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Performance Audit

Department of Health and Ageing's Management of the Multipurpose Services Program and the Regional Health Services Program

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Australian National
Audit Office

Canberra ACT
13 April 2004

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*. Pursuant to Senate Standing Order 166 relating to the presentation of documents when the Senate is not sitting, I present the report of this audit and the accompanying brochure. The report is titled *Department of Health and Ageing's Management of the Multipurpose Services Program and the Regional Health Services Program.*

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

Yours sincerely

P. J. Barrett
Auditor-General

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

AUDITING FOR AUSTRALIA

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Contents

Abbreviations

the Act	*Aged Care Act 1997*
AHCA	Australian Health Care Agreement
AHMAC	Australian Health Ministers' Advisory Council
ARIA	Accessiblity/Remoteness Index of Australia
ANAO	Australian National Audit Office
ASGC	Australian Standard Geographical Classification
CACP	Community Aged Care Package
GP	general practitioner
RHSP Guide	Regional Health Services Program State Office Guide
MPSP Guidelines	Multipurpose Services Program Guidelines for State and Territory Offices
Health	Department of Health and Ageing
HECS	Higher Education Contribution Scheme
JOG	Joint Officers Group
MPS	Multipurpose Services
MPSP	Multipurpose Services Program
n.a.	not applicable
NRHS	National Rural Health Strategy
the Principles	Flexible Care Subsidy Principles 1997
RRMA	Rural, Remote and Metropolitan Areas
RCS	Residential Classification Scale
RHS	Regional Health Services
RHSP	Regional Health Services Program
State(s)	State(s) and/or Territory(ies)

Summary and Recommendations

Summary

Rural health in Australia

1. Over six million Australians (34 per cent of the total population) lived in rural or remote areas in 2001.[1] Typically, the health of those people is worse than for people living in metropolitan areas. For example, life expectancy is higher in metropolitan areas, and death rates increase with remoteness. They are 10 per cent higher in regional and remote areas compared with major cities, and 50 per cent higher in very remote areas.[2]

2. Rates of hospitalisation are also higher for remote Australians compared to those living in capital cities, while general practitioner consultations are lower. In general, health workers and pharmacists are under-represented in rural and remote areas. [3,4,5,6,7] Therefore, access to health services is likely to be more limited for people living in rural and remote areas compared to people living in major cities.[8]

3. Additional contributors to poor health and higher mortality in rural and remote areas include lower socio-economic status; higher risk of injury as a result of the types of work and conditions experienced; low quality roads;

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1 Based on the Australian Standard Geographical Classification Remoteness Structure. Australian Bureau of Statistics 2003, *Australian Social Trends, Population – Population distribution: Population characteristics and remoteness*, Australian Bureau of Statistics, Canberra, <www.abs.gov.au/Ausstats>, viewed 10 December 2003.

2 Figures for death rates between 1997–99. Australian Institute of Health and Welfare. *Rural, regional and remote health, a study on mortality, summary of findings*, Australian Institute of Health and Welfare, Canberra, October 2003, pp. 5-6, 11 & 18.

3 Australian Institute of Health and Welfare, National Hospital Morbidity Database – hospital separation rates for 1995–96. Hospital separation rates provide a measure of the number of hospital care episodes per person. id., *Health in rural and remote Australia*, 1998, p. 93.

4 Medicare utilisation rates for GP consultations, 1995–96. ibid, 1998, p. 98.

5 Australian Bureau of Statistics 2003, *Australian Social Trends, Population – Population distribution: Population characteristics and remoteness*, and *Australian Social Trends, Health – Health services: Medical Practitioners,* <www.abs.gov.au/Ausstats/abs@.nsf>, viewed 10 December 2003.

6 Australian Institute of Health and Welfare, <www.aihw.gov.au/labourforce/health.html>, viewed 10 December 2003.

7 Based on Australian Institute of Health and Welfare data 'employed pharmacists characteristics by geographic location (RRMA) of main job, 1996'. id., *Australia's Health 2002*, Australian Institute of Health and Welfare, Canberra, July 2002, p. 273.

8 id., *Australia's Health 2002*, July 2002, p. 215.

indigenous health needs; physical inactivity; overweight and obesity; smoking; hazardous or harmful alcohol consumption; and poor diet.[9,10]

Rural health policy and programs

4. Health services across Australia are provided by a combination of public, private and not-for-profit organisations. State Governments, partially funded by the Commonwealth via the Australian Health Care Agreements (AHCAs)[11], are responsible for the provision of health services through the public hospital system. The Department of Health and Ageing (Health) is responsible for implementing the Australian Government's rural health policies.

5. Health funds the various rural health programs under a number of Health and Ageing Portfolio Outcomes. The 2003–04 Federal Budget lists over 30 key Commonwealth funded rural health programs and initiatives. Outcome 5: Rural Health, provides the umbrella for targeted rural and remote health programs funded by Health. The objective of Outcome 5 is to improve health outcomes for Australians living in regional, rural and remote locations. The total appropriation allocated in the 2003–04 Federal Budget for the administered expenses of Outcome 5 is $110.3 million.[12]

6. Health funds two rural health programs of particular importance to the communities they serve—the Multipurpose Services Program (MPSP) and the Regional Health Services Program (RHSP).

7. The MPSP is a joint program with the State Governments that aims to provide a flexible and integrated approach to the delivery of health and aged care services to small rural communities. Services provided by a Multipurpose Service (MPS) vary, but may include residential aged care, acute care, community and allied health, rehabilitation, and health education. The Commonwealth funds the aged care portion of a MPS and the State Governments fund other identified health needs. The Commonwealth is the minority funder of the program, providing around $45 million a year. Commonwealth funding of an individual MPS is contingent on the commitment of the relevant State Government to provide recurrent funding,

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9 id., *Health in rural and remote Australia,* 1998, p. 1.

10 id., *Australia's Health 2002*, July 2002, p. 215.

11 The AHCAs are bilateral agreements between the Commonwealth and each State Government for the provision and joint funding of health services, especially hospital funding.

12 Administered expenses are managed by Health on behalf of the Commonwealth. They include grants, subsidies and benefits.

and capital funding where necessary. Total Commonwealth and State Government funding to the 86 MPSs operational at August 2003 amounts to approximately $188 million a year.

8. The RHSP is a Commonwealth program that aims to help small rural communities expand their local primary health care services. Services provided by a Regional Health Service (RHS) may include allied health care, health promotion and prevention, and general practitioner services. The Commonwealth allocates around $42 million to the RHSP, funding 152 RHS projects as at 31 August 2003.

Audit objective

9. The objective of the audit was to assess the effectiveness of Health's management of the MPSP and the RHSP. To achieve the audit's objective, the ANAO examined whether Health:

- had an effective approach to planning the programs;
- had an effective approach to delivering the programs;
- effectively used performance information to manage the programs; and
- effectively managed its relationship with all stakeholders of the programs.

10. To form an opinion against the audit objective, the audit team interviewed relevant personnel at Health's Central Office and a selection of State Offices, in three State Governments, and in key stakeholder groups. The audit team also reviewed a selection of Health's files, data and other relevant documentation and reports. The team attended the 7th National Rural Health Conference and visited a selection of services.

Key Findings

Program objectives and indicators (Chapter 2)

Program objectives and performance indicators are consistent.

11. The objectives of the MPSP and RHSP, which are clearly defined and documented, are aligned with Health's overall objective and the objective for Portfolio Outcome 5: Rural Health. The ANAO also found that performance indicators developed for the two programs are consistent with the programs' objectives.

Health staff do not have confidence in the integrity of data held by the central rural health database.

12. Health's State Office staff have independently developed effective systems to monitor services. These systems shadow the centrally developed rural health database, resulting in inconsistencies between the data held in the database and by the State Offices. Due to the data inconsistencies, as well as limited access to the database, the database does not meet the needs of State Office staff. Also, Health's Central Office staff do not have confidence in the integrity of the data held by the database.

Performance information is not used effectively.

13. The ANAO found that performance data on individual services is not collated or analysed systematically. Health is not using service performance data to identify good practice or to identify potential improvements to the programs. In addition, Health does not have baseline information on health service provision or health outcomes and, consequently, is not able to measure the progress of the two programs against their respective objectives.

Health has developed a risk management plan for the RHSP but not for the MPSP.

14. There is no risk management plan for the MPSP as a whole. In contrast, Health manages risk in the RHSP via a risk management plan developed for the program as a whole, and by requiring risk management plans for individual RHSs.

Selecting and funding services (Chapter 3)

Health's approaches to selecting and assessing potential MPS sites are consistent with the program's objectives and are effective.

15. Health's State Offices have developed clear and systematic approaches to identifying potential MPS sites. Once identified, these sites are assessed against selection criteria that are consistent with the program's objectives. The ANAO found that Health's staff apply these selection criteria, and operational MPSs meet the criteria. The principle of flexible, pooled funding that forms the basis of the MPSP funding model is also consistent with the objectives of the MPSP.

One-third of MPS funding agreements have been extended and, therefore, MPSs may be implementing out of date service delivery plans.

16. The ANAO found that one-third of MPSs are operating with extended funding agreements, with almost half of the extended agreements originally expiring in or before 2001. Service delivery plans are developed prior to signing funding agreements. Therefore, MPSs operating with extended agreements may be implementing service delivery plans that are not current or relevant to current community needs.

Targets in MPS funding agreements are indicative only, and, in the opinion of the ANAO, are not an adequate measure of outputs and outcomes.

17. In the opinion of the ANAO, targets included in MPS funding agreements (bed numbers and budget figures) are input measures that guide funding levels, not an adequate measure of outputs or outcomes. In addition, bed numbers are indicative only. Applying the principle of flexible funding, funding provided to MPSs may be used to provide any appropriate aged care services. Therefore, as bed numbers are not an accurate description of the actual services provided, they are not a useful target.

Health's approaches to selecting, assessing and funding RHSs are consistent with the program's objectives and are effective.

18. The selection criteria Health uses to assess potential RHS projects are consistent with the program's objectives and Health's State Offices have developed effective approaches to selecting and assessing RHS projects. The funding formula for the distribution of RHSP funds, developed in 1999, is also broadly consistent with the objectives of the program. The funding formula is based on the Rural, Remote and Metropolitan Areas (RRMA) geographical classification system and does not take into account relative health needs across and within States. However, estimates of unmet health service need are

incorporated into the approaches used by the State Offices to identify priority areas.

Financial management (Chapter 4)

MPSP financial controls are sound.

19. Financial management of the MPSP is straightforward. MPS payments are made according to a payment schedule calculated using the MPS funding formula. Financial controls, which include the separation of duties and accuracy checks, are effective in ensuring that payments are accurate and made in accordance with Health guidance and relevant legislation.

Health's knowledge of State Government contributions to MPSs is limited.

20. In the past, Health has not required or kept data on State recurrent and capital contributions to MPSs. However, the Commonwealth and State Governments recently agreed to changes to reporting requirements. Under these changes, to be implemented over the next six to twelve months, States Governments will provide Health with data on recurrent and capital funding contributions.

Underspent funding is a significant issue in the RHSP.

21. The ANAO found that Health has effective mechanisms to control the accuracy of payments made under the RHSP. However, a significant financial issue in the RHSP is the level of underspent RHSP funds. This level has increased by 9.6 per cent from 2001–02 to 2002–03, with $6.6 million not spent by RHSs during this two-year period. The ANAO found that Health has not identified and systematically analysed the reasons RHSs are not using all available Commonwealth funds.

Relationship management (Chapter 5)

Generally, the delineation of internal roles and responsibilities is effective.

22. The guidelines for both programs outline the roles and responsibilities of Health's Central and State Office staff. The ANAO found that, while there was some duplication of roles, overall the arrangements work well.

Guidelines for the MPSP are effective, but guidance for the RHSP is currently inadequate.

23. Health developed and released the *Multipurpose Services Program Guidelines for State and Territory Offices* (MPSP Guidelines) in 2002. The ANAO found that the MPSP Guidelines are clear and useful, and that Health's managers and staff comply with them. In contrast, while the *Regional Health*

Services Program State Office Guide (RHSP Guide) was developed within the first year of the program, it does not assist health staff with program management, as it is out-of-date and contains inaccuracies. As a result, the RHSP Guide is not used by staff.

Health has developed constructive working relationships with the State Governments.

24. Health uses a number of strategies to manage its relationship with the State Governments. These include protocols and joint consultative groups. The ANAO found that these strategies are working well and that Health has overcome some initial tensions to develop and maintain constructive working relationships with the State Governments.

Under the MPSP, activity reporting to Health has been variable.

25. MPSP funding agreements between the Commonwealth and a MPS require that services report to Health regularly. This reporting has been inconsistent, with some services not providing activity reports to Health for a significant period. The ANAO expects that the new reporting requirements, to be implemented over the next six to twelve months, will improve reporting from MPSs. Reporting by RHSs is effective, with services providing reports of an acceptable quality.

Health provides some support to services, although its relationship with services could be improved.

26. Health holds forums and workshops for service staff, has produced two editions of a newsletter for the MPSP, and conducts site visits to services. While the forums have been generally well received, production of the newsletter has been ad hoc and site visits limited. As a result, many of the services visited by the ANAO did not consider the guidance that they receive from Health is adequate. Health's relationship with services could be improved by more effective communication and the identification and promotion of better practice to MPSs and RHSs.

Overall audit conclusion

27. The ANAO recognises that, when managing the MPSP and RHSP, Health must manage the difficult job of balancing available resources with existing and emerging health service needs in rural and remote Australia. In general, the ANAO concludes that Health's management of the MPSP and RHSP is effective. Health has developed an effective approach to planning and delivering the programs, and manages its relationships with stakeholders of the programs.

28. The ANAO has identified a number of areas where Health could further improve its management of the programs. These are addressed by the recommendations.

Health's comments

29. Health agrees with the ANAO recommendations and has already introduced measures to improve management of the programs in line with these recommendations.

Recommendations

Recommendation No.1 Para. 2.31

The ANAO recommends that Health review the central rural health database to make sure that the system meets all user needs, including the needs of Health's State Offices, and contains accurate and up-to-date information.

Health's response: Agreed.

Recommendation No.2 Para. 2.33

The ANAO recommends that Health develop baseline health information and intermediate performance indicators, and analyse performance data on the two programs. This would allow Health to identify areas for improvement and inform the future strategic direction of the programs, and will assist Health to identify and measure the impact of the MPSP and RHSP on health service provision and health outcomes.

Health's response: Agreed.

Recommendation No.3 Para. 2.36

The ANAO recommends that Health analyse the risks to the MPSP, and develop a risk management plan that identifies Health's potential risk exposures under the program and describes treatments that reduce those risks to an acceptable level.

Health's response: Agreed.

Recommendation No.4 Para. 3.61

The ANAO recommends that Health make sure that: all MPSs have current funding agreements, incorporating agreed targets and up-to-date service plans; the conditions of the funding agreements are valid; and MPSs are implementing service plans that are relevant to the needs of the target communities.

Health's response: Agreed.

Recommendation No.5 Para. 4.18

The ANAO recommends that Health investigate the causes of RHS underspends, and develop indicators that will highlight significant levels of underspends so that they may be managed in an appropriate and timely fashion.

Health's response: Agreed.

Recommendation No.6 Para. 5.35

The ANAO recommends that Health improve its communication with services (within the context of protocols between Health and State Governments), and identify and promote examples of better practice in establishing and operating an MPS or RHS.

Health's response: Agreed.

Recommendation No.7 Para. 5.37

The ANAO recommends that Health complete and re-issue the revised RHSP Guide as a matter of priority.

Health's response: Agreed.

Audit Findings and Conclusions

1. Introduction

This Chapter provides a background to the audit, including the audit objective, approach and methodology. It also describes the rural health environment, including data on the health status of rural populations, the policy environment and specific programs.

Rural health in Australia

Health of Australians living in rural and remote areas

1.1 The population of Australia is predominantly focused in coastal areas, with the majority of people living in cities on the east coast. However, a significant proportion of people live outside urban areas, in more isolated locations. Of the 18.8 million people living in Australia in 2001, 34 per cent lived in rural or remote areas.[13] The majority of these were in regional areas (31 per cent), with the remainder in remote areas.[14]

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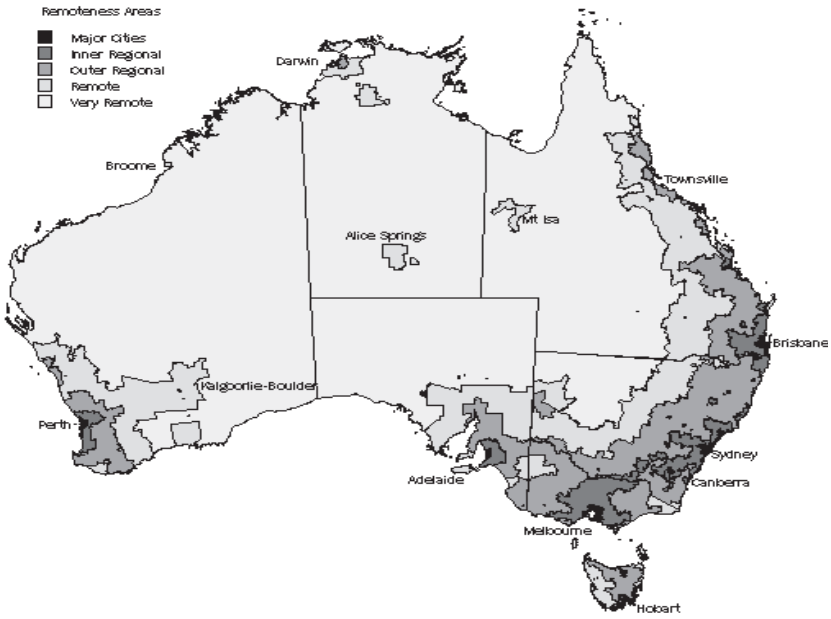
[13] Based on the Australian Standard Geographical Classification Remoteness Structure. Australian Bureau of Statistics 2003, *Australian Social Trends, Population – Population distribution: Population characteristics and remoteness*, Australian Bureau of Statistics, Canberra, <www.abs.gov.au/Ausstats>, viewed 10 December 2003.

[14] There are a number of methods for measuring remoteness. The most common three are Rural, Remote and Metropolitan Areas (RRMA), Accessibility/Remoteness Index of Australia (ARIA) and Australian Standard Geographical Classification (ASGC) Remoteness Structure. The schemes are not equivalent, with differing classifications of remoteness. RRMA was the first classification scheme and is based on the size of the local population centre as well as a measure of remoteness. ARIA followed, measuring the remoteness of a point based on the road distances to the nearest ABS defined Urban Centre. Its premise is that remoteness is a factor of the relative distance one must travel to access a full range of services. More recently, the ABS developed the ASGC scheme that classifies Australia into six areas according to their relative remoteness.

Figure 1.1

Australian areas based on the ASGC Remoteness Structure, 2001



Source: Australian Bureau of Statistics 2003, *Australian Social Trends, Population—Population distribution: Population characteristics and remoteness*, Australian Bureau of Statistics, Canberra, <www.abs.gov.au/Ausstats>, viewed 10 December 2003.

1.2 The demography of rural and remote populations differs from those in capital cities. For example, remote area populations tend to have a greater number of males than females, and proportionally more children and working age males than other areas. Regional areas have the highest proportion of people aged 65 and over. However, in remote areas this proportion was the lowest of all areas.[15]

1.3 Rural, remote and regional areas also have a greater proportion of indigenous people, accounting for two to five per cent in regional areas, 12 per cent in remote areas and 45 per cent in very remote areas compared to

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[15] Australian Institute of Health and Welfare, *Rural, regional and remote health, A study on mortality, summary of findings*, Australian Institute of Health and Welfare, Canberra, October 2003, p. 5. Australian Bureau of Statistics 2003, *Australian Social Trends, Population – Population distribution: Population characteristics and remoteness*, Australian Bureau of Statistics, pp. 5–6, <www.abs.gov.au/Ausstats/abs@.nsf>, viewed 10 December 2003.

one per cent of the population in major cities. These higher proportions are likely to impact on inter-regional difference in mortality and morbidity.[16]

1.4 On average, mortality and morbidity rates differ between populations depending on where they live. Typically, the health of people living in rural and remote areas is worse than for people living in metropolitan areas. For example, in 1999, those living in metropolitan areas had the highest life expectancy[17], living, on average, one year longer than Australians in rural areas, and approximately three years longer than Australians in remote areas.[18]

1.5 Death rates increased with remoteness and were 10 percent higher in regional and remote areas compared with major cities and 50 percent higher in very remote areas.[19] This is the case even after taking into account inter-regional differences in age, sex, indigenous status and the migration of frail elderly people. Some possible explanations for the higher mortality rate are geographic isolation from health care, lower number of health services and providers, lower socio-economic status, higher risk of injury as a result of the type of work and conditions experienced, low quality roads, and indigenous health needs.[20] Physical inactivity, being overweight, smoking, hazardous or harmful alcohol consumption, high blood pressure, and poor diet may also contribute to the poor health of rural Australians.[21]

1.6 Rates of hospitalisation are higher for remote Australians compared to those living in capital cities—an average of 296 and 346 hospital separations (per 1 000 population) for males and females respectively for rural and remote areas compared to 267 and 292 in capital cities.[22] However, remote Australians consulted a general practitioner on fewer occasions, with lower numbers of Medicare claims for consultations.[23]

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16 Australian Institute of Health and Welfare, *Rural, regional and remote health, A study on mortality, summary of findings*, Australian Institute of Health and Welfare, Canberra, October 2003, p. 5.

17 Life expectancy is defined as 'the average number of years a newborn can expect to live, if current age-specific death rates continue to apply throughout that person's lifetime', ibid, p. 11.

18 Australian Institute of Health and Welfare, *Australia's Health 2002*, Australian Institute of Health and Welfare, Canberra, 2002, pp. 217-8.

19 Figures for death rates between 1997–99, Australian Institute of Health and Welfare. *Rural, regional and remote health, a study on mortality, summary of findings*, Australian Institute of Health and Welfare, Canberra, October 2003, pp. 5-6 & 18.

20 id., *Health in rural and remote Australia,* 1998, p. 1.

21 id., *Australia's Health 2002*, July 2002, p. 215.

22 Australian Institute of Health and Welfare, National Hospital Morbidity Database – hospital separation rates for 1995–96. Hospital separation rates provide a measure of the number of hospital care episodes per person. id., *Health in rural and remote Australia*, 1998, p. 93.

23 Medicare utilisation rates for GP consultations, 1995–96. ibid, 1998, p. 98.

1.7 In general, health workers are under-represented in rural and remote areas. For example, in 2001, just over 20 per cent of medical practitioners worked in rural and remote areas, with between 1.5 and 1.8 medical practitioners per 1 000 people living in regional areas, and less than one practitioner per 1 000 population in very remote areas. This compares with around three practitioners for every 1 000 people living in major cities.[24] Similarly, there were approximately 1.6 allied health workers per 1 000 people in rural and remote areas, compared with 2.3 working allied health professionals in major cities. Most categories of nursing are the only health occupations with a greater proportion per population working in rural and remote areas than in major cities. For example, there were approximately 1.5 enrolled nurses and 13 nursing workers in every 1 000 people in rural and remote areas, compared with 0.7 enrolled nurses and 1.2 nursing workers in major cities.[25] Pharmacists were also under-represented, with a rate of 84.9 employed pharmacists per 100 000 of population in major cities compared to 50.9, 40.9 and 27.9 in other rural areas, remote centres and other remote areas respectively.[26]

1.8 Therefore, people living away from major cities are likely to experience more limited access to:

- preventative services such as immunisation and information allowing healthy life choices;
- health management and monitoring;
- specialist surgery and medical care;
- emergency care, for example, ambulance services;
- rehabilitation services after medical or surgical intervention; and
- aged care services. [27]

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[24] Australian Bureau of Statistics 2003, *Australian Social Trends, Population – Population distribution: Population characteristics and remoteness*, and *Australian Social Trends, Health – Health services: Medical Practitioners,* <www.abs.gov.au/Ausstats/abs@.nsf>, viewed 10 December 2003.

[25] Australian Institute of Health and Welfare, <www.aihw.gov.au/labourforce/health.html>, viewed 10 December 2003.

[26] Based on Australian Institute of Health and Welfare data 'employed pharmacists characteristics by geographic location (RRMA) of main job, 1996'. id., *Australia's Health 2002*, Australian Institute of Health and Welfare, Canberra, July 2002, p. 273.

[27] id., *Rural, regional and remote health, a study on mortality, summary of findings*, Australian Institute of Health and Welfare, Canberra, October 2003, pp. 3–4.

The roles of the Commonwealth and State Governments in healthcare

1.9 Health services across Australia are provided by a combination of public, private and not-for-profit organisations. Commonwealth, State and local governments provide services in addition to private sector, community and charitable groups.

1.10 State Governments are responsible for the provision of health services through the public hospital system. They are partially funded via the Australian Health Care Agreements, which are specific-purpose grants from the Commonwealth.

1.11 The Commonwealth's direct health responsibilities relate mainly to the areas of quarantine; the health needs of veterans; pharmaceutical, sickness and hospital benefits; and medical services. In most cases, its role involves providing financial assistance to service providers. This is the case for rural health, where the Commonwealth does not directly provide services but, through a number of programs, provides funds to enable local service providers to meet the health needs of rural communities. The Commonwealth also funds programs designed to increase the number of health professionals working in rural and remote areas.

Rural health policy and programs

1.12 The Commonwealth has implemented a number of rural health policies to address inequalities in health services and outcomes. In 1994, Federal and State Health Ministers endorsed the National Rural Health Strategy (NRHS). The NRHS aimed to provide the framework and policy to guide the appropriate application of rural health services, address rural health priorities, adopt tailored approaches to the unique needs of rural Australians, and measure the progress towards achieving its goals. In May 2000, the Government announced a new strategy called the Regional Health Strategy: More Doctors, Better Services. The key objectives of the strategy were to increase the number of doctors and specialists living and visiting regional areas, and to support regional health services.

1.13 The Department of Health and Ageing (Health) is responsible for implementing the Australian Government's rural health policies. In recent years, Health's role in funding and delivering programs targeting rural and remote health has grown. For example, in 1996–97 Health's budget for programs with a rural health component was approximately $190 million. In 2002–03, expenditure on rural and remote heath programs increased to

approximately $685 million.[28] This rise reflects an increase in the number of Commonwealth funded rural health programs. The 2003–04 Federal Budget lists over 30 key Commonwealth funded rural health programs and initiatives.[29]

1.14 Health funds the various rural health programs through a number of Health and Ageing Portfolio Outcomes. Outcome 5: Rural Health, provides the umbrella for targeted rural and remote health programs funded by Health. The objective of Outcome 5 is to improve health outcomes for Australians living in regional, rural and remote locations. The total appropriation allocated in the 2003–04 Federal Budget for the administered expenses of Outcome 5 is $110.3 million.

1.15 Health's key focus areas for rural health, as described in the 2003–04 Federal Budget, are shown in Figure 1.2.

Figure 1.2

Key focus areas for rural health

Better access to health and aged care services for rural communities Programs in this area are designed to increase the level of health care services in rural and remote areas. They include the MPSP and the RHSP. In general, the programs aim to improve access to primary health care, specialist medical services and radiology services, and assist the viability of rural practices.
More health professionals practising in rural areas The Government assists in recruiting and maintaining health professionals in rural areas by providing rural health scholarships, and funding University Departments of Rural Health and rural clinical schools.
Support to retain health professionals in rural areas Health provides a range of targeted measures to make rural health professions more viable and rewarding. These measures include the HECS Reimbursement Scheme, Rural Retention payments, and workforce and family support for rural GPs.

Source: Adapted from *Portfolio Budget Statements 2003–04*, Health and Ageing Portfolio, Budget Related Paper No.11, pp.173–176.

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[28] Department of Health and Ageing, *Annual Report 2002–03*, Department of Health and Ageing, Canberra, October 2003, p. 167.

[29] These programs and initiatives are listed in Appendix 1.

The Multipurpose Services Program and the Regional Health Services Program

1.16 Two rural programs that Health funds under Outcome 5: Rural Health are the MPSP and the RHSP. This audit focuses on the effectiveness of Health's management of these programs.

Multipurpose Services Program

1.17 The MPSP aims to provide a flexible and integrated approach to health and aged care services delivery to small rural communities. It is a joint program with the State Governments and aims to combine Commonwealth and State funds to provide health and aged care services through one facility. In essence, the Commonwealth provides aged care funding and the States fund other identified health needs. The Commonwealth is the minority funder of the program, providing around $45 million a year. Total Commonwealth and State Government funding to the 86 MPSs operational at August 2003 amounted to $188 million a year.

1.18 The facilities provided by a MPS vary from service to service. For example, a MPS can provide any combination of residential aged care services, acute services (including emergency, maternity and minor procedural surgery), and community and allied health services (such as physiotherapy, podiatry, day care, counselling, rehabilitation and health education). The catchment population for a MPS varies, but is generally between 1 000 and 4 000 people. As at August 2003, there were 86 MPSs operating across Australia. Figure 1.3 presents case studies of two MPSs.

Figure 1.3

MPS Case Studies

Upper Murray Health and Community Services, Victoria

Upper Murray Health and Community Services (UMH&CS) opened as a MPS in July 1995. UMH&CS has utilised the MPSP to reorientate a traditional rural hospital with the objective of providing integrated, coordinated services that will improve the health of the community. UMH&CS is based in Corryong in the Northeast of Victoria and close to the NSW border. Its catchment population of 3 200 is both ageing and declining. The MPS receives funding of $1.1 million a year from the Commonwealth and around $3 million a year from the Victorian State Government. The following services are provided by the MPS.

Acute Services

- general medicine
- accident and emergency
- maternity
- surgery—minor procedural & diagnostic general surgery and gynaecological surgery

Residential Services

- 25 high care places; 28 low care places; 8 Community Aged Care Packages

Community Services and Allied Health

- general practice medicine and nursing
- women's health
- physiotherapy—inpatient and outpatient services
- occupational therapy—inpatient and outpatient and community day services
- care coordination—inpatient and community
- allied health assistant
- podiatry
- speech therapy
- dietetics
- family counselling/ social work
- day care
- community transport
- palliative care
- health promotion officer
- community development
- public health officer
- cardiac rehabilitation
- childbirth education
- asthma education
- diabetes education
- HACC—home care; home maintenance; meals on wheels; social support; adult day activities; senior citizens visiting service; rural financial counsellor; alcohol & other drugs counsellor; domestic violence counsellor; adult, child and adolescent mental health; optometry; audiology

Kangaroo Island MPS, South Australia

The Kangaroo Island MPS commenced in April 1999. Kangaroo Island has utilised the MPSP to reorient a traditional rural hospital with the objective of providing integrated, coordinated services that will better meet the health needs of the community. Kangaroo Island lies off the coast of South Australia, a 25-minute flight from Adelaide. The Island is large, covering 4 500 square kilometres and has a total population of approximately 4 300. Around half the population lives in four main towns—Kingscote, Penneshaw, American River and Parndana. The population overall is ageing, this is especially evident in and around Penneshaw and American River. The MPS receives funding of approximately $1 million a year from the Commonwealth and around $2 million a year from the South Australian State Government. The following services are provided by the MPS.

Acute Services

- accident and emergency
- general medicine
- obstetric care
- improved medical centre/day surgery facilities
- extended high level aged care capacity to 14 places
- integrated care planning across all aged care services

Residential Services

- community nursing care
- development of independent/semi-independent living units adjacent to community health centres in Penneshaw, American River and Parndana
- 15 high care places; 24 low care places; 4 Community Aged Care Packages

Community Services and Allied Health

- health promotion
- palliative care
- community nursing
- family support
- mental health
- youth health
- diabetes education
- asthma education

Source: Health.

Regional Health Services Program

1.19 The RHSP aims to help small rural communities expand their local primary health care services. Health services available through the RHSP include rural health promotion, general practitioner services, illness and injury prevention, acute and palliative care, community nursing aged care, mental health, podiatry, radiology and immunisation.

1.20 The Commonwealth allocates around $42 million annually to the RHSP, funding 152 projects as at 31 August 2003. Figure 1.4 presents case studies of two RHSs.

Figure 1.4

RHS Case Studies

North West Allied Health RHS, Queensland

North West Allied Health Regional Health Service commenced in June 2001 and is managed by the North & West Queensland Primary Care Association—a Division of General Practice. It receives $4.46 million in funding over three years.

The project provides a multi-disciplinary allied health service to eleven culturally diverse (indigenous, non-indigenous and mixed) remote communities. Outreach services extend over 373 000 square kilometres of north western Queensland, including Cloncurry, Camooweal, Dajarra, Julia Creek, Richmond, Hughenden, Normanton, Karumba, Mornington Island and Doomadgee. The service operates as a fly-in fly-out model with allied health professionals based in Mt Isa. The services provided include:

- physiotherapy;
- dietetics;
- podiatry;
- occupational therapy;
- speech pathology; and
- psychology.

Objectives and intended outcomes of the project include:

- assist members of the 10 communities to achieve improved health through increased access to a range of primary health care services;
- establish and maintain mechanisms for effective community participation;
- improve community awareness of health promotion and prevention strategies; and
- adopt integrated approaches to the planning and delivery of health services to maximise health gain.

Beaufort/Skipton Regional Enhanced Access & Community Health, Victoria

Beaufort/Skipton Regional Health Service commenced in March 2001 and is managed by the Beaufort and Skipton Health Service. It receives $1.11 million in funding over three years. The aim of the project is to provide enhanced access to primary health care services for communities in the Beaufort/Skipton region including: Raglan, Lexton, Skipton, Snake Valley, Linton and Streatham. The services provided include:

- community health nursing;
- social work;
- physiotherapy;
- occupational therapy; and
- community transport coordination.

The services are provided from the base sites of Beaufort and Skipton. The Beaufort/Skipton RHS works with the adjoining East Grampians, Maryborough and Camperdown Health Services to provide complementary services/programs within the region.

Intended outcomes of the project include:

- a reduction in the health service gaps identified throughout the area;
- improved access for isolated people to a wider range of health services both within the area and to more specialist services located out of area;
- a multi-disciplinary team able to respond to clients' health needs in a comprehensive way; and
- the provision of education and health promotion to specific target groups in order to address known risk factors for chronic disease.

Source: Health.

Previous coverage of rural health

1.21 The ANAO audits the financial statements of Health annually. Other ANAO performance audits relevant to the health of Australians living in rural and remote areas include:

- *The Aboriginal and Torres Strait Islander Health Program Follow-up Audit*, Department of Health and Ageing, No.15, 2002–03;
- *Aboriginal and Torres Strait Islander Health Program*, Department of Health and Aged Care No.13, 1998–99;
- *Planning of Aged Care*, Department of Health and Aged Care, No.19, 1998–99; and
- *Planning for Rural Health*, Department of Health and Family Services, No.45, 1997–98.

The audit

Audit objective and scope

1.22 The objective of the audit was to assess the effectiveness of Health's management of the MPSP and the RHSP. To achieve the audit's objective, the ANAO examined whether Health:

- had an effective approach to planning the programs;
- had an effective approach to delivering the programs;
- effectively used performance information to manage the programs; and
- effectively managed its relationship with stakeholders of the programs.

Audit methodology

1.23 To form an opinion against the audit objective, the audit team:

- interviewed relevant personnel at Health's Central Office;
- interviewed relevant personnel at a selection of Health's State Offices;
- interviewed relevant personnel in three State Governments;
- interviewed stakeholders, including the National Rural Health Alliance;
- reviewed a selection of files in Health's central and State Offices;
- reviewed other relevant documentation and reports;

- analysed Health's statistical data;
- visited services in New South Wales;
- attended the 7th National Rural Health Conference;
- attended the Queensland Regional Health Service (RHS) Forum; and
- conducted a literature search.

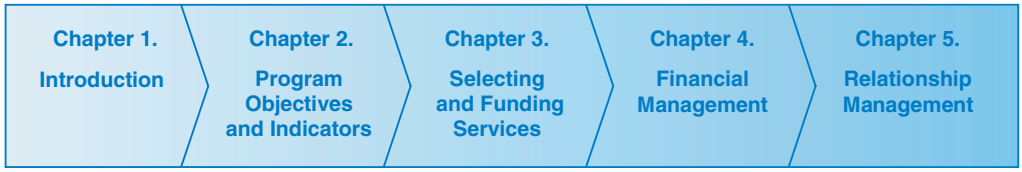
1.24 Audit fieldwork was conducted over the period July to September 2003. The audit was conducted in accordance with ANAO Auditing Standards at a cost of $340 000.

Report structure

1.25 This report is divided into five Chapters, as illustrated in Figure 1.5.

Figure 1.5

Report structure



1.26 Chapter 1 introduced the audit and described the rural health environment. Chapter 2 discusses program objectives and indicators, and how performance information is produced and used. Chapter 3 examines how services are selected and funded, while Chapter 4 discusses Health's financial management of the two programs. Finally, Chapter 5 describes the relationships between Health and its internal and external stakeholders.

2. Program Objectives and Indicators

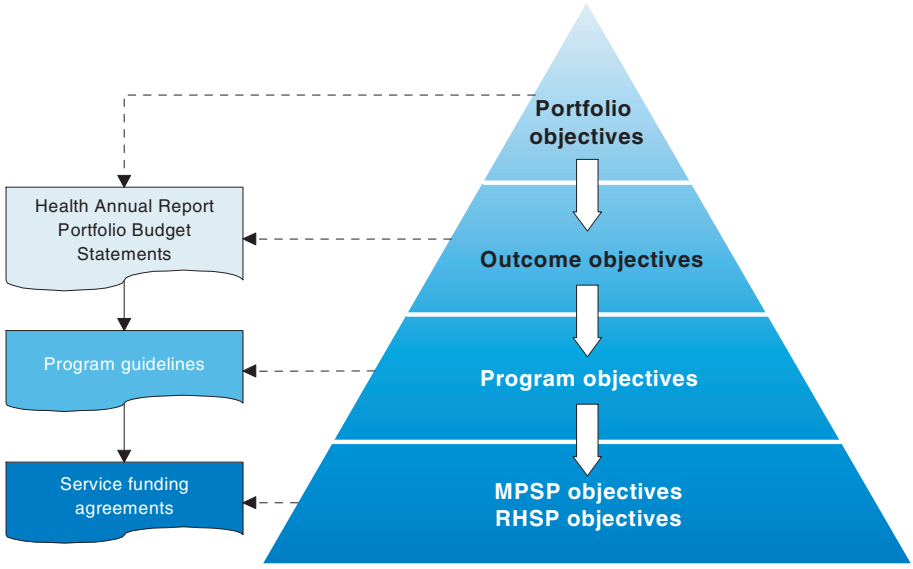
This Chapter discusses the objectives and performance indicators of the two programs and demonstrates how they align with the broader Health objectives. The Chapter also reviews how Health produces and uses performance information in monitoring and evaluating each program and individual service.

Alignment of objectives

2.1 Objectives cascade from Health's high level, overall objective, through Health's outcome level objectives, to the level of individual programs and services, as illustrated by Figure 2.1

Figure 2.1

Cascading performance objectives



Source: ANAO.

2.2 The ANAO examined the objectives at each level and found that the objectives of the two programs support, and are aligned with, Health's portfolio objective and the Outcome 5 objective. This alignment is demonstrated graphically in Figure 2.2.

Figure 2.2

Alignment of objectives

Department of Health and Ageing[30]

Better health and healthier ageing for all Australians through a world class health and ageing system which:

- ⇨ meets people's needs, throughout their life;
- ⇨ is responsive, affordable and sustainable;
- ⇨ provides accessible, high quality service including preventative, curative, rehabilitative maintenance and palliative care; and
- ⇨ seeks to prevent disease and promote health.

Outcome 5: Rural Health[31]

Improved health outcomes for Australians living in regional, rural and remote locations.

Multipurpose Services Program[32]

The MPSP aims to provide a flexible and integrated approach to health and aged care services delivery to small rural communities.

Health seeks to achieve the following MPS Program objectives for small rural and remote communities

- ⇨ improved access to a mix of health and aged care services that meet community needs;
- ⇨ more innovative, flexible and integrated service delivery;
- ⇨ flexible use of funding and/or resource infrastructure within integrated service planning;
- ⇨ improved quality of care for clients; and
- ⇨ improved cost-effectiveness and long term viability of services.

Regional Health Services Program[33]

The RHSP aims to help small rural communities expand their local primary health care services. It achieves this based on the following principles:

- ⇨ local solutions for local health problems ensuring there is to be real health gain;
- ⇨ flexible, innovative and integrated solutions promoting better health;
- ⇨ governments supporting improved access to health services, particularly in small communities; and
- ⇨ the Australian Government, State and Territory and local governments collaborating to provide the best way to improve health in rural communities.

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30 Department of Health and Ageing, *Annual Report 2002–03*, Department of Health and Ageing, Canberra, October 2003, p. 18.

31 Department of Health and Ageing, *Annual Report 2002–03*, Department of Health and Ageing, Canberra, October 2003, p. 19.

32 *Multipurpose Services Program Guidelines for State and Territory Offices*, Department of Health and Ageing, unpublished, p. 3.

33 <www.ruralhealth.gov.au/services/rhsp.htm>, viewed 17 December 2003.

Performance indicators

2.3 Reflecting the cascading performance objectives, performance indicators relevant to the MPSP and RHSP have been developed at the outcome level and by Health's State Offices in their business plans.

2.4 Health's annual report and Portfolio Budget Statements include four performance indicators for Outcome 5: Rural Health. Indicator 4 addresses 'access to primary heath care services for rural/remote communities', relating specifically to the MPSP and RHSP.[34] The targets for this indicator for 2003–04 are:

- increased number of RHSs over the expected baseline of 120 services of approximately 20 new services and seven planning projects; and
- increased number of MPSs available to people in rural/remote Australia.

2.5 Under the administered items for Outcome 5, Health provides performance information on health services for rural communities, including for the MPSP and RHSP. Qualitative and quantitative measures for 2003–04 include:

- all RHSs comply with service agreements, meet identified community needs and have a quality improvement framework;
- at least 20 service delivery and seven service planning projects approved [for regional health services]. Majority to be in regions identified as being of highest priority;
- all MPSs comply with service agreements, meeting identified community needs and have a quality improvement framework; and
- at least 12 MPSs approved as flexible care services.

2.6 These indicators and measures were revised as part of Health's Portfolio Additional Estimates Statements 2003–04. The Additional Estimates Statements require:

- up to 10 additional RHSs to become operational; and
- at least eight new MPSs established in 2003–04.[35]

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[34] Indicators 1 to 3 are not relevant to the MPSP or the RHSP; they relate to the Medical Specialist Outreach Assistance Program, clinical and training placements, and pharmacy services.

[35] Department of Health and Ageing 2004, *Portfolio Additional Estimates Statements 2003-2004, Health and Ageing Portfolio, Explanation of Additional Estimates*, Department of Health and Ageing, February 2004 p. 115.

2.7 The Outcome 5 performance indicators are aligned with the objectives of the two programs.

2.8 Beneath the outcome level performance measures, the ANAO found that the two Health State Offices visited had developed business plans that included Outcome 5 performance measures for program management, including measures for the MPSP and RHSP. The measures established broad qualitative standards of service to be delivered by the State Office and strategies to adopt, including timely program management, evidence of stakeholders support, monitoring of project expenditure and financial and service reporting requirements. The number and content of performance measures differed depending on the State but were broadly similar. The ANAO found that the performance indictors contained in the business plans examined are consistent with the project objectives.

Producing performance information

Service files

2.9 Service records are paper-based files containing all information relating to an MPS or RHS. Each MPS and RHS has its own separate set of colour-coded paper files that contain, for example, the application form, funding agreement, service plans and progress reports. Service files are stored in a central location and are accessible by program staff. The quality and methods of records management varied between States, with each State independently developing their own filing systems.

2.10 The ANAO asked program staff about their perceptions of the usefulness and effectiveness of the State's filing system. Staff were generally aware of the filing systems, and acknowledged that they were easy to understand and met their needs. However, some staff felt that the systems could be simplified and improved. On reviewing paper-based files in Central and State Offices, the ANAO found that the quality of the records could be improved, thereby improving administrative efficiency.[36] In particular, there was:

- duplication of documents within and between some files;
- inconsistent document folioing and ordering (non-chronological);
- the absence of complete contents pages;

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[36] Record-keeping polices and practices were assessed against Australian Standard Records Management (AS ISO 15489). This included reviewing a sample of files at Central Office and two State Offices and examining guidance documents on records management provided to program staff.

- differences in the accuracy of file lists;
- insufficient documentation of decisions; and
- examples where documents lacked a date and source.

2.11 The ANAO suggests that Health complies with the Australian record-keeping standard[37] to make sure that record-keeping practices support staff needs and facilitate management of the programs.

Collated performance data

2.12 Health's Central Office has developed a rural health database. The database is designed to act as a central repository for data relating to rural health programs, including the MPSP and RHSP. It aims to provide Central Office staff with the ability to obtain data ranging from detailed information on a single service to broad information on the impact services may be having in specific areas of the country. The ANAO found that although Health's Central Office staff use the database, they do not have confidence in the integrity of the data within the system. As a result, when Central Office staff require accurate, up-to-date information on the MPS or RHS, they contact the relevant State Office to verify data in the system.

2.13 In addition, the ANAO found that, until recently, the database was only available to State Office staff on a 'read-only' capacity. Data is entered into the data-base by Central Office staff. State Office staff informed the ANAO that the database did not meet their needs, largely due to their limited access and the inaccuracies in the data it contains. As a result, they did not use the database. Instead, States relied on their own systems to collect and store data from progress reports, and from contact between project offices and the auspices[38] and services. These systems differed from State to State and within States. For example, one State Office has developed a MPS activity status spreadsheet that collates, on a monthly basis, data on the status of existing MPSs and potential MPS sites. Depending on the phase that the MPS is in (for example, operational or in development), different information is collected and displayed in the spreadsheet. In addition, most project officers have developed systems to monitor individual services. For example, in the State mentioned above, a project officer has developed a spreadsheet detailing the status, issues and action required for each MPS in one region. The spreadsheet assists her to monitor the MPSs for which she is responsible.

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[37] AS ISO 15489.

[38] An auspice is an organisation or group charged with responsibility for the management of the MPS and its financial affairs. (*Multipurpose Services Program Guidelines for State and Territory Offices*, p. 123.)

2.14 The existence of a central rural health database and the States' shadow systems has resulted in inconsistency between the Central and State Offices, with databases not being kept up-to-date, data appearing on one database and not another, and dissimilar data occurring for the same data items. Health recognises the need for broader access to the rural health database, including the capacity to input and edit data. State access was trialled for four months in 2003 and Health anticipates that the States will have full access by early 2004.

Using performance information

2.15 The ANAO would expect that performance information received from services is produced and used to manage and monitor:

- the status of individual services; and
- the progress and effectiveness of the programs nationally.

2.16 Project officers, relying on their individually developed information systems developed from knowledge garnered from progress reports and direct contact with auspices and services, have a broad knowledge of the services they monitor, including any issues and problems the services are facing. Therefore, the ANAO found that systems implemented in the State Offices are effective to monitor the status of individual services.

2.17 However, while data is consolidated into State systems and the central database, it is not used to manage and monitor the programs holistically. That is, performance information on individual services is not consolidated and analysed systematically, either at the State level or nationally. As such, the ANAO found that there is no holistic analysis to identify trends, to inform improvements to the programs, or to identify good practice. Health has informed the ANAO that enhancements to the central rural health database, to improve data collation and analysis, will be used to guide program planning, monitoring and evaluation in the future.

2.18 In addition, the ANAO found that, currently, Health does not have baseline information on health service provision or health outcomes. As such, Health is not able to determine and, therefore, measure improvements in the service level or health outcomes in a region or State. Consequently, Health is not able to measure progress against its Outcome 5 objective of improving the health of Australians living in regional, rural and remote locations.

2.19 The ANAO notes that the MPSP and RHSP are designed to improve access to health and aged care services and do not purport to address the total health needs of an individual. However, the absence of baseline data also makes it difficult to measure the progress of the two programs against their

respective objectives. Central Office has informed the ANAO that information from the new MPS reporting system would provide a benchmark for measuring improvements in services and health outcomes in areas serviced by a MPS. In this context, the ANAO suggests that this information could be used to develop at least intermediate performance indicators.

2.20 Despite the absence of reliable performance information and baseline health data, Health has evaluated the MPSP twice and the RHSP once.

2.21 In December 1995, the Australian Government commissioned an independent evaluation of the pilot MPS sites. The evaluation concluded that 'the overall model of the MPS does provide positive opportunities for improved service delivery in rural and remote communities'.[39] As a result, the Australian Government continued the program. In November 2000, an independent evaluation of the MPSP in Victoria was completed for Health and the Victorian Department of Human Services. The evaluation concluded that 'overall, the Program is meeting its objectives'.[40]

2.22 The RHSP was evaluated in late 2003 as part of the Federal Budget process. The evaluation was completed in October 2003 and, in general, supports the program. The report of the evaluation makes 14 recommendations to further improve the operation of the program. Health advised the ANAO that the recommendations are scheduled to be addressed in the 2004–05 Federal Budget.

Managing program risk

2.23 The ANAO found that Health has not developed a risk management plan for the MPSP. While Health is a minority funder of the program, it is, potentially, exposed to a number of risks. These risks include, for example, the program not meeting its objectives, inappropriate or inaccurate payments to MPSs, high Health staff turnover, poor relationships with stakeholders, and inefficient contract management. Therefore, the ANAO recommends that Health analyse and evaluate its potential risk exposure under the MPSP and develop a risk management plan for the program.

2.24 Health has developed a risk management plan for the RHSP. The program-wide risk management plan identifies potential risks, considers their impact and proposes strategies to control or mitigate the risks. Risk

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[39] Centre for Ageing Studies – The Flinders University of South Australia, Health Solutions, and Consortium for Evaluation Research and Training, *Evaluation of the Pilot Multi-purpose Services Program, Final Report*, December 1995, p. 2.

[40] Sach and Associates, *Multi-purpose Services Program Evaluation (Victoria)*, November 2002, p. ii.

management plans for individual RHS projects are also a condition of approval of funding agreements. The individual project plans are based on the program-wide risk management plan. The ANAO examined a sample of RHS files and found that all had risk management plans. However, there was no evidence that these plans were used or updated by Health. Program staff instead relied on activity reports to identify, monitor and manage risks.

Summary

2.25 The objectives of the MPSP and RHSP are clearly defined and documented in Health's Annual Report, Portfolio Budget Statements, website and the program guidelines. The objectives of the two programs are aligned with Health's overall objective and the objective for Outcome 5. Health has developed performance indicators for the MPSP and RHSP nationally. The States visited by the ANAO had also developed performance measures, articulated in their business plans. The ANAO concludes that these performance indicators are consistent with the objectives of the two programs.

2.26 Health's Central and State Offices have identified their record-keeping requirements and have implemented paper-based systems that generally meet those requirements. However, the ANAO found a number of problems with the records examined, and concludes that the systems could be improved in line with the Australian record-keeping standard.

2.27 Information from progress reports, combined with information from contact with auspices and services, is collected into systems used to monitor services. These systems, developed independently in each State, generally comprise spreadsheets used to monitor individual services only. The ANAO concludes that the systems are effective for this purpose. However, the State systems shadow the centrally developed rural health database, resulting in inconsistencies between the data held in the central database and the States.

2.28 Health does not have baseline information that would enable it to measure improvements in health outcomes or service levels associated with the MPSP and RHSP. In addition, data is not analysed systematically, at the State or national levels, to identify trends and good practice, or to inform improvements to the programs.

2.29 Health has completed two evaluations of the MPSP. Both evaluations were of limited scope—one evaluated the pilot MPS sites and the other evaluated the program in Victoria. Health has not evaluated the effectiveness of the MPSP nationally. The first evaluation of the RHSP was completed at the end of 2003. The outcome of the evaluation will assist Health to achieve improvements in the program.

2.30 There are no risk management plans for the MPSP as a whole. In contrast, Health manages risk in the RHSP via a risk management plan developed for the program as a whole, and by requiring risk management plans for individual RHSs.

Recommendation No.1

2.31 The ANAO recommends that Health review the central rural health database to make sure that the system meets all user needs, including the needs of Health's State Offices, and contains accurate and up-to-date information.

Health's response

2.32 Agreed. Changes to the database have been implemented to meet user needs, particularly the needs of State Offices.

Recommendation No.2

2.33 The ANAO recommends that Health develop baseline health information and intermediate performance indicators, and analyse performance data on the two programs. This would allow Health to identify areas for improvement and inform the future strategic direction of the programs, and will assist Health to identify and measure the impact of the MPSP and RHSP on Health service provision and health outcomes.

Health's response

2.34 Agreed. Enhancements have been implemented to the rural health database which will make it possible to collate and analyse data on health service provision more comprehensively than in the past. It is planned to use this improved capacity to guide program planning, monitoring and evaluation. In addition, the programs can draw on the limited health outcomes information currently collected by Australian Institute of Health and Welfare.

2.35 It should be noted, however, that it would not be appropriate to attempt to attribute changes in health outcomes solely to the MPS and RHS programs. The two programs are designed to improve access to health and aged care services in small rural and remote communities and therefore increases to service availability is the primary indicator of success. While such access is of course likely to have positive health impacts, neither program purports to address the total health needs of an individual in a way that would mean that health improvements could be directly attributable to their availability. They do not, for example, include general practice services.

Recommendation No.3

2.36 The ANAO recommends that Health analyse the risks to the MPSP, and develop a risk management plan that identifies Health's potential risk exposures under the program and describes treatments that reduce those risks to an acceptable level.

Health's response

2.37 Agreed. A risk management plan for the MPS Program is being developed and should be completed by the end of this financial year.

3. Selecting and Funding Services

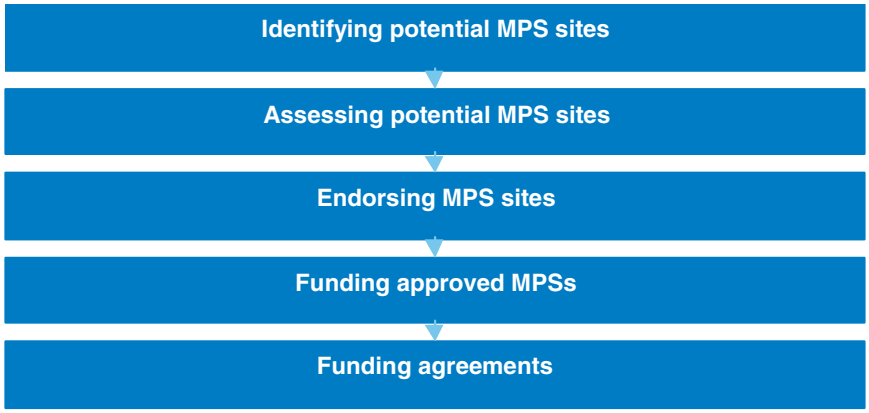
This Chapter discusses two dimensions of Health's management of the MPSP and RHSP, how potential services are identified and assessed and how selected services are funded.

Multipurpose Services Program

3.1 Selecting and funding suitable MPS sites requires cooperation between Health, representing the Commonwealth, and the relevant State Government. Figure 3.1 outlines the main points addressed in this Chapter—from initial site identification to signing of MPS funding agreements, including the involvement of the Commonwealth and the States.

Figure 3.1

From site selection to funding



Source: ANAO analysis, based on the *Multipurpose Services Program Guidelines for State and Territory Offices*.

Identifying potential MPS sites

3.2 MPS sites are identified in two ways—first, self-identified by interested communities or second, identified and agreed jointly by the Commonwealth (Health's State Office) and the relevant State Government. Agreeing potential MPS sites involves negotiation between the Commonwealth and State Governments, and with the rural communities affected. During the early stages of the program, while the roles and responsibilities of the Commonwealth and State Governments were being defined, some misunderstandings and tension existed. However, in recent years these roles

are clearer and systematic approaches to site identification have been adopted, although these approaches vary from State to State.

3.3 For example, in New South Wales, 15 sites were identified and endorsed by the Commonwealth and State Health Ministers during the early stages of the program, and a further 16 were identified and endorsed in 1997–98. In 2000, recognising that a systematic approach to site identification was required, Health's State Office, in collaboration with NSW Health, developed a framework to rank MPS sites, called the *Framework to Prioritise Smaller Rural Communities for the Development of Multipurpose Services*. The Framework considered existing hospitals in small rural communities that would benefit from adopting the MPS model. These sites were ranked according to a data model using an agreed set of variables that included population, the need for acute care services, and a variety of aged care factors, including lack of existing aged care places and appropriateness of existing residential aged care services. As a result of this Framework, 12 sites were identified as suitable for endorsement as potential MPSs and a further 13 sites identified for further investigation. Of these, four are now operational.

3.4 In Queensland, Queensland Health developed a list of potential sites that was discussed with the Commonwealth via the Joint Officers Group (JOG) in 1997. The JOG agreed to prioritise sites based on the list. In early 2003, Health's Queensland State Office developed a new methodology for site identification, *MPS Planning and Targeting Working Paper.* The paper was discussed with Queensland Health in August 2003 and will be implemented in early 2004.

3.5 A similar approach was taken in South Australia during the early 1990s, with the State Office, jointly with the South Australian Department of Human Services, identifying needs areas. More recently, the State has employed an expression of interest process to identify potential sites. In 1996, Western Australia also used an expression of interest process to identify MPS sites.

3.6 Overall, the ANAO found that Health's State Offices have developed effective approaches to identifying potential MPS sites.

Assessing potential MPS sites

3.7 Following identification, the Commonwealth and State Governments investigate sites to make sure they meet the preconditions that a site must demonstrate for selection as a potential MPS. These preconditions are listed in Figure 3.2. The crucial factor in selecting a MPS site is support from the relevant State Government. Without State Government commitment to

providing the majority of recurrent funding, and capital funding where necessary, a MPS cannot be developed.

Figure 3.2

Preconditions for MPS selection

Insufficient catchment populations to sustain separate acute hospital, residential care, community health and home care services (generally from around 1 000 to 4 000 persons).
Inability to access the mix of health and aged care services appropriate to needs due to isolation.
Complementary (rather than competing) services.
Common service boundaries reflecting a common sense of community.
Consumer/community involvement in and commitment to the MPS model.
Sustained access to effective leadership and management skills.
Support from existing services, including local health professionals such as the general practitioner(s).
Capacity to achieve financial viability under MPS funding arrangements.
Willingness and capacity to participate in the change management processes essential to gaining the most benefit from the flexibility of the model.
No adverse impact on services in nearby towns.

Source: Department of Health and Ageing, *Multipurpose Services Program Guidelines for State and Territory Offices*, Canberra, 2002, p. 47.

3.8 Broadly, the objective of the MPSP[41] is to improve quality and access to integrated health and aged care services via a flexible funding model. The MPS preconditions are consistent with the program's objectives. They guide Health personnel in selecting MPS sites that are consistent with the purpose and objectives of the program. The ANAO found that MPS preconditions are clearly stated and understood by Health personnel. The ANAO also found that, generally, operational MPSs meet the preconditions and that Health complies with the processes for site development and approval, as described in the MPSP Guidelines.[42]

Endorsing MPS sites

3.9 When an identified site is found to meet the MPS preconditions, Health recommends it to the Minister for Health for endorsement. A parallel process

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41 The objectives of the MPSP are listed in Chapter 2.

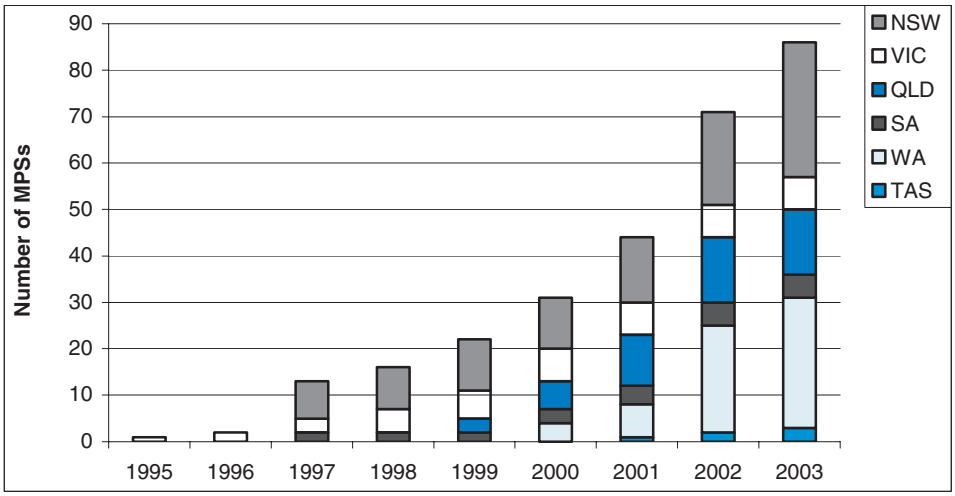
42 The *Multipurpose Services Program Guidelines for State and Territory Offices* is discussed in more detail in Chapter 5.

occurs at the State Government level. The Commonwealth and State Ministers then make the decision to endorse the MPS site.

3.10 The processes for identifying and endorsing potential MPS sites have been effective, and the MPSP has grown since its inception. As illustrated by Figure 3.3, there was an early surge in MPS numbers following the success of the pilot sites and growth has accelerated again over the past two years. The recent growth is largely the result of increased involvement in the program by some State Governments. This is most notable in New South Wales, Western Australia and Queensland, where State Governments have increased capital and recurrent funding to many small rural hospitals, including MPSs.

Figure 3.3

Number of operational MPSs by State, 1995 to 2003



Source: ANAO analysis of Health data.

Funding approved MPSs

3.11 Following Ministerial endorsement of a MPS site, the Commonwealth makes a commitment to provide funding to that MPS, subject to all parties endorsing the requirements and conditions of the service plan and funding agreement.

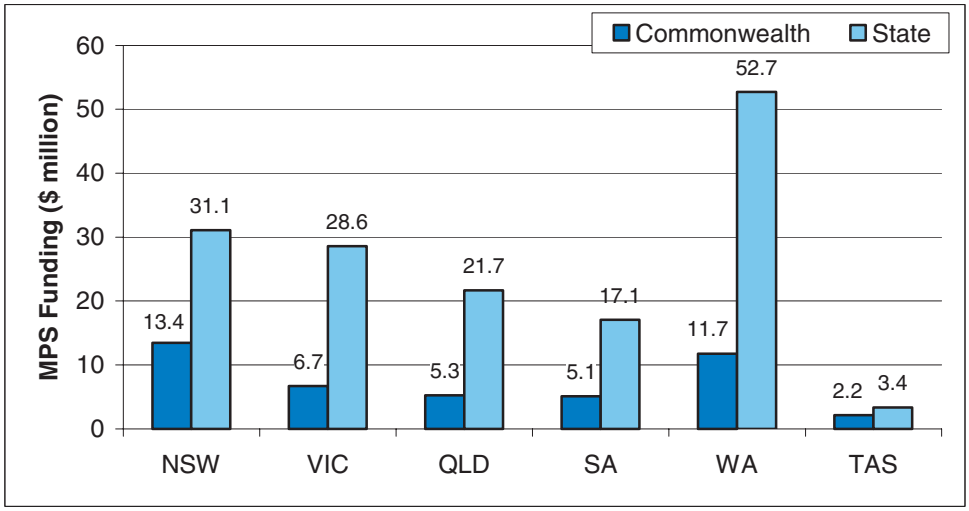
3.12 Commonwealth and State funding for a MPS is pooled into one account, administered by the auspice, to be used flexibly by the MPS. The pooled program funding may include residential and community aged care, acute hospital services, community health, and ambulance and community transport services. Other sources, such as community and charitable organisations and local government, may also contribute funds into this pool.

The MPSP objective to improve quality and access to integrated health and aged care services, via a flexible funding model, is consistent with the principle of flexible, pooled funding that forms the basis of the MPSP funding model.

3.13 While the Commonwealth is the minority funder for the MPSP on the whole, it is the majority funder for four of the 86 MPSs currently operational. Commonwealth funding to MPSs totals $44.4 million per year, based on current rates.[43] During 2002–03, State recurrent funding[44] to the 81[45] operational MPSs totalled $146.5 million. Commonwealth funding to the five MPSs that opened between 30 June 2003 and 31 August 2003 will amount to $2.8 million in 2003–04 and State recurrent funding will be $7.9 million. Therefore, total government (Commonwealth and State) funding to the 86 MPSs operational at August 2003 amounts to $188.1 million a year.

Figure 3.4

MPS Commonwealth and State funding a year, as at August 2003



Note: State funding does not incorporate capital contributions; amounts are derived from funding agreements. Commonwealth funding is calculated based on current rates.

Source: ANAO analysis of Health data.

3.14 The Commonwealth funds the aged care portion of a MPS. This funding is provided through the flexible care subsidy provisions of the *Aged*

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43 The MPS funding formula of is explained in more detail later in this Chapter and in Appendix 2.

44 Does not incorporate capital contributions. Amounts are derived from funding agreements.

45 Excludes one service that ceased to operate under the MPSP in mid-2003.

Care Act 1997 (the Act). The Commonwealth's contribution for aged care is based on the following variables[46]:

- number of residential aged care accommodation places (high and low care);
- residential aged care accommodation place subsidy rate (based on a percentage of Resident Classification Scale (RCS) 3 for high care places and RCS 7 for low care places);
- number of Community Aged Care Package (CACPs);
- CACP rate;
- concessional resident supplement; and
- viability supplement.

Figure 3.5

MPS funding formula—Commonwealth contribution[47]

Daily Commonwealth MPS funding = h(H + R + V) + l(L + R + V) + c.C

Where:

h = number of high care places	H = high care basic subsidy
l = number of low care places	L = low care basic subsidy
R = concessional resident supplement	V = viability supplement
c = number of CACPs	C = CACP rate

3.15 The report of the RCS Review, commissioned by the Minister for Ageing and released in February 2003, recommended that Health support the development of a new model for residential aged care funding, for example, by trialling alternative funding models. MPS funding is calculated, using the formula expressed above, with high and low care subsidies based on a percentage of the RCS 3 and 7 rates, respectively. As such, any change to the RCS will impact on the funding of the MPSP.

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46 These variables are discussed in more detail in Appendix 2.

47 The formula is discussed in more detail in Appendix 2.

Funding agreements

3.16 The Commonwealth has a MPS funding agreement for each MPS. The agreement is the contractual basis whereby agreed services are provided in exchange for defined levels of funding. Three standard agreements are used for the MPSP:

- Standard Bipartite Funding Agreement between the Australian Government and a State Government (where the auspice is not a legally incorporated entity separate from the State Government);
- Standard Tripartite Funding Agreement between the Australian Government, State Government and a MPS auspice; and
- Short Form Funding Agreement for one-off funding for specified projects.

3.17 The agreements contain standard clauses covering, for example, records and recording of information, confidentiality, intellectual property, indemnity, insurance, and dispute resolution. The agreements also contain the objectives of the MPS, a list of the services to be provided, the number and type of aged care services that the MPS will be funded for, and a budget.

3.18 A service delivery plan describes the services to be provided by the MPS. Prior to signing a funding agreement, all parties must agree on the contents of the service delivery plan. At the end of each three-year funding period MPSs are required to provide a revised service plan to Health.

3.19 The ANAO found that, of the 86 MPSs operational in August 2003, the agreements of 29 MPSs were extended beyond their original term. Fourteen of the extensions were made by variation to the existing agreement and 15 extensions were made by letter. Of the extended agreements, ten (34.5 per cent) originally expired in 2000, four (13.8 per cent) in 2001, eight (27.6 per cent) in 2002 and seven (24.1 per cent) in 2003. Health informed the ANAO that agreements were extended by letter or variation as a temporary measure to cover MPSs while a new agreement template is finalised.

3.20 The one-third of MPSs operating with extended agreements are, therefore, implementing service delivery plans that have not been reviewed and that may not be current. Indeed, one service delivery plan was originally developed in 1995 and another in 1996, 11 (12.8 per cent) were developed in 1997, and a further 9 (10.5 per cent) in 1998 and 1999 (three and six respectively).

3.21 During the course of this audit, the ANAO examined whether MPS agreements complied with specific provisions of the relevant legislation, specifically the Act and the *Flexible Care Subsidy Principles 1997* (the Principles).

3.22 Section 50–1 (1) of the Act states that:

> an approved provider is eligible for a flexible care subsidy in respect of a day if the Secretary is satisfied that, during that day the approved provider holds an allocation of places for flexible care subsidy … and the approved provider provides flexible care to a care recipient…[48]

3.23 However, the structure of the MPSP provides for flexible funding arrangements where funding is pooled and averaged over a year. As such, the Secretary would not be able to determine, on any given day, the actual number of recipients receiving care.

3.24 Legal advice obtained by the ANAO does qualify the above by suggesting that section 50–1 sets only a minimum requirement that at least one person receive flexible care on any given day. The implication is that there would not be a breach of the Act if the MPS is providing care to at least one person on each day of the year.

3.25 The amount of flexible care subsidy payable is advised by the Minister for Ageing in a 'determination', made as per section 52–1 of the Act. Since September 1997, when the Act became law, determinations made by the Minister reflected the requirements and wording of the Act, including reference to conditions related to the allocation of places. In July 2003, the former Minister issued a determination, effective from 1 July 2003, which does not refer to conditions related to the allocation of places. Legal advice obtained by the ANAO advises that the determination remains consistent with the Act.

3.26 Nevertheless, as there appears to remain some issue of clarity between the objectives of the MPSP, to provide flexibility in funding service delivery, and the specific requirements of the Act, the ANAO suggests that this should be resolved when the opportunity arises.

3.27 Principle 15.14 (6)[49] requires that an approved provider enter into

> an agreement with the Commonwealth and State to ensure that the flexible care service achieves agreed targets for the aged care and health needs of the multi-purpose service site.

3.28 The Act does not define 'targets'. The ANAO defines targets as 'quantifiable performance levels or changes in level to be attained at a specified

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[48] The Secretary referred to in the Act is the Secretary of the Department of Health and Ageing.

[49] Of the *Flexible Care Subsidy Principles 1997*.

future date'.[50] Good practice suggests that targets focus on outputs and outcomes.

3.29 The majority of MPS agreements contain, at most, a list of service types to be provided by the MPS, the number of flexible aged care places the MPS will be funded for, and a budget for the funding period. Health argues that the combination of bed numbers and budgetary inputs are targets sufficient to meet the requirements of the Act. The ANAO notes that these are input measures, and while they may be suitable as a basis for funding, they do not reflect targets for outcomes; that is, what the services are expected to achieve.

3.30 Moreover, even as funding targets, the target for residential aged care accommodation (for example, 20 high care accommodation beds) is indicative only. Under the MPSP flexible funding arrangements, the number of bed places specified in the agreements is used as the basis to calculate the funding, and is not necessarily equivalent to the number of actual beds provided. The funding may be used to provide any appropriate aged care services, to the level broadly commensurate with MPS funding. Therefore, numbers of bed places are not useful targets for residential aged care accommodation as they are not an accurate description of the actual services provided.

3.31 A small number of agreements do contain some targets for level of service provision. However, these targets are limited in that they do not cover all services provided by the MPS. For example, Figure 3.6 presents an extract from a MPS agreement that contains limited service provision targets.

[50] ANAO and Department of Finance, *Performance Information Principles*, November 1996, p. 34.

Figure 3.6

Extract from a MPS funding agreement

Summary of Proposed Services

Acute Services	
Emergency Service	24 hours per day by 7 days per week, 4 trolley spaces
Acute Accommodation	8 beds
Residential Aged Care Services	
High Care Accommodation	20 beds
Diversional Therapy	6 hours per day by 5 days per week
Clinical Support Services	
Radiography Services	4 sessions per week (0.4 full-time equivalent)
Physiotherapy	2 sessions per week—inpatient (0.2 full-time equivalent) 6 sessions per week—community health (0.8 full-time equivalent)

Source: Extract from a MPS funding agreement.

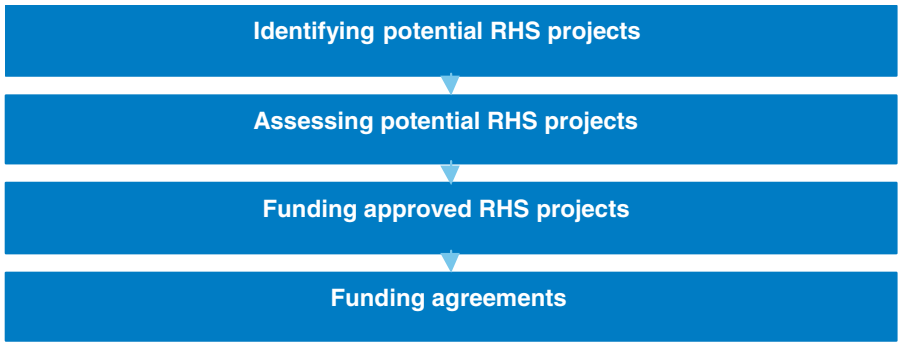
3.32 To allow Health to effectively monitor the performance of MPSs, the ANAO would expect to see similar targets, which included reference to specific services and service levels, included in all agreements. Where possible, they should be expanded by intermediate outcome indicators.

Regional Health Services Program

3.33 Figure 3.7 outlines the main points addressed in this section of this Chapter—from initial project identification to signing of RHS funding agreements.

Figure 3.7

From project selection to funding



Source: ANAO.

Identifying potential RHS projects

3.34 Health's State Offices are responsible for identifying potential RHS projects. To do so, the State Offices have developed systematic approaches, based primarily on disadvantage in terms of unmet health service need. The main approaches, adopted by States, to identifying projects are:

- calling for submissions from potential auspice organisations;
- targeting specific communities; or
- a combination of the two approaches above.

3.35 For example, the New South Wales State Office developed an Area Prioritisation Model. The Model calculates a regional disadvantage score based on a number of variables, including health status, socio-economic characteristics and existing health services. The State Office then advertised for submissions, using the Model to assess the submissions received. Ninety applications were received as a result of the advertisement. Of these, the Minister for Health endorsed 15 projects. Thirty-two proposals received were not considered to be appropriate to be funded under the RHSP as they did not meet the program's criteria for funding. The remaining proposals were the subject of discussions between the State Office and potential service providers and/or auspices. These discussions resulted in applications being modified and, in some cases, a number of small projects being combined into one application. Six areas, identified by the Model as areas of high need, were not the subject of a submission. These areas were specifically targeted by the State Office via consultations with key stakeholders in each of the regions and assistance given to completing applications for RHSP funding.

3.36 Taking a similar approach, the Tasmanian State Office engaged a consultant to identify needs based on local government areas and advertised for submissions, approaching health providers in identified need areas that did not respond to the advertisement. The Queensland State Office developed a planning framework to identify areas most disadvantaged in terms of available health services and held three information forums to promote the program in targeted areas.

Assessing potential RHS projects

3.37 There are six selection criteria, referred to as criteria for funding, for the RHSP. These are listed in Figure 3.8.

Figure 3.8

Criteria for RHS funding

Access to quality, multi-disciplinary, comprehensive primary health care services.
Mechanism for effective community participation in determining local health needs and priorities as well as the ongoing review, planning and management of health services.
Integrated and coordinated approaches to planning and delivery of health services to maximise health gain.
Includes a quality improvement framework that addresses organisation and cultural change.
The population of towns receiving the services must be under 5 000.
The majority of proposed funding must be used to deliver new or enhanced primary health care services.

Source: RHS Circular Edition Number 4.

3.38 The objective of the RHSP[51] is to help small rural communities expand their local primary health care services by providing flexible, innovative and integrated local solutions to promoting health and improving access to health services. The criteria for RHS funding are consistent with this objective.

3.39 State Offices assess applications against these criteria. An advisory committee in each State also reviews the RHS applications against the criteria and provides advice to the State Office. The committees are comprised of representatives from the State Office, State Government and stakeholders. Once sites are identified and applications accepted by the State Offices, Central Office reviews the applications for national consistency.

3.40 The ANAO found that the criteria are clear and understood by Health personnel. Further, the criteria are addressed in service plans and, generally, operational RHSs meet the criteria. The ANAO found that, within States, Health had implemented effective systematic approaches for identifying and assessing RHS projects.

Funding approved RHS projects

3.41 Once it is determined that a RHS project meets the criteria for funding, a recommendation is made to the Minister for Health to endorse the project and approve funding.

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[51] The objectives of the RHSP are listed in Chapter 2.

3.42 Health developed a funding formula for the distribution of RHSP funds to the States in 1999. The funding formula provided for a weighted per capita distribution based on the RRMA classification.[52]

Table 3.1

RHS funding based on the RRMA classification, developed in 1999

	2000–01		2001–02	
	Proposed Allocation ($'000)	As % of total (%)	Proposed Allocation ($'000)	As % of total (%)
NSW	5 030	22.4	5 260	22.5
VIC	4 060	18.0	4 240	18.1
QLD	4 930	21.9	5 150	22.0
SA	2 290	10.2	2 370	10.1
WA	3 100	13.8	3 220	13.8
TAS	1 440	6.4	1 480	6.3
NT	1 650	7.3	1 690	7.2
Total	22 500	100.0	23 410	100.0

Note: Health developed funding distributions for two years only, 2000–01 and 2001–02.
Source: ANAO analysis of Health data.

3.43 Based primarily on the RRMA classification, the formula does not take account of health needs in rural and remote areas. It does, however, provide an indication of the relative target populations in each State, consistent with the program's objective of expanding primary health care services in rural communities.

3.44 However, the amount of RHS funds allocated to States differed from the above projections. Table 3.2 shows the amounts allocated to States from 2000–01 to 2003–04.

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[52] RRMA, the Rural, Remote and Metropolitan Areas classification, is a method of classifying geographical areas on the basis of location and size. Rural and remote areas are classified RRMA 3 (large rural centres) to RRMA 7 (other remote areas).

Table 3.2

RHS funding allocation

	2000–01		2001–02		2002–03		2003–04	
	Alloc. ($'000)	As % of total (%)	Alloc. ($'000)	As % of total (%)	Alloc. ($'000)	As % of total (%)	Alloc. ($'000)	As % of total (%)
NSW	1 400	12.3	3 750	13.6	6 250	17.5	7 750	18.3
VIC	2 500	21.9	7 250	26.4	7 750	21.7	8 250	19.4
QLD	2 500	21.9	5 000	18.2	6 500	18.2	8 000	18.9
SA	1 600	14.0	3 000	10.9	4 000	11.2	5 000	11.8
WA	1 400	12.3	2 500	9.1	4 000	11.2	5 000	11.8
TAS	1 000	8.8	2 000	7.3	2 500	7.0	3 000	7.1
NT	1 000	8.8	2 500	9.1	2 500	7.0	3 000	7.1
National[53]	n.a.	n.a.	1 516	5.5	2 226	6.2	2 439	5.8
Total	11 400	100.0	27 516	100.0	35 726	100.0	42 439	100.0

Note: Percentage figures for 2001–02 and 2003–04 do not total 100 due to rounding.
Source: ANAO analysis of Health data.

3.45 The most significant difference occurs in the first year of the program. In 2000–01 the amount of funding allocated in total and to individual States differed significantly to the amount originally proposed, with only 51 per cent of the total available funds allocated in 2000–01. This is because the RHSP was implemented at a slower rate than planned. There are number of reasons for this, including:

- difficulty recruiting health professionals to rural and remote areas;
- length of time required to engage communities in developing plans for new health services; and
- infrastructure issues, such as the availability of buildings in which to provide services.

3.46 However, the relative proportions allocated to the States are broadly consistent with the original proportions shown in Table 3.1. That is, in most

[53] National projects are RHS projects funded and managed by Health's Central Office, not by an individual State Office.

States, the amount of funding allocated relative to the total funding available under the program is consistent with the funding proposed by the funding formula developed in 1999 based on the RRMA classification.

3.47 The notable exception is New South Wales State Office which allocated only 12 per cent of the total program funding in 2000–01 and 14 per cent in 2001–02. This reflects the number of funding agreements signed in New South Wales during the early stages of the program. Of the 55 funding agreements signed in the first year of the program, six agreements (11 percent) were signed in New South Wales. These contracts represent only 19 per cent of the total contracts in place in New South Wales as at 31 August 2003. Therefore, the RHSP was implemented in New South Wales at a slower rate than in the other States. By 2002–03, funding allocated to projects in New South Wales was consistent with the proportion originally proposed by the distributions proposed in 1999.

3.48 In comparison, the program was implemented relatively quickly in Queensland and Victoria, which accounted for over half of the agreements signed within the first year. Sixteen agreements were signed for services in Queensland and 14 in Victoria. These agreements represent 80 per cent and 56 per cent respectively of the total number of funding agreements in each State as at 31 August 2003. As a result, the two States accounted for 44 per cent of the available funding in 2000–01 and 45 per cent in 2001–02. These amounts equate broadly with the allocations originally proposed, where 22 per cent of funds were allocated to Queensland and 18 per cent to Victoria, a total of 40 per cent.

3.49 Distribution of funds within each State is largely the decision of the State Office. As discussed earlier, the State Offices visited by the ANAO developed a systematic approach to assessing RHS projects that included a formula for assigning funding within the State, usually by region or local government area. The ANAO found that, in general, funds distribution reflects applications received, subject to negotiation between the auspice and State Office. That is, funding is approved as applications are received, and the amount of funding provided to individual services is largely based on the budget proposed in that RHS's application. The budget is assessed by the State Office to make sure that it is appropriate to the service model proposed and is often subject to negotiation between the State Office and the auspice.

3.50 In summary, the ANAO found that Health has developed criteria for selecting RHS projects and that Health applies the criteria. Further, the ANAO found that funding allocations are broadly consistent with the funding formula developed to distribute RHSP funding across States. However, this formula, based on the RRMA classification (largely a geographical classification

system), does not take into account relative health needs across and within states. State Offices have, however, implemented models to identify priority areas, within their States, that incorporate an element of health need and disadvantage.

Funding agreements

3.51 Three standard funding agreements are used for the RHSP:

- Standard Funding Agreement between the Commonwealth and a service provider (non-government organisation);
- Standard Funding Agreement between the Commonwealth and a State Government; and
- Short Form Standard Funding Agreement between the Commonwealth and a service provider/local government authority for a RHS planning project.

3.52 The agreements contain standard clauses covering, for example, records and recording, confidentiality, intellectual property, indemnity, insurance, and dispute resolution. The agreements also contain a detailed service delivery plan that outlines outcomes, objectives, strategies, and performance indicators, a budget, and reporting requirements.

3.53 Of the 152 RHS agreements in place at 31 August 2003, 34 (22 per cent) will expire by the end of 2003, with a further 70 contracts (46 per cent) expiring during 2004. Health has developed a Funding Renewal Framework to guide the RHS funding renewal decision. The Framework is supported by a Guide for State and Northern Territory Offices that outlines the steps in the renewal process.

3.54 The bases for renewing the funding for an individual RHS are:

- a review of the RHSs performance against its objectives;
- an assessment of the community's current and anticipated primary health care needs; and
- the RHSs ability to meet the community's current and anticipated needs.

3.55 The Funding Renewal Framework was finalised in September 2003. Agreements expiring prior to finalisation of the Framework were extended by up to one year. At 31 August 2003, 13 agreements had been extended.

Summary

Multipurpose Services Program

3.56 The ANAO concludes that Health has developed an approach to selecting and assessing MPSs that is effective. Also, the criteria Health uses to assess potential sites is consistent with the objectives of the program and guide Health personnel in selecting MPS sites for development. The principle of flexible, pooled funding that forms the basis of the MPSP funding model is also consistent with the objectives of the MPSP.

3.57 The ANAO found that one-third of MPSs are operating with extended funding agreements. The ANAO concludes that, as a result, these MPS may be implementing service plans that are not current or relevant to current community needs. With respect to the MPS agreements, Health needs to confirm that the agreements, including targets, comply with the relevant legislation, specifically the Act and the Principles.

Regional Health Services Program

3.58 The ANAO concludes that, as with the MPSP, Health has developed an approach to selecting and assessing RHS projects that is effective. Also, the selection criteria Health uses to assess potential RHS projects are consistent with the objectives of the program.

3.59 The funding formula for the distribution of RHSP funds, developed in 1999, is broadly consistent with the RHSP objectives. However, this formula, based on the RRMA geographical classification system, does not take into account relative health needs across and within states. The approaches adopted by the State Offices to identifying priority areas incorporate an element of health need and disadvantage.

3.60 Health's State Offices were responsible for implementing the RHSP, and did so at varying rates. By 2003, the proportion of funds distributed to individual states was broadly consistent with the proportions proposed by the 1999 RRMA-based funding formula.

Recommendation No.4

3.61 The ANAO recommends that Health make sure that: all MPSs have current funding agreements, incorporating agreed targets and up-to-date service plans; the conditions of the funding agreements are valid; and MPSs are implementing service plans that are relevant to the needs of the target communities.

Health's response

3.62 Agreed. The Australian Government has been working with all State Governments for some time to develop revised funding agreements for the MPS program. It is planned that revised agreements will be in place in all States within six months. These agreements will incorporate agreed targets and up-to-date service plans based on the needs of the target communities.

4. Financial Management

This Chapter discusses Health's financial management of the MPSP and RHSP. It considers the guidance available to Health staff and the mechanisms used to make sure accuracy of payments. Health's knowledge of State contributions to MPSs and the significant issue of underspent RHSP funds are also covered.

Multipurpose Services Program

4.1 The Commonwealth's component of MPS funding is a function of aged care accommodation and CACPs and related subsidies, and the viability and concessional resident supplements.[54] Consequently, financial management for the MPSP is driven by the level of Commonwealth funding and is straightforward. Based on the funding calculation, Central Office provides to the State Offices a schedule of the amounts to be paid, monthly in advance, to each MPS. Payments are then made, as per the schedule, by the State Offices.

4.2 To assist Health personnel, financial management guidance is provided in the MPSP Guidelines.[55] The MPSP Guidelines include direction on Health's obligations under the *Financial Management and Accountability Act 1997* and the *Aged Care Act 1997*, how MPS payments are calculated, application of fees, bonds and charges, and access to the Pharmaceutical Benefits Scheme. The MPSP Guidelines also refer staff to relevant Chief Executive Instructions and Health's Procedural Rules.

4.3 Central and State Offices use a number of mechanisms to make sure payments made to MPSs are accurate. These include a number of points at which accuracy checks are made, and a separation of duties whereby different staff members process the payment requests and sign-off on the accuracy of the payments. The ANAO found that these mechanisms are effective in ensuring that payments are accurate and made in accordance with Health guidance and relevant legislation.

4.4 Health's knowledge of State contributions to a MPS is based on information provided in the funding agreement. Until recently, most States have not been required, as a matter of course, to report to the Commonwealth the amount of State funding actually paid to individual MPSs. Financial reporting from MPSs to the Commonwealth is variable and basic. Financial statements ordinarily contain only baseline information, often relating only to

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[54] See Chapter 3 and Appendix 2 for more details.

[55] The *Multipurpose Services Program Guidelines for State and Territory Offices* is discussed in more detail in Chapter 5.

Commonwealth contributions. Information on State contributions is limited at best. As such, Health has not been able to ascertain if amounts paid by the State to a MPS equate to the amounts in agreements.

4.5 Until recently, Health did not keep data on State capital contributions to MPSs. In most cases, the States will have provided capital funding at some stage during the life of the MPS and/or, for those facilities that converted to MPS status, prior to becoming a MPS. With knowledge of the amount of State contributions, Health would have a comprehensive picture of the total amount of funding provided to individual MPSs and the MPSP as a whole. This knowledge would benefit Health in a number of ways. For example, it would assist Health to measure State compliance with the funding agreements, allow Health to measure overall expenditure on the MPSP relative to cost, and assure Health of the medium and long-term viability of individual MPSs and of development of the program nationally.

4.6 New reporting arrangements have recently been agreed between the Commonwealth and the States and will be adopted over the next six to twelve months. Under these arrangements, in future the States will provide recurrent and capital funding data to the Commonwealth.

Regional Health Services Program

4.7 The State Offices are primarily responsible for ongoing financial management of the RHSP. The RHSP Guide[56] provides limited financial management guidance to the State Offices. The RHSP Guide is supplemented by RHS Circulars covering specific areas, for example, re-allocating underspends, withholding payments, and the Goods and Services Tax.

4.8 As with the MPSP, a number of mechanisms are used by the central and State Offices to make sure payments made to RHSs are accurate. These include a number of points at which the accuracy of payments is checked, and a separation of duties whereby different staff members process the payment requests and sign-off on the accuracy of the payments. The ANAO found that these mechanisms are effective in ensuring that payments are made in accordance with Health's guidance and relevant legislation, and are appropriate and accurate.

RHSP underspends

4.9 As discussed in Chapter 3, each Health State Office receives a nominal funding allocation based on projected RHS spending requirements. However,

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[56] The *Regional Health Services Program State Office Guide* is discussed in more detail in Chapter 5.

the amount of RHS expenditure each financial year, illustrated in Table 4.1, differed from the allocated amount.[57]

Table 4.1

RHSP expenditure

	2000–01		2001–02		2002–03	
	Allocation ($'000)	Expenditure ($'000)	Allocation ($'000)	Expenditure ($'000)	Allocation ($'000)	Expenditure ($'000)
NSW	1 400	1 587	3 750	3 051	6 250	3 755
VIC	2 500	2 265	7 250	5 784	7 750	7 809
QLD	2 500	2 335	5 000	4 828	6 500	5 145
SA	1 600	1 135	3 000	2 904	4 000	2 903
WA	1 400	2 756	2 500	2 013	4 000	3 418
TAS	1 000	1 009	2 000	1 684	2 500	2 146
NT	1 000	529	2 500	1 299	2 500	1 729
National	n.a.	101	1 516	2 822	2 226	5 391
Total	11 400	11 718	27 516	24 386	35 726	32 298

Source: ANAO analysis of Health data.

4.10 Overspends and underspends occur when the amount of funding expended in the RHSP is greater or less than the allocated amount. Within the RHSP, a significant financial management issue is the level of underspent funds. Underspends reflect the amount of funding allocated but not paid to RHSs or funding reclaimed by Health. The RHSP funding agreements give Health the legal power to withhold payments, partially or in full, to individual RHSs. Withholding of agreed funding may occur for a number of reasons, including:

- the RHS not providing progress reports, as specified by the funding agreement, or providing an inadequate progress report; and
- evidence to suggest that the RHS's auspice does not require the full payment amount as it has not expended all monies from previous payments (that is, the RHS has an underspend).

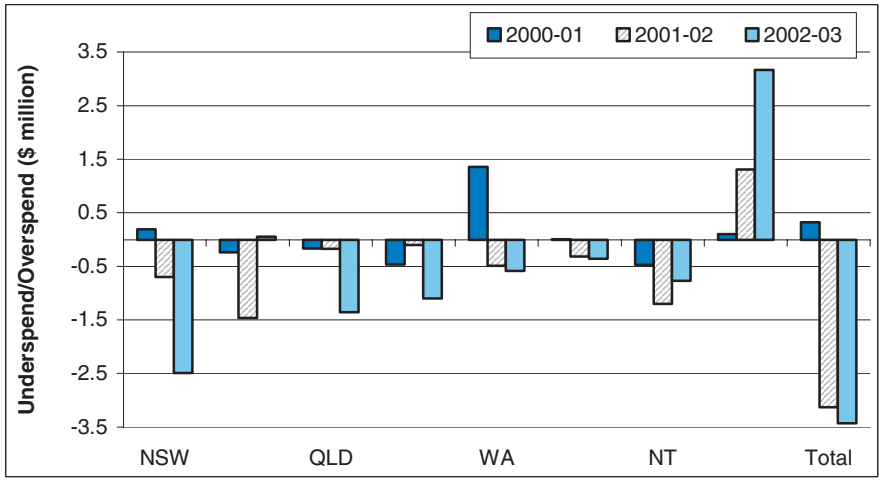
4.11 As Figure 4.1 demonstrates, in 2001–02 and 2002–03 over $3 million was underspent each year in the RHSP. The total underspend over this two year period was $6.6 million from a total of $63.2 million allocated (10.4 per

[57] See also Chapter 3, and specifically Table 3.2, for a discussion of RHS funding allocations.

cent of the allocation). The level of underspent funds is increasing—from 2001–02 to 2002–03 underspends increased by 9.6 per cent.

Figure 4.1

RHSP over/underspends



Note: The above represents total underspent funds for the financial year, after adjustments for variations to funding agreements and expenditure on one-off projects.
Source: ANAO analysis of Health data.

4.12 The real level of underspends in the RHSP is, in fact, higher than the level revealed by a comparison of year-end allocated and expenditure figures. The expenditure figure includes adjustments for variations to funding agreements and expenditure on one-off projects. Health provides guidance on re-allocating RHS underspends.[58] Funding underspends may be re-allocated to fund variations to agreements or new one-off projects. The guidance covers the type of projects underspent funds may be applied to, how to assess proposals for using underspent funds, and the approval process.

4.13 As at 31 August 2003, there were 39 one-off projects, representing one quarter of RHS agreements in existence at that time. All one-off projects meet Health's principles regarding the types of projects that qualify for RHS underspent monies.

4.14 The ANAO found that underspends are occurring for a variety of reasons related to initial program implementation and operational delays, and ongoing issues such as the difficulty of recruiting and retaining health

[58] RHS Circular No.8.

professionals in rural and remote areas, and the limited business management/governance capacity of some services.

4.15 To understand and manage the increasing issues of underspends, Health needs to investigate the pattern of underspends to identify the primary causes. Additionally, the ANAO recommends that Health develop indicators to determine when underspends are at significant levels within individual RHSs and across the program as a whole, and take appropriate action. In doing so, Health needs to balance its financial accountability with the needs of existing services. Identifying the reasons why underspends are occurring will also assist Health in planning for future services.

Summary

4.16 Financial management of the MPSP is straightforward, with payments made to MPSs as per a payment schedule calculated using the MPS funding formula. The ANAO concludes that accuracy controls, including separation of duties and accuracy checks, are effective. Therefore, Health's financial management practices generally support its management of the MPSP. However, Health's knowledge of individual MPS funding is limited. Health has not, as a matter of course, received information on State funding to MPSs. It is anticipated recent changes to reporting requirements will provide the Commonwealth with full knowledge of State recurrent and capital MPSP funding.

4.17 As with the MPSP, Health has implemented a number of effective mechanisms to control accuracy of payments made under the RHSP program. However, the phenomenon of RHSs not using Commonwealth funds available to them is a significant issue in the RHSP. To understand and overcome this increasing problem, Health should identify and systematically analyse the reasons why RHSs are not using all of their funding. Additionally, Health should implement indicators to determine when underspends are at significant levels within individual RHSs, and across the program as a whole, and take appropriate action.

Recommendation No.5

4.18 The ANAO recommends that Health investigate the causes of RHS underspends, and develop indicators that will highlight significant levels of underspends so that they may be managed in an appropriate and timely fashion.

Health's response

4.19 Agreed. Health is continually monitoring the expenditure under the program. Underspends in the early years of implementation of the program were largely the result of delays in recruitment of health professional staff to rural and remote areas. The program has continued to support appropriate short-term projects to complement the longer term service provision.

5. Relationship Management

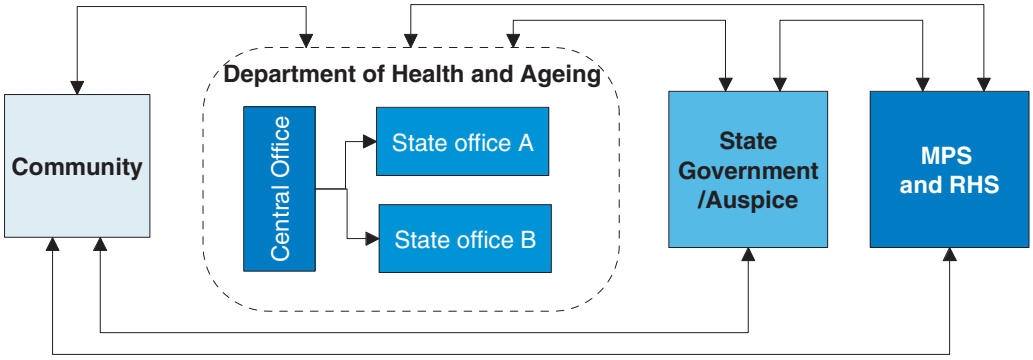
This Chapter discusses Health's relationship with internal and external stakeholders. It considers the roles and responsibilities of relevant parties and the mechanisms used by them to consult and communicate. The Chapter also reviews how Health identifies and promotes better practice.

Key relationships

5.1 Health interacts regularly with a number of internal and key external stakeholders. Figure 5.1 summarises the relationship between Health's Central Office and State Office, Health and State Governments, and between Health and services. The Chapter is structured into three parts to address these relationships.

Figure 5.1

Relationships between Health, State Government and services



Source: ANAO analysis.

Health's Central Office ⇔ Health's State Offices

5.2 Broadly, Health's Central Office develops national rural health policy and strategies and administers a small number of grant programs. State Offices are responsible for implementing programs, overseeing planning processes, facilitating regional planning and advising on policy and program issues from a local perspective. State Offices are also responsible for monitoring the performance of services funded by Health, collecting performance data and communicating this to Central Office, program management and financial administration.

5.3 Descriptions of the processes to be adopted for the MPSP and RHSP, including roles and responsibilities, are outlined in the program guidelines.

5.4 From the MPSP commencement in 1995 until 2002, guidance to State Offices was limited, with individual States relying on their interpretation of Central Office instructions. This resulted in varying practices between States, such as inconsistent funding agreements and reporting requirements.

5.5 In September 2002, Central Office, in consultation with State Offices, developed and released the MPSP Guidelines. The MPSP Guidelines contain information on the various aspects of program management, proforma letters and contracts for the different stages of the MPS process. The ANAO found that the MPSP Guidelines were comprehensive and encouraged national consistency. This was confirmed by staff at State Offices who informed the ANAO that they found the MPSP Guidelines clear, easy to understand and a useful resource. Further, the ANAO found that there were controls in place to promote compliance with the MPSP Guidelines, such as requiring supervisors' written approval at specified milestones.

5.6 Health released the RHSP Guide in January 2001. The ANAO found that the RHSP Guide had not been reviewed since its release and contained incorrect and out-of-date information. Program staff reported to the ANAO that they did not use the RHSP Guide as it did not provide sufficient guidance and lacked specific direction on managing individual RHS. Health is revising the RHSP Guide and anticipates that the new guide will be completed by early 2004.

5.7 As supplementary guidance, from July 2002 Central Office produced RHS Circulars to clarify issues and inform State Offices of program updates. State Office staff informed the ANAO that the Circulars were useful, easy to understand, and provided useful information in a timely manner. The ANAO found that staff complied with the defined procedures, delegations and internal checkpoints outlined in the Circulars.

5.8 In addition to the national program guidance, some State Offices have produced their own customised documents summarising the roles and responsibilities of the Central Office and that State Office.

5.9 However, despite the existence of the national and State developed documents, the ANAO found that a limited amount of work was duplicated between the State and Central Offices. For example, evaluation of RHS sites involved State Offices making a recommendation based on their own assessment and then Central Office re-assessing the site before approval.

5.10 Program managers from across the States formally meet at Central Office at least twice a year to discuss program specific issues and general

program policy. States also meet individually with the Central Office staff on an ad hoc basis. Staff in the Central and State Offices also remain in regular telephone and email contact.

Health ⇔ State Governments

5.11 Commonwealth and State Governments have adopted a number of strategies to manage their relationships for the MPSP and RHSP. These include protocols, bilateral agreements and Joint Officers Groups (JOGs). The MPSP Guidelines and the RHSP Guide also provide general guidance on the relationship between Health and State Government agencies. In addition, the Rural Health Policy Sub-committee of the Australian Health Ministers' Advisory Council (AHMAC) provides a forum to discuss and resolve program policy issues.

Protocols

5.12 The Australian Government and the State Governments have agreed on a set of National Principles for Commonwealth/State Collaboration on Rural Health Matters. These National Principles reflect a nationally agreed understanding of working relationships between governments on matters relating to rural health.

5.13 In addition to these National Principles, in 2001, the AHMAC National Rural Health Policy Sub-Committee established high-level national protocols specifically for the MPSP and RHSP. Some State Offices, in collaboration with State Governments, have also developed more detailed protocols. For example, early in the program, Health's New South Wales State Office and NSW Health developed a joint protocol to clearly identify each agency's roles and responsibilities in the planning, developing and funding of MPSs.

RHSP bilateral agreements

5.14 Another mechanism used to define the roles and responsibilities for the implementation of the RHSP is through bilateral agreements between Health and State Government agencies. The aim of these agreements is primarily to define and state the respective roles, responsibilities and arrangements for delivery of regional health services in rural and remote regions. In addition, each agreement commits both parties to make sure ongoing maintenance of effort in service delivery.

5.15 At the time of fieldwork, the ANAO found that not all States had agreements in place. Signed bilateral agreements existed with the Queensland, South Australia, Tasmania and Northern Territory Governments. The

remaining States have not signed bilateral agreements. In some of these States, alternative arrangements have been made to manage the relationships between Health and the State Government. For example, a Document of Commitment, signed by all key stakeholders is attached to each RHS funding agreement in New South Wales. The purpose of the Document of Commitment is to inform key community stakeholders of the new services being funded under the program.

Joint Officers Group

5.16 A JOG, or steering committee, operates in each State as a forum for communication. Each JOG has Commonwealth and State Government representation and meets monthly or bi-monthly to discuss issues related to the program. For example, the main functions of the Queensland JOG, which are similar to those of JOGs in other States, are to:

- endorse and prioritise appropriate sites for MPS development and provide advice to respective ministers;
- oversee the implementation/effectiveness of the program and contribute to policy development at a national level;
- ensure the application of appropriate evaluation and review methodologies;
- ratify key policies and procedures; and
- monitor funding agreement reporting, manage financial issues and conduct site visits.

5.17 The ANAO considers that the JOGs are an effective forum for communication, providing an opportunity for the States and Commonwealth to discuss and resolve issues.

General relationship issues

5.18 In the past, infrequent consultation and limited cooperation between Health and State Governments resulted in strained relations. The ANAO also found that Health and many of the State Government departments have experienced high staff turnover. This affects relationships, with staff turnover limiting the formation of long-term working relationships. However, current relations are reported to be improving, with representatives from Health's State Offices and State Governments describing relationships as maturing. For example, some State Offices and State Governments are now conducting jointly funded forums, site visits and co-signing correspondence to services.

Health ⇔ Services

Services → Health

5.19 The MPSP Guidelines and each MPS funding agreement specifies reporting requirements. Services are required to report three times a year, providing half year progress reports, an annual service activity report, and an annual audited financial statement (for State Government entities, the Commonwealth accepts financial statements audited by State Auditors-General).

5.20 The ANAO found that MPS reporting practices vary between the States. For example, one Health State Office has not received reports for 18 months. In another State, until recently, MPSs have not been required to provide progress reports. This is the result of interim arrangements between the State and Commonwealth to simplify the reporting regime. Two other States that are receiving MPS activity reports, commented to the ANAO that the reports did not provide adequate information.

5.21 During the AHMAC meeting in March 2003, the Commonwealth and States agreed on a new activity reporting system for MPSs. The ANAO anticipates that the new requirements, to be adopted over the next six to twelve months, will lead to greater compliance and utility. The new service agreements will consist of a core national reporting component and a section for additional State information as required.

5.22 RHS reporting requirements are specified in individual RHS funding agreements. They include the provision of six-month and twelve-month progress reports, including a financial report, and a final report on project completion. The ANAO found that RHSs provide reports to Health as per the requirements of the funding agreements. Central Office stated that it is largely satisfied with the quality of progress reports received from RHSs and considers them useful and of a high standard. The ANAO examined a selection of progress reports and confirmed Health's opinion, finding the reports to be of satisfactory quality and to comply with the requirements of the funding agreements.

Health → Services

5.23 With the information it receives, Health should be able to identify examples of better practice across services in the two programs. By sharing this information, it provides an opportunity for services to learn about what others are doing, how they are approaching similar issues and potential solutions to common problems. However, the ability of services to learn about better

practice, form networks and share experiences is limited by the isolation of many rural communities. The ANAO examined whether Health had identified and promoted examples of better practice in the two programs and found some, limited evidence that it has done so.

5.24 Health has conducted workshops and forums for services, on a State basis, covering such topics as site planning, program evaluation, managing transitions, and the renewal of funding. These forums have been generally well received by services. Health has produced a *Multipurpose Services Model* publication, which is intended to provide guidance to communities interested in developing a MPS. The model includes a number of case studies to illustrate innovative practices in MPSs. Two issues of a newsletter, *MPS Program Quality News*, have been produced, in December 2002 and April 2003. The newsletter informs services of program initiatives and updates, and assists in networking and information exchange between MPSs. The ANAO encourages Health to continue producing the newsletter as a means of communicating with all services. To inform the public about the programs, Health has also created and distributed a variety of materials, including a RHSP brochure and booklet, and a MPSP brochure and video.

5.25 For the MPSP, Health and the State Governments developed the National Quality Improvement Framework for MPSs in October 2002. The framework establishes broad, agreed principles and strategies for sustaining and improving quality of care in MPSs. It aims to assist MPSs by:

- providing a broad national structure for promoting continuous quality improvement;
- facilitating more appropriate standards and accreditation approaches for MPSs; and
- encouraging quality processes that meet the needs of individual MPS providers.

5.26 This framework includes the Leading Practice Support Program, which is designed to assist services in implementing quality improvement approaches. The program provides funds, support and a coordinated structure to identify and disseminate good practice and to facilitate the transfer of ideas and knowledge between services. The objectives are to:

- develop and identify sustainable leading practice quality improvement approaches within MPSs, particularly models that solve local problems and can potentially be applied more broadly;
- enhance the capacity of MPSs to undertake project management, research and evaluation work;

- facilitate the sharing of experience and knowledge in quality improvement between MPS sites and the establishment of collaborative networks between MPSs and other agencies both within and outside their communities; and
- showcase and disseminate information on innovative activities and models of care and service delivery in rural settings, and information on community participation.

5.27 At the State level, each State Office has adopted its own approach to communicating with MPSs and RHSs. For example, the South Australian State Office has bi-monthly, face-to-face, half-day meetings with all MPSs and RHSs. The State Office in Tasmania holds one-day forums with RHS managers and staff every six months, and has one-day manager meetings for MPSs every quarter. Western Australia's State Office is planning its first RHS forum and holds networking days for MPSs twice a year.

5.28 State Offices also conduct site visits to meet with service staff, supplementing email and phone contact. These visits serve two main purposes: firstly, they provide an opportunity for services to ask questions and learn about new developments from Health; secondly, they assist Health staff to develop an understanding of the environment and issues that the services face, thereby building trust between the two parties. However, the ANAO found that visits are infrequent, largely due to resource constraints.

5.29 A number of services expressed concerns to the ANAO about the level of guidance provided by Health. These concerns include a perception of insufficient guidance from Health and difficulties in contacting Health to seek guidance, raise issues and ask questions. In addition, Health's identification and dissemination of good practice in the planning and management of services is limited.

Summary

5.30 The roles and responsibilities of Health's central and State Offices are outlined in the guidelines for each program. The ANAO concludes that, on the whole, these arrangements work well, but with some duplication of roles in some sections of the process.

5.31 The MPSP Guidelines, developed and released in 2002, are clear and useful and Health's managers and staff comply with them. The RHSP Guide was developed within the first year of the program. However, it does not assist Health staff with RHSP management as it is out-of-date and contains inaccuracies. As a result, the RHSP Guide is not used. Therefore, the ANAO concludes that RHSP guidance is currently inadequate.

5.32 To manage its relationship with the State Government, Health has developed a number of strategies, including protocols and joint consultative groups. The ANAO concludes that, after some initial tensions, Health has developed and maintained constructive working relationships with the State Governments.

5.33 Until recently, progress reporting from MPSs was not consistent, with some services not reporting activity to Health for a significant period. The ANAO anticipates the new reporting requirements will improve compliance with the terms of the funding agreements. Reporting by RHSs is effective, with services providing reports of an acceptable quality.

5.34 To support services, Health holds forums and workshops, has produced a newsletter for the MPSP, and conducts site visits. While the forums have been generally well received, production of the newsletter has been ad hoc and site visits limited. The ANAO concludes that Health's management of its relationships with services could be improved by more effective communication, and the identification and promotion of better practice to MPSs and RHSs.

Recommendation No.6

5.35 The ANAO recommends that Health improve its communication with services (within the context of protocols between Health and State Governments), and identify and promote examples of better practice in establishing and operating an MPS or RHS.

Health's response

5.36 Agreed. Initiatives are in place in both programs to identify and promote examples of leading practice.

Recommendation No.7

5.37 The ANAO recommends that Health complete and re-issue the revised RHSP Guide as a matter of priority.

Health's response

5.38 Agreed. Revised RHSP Guidelines will be issued shortly.

Canberra ACT
13 April 2004

P. J. Barrett
Auditor-General

Appendices

Appendix 1: Key Rural Health Programs

Outcome 1: Population Health and Safety

Managing Rural Chronic Disease and Illness

Outcome 2: Access to Medicare

Better Treatment of Cancer Patients in Regional Areas
Enhanced Rural and Remote Pharmacy Package
Rural Loadings in the Practice Incentives Program for General Practices

Outcome 3: Enhanced Quality of Life for Older Australians

Adjustment Grants for Small Rural Aged Care Facilities
Restructuring Rural and Urban Fringe Aged Care Homes Program
Capital Funding Boost for Rural and Regional Australia
More Aged Care Nurses (scholarships in rural and regional universities)

Outcome 4: Quality Health Care

Higher Education Contribution Scheme Reimbursement
More Allied Health Services in Rural Areas
New General Practitioner Registrars
Nursing in General Practice
Rural and Remote General Practice Program
Rural Australia Medical Undergraduate Scholarship Scheme
John Flynn Scholarship Schemes
Rural Retention Program
Rural Women's GP Service
Workforce Support for Rural General Practitioners

Outcome 5: Rural Health

Commonwealth Remote and Rural Nursing Scholarships Program
Medical Specialist Outreach Assistance Program
Multipurpose Centres
Multipurpose Services Program
National Rural and Remote Health Support Services Program
Regional Health Services Program
Royal Flying Doctor Service
Rural and Remote Pharmacy Workforce Development Program
Rural Specialist Workforce Support Programs
University Departments of Rural Health

Outcome 8: Choice Through Private Health

Bush Nursing, Small Community and Regional Private Hospitals

Outcome 9: Health Investment

Medical Rural Bonded Scholarships
Medical School Places for Overseas Trained Doctors
Rural Clinical Schools

Source: *Portfolio Budget Statements 2003–04*, Health and Ageing Portfolio, Budget Related Paper No.11, pp.171–172.

Appendix 2: MPS Aged Care Funding

Commonwealth funding of the aged care portion of an MPS is provided through the flexible care subsidy provisions of the *Aged Care Act 1997* (the Act). The Commonwealth's contribution for aged care is based on the following calculation.

Daily Commonwealth MPS funding = h(H + R + V) + l(L + R + V) + c.C

Where:

h = number of high care places	H = high care basic subsidy
l = number of low care places	L = low care basic subsidy
R = concessional resident supplement	V = viability supplement
c = number of CACPs	C = CACP rate

Resident Classification Scale (RCS): RCS is a scale of the care requirements of each resident of aged care homes against which different levels of Commonwealth subsidy are paid. In MPSs, residents are not classified, with the subsidy cashed out according to the number of places allocated at either RCS 3 (high care) or RCS 7 (low care).

High care place: residential care for people with high levels of need, often with complex, chronic health conditions. This level of care is classified as RCS 1 to RCS 4.

Low care place: residential care for people with lower levels of need, who may need assistance with daily living. This level of care is classified as RCS 5 to RCS 8.

Community Aged Care Package (CACP): care consisting of a package of personal care services and other personal assistance provided to help older people with complex care needs in order to remain living in their own homes.

Basic subsidy: is a component of the Residential Care Subsidy, paid by the Commonwealth to approved providers for providing residential care to care recipients.[59] It is derived from the State-specific RCS rates depending on the type of care place. The basic subsidy for the MPS is calculated with:

- High care places receiving 98 per cent of the State specific RCS 3 rate;
- Low care places receiving 94 per cent of the national RCS 7 rate; and
- CACPs receiving 94 per cent of the national community care rate for designated CACP places.

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[59] Unlike the Residential Care Subsidy, the flexible payment is not linked to the actual level of care provided.

Concessional Resident Supplement: is a component of the Residential Care Subsidy. It is an additional supplement paid by the Commonwealth to services based on the average ratio of concessional residents for that region. A concessional resident is a person who is not required to pay an accommodation bond or charge (according to criteria defined in the Act).

Viability Supplement: is an amount determined by the total points allocated to three criteria (higher points resulting in a higher supplement). The criteria are:

- the *remoteness* of a MPS location (based on the ARIA scale);
- the *size* of a MPS (number of places); and
- whether 50 per cent or more of a home's residents are people who have *Special Needs* (excluding people who are financially disadvantaged and people living in rural and remote areas).

Source: *Multipurpose Services Program Guidelines for State and Territory Offices* and the *Aged Care Act 1997* (Section 44).

Index

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Audit Report No.39
Integrity of the Electoral Roll—Follow-up Audit
Australian Electoral Commission

Audit Report No.38
Corporate Governance in the Australian Broadcasting Corporation—Follow-up Audit

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(Financial Year 2002–2003 Compliance)

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Governance of the National Health and Medical Research Council
National Health and Medical Research Council
Department of Health and Ageing

Audit Report No.28 Audit Activity Report
Audit Activity Report: July to December 2003
Summary of Outcomes

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Management of Internet Portals at the Department of Family and Community Services

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Health Insurance Commission

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The Australian Taxation Office's Management of Aggressive Tax Planning
Australian Taxation Office

Audit Report No.22 Financial Statement Audit
Audits of the Financial Statements of Australian Government Entities for the Period Ended 30 June 2003
Summary of Results

Audit Report No.21 Performance Audit
Special Employee Entitlements Scheme for Ansett Group Employees (SEESA)
Department of Employment and Workplace Relations
Department of Transport and Regional Services

Audit Report No.20 Performance Audit
Aid to East Timor
Australian Agency for International Development

Audit Report No.19 Business Support Process Audit
Property Management

Audit Report No.18 Performance Audit
The Australian Taxation Office's Use of AUSTRAC Data Follow-up Audit
Australian Taxation Office

Audit Report No.17 Performance Audit
AQIS Cost-recovery Systems Follow-up Audit
Australian Quarantine and Inspection Service

Audit Report No.16 Performance Audit
Administration of Consular Services Follow-up Audit
Department of Foreign Affairs and Trade

Audit Report No.15 Performance Audit
Administration of Staff Employed Under the Members of Parliament (Staff) Act 1984
Department of Finance and Administration

Audit Report No.14 Performance Audit
Survey of Fraud Control Arrangements in APS Agencies

Audit Report No.13 Performance Audit
ATSIS Law and Justice Program
Aboriginal and Torres Strait Islander Services

Audit Report No.12 Performance Audit
The Administration of Telecommunications Grants
Department of Communications, Information Technology and the Arts
Department of Transport and Regional Services

Audit Report No.11 Performance Audit
Annual Performance Reporting

Audit Report No.10 Performance Audit
Australian Defence Force Recruiting Contract
Department of Defence

Audit Report No.9 Performance Audit
Business Continuity Management and Emergency Management in Centrelink
Centrelink

Audit Report No.8 Performance Audit
Commonwealth Management of the Great Barrier Reef Follow-up Audit
The Great Barrier Reef Marine Park Authority

Audit Report No.7 Business Support Process Audit
Recordkeeping in Large Commonwealth Organisations

Audit Report No.6 Performance Audit
APRA's Prudential Supervision of Superannuation Entities
Australian Prudential Regulation Authority

Audit Report No.5 Business Support Process Audit
The Senate Order for Departmental and Agency Contracts (Autumn 2003)

Audit Report No.4 Performance Audit
Management of the Extension Option Review—Plasma Fractionation Agreement
Department of Health and Ageing

Audit Report No.3 Business Support Process Audit
Management of Risk and Insurance

Audit Report No.2 Audit Activity
Audit Activity Report: January to June 2003
Summary of Outcomes

Audit Report No.1 Performance Audit
Administration of Three Key Components of the Agriculture—Advancing Australia (AAA) Package
Department of Agriculture, Fisheries and Forestry—Australia
Centrelink
Australian Taxation Office

Better Practice Guides

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Public Sector Governance	July 2003
Goods and Services Tax (GST) Administration	May 2003
AMODEL Illustrative Financial Statements 2003	May 2003
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Building Capability—A framework for managing learning and development in the APS	Apr 2003
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Audit Committees	Jul 1997
Management of Corporate Sponsorship	Apr 1997
Telephone Call Centres Handbook	Dec 1996
Paying Accounts	Nov 1996
Asset Management Handbook	Jun 1996