

The Auditor-General  
Audit Report No.21 2002-03  
Performance Audit

# **Performance Information in the Australian Health Care Agreements**

**Department of Health and Ageing**

Australian National Audit Office

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of Australia 2002

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Canberra ACT  
11 December 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 *Performance Information in the Australian Health Care Agreements*.

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

A handwritten signature in black ink, appearing to read 'P. J. Barrett', is positioned above the printed name.

P. J. Barrett  
Auditor-General

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

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# Contents

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Abbreviations	6
Glossary	7
<b>Summary and Recommendations</b>	<b>9</b>
Summary	11
Key Findings	15
Recommendations	18
<b>Audit Findings and Conclusions</b>	<b>21</b>
1. Introduction	23
Background and context	23
Audit scope and objective	29
Audit approach	29
Previous audits and better practice guides	30
Structure of the report	31
2. Development and Review of AHCA Performance Information	33
Introduction	33
Process for developing performance indicators	33
Publication of the annual AHCA performance report	36
3. Specific Performance Information Needs	41
Introduction	41
Conditions of funding	43
AHCAs' objectives	44
4. General Performance Information Needs	48
Introduction	48
Performance information in the AHCA annual report	49
Performance information in Health's budget documentation and annual report	52
5. Financial Information	60
Introduction	60
Financial controls	60
Health's estimate of total AHCA expenditure	61
Financial accountability of the States and Territories	62
<b>Appendices</b>	<b>65</b>
Appendix 1: Administrative characteristics of 'Ideal' SPP Agreements	67
Appendix 2: Principle Performance Indicators in the AHCA, Annual Performance Report 1998-99	68
Index	69
Series Titles	71
Better Practice Guides	73

## Abbreviations

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AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers' Advisory Council
CRF	Consolidated Revenue Fund
DHFS	Department of Health and Family Services
Finance	Department of Finance and Administration
FMA	<i>Financial Management and Accountability Act 1997</i>
GPP	General Purpose Payments
HCG	Health Care Grant
Health	Department of Health and Ageing (also called Health)
NHDF	National Health Development Fund
NHMBWG	National Health Ministers' Benchmarking Working Group
NHPC	National Health Performance Committee
PBS	Portfolio Budget Statements
SPP	Specific Purpose Payment

# Glossary

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## **Administered Items**

Expenses, revenues, assets or liabilities managed by agencies on behalf of the Commonwealth. Agencies do not control administered items. Administered items include grants, subsidies and benefits (for example, funding for the Pharmaceutical Benefits Scheme).

## **Departmental Items**

Departmental items or outputs are those assets, liabilities, revenues and expenses applied to the production of an agency's outputs.

## **General Purpose Payments, (GPPs)**

GPPs involve general budget support to the States and Territories. They allow the States and Territories to use Commonwealth financial assistance according to their own priorities. They are referred to as 'untied' grants due to the unconditional nature of this financial assistance.

## **Non-Admitted Patient Care**

Non-admitted patient care includes emergency and outpatient services.

## **Outcomes (Actual)**

The results, impacts or consequences of actions by the Commonwealth on the Australian community. Actual outcomes are the results or impacts actually achieved. They include the impact of all influences, not just the Commonwealth.

## **Outcomes (Planned)**

The results or impacts on the community or environment that the Government intends to achieve.

## **Outputs**

The goods or services produced by agencies on behalf of government for external organisations or individuals. Outputs include goods and services produced for other areas of government external to the agency.

## **Special Appropriation**

Moneys appropriated by Parliament in an Act separate to an annual Appropriation Act, where the payment is for a specified amount. Special appropriations are not subject to Parliament's annual budget control, unlike the annual appropriations.

## **Specific Purpose Payments, (SPPs)**

SPPs typically involve Commonwealth financial assistance to State, Territory or local governments for a specific purpose. Commonwealth financial assistance as SPPs enables the Commonwealth Government to pursue either a Commonwealth or a national policy objective in a particular functional area. As such, SPPs can be drawn from the Commonwealth's Consolidated Revenue Fund under the annual general Appropriation Acts or through Special Appropriation Acts. These Acts have a dual role of authorising the expenditure of public moneys and restricting the expenditure to a particular purpose.



# **Summary and Recommendations**



# Summary

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## Overview

1. The Commonwealth Government, through the Australian Health Care Agreements (AHCAs), is expecting to provide financial assistance of \$31.7 billion to the States and Territories over five years to 2002–03. These moneys are for the provision and joint funding of health and emergency services, particularly hospital services. The Commonwealth Department of Health and Ageing (Health) administers the AHCAs on behalf of the Commonwealth Government. The Australian National Audit Office (ANAO) has examined whether Health has the performance information necessary to administer the AHCAs. In the broad, the ANAO has concluded that, while agreement with the States and Territories has been reached on a set of indicators, Health should seek to expand the range of performance information to be in an adequate position to monitor whether the Commonwealth's policy objectives for the AHCAs are being met and to inform future policy directions.

2. The role of performance indicators is important to the administration of the AHCAs. These Agreements are the largest, in monetary terms, of all Commonwealth Specific Purpose Payments (SPPs) to the States and Territories.<sup>1</sup> The performance indicators should be sufficient to allow an informed assessment as to whether the Commonwealth's policy objectives are being achieved. They should also facilitate the assessment of efficiency in service delivery, which is particularly important given the magnitude of financial assistance provided. The Federal Government has indicated more generally its intention to seek greater accountability from the States and Territories for SPPs, through outcomes based funding and measurement against outputs.

## The Australian Health Care Agreements

3. The AHCAs are five-year bilateral agreements between the Commonwealth and each State and Territory Government for the provision and joint funding of health care services. When the current Agreements end on 30 June 2003, the Commonwealth expects the AHCAs to be replaced by a further round of five-year bilateral agreements for 2003–08.

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<sup>1</sup> The AHCAs are expected to involve \$7.1 billion for 2002–03. The next largest SPP involves \$3.7 billion paid through the States and Territories for non-Government schools.

4. Under the AHCAs, the Commonwealth and the States and Territories are committed to ensuring that the Australian health care system is a world class system which:

- maximises the health of individuals and the community;
- reflects a balance between investment in the health of individuals and the health of the community;
- responds flexibly to community and consumer needs;
- is integrated and coordinated;
- achieves best practice, evidence based health care; and
- matches proven health services with health service priorities.

5. The AHCAs involve special appropriations, which are made under the *Health Care (Appropriation) Act 1998 (the Act)*<sup>2</sup>. The Act caps the total level of financial assistance at \$29.6 billion. The details of the funding arrangements are set out in the AHCAs.

6. At the time of the audit, Health estimated that spending on the AHCAs would total \$31.7 billion over the five years to 30 June 2003. This is \$2.09 billion more than the amount of financial assistance authorised under the Act. The additional amount is the result of:

- government decisions to provide the States and Territories with more financial assistance, and to change the index for adjusting the Health Care Grants; and
- the terms of the Agreements, which provide for funding to be adjusted for more recent data on population growth and ageing, and entitled veterans population.

7. Health has prepared an amendment to the Act to authorise an increase in the total level of financial assistance. The amendment will need to be passed by Parliament by April 2003 for AHCA payments not to exceed the current appropriated amount, if spending continues at the current rate. The Bill to amend the Act was introduced in the House of Representatives on 29 August 2002.

## AHCAs as Specific Purpose Payments, (SPPs)

8. The Commonwealth's Budget Papers identify financial assistance to the States and Territories under the AHCAs as SPPs.<sup>3</sup> The AHCAs comprise one

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<sup>2</sup> The full title of the Act is *An Act to provide financial assistance for the period of 5 years starting on 1 July 1998 in respect of health care services*.

<sup>3</sup> Commonwealth of Australia, *Federal Financial Relations 2002-2003*, Budget Paper No.3, p. 43. See also the Glossary in this report for the definition of a SPP.

third of all SPPs provided by the Commonwealth to the States and Territories in 2002–03, or \$7.1 billion of \$21.56 billion.

9. Two sets of guidelines bear on the administration of SPPs, Finance's guidelines on the Government's Outcomes and Outputs Framework which was introduced in the 1999–2000 Budget, and the Joint Committee of Public Accounts and Audit's (JCPAAs) preferred administrative characteristics for SPP agreements<sup>4</sup>. During the audit, Health queried the applicability of these guidelines to the AHCAs. The ANAO examined this question, and concluded that the principles in both guidelines, particularly the requirements for performance information, provide a useful framework for AHCA administration by enhancing accountability. The Agreements include provision for the development of performance indicators for reporting purposes.

## The States and Territories

10. AHCAs are typical of many programs administered by Health, in that service provision is the responsibility of the States and Territories. This means that the source of the data needed for performance indicators is not within Health's control. Consequently, the cooperation of the States and Territories has been necessary to develop and apply performance indicators for accountability purposes.

## Audit scope and objective

11. The audit objective was to form an opinion on whether Health has the performance information necessary to administer the AHCAs.

12. A strong focus of the audit was accountability for performance, including financial accountability. Health requires robust performance indicators to inform its management decisions and policy advice to Government. This is critical given the very significant Commonwealth outlays involved, and is against the background of the ANAO's 1998 findings<sup>5</sup> that identified the need for Health to make substantial improvements in order to bring its management of SPPs up to an adequate standard of accountability.<sup>6</sup>

<sup>4</sup> Joint Committee of Public Accounts and Audit, June 1998, *General and Specific Purpose Payments*, p. 57–8.

<sup>5</sup> Australian National Audit Office, Audit Report No.31, 1998–99, *The Management of Performance Information for Specific Purpose Payments—The State of Play*.

<sup>6</sup> Australian National Audit Office, Audit Report No.31, 1998–99, *The Management of Performance Information for Specific Purpose Payments—The State of Play*, Summary Brochure, p. 1.

## Overall conclusion

13. Health has some, but not all, of the performance information it needs to adequately administer the \$31.7 billion in Commonwealth funding expected to be provided through AHCAs up to 2002–03. It has the financial information required to ensure the accuracy of total payments made to the States and Territories in accordance with those approved by the Minister for Health and Ageing. There is, however, only limited information on the performance of the States and Territories in meeting the conditions of federal funding on free and equitable access to public hospital services. Further, Health has only partial performance information on the effectiveness and efficiency of the AHCAs.

14. The AHCAs commit the States and Territories to improve performance against a set of national performance indicators, which were to be developed under the Agreements. Health has worked with the States and Territories to develop these indicators. The choice of indicators was influenced by the availability of data, and by the constraints of reaching agreement in a national forum. The States and Territories also have a responsibility to provide data according to the provisions of the Agreements, in an agreed format and timeframe. Health is monitoring State and Territory performance against these indicators, although the late receipt of data from some States and Territories is an issue for the department to manage.

15. The AHCAs also identify the need for continued development of performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services. The ANAO found no evidence of a long-term plan to address the development of these indicators. This affects Health's capacity to monitor whether the States and Territories are meeting the objectives and conditions of federal funding, as well as outcomes and outputs under the Agreements. Health has an opportunity in the renegotiation of the Agreements in 2003 to seek agreement from the States and Territories to enhance performance information for its administration of the AHCAs.

16. The ANAO found that Health has effective financial controls to ensure that the States and Territories receive accurate and timely payments pursuant to the Agreements. During the audit, there were deficiencies in Health's record keeping associated with estimates of payments under the Agreements. Subsequently, Health advised that it has addressed these problems.

## Key Findings

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### **The utility of the current set of performance indicators**

17. The AHCAs commit the States and Territories to improving performance against a set of broad indicators listed in the Agreements. Health and the States and Territories, through the Working Group on Performance Measures and Data, developed a set of related performance indicators for national reporting in an annual performance report. Health is responsible for the preparation of the report, with data supplied by the States and Territories.

18. The annual performance report is the main accountability mechanism under the AHCAs. It represents a significant advance on the reporting regimes of previous agreements, due to the data it provides for assessing and comparing State and Territory performance.

19. Despite this, it is too early to determine whether the annual report and, in particular, the publication of data will meet expectations in terms of promoting performance improvements. Only one report has been published, for the first year of the Agreements (1998–99). The final draft of the second report for 1999–2000 was provided to the States and Territories in November 2001 for consideration and agreement by State and Territory health ministers. All public hospital activity and waiting times data required for the publication of the report was included at that time. The delays in publication are due to late provision of data from some States and Territories, and the time taken to reach agreement with the States and Territories on the content of the report prior to publication.

20. The set of national indicators is the main information used by Health to assess the success of the AHCAs. The choice of indicators was influenced by the availability of data that already existed in national data sets, and by the constraints of reaching agreement in a national forum. The ANAO found that the indicators provide only partial coverage of AHCA objectives, which are high level and difficult to measure. Further, they provide only partial coverage of whether the States and Territories have met the conditions and principles of funding.

21. Health uses some of the national indicators to monitor the efficiency of the AHCAs. Health's ability to monitor efficiency is limited because the information is incomplete. For example, the States and Territories are not required to identify their expenditures under the Agreements. Other indicators provide good information on outputs, but Health requires additional information to fully interpret the results being achieved.

## **Development and review of AHCA performance indicators**

22. The AHCAs commit the parties to the continued development of performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services. An intention was to facilitate Health's monitoring of AHCA outcomes, including whether the States and Territories were achieving the conditions and principles of funding.

23. The Australian Health Ministers' Advisory Council (AHMAC) established the Working Group on Performance Measures and Data in 1998. The task of the Working Group was to advise AHMAC on issues relating to performance measures and data arising from the AHCAs. This resulted in the set of national indicators included in the annual performance report. The Working Group was disbanded in 1999. No other mechanism was put in place for the ongoing development and review of AHCA performance information needs—although, on a recommendation from the Working Group, AHMAC established the National Health Performance Committee (NHPC) to develop a national performance measurement framework for the health system.

24. The ANAO examined the set of national indicators and concluded that, while individual indicators have the potential to contribute to monitoring, the set of indicators is not adequate for:

- monitoring State and Territory conformance with the conditions and principles of funding;
- providing an informed assessment of progress against AHCA objectives; and
- monitoring the efficiency of the AHCAs.

25. The ANAO found no evidence of further planning by Health for the continued development and review of performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services, consistent with the commitment in the AHCAs.

26. Notwithstanding, Health has taken a step forward in building a database on the effects of AHCAs on hospital and related services across Australia. This task will be ongoing, which reinforces the need for Health to review its information needs independently of the States and Territories and to develop a long-term information plan for the systematic development and review of performance indicators. It also demonstrates the need for Health to continue to work with the States and Territories on performance indicator development for the benefits this provides, not only to its own administration of the AHCAs but also to the States and Territories for the advantages that shared information offers through national monitoring and reporting of results. Negotiation of the next round of AHCAs in 2003 provides Health with this opportunity.



## Financial information

27. The ANAO found that Health's controls are effective in ensuring accurate and timely payments to the States and Territories. The ANAO, however, noted delays in the receipt of acquittal information from some States and Territories.

28. At the time of the audit, the ANAO was unable to independently verify Health's estimate of total planned expenditure under the AHCAs. This reflects a deficiency in the department's record keeping practices, rather than a lack of Ministerial authority to approve the level of payments proposed under the Agreements. Following receipt of the draft report, Health advised that it had subsequently established a register of variations to the original amount approved by the Minister in order to remedy problems in its record keeping practices. ANAO suggests that, in future agreements, Health maintain original estimates models for each year of each agreement. Such action, in conjunction with the steps already taken by Health, will address comprehensively the record keeping issues highlighted by the audit.

## Health's response

29. Health has found the audit of value in reviewing its processes and for preparing for the 2003–08 AHCAs. Comments made by the ANAO on the utility of the current performance indicators, and on the development and review of performance indicators are well-made and timely with the negotiation of the new agreements that are due to commence in 2003. With regard to financial information, a register of variations to estimates of funding under the agreements has been established to complement the comprehensive records already held by the department.

# Recommendations

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**Recommendation No. 1**  
**Para. 2.25**

ANAO recommends that, in order to administer the AHCAs, Health:

- review its performance information needs according to the outcome the Commonwealth is seeking, in preparation for the negotiation of the 2003–08 Agreements; and
- in the context of this review, take account of the guidelines on the Government’s Outcomes and Outputs Framework and the JCPAA’s preferred administrative characteristics for SPP agreements.

*Health’s Response:*

Agreed, noting that the Government is yet to decide on the approach it will be taking to these issues in the 2003–08 Agreements.

**Recommendation No. 2**  
**Para. 4.32**

ANAO recommends that Health develop a long-term information plan for the administration of the AHCAs, aimed at obtaining commitment from the States and Territories to a process for the development and review of performance information needs over the life of any new funding agreements. This would provide for:

- systematic development and continued appropriateness of performance indicators;
- reporting mechanisms on the level and type of progress made; and
- development of a performance information regime that is appropriate in terms of the relevant legislation, the stated objectives and principles of the new arrangements, and the Government’s Outcomes and Outputs Framework.

*Health’s Response:*

The Department of Health and Ageing will administer the next Australian Health Care Agreements according to the policy framework agreed by Government. The matters covered by this recommendation are matters of policy not administration.

**ANAO comment:** The recommendation is directed to Health's administration of the AHCAs within the framework agreed by Ministers, which provides for the development of national level performance indicators, including indicators on efficiency, quality, appropriateness, accessibility and equity of health services. The ANAO envisaged that such a plan would assist in informing the Commonwealth Health Minister (and State and Territory Ministers) of the potential for improvements to the current performance information regime.

**Recommendation  
No. 3  
Para. 5.21**

In order to verify the accuracy and validity of payments made in relation to funding agreements, the ANAO recommends that Health establish clear audit trails by maintaining a register/s of all variations made to estimates of funding under the agreements used for calculating payments during the life of those agreements.

***Health's Response:***

Agreed. Such a register has already been established.



# **Audit Findings and Conclusions**



# 1. Introduction

*This chapter introduces the Australian Health Care Agreements. It describes the role of performance information in meeting legislative requirements for the efficient and effective use of Commonwealth resources. It also sets out the audit's approach, objective and methodology.*

## Background and context

### The Australian Health Care Agreements

**1.1** The Commonwealth Department of Health and Ageing (Health) administers the Australian Health Care Agreements (AHCAs) on behalf of the Commonwealth Government.<sup>7</sup> The AHCAs are five-year bilateral agreements between the Commonwealth and each State and Territory Government for the provision and joint funding of health services, especially hospital services.<sup>8</sup> When the current Agreements expire on 30 June 2003, the Commonwealth expects the AHCAs to be replaced by a further round of five-year bilateral agreements for 2003–08. The AHCAs' objectives are shown in Figure 1.

#### Figure 1

##### Objectives of the Australian Health Care Agreements<sup>9</sup>

The Commonwealth and [the relevant State/Territory] are committed to ensuring that the Australian health care system is a world class system which:

- maximizes the health of individuals and the community;
- reflects a balance between investment in the health of individuals and the health of the community;
- responds flexibly to community and consumer needs;
- is integrated and coordinated;
- achieves best practice, evidence based health care; and
- matches proven health services with health service priorities.

<sup>7</sup> Copies of the AHCAs are available on Health's website at: <<http://www.health.gov.au/haf/docs/hca/index.htm>>.

<sup>8</sup> The reason for the AHCAs, as specified in each Agreement, is: 'In recognition of the co-operative relationship between the Commonwealth and [each State/Territory] in the provision of health services, this Australian Health Care Agreement is an agreement to provide and jointly fund health care for eligible persons who choose to use State funded health services.' AHCAs, clause 1.

<sup>9</sup> AHCAs, clause 4.

1.2 The AHCAs involve special appropriations<sup>10</sup>, which are made pursuant to the *Health Care (Appropriation) Act 1998* (the Act)<sup>11</sup>. The Act caps the total level of financial assistance at \$29.65 billion.<sup>12</sup> Payments made under the AHCAs are appropriated from the Commonwealth's Consolidated Revenue Fund (CRF) as Health Care Grants (HCGs)<sup>13</sup> and grants for the National Health Development Fund (NHDF). The details of the funding arrangements, as agreed between the Commonwealth and each State and Territory, are set out in the AHCAs. While the total level of financial assistance specified in the Act cannot be exceeded over the life of the AHCAs, the Minister for Health and Ageing determines the level of financial assistance to the States and Territories annually, or more frequently as required.

1.3 At the time of the audit, Health estimated that spending on the AHCAs would total \$31.7 billion. This is \$2.09 billion more than authorised under the Act. The additional amount is the result of:

- government decisions to provide the States and Territories with more financial assistance, and to change the index for adjusting the Health Care Grants; and
- the terms of the Agreements, which provide for funding to be adjusted for more recent data on population growth and ageing, and entitled veterans' population.

1.4 Health has prepared an amendment to the Act to authorise an increase in the total level of financial assistance. The amendment will need to be passed by Parliament by April 2003 for AHCA payments not to exceed the current appropriated amount, if spending continues at the current rate. The Bill to amend the Act was introduced in the House of Representatives on 29 August 2002.

1.5 While the AHCAs do not specify any matching funding requirements for State and Territory governments, they do require the States and Territories to maintain an agreed annual level of public patient hospital services.<sup>14</sup> The AHCAs

<sup>10</sup> Special appropriation—moneys appropriated by Parliament in an Act separate to an annual Appropriation Act, where the payment is for a specified amount. Special appropriations are not subject to Parliament's annual budget control, unlike the annual appropriations. Health and Aged Care Portfolio, *Portfolio Budget Statements 2002-2003*, Glossary.

<sup>11</sup> The full title of the Act is *An Act to provide financial assistance for the period of 5 years starting on 1 July 1998 in respect of health care services*.

<sup>12</sup> The Act states that 'The total amount paid by way of financial assistance under this section must not exceed \$29 655 056 000'. See Commonwealth of Australia 1998, *Health Care (Appropriation) Act 1998*, No.74, Grants of financial assistance, 4 (3).

<sup>13</sup> For the HCGs, equalised AHCA grants are included in the revenue pool to which the Commonwealth Grants Commission relativities are applied, resulting in a more transparent and more immediate equalisation than is the case with other SPPs.

<sup>14</sup> Clause 22 of the AHCAs commits each State and Territory to an annual hospital separation rate, which is increased by 2.1 per cent per annum. Finance's guidelines on the Outcomes and Outputs Framework require the specification of targets. For the purposes of Health's administration of the AHCAs, the clause 22 rates perform the same function as targets.



further provide for a review of financial assistance where there is a shortfall of at least five per cent between a State or Territory's actual level of activity and the specified annual separation rate.<sup>15</sup>

## AHCAs as Specific Purpose Payments

1.6 The Commonwealth's Budget Papers identify financial assistance to the States and Territories under the AHCAs as Specific Purpose Payments (SPPs).<sup>16</sup> The Commonwealth has specified the purpose of financial assistance in the Act, which is for the provision of health and emergency services traditionally provided by hospitals. This includes assistance for projects or programs to improve the efficiency and effectiveness of hospital-related services, to reduce the demand for hospital services or to improve patient outcomes. The purposes of funding are detailed in Figure 2.

### Figure 2

#### ***Health Care (Appropriation) Act 1998, Purposes of Funding***

The Minister may grant financial assistance to a State, or to a hospital or other person, for the purpose of:

- (a) providing, or paying for, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals; or
- (b) funding projects or programs that are designed:
  - (i) to improve the efficiency and effectiveness of, or reduce demand for, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals; or
  - (ii) to improve patient outcomes in relation to the delivery of such services.

1.7 The Commonwealth Parliament has also attached conditions to State and Territories' receipt of AHCA funding. The Act denotes these conditions as a set of principles that concern free public patient access to State and Territory hospital services, based on clinical need and regardless of geographic location.<sup>17</sup> The conditions and full set of principles are depicted in Figure 3.

<sup>15</sup> Clause 23 of the AHCAs provides for a review of financial assistance where the Commonwealth is satisfied that there is an ongoing reduction in the level of services delivered by the States and Territories against the annual separation rate, and the shortfall is not the result of the particular State or Territory taking action to provide public hospital services in other settings.

<sup>16</sup> Commonwealth of Australia, *Federal Financial Relations 2002-2003*, Budget Paper No.3, p. 43. See also the Glossary in this report for the definition of a SPP.

<sup>17</sup> Commonwealth of Australia 1998, *Health Care (Appropriation) Act 1998*, No. 74, Section 6(2).

### Figure 3

#### **Health Care (Appropriation) Act 1998, Conditions and Principles of Funding**

A grant of financial assistance ... is not payable to a State unless the Minister is satisfied that the State is adhering to the principles ...

##### **Principle 1**

Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals.

##### **Principle 2**

Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period.

##### **Principle 3**

Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of their geographic location.

**1.8** The provision of financial assistance as a SPP enables the Commonwealth Government to pursue a national policy objective. The 'National Health Policy' is premised on equity of access, standards of access and care, patient outcomes and the cost-effective use of health resources.<sup>18</sup> It provides for a collaborative approach where:

- national consistency is required to achieve efficiency, effectiveness and equity;
- there are implications for wider national social and economic objectives; and
- there are implications for international relations.

#### **Performance information requirements for the management of Commonwealth resources, including Specific Purpose Payments**

**1.9** There are two sets of guidelines that are applicable to the administration of SPPs, including those administered by Health. These include guidelines specific to the administration of SPPs, and program management responsibilities that apply to the administration of Commonwealth funds more generally.

**1.10** The administration of SPPs was reviewed by the Joint Committee of Public Accounts in 1994–95<sup>19</sup>, and again by the Joint Committee of Public Accounts

<sup>18</sup> The 'National Health Policy' is specified in the AHCAs, Part 4—Roles and Responsibilities of Governments under this Agreement, clause 14.

<sup>19</sup> JCPA, November 1995, *The Administration of Specific Purpose Payments: A Focus on Outcomes*.

and Audit in 1998<sup>20</sup>. These Committees, which are referred to as the JCPAA for the remainder of this report, aimed to improve public accountability for SPP performance by addressing the range of administrative practices employed by Commonwealth agencies.

**1.11** The JCPAA recommended greater clarification of the responsibilities between the levels of government, involving:

- States and Territories being responsible for accounting to the Commonwealth for outcomes, including justifying the expenditure of Commonwealth funds in terms of their performance towards achieving agreed objectives; and
- Commonwealth agencies, administering SPP agreements on behalf of the Commonwealth Government, being responsible for strategic planning and performance assessment.<sup>21</sup>

**1.12** The JCPAA also recommended a set of administrative features that, when taken together, reflect an 'ideal' SPP agreement.<sup>22</sup> These are expected to improve the capacity of Commonwealth agencies to assess outcomes achieved against stated SPP objectives through a more systematic approach to the development of performance indicators. The set of administrative features that characterise 'ideal' SPP agreements is provided in full at Appendix 1.

**1.13** The Committee did not consider that any particular SPP warranted an exception from its better practice administrative characteristics. The JCPAA noted that, despite their diverse nature and size, SPPs:

... have sufficient characteristics in common to allow valid generalisations to be made about their administration.<sup>23</sup>

**1.14** In the 1999–2000 Budget, the Government introduced the accrual-based Outcomes and Outputs Framework for the effective and efficient management of Commonwealth resources. The Framework requires agencies to align their proposed resources, activities and reporting of performance against the outcomes sought by the Government. This allows Parliamentarians and the public to

<sup>20</sup> JCPAA, June 1998, *General and Specific Purpose Payments*.

<sup>21</sup> JCPA, pp. 33 and 21. The Committee defined strategic planning as: *...the financial management, resource allocation, information distribution and coordination necessary to achieve SPP objectives at the national level. Strategic planning includes such tasks as the development of national strategic plans; the specification and maintenance of national data collection systems, and the commissioning and funding of research for policy development. In some SPPs, strategic planning may also include development of appropriate service delivery structures to ensure basic national consistency.*

<sup>22</sup> JCPA, p. 51, and JCPAA, pp. 57–8.

<sup>23</sup> JCPA, 1995, p. 4.

ascertain the real costs of delivering benefits to the Australian community (outcomes) and of agency goods and services (outputs), as published by agencies in their associated Budget documentation.<sup>24</sup>

**1.15** Performance information is integral to the Framework. Its three roles are to inform management decisions, inform policy decisions, and provide information needed for accountability purposes.<sup>25</sup>

**1.16** To carry out these roles effectively, administrators are required to specify and review performance indicators for their continued appropriateness, to monitor performance, to identify areas for improvement, and to publish the results to account to Parliament. As such, the Outcomes and Outputs Framework recognises that performance information is best where it can be used for both internal management and external accountability purposes.

**1.17** The Outcomes and Outputs Framework does recognise constraints on performance information for administered items—especially those where Commonwealth agencies oversee rather than control service delivery, such as with SPPs.<sup>26</sup> It further accepts that reporting of performance can be affected by terms set down in legislation and/or associated arrangements, such as intergovernmental agreements. The guidelines suggest that such terms may override an agency's capacity to report on the efficiency of administered items.<sup>27</sup> They make allowance for agencies to report on performance according to the terms of the relevant legislation and/or associated arrangements with the proviso that, where possible, reporting is in terms of efficiency indicators of the administered item.<sup>28</sup>

**1.18** During the audit, Health queried the applicability of both the Outcomes and Outputs Framework and the set of administrative characteristics for 'Ideal' SPP agreements to the AHCA's. The department's view is that, where the AHCA's are administered in the form agreed by the Government with the States and Territories, performance information is collected and published for accountability purposes rather than for the purposes of administration. The ANAO examined

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<sup>24</sup> The main Budget documentation includes Budget papers, portfolio budget statements (PBSs) and agency annual reports.

<sup>25</sup> Department of Finance and Administration 2000, *The Outcomes and Outputs Framework*, [online] <[http://www.finance.gov.au/budgetgroup/Commonwealth\\_Budget\\_-\\_Overview/the\\_outcomes\\_outputs\\_framework.html](http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/the_outcomes_outputs_framework.html)>

<sup>26</sup> DoFA 2000, *Performance Reporting Under the Outcomes and Outputs Framework*, [online] <[http://www.finance.gov.au/budgetgroup/Commonwealth\\_Budget\\_-\\_Overview/performance\\_reporting.html](http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/performance_reporting.html)> [accessed 7 April 2002].

<sup>27</sup> This includes the efficiency of third party outputs, as measured by a combination of indicators that include the quality, quantity and price of outputs.

<sup>28</sup> Department of Finance and Administration 2000, *Performance Reporting Under the Outcomes and Outputs Framework*, [online] <[http://www.finance.gov.au/budgetgroup/Commonwealth\\_Budget\\_-\\_Overview/performance\\_reporting.html](http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/performance_reporting.html)>, [accessed 7 April 2002].

this question, and concluded that the principles in both guidelines, particularly the requirements for performance information, provide a useful framework for ongoing AHCA administration, to inform management and policy decisions, and provide information needed for accountability purposes.

## Audit scope and objective

**1.19** The audit objective was to form an opinion on whether Health has the performance information necessary to administer the AHCAs.

**1.20** The audit was scheduled because the ANAO had not previously carried out a performance audit of Health's administration of Commonwealth financial assistance to the States and Territories for hospital and related services. The ANAO had only surveyed Health's administration of the Health Care Grants in audits that accompanied the JCPAA's reviews of SPP administration.

**1.21** A strong focus of the audit was accountability for performance, including financial accountability. Health requires a robust performance information regime to inform its management decisions and policy advice to Government. This is critical given the very significant Commonwealth outlays involved, and is against the background of the ANAO's 1998 findings that identified the need for Health to make substantial improvements in order to bring its management of SPPs up to an adequate standard of accountability.<sup>29</sup> The 1998 audit included a more general finding that Commonwealth agencies would benefit from greater attention to financial accountability, as there had been a significant deterioration in the rate of acquitting SPP agreements.<sup>30</sup>

## Audit approach

**1.22** The current audit used the JCPAA's set of recommended administrative characteristics for SPP agreements, the Government's Outcomes and Outputs Framework, and standard financial accountability requirements drawn from the *Financial Management and Accountability Act 1997* and ANAO experience as guidance on the performance information requirements necessary for the administration of SPPs.

**1.23** All performance and financial data collected by Health for reporting on AHCA performance was included within the scope of the audit.

<sup>29</sup> Australian National Audit Office, Audit Report No.31, 1998–99, *The Management of Performance Information for Specific Purpose Payments—The State of Play*, Summary Brochure, p. 1.

<sup>30</sup> Australian National Audit Office, Audit Report No.31, 1998–99, *The Management of Performance Information for Specific Purpose Payments—The State of Play*, Summary Brochure.

**1.24** The main methods of inquiry involved:

- a review of Health's documents and data. The most recent of these included the Australian Health Care Agreements, Annual Performance Report 1998–99<sup>31</sup>, and Health's 2000–2001 Portfolio Budget Statements and Annual Report. These were the most recent full-cycle external reporting documents by the Department available during the audit. In addition, the audit included the most recent performance indicators in Health's Portfolio Budget Statements for 2002–03; and
- interviews with officers of the Commonwealth Department of Health and Ageing, State and Territory health departments, Australian Institute of Health and Welfare, National Health Performance Committee, the Canberra Hospital, Productivity Commission and the Commonwealth Department of Finance and Administration.

**1.25** Fieldwork was conducted between November 2001 and April 2002 in Health's national office in Canberra. The audit team met with representatives of State and Territory health departments and other stakeholders in Canberra, Melbourne, Sydney and Brisbane.

**1.26** A consultant, Dr Russell Ayres of Challenge Consulting, was engaged to assist with technical issues associated with the application of the Outcomes and Outputs Framework.

**1.27** The audit was conducted in accordance with ANAO auditing standards and cost an estimated \$360 000.

## Previous audits and better practice guides

**1.28** The ANAO has published a better practice guide and several audit reports relevant to improving performance information. In order of most recent publication, these include:

- *Performance Information in Portfolio Budget Statements*, Better Practice Guide, May 2002;
- *Performance Information in Portfolio Budget Statements*, Audit Report No.18, 2001–02;
- *ATO Performance Reporting under the Outcomes and Outputs Framework*, Audit Report No.46, 2000–01;
- *Performance Information for Commonwealth Financial Assistance under the Natural Heritage Trust*, Audit Report No.43, 2000–01; and

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<sup>31</sup> The report is available on Health's website at: <<http://www.health.gov.au:80/haf/docs/hca/ahcarpt98.htm>>

- *The Management of Performance Information for Specific Purpose Payments—The State of Play*, Audit Report No.31, 1998–99.

**1.29** Relevant reviews, in order of most recent publication, include:

- Joint Committee of Public Accounts and Audit, *Review of the Accrual Budget Documentation*, Report No.388, June 2002;
- Joint Committee of Public Accounts and Audit, 1998, *General and Specific Purpose Payments to the States*, Report No.362; and
- Joint Committee of Public Accounts, 1995, *The Administration of Specific Purpose Payments: A Focus on Outcomes*, Report No.342.

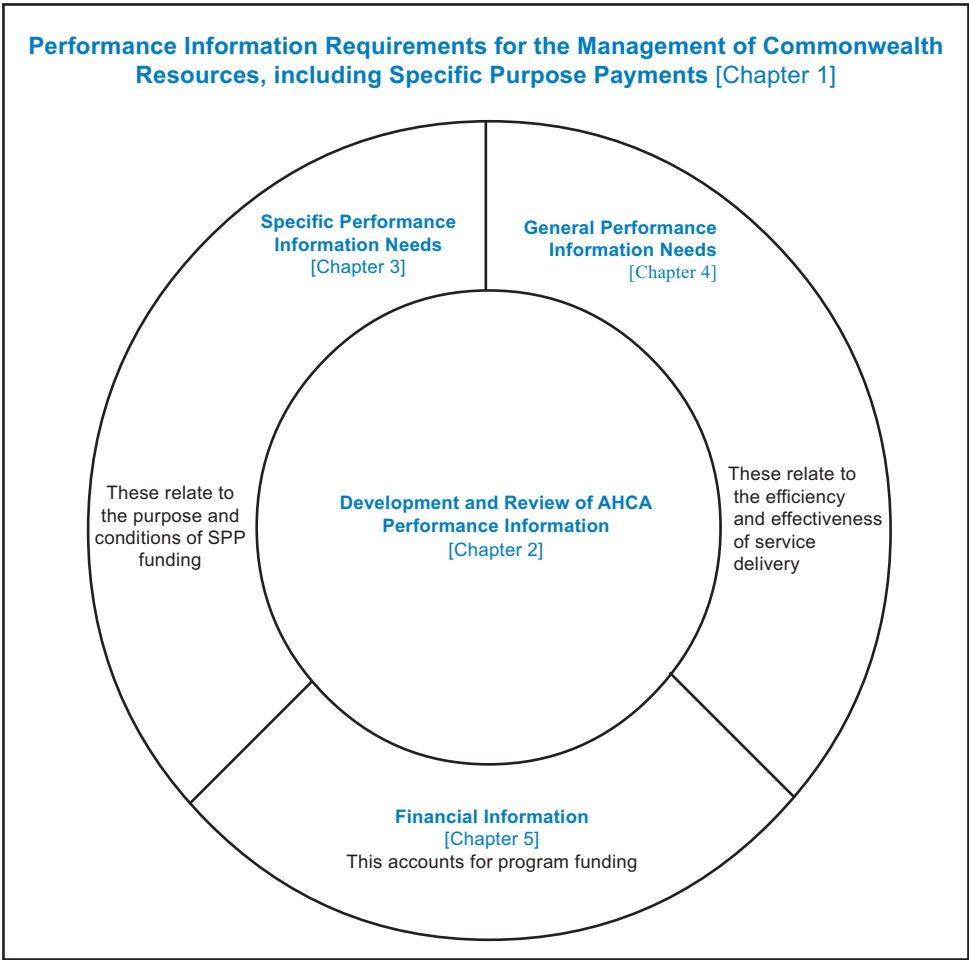
## Structure of the report

**1.30** The structure of the report is based around the performance and financial information requirements for AHCA accountability. This report structure includes:

- a chapter on Health’s processes to develop and review AHCA performance information for ongoing appropriateness (chapter 2);
- specific performance information germane to the AHCAs as SPPs, which includes the ability to report to Parliament on whether the conditions and purpose of funding have been met (chapter 3);
- the more general performance information required for program management purposes, which includes accounting for the effectiveness of outcomes achieved and the efficiency of departmental outputs and administered items (chapter 4); and
- Health’s processes to ensure the financial accountability of the States and Territories in the administration of the AHCAs (chapter 5).

**1.31** Figure 4 depicts how the development and review of AHCA performance information is informed by their specific and general performance information needs, as well as financial information. The Figure also depicts the structure of the report.

**Figure 4**  
**Report Structure**





## 2. Development and Review of AHCA Performance Information

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*This chapter reviews Health's processes to develop and review information for AHCA administration, including mechanisms that involve the States and Territories. It concludes that Health reached national agreement in concert with the States and Territories on an initial set of indicators, but that further work is necessary to develop the performance information.*

### Introduction

**2.1** The development of performance indicators in the administration of SPPs is more complicated than in programs where agencies have direct control of service delivery. This is because the Commonwealth is dependent upon the States and Territories for the provision of data and, therefore, may require agreement with individual States and Territories, or agreement nationally, on the range of performance indicators needed for accountability purposes. This is the case for Health with respect to its administration of the AHCAs. In regard to the latter, the parties are committed to the sharing and reporting of information and to contribute to the development of national performance indicators on health outputs and outcomes.<sup>32</sup>

### Process for developing performance indicators

**2.2** The development of AHCA performance indicators commenced in 1997–98, during the negotiation of the AHCAs. At that time, Health established the need for reliable data and information. Health recognised that, while much information already existed, it was not always available in an integrated or timely way. This led to inclusion in the AHCAs of a commitment to two areas of performance indicator development. The first includes developing a set of national performance indicators from the range of broad indicators specified in the Agreements (as set out in Schedule C of the AHCAs)<sup>33</sup>, for the purposes of monitoring, reporting and improving performance.<sup>34</sup> The second includes developing performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services.<sup>35</sup>

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<sup>32</sup> AHCAs, clauses 20 and 21.

<sup>33</sup> See Figure 5.

<sup>34</sup> Clauses 20, 21 and 68 (clause 69 in the Northern Territory Agreement) of the Agreements; and Schedule C, clause 3, refer.

<sup>35</sup> Clause 67 of the Agreements refers.

**2.3** The aim of the performance reporting framework is to demonstrate the contribution of overall funding to better health outcomes for all Australians.<sup>36</sup> It is also expected to lead to performance improvements, as:

Reporting will enable the Commonwealth and States and Territories to compare performance within the acute health sector and to set benchmarks which are intended to:

- stimulate improvement in service performance and health outcomes;
- inform national and State acute health policy development and, where possible, consumer decisions; and
- facilitate best practice service delivery.<sup>37</sup>

**2.4** The Australian Health Ministers' Advisory Council (AHMAC) established a Working Group on Performance Measures and Data (Working Group) on 6 August 1998. The Working Group comprised representatives of the Commonwealth and all State and Territory health departments, and was charged with developing the AHCA reporting framework. The Working Group, which was disbanded following its report to AHMAC in April 1999, provided recommendations covering the style and content of annual AHCA performance reports, performance measures to be included in the annual reports, and establishment of a National Health Performance Committee (NHPC). AHMAC further agreed that Health would have responsibility for the preparation of the annual performance reports, based on information provided by the States and Territories.

**2.5** With respect to the indicators chosen to report performance, the Working Group concentrated on the range of broad indicators listed in the AHCAs, and for which reliable data already existed for the most part:

The Working Group is conscious of the wide variety of material on activity levels, system performance and benchmarking which is available across Australia at the national, state and territory, regional and individual health unit level. In this report the Working Group has concentrated on developing for the AHCA Report a limited range of performance measures in the areas described in Schedule C to the Agreements. Most of the data on these measures already exists in national data sets, although some development activity is proposed.

**2.6** This resulted in a set of national performance indicators, which were an amplification of the seven broad indicators listed in Schedule C of the AHCAs. The list of AHCA indicators is reproduced in Figure 5, with the full set of indicators reported in the AHCA annual report provided at Appendix 2.

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<sup>36</sup> AHCAs, Schedule C, clause 1.

<sup>37</sup> AHCAs, Schedule C, clause 2.

**Figure 5****Performance Indicators Listed in the AHCAs (Schedule C)**

The Commonwealth and [the relevant State/Territory] agree to work together to develop and refine appropriate high level performance indicators where these do not presently exist. These indicators could include:

- waiting times for access to services;
- indicators of Aboriginal and Torres Strait Islander health;
- indicators of integration of care processes and indicators of access to primary care;
- measures of quality of care, including patient satisfaction;
- indicators of effort in medical training and medical research;
- mental health reform indicators; and
- indicators of access to and quality of palliative care services.

**2.7** In relation to this set of indicators, the Working Group proposed the referral of some performance indicator development to various bodies. For example, performance indicator development for mental health is proceeding under the AHMAC National Mental Health Working Group, in collaboration with the NHPC and the Steering Committee for the Review of Commonwealth/State Service Provision. This work, however, relates to only one aspect of health care services for which financial assistance is provided to the States and Territories under the AHCAs.

**2.8** The NHPC, which includes Commonwealth, State and Territory representatives, has a role in continuing the development of performance indicators as part of its terms of reference to develop and maintain a national performance measurement framework for the health system. This encompasses benchmarking for health system improvement, providing information on national health system performance and reporting progress to the Australian Health Ministers' Conference and other national authorities.

**2.9** Work on developing performance indicators relevant to the AHCAs is occurring in one other area. This involves refinement of the National Health Data Dictionary, which is the basis for definitions and data elements in the national minimum data sets. The Dictionary is aimed at ensuring consistent interpretation of performance indicators used for reporting in the Health area and, as such, underpins the ability to compare data within and across jurisdictions.

**2.10** In terms of Health's performance information needs, the Working Group provided a forum to achieve Commonwealth and State and Territory consensus on an initial set of national indicators for reporting on AHCA performance. It did not, however, result in either:

- a process for reviewing AHCA performance information needs more generally, such as indicators on efficiency, quality, appropriateness, accessibility and equity of health services; or
- a mechanism to follow up progress on the developmental work it proposed.<sup>38</sup>

**2.11** The establishment of the NHPC—while significant in terms of providing an ongoing Commonwealth, State and Territory forum for performance indicator development in the health arena—is expected to result in indicators that are broader and at a higher level than those needed by Health in terms of its administration of the AHCAs. That is, the NHPC's work is not specific to measuring whether the AHCA objectives concerning hospital and associated services are being met.

**2.12** Health has not independently reviewed the performance information it needs to administer the health and emergency services provided by hospitals and the associated reform purposes of financial assistance under the AHCAs. An exercise of this kind would assist the Commonwealth in its subsequent negotiations with the States and Territories, and should be undertaken in a manner consistent with the Government's Outcomes and Outputs Framework and the JCPAA's preferred administrative characteristics for SPP agreements.

## **Publication of the annual AHCA performance report**

**2.13** The AHCA annual report is the main accountability mechanism under the AHCAs. AHMAC agreed that the reports should be published on an annual basis, with the Working Group proposing the first report to be published in September 2000 for the 1998–99 financial year. The Committee further agreed to the form, content and structure of the report, and to its review by the States and Territories prior to its publication by Health. This review provides for the States and Territories to check the accuracy of data, to comment on its implications and, where necessary, to include caveats on the completeness and/or reliability of data sets prior to its publication. Health has indicated that the States and Territories have been invited to comment and provide suggestions on improvements in the format and content of the report since that time.

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<sup>38</sup> Health receives information on performance indicator development from individual bodies with responsibility for developing performance measures.

**2.14** In terms of the provision of data, the AHCAs specify timeframes for two performance indicators. The States and Territories are responsible for providing elective surgery and emergency department waiting times data on a quarterly basis, three months after the end of the quarter, and morbidity data no later than six months after the end of the financial year. There are neither rewards nor penalties in the Agreements for the States and Territories in terms of the timeliness of providing performance data.

**2.15** Health has published one annual AHCA performance report.<sup>39</sup> This is for the first year of the Agreements, the 1998–99 financial year. The report, which was published in February 2001, five months after the publication date agreed by AHMAC<sup>40</sup>, includes data on the set of performance indicators agreed by AHMAC as well as information on progress against the reform items.<sup>41</sup> At the time of the audit, Health had prepared a second AHCA annual performance report for the 1999–2000 financial year, which includes all public hospital activity and waiting times data required for the publication of the report. The draft report was provided to the States and Territories for consideration and agreement, including at ministerial level, in November 2001. Over two years have elapsed since the end of the financial year to which its data applies.

**2.16** The reasons for the extended preparation time of the reports include late receipt of data by Health and the time taken to clear the reports with the States and Territories. For example, while Health does make sustained efforts to obtain complete and timely data from the States and Territories, several jurisdictions provided data late. In total, 11 months transpired from the due date before Health had received full and corrected returns on hospital activity and waiting times data from all States and Territories. Health's departmental annual report for 2001–02 indicates that waiting times data was not received from Western Australia and Tasmania.<sup>42</sup>

**2.17** Despite the lengthy preparation time, the parties to the AHCAs recognise the annual performance report as a significant advance on the reporting regimes of previous agreements. The report provides tables of data for each of the performance indicators agreed to by AHMAC, for all jurisdictions.

<sup>39</sup> The *Australian Health Care Agreements Annual Performance Report 1998–99* can be found on Health's website at: <<http://www.health.gov.au:80/haf/docs/hca/ahcarpt98.htm>>.

<sup>40</sup> The report was published 20 months after the reporting period.

<sup>41</sup> AHCAs, Part 5: Measure and Share reform proposals (clauses 27, 28 and 35); Strategic plans for Quality Improvement and Enhancement (clauses 29 and 30); Strategic Plans for National Health Development Fund Projects (clauses 31 and 32); and Information Technology Reform (clauses 33 and 34).

<sup>42</sup> Department of Health and Ageing, *Annual Report 2001–02*, pp. 120–1.

**2.18** Nevertheless, State and Territory officials interviewed during the audit expressed a need to improve the design of the performance report. Two States indicated that the utility of the report for policy purposes was diminished without analysis of the data<sup>43</sup>. A further State viewed the report as an accountability mechanism, with its value to inform policy limited by the late publication and the lack of analysis in the report. Health indicated that, while there is little opportunity to change the format, content and process under the current Agreements, the 2000–01 performance report provides an opportunity to report and analyse time series data for the 1998–99 to 2000–01 period.

## Conclusion

**2.19** Health has reached national agreement, in concert with the States and Territories, on a set of national performance indicators for accounting for AHCA performance. This was through the joint Working Group on Performance Measures and Data, which produced agreement on an initial set of indicators for reporting purposes and on the publication of associated data in an annual AHCA performance report. The parties to the AHCAs recognise the report as a significant advance on the reporting regimes of previous agreements, due to the data it provides for State and Territory comparisons of performance. States and Territories interviewed on this point during the audit supported the continuation of the report.

**2.20** Notwithstanding the level of support for the report, it is too early to determine whether the annual report, and in particular the publication of data, will meet expectations in terms of promoting performance improvements. Health and some State health officials believe that its utility for policy-making purposes could be enhanced, as issues associated with its preparation time and data analysis are addressed. Time series data and its analysis should assist with the identification of areas for performance improvement. Further, the structure of the report does not readily demonstrate the contribution of overall AHCA funding to better health outcomes for all Australians. This may have been affected by the choice of the Working Group to focus on existing data, and the absence of a mechanism to review performance information needed to report on health outcomes and outputs at the national level.

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<sup>43</sup> The Australian Institute of Health and Welfare (AIHW) regularly publishes data on hospitals. Its most recent publication is *Australian Hospital Statistics 2000–2001*. There are similarities and differences between Health's *Annual Performance Report* and the AIHW publication. Differences include the year to which the data apply, data comprehensiveness and data measures.

**2.21** The process adopted for performance indicator development did not lead to complete review of performance indicators on efficiency, quality, appropriateness, accessibility and equity of health services. Health has not independently reviewed these performance information needs. If this were undertaken, it would assist the Commonwealth in its preparations for the negotiation of the 2003–08 AHCAs. Such an exercise should be undertaken in a manner consistent with the Government's Outcomes and Outputs Framework and the JCPAA's preferred administrative characteristics for SPP agreements.

**2.22** While Health has taken a step forward in building a database on the effects of AHCAs on hospital and related services across Australia, the task will be ongoing. This reinforces the need for Health to review its information needs independently of the States and Territories and to develop a long-term information plan for the systematic development and review of performance indicators. It also demonstrates the need for Health to continue to work with the States and Territories on performance indicator development for the benefits this provides, not only to its own administration of the AHCAs, but also to the States and Territories for the advantages that shared information offers through national monitoring and reporting of results.

**2.23** Renegotiation of the agreements in 2003 is an opportunity for Health to enhance performance information processes to assist its administration of the AHCAs, by:

- supplementing the current focus on available data as the key criterion for selecting performance indicators;
- ensuring ongoing review of the appropriateness of performance indicators; and
- ensuring consistency between the AHCA performance indicator regime and the NHPC's performance information framework for the broader health system.

**2.24** Initiatives could include establishment of a permanent or semi-permanent body like the Working Group established by AHMAC. Such a body would build on the level of commitment of the parties to national reporting of performance achieved with the current Agreements and, most importantly, could assist in achieving ongoing improvements in indicator development.

## Recommendation No.1

2.25 ANAO recommends that, in order to administer the AHCAs, Health:

- review its performance information needs according to the outcome the Commonwealth is seeking, in preparation for the negotiation of the 2003–08 Agreements; and
- in the context of this review, take account of the guidelines on the Government's Outcomes and Outputs Framework and the JCPAA's preferred administrative characteristics for SPP agreements.

### *Health's Response*

2.26 Agreed, noting that the Government is yet to decide on the approach it will be taking to these issues in the 2003–08 Agreements.



## 3. Specific Performance Information Needs

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*This chapter reviews the performance information available to Health on the AHCAs' objectives of funding concerning hospital and associated services, and the conditions of funding associated with access to these services. The chapter concludes that Health has limited information on both of these.*

### Introduction

**3.1** The level of Commonwealth financial assistance paid to the States and Territories for hospital and associated health care services has increased over the last decade. The Medicare Agreements that covered the period from 1993–94 to 1997–98 involved a total of \$23.4 billion. This compares with a total of \$31.7 billion expected for the AHCAs between 1998–99 and 2002–03, with the annual level of financial assistance in 2002–03 to exceed \$7.1 billion. The extent of this increase in expenditure over the past decade means that AHCA funding will account for almost 33 per cent of all Commonwealth SPP funding to State, Territory and local government sectors in 2002–03. Figure 6 compares the composition of estimated SPP payments to and through the States and Territories for 1997–98 and 2002–03.

**3.2** The level of funding involved with the AHCAs has led to specific performance information requirements for their administration. The Government sought to improve accountability by specifying the conditions and purposes of financial assistance in the *Health Care (Appropriation) Act 1998* (the Act). Consequently, Health requires performance information to advise the Minister on whether these have been met. In addition, the JCPAA's better practice administrative characteristics for SPP agreements suggest measurable performance indicators, linked to and specified for each SPP program objective in order to account for performance.

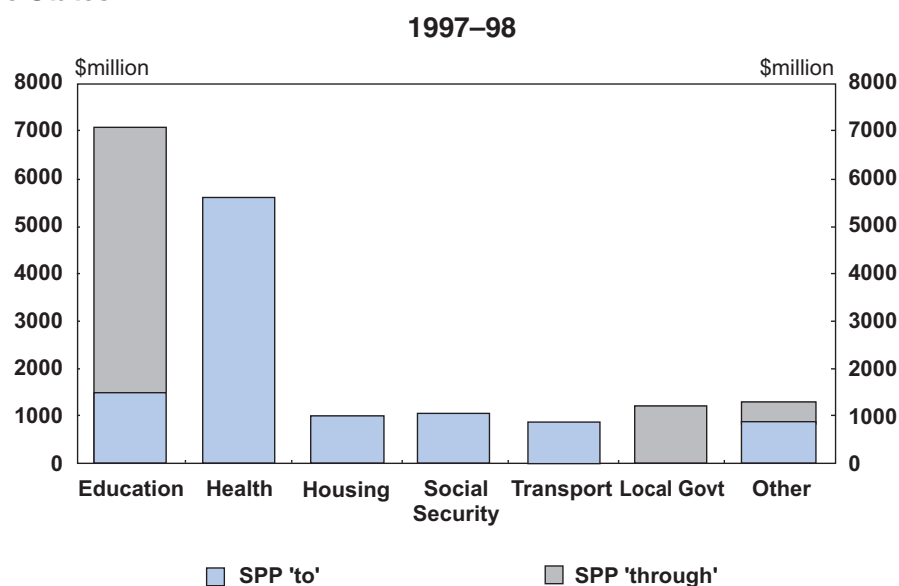
**3.3** Health expressed its view during the audit that the JCPAA's better practice administrative characteristics do not apply to the AHCAs. This was on the basis of constraints imposed by the status of the AHCAs as intergovernmental agreements, rather than departmental-level agreements.

**3.4** While appreciating that the AHCAs require agreement by the Commonwealth and States and Territories, measuring achievements against the objectives set by Health Ministers (see Figure 1) can only be advanced through an ongoing focus on improvements to performance information as envisaged by the terms of the Agreements. In this context, the guidelines provided by the

JCPAA provide a useful framework to achieve this. The use of intergovernmental agreements is consistent with the JCPAA's better practice standards for SPPs involving large expenditures. It is the JCPAA's view that large SPPs should use intergovernmental agreements, underpinned by legislation, for the purposes of verifying States and Territories' acceptance of the conditions attached to funding and for improving Parliament's ability to scrutinise their design and implementation. While the Committee did not consider any particular SPP warranted an exception,<sup>44</sup> it did recognise a constraint in terms of the timeframe for incorporating the set of better practice administrative characteristics into SPPs.<sup>45</sup> This included reference to Health.

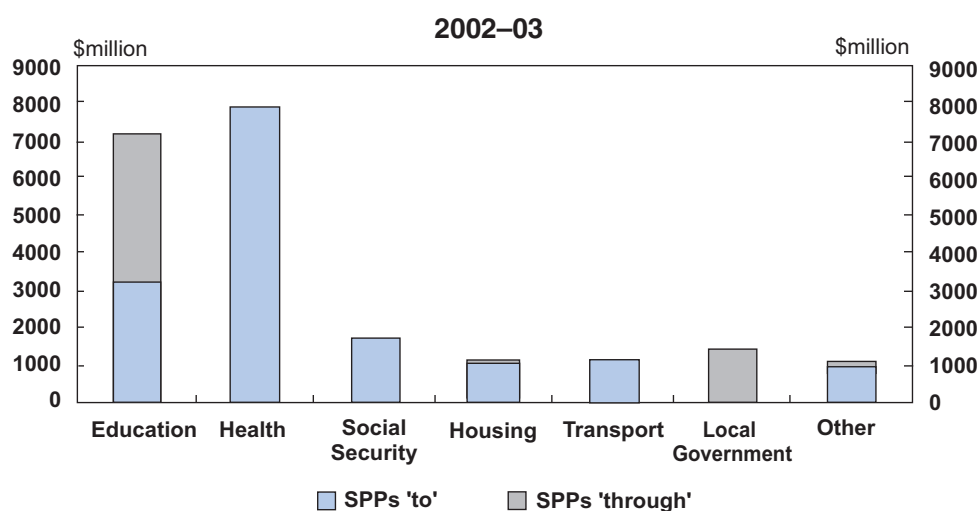
3.5 On this basis, the remainder of this chapter examines whether Health has the performance information necessary to meet the specific administrative needs of the AHCAs. With respect to the purpose of funding, this is covered by the examination of performance information for the objectives of the AHCAs, given that these encompass the purposes of funding.

**Figure 6**  
**Composition of Estimated Specific Purpose Payments 'to' and 'through' the States**



<sup>44</sup> JCPA, 1995, p. 4.

<sup>45</sup> JCPA, 1998, pp. xii and 100.



Source: Department of Finance and Administration

## Conditions of funding

**3.6** The AHCAs refer to the conditions and principles of funding. Clause 13 of the Agreements repeats the set of principles contained in the Act, concerning free public patient access to State and Territory hospital services, based on clinical need, and regardless of geographic location. The set of principles as stated in the Act is provided at Figure 3, chapter 1.

**3.7** With respect to the principles, clauses 13 states that:

Principles 2 and 3 are met if [the respective State or Territory] is using its best endeavours to achieve the outcomes sought in those principles to the greatest extent practicable.

**3.8** In addition, the AHCAs specify a commitment to develop performance indicators that would encapsulate reporting on the principles. Clause 67 uses terms consistent with equitable and appropriate access to services. It states:

The Commonwealth and [the respective State or Territory] agree to continue the development of performance indicators on ... appropriateness, accessibility and equity of health services.

**3.9** As indicated in chapter 2, Health developed a range of performance indicators in conjunction with the States and Territories to account for AHCA performance. This was to demonstrate that overall funding is contributing to better health outcomes for all Australians. Performance indicators were selected largely on the basis of available data, and included in the *Australian Health Care Agreements Annual Performance Report 1998–99*. Health requires information on whether the objectives, conditions and principles of funding have been achieved in order to guide its administration and to provide ministerial advice. Because of this, the ANAO reviewed information in the 1998–99 AHCA annual report to establish its

utility for these purposes. Information on all three principles was reviewed, taking account of clause 13 above. This was on the basis of Parliament's expectations and Health's need for the information to improve its administration of the AHCAs.

**3.10** The ANAO found that there were indicators for reporting on principles 1 and 2, but none for reporting directly on principle 3.<sup>46</sup> The indicators for reporting on principles 1 and 2 varied in their validity and applicability, although each relevant indicator referred to the respective principles to some extent. Figure 7 provides details of the extent to which current performance indicators relate to the principles.

### Figure 7

#### Performance Indicators for AHCAs' Conditions and Principles of Funding

**Principle 1—Eligible persons are to be given the choice to receive, free of charge as public patients, health and emergency services of a kind or kinds that are currently, or were historically, provided by hospitals**

There are no indicators that measure this Principle directly. There are, however, two performance indicators that measure the level of activity associated with access to public hospital services: public patient weighted separations per 1000 applicable weighted population; and non-admitted patient activity.

**Principle 2—Access to such services by public patients free of charge is to be on the basis of clinical need and within a clinically appropriate period**

There are two performance indicators that together partially address this Principle. These are elective surgery and emergency department waiting times, both of which have specified categories and associated targets for the timely receipt of services.

**Principle 3—Arrangements are to be in place to ensure equitable access to such services for all eligible persons, regardless of geographic location**

No performance indicator addresses this Principle directly. The level of servicing by general practitioners provides some indication of access to health care services across metropolitan, rural and remote areas.

### AHCAs' objectives

**3.11** The JCFAA suggests that SPP agreements should have clear, achievable and measurable objectives, as a prerequisite for the systematic development of performance indicators that can account for the expenditure of Commonwealth funds.<sup>47</sup> Where objectives are high level, broad and difficult to measure, as with the AHCAs, the ANAO's Better Practice Guide on *Performance Information in Portfolio Budget Statements*

<sup>46</sup> Reporting in Chapter 6 of the AHCA performance report was agreed as a means of measuring the extent to which people have access to primary health care services by geographic location.

<sup>47</sup> See Appendix 1.

suggests the development of intermediate outcomes to provide a more appropriate basis for the development of outputs and relevant effectiveness indicators.<sup>48</sup>

**3.12** Within this context, the ANAO analysed the set of indicators to establish whether they could be used to measure and monitor achievement of the AHCAs' objectives. The findings are presented in Table 1 below.

**Table 1**

**Links Between AHCAs' Objectives and Performance Indicators**

AHCAs' Objectives	Relevant Performance Indicator/s*	Links/Comment
The Commonwealth and the [respective State/Territory] are committed to ensuring that the Australian health care system is a world class system which:	None	No measures available for 'world class system'.
☐ maximises health of individuals and the community	None	There are no health outcome indicators in the AHCAs.
☐ reflects balance between investment in the health of individuals and the health of the community	None	No measures available.
☐ responds flexibly to community and consumer needs	3, 4, 5, 6, 7, 8, 9 and 18	The connection between this component of the objective and the relevant indicators is not strong. Most are proxy or partial indicators of the effectiveness or quality of health services.
☐ integrated and coordinated	7	This is a partial indicator of integrated care.
☐ best practice, evidence based health care	9, 10 and 11	Indicator 9 relates to this component of the objective on the assumption that the accreditation process is based on best practice concepts. Indicators 10 and 11 measure inputs (training and research) that might be expected to lead to 'best practice health care'.
☐ matches proven health services with health service priorities	12 to 13, and 18 to 23	As above, the connection between this component of the objective and the indicators is not strong. Most are proxy or partial indicators of the effectiveness or quality of health services in addressing this aspect of the objective.

\*See Appendix 2 for the list of AHCA performance indicators

Source: ANAO

<sup>48</sup> Australian National Audit Office, *Performance Information in Portfolio Budget Statements*, Better Practice Guide, May 2002, p. 9.

**3.13** The analysis shows that several of the AHCA objectives have no related performance indicators. The links between the performance indicators and the remaining objectives are generally indirect or partial. For example, with respect to an ‘integrated and coordinated’ health care system, the performance indicator is mode of separation by care type by age group. The *Australian Health Care Agreements Annual Performance Report 1998–99*, which bears a similar heading, provides data as to where patients were discharged, such as another acute hospital or nursing home.<sup>49</sup> While this implies levels of coordination or integration between services, additional information would be required to determine optimal performance and the underpinning reasons for the results.

**3.14** One important indicator used by Health to administer the AHCAs is not related to the AHCAs’ objectives. ‘Public patient weighted separations per 1000 applicable weighted population’ is used as the basis for triggering possible reviews of the level of the base funding grant. A reduction could occur if States or Territories failed to meet the agreed level of services, as measured by the annual hospital separation rate. The clause is not intended to result in a reduction of financial assistance where a State or Territory maintains the agreed level of service but through a different service delivery model involving the provision of services in other settings (that is, not hospitals). Therefore, the performance indicator is used for AHCA administration, by informing policy advice. A further indicator ‘average cost per separation’ is an important efficiency measure.

**3.15** Health indicated that the relationship between the objectives which the Commonwealth and States share for the whole health system, as set out in clause 4 of the Agreements<sup>50</sup>, and the role of the AHCAs in contributing to achievement of these objectives is not clearly stated in the current AHCAs. Health suggests that clause 4 should be interpreted as a contextual statement about the broader Commonwealth and State/Territory relationship in health, rather than a statement of the objectives of the AHCAs alone, and that this statement should be clearly stated in the next AHCAs.

## Conclusion

**3.16** Commonwealth, State and Territory Ministers envisaged in the financing Agreements that performance information would be developed and enhanced on the appropriateness, accessibility and equity of health services. An intention was to facilitate Health’s monitoring of AHCA outcomes, including whether

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<sup>49</sup> This is the only AHCA objective to have a similar heading in the *Australian Health Care Agreements Annual Performance Report 1998–99*. The data provided in the report is identified by demography and the nature of hospital episode, that is, according to whether the hospital experience was categorised as ‘acute’, ‘rehabilitation’, ‘palliative’, ‘non-acute’ or ‘other’ episode of care.

<sup>50</sup> See Objectives of the Australian Health Care Agreements at Figure 1.

the States and Territories were achieving the conditions and principles of funding. The ANAO's analysis of the indicators developed under the Agreements shows that Health has only partial information to monitor State and Territory adherence to the conditions.

**3.17** While the measurement of performance against objectives was not specified as a requirement of the AHCAs, it is better practice and the information is necessary for effective administration. The ANAO's analysis shows that the indicators provide only partial coverage of the objectives and, where linkages do exist, they are often indirect. Health's ability to develop appropriate indicators of performance is affected by the high level and broad nature of the objectives. It would be appropriate for Health to address this in the next Agreements by developing intermediate outcomes to make the measurement of objectives more direct. Chapter 4 provides further analysis of information on achievement of AHCA objectives.

**3.18** The reasons for these outcomes are due, at least in part, to the process adopted for performance indicator development. As discussed in chapter 2, Health was constrained by the need to reach national agreement. The process focussed on developing the national set of indicators based on existing data, rather than a broader consideration of AHCA accountability requirements, with no mechanism in place to review performance information needs.

**3.19** As the AHCAs are due to expire on 30 June 2003, Health has an opportunity within the context of negotiations for the new agreements to progress enhancements to the performance information framework. In doing so, performance indicator development should be regarded as part of an integrated approach to the demonstration of accountability, alongside development of policy objectives for the new agreements.

## 4. General Performance Information Needs

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*This chapter reviews Health's performance information on the effectiveness and efficiency of hospital and associated health care services funded by the AHCAs, including the department's role in this area. Its conclusion is similar to that in the previous chapter, which is that the Health has limited performance information on the AHCAs' contribution to improvements in the effectiveness and efficiency of hospital and hospital-related health services.*

### Introduction

**4.1** One of the purposes of the AHCAs is to improve the effectiveness and efficiency of hospital-related health care services. This purpose accords with Health's resource management requirements under the Outcomes and Outputs Framework. In relation to this, the Commonwealth and the States and Territories have a mutual interest to maximise performance within budgetary constraints. The large sums involved mean that even a small efficiency gain produces substantial savings to the Commonwealth and/or State and Territory governments, or frees funds for service delivery elsewhere.

**4.2** The JCPAA has provided guidance on the role expected of Commonwealth agencies for improving SPP performance, where responsibility for service delivery resides with the States and Territories rather than with the Commonwealth agency. This guidance encompasses Commonwealth leadership for strategic planning and performance assessment at the national level.<sup>51</sup> Health has recognised this role as appropriate<sup>52</sup>, indicating in its Portfolio Budget Statements (PBS) that:

As the achievement of this outcome is dependent on a range of stakeholders, including State and Territory governments, private-for-profit and private-not-for-profit organizations, the Department plays a national leadership role in ensuring that these different stakeholders work together to achieve the outcome.<sup>53</sup>

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<sup>51</sup> See chapter 2 of this report.

<sup>52</sup> *Portfolio Budget Statements 2000–01, Health and Ageing Portfolio*, p. 73. Health's key strategic directions in Outcome 2 for 2000–01 were: improving access to Commonwealth health programs across the population; pursuing quality improvements through the use of sound evidence and information technology development; continuing to pursue long term financial sustainability in health programs; and developing strategies to better integrate health care across programs around the needs of individual patients.

<sup>53</sup> *Portfolio Budget Statements 2000–01, Health and Ageing Portfolio*, p. 97.



**4.3** As indicated earlier, another source of guidance to agencies on SPP administration are Finance's guidelines on the Outcomes and Outputs Framework. Health expressed its view during the audit that the Outcomes and Outputs Framework was inappropriate for assessing its performance in administering the AHCAs. As with the JCPAA's requirements, Health referred to the intergovernmental nature of the Agreements as a constraint, and suggested that any assessment of its administration would be difficult because of its inability to control the level of conformity with the Framework.

**4.4** Despite these reservations, Health is required to administer the AHCAs according to the Framework. The AHCAs contain specific features that are consistent with this expectation, including an outputs-based funding model. This includes an adjustment to the annual level of HCGs paid to the States and Territories to reflect changes in hospital output costs, and changes in the utilisation of public hospital services.<sup>54</sup> There also exists a mechanism to review funding levels should public hospital utilisation fall below levels agreed between the Commonwealth and each State and Territory government.<sup>55</sup> Health has relevant performance indicators for these, which it uses to conform to the Outcomes and Outputs Framework.

**4.5** On this basis, the remainder of the chapter examines whether Health has the performance information necessary for its strategic planning and performance assessment role at the national level. The first part of the chapter addresses this issue by reviewing performance information in the *Australian Health Care Agreement Annual Performance Report 1998–99*. The second part reviews the performance information in Health's budget documentation and annual report to Parliament, including Health's description of its own leadership role.

## Performance information in the AHCA annual report

**4.6** The AHCA annual report contains the full set of data on the indicators to which all States and Territories agreed. It also contains information on the reform agenda, which includes measure and share reform proposals, and plans for quality improvement and enhancement. The analysis is provided in Table 2. It shows that the set of indicators, when taken together, provide useful information on health outcomes and outputs related to AHCAs. There are:

- four indicators for effectiveness; and
- eighteen indicators for efficiency (4 price indicators, 3 quantity indicators and 11 quality indicators).

<sup>54</sup> Indexation for utilisation of public hospital services is measured by the applicable weighted population, which refers to the total population less the insured population less the entitled veterans (Gold Card holders).

<sup>55</sup> This relates to the provision to review funding levels according to changes in public hospital utilisation rates, under clause 23 of the AHCAs.

**4.7** The most important indicators for Health are for information on efficiency, including the indicators: public admitted patient separations per 1000 applicable weighted population, waiting times for elective surgery and waiting times for emergency department services (indicators 1, 4 and 5, respectively).<sup>56</sup> Health's use of this information is discussed later in the chapter.

**4.8** Apart from these three indicators, it is difficult to establish the appropriateness of the full set of indicators for reporting on the effectiveness and efficiency of the AHCAs. This is because the indicators are not matched against the outcomes and outputs to be achieved, which leads to difficulties for Health in terms of assessing the effects of the AHCAs on hospital and related services. The most useful information associated with the above indicators is that which Health can associate directly with the AHCAs' objectives.

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<sup>56</sup> *Portfolio Budget Statements 2000–01, Health and Ageing Portfolio*, p. 104.

**Table 2**  
**Efficiency and effectiveness attributes of AHCA performance indicators**

AHCA Performance Indicators <sup>57</sup>	Characteristics Under the Outcomes and Outputs Framework			
	Outcome Indicators	Output Indicators		
		Price	Quantity	Quality
1. Public patient weighted separations per 1000 applicable weighted population			✓	
2. Average cost per separation		✓		
3. Public hospital non-admitted patient occasions of service			✓	
4. Waiting times for elective surgery	✓			✓
5. Waiting times for emergency department services	✓			✓
6. Estimated per capita expenditure on ATSI health services			✓	
7. Mode of separation by care type by age group				✓
8. GP services and benefits paid under the MBS (rural, remote and metropolitan)—total and per capita				✓
9. No. of hospitals and available beds accredited with Australian Council of Healthcare Standards				✓
10. No. of recognised vocational training positions/ trainees by area of speciality				✓
11. Value of NH&MRC grants for research undertaken in public hospitals	✓			✓
12. Spending on mental health—by level of government		✓		
13. Spending on mental health care—community and hospital services		✓		
14. Trends in consumer participation and consultation in mental health services	✓			
15. Spending on palliative care		✓		
16. Progress on 'Measure and Share' initiatives				✓
17. Progress on Quality Improvement and Enhancement strategic plans				✓
18. Progress on National Health Development Fund strategic plans				✓
19. Progress on Information technology Reform initiatives				✓
<b>TOTAL</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>11</b>

<sup>57</sup> Indicators 1, 4 and 5 are all reported on in Health's 2000–01 Portfolio Budget Statements and annual reports.

## Performance information in Health's budget documentation and annual report

**4.9** This section draws on Health's budget documentation for the 2000–01, as it was the most recent full-cycle external reporting by Health at the time of the audit. The indicators are also provided for 2002–03 because of their currency. The focus is Outcome 2, or access to acute health care for all Australians, for which Health provides the bulk of financial assistance under the AHCA.<sup>58</sup>

### Effectiveness indicators

**4.10** Health has four indicators to provide it with information on the effectiveness of the AHCA in contributing to Outcome 2. Table 3 lists Health's projected and actual reporting of these for 2000–01.

**Table 3**

#### Projected and Actual Reporting of AHCA Effectiveness for 2000–01

<b>Outcome 2—Access to Medicare</b> Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians	
<b>Projected performance</b> <b>(PBS 2000–01)</b>	<b>Actual performance</b> <b>(Annual report 2000–01)</b>
<b>Indicator # 8:</b> Overall growth rates in Medicare outlays, including ... AHCA growth rates <sup>1</sup>	Chart and text on annual growth in government outlays on Medicare, 1996–97 to 2000–01, including AHCA/Medicare Agreements component. <sup>2</sup>
<b>Indicator # 9:</b> "... AHCA ... Medicare outlays as a percentage of GDP" <sup>1</sup>	Chart and text on annual growth in government outlays as a percentage of GDP, 1996–97 to 2000–01, including AHCA/Medicare Agreements component. <sup>3</sup>
<b>Indicator # 10:</b> "Departmental expenses (Health Insurance Commission and Department) as a percentage of administered expenses for Outcome 2" <sup>1</sup>	Table on Departmental expenses as a proportion of administered expenses. This does not involve a breakdown to the level of the AHCA. <sup>4</sup>
<b>Indicator # 11:</b> "Commonwealth expenses per capita on Medicare [including] AHCA components" <sup>1</sup>	Annual government outlays per capita on Medicare 1996–97 to 2000–01, including AHCA/Medicare Agreements component. <sup>5</sup>

<sup>1</sup> PBS 2000–2001, p. 90.

<sup>2</sup> PBS 2000–2001, p. 139.

<sup>3</sup> Annual Report 2000–2001, Volume 1, p. 66, Figure 2.3.

<sup>4</sup> Annual Report 2000–2001, Volume 1, p. 70, Table 2.3.

<sup>5</sup> Annual Report 2000–2001, Volume 1, p. 66, Figure 2.2.

<sup>58</sup> Health Care Grants are attributed to Outcome 2 and are around 98 per cent of Health's AHCA finance. The much smaller National Health Development Fund is also attributed to Outcome 2; Health Care Grants attributed to Outcome 4 are around 2 per cent; national programs in the areas of mental health, casemix development and palliative care are part of Outcome 4. Under these arrangements, Health Care Grant funding which is identified for mental health and palliative care is attributed to Outcome 4.

**4.11** This Table shows that Health requires additional information to report on the 'cost effectiveness' of the AHCAs in providing access through Medicare to acute health care for all Australians. This is because the four indicators only provide information about Commonwealth outlays (that is, inputs). This is the same for 2002–03, where reporting is proposed for only two of these indicators, numbers 8 and 11 above.<sup>59</sup> This means that information is limited to the financial purpose of funding<sup>60</sup>, providing analysis of overall levels of Commonwealth financial assistance from one year to the next, and its cost on a per capita basis. It does not, however, provide information on the purposes of funding to improve either the effectiveness of hospital services or the effectiveness of patient outcomes. Health requires additional information, such as areas of improved patient outcomes, to identify the full effects of AHCA funding on the achievement of Outcome 2.

### **Efficiency of the administered item**

**4.12** Finance's guidelines for the performance of administered items encompass the importance of Commonwealth agencies having information on the efficiency of outputs delivered by the recipients of financial assistance, such as State and Territory governments.<sup>61</sup> This is where efficiency refers to the extent to which inputs are minimised for a given level of outputs.<sup>62</sup> Because efficiency is affected by the resources available to the program, and as it depends on the quality and quantity of services being provided, Finance advises that efficiency is determined through indicators that show the combined effect of price, quality and quantity.

**4.13** Health has four indicators of the efficiency of State and Territory outputs under Outcome 2. Three of these cover quality and quantity aspects of efficiency, which were agreed nationally between the Commonwealth and the States and Territories. The fourth is a cost indicator. This is in lieu of price information, which the States and Territories are not required to provide under the 1998–2003 AHCAs. The same indicators are proposed for reporting in 2002–03<sup>63</sup>, although there is an increase in the target for the number of public patients to be treated in hospitals. The department's planned and actual reporting of these indicators for 2000–01 is reproduced in Table 4.

<sup>59</sup> These are included in Health's 2002–03 PBS as Indicators 9 and 10. See p. 89.

<sup>60</sup> See Table 2 of this report, chapter 1.

<sup>61</sup> Finance's guidelines for reporting SPPs under the Outcomes and Outputs Framework recognise that the nature and scope of performance indicators generally arise from the specific circumstances and characteristics of the items themselves, including terms and conditions attached to financial assistance. It recognises this as a possible constraint, if national agreement is required on the set of performance indicators. *Performance Reporting Under the Outcomes and Outputs Framework*, [online] [http://www.finance.gov.au/budgetgroup/Commonwealth\\_Budget\\_-\\_Overview/performance\\_reporting.html](http://www.finance.gov.au/budgetgroup/Commonwealth_Budget_-_Overview/performance_reporting.html), [accessed 7 April 2002].

<sup>62</sup> Efficiency can also be the extent to which outputs are maximised for the given level of inputs. See Department of Finance and Administration's Budget Group Glossary online at: <http://www.finance.gov.au>

<sup>63</sup> *Portfolio Budget Statements 2002–03, Health and Ageing Portfolio*, p. 93.

**Table 4****Health's Budget and Annual Report Information on the Efficiency of Outputs Associated with AHCA's 2000–01**

<b>Outcome 2—Access to Medicare</b> Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians	
<b># 3 Access to public hospital services for public patients</b>	
<b>Projected performance</b> <b>(PBS 2000–01)</b>	<b>Actual performance</b> <b>(Annual report 2000–01)</b>
<b>Quality:</b> All States and Territories maintain, or improve, their performance levels for emergency department and elective surgery waiting times at no less than 1 July 1998 levels <sup>1</sup>	Data showing each State/Territory's performance in: <ul style="list-style-type: none"> <li>• emergency department waiting times for 1999–2000<sup>4</sup></li> <li>• elective surgery waiting times for 1999–2000<sup>3</sup></li> </ul>
<b>Quantity:</b> An estimated national average of 281 public patient weighted separations per 1000 applicable weighted population <sup>1</sup>	A national average of 278.8 public hospital separations per 1,000 applicable weighted population for 1999–2000, against a performance measure of 275.5 <sup>5</sup>  Table showing State by State weighted separations per 1000 applicable weighted population for admitted patient activity, and occasions of service per 1,000 weighted population for non-admitted patients, 1999–2000 <sup>5</sup>
<b>Cost:</b> \$6 232.851m <sup>2</sup>	\$6 202.870 m <sup>6</sup>

<sup>1</sup> PBS 2000–2001, p. 99.<sup>2</sup> PBS 2000–2001, pp. 94 and 99.<sup>3</sup> Annual Report 2000–2001, Vol 2, p. 382.<sup>4</sup> Annual Report 2000–2001, Vol 2, p. 383.<sup>5</sup> Annual Report 2000–2001, Vol 2, p. 384.<sup>6</sup> Annual Report 2000–2001, Vol 1, p. 80. Includes total of Special Appropriations.

**4.14** This information is insufficient for Health to determine the efficiency of AHCA-funded health care services delivered by the States and Territories. This is due, in large part, to the absence of information on State and Territory contributions to the AHCA's.

**4.15** The States and Territories have agreed to provide certain quantities of hospital services to public patients.<sup>64</sup> This agreement involves an annual separation rate for each State and Territory, and it is measured by public patient

<sup>64</sup> Clause 22 of the AHCA's commit the States and Territories to 'provide services to public patients at an indicative public patient weighted separation rate...'.

weighted separations per 1000 applicable weighted population.<sup>65</sup> The separation rate increases by 2.1 per cent per annum, and is used to trigger a review of the level of Commonwealth financial assistance to the States and Territories if there is a shortfall of at least five per cent between a State or Territory's actual level of activity and its annual separation rate.<sup>66</sup>

**4.16** Health collects and monitors patient activity data, provided by the States and Territories, to determine the level of compliance with agreed separation rates on an annual basis. Since the commencement of the AHCAs, the reporting shows that no jurisdiction has dropped below 95 per cent of its separation rate, although two jurisdictions have approached it.<sup>67</sup>

**4.17** Health experiences delays in the receipt of this data from the States and Territories, noting that there is a variety of reasons for this.

**4.18** The delays have implications for Health's administration of the AHCAs, by affecting a timely response should the actual levels of patient activity fall to levels that warrant a review of financial assistance. Such time lags may impede an appropriate Commonwealth response. Health has pointed to delays in the receipt of information in some cases affecting the utility of information in the annual performance report.

**4.19** With respect to the quality and quantity indicators more generally, the indicators require additional information for the results to be fully interpreted. For example, there are many reasons that could contribute to variations in patient/hospital activity levels. These reasons could include improved hospital efficiency, increased State and Territory funding, or increased re-admission rates. As in chapter 2, this points to the need for Health to review its information requirements with a view to obtaining better information to inform its administration. It also points to the importance of Health considering an evaluation of the AHCAs.

**4.20** As part of this audit, ANAO examined documentation for other SPP programs outside of the Health portfolio. In the Education portfolio, the Commonwealth finances government schools in the States and Territories. In turn, the States and Territories have agreed to provide performance information to the Department of Education, Science and Technology. The national report

<sup>65</sup> The term 'applicable weighted population' is a technical term that refers to the total population less the insured population less the entitled veterans (Gold Card holders).

<sup>66</sup> Clause 23 provides for the Commonwealth to review the level of financial assistance, should it be satisfied that: there was an ongoing reduction in the level of services delivered by the State or Territory concerned; and the shortfall was not the result of the particular State or Territory taking action to provide public hospital services in other settings.

<sup>67</sup> Health's annual report for 2001-2002, which was published during the production of this report, shows that some States and Territories have subsequently fallen below 95 per cent. See Department of Health and Ageing, *Annual Report 2001-02*, p. 122.

published under those agreements contains statistical data and data interpretation. ANAO encourages Health to determine whether it can strengthen its performance information for administrative purposes and for Parliamentary reporting by reviewing the relevant approaches in the Education, Science and Technology portfolio.

## **Efficiency of departmental outputs**

**4.21** Health stated in its 2000–01 Budget documentation that it would provide information about its national leadership in the continued implementation of the AHCAs. A Health goal was to improve program performance, which includes producing financial savings or improvements in service quality.

**4.22** Health's actual reporting of its leadership role on the reform agenda did not match its proposed reporting. Health's budget documentation anticipated how its leadership role would be described by stakeholders' views on the department's contribution to the development of national policy, planning and strategy development and implementation, and national leadership commensurate with the funds allocated. Health did not provide information in the subsequent annual report on these dimensions of its role. The reform initiatives are central to meeting the purposes of funding, because they are designed to improve the effectiveness and efficiency of hospital and hospital-related services. There was no information provided on the reform options identified in the AHCAs or on Health's activities to encourage performance improvements with State and Territory governments.

**4.23** Notwithstanding, Health has taken action in this area. *The Australian Health Care Agreements, Annual Performance Report 1998–99* outlines Health's activities, some of which were with the States and Territories. With respect to:

- pharmaceutical reform measures, Health consulted extensively with the States and Territories;
- quality improvement and enhancement, Health developed a framework for strategic plans that identified seven areas for national collaboration and cooperation; and
- information technology reform, Health progressed several projects and initiatives aimed at contributing to the creation of a national strategic framework for health information management/technology, and targeting key areas for national action.

**4.24** Health provided guidance to the States and Territories on some general parameters for the development of plans for the National Health Development Fund (NHDF). The NHDF is the key initiative under which significant health



system restructuring is intended to take place. Funding is aimed at improving patient outcomes, improving the effectiveness and efficiency of public hospital services, or reducing the demand for public hospital services, or in other words to achieve the purposes of funding under the *Health Care (Appropriation) Act 1998*.

**4.25** No activity was reported for States and Territories on the broader measure and share reform proposals, as no proposals were made by the States and Territories under the Agreements. This proposed reform is to improve the coordination of Commonwealth and State/Territory health care services to produce net savings to both levels of government. However, the Commonwealth's activity in pharmaceutical reform has been reported as the only type of measure and share proposal which has occurred under the Agreements.

**4.26** The draft AHCA annual performance report for 1999–2000 showed similar levels of activity by Health in each area of reform.

## Split Outcomes

**4.27** Finance acknowledges that it is desirable, but not essential, for departmental outputs (and, by extension, administered items) to be structured so that they fall within outcome boundaries. In the case of the AHCAs, this has not been possible, resulting in reporting across several outcomes.<sup>68</sup>

**4.28** This split reporting makes it difficult to identify and find all performance attributable to the AHCAs. The effect of this split reporting, which also occurs with data on efficiency, impedes identification of the total costs of government services, which is an aim of the accrual-based Outcomes and Outputs Framework. For example, the indicators on the level of achievement against Outcome 4 concern total spending on mental health, and do not differentiate between the AHCAs and other funding arrangements.<sup>69</sup>

## Conclusion

**4.29** Health includes information on the effects of the AHCAs in its budget documentation and annual reports. Information on the effectiveness of the AHCAs, however, is about the department's expenditure on the AHCAs. This

<sup>68</sup> The AHCAs included elements that relate to both 'Access to Medicare' (public hospital services), and 'Quality of Health Care', (mental health services and palliative care). There is a third Outcome (Number 7—Aboriginal and Torres Strait Islander health) which, while not including reporting on AHCA matters in Health's PBS and annual reports, is addressed in part in the AHCAs' annual performance report, giving rise to further potential confusion over AHCA reporting.

<sup>69</sup> The same observation is made about indicator number 11 under Outcome 2, which addressed the ratio between all administered items under Outcome 2 and associated departmental expenses, without separating this information down to specific administered items.

can be considered as input information, and not information about the effectiveness of the AHCAs. Health, however, does have some information to monitor the efficiency of State and Territory hospital and related services, from the three measures: emergency department waiting times, elective surgery waiting times, and the numbers of public patients admitted to hospitals. Nevertheless, Health requires additional information to fully interpret the results being achieved. There is potential for the broader set of national indicators, agreed to by the States and Territories, to be used for monitoring the effectiveness of the AHCAs and the efficiency of services. However, to meet Health's needs, a greater level of alignment is required between these indicators and the outcomes and outputs desired from the AHCAs.

**4.30** Health has a leadership role associated with the administration of the AHCAs to ensure the effective and efficient use of Commonwealth resources. Health recognises this role specifically in relation to the reform elements of the AHCAs. It indicated in its budget documentation that it would make information available on its leadership success, by reporting on its own efficiency against key parts of the AHCAs aimed at improving the effectiveness and efficiency of hospital-related services, reducing the demand for hospital services and improving patient outcomes. While the results have not been reported in Health's departmental annual report, the AHCA annual report shows that, while progress has been made, it has not been consistent across all areas identified for reform. This includes limited progress in two of the key areas associated with producing structural reform of the health system and improving coordination of Commonwealth and State and Territory services. The results point to the need for greater effort in these areas.

**4.31** These results show a continuing need for both more information on the conditions and objectives of funding and greater levels of leadership required to improve the effectiveness and efficiency of services funded under the AHCAs. This will require Health to continue to work with the States and Territories on performance indicator development for the benefits this provides, not only to its own administration of the AHCAs, but also to the States and Territories for the advantages that shared information offers through national monitoring and reporting of results. It reinforces the findings of earlier chapters of the need for Health to review its information needs independently of the States and Territories, and to develop a long-term information plan for the systematic development and review of performance indicators. Negotiation of the next round of AHCAs in 2003 provides Health with this opportunity.

## Recommendation No.2

**4.32** ANAO recommends that Health develop a long-term information plan for the administration of the AHCAs, aimed at obtaining commitment from the States and Territories to a process for the development and review of performance information needs over the life of any new funding agreements. This would provide for:

- systematic development and continued appropriateness of performance indicators;
- reporting mechanisms on the level and type of progress made; and
- development of a performance information regime that is appropriate in terms of the relevant legislation, the stated objectives and principles of the new arrangements, and the Government's Outcomes and Outputs Framework.

### *Health's Response*

**4.33** The Department of Health and Ageing will administer the next Australian Health Care Agreements according to the policy framework agreed by Government. The matters covered by this recommendation are matters of policy not administration.

**4.34 ANAO comment:** The recommendation is directed to Health's administration of the AHCAs within the framework agreed by Ministers, which provides for the development of national level performance indicators including indicators on efficiency, quality, appropriateness, accessibility and equity of health services. The ANAO envisaged that such a plan would assist in informing the Commonwealth Health Minister (and State and Territory Ministers) of the potential for improvements to the current performance information regime.

## 5. Financial Information

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*This chapter considers Health's financial control system to determine whether it can be relied on to produce materially correct financial information, and accurate and timely payments to the States and Territories. It identifies a deficiency in Health's record keeping practices associated with calculating the estimate of total planned expenditure under the AHCA, and comments on Health's processes for ensuring financial accountability of the States and Territories.*

### Introduction

**5.1** The JCPAA has specified that SPP financial accountability requirements should be as streamlined as possible, especially to improve administrative efficiency and to avoid duplication between Commonwealth and State and Territory Auditors-General. Under the AHCA, States and Territories are required to provide a 'statement' of expenditure that describes how Commonwealth funds have been spent on the SPP over the period, and a 'certification' of expenditure to ensure that Commonwealth funds are expended in a manner consistent with the agreement.

**5.2** Health also requires a financial model that can ensure both accurate and timely payments to the States and Territories, and an accurate estimate of total AHCA expenditure.

**5.3** This chapter examines Health's processes to ensure the effective operation of these aspects of financial management.

### Financial controls

**5.4** Health has two financial systems for calculating and making AHCA payments to the States and Territories. The electronic transfer of funds is made from a financial management information system (FMIS). The latter uses data calculated separately on Health's Funding System (HFS). The two systems are linked electronically. Health's calculation of payments to each State and Territory is drawn from the schedule of grants in each AHCA.

**5.5** The ANAO evaluated Health's documentation processes and tested its financial control systems to ensure that they can be relied on to produce accurate and timely payments to the States and Territories. Health's financial controls are satisfactory, ensuring accurate and timely payments to the States and Territories. Several processes ensure that payments are correct. The AHCA schedules, which set out the level of HCGs payable to the States and Territories for each funding year, are reconciled with the estimates in Health's Funding System.

**5.6** A difficulty with Health's processes is that the same staff perform all duties associated with the AHCAs. These include:

- the day-to-day administration of the AHCAs;
- revising the estimates model;
- data entry;
- data verification; and
- reconciliation functions.

**5.7** This means that a considerable amount of knowledge is concentrated with a small number of individuals. Furthermore, the reconciliation function, which is intended to detect irregularities, is performed by the same staff who are making variations to the model and calculating payments. This increases the risk that intended controls might not effectively detect and/or prevent either accidental or intentional irregularities. The ANAO suggests that Health consider greater separation of responsibilities within the group and, in particular, that the reconciliations of financial data are reviewed by a person independent of the operational duties.

## **Health's estimate of total AHCA expenditure**

**5.8** Health estimated that the level of financial assistance to the States and Territories under the AHCAs would total \$31.7 billion over the five years to 30 June 2003. This includes a cumulative amount of \$2.09 billion more than the \$29.6 billion appropriated under the *Health Care (Appropriation) Act 1998* (the Act). The reasons for the additional expenditure include:

- government decisions to provide the States and Territories with more financial assistance, and changes to the indexes for adjusting the Health Care Grants; and
- the terms of the Agreements, which provide for funding to be adjusted for more recent data on population growth and ageing, and entitled veterans population.

**5.9** Health has prepared an amendment to the Act to authorise an increase in the total level of financial assistance available through the AHCAs. The Bill to amend the Act was introduced in the House of Representatives on 29 August 2002.

**5.10** During the audit, the ANAO sought to independently verify the accuracy of the proposed additional expenditure. This was not possible, however, because:

- Health revises the estimates model to reflect decisions and population data changes as they occur, and was not able to provide a record of the original model for comparative purposes; and
- at the time of the audit, Health was not able to provide the ANAO with a complete set of the documentation to support all variations to the financial model during the life of the Agreements.

**5.11** Health did not agree with this finding. Consequently, Health engaged a consultant to review documentation supporting estimates of payments to the States and Territories under the AHCAs. The principal aim of the review was to provide an opinion on the completeness and accuracy of the documentation supporting the \$31.7 billion approved by the Minister for Health and Ageing for distribution to the States and Territories over the five years of the Agreements to 30 June 2003.

**5.12** The consultant established a register of all variations to the original amount approved. The consultant recommended that Health maintain the register for the current Agreements, and establish a similar register for any new agreements, to enable Health to efficiently discharge its accountability to substantiate all variations to estimates relating to the Agreements. ANAO suggests that, in future agreements, Health maintain original estimates models for each year of each agreement. Such action, in conjunction with the steps recommended by the consultant, will address comprehensively the record keeping issues highlighted by the audit.

## Financial accountability of the States and Territories

**5.13** The States and Territories are required to account for AHCA expenditure through the provision of statements and certifications of expenditure. These are intended to provide the Commonwealth with assurance that financial assistance provided under the AHCAs has been spent in accordance with the terms of the Agreements.<sup>70</sup> Separate assurance is required under the AHCAs for the Health Care Grants (HCGs), NHDF and mental health reform.

**5.14** Health provides the States and Territories with forms designed for this purpose, apart from for mental health reform. For the HCGs, the States and Territories are required to indicate the total funds received in the relevant grant year, according to the various funding elements, that is, the general component, mental health, palliative care, quality improvement and adjustments, within five months of the end of each grant year.

<sup>70</sup> The financial accountability requirements are specified in Schedule E, clause 23 of the AHCAs.

**5.15** The States and Territories have provided the Commonwealth with assurance on their expenditure of the HCG funding through the provision of completed information forms. Some States and Territories, however, have provided assurance up to 12 months after the end of the financial year, and these assurances have often included only the total funds received.

**5.16** In some instances, Health has responded to the late assurances of States and Territories by resending forms in the month after they were due. This has been accompanied by provision of the financial information required from the States and Territories. The department has advised that it has now received assurance for the relevant financial years from all States and Territories.

**5.17** With respect to the NHDF, the States and Territories meet their obligation to certify that they have received the relevant amount of AHCA funding for each financial year. The NHDF form does not contain a statement on how funds were expended within the scope of the relevant AHCA conditions.

## **Conclusion**

**5.18** Health seeks authority from the responsible Minister for the amounts payable to the States and Territories on an annual basis. The ANAO found that Health's controls are effective in ensuring the accuracy of total payments made to the States and Territories in accordance with those approved by the Minister for Health and Ageing.

**5.19** The ANAO found that Health has effective financial controls to ensure that the States and Territories receive accurate and timely payments pursuant to the Agreements. During the audit, there were deficiencies in Health's record keeping associated with estimates of payments under the Agreements. Subsequently, Health advised that it has addressed these problems.

**5.20** The States and Territories account for AHCA expenditure through the completed forms supplied by State and Territory health departments. These forms identify AHCA funding and its expenditure consistent with the terms of the Agreements. The time taken by some States and Territories in furnishing the relevant information to the Commonwealth means that the ability to reconcile payments made and received is often twelve months after the end of the financial year. This gives rise to two issues. First, while Health is making its best efforts to obtain assurance from the States and Territories, it has resulted in the practice at times of furnishing the information in advance of Health's receipt of statements and certifications of expenditure. This practice reduces the opportunity to confirm that payments reconcile with financial assistance received, because States were advised in advance of the information they needed to provide. Second, it creates Commonwealth inefficiencies, by adding to Health's administrative workload.

## Recommendation No.3

5.21 In order to verify the accuracy and validity of payments made in relation to funding agreements, the ANAO recommends that Health establish clear audit trails by maintaining a register/s of all variations made to estimates of funding under the agreements used for calculating payments during the life of those agreements.

### *Health's Response*

5.22 Agreed. Such a register has already been established.

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Canberra ACT  
11 December 2002

P. J. Barrett  
Auditor-General



# Appendices



## Appendix 1

### Administrative characteristics of 'Ideal' SPP Agreements<sup>1</sup>

For the efficient and effective management of SPP programs, it is important that:

- SPP arrangements are administered under agreements between the parties or legislation where appropriate;
- the roles of the parties to SPP arrangements and their responsibilities for particular program management activities are clearly defined and the communication and consultation arrangements to operate between the parties are adequately specified;
- there is appropriate recognition of the contribution of the Commonwealth and other parties to the provision of SPP-funded services;
- SPP program objectives are specified in terms of clear, achievable and measurable outcomes;
- requirements regarding the financial contributions of the parties to SPP arrangements (input controls) are phased out, except where they are essential to the design and management of individual SPP programs;
- input controls that continue to be used for individual SPP programs are clearly identified and defined;
- SPP payments are released no earlier than necessary to meet the identified immediate funding needs of the other parties to SPP arrangements;
- measurable performance indicators are linked to and specified for each SPP program objective and basic data collection requirements are identified for each performance indicator;
- SPP financial accountability requirements are as streamlined as possible;
- there are graduated sanctions for non-compliance with SPP program conditions and appropriate processes are in place for apparent instances of non-compliance to be examined with other relevant parties to SPP arrangements before sanctions are applied;
- SPP programs and associated administrative activities are subject to periodic evaluation and review;
- the Parliament and the public have ready access to reliable and up to date information about SPP programs and their performance results; and
- small SPP programs are broadbanded in portfolio areas as far as practicable.

<sup>1</sup> JCPAA, 1998, pp. 57 and 58.

## Appendix 2

### Principal Performance Indicators in the AHCA, *Annual Performance Report 1998–99*

1. Public patient weighted separations per 1000 applicable weighted population
2. Average cost per separation
3. Public hospital non-admitted patient occasions of service
4. Waiting times for elective surgery
5. Waiting times for emergency department services
6. Estimated per capita expenditure by governments on Aboriginal and Torres Strait Islander health services
7. Mode of separation by care type by age group
8. GP services and benefits paid under the Medicare Benefits Scheme (rural, remote and metropolitan)—total and per capita
9. Number of hospitals and available beds accredited with the Australian Council of Healthcare Standards
10. Number of recognised vocational training positions/trainees by area of speciality
11. Value of National Health and Medical Research Council grants for research primarily undertaken in public hospitals
12. Spending on mental health—by level of government
13. Spending on mental health care—community and hospitals
14. Progress against objectives of the National Mental Health Strategy
15. Collection of data for the Mental Health National Minimum Data Set
16. Implementation of National Standards for Mental Health Services
17. Collection of consumer outcome data
18. Trends in consumer participation and consultation in mental health service organizations
19. Spending on palliative care
20. Progress reporting on Measure and Share reform proposals
21. Progress reporting on Quality Improvement and Enhancement (strategic plan)
22. Progress reporting on National Health Development Fund (strategic plans)
23. Progress reporting on Information Technology reform

# Index

---

## A

accountability 11, 13, 15, 27, 28, 29, 31, 33, 36, 38, 41, 47, 60, 62, 67

acquittal 17

Annual Report 15, 28, 30, 34, 36, 37, 38, 43, 49, 51, 52, 54, 55, 56, 57

appropriation 12, 24, 25, 26, 54, 57, 61

Australian Health Ministers' Advisory Council (AHMAC) 16, 34, 35, 36, 37, 39

## C

Commonwealth 11, 12, 13, 14, 18, 19, 23, 24, 25, 26, 27, 28, 29, 30, 32, 33, 34, 35, 36, 39, 40, 41, 43, 44, 46, 48, 49, 53, 55, 57, 58, 59, 60, 62, 63, 67

## E

effectiveness 14, 25, 26, 31, 32, 45, 48, 49, 50, 51, 52, 53, 56, 57, 58

efficiency 11, 14, 15, 16, 19, 25, 26, 28, 31, 32, 33, 36, 39, 46, 48, 49, 50, 51, 53, 54, 55, 56, 57, 58, 59, 60

equity 14, 16, 19, 26, 33, 36, 39, 43, 46, 59

expenditure 15, 17, 27, 41, 42, 44, 57, 60, 61, 62, 63, 68

## F

Finance (Department of Finance and Administration) 13, 24, 28, 30, 49, 52, 53, 55, 57

financial accountability 13, 29, 31, 60, 62, 67

financial assistance 11, 12, 24, 25, 26, 29, 30, 35, 36, 41, 46, 52, 53, 55, 61, 62, 63

financial control(s) 14, 60, 63

funding 11, 12, 14, 15, 16, 17, 18, 19, 23, 24, 25, 26, 27, 31, 32, 34, 38, 41, 42, 43, 44, 46, 47, 49, 52, 53, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 67

## H

Health Care Grant (HCG) 12, 24, 29, 49, 52, 60, 61, 62, 63

Health care system 12, 23, 46

Health Care (Appropriation) Act 1998 12, 24, 25, 26, 41, 57, 61

health care services 11, 12, 24, 35, 41, 44, 48, 54, 57

hospital 11, 14, 15, 16, 23, 24, 25, 26, 29, 30, 36, 37, 38, 39, 41, 43, 44, 46, 48, 49, 50, 53, 54, 55, 56, 57, 58, 68

## I

information needs 16, 18, 31, 32, 36, 39, 40, 41, 47, 48, 58, 59

## J

Joint Committee of Public Accounts and Audit (JCPAA) 13, 18, 26, 27, 29, 31, 36, 39, 40, 41, 42, 44, 48, 49, 60, 67

## **N**

National Health Development Fund (NHDF) 24, 37, 52, 56, 62, 63, 68

National Health Performance Committee (NHPC) 16, 30, 34, 35, 36, 39

National Health Policy 26

national indicators 15, 16, 36, 58

new agreements 17, 47, 62

## **O**

objectives 11, 14, 15, 16, 18, 23, 26, 27, 36, 41, 42, 43, 44, 45, 46, 47, 50, 58, 59, 67, 68

Outcomes and Outputs Framework 13, 18, 24, 27, 28, 29, 30, 36, 39, 40, 48, 49, 53, 57, 59

## **P**

payments 11, 12, 13, 14, 17, 19, 24, 25, 26, 27, 29, 31, 32, 41, 42, 60, 61, 62, 63, 64, 67

performance indicators 11, 13, 14, 15, 16, 17, 18, 19, 27, 28, 30, 33, 34, 35, 37, 38, 39, 41, 43, 44, 45, 46, 49, 51, 53, 58, 59, 67, 68

Performance Report 15, 16, 28, 30, 34, 36, 37, 38, 43, 44, 46, 49, 53, 55, 56, 57, 68

Portfolio Budget Statements 24, 28, 30, 44, 45, 48, 50, 51, 53

public patient(s) 24, 25, 26, 43, 44, 46, 53, 54, 58, 68

## **Q**

quality 14, 16, 19, 28, 33, 35, 36, 37, 39, 48, 49, 53, 55, 56, 57, 59, 62, 68

## **R**

record keeping 14, 17, 60, 62, 63

renegotiation 14, 39

## **S**

separation rate 24, 25, 46, 54, 55

service delivery 11, 27, 28, 33, 34, 46, 48

Specific Purpose Payments (SPPs) 11, 12, 13, 25, 26, 27, 29, 31, 32, 42

State and Territory Government (States and Territories) 11, 12, 13, 14, 15, 16, 17, 18, 23, 24, 25, 27, 28, 29, 31, 33, 34, 35, 36, 37, 38, 39, 41, 42, 43, 47, 48, 49, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63

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---

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