The Auditor-General
Audit Report No.15 2002–03
Performance Audit

The Aboriginal and Torres Strait Islander Health Program Follow-up Audit

Department of Health and Ageing

Australian National Audit Office

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Australian National
Audit Office

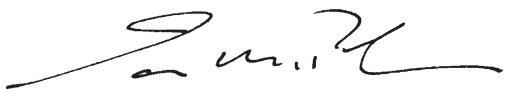
Canberra ACT
29 October 2002

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997.* I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *The Aboriginal and Torres Strait Islander Health Program Follow-up Audit.*

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

Yours sincerely



Ian McPhee
Acting Auditor-General

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

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Contents

Abbreviations/Glossary

AACAP	Army–ATSIC Community Assistance Program
ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Service
ACCT	Aboriginal and Torres Strait Islander Coordinated Care Trials
AHMAC	Australian Health Ministers' Advisory Council
AHMC	Australian Health Ministers' Conference
AHS	Aboriginal Health Service
AHWWG	Aboriginal Health Workforce Working Group
AIDA	Australian Indigenous Doctors' Association
AIHW	Australian Institute of Health and Welfare
ANAO	Australian National Audit Office
ATSIC	Aboriginal and Torres Strait Islander Commission
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
DAA	Department of Aboriginal Affairs
DHAC	Department of Health and Aged Care
DASR	Drug and Alcohol Services Report
FAS	First Assistant Secretary
HAHU	Heads of Aboriginal Health Units
Health	Department of Health and Ageing: formerly the Department of Health and Aged Care; and the Department of Human Services and Health
IFI	Integrated Funding Initiative
MBS	Medicare Benefits Scheme
MoU	Memorandum of Understanding
NACCHO	National Aboriginal Community Controlled Health Organisation
NAGATSIHID	National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data
NAHS	National Aboriginal Health Strategy
NHIC	National Housing and Infrastructure Centre

NHIMG	National Health Information Management Group
NIHIP	National Indigenous Health Infrastructure Plan
NPI	National Performance Indicators
NSW	New South Wales
OATSIH	Office for Aboriginal and Torres Strait Islander Health: formerly OATSIHS
OATSIHS	Office for Aboriginal and Torres Strait Islander Health Services
PBS	Pharmaceutical Benefits Scheme
PHC	Primary Health Care
PHCAP	Primary Health Care Access Program
Program	The Aboriginal and Torres Strait Islander Health Program
SAR	Service Activity Reporting
SCATSIH	Standing Committee on Aboriginal and Torres Strait Islander Health
SMS	Substance Misuse Service
TSRA	Torres Strait Regional Authority
WHO	World Health Organisation

Summary and Recommendations

Summary

Overview

1. In 1998, the Australian National Audit Office (ANAO) completed an audit of the Commonwealth Department of Health and Aged Care's (Health's) administration of the Aboriginal and Torres Strait Islander Health Program. The audit report[1] made 12 recommendations for improvement. This follow-up audit examined Health's implementation of the recommendations and found that progress has been made, with eight recommendations fully implemented, one partially implemented and three not implemented but in the process of implementation.

Background

2. The Commonwealth Government transferred responsibility for Aboriginal and Torres Strait Islander health from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the, then, Department of Human Services and Health[2] in 1995. The primary purpose of the transfer was to ensure that primary health care for Indigenous Australians had a priority position within the mainstream health system, against the background of continuing high rates of Aboriginal and Torres Strait Islander morbidity and mortality.

3. At the time of the transfer, Australian Bureau of Statistics' (ABS) research indicated that Aboriginal and Torres Strait Islander people had a life expectancy at birth 15–20 years less than other Australians. Their life expectancy was lower than that for residents of most countries of the world with few exceptions. Further, Indigenous people were 2–3 times more likely to be hospitalised. In the previous 10 years, there had been little improvement in the mortality of Indigenous Australians.

4. The ANAO concluded a performance audit of Health's administration of the Aboriginal and Torres Strait Islander Health Program (the Program) in 1998. The objective of the audit (1998 audit) was to form an opinion on the administrative effectiveness, efficiency and accountability of Health's delivery of health services to the Aboriginal and Torres Strait Islander population.

5. The 1998 audit found that Health had taken a national role in the Program; was in the process of bedding down in the Office for Aboriginal and Torres

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1 Australian National Audit Office Audit Report No.13, 1998–99, *The Aboriginal and Torres Strait Islander Health Program*, Canberra.

2 Now the Department of Health and Ageing (Health).

Strait Islander Health Services (OATSIHS) its program administration; and met the Government's and the Parliament's external accountability requirements. However, the ANAO found that management processes could be enhanced and made 12 recommendations for improvement.

Audit approach

6. This audit focused on Health's implementation of the recommendations of the 1998 audit. The objective was to assess the extent to which Health has implemented the recommendations from the 1998 audit, taking account of any changed circumstances or new administrative issues identified as impacting on the implementation of the recommendations.

Conclusion

7. Health has made progress against the 12 recommendations of Audit Report No.13 1998–99, with eight recommendations implemented, one partially implemented and three not implemented but in the process of implementation.

8. The ANAO made no further recommendations.

Key findings

9. Table 1 summarises the progress that has been made to implement the recommendations from the 1998 audit report. Further detail can be found at Appendix 1.

Table 1

Progress against the implementation of recommendations from the 1998 audit

Rec.	*Subject of recommendation*	*Progress*
1.	Identification and adoption, where justified, of international better practice in terms of program objectives, delivery mechanisms and efficient resource usage in Indigenous health programs.	Implemented
2.	Measurement of achievements against the Program objective.	Implemented
3.	Establishment of a suitable timeframe for needs-based funding.	Not Implemented
4.	Identification of: a means to gain a total funding picture of Aboriginal Health Services (AHSs); and the most effective methods of funding AHSs and Substance Misuse Services (SMSs).	Implemented
5.	Late financial returns followed-up and the acquittal process reviewed across State offices.	Implemented
6.	Collection and analysis of information from funded organisations to enable effective reporting.	Implemented
7.	Identification of skill profiles, assessment of the level of skills available and identification of an appropriate strategy to address skill gaps within AHSs.	Implemented
8.	More effective coordination of environmental and primary health programs through the sharing of data between Health and ATSIC.	Not Implemented
9.	State Forum focus on health status outcomes, establishment of a timeframe for needs-based funding, examination of the feasibility of offering incentives to complete regional planning and identification of health needs where regional planning is delayed.	Implemented
10.	Work with stakeholders to identify models of better practice in primary health programs that could be applied to relevant programs.	Implemented
11.	Compliance with reporting obligations under the Framework Agreements.	Not Implemented
12.	Coordination between the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and mainstream programs in order to deliver effective and efficient funding to AHSs, including the streamlining of accountabilities.	Partially Implemented

Audit Findings and Conclusions

1. Introduction

This chapter provides an overview of the health of Indigenous Australians, including population, health status, Commonwealth responsibility, the Commonwealth Department of Health and Ageing's (Health's) approach, funding for Indigenous health programs and relevant events since the 1998 audit. In addition, it introduces the audit approach, objective, methodology and report structure.

An overview of Indigenous health in Australia

Aboriginal and Torres Strait Islander population

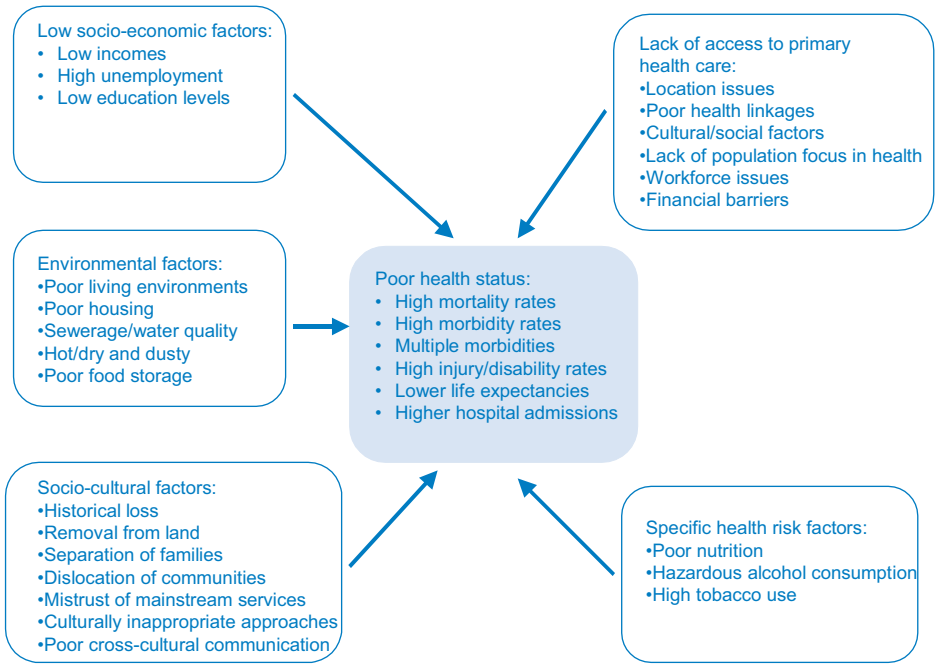
1.1 The Indigenous population is increasing in size and representation within the total Australian population. The Indigenous population is currently estimated at 460 140 based on 2001 Census figures, which represents 2.4 per cent of the total estimated resident population of Australia[3]. At the time of the 1998 audit, the estimated Indigenous population was 386 000, based on 1996 Census figures, which represented 2.1 per cent of the total Australian population.

Indigenous health

1.2 The factors impacting the health status of Aboriginal and Torres Strait Islander people are illustrated under Figure 1.1.

[3] The number of people who identified as being of Indigenous origin increased by 16.2 per cent to 410 003 people in 2001, up from 352 970 people in 1996. To arrive at an estimate of the size of the Aboriginal and Torres Strait Islander population using the Census count (on a usual residence basis), allowance is made for net undercount, and for instances in which Indigenous status is unknown. This is the basis for ABS' estimate of 460 140.

Figure 1.1
Factors affecting Aboriginal and Torres Strait Islander health[4]



1.3 Aboriginal and Torres Strait Islander people continue to suffer a greater burden of ill health than other Australians. Health has reported that:

> Global health statistics released by the World Health Organisation (WHO) in June 2000 show that the Australian population in general is one of the healthiest of any developed country and has ready access to a world-class health care system. Other sources indicate that the Indigenous Australian population is the least healthy of all Indigenous populations within comparable developed countries, and that Aboriginal and Torres Strait Islander Australians do not have the same level of access to appropriate health care as the rest of the population.[5]

1.4 In *Australia's Health 2002*[6], the Australian Institute of Health and Welfare (AIHW) found that, in certain age groups, the age-specific death rates for Aboriginal and Torres Strait Islander peoples were up to 5–6 times higher than the all-Australian rates for the period 1997–99. In addition, the AIHW found that:

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[4] Commonwealth Department of Health and Aged Care, 2000, *Annual Report 1999–2000*, Canberra, p. 266.

[5] Commonwealth Department of Health and Aged Care, 2001, *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*, DHAC, Canberra, p. 10, viewed 14 October 2002, <www.health.gov.au/oatsih/pubs/pdf/bhcs.pdf>.

[6] Australian Institute of Health and Welfare, 2002, *Australia's Health 2002*, AIHW, Canberra.

- for the period 1998–99, Indigenous people in every age group were more likely than other people to be hospitalised for most diseases and conditions, indicating a higher occurrence of illness at more acute levels; and
- for the period 1996–98, babies of Indigenous mothers were twice as likely to die at birth and during the early postnatal phase than babies born to other Australian mothers.

1.5 The lack of improvement in mortality rates for Australia's Indigenous community is in contrast to improvements in Indigenous communities within comparable countries. The 1998 audit report noted that the all causes mortality rate for Australia's Indigenous population was twice as high as the New Zealand Maori rate, 2.3 times the United States Indigenous rate and 3.1 times the total Australian rate. The Maori death rate declined by 44 per cent between 1974 and 1994, and the United States Indigenous rate by 30 per cent in the same period. In contrast, there was no significant reduction in the death rate for Australia's Indigenous population between 1985 and 1995[7].

Commonwealth responsibility for Indigenous health

1.6 Commonwealth responsibility for the Aboriginal and Torres Strait Islander Health Program (the Program) was transferred from the Department of Health to the Department of Aboriginal Affairs (DAA) in 1984. The Program was subsequently transferred to the Aboriginal and Torres Strait Islander Commission (ATSIC), following its establishment in 1990.

1.7 In 1995, responsibility for the Program was returned to the, then, Department of Human Services and Health[8]. The transfer was initially for a five-year period from 1995 to 2000, with a review at the end of this period. The transfer to the Health portfolio was designed to facilitate improved resourcing of, access to, and appropriateness of health services and programs for Indigenous people. At the time of the transfer, there were 175 funded primary health care and substance use organisations. Health now funds 205 organisations to provide primary health care services[9] and substance use services[10] to the Indigenous community.

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7 AMA, Public Health Association of Australia Inc, 1997, *Submission to the House of Representatives Standing Committee on Family and Community Affairs Inquiry into Indigenous Health*, Canberra, quoted in Australian National Audit Office Audit Report No. 13, 1998–99, *The Aboriginal and Torres Strait Islander Health Program*, Canberra, p. 39.

8 Now the Department of Health and Ageing (Health).

9 In Australia, the primary health care sector is generally the first point of contact with the health system. It provides most basic clinical services, including identification and treatment of illness, management of chronic disease, and it has a significant role in action to improve health status.

10 Substance use services help people who are misusing various substances (including alcohol, drugs and petrol). Services provided can include: residential treatment and rehabilitation facilities; non–residential counselling and therapy; community–based education; diversion and mobile assistance; and after–care and supported accommodation.

The Department of Health and Ageing

1.8 Health's mission is to 'lead the development of Australia's health and aged care programs to achieve a world class health and ageing system for all Australians'[11]. In order to fulfil this role, the department has 3800 staff spread across Central office and eight State and Territory offices. Health is responsible for the second largest budget of all Commonwealth Government departments, with an appropriation for 2002–03 of $30.8 billion. Of this, $30.0 billion were funds administered by Health[12].

1.9 The services provided by the Health and Ageing Portfolio are delivered through nine outcomes[13]. Aboriginal and Torres Strait Islander health is the focus of Portfolio Outcome 7. The estimated resourcing for Outcome 7 for 2002–03 is $253.6 million. This comprises $231.2 million for Indigenous health services and $22.4 million for Health's administration of the Program.

1.10 Health estimates that there will be about 190 staff administering the Program in 2002–03. This represents a significant increase from 117 staff in 1998–99, reflecting additional budget funding for this Program (see below).

Health's approach

1.11 The ANAO found in the 1998 audit that Health had built its administrative capacity for the delivery of the Program from a small base. Health has continued to build its capacity to deliver the Program through an approach which aims to:

- improve access by Indigenous peoples to mainstream health programs;
- improve the responsiveness of the mainstream health programs to the needs of Indigenous people; and
- provide Indigenous specific health programs, with a focus on primary health care.

1.12 While the Office for Aboriginal and Torres Strait Islander Health (OATSIH) is the focal point for Health's Indigenous health program, all areas of Health are responsible for identifying and incorporating Indigenous health components into relevant mainstream programs.

1.13 Health's work since the 1998 audit has focused on the establishment of the foundations on which a long-term program will be built. This work has been guided by a systematic, planned approach aimed at realising long-term goals in Aboriginal and Torres Strait Islander health. The approach focuses on: national leadership and coordination; regional plans; service system

[11] Portfolio Budget Statements 2002–2003, Health and Ageing Portfolio, Budget Related Paper No.1.11, Commonwealth of Australia, Canberra, p. 7.

[12] Portfolio Budget Statements (PBS), 2002–2003, p. 19–20.

[13] The nine Portfolio Outcomes are provided at Appendix 2.

improvement; capacity building; action in mainstream programs; workforce development; data collection; and implementation of integrated primary health care programs.

1.14 Interim outputs identified by Health as having resulted from initiatives implemented under the approach include:

- formalisation of cooperative arrangements between parties through agreements on Aboriginal and Torres Strait Islander Health (Framework Agreements)[14];
- establishment of the National Performance Indicators for Aboriginal and Torres Strait Islander Health (NPIs);
- regional planning in all States and Territories to identify needs, gaps and priorities on a region-wide coordinated basis;
- an increase in the number of primary health care services;
- an increase in the provision of health services through Aboriginal Community Controlled Health Services[15] (ACCHSs), with more than 1 000 000 patient episodes of care provided in 1998–99;
- improved access to primary health care through the Aboriginal and Torres Strait Islander Coordinated Care Trials (ACCTs)[16] and the Remote Communities Initiative (RCI)[17];
- targeted services to improve eye health, hearing health, sexual health, immunisation, substance use, and social and emotional wellbeing;
- refined enrolment and claiming processes for the Medicare Benefits Scheme (MBS);
- increased numbers of doctors providing services to Indigenous Australians through Section 19(2)[18] arrangements under the *Health Insurance Act 1973*; and

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[14] Agreements were negotiated between the Commonwealth Government, State/Territory governments, the Aboriginal and Torres Strait Islander Commission (ATSIC)—or the Torres Strait Regional Authority (TSRA) in the Torres Strait Agreement—and the National Aboriginal Community Controlled Health Organisation (NACCHO) State or Territory affiliate body. These agreements were signed in each State and Territory and the Torres Strait between 1996 and 1999 and committed signatories to four key areas: increasing the level of resources allocated to reflect the level of need; joint planning; improving access to mainstream and Aboriginal and Torres Strait Islander specific health and health related services; and improving data collection and evaluation.

[15] An ACCHS is a community controlled health service with a governing board elected by members of the local Indigenous community. The term ACCHSs can be used to refer to either Aboriginal Health Services (AHSs) or Substance Misuse Services (SMSs).

[16] An overview of the ACCTs can be found at paragraph 2.5 of this report.

[17] An overview of the RCI can be found at paragraph 2.27 of this report.

[18] Section 19(2) arrangements allow Aboriginal Health Services to claim Medicare as well as receiving other Commonwealth and State/Territory Government assistance.

- improved access to pharmaceuticals in remote Indigenous communities through Section 100[19] arrangements under the *National Health Act 1953*.

1.15 Health is developing and implementing initiatives to improve the effectiveness and comprehensiveness of the primary health care system for Indigenous Australians. In the 1999–2000 Budget, the Federal Government announced the Primary Health Care Access Program (PHCAP) as a new measure to address the poor health status of Aboriginal and Torres Strait Islander people by enabling better access to comprehensive primary health care[20] services. The aim of PHCAP is to establish a framework for the expansion and regional coordination of comprehensive primary health care services. This will be done through an increase in resources and through reforms to the local health system (such as better use of mainstream services). Under PHCAP, the Commonwealth Government is providing $78.8 million over four years, to be implemented in regions where joint regional planning is complete and capacity exists to use the funds effectively. These funds will be allocated on a needs basis in line with regional plans. In the 2001–02 Budget, the Government announced that it would provide an additional $19.7 million each year from 2003–04, taking the total recurrent base for PHCAP to $54.8 million per annum.

1.16 Case studies illustrating improved health outcomes resulting from the adoption of comprehensive primary health care approaches are featured in Health's publication, *Better Health Care: Studies in Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*[21]. Programs with encouraging health outcomes include:

- Antenatal Care Program, Nganampa Health Council, South Australia—
  - — perinatal mortality rates decreased from 45.2/1000 to 8.6/1000, compared with a national average rate for non-Indigenous babies of 6.7/1000;
  - — low birth weight decreased from 14.2 to 8.1 per cent, compared with a national average for non-Indigenous babies of 6.2 per cent; and
  - — mean birth weight increased from 3080 to 3183 grams, compared with a national mean of 3365 grams for non-Indigenous babies.

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[19] Section 100 arrangements allow access to supplies of pharmaceuticals at no cost to the patient.

[20] Health identified from international experience that a comprehensive approach to primary health care can contribute to improvements in health status in developing countries and among Indigenous populations in developed countries comparable to Australia. Comprehensive primary health care for Aboriginal and Torres Strait Islander people largely involves the provision of services that do not currently exist or are inadequately resourced. It also requires changes to the mix and level of services, changes to the nature of service delivery, and action across mainstream and Indigenous specific services, with significant coordination between providers at the local level.

[21] Commonwealth Department of Health and Aged Care, 2001, *Better Health Care: Studies in the Successful Delivery of Primary Health Care Services for Aboriginal and Torres Strait Islander Australians*, DHAC, Canberra.

- Renal Disease Program, Tiwi Islands, Northern Territory—
  - preliminary estimates suggest that progression to end-stage renal failure has been reduced by over 50 per cent, and that there has been a reduction in deaths from all causes.
- Improving Diabetes Care in the Primary Health Care Setting, Torres Strait, Queensland—
  - after one year, hospital admission rates among diabetics had fallen by 18 per cent; and
  - the greatest improvements in both quality of care and reduction in hospitalisations occurred in the centres that had locally managed recall systems, where the proportion of diabetics hospitalised for diabetes-related conditions fell by 41 per cent, mainly due to a reduction in diabetes-related infections.

1.17 Current mortality rates and chronic disease levels are an outcome of sub-standard health care inputs and other factors over many years. Given this context, Health has advised that it will take a considerable time before the impact of efforts to improve the health status of Aboriginal and Torres Strait Islander people show as improvements in national statistics. In reality, chronic disease levels may initially appear to increase due to a greater number of people being diagnosed as a result of improved access to health care and screening programs. However, it is anticipated that improvements in interim indicators—such as infant mortality and birth weights—will result in reduced levels of chronic disease in later life and eventually improved mortality rates.

1.18 In summary, Health is in the process of building the foundations for a comprehensive primary health care system. Indigenous health is now an area of focus across the Health portfolio, and forms an intrinsic part of policy development and program delivery. Health's long-term strategic approach to remedy the poor health status of Indigenous Australians acknowledges the requirement for concerted and sustained effort. Trials of comprehensive primary health care approaches are, however, beginning to show that improved health outcomes from targeted health interventions are possible.

Funding for Indigenous health programs

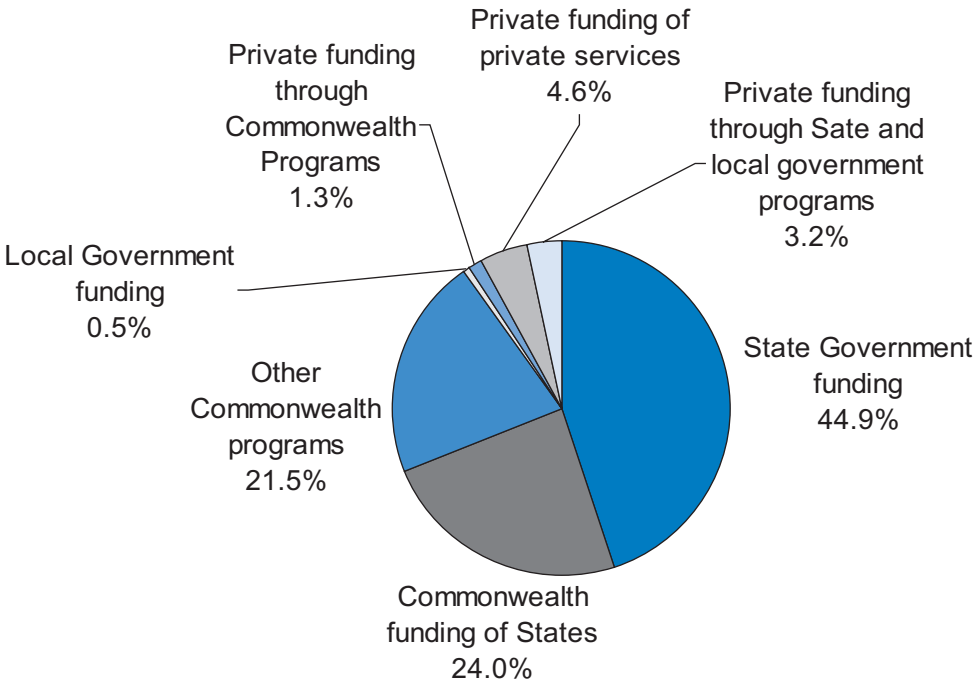
1.19 In 1998–99 (the most recent AIHW report on *Expenditure on Health Services for Aboriginal and Torres Strait Islander People*[22]), an estimated $1245 million was spent on health services by, and for, Aboriginal and Torres Strait Islander peoples.

[22] Australian Institute of Health and Welfare, 2001, *Expenditure on Health Services for Aboriginal and Torres Strait Islander People 1998–99*, AIHW Cat. No. IHW 7, Australian Institute of Health and Welfare and Commonwealth Department of Health and Aged Care, Canberra.

Figure 1.2 provides a breakdown of expenditure on health services by, and for, Aboriginal and Torres Strait Islander people by funding provider.

Figure 1.2

Funding of recurrent health expenditure for Aboriginal and Torres Strait Islander people, 1998–99[23]



Note: 'Private funding' includes funding from out-of-pocket payments by patients, health insurance funding and other funding sources such as workers' compensation.

1.20 The amount represented 2.6 per cent of the then total health expenditure by Commonwealth, State and local governments as well as expenditure from private sources such as private health insurance and out-of-pocket expenses. An average of $3065 was spent on each Indigenous person, compared with $2518 for each other Australian. Overall, for each dollar spent on health services for other Australians, $1.22 was spent on Aboriginal and Torres Strait Islander people[24].

1.21 The AIHW found that 'Despite their much poorer health status—on average three times worse than other Australians'—total expenditures per person for health services for Aboriginal and Torres Strait Islander people are not much higher than for the rest of the population.'

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[23] ibid., p. 7.

[24] Australian Institute of Health and Welfare, 2002, *Australia's Health 2002*, AIHW, Canberra.

1.22 The Commonwealth's funding of services through the Aboriginal and Torres Strait Islander Health Program increased from $155.3 million in 1998–99 to an estimated $231.2 million in 2002–03. Of the $231.2 million estimated for 2002–03:

- $212.5 million (including PHCAP funding of $33.5 million increasing to $54.8 million in 2003–04) will be provided to organisations providing or brokering comprehensive primary health care services, specialist services and substance use services; and
- $18.7 million is for infrastructure to support the development and operation of high quality health care services, including workforce development, specific health strategies, data, evaluation and research, and support for advocacy and representation.

Events since the 1998 audit

1.23 Relevant events since the 1998 audit include:

- PHCAP was announced in the 1999–2000 Commonwealth Budget;
- the National Aboriginal and Torres Strait Islander Health Council was restructured;
- the National Aboriginal and Torres Strait Islander Health Council released for discussion the draft National Strategic Framework for Aboriginal and Torres Strait Islander Health; and
- the Australian Health Ministers' Advisory Council (AHMAC) agreed to establish the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH), which superseded the Heads of Aboriginal Health Units (HAHU)[25].

The 1998 audit

1.24 The ANAO had originally planned a performance audit of the Indigenous health program as part of the ANAO's strategic coverage of ATSIC programs. Indigenous health was also an important area of public policy, which had not previously been audited by the ANAO.

1.25 The transfer of responsibility for Indigenous health from ATSIC to Health delayed the commencement of the audit. However, the ANAO advised Health that an audit would be conducted shortly after the transfer to ensure that Health was implementing the 1995–96 Federal Budget initiatives that accompanied the

[25] Additional information on Indigenous health policy timelines can be obtained from the Indigenous Health*infonet* at the internet address: <www.healthinfonet.ecu.edu.au>.

transfer of responsibility. In addition, at that time, the ANAO indicated that it would seek to establish whether Health had developed a strategy to meet the objectives of the transfer, and whether it had integrated Indigenous health into mainstream programs.

1.26 The objective of the 1998 audit was to form an opinion on the administrative effectiveness, efficiency and accountability of Health's delivery of health services to the Aboriginal and Torres Strait Islander population. The ANAO made 12 recommendations for improvement. Health accepted all of the recommendations—with one agreed with qualification. The audit report was tabled in Parliament in November 1998.

1.27 Overall, the ANAO found that:

> …DHAC had taken a national role in the Aboriginal and Torres Strait Islander health program; was in the process of bedding down in OATSIHS its program administration; and met the Government's and the Parliament's external accountability requirements. However, management processes could be enhanced by greater attention to allocation of program resources on the basis of need; improved data collections; clearer identification of Indigenous Australians as a special needs group in Health's mainstream programs; clearer specification of the health outputs and outcomes of performance standards Health expects from its programs; information systems which measure the level of its achievement of raising the health status of Aboriginal and Torres Strait Islander people; greater cooperation with ATSIC in environmental health; and provision of more information to stakeholders about Health's role and focus.[26]

Follow-up audit objective and focus

1.28 A follow-up audit of the Program was identified as a priority for 2002 through the ANAO's audit strategic planning process. Indigenous health remains an important area of public policy, and sufficient time has passed to allow the ANAO to assess Health's implementation of the recommendations from the 1998 audit.

1.29 This current audit focused on Health's implementation of the recommendations of Audit Report No.13, 1998–99, *The Aboriginal and Torres Strait Islander Health Program*. The objective was to assess the extent to which Health has implemented the recommendations of the 1998 audit, taking account of any changed circumstances or new administrative issues identified as impacting the implementation of these recommendations.

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[26] Australian National Audit Office Audit Report No.13, 1998–99, *The Aboriginal and Torres Strait Islander Health Program*, Canberra, p. 13.

1.30 The primary focus of this audit was on the Office for Aboriginal and Torres Strait Islander Health (OATSIH). However, the ANAO also examined other areas of Health to determine whether the recommendations from the 1998 audit were implemented. There were also discussions with ATSIC on the coordination between Health and ATSIC.

1.31 Stakeholders raised a number of issues with the ANAO during the course of fieldwork. Some of these issues were outside the scope of this audit. As a result, these issues are not addressed in this report. Specific issues excluded are: issues over the implementation and appropriateness of PHCAP; the role and functions of the State/Territory Health Forums; and the effectiveness of the Framework Agreements.

Audit methodology

1.32 The ANAO established audit criteria to guide the audit in determining whether Health has implemented the recommendations. The ANAO wrote to Health at the commencement of the audit to request information on the implementation of the recommendations of the 1998 audit. Following receipt of Health's response, the ANAO:

- interviewed key personnel in Health's Central Office and two State/Territory offices;
- interviewed key stakeholders;
- interviewed service providers funded under the Program;
- reviewed Health documents in Canberra and State/Territory offices; and
- considered the findings of ANAO audits and other reviews since the 1998 audit.

Other relevant audits

1.33 Relevant ANAO audit reports taken into account in planning this audit include:

- Performance Audit Report No.13, 1998–99, *The Aboriginal and Torres Strait Islander Health Program*, Department of Health and Aged Care;
- Performance Audit Report No.2, 2002–03, *Grants Management*, Aboriginal and Torres Strait Islander Commission;
- Performance Audit Report No.36, 2000–01, *Municipal Services for Indigenous Communities*, Aboriginal and Torres Strait Islander Commission; and

- Performance Audit Report No.39, 1998–99, *National Aboriginal Health Strategy: delivery of housing and infrastructure to Aboriginal and Torres Strait Islander communities*, Aboriginal and Torres Strait Islander Commission.

Other reviews

1.34 Major strategic reviews considered during the audit include:

- *Report on Indigenous Funding 2001*, Commonwealth Grants Commission, 2001; and
- *Health is Life*, House of Representatives Standing Committee on Family and Community Affairs, 2000.

1.35 A list of specific issue reviews can be found at Appendix 3. Fieldwork was conducted from March-June 2002.

1.36 The follow-up audit was conducted in accordance with ANAO Auditing Standards at a cost of $152 300.

Report structure

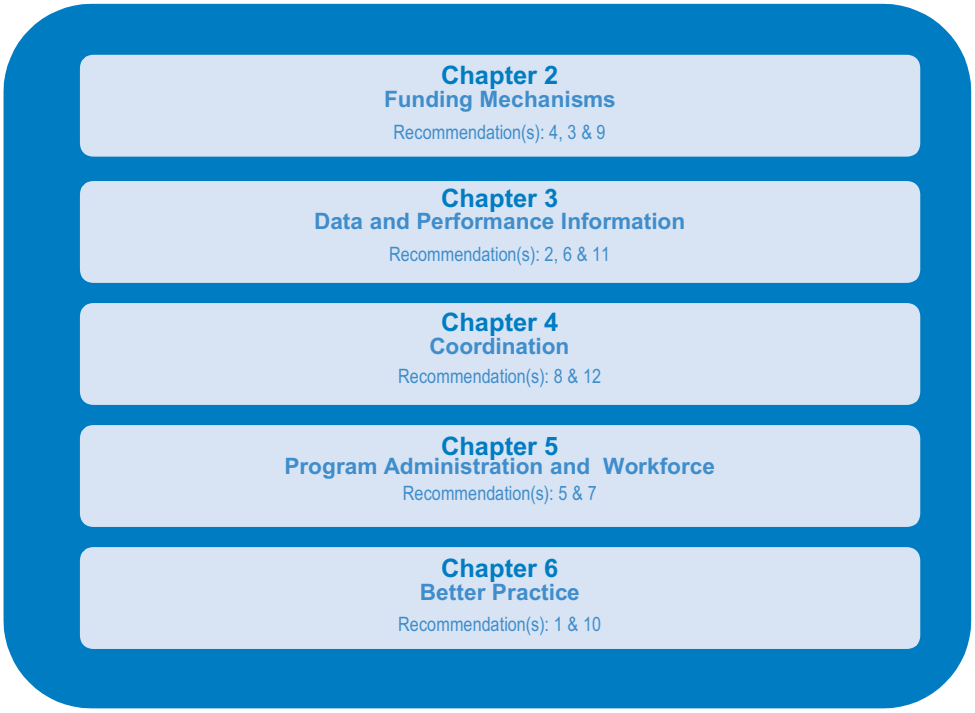
1.37 The report is organised into six chapters. The report structure is illustrated in Figure 1.3.

1.38 In Chapters 2, 3, 4, 5 and 6, recommendations from the 1998 audit are grouped under the following headings:

- Funding Mechanisms;
- Data and Performance Information;
- Coordination;
- Program Administration and Workforce; and
- Better Practice.

1.39 The findings against the implementation of recommendations in Chapter 2—Funding Mechanisms—have been re-ordered to improve the flow of the findings.

Figure 1.3
Report structure



2. Funding Mechanisms

This chapter discusses Health's implementation of recommendations from the 1998 audit report on funding mechanisms. The ANAO concluded that Recommendations 4 and 9 have been implemented. Recommendation 3 has not been implemented.

Effective funding methods (Recommendation 4)

Recommendation 4 of Audit Report No.13, 1998–99

2.1 The ANAO recommends that, as part of the health needs-based planning process, DHAC identify, in conjunction with stakeholders:

- a means by which a total funding picture of Aboriginal Health Services (AHSs) can be obtained and revised on a regular basis for the information of decision-makers; and
- the most effective methods of funding Aboriginal Health and Substance Misuse Services.

Findings of this audit

Total Funding Picture

2.2 The 1998 audit report found that, in order for needs-based planning to be effective, there was a need for more information exchange between the States/Territories and the Commonwealth on funding provided to Aboriginal Health Services (AHSs), including a total funding picture of AHSs. Health has developed PHCAP with the primary purpose of directing new funding to areas of need identified in regional plans. Secondary functions of PHCAP will include improving information exchange between the Commonwealth and States/Territories and obtaining and revising a total funding picture of AHSs. Health intends to achieve these secondary functions through:

- the disclosure of funding sources by AHSs during local area planning; and
- agreements to share funding data between the Commonwealth and State/Territory governments.

2.3 The South Australian and Northern Territory governments have signed an MoU with the Commonwealth for the implementation of PHCAP. The remaining States and Territory are yet to sign an MoU with the Commonwealth. The ANAO noted that the MoU for South Australia and the MoU for the Northern Territory establish the requirement for sharing, and ongoing revision of funding data.

2.4 In the interim, Health is obtaining funding information from sources such as: regional plans[27]; Service Activity Reporting (SAR) surveys[28]; and national expenditure reports[29]. While these information sources do not, in isolation, provide Health with a total funding picture of services, they do contribute to Health's overall knowledge of funding levels.

Improved Funding Mechanisms

2.5 Health conducted Coordinated Care Trials to test a new approach to health care financing and delivery aimed at providing better health services to people with chronic and complex care needs. There were both mainstream and Indigenous trials. The Indigenous trials were structured to accommodate the particular service contexts and needs of Indigenous communities. Four Aboriginal and Torres Strait Islander Coordinated Care Trials (ACCTs)[30] were conducted in five locations. The PHCAP funding model has been developed from the model tested under the ACCTs.

2.6 Further, Health is currently testing approaches designed to streamline the accountability arrangements of funded services. An example is the Integrated Funding Initiative (IFI) between Health and an Indigenous organisation. The organisation provides primary health care and substance use services to Aboriginal and Torres Strait Islander people. The Initiative was approved at the commencement of the 1999–2000 financial year, and involves:

- the development of a single funding agreement covering each project funded by Health;
- a single payment to be made each period for all Health projects; and
- a single financial acquittal.

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[27] The Aboriginal and Torres Strait Islander Framework Agreements commit all parties to joint regional planning. The purpose of regional planning is to provide a rational and justifiable (transparent) process for identifying the overall and relative primary health care needs of Indigenous communities including improved access to existing primary health care services and new services as required. Essentially, the task required dividing each State/Territory into regions, mapping existing primary health care services (mainstream and Indigenous specific) and identifying gaps in service delivery and prioritising regions according to relative need.

[28] The SAR survey collects service level data on health care and health related activities from Commonwealth funded Aboriginal primary health care services.

[29] The expenditure reports examine expenditures on the provision of health services to Aboriginal and Torres Strait Islander people by Australian governments and the private sector in particular financial years. The current report is for the 1998–99 financial year.

[30] The ACCTs incorporated a number of key elements, including: matching of services to need, funds pooling across multiple agencies and capacity building at an organisational, community and individual level. More information can be found in: KPMG Consulting, 2000, *The Aboriginal and Torres Strait Islander Coordinated Care Trials National Evaluation Report (National Evaluation Summary, Volume 1 and Volume 2)*, Commonwealth Department of Health and Aged Care, Canberra.

2.7 Health considers that a single, combined funding agreement might lead to greater flexibility and a reduction in administrative costs for funded services.

Summary

2.8 Health has identified PHCAP as a key means to improve information exchange between the Commonwealth and States/Territories and by which a total funding picture of AHSs will be obtained and revised. Health has also conducted trials to identify the most effective funding methods. PHCAP, which incorporates the lessons from these trials, is the mechanism being introduced by Health as an effective method of providing needs-based funding to AHSs and SMSs.

Conclusion

2.9 Health has adequately implemented this recommendation.

Timeframe for needs-based funding (Recommendation 3)

Recommendation 3 of Audit Report No.13, 1998–99

2.10 The ANAO recommends that DHAC establish a suitable timeframe for the implementation of funding AHSs and Substance Misuse Services on the basis of the health needs of the Aboriginal and Torres Strait Islander communities to whom they deliver services.

Findings of this audit

2.11 Health informed the ANAO that the implementation of funding on the basis of need is a long-term, complex activity. The complexity of this issue was acknowledged in the Commonwealth Grants Commission's *Report on Indigenous Funding 2001*[31], where it was concluded 'that there are complex issues surrounding the link between changes in the needs of Indigenous people and the level and type of services designed to achieve those changes.'

2.12 Aboriginal and Torres Strait Islander peoples' health needs were identified, by region, through the regional planning process. The Federal Government subsequently approved limited additional funding to meet health needs identified under the regional plans. PHCAP was developed by Health as the mechanism to direct new funds—over and above existing core operating funding provided to services—to priority sites. Stakeholders, through the State/Territory

[31] Commonwealth Grants Commission, 2001, *Report on Indigenous Funding 2001*, Canberra, p. 101.

Health Forums[32], recommend priority sites to receive PHCAP funding. Local area selection is made on the basis of need and capacity to utilise funds effectively, using the regional plans as a basis for decision-making.

2.13 The completion of the regional plans led to an expectation amongst stakeholders that sufficient funds would be provided to meet identified needs. However, Health can only commit to a timeframe for needs-based funding within existing funds approved for PHCAP.

2.14 Health has been actively working to put in place MoUs—required for the provision of PHCAP funds—with all States and Territories. As mentioned earlier, South Australia and the Northern Territory have signed an MoU with the Commonwealth. Negotiations with Queensland and Western Australia are well advanced. Until MoUs are in place, Health advised it is not in a position to commit to a timeframe for the introduction of PHCAP into each State and Territory. Further, in order to ensure that the timeframe is 'suitable' each timetable will need to be discussed with, and endorsed by, each State/Territory Health Forum.

2.15 While acknowledging the difficulties faced by Health and the Forum partners in establishing a timeframe for needs-based funding across all States and Territories, the ANAO noted that Health has not established a formal, detailed plan—including timeframes for the implementation of PHCAP—in those States and Territories where a signed MoU exists and approved funding is available. Nor has the department established a timeframe for agreement on the guiding principles for PHCAP with those States and Territories that are yet to agree. Health has, however, developed—for internal planning and budgeting purposes—a high level, long-term timeframe to guide the department's implementation of PHCAP. In addition, Health and Forum partners have developed supplementary timeframes for discrete components of PHCAP.

2.16 In an attempt to address stakeholder concern in the absence of an endorsed, detailed timeframe for the implementation of PHCAP in each State and Territory, Health informed the ANAO that there has been recent activity to provide greater clarity on the implementation of PHCAP. Health has provided progress reports to the State/Territory Health Forums, the Aboriginal and Torres Strait Islander Health Council, SCATSIH and State and Territory government agencies. Health is also drafting PHCAP Implementation Guidelines. The aim of the Guidelines

[32] Planning forums (health forums) in each State and Territory (and the Torres Strait) were established under the Framework Agreements. Their role has been to identify the key issues in relation to regional planning, contribute to policy development and planning and to evaluate the implementation of the Framework Agreements. They include representation from the Commonwealth Government, State/Territory governments, the Aboriginal and Torres Strait Islander Commission (ATSIC)—or the Torres Strait Regional Authority (TSRA) in the Torres Strait Agreement—and the National Aboriginal Community Controlled Health Organisation (NACCHO) State or Territory affiliate body.

is to provide stakeholders with additional information on the principles and methodology underpinning PHCAP.

Conclusion

2.17 As an endorsed, detailed timeframe for the implementation in each State and Territory of funding on the basis of health needs has not been established, Health has not implemented this recommendation.

2.18 Health has, however, established a process for funding AHSs and Substance Misuse Services on the basis of health needs of the Aboriginal and Torres Strait Islander communities to whom they deliver services. Health is working with the States and Territories to implement this process and has developed a high-level timeframe to guide the department's implementation of PHCAP.

2.19 A precursor to the establishment of a detailed timeframe for each State and Territory is a signed MoU. Two States have signed MoUs and negotiations are well advanced with two more. Further, Health has provided stakeholders with information on the implementation of funding of health needs under PHCAP via progress reports to stakeholder forums. In addition, Health is developing PHCAP Implementation Guidelines to further inform stakeholders.

2.20 The ANAO will consider this recommendation fully implemented when a detailed plan for the implementation of PHCAP outlining timeframes and responsibilities of each partner, endorsed by the State/Territory Health Forums, is established for all States and Territories.

Funding against identified health needs (Recommendation 9)

Recommendation 9 of Audit Report No.13, 1998–99

2.21 The ANAO recommends that DHAC:

- emphasise in State Forums the importance of a focus on health status outcomes as a key component of regional planning;
- take action, through its State Forum representatives, to establish a timeframe for the implementation of needs-based funding;
- examine the feasibility of providing suitable incentives to stakeholders to complete regional planning; and

- where the progress of regional planning is likely to unduly delay the health needs of the Aboriginal and Torres Strait Islanders being identified, address other suitable options and take action to identify those health needs as a matter of priority.

Findings of this audit

Emphasis on health status outcomes

2.22 The State/Territory Health Forums established under the Framework Agreements were responsible for developing regional plans. Each Forum was encouraged to develop an approach to regional planning that reflected local factors such as geographical and demographical features, past experience of planning in the jurisdiction and the availability of data. Regional plans were developed utilising a number of different approaches to measure need including: population to staff ratios; availability of health services; morbidity data; adequacy and appropriateness of housing and infrastructure; and local knowledge.

2.23 Regional planning is now complete in every State and Territory, except for Tasmania, where planning is nearing completion. The ANAO reviewed regional plans for New South Wales, South Australia and Western Australia. Health status information was included in each of the plans. The ANAO concluded from the review that State/Territory Health Forums were aware of the need for regional plans to include a focus on health status outcomes.

Timeframe for needs-based funding

2.24 This issue is addressed earlier under the ANAO's conclusion against Recommendation 3. The ANAO concluded that Health has not established a suitable timeframe for needs-based funding of Aboriginal Health Services and Substance Misuse Services. As a result, Health has not implemented this part of Recommendation 9.

Incentives for regional planning

2.25 As regional plans are complete for all States and Territories except Tasmania, incentives are no longer a national concern. In Tasmania the regional planning process is nearing completion. Therefore, this aspect of Recommendation 9 has been addressed by Health.

Interim options to meet health needs

2.26 Health developed and implemented initiatives to identify and target available funding against the health needs of Aboriginal and Torres Strait Islanders prior to the completion of regional planning. In addition, a number of these initiatives are continuing while PHCAP is being implemented.

2.27 The Remote Communities Initiative (RCI) was implemented to improve access to primary health care services in remote Aboriginal and Torres Strait Islander communities that had little or no access to such services. In 2000–01, seven projects were funded to expand primary health care services as a result of this initiative. Forty communities have benefited from the initiative to date.

2.28 The SAR Enhancement Funding Process allocates additional funding to services on the basis of need, as identified through analysis of SAR and other data from services. Over the last two years, approximately one third of Commonwealth funded services have been allocated additional recurrent funding through this process. As a result, an additional $3.1 million has been allocated to the base level of funding for services on a recurrent basis ($1.5 million in 2000–01 and $1.6 million in 2001–02). Health plans to allocate an additional $1.5 million recurrent funding to existing Commonwealth funded Aboriginal primary health care services, commencing in the 2002–03 financial year. This funding will be allocated on the basis of need, ensuring that services with the highest relative needs have priority in the funding process.

2.29 In the 1998–99 Budget a recurrent funding base for capital works of $2 million was established. This enabled infrastructure reviews of all services to be carried out and a National Indigenous Health Infrastructure Plan (NIHIP) to be developed, including a priority list for capital works. These funds enabled services to access funds before regional planning was completed. In the last three years, capital works projects worth $29 million have been approved to meet the needs identified by services.

Conclusion

2.30 Health has implemented three out of the four elements of this recommendation. The ANAO addressed the fourth element under the conclusion for Recommendation 3. Therefore, for the purposes of this report, the ANAO considers that Health has adequately implemented this recommendation.

3. Data and Performance Information

This chapter provides a background to data and performance issues. It also discusses the implementation of recommendations from the 1998 audit report relating to data and performance information. The ANAO concluded that Recommendations 2 and 6 have been implemented, with progress made against Recommendation 11.

Background

3.1 The ANAO noted in the 1998 audit report that 'Without an improvement in the quality of Indigenous health data it will be difficult for DHAC to measure achievement against…indicators for the Aboriginal and Torres Strait Islander Health Program.' Poor quality Indigenous health data remains a problem.

3.2 The National Health Information Management Group noted in the *National Summary of 1999 Jurisdictional Reports against the Aboriginal and Torres Strait Islander Health Performance Indicators*[33] that:

> While some improvements in the ability to report against indicators are evident in this year's report, the gaps and deficiencies in the first report remain:
>
> - data quality problems affecting most jurisdictions (although to varying degrees);
> - definitional problems associated with many of the performance indicators; and
> - lack of available data or methods for collecting data for several of the indicators.
>
> In particular, the identification of Aboriginal and Torres Strait Islander people in routine data collections is still the single most significant quality issue detracting from meaningful reporting against the indicators. All jurisdictions must continue their efforts to improve data quality and their ability to report comprehensively against the indicators.

3.3 In response to the poor quality and limited availability of Indigenous health data, the Australian Health Ministers' Advisory Council (AHMAC) established the National Advisory Group on Aboriginal and Torres Strait Islander Health Information and Data (NAGATSIHID) in October 2000. The role of the Group is to provide broad strategic advice to AHMAC and the National Health Information Management Group (NHIMG) on the improvement of the quality and availability of data and information on Aboriginal and Torres Strait Islander

[33] National Health Information Management Group (NHIMG), 2001, *National Summary of the 1999 Jurisdictional Reports against the Aboriginal and Torres Strait Islander Health Performance Indicators*, AIHW Cat. No. IHW 8, Australian Institute of Health and Welfare, Canberra, p. iii.

health and health service delivery. NGATSIHID also oversees the implementation of the Aboriginal and Torres Strait Islander Health Information Plan, endorsed by AHMAC in 1997.

3.4 The Aboriginal and Torres Strait Islander Health Information Plan sets the long-term strategy to improve the quality and availability of data and information on Aboriginal and Torres Strait Islander health and health service delivery. Health informed the ANAO that OATSIH has a key role to play in implementing the Plan, including:

- contribution to national leadership through participation on NAGATSIHID;
- direct responsibility for ensuring improvement in departmental administrative data collections; and
- development and refinement of a performance monitoring framework for Commonwealth funded services.

3.5 In addition to its role in NAGATSIHID, Health also provides funding for the Aboriginal and Torres Strait Islander Health and Welfare Unit, which is within the Australian Bureau of Statistics (ABS) National Centre for Aboriginal and Torres Strait Islander Statistics (based in Darwin). This unit collates a range of data to produce a report every two years on Indigenous health. The unit also works in collaboration with States and Territories to improve the accuracy of data relating to Indigenous health.

3.6 In relation to departmental data collections, Health advised the ANAO that an OATSIH Indigenous Health Information Workplan is currently being developed and will be implemented in 2002–03. The aim of the Workplan is to consolidate Health's current efforts and guide future efforts to improve the availability and quality of data on Indigenous health and health service delivery.

Performance measurement (Recommendation 2)

Recommendation 2 of Audit Report No.13, 1998–99

3.7 The ANAO recommends that DHAC measure the achievement of its Aboriginal and Torres Strait Islander Health Program objective of raising health status by ensuring access to effective high quality health care and population health programs.

Findings of this audit

Departmental Reporting

3.8 Aboriginal and Torres Strait Islander health is a portfolio outcome (currently Outcome 7) for Health. When the 1998 audit was conducted, the outcome objective was 'To raise the health status of Aboriginal and Torres Strait Islander peoples by ensuring access to effective high quality health care and population health programs.' The current outcome objective is 'Improved health status for Aboriginal and Torres Strait Islander peoples.'

3.9 In the Portfolio Budget Statements 2002–03 for the Health and Ageing portfolio, Health identified four performance indicators to assess overall performance against the outcome objective[34]. In addition, Health has established performance targets for administered items and departmental outputs. Health includes details of its achievements and under-achievements in annual reports, including commentary and progress against performance indicators.

National Performance Indicators for Aboriginal and Torres Strait Islander Health

3.10 Health reports to the Australian Health Ministers' Advisory Council (AHMAC) against the National Performance Indicators for Aboriginal and Torres Strait Islander Health[35]. Reports from the Commonwealth, States and Territories are published in a national summary. National summaries have been published for 1998 and 1999.

Reporting Under the Framework Agreements

3.11 Health reports to the Australian Health Ministers' Conference (AHMC) against progress to implement commitments under the Framework Agreements. Health has produced two reports under the Framework Agreements. The first report was for the period 1996–99, with the second report covering the period

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[34] The performance indicators are:

Indicator 1: Life expectancy at birth by sex (National Performance Indicator 1.1);

Indicator 2: Per capita funding for primary health care for Aboriginal and Torres Strait Islander peoples across all government health programs;

Indicator 3: Number of health professionals (doctors, nurses and health workers) in Commonwealth funded Aboriginal health services; and the number of indigenous students who have graduated from tertiary degree training in medicine and nursing;

Indicator 4: Data on the performance of government programs to improve the health status of Aboriginal and Torres Strait Islander peoples.

[35] There are 56 indicators under the National Performance Indicators for Aboriginal and Torres Strait Islander Health. A list of the indicators can be found at Appendix Five of the following document: National Aboriginal and Torres Strait Islander Health Council, 2001, *National Aboriginal and Torres Strait Islander Health Strategy, Consultation Draft*, NATSIHC, Canberra.

1999–2000. Further information on reporting under the Framework Agreements is included in the findings against the implementation of Recommendation 11.

Conclusion

3.12 The ANAO recognises that the monitoring of performance is an ongoing activity. However, Health needs to continue its efforts to measure changes in Indigenous health status and to improve data quality and availability.

3.13 The ANAO considers that actions taken by Health adequately respond to the issues identified in the 1998 audit report. While data difficulties continue to limit full reporting, Health is working to implement a long-term strategy to improve the quality and availability of Indigenous health data. Therefore, for the purposes of this report, the ANAO considers that Health has adequately implemented this recommendation.

Performance data collection (Recommendation 6)

Recommendation 6 of Audit Report No.13, 1998–99

3.14 The ANAO recommends that DHAC collect and analyse information from funded organisations, which would enable it to report effectively against relevant national and departmental performance indicators.

Findings of this audit

3.15 Health implemented service activity reporting for AHSs in 1997–98 and for Substance Misuse Services in 1999–2000. The SAR/DSAR surveys collect service activity data from funded organisations. Collected data is subsequently analysed by Health in order to produce a summary of key findings. The key findings are published in a Key Results booklet[36]. Individual service reports, which contrast individual services with State, Territory and national averages, are also provided to services. The ANAO found that the information collected under the SAR/DSAR surveys corresponds with established national and departmental performance indicators.

3.16 Stakeholders and Health staff advised the ANAO that delays currently exist for the receipt, processing and analysis of SAR/DSAR data. In addition, the ANAO found that data collected through the SAR survey was not audited by Health to verify its accuracy. Health did, however, indicate that a process to

[36] Office for Aboriginal and Torres Strait Islander Health and National Aboriginal Community Controlled Health Organisation, 2001, *Service Activity Reporting: 1998–1999 Key Results*, Commonwealth Department of Health and Aged Care, Canberra.

verify the accuracy of SAR data was being considered by the SAR Steering Committee.

3.17 The ANAO found that funded organisations were generally supportive of the survey.

Conclusion

3.18 Health has implemented this recommendation. However, the ANAO suggests that Health should identify opportunities to expedite publication of analysed data. In addition, Health should continue efforts, through the SAR Steering Committee, to identify a suitable mechanism to verify the accuracy and reliability of SAR data.

Performance reporting (Recommendation 11)

Recommendation 11 of Audit Report No.13, 1998–99

3.19 The ANAO recommends that, as part of its national role, DHAC meet its reporting obligations under the Framework Agreements and work with State/Territory health agencies to assist them to fulfil their reporting obligations.

Findings of this audit

3.20 Commonwealth, State and Territory agencies agreed to report to AHMC on a six-monthly basis on the progress of implementing commitments under the Framework Agreements. Health informed the ANAO that annual reporting was adopted to coincide with the annual AHMC. Commonwealth, State and Territory agencies subsequently agreed to report on an annual basis under the re-signed Framework Agreements.

3.21 The Commonwealth, States and Territories are responsible for preparing a report for their jurisdictions, with Health coordinating the contributions from each jurisdiction through OATSIH State/Territory Directors. A joint report, comprising jurisdictional reports from the Commonwealth, State and Territory agencies (and NACCHO), was provided to AHMC in August 1999 for the period 1996–99.

3.22 The Commonwealth's progress report for the period 1999–2000 was submitted to AHMC in June 2002. Health indicated that this report was delayed while waiting for contributions from other jurisdictions. The ANAO was informed that five other jurisdictions have also reported separately to AHMC for the period

1999–2000, with three jurisdictions yet to report. Health is planning to produce a consolidated report once the remaining jurisdictions finalise their reports.

Conclusion

3.23 As the Commonwealth, States and Territories have not reported to AHMC in accordance with established timeframes, the obligation relating to the frequency of reporting under the Framework Agreements has not been met. As a result, the recommendation has not yet been fully implemented. Health has, however, made progress toward the implementation of this recommendation through coordination of the reporting process with States and Territories and submitted reports for 1996–99 and 1999–2000.

3.24 The Framework Agreement partners should consider reviewing the frequency of reporting under the Framework Agreements to determine the most time and cost effective reporting timeframe. If required, the Framework Agreements should then be amended.

3.25 The ANAO considers that Health will have sufficiently implemented this recommendation once Health and other jurisdictions are complying with the reporting obligations established under the Framework Agreements.

4. Coordination

This chapter discusses the implementation of recommendations from the 1998 audit report relating to coordination. The ANAO concluded that Health and ATSIC have not implemented Recommendation 8. Health has made significant progress in implementing Recommendation 12.

Primary health and environmental health programs (Recommendation 8)

Recommendation 8 of Audit Report No.13, 1998–99

4.1 The ANAO recommends that DHAC and ATSIC more effectively coordinate their primary and environmental health programs by sharing data on the level, nature and geographical location of their expenditures.

Findings of this audit

4.2 The 1998 audit found that Health's programs to improve access to health and medical services could be better integrated with ATSIC's programs to provide adequate housing, water and sewerage systems in Indigenous communities. The potential impact of poor environmental health on improved health outcomes from comprehensive primary health care was raised by the Commonwealth Grants Commission in its report on Indigenous funding[37]. It found that:

> The ability of existing and expanded primary health care services to reduce infectious and parasitic diseases and other environmental health related conditions can be compromised if environmental health issues are not dealt with.

4.3 ATSIC has a major funding responsibility for Indigenous environmental health through its housing and infrastructure programs, coordinated through its National Housing and Infrastructure Centre (NHIC). In addition to the provision of housing and related health infrastructure, NHIC has been involved in projects to improve service delivery and has represented Indigenous community needs on key working groups. National expenditure on ATSIC's Community Housing and Infrastructure Program totalled $234.85 million for the 2000–01 financial year.

4.4 An important coordinating mechanism between Health and ATSIC was a Memorandum of Understanding (MoU), signed in 1995. The purpose of the MoU was to provide a basis of cooperation between the two agencies. This MoU

[37] Commonwealth Grants Commission, 2001, *Report on Indigenous Funding 2001*, Canberra, p. 131.

expired on 30 June 2000. A new MoU was signed on 24 September 2002, over two years after the previous MoU expired.

4.5 Under the 1995 MoU, a Joint Committee was established. The 1998 audit found that the Joint Committee was established to facilitate national policy development, and as a basis for cooperation between Health and ATSIC. The new MoU also refers to a Joint Committee providing an effective basis for cooperation between ATSIC and Health. It is expected that the Joint Committee will continue to have an important role in structuring the relationship between the two agencies.

4.6 In addition to the Joint Committee, the ANAO found that Health and ATSIC coordinate primary health care and environmental health programs at the national, State/Territory and program level. While the ANAO concluded that established coordination mechanisms allow the limited exchange of data on the level, nature and geographic location of expenditures, these mechanisms are ad hoc and lack structure. As a result, appropriate data and information is not readily available to interested stakeholders.

4.7 ATSIC informed the ANAO that its participation in, and contribution to, health-related forums is variable. This variability was attributed to capacity issues within ATSIC and the number of committees and advisory structures that are Indigenous related and require ATSIC representation. ATSIC advised that the equivalent of one and a half staff are responsible for health policy and there are currently between 30 to 35 health-related committees.

4.8 The ANAO reviewed ATSIC's involvement in the State/Territory Health Forums and found that participation in, and contribution to, the Forums was variable, both between jurisdictions and over time. Stakeholders indicated that ATSIC was not reporting to the Forums to the same extent as other Forum partners. The ANAO reviewed minutes and agendas from a sample of Forums to assess the level and nature of ATSIC reporting. The ANAO found that ATSIC's contribution to the Forums through formal reporting was limited and did not include information on the level, nature and geographical location of ATSIC expenditure. The effectiveness of the Forums would be enhanced if ATSIC were to provide formal reports.

4.9 ATSIC informed the ANAO that significant coordination is undertaken at the State/Territory level, however a large amount of data is maintained at the regional level and may not be available at the State/Territory level. This issue was raised in the ANAO's *Municipal Services for Indigenous Communities* audit report[38]. The ANAO found that:

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[38] Australian National Audit Office Audit Report No.36, 2000–01, *Municipal Services for Indigenous Communities*, Canberra, p. 17.

ATSIC does not collect and collate the information its Regional Offices possess on local level service provision (including ATSIC's roles), nor does it provide this information on a regular basis to the relevant Commonwealth agencies. Therefore those agencies are not necessarily informed about gaps in service provision in States and Regions.

4.10 The ANAO considers that the lack of an overarching, coordinating structure is contributing to the current ad hoc and unstructured nature of data exchange between Health and ATSIC.

Conclusion

4.11 The ANAO found that information is exchanged between Health and ATSIC, but many of the mechanisms are informal and are not coordinated under an overarching framework. Further, the MoU between Health and ATSIC, which established the Joint Committee, lapsed on 30 June 2000 and was not renewed until 24 September 2002.

4.12 The ANAO considers that regular, formal reporting by ATSIC would enhance the effectiveness of the State/Territory Health Forums as a means to share information between Health, ATSIC, State/Territory governments and State/Territory affiliates of NACCHO. As a matter of priority, ATSIC should commence formal reporting to the Forums in each jurisdiction on the level, nature and geographical location of ATSIC expenditure.

4.13 The ANAO considers that this recommendation will be sufficiently implemented once the Joint Committee, through regular meetings, identifies and establishes a suitable framework to coordinate the sharing of data on the level, nature and geographical location of expenditure to facilitate planning. Ongoing monitoring of the effectiveness of the framework should form part of the Committee's function.

Health portfolio (Recommendation 12)

Recommendation 12 of Audit Report No.13, 1998–99

4.14 The ANAO recommends that DHAC coordinate the efforts of OATSIHS and mainstream programs in order to deliver the most effective and efficient funding to AHSs, including in relation to streamlining their accountability arrangements to make them more effective.

Findings of this audit

4.15 The two elements of this recommendation—coordination between OATSIH and mainstream programs and streamlining of accountabilities—have been addressed separately.

Coordination between OATSIH and mainstream programs

4.16 Since the 1998 audit, Health has worked to increase the profile of Indigenous health through cultural change across the department. The ANAO found that Health program managers now systematically review proposed policy and programs to determine the impact on Aboriginal and Torres Strait Islander people. Where an impact is identified, mainstream program managers talk with OATSIH and stakeholder groups where appropriate.

4.17 Cross-department coordination has been improved through the establishment of a First Assistance Secretaries' (FAS) Working Group on Indigenous Health in October 2001. In addition, Health is finalising a department-wide Aboriginal and Torres Strait Islander Health Business Plan for 2002–03. The Plan identifies and coordinates major initiatives across the mainstream program areas of the department. The FAS Working Group is responsible for the annual development of, and quarterly reporting against, the Plan.

4.18 OATSIH and mainstream program areas are coordinating efforts across a broad range of activities. Coordination mechanisms include regularly scheduled, formal meetings between senior division officers, joint committees, working groups, program level consultation and ad hoc conversations. In addition, a number of mainstream programs now incorporate Indigenous specific components into program development and implementation.

4.19 A problem resulting from an increased focus on Indigenous health within mainstream programs was voiced by NACCHO when it stated that 'there was no way that individual Aboriginal Health Services can keep abreast of all the policies and programs within the bounds of Aboriginal health, and much less across the whole mainstream spectrum as well.' NACCHO considered that OATSIH should be more active in identifying relevant mainstream programs and then actively assisting Aboriginal Health Services to access them.

Streamlining accountability arrangements

4.20 In order to effectively report against Health's performance indicators, managers of the department's mainstream programs have incorporated performance reporting and acquittal obligations into funding agreements with service providers. As a result, service providers with multiple funding agreements face multiple acquittal and reporting obligations and high

compliance costs. The ANAO found in the 1998 audit report that 'multiple grants with associated multiple acquittal arrangements place a strain on AHS administrative costs.'

4.21 AHSs visited by the ANAO acknowledged the need to be accountable for the expenditure of public funds and were committed to meeting accountability arrangements. However, AHS representatives indicated that, from their perspective, they are facing increasing demands from multiple acquittal and accountability arrangements. Grant funding for targeted health programs involve separate accountability arrangements, resulting in an additional administrative workload for AHSs. As a result, some AHSs are reluctant to apply for additional grant funding.

4.22 This reluctance may impact the achievement of Health's Program outcomes. The balance between accountability arrangements and the achievement of Program outcomes is discussed in the ANAO's Better Practice Guide on the Administration of Grants. It states that:

> The goal should be to balance the requirements of accountability, the protection of the Commonwealth's interests and the achievement of value for money for public funds expended against facilitating the achievement of the outcomes of the grant program.[39]

4.23 The Commonwealth Grants Commission, in its *Report on Indigenous Funding 2001*[40], commented on the issue of multiple accountability arrangements:

> Many of these organisations [Aboriginal Community Controlled Health Services (ACCHSs)] commented on how complex, fragmented and short-term funding arrangements adversely affect their operations.
>
> (i) Funds provided for specific health programs may not reflect the health priorities of a community and cause a lack of flexibility in service provision. As a result, the services provided can be determined by the purpose of the funds and not by local health priorities. This can make it more difficult to provide a holistic service.
>
> (ii) The administration of specific purpose funds and Medicare claims is complex, time consuming and costly. Many ACCHSs pointed to the reporting tasks arising from their 20 to 30 program grants. On the other hand, the funding agencies noted that it was necessary for funding arrangements to be able to target priority health concerns and to be accountable to Parliaments.

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[39] Australian National Audit Office, 2002, *Administration of Grants*, the Auditor–General Better Practice Guide, Canberra, p. 49.

[40] Commonwealth Grants Commission, 2001, *Report on Indigenous Funding 2001*, Canberra, p. 130.

4.24 The ANAO recognises that significant barriers exist to streamlining the accountability arrangements of AHSs, particularly in relation to grant funding within an appropriation-based system. Additional barriers arise where advocates for particular programs pressure funding bodies, in some cases strongly, to ensure that program specific funding is maintained. This pressure limits Health's ability to streamline accountability arrangements through the incorporation of multiple funding sources into AHSs base funding. As a result, AHSs' flexibility to reallocate funds at the local level to target areas of greatest need is reduced.

4.25 However, the ANAO considers that Health should, in consultation with the State/Territory Health Forums, identify strategies to overcome barriers and streamline accountability arrangements to improve the effectiveness of AHSs. Appropriate strategies should be implemented as a priority.

4.26 Health should be guided by better practice when developing strategies to streamline the accountability arrangements for AHSs. The ANAO's Better Practice Guide on the Administration of Grants provides further information on appropriate management of funding agreements, in particular monitoring arrangements and grant acquittals. In developing effective funding agreements, the ANAO recommends that 'The stringency of acquittal procedures should be balanced against the level of risk and take into account the cost of compliance.'[41]

4.27 Further, the Joint Committee on Public Accounts and Audit (JCPAA) has developed a set of principles for sound Specific Purpose Payment (SPP) program administration[42]. The JCPAA found that, for efficient and effective management of SPP programs, it is important that:

- SPP financial accountability requirements are as streamlined as possible; and
- smaller SPP programs are broadbanded in portfolio areas as far as practicable.

4.28 While the grants provided by Health under the Program are not, in the main, SPPs, the ANAO considers that the principles developed by the JCPAA are more widely applicable and should be taken into consideration by Health.

4.29 Health is trialing approaches designed to streamline the accountability arrangements of AHSs, for example the Integrated Funding Initiative (IFI)[43].

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[41] Australian National Audit Office, 2002, *Administration of Grants*, the Auditor–General Better Practice Guide, Canberra, p. 61.

[42] Joint Committee on Public Accounts and Audit, 1998, General and Specific Purpose Payments, AGPS, Canberra, p. 57–58.

[43] A definition of the IFI can be found at paragraph 2.6 of this report.

Conclusion

4.30 The ANAO found that Health has established mechanisms to coordinate the efforts of OATSIH and the department's mainstream programs in order to deliver the most effective and efficient funding to AHSs. However, Health has not yet reached an effective balance between the accountability needs of departmental programs and the impact of accountability arrangements on the administration workload for AHSs.

4.31 The ANAO considers that this recommendation will be sufficiently implemented once Health, in consultation with State/Territory Health Forum partners, develops and implements a suitable strategy to streamline the accountability arrangements of AHSs.

5. Program Administration and Workforce

This chapter discusses progress in the implementation of recommendations from the 1998 audit report relating to program administration and workforce. The ANAO concluded that Recommendations 5 and 7 have been implemented.

Grants management (Recommendation 5)

Recommendation 5 of Audit Report No.13, 1998–99

5.1 The ANAO recommends that DHAC:

- follow-up late financial returns and review them in a timely fashion in accordance with departmental procedures; and
- assess this review activity across State Offices for greater program effectiveness.

Findings of this audit

5.2 Health's procedures covering periodic financial returns required from funded services are established under the OATSIH Program Management Guidelines. The ANAO found that actions taken by Health to follow-up late financial returns were in accordance with the established Guidelines.

5.3 Health has identified issues affecting the ability of funded services to submit timely and accurate financial returns. To assist services, Health prepared and distributed a booklet entitled *Grant Acquittal Information for Funded Organisations and their Auditors*[44] to funded organisations. This booklet provides a uniform set of guidelines to all funded organisations on how to fulfil their acquittal obligations.

5.4 OATSIH staff informed the ANAO that the timely review of financial returns has been affected by resourcing issues in State/Territory offices. The ANAO raised this issue in a letter to Health's Victorian State office in May 2002. In that letter, the ANAO recommended that Health examine the adequacy of resourcing in the OATSIH Division.

5.5 The ANAO's audit of Health's 2001–02 financial statements did not identify any anomalies in the OATSIH acquittal process.

[44] Unpublished document.

5.6 OATSIH is currently implementing a proposal to improve the dissemination of analysed data on the processing of financial returns and introduce formalised benchmarking for State/Territory offices.

Conclusion

5.7 Health has controls in place to monitor the acquittal of funds provided to services and is taking action, in accordance with established guidelines, when acquittals are not provided. Therefore, Health has implemented this recommendation.

5.8 The ANAO does, however, advise Health to assess the adequacy of staff resources in State/Territory offices to ensure timely review of financial returns from funded services.

Workforce planning (Recommendation 7)

Recommendation 7 of Audit Report No.13, 1998–99

5.9 The ANAO recommends that DHAC:

- use its Workforce Modelling project to identify the skill profiles required by AHSs to deliver primary health care to Aboriginal and Torres Strait Islander communities;
- assess the level of skills available in AHSs and any skill gaps; and·identify an appropriate strategy to address the skill gaps.

Findings of this audit

5.10 The House of Representatives Standing Committee on Family and Community Affairs' *Health is Life: Report on Indigenous Health*[45] found that 'One of the keys to achieving any effective improvement in primary and secondary health care for Indigenous Australians is adequate staffing, both in terms of numbers of staff and skill levels.'

5.11 National action to address the adequacy of staffing is being coordinated under the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*[46]. The framework builds upon a number of previous reviews to propose a comprehensive reform agenda. The strategies that form the framework

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[45] House of Representatives Standing Committee on Family and Community Affairs, 2000, *Health is Life*, Canberra, p. 97.

[46] Standing Committee on Aboriginal and Torres Strait Islander Health, 2002, *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework*, AHMAC, Canberra.

encompass both joint actions and responsibilities specific to either the Commonwealth or State and Territory governments.

5.12 The National Aboriginal and Torres Strait Islander Health Council will oversee the implementation of the Framework, and will have a role in considering the annual reports on implementation of the strategies prior to referral to SCATSIH and AHMAC.

Skill profiles

5.13 As part of the development of the Workforce Strategic Framework, Health was responsible for the development of an *Aboriginal and Torres Strait Islander Health Workforce Draft National Strategic Framework—Consultation Draft, November 2001*. The Consultation Draft included staff to population ratios for a base model of health care for Indigenous people. These ratios were based on findings from a number of previous workforce reviews.

5.14 AHMAC acknowledged the potential use of indicative workforce ratio targets for Aboriginal Health Services as a planning tool in allocation and targeting of resources. However, it determined that the methodology underpinning the ratios required further development and as a result the ratios were not included in the endorsed Workforce Strategic Framework. AHMAC referred the task of further development of a nationally consistent formulation of indicative workforce ratio targets to the Aboriginal Health Workforce Working Group (AHWWG).

Identifying skill gaps

5.15 Health initially assessed the level of skills available in AHSs and any skill gaps through the Review of Base Funding 1995–96. Health continues to collect workforce data on the skills available to funded services and skill gaps through the SAR/DSAR surveys. The surveys gather information on the number of paid and unpaid full time equivalent positions, the number of staff vacancies and the duration of the vacancy and training undertaken by staff members. Analysed data is produced in the SAR Key Results report[47].

Addressing skill gaps

5.16 Health advised the ANAO that initiatives to address skill gaps in AHSs are now coordinated under the *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework.*

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[47] Office for Aboriginal and Torres Strait Islander Health and National Aboriginal Community Controlled Health Organisation, 2001, *Service Activity Reporting: 1998–1999 Key Results*, Commonwealth Department of Health and Aged Care, Canberra.

5.17 Initiatives undertaken by Health to address skill gaps in AHSs prior to the endorsement of the Framework, include:

- 326 Aboriginal Health Workers completed training in courses funded by OATSIH in 2000;
- OATSIH funded courses completed by 77 tertiary graduates in epidemiology, nursing, environmental health and mental health;
- the Puggy Hunter Memorial Scholarship scheme, which provides scholarships to Aborigines in the fields of medicine, nursing and Aboriginal Health Worker training; and
- Health provides funding to both the Australian Indigenous Doctor's Association (AIDA) and the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) to establish these organisations as the key bodies representing the needs of Indigenous doctors and nurses.

5.18 An associated workforce issue raised by a number of stakeholders concerned the significant movement of staff throughout the sector. This was an important issue for AHSs given their limited capacity to cope with high staff turnover. AHS representatives commented that the cost of training new staff creates a drain on both experienced staff and financial resources.

Conclusion

5.19 Since the task of further development of skill profiles has been referred to the AHWWG, the ANAO considers that Health has adequately implemented this recommendation.

6. Better Practice

This chapter discusses the implementation of recommendations from the 1998 audit report relating to Health's use of better practice. The ANAO concluded that Recommendations 1 and 10 have been implemented.

Identification of international better practice (Recommendation 1)

Recommendation 1 of Audit Report No.13, 1998–99

6.1 The ANAO recommends that DHAC identify better practice in terms of program objectives, delivery mechanisms and efficient resource usage in Indigenous health programs in comparable countries and adopt, where justified, to improve overall program performance.

Findings of this audit

6.2 The ANAO reviewed Health's use of international better practice and found that the department's approach to improving the health status of Aboriginal and Torres Strait Islander people has been guided by experience and better practice in comparable countries.

6.3 Health has reviewed literature, arranged seminars, funded an overseas study tour and visited international health agencies to identify relevant models of better practice in the delivery of Indigenous health programs. In addition, Health is strengthening links with International research organisations and Indigenous health service delivery agencies in other countries through formal cooperation agreements and an International Indigenous Health Forum to be held in 2003.

Conclusion

6.4 Health has implemented this recommendation.

Identification of Australian models of better practice (Recommendation 10)

Recommendation 10 of Audit Report No.13, 1998–99

6.5 The ANAO recommends that DHAC, in its national role, work with other stakeholders through State Forums to identify models of best practice in primary health care which could be applied to relevant programs.

Findings of this audit

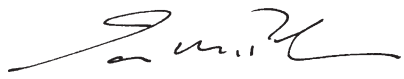
6.6 Stakeholder involvement in the identification of better practice models occurs through a number of avenues. State/Territory Health Forums represent one of these avenues.

6.7 In addition to working with stakeholders to identify models of better practice for the delivery of primary health care services to Aboriginal and Torres Strait Islander people, Health has also communicated better practice models to inform service delivery. The dissemination of models of better practice is coordinated under OATSIH's Communication Plan, dated June 2001.

6.8 Material distributed by Health with a focus on better practice, includes: better health care publications (which provide case studies of model ACCHSs); evaluation reports for service delivery and funding trials; and a regular newsletter. In addition to printed material, Health is utilising the Internet to disseminate information on better practice to service providers and the general population.

Conclusion

6.9 Health has adequately implemented this recommendation.



Canberra ACT
29 October 2002

Ian McPhee
Acting Auditor-General

Appendices

Appendix 1

Summary of Progress Against the Recommendations

Recommendations of Audit Report No.13, 1998–99, The Aboriginal and Torres Strait Islander Health Program	*Status*	*Conclusions against the recommendations*
1 The ANAO recommends that DHAC identify better practice in terms of program objectives, delivery mechanisms and efficient resource usage in Indigenous health programs in comparable countries and adopt, where justified, to improve overall program performance.	✓	Health has implemented this recommendation.
2 The ANAO recommends that DHAC measure the achievement of its Aboriginal and Torres Strait Islander Health Program objective of raising health status by ensuring access to effective high quality health care and population health programs.	✓	The ANAO recognises that the monitoring of performance is an ongoing activity. However, Health needs to continue its efforts to measure changes in Indigenous health status and to improve data quality and availability. The ANAO considers that actions taken by Health adequately respond to the issues identified in the 1998 audit report. While data difficulties continue to limit full reporting, Health is working to implement a long-term strategy to improve the quality and availability of Indigenous health data. Therefore, for the purposes of this report, the ANAO considers that Health has adequately implemented this recommendation.

Recommendations of Audit Report No.13, 1998–99, The Aboriginal and Torres Strait Islander Health Program	*Status*	*Conclusions against the recommendations*
3 The ANAO recommends that DHAC establish a suitable timeframe for the implementation of funding AHSs and Substance Misuse Services on the basis of the health needs of the Aboriginal and Torres Strait Islander communities to whom they deliver services.	×	As an endorsed, detailed timeframe for the implementation in each State and Territory of funding on the basis of health needs has not been established, Health has not implemented this recommendation. Health has, however, established a process for funding AHSs and Substance Misuse Services on the basis of health needs of the Aboriginal and Torres Strait Islander communities to whom they deliver services. Health is working with the States and Territories to implement this process and has developed a high-level timeframe to guide the department's implementation of PHCAP. A precursor to the establishment of a detailed timeframe for each State and Territory is a signed MoU. Two States have signed MoUs and negotiations are well advanced with two more. Further, Health has provided stakeholders with information on the implementation of funding of health needs under PHCAP via progress reports to stakeholder forums. In addition, Health is developing PHCAP Implementation Guidelines to further inform stakeholders. The ANAO will consider this recommendation fully implemented when a detailed plan for the implementation of PHCAP outlining timeframes and responsibilities of each partner, endorsed by the State/Territory Health Forums, is established for all States and Territories.

4	The ANAO recommends that, as part of the health needs-based planning process, DHAC identify, in conjunction with stakeholders: • a means by which a total funding picture of AHSs can be obtained and revised on a regular basis for the information of decision-makers; and • the most effective methods of funding Aboriginal Health and Substance Misuse Services.	✓	Health has adequately implemented this recommendation.
5	The ANAO recommends that DHAC: • follow-up late financial returns and review them in a timely fashion in accordance with departmental procedures; and • assess this review activity across State Offices for greater program effectiveness.	✓	Health has controls in place to monitor the acquittal of funds provided to services and is taking action, in accordance with established guidelines, when acquittals are not provided. Therefore, Health has implemented this recommendation. The ANAO does, however, advise Health to assess the adequacy of staff resources in State/Territory offices to ensure timely review of financial returns from funded services.
6	The ANAO recommends that DHAC collect and analyse information from funded organisations, which would enable it to report effectively against relevant national and departmental performance indicators.	✓	Health has implemented this recommendation. However, the ANAO suggests that Health should identify opportunities to expedite publication of analysed data. In addition, Health should continue efforts, through the SAR Steering Committee, to identify a suitable mechanism to verify the accuracy and reliability of SAR data.
7	The ANAO recommends that DHAC: • use its Workforce Modelling project to identify the skill profiles required by AHSs to deliver primary health care to Aboriginal and Torres Strait Islander communities; • assess the level of skills available in AHSs and any skill gaps; and • identify an appropriate strategy to address the skill gaps.	✓	Since the task of further development of skill profiles has been referred to the AHWWG, the ANAO considers that Health has adequately implemented this recommendation.

Recommendations of Audit Report No.13, 1998–99, The Aboriginal and Torres Strait Islander Health Program	*Status*	*Conclusions against the recommendations*
8 The ANAO recommends that DHAC and ATSIC more effectively coordinate their primary and environmental health programs by sharing data on the level, nature and geographical location of their expenditures.	×	The ANAO found that information is exchanged between Health and ATSIC, but many of the mechanisms are informal and are not coordinated under an overarching framework. Further, the MoU between Health and ATSIC, which established the Joint Committee, lapsed on 30 June 2000 and was not renewed until 24 September 2002. The ANAO considers that regular, formal reporting by ATSIC would enhance the effectiveness of the State/Territory Health Forums as a means to share information between Health, ATSIC, State/ Territory governments and State/Territory affiliates of NACCHO. As a matter of priority, ATSIC should commence formal reporting to the forums in each jurisdiction on the level, nature and geographical location of ATSIC expenditure. The ANAO considers that this recommendation will be sufficiently implemented once the Joint Committee, through regular meetings, identifies and establishes a suitable framework to coordinate the sharing of data on the level, nature and geographical location of expenditure to facilitate planning. Ongoing monitoring of the effectiveness of the framework should form part of the Committee's function.

9	The ANAO recommends that DHAC: • emphasise in State Forums the importance of a focus on health status outcomes as a key component of regional planning; • take action, through its State Forum representatives, to establish a timeframe for the implementation of needs-based funding; • examine the feasibility of providing suitable incentives to stakeholders to complete regional planning; and • where the progress of regional planning is likely to unduly delay the health needs of the Aboriginal and Torres Strait Islanders being identified, address other suitable options and take action to identify those health needs as a matter of priority.	✓	Health has implemented three out of the four elements of this recommendation. The ANAO addressed the fourth element under the conclusion for Recommendation 3. Therefore, for the purposes of this report, the ANAO considers that Health has adequately implemented this recommendation.
10	The ANAO recommends that DHAC, in its national role, work with other stakeholders through State Forums to identify models of best practice in primary health care which could be applied to relevant programs.	✓	Health has adequately implemented this recommendation.

Recommendations of Audit Report No.13, 1998–99, The Aboriginal and Torres Strait Islander Health Program	Status	Conclusions against the recommendations
11 The ANAO recommends that, as part of its national role, DHAC meet its reporting obligations under the Framework Agreements and work with State/Territory health agencies to assist them to fulfill their reporting obligations.	×	As the Commonwealth, States and Territories have not reported to AHMC in accordance with established timeframes, the obligation relating to the frequency of reporting under the Framework Agreements has not been met. As a result, the recommendation has not yet been fully implemented. Health has, however, made progress toward the implementation of this recommendation through coordination of the reporting process with States and Territories and submitted reports for 1996–99 and 1999–01. The Framework Agreement partners should consider reviewing the frequency of reporting under the Framework Agreements to determine the most time and cost effective reporting timeframe. If required, the Framework Agreements should then be amended. The ANAO considers that Health will have sufficiently implemented this recommendation once Health and other jurisdictions are complying with the reporting obligations established under the Framework Agreements.
12 The ANAO recommends that DHAC coordinate the efforts of OATSIHS and mainstream programs in order to deliver the most effective and efficient funding to AHSs, including in relation to streamlining their accountability arrangements to make them more effective.	**P**	The ANAO found that Health has established mechanisms to coordinate the efforts of OATSIH and the department's mainstream programs in order to deliver the most effective and efficient funding to AHSs. However, Health has not yet reached an effective balance between the accountability needs of departmental programs and the impact of accountability arrangements on the administration workload for AHSs. The ANAO considers that this recommendation will be sufficiently implemented once Health, in consultation with State/Territory Health Forum partners, develops and implements a suitable strategy to streamline the accountability arrangements of AHSs.

Legend

✓ Recommendation implemented **P** Progress being made against Recommendation × Recommendation not implemented

Appendix 2

The Department of Health and Ageing Portfolio Outcomes

1. Promotion and protection of the health of all Australians and minimising the incidence of preventable mortality, illness, injury and disability.
2. Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.
3. Support for healthy ageing for older Australians and quality and cost-effective care for frail older people and support for their carers.
4. Improved quality, integration and effectiveness of health care.
5. Improved health outcomes for Australians living in regional, rural and remote locations.
6. Reduced consequences of hearing loss for eligible clients and a reduced incidence of hearing loss in the broader community.
7. Improved health status for Aboriginal and Torres Strait Islander peoples.
8. A viable private health industry to improve the choice of health services for Australians.
9. Knowledge, information and training for developing better strategies to improve the health of Australians.

Appendix 3

Specific Health Reviews

Health Systems

- Keys Young, 1997, *Market Research into Aboriginal and Torres Strait Islander access to Medicare and the Pharmaceutical Benefits Scheme*, Health Insurance Commission, Canberra.
- KPMG Consulting, 2001, *The Aboriginal and Torres Strait Islander Coordinated Care Trials National Evaluation*, Commonwealth Department of Health and Aged Care, Canberra.

Program Management Reviews

- Office for Aboriginal and Torres Strait Islander Health, 2000, *Aboriginal and Torres Strait Islander Health Review of the Capital Works Program-Evaluation Report*, Commonwealth Department of Health and Aged Care, Canberra (unpublished).
- Office for Aboriginal and Torres Strait Islander Health, 2000, *Mid Term Review of the Patient Information and Recall Systems Project*, Commonwealth Department of Health and Ageing, Canberra.
- Hall Chadwick, 1999, *Review of the Effect of FBT and GST Reforms on Aboriginal Community Controlled Services,* Commonwealth Department of Health and Aged Care, Canberra (unpublished).

Mental Health and Emotional and Social Well Being

- Swan, P, and Raphael, B, 1995, *Ways Forward*, National Mental Health Strategy, Canberra.
- Urbis Keys Young, 2001, *Review of the Emotional and Social Wellbeing (Mental Health) Action Plan*, Commonwealth Department of Health and Aged Care, Canberra (unpublished).
- Human Rights and Equal Opportunities Commission, 1997, *Bringing Them Home*, HREOC, Sydney.

Other Health Issues

- Mandala Consulting et al, 2000, *Evaluation of the Influenza Vaccine Program for Older Australians and the National Indigenous Pneumococcal and Influenza Immunisation Program*, Commonwealth Department of Health and Aged Care, Canberra (unpublished).
- Office for Aboriginal and Torres Strait Islander Health, 1999, *Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program*, Commonwealth Department of Health and Aged Care, Canberra.
- Urbis Keys Young, 2000, *Mid-term Review of the National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99 (NIASHS)*, Commonwealth Department of Health and Aged Care, Canberra.
- Taylor, H, 1997, *Eye Health in Aboriginal and Torres Strait Islander Communities*, Commonwealth Department of Health and Family Services, Canberra.

Workforce Reviews

- Curtin Indigenous Research Centre, Centre for Education, Research and Evaluation and Jojara and Associates, 2001, *Training revisions: National Review of Aboriginal and Torres Strait Islander Health Worker Training*, Commonwealth Department of Health and Aged Care, Canberra.
- KPMG Consulting, 2000, *Review of the Recruitment and Promotion Services Project*, Commonwealth Department of Health and Aged Care, Canberra.
- Kent, R, 1999, *Review of the Office for Aboriginal and Torres Strait Islander Health Management Support and Development Program*, Commonwealth Department of Health and Aged Care, Canberra (unpublished).
- Oceania Health Consulting, 1999, *An Evaluation of the Master of Applied Epidemiology in Indigenous Health at the National Centre for Epidemiology and Population Health*, Commonwealth Department of Health and Aged Care, Canberra (unpublished).
- Review Consortium (OZ Train, SACRRH and Tony Lawson Consulting, 2001, *Final Report of the Evaluation of Health Services Management Training for Aboriginal and Torres Strait Islander People*, Commonwealth Department of Health and Aged Care, Canberra.

Data Reviews

- Aboriginal and Torres Strait Islander Health and Welfare Information Unit, 1997, *The Aboriginal and Torres Strait Islander Health Information Plan…This Time Let's Make It Happen*, AIHW cat. no. HWI 12, Australian Health Ministers' Advisory Council, Australian Institute of Health and Welfare and Australian Bureau of Statistics, Canberra.

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