposal 10

During 1994-95, mainstream programs should seek to better meet the special needs of target groups in rural areas, and of these special priority should be given to improving:

- the coordination and streamlining of funding and management of health services for Aboriginal and Torres Strait Islanders; and
- rural mental health services.

Proposal 11

For isolated communities, there needs to be:

(a) a re-examination of the Medicare funding arrangements to better meet the unique health needs of those communities;

(b) the development of funding mechanisms to facilitate a greater emphasis on primary health care;

(c) an increase in the availability of training in public health, with Health Authorities facilitating increased participation by health care providers;

(d) an investigation of the use of mobile or outreach services and flexible service delivery and management methods where population density is too low to support fixed services; and

(e) increased training in and commitment to the primary health care approach, initially targeting community leaders and people with health service management roles.

Proposal 12

During 1994-95, special emphasis should be given by Health Authorities to implementing primary health care approaches for meeting rural health needs and to public health programs targeted towards the early detection an prevention of health problems consistent with agreed National Health Goals and Targets. Given the national recognition now being accorded to health promotion and prevention of ill health as a priority concern in rural areas, there should be a review of the Medicare funding arrangements in order to identify ways in which the arrangements, including Medical Benefits and incentive payments, could more appropriately support public health activities.

Proposal 13

It is suggested that AHMAC supports the development and adoption of national and local indicators for rural and remote Australia in order to:

- measure performance in the development and delivery of services;
- measure the health status of rural and remote populations;

- monitor health outcomes for rural and remote populations, including those for specifically targeted groups; and
- provide communities with information about their health status,

by requesting the State/Commonwealth steering group outlined in proposal 2 to report to AHMAC on:

- the current status of indicator use and development;
- priority areas for funding of special projects to advance the development of indicators for specific rural issues; and
- targets for health status of rural and remote populations.

It is further proposed that, pending the development of indicators, an interim set of outcome measures be adopted to monitor the progress of health service performance in rural and remote areas which relate to the priorities outlined above, namely:

- Regional health plans or frameworks are available to provide directions for the delivery of rural health services;
- Applications for funding to pilot model health plans within priority categories have been submitted to RHSET;
- The number of multipurpose trial sites has been expanded and alternative funding models implemented;
- There is an increase in the number of rural health service personnel accessing rural health training programs; and
- There is an increase in the supply of targeted health care providers and a reduction in the turnover rate of health care providers employed in rural areas.

Appendix B

Performance audits in the Health and Family Services Portfolio

Set out below are the titles of the reports of the main performance audits by the ANAO in the Health and Family Services Portfolio tabled in the Paliament in recent years.

Audit Report No.19 1994-95
Efficiency Audit
Validation of Nursing Home Funding
Department of Human Services and Health

Audit Report No.5 1995-96
Provision of Hearing Services
Australian Hearing Services

Audit Report No.18 1995-96
CETP
Department of Health and Family Services

Audit Report No.24 1995-96
Impact of Sunset Clause on Investigatory Powers
Health Insurance Commission

Report No. 8 1996-97
Drug Evaluation by the Therapeutic Goods Administration
Department of Health and Family Services

Report No.31 1996-97
Medifraud and Inappropriate Practice
Health Insurance Commission

Report No. 12 1997-98
Pharmaceutical Benefits Scheme
Department of Health and Family Services

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Series Titles

Titles published in the financial year 1997-98

Audit Report No.1
Audit Activity Report: Jan-Jun 1997
Summary of Audit Outcomes

Audit Report No.2 Performance Audit
Government Business Enterprise Monitoring Practices
Selected Agencies

Audit Report No.3 Performance Audit
Program Evaluation in the Australian Public Service

Audit Report No.4 Performance Audit
Service Delivery in Radio and Telecommunications
Australian Telecommunications Authority and Spectrum Management Agency

Audit Report No.5 Performance Audit
Performance Management of Defence Inventory
Defence Quality Assurance (preliminary study)

Audit Report No.6 Performance Audit
Risk Management in Commercial Compliance
Australian Customs Service

Audit Report No.7 Performance Audit
Immigration Compliance Function
Department of Immigration and Multicultural Affairs

Audit Report No.8 Performance Audit
The Management of Occupational Stress in Commonwealth Employment

Audit Report No.9 Performance Audit
Management of Telecommunications Services in Selected Agencies

Audit Report No.10 Performance Audit
Aspects of Corporate Governance
The Australian Tourist Commission

Audit Report No.11 Performance Audit
AUSTUDY
Department of Employment, Education, Training and Youth Affairs

Audit Report No. 12 Performance Audit
The Pharmaceutical Benefits Scheme
Department of Health and Family Services

Audit Report No.13 Performance Audit
Third Tranche Sale of the Commonwealth Bank of Australia

Audit Report No.14 Financial Control and Administration Audit
Official Travel by Public Sector Employees

Audit Report No.15 Financial Control and Administration Audit
Internet Security Management

Audit Report No.16 Performance Audit
Equity in Employment in the Australian Public Service
PSMPC and other agencies

Audit Report No.17 Performance Audit
Sydney Airport Noise Amelioration Program
Department of Transport and Regional Development

Audit Report No.18 Performance Audit
Management of the Implementation of the New Commonwealth Services Delivery Arrangements
Centrelink

Audit Report No.19 Performance Audit
Risk Management in ATO Small Business Income
Australian Taxation Office

Audit Report No.20 Performance Audit
Sales Tax
Australian Taxation Office

Audit Report No.21 Financial Control and Administration Audit
Protective Security

Audit Report No.22 Financial Control and Administration Audit
Audits of the Financial Statements of Commonwealth Entities for 1996-97
Summary of Results and Outcomes

Audit Report No.23 Performance Audit
Ministerial Travel Claims

Audit Report No.24 Performance Audit
Matters Relevant to a Contract with South Pacific Cruise Lines Ltd
Department of Employment, Education, Training and Youth Affairs

Audit Report No.25 Performance Audit
Gun Buy-Back Scheme
Attorney-General's Department

Audit Report No.26 Performance Audit
Strategic and Operational Management
National Registration Authority for Agricultural and Veterinary Chemicals

Audit Report No.27 Performance Audit
Managing the Year 2000 Problem
Risk Assessment and Management in Commonwealth Agencies

Audit Report No.28 Performance Audit
Contracting Arrangements for Agencies Air Travel

Audit Report No.29 Financial Control and Administration Audit
Management of Accounts Receivable

Audit Report No.30 Performance Audit
Evaluation Processes for the Selection of
– Records Management Systems
– Internet Access Services
for the Commonwealth
Office of Government Information Technology

Audit Report No.31 Financial Statement Audit
Aggregate Financial Statement prepared by the Minister for Finance and Administration
Year ended 30 June 1997

Audit Report No.32 Performance Audit
The Management of Boat People
Department of Immigration and Multicultural Affairs
Australian Protective Service
Australian Customs Service Coastwatch

Audit Report No.33 Performance Audit
Commonwealth Management of the Great Barrier Reef
Great Barrier Reef Marine Park Authority

Audit Report No.34 Performance Audit
New Submarine Project
Department of Defence

Audit Report No.35 Performance Audit
DEETYA International Services
Department of Employment, Education, Training and Youth Affairs

Audit Report No.36 Performance Audit
Audit Activity Report
July to December 1997
Summary of Outcomes

Audit Report No.37 Performance Audit
Protection of Confidential Client Data from Unauthorised Disclosure
Department of Social Security
Centrelink

Audit Report No.38 Performance Audit
Sale of Brisbane Melbourne and Perth Airports

Audit Report No.39 Performance Audit
Management of Selected Functions of the Child Support Agency
Australian Taxation Office

Audit Report No.40 Performance Audit
Purchase of Hospital Services from State Governments
Department of Veterans' Affairs

Audit Report No.41 Financial Control and Administration Audit
Asset Management

Audit Report No.42 Preliminary inquiry
Preliminary Inquiries into the Natural Heritage Trust

Audit Report No.43 Performance Audit
Life-cycle Costing in the Department of Defence
Department of Defence

Audit Report No.44 Performance Audit
The Australian Diplomatic Communications Network - Project Management
Department of Foreign Affairs