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JOINT COMMITTEE OF PUBLIC ACCOUNTS AND AUDIT

Reference: Review of Auditor-General's reports Nos 35 to 52 (2005-06)

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**JOINT STATUTORY COMMITTEE OF
PUBLIC ACCOUNTS AND AUDIT**

Wednesday, 11 October 2006

Members: Mr Anthony Smith (*Chair*), Ms Grierson (*Deputy Chair*), Senators Mark Bishop, Hogg, Humphries, Murray, Nash and Watson and Mrs Bronwyn Bishop, Mr Broadbent, Dr Emerson, Dr Jensen, Miss Jackie Kelly, Ms King, Mr Laming and Mr Tanner

Members in attendance: Senator Nash and Ms King and Mr Anthony Smith

Terms of reference for the inquiry:

To inquire into and report on:

Review of Auditor-General's reports Nos 35 to 52 (2005-06)

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Committee met at 12.17 pm

BIRD, Ms Sheila, Group Executive Director, Performance Audit Services Group, Australian National Audit Office

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LUCAS, Ms Roz, Director, Contract Management Advisory Unit, Primary and Ambulatory Care Division, Department of Health and Ageing

Audit Report No. 41 2005-06: Administration of primary care funding agreements—Department of Health and Ageing

CHAIR (Mr Anthony Smith)—Welcome. I declare open the public hearing of the Joint Committee of Public Accounts and Audit, which is examining the Auditor-General's Audit report No. 41 of 2005-06 entitled *Administration of primary care funding agreements—Department of Health and Ageing*. As always, I remind participants that only members of the committee can put questions to witnesses. Given the short time available today, statements and comments by witnesses should be relevant and succinct. We have reviewed the report and we are aware of the substance of it, the recommendations and your attitude to the recommendations.

As legal proceedings of the parliament, today's hearing warrants the same respect as proceedings of the House itself. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of the parliament. The evidence given today is being recorded by Hansard and will attract parliamentary privilege. As I have said, we have reviewed the report, we have had a briefing on it, and we are aware of the recommendations. I now invite you to make an opening statement on your attitude to the report and some progress and then we will have some questions.

Mr Davies—I will be very brief in my opening remarks. Firstly, I reiterate that the department always welcomes the outcomes of ANAO audits, takes the recommendations very seriously and seeks to respond appropriately. This audit highlights the challenges we face in getting the balance right between rigorous accountability, which is obviously always a prime consideration, and flexibility especially in an area like primary care, which, by its very nature, can be very hard to encapsulate, describe and conceptualise in really rigorous, concrete terms. We are not trying to say that that means we can lower our standards, but it does show that this is an area where rigorous contracting is always going to be a challenge, and it is hopefully a challenge we are increasingly able to rise to.

I think it is good that the report acknowledges that we were well advanced in establishing guidance and training to equip staff to do better and we have already, since the report was handed down, implemented a number of changes in our processes. We have increased resourcing in this area and we have bolstered the training that we provide to staff so there is an increased emphasis on ensuring that performance requirements are better articulated and monitored. We can go into detail, if the committee wishes, as to what those changes have been.

I guess in conclusion, our view of audit is always that it is best regarded as a learning, developmental input and I think this is a very good example of where colleagues from ANAO found some weaknesses. They were weaknesses on which, to some degree, there was already work underway at the time the audit happened. But certainly the input from the ANAO and the report they provided us with have added both scale and impetus to the improvements that we have been putting in place since then. As I said, I am happy to talk about those if the committee wishes.

CHAIR—I will open it straight up to questioning. Senator Nash has some questions on the audit and some of the problems discovered in it. I know that Ms King has some questions on resourcing.

Senator NASH—I have some questions, firstly, on the findings on the funding agreements. In 54 per cent of the agreements reviewed the description of the activities was not clearly stated, and in 66 per cent of agreements reviewed the budget did not provide the detail necessary to effectively monitor expenditure. They seem to be quite high figures. I understand that you have agreed to address this but my question is: why was that the situation in the first place? If you admit that it needs rectifying, how did it get to that position in the first place?

Mr Eccles—I can cover that. I will answer the questions in order. The first thing you mentioned was the finding that the description of activities and associated performance information was not clearly stated in 54 per cent of agreements. There are a couple of reasons for that. I will tell you some of the steps we have taken to improve the situation and then—

Senator NASH—No, start the other way. Go the other way first. Why was it there? I am happy to hear what you are going to do about it but I want to know why it was there in the first place.

CHAIR—Start from the problem.

Mr Eccles—Okay, I will start from the problem. We accept that there is a problem. That was part of the findings that we accepted and agreed with. One of the reasons—I think Mr Davies alluded to it—is that some of the contracts we have in place support developmental or innovative activity, and often at the commencement of contracts, which might be providing services in hard-to-reach areas, it is quite difficult to project or predict exactly what the deliverables are expected to be. As you would appreciate, in healthcare delivery in some areas there is a bit of a workforce shortage, for example, and it is quite difficult to pin down in these contracts expectations that there will be particular personnel provided for particular hours per week. I think part of the problem does go to that.

Quite often some of the contracts—and I will use the Primary Care Collaboratives Program as an example—are quite innovative approaches for Australia and it is a little bit difficult to identify exactly what the deliverables are going to be until after the contract has been in place for some time. While I think it is fair to say—obviously it is the case—that the performance information was not clearly stated, there certainly was information in there. It just probably could have been clearer, and that is something that we are making sure will be fixed in the future. It strikes at some of the issues to do with the difficulty for us in proposing precise deliverables when we are funding organisations to almost test the way that services can be best delivered and shaping it in terms of local flexibility. That said, we have processes in place to fix the situation and make sure that the project managers certainly contemplate, to their best endeavours, all options in trying to get better specifications, timelines and relevant performance information as part of contracts. This comes down to difficulty in predictability about where things are going in some of these services.

Ms KING—I understand the complexity of the programs, but surely there is a capacity to build in performance indicators around the outcomes that you are wanting to achieve. I do understand the difficulty with that; deliverables are not a substitute for the policy outcomes you are wanting to achieve.

Mr Davies—Without getting too abstruse, I think you have put your finger on something that really goes to the heart of the problem we face here. Classically, we can either buy inputs, outputs or outcomes. In an ideal world, we would buy outcomes. We would say, ‘Make these people healthier by this much.’ As you all know, we do not have a metric for measuring health, and we certainly do not have a way of imputing changes in health to the activities of primary care providers. At the other extreme, if we specify input too rigorously, if we monitor purely on the basis of input, then we squeeze creativity and innovation out of the system.

Ms KING—And you may not necessarily get the information you need to see whether the outcomes have been achieved or even the outputs.

Mr Davies—So we probably find ourselves somewhere around the outputs as to what we really would like to be contracting for. But I think even then, if you say outputs are delivering this many group sessions of physiotherapy or something, again, although to a lesser degree than with inputs, we could still be accused of suppressing creativity. We are always moving along that spectrum between inputs, outputs and outcomes. In a sense, the further we go towards outcomes, the less rigorous we can be but the greater the opportunity for innovation. A lot of these contracts are about, as Richard said, new and innovative ways of delivering care.

Senator NASH—Do you find—and I completely take your point about flexibility—that within some of these programs you might start off in a certain direction then, as they are being delivered, realise that there is a better way to do it?

Mr Eccles—Absolutely. That strikes very much at some of the things that are also in our report which we are going to improve, and that is that there is very regular contact between the project managers and the people who are delivering the services or receiving the funding. There is an ongoing dialogue about constantly making sure that you maintain the relevant services for the needs of an area. In some of these areas, the whole dynamic of the health needs can change with a health worker leaving or a new health worker coming in and these contracts need to have

inbuilt flexibility. Let us face it: there is a shortage of health workers and, if you cannot get a physio, you may need to settle for something else. There is flexibility and there is ongoing dialogue and one of the things that the report found and that we are looking at is the importance of better documentation of those changes midway through contracts.

Senator NASH—So if there is a change and you have to operate this way, there is better documentation of why it had to change—

Mr Davies—So that we know what happened and why it happened. Even that is information that we can learn from as the program goes forward.

Senator NASH—Is it the same scenario for my second question about the detail necessary, that you cannot put that prescribed amount of detail in there because that flexibility is needed? Or is it just—

Mr Eccles—It is a variation on the same problem, but it is difficult to tie it down. That said, there is no doubt that we can do better on that and that one of the ways that we are moving forward is by being clearer in our requirements of these organisations that receive funding to work with us to develop a very robust project plan with the level of financial detail upfront. We need something like that so that the flexibility that can take place later is more transparent and easily able to be documented. It is a similar sort of problem—that by imposing too many dollars for X potentially could be seen to be restrictive unless we encourage the flexibility that we talked about earlier.

Senator NASH—With the flexibility part of it, on the flip side, to what extent was a good enough eventuality not achieved because of individuals? You have talked about the structure of how things work but can you point to how much you think it has been due to individuals working within this system that we have not had a good enough outcome. This is a bit convoluted. You talked about the process and why it is a difficult process to define and determine because of the need for flexibility but where there has not been a good enough outcome in place—and I mean a general outcome—have you tried to determine whether it is the individuals working within the environment that have contributed to that?

Mr Eccles—It is a very difficult thing to attribute the reason for change in a particular area. Health is a little bit different in that so often the strength of programs and the impact that they make is vested in the capacity and the vitality of the individuals who are receiving funding.

Senator NASH—I guess that was my question.

Mr Eccles—In rural Australia I think we probably all know examples of small rural communities that have flourished when there has been a natural leader or some champion for a cause come in and, on the flip side, they have withered a little bit when that sort of person leaves. We do see that the strength of management and the strength of leadership in these organisations are very closely linked to the results that they achieve.

Senator NASH—So how do you measure that and what do you do, to put it bluntly, if somebody is not performing as well as they should?

Mr Eccles—It is extremely difficult to measure. It is about cause and effect. I will use the example of divisions of general practice. There are some outstanding divisions and there are others that are on the way up and may not be quite so outstanding.

Senator NASH—And others that spend a lot of money and do not deliver much. Sorry, that is a very general comment.

Mr Eccles—There are instances where it is the strength, the innovation and the vision of the leadership team that is a determinant and others where it is just the fact that they are in a better place and they have a bigger workforce. So to attribute it to the strength of the individuals is a very difficult thing to do. We do make sure that, with divisions of general practice, we fund the ADGP, for example, to do a lot of leadership and management training to make sure that there is a strong and vital leadership group coming through the network.

Senator NASH—How do you measure that? How do you measure what is a good outcome for the divisions of general practice—and I have the greatest respect for them; I think they are terrific—and the outcomes that they get? Sometimes I hear comments from regional doctors who say that the administration and guff that comes out of the division of general practice really they do not see as being necessary. Obviously funding goes to the divisions to do that. This is a bit of a devil's advocate question I guess, but how do you measure the funding that goes in there and what is an appropriate spend of the money in terms of health outcomes?

Mr Davies—I think you have almost summed up our lives in that simple statement. I am sure that some if not a lot of that red tape and guff that comes out of the division is actually required by the division to report back to us on their compliance with one of the contracts that is the subject of this audit. You have just characterised the sort of loose-tight tension that I was trying to capture. If you actually spoke to the people working in most divisional offices—the bureaucrats, if you like—they would say that they are over-monitored. I was beaten up just last week by a senior person from the world of divisions saying that the department is still micromanaging divisions. We would probably argue that we are managing them at an appropriate level or are certainly moving towards that.

Senator NASH—It is just a question of accountability, I guess.

Mr Davies—Yes, it is public money at the end of the day. Going back to my earlier comment about outputs and outcomes, we are developing what will end up being a really quite sophisticated performance management framework for divisions. That will hopefully mean that we can shift our focus more towards what they are achieving rather than what they are doing. That is a multi-year project to move towards that and business as usual has to go on in the meantime.

Senator NASH—Yes, because they are a relatively new beast. When did they come into practice?

Mr Davies—The first ones were in the early nineties.

Mr Eccles—I am trying to remember what job I had then. It would have been about 1992, I think.

Mr Davies—There was no national coverage until the late nineties.

Mr Eccles—Yes, I think ADGP started in 1996 or so.

Senator NASH—Yes, so it has been in the last 10 years.

Mr Davies—If I could just return to one other point you made, Senator, which I think, again, Mr Eccles was outlining how we monitor. The other thing is that there are 25,000 GPs out there, staying with the example of divisions. They monitor—some of them very effectively. There are also a great many people in this building who are a very good source of intelligence as to how divisions, and other primary care organisations that we fund, are performing. We have our network of state offices of the department, our colleagues in the state and territory health departments, so I would not underplay the value and significance of being a well-connected, outward-looking department that also has an ear to the ground. It is not rigorous monitoring in the form of performance measures, but it provides us with an awful lot of very useful intelligence.

Senator NASH—I just have one last question. In your opening remarks you were talking about increased resources that you are putting into meeting those performance requirements. What are those increased resources and has funding had to be taken from somewhere else to increase those resources?

Mr Eccles—It is increasing internal resources. In light of the ANAO report—and I think everyone would accept that it is a good thing to do—we have made training mandatory for all staff in the division. We have already given a presentation that everyone has attended and between 60 and 70 per cent of all staff who look after contracts have attended the courses that have been developed and tailored in light of the ANAO report. So we are making that available, and we expect 100 per cent attendance by the end of the month.

Senator NASH—Can I just ask why you had not thought of doing that before?

Mr Eccles—We had, but we had not made it mandatory. It was something that, in light of this report, we thought it was now time to do.

Senator NASH—An extra push along?

Mr Eccles—Yes. You mentioned resources in particular—I will give you an example. One of the resources that has come out since the ANAO report has been a program management guideline, so that everyone in the department—both in our state offices and in our central office—who have anything to do with managing general practice divisions have a guideline so that they can implement, set the criteria and set the performance indicators in a nationally consistent manner. That is something we worked with the divisions network to develop. In terms of resources, it is not so much in terms of money—

Senator NASH—But in terms of allocating.

Mr Eccles—Exactly right. We have also made sure that we have a small unit whereby no contract comes to me as a delegate, for example, without it going through Ms Lucas's area,

which is staffed by a couple of experts in procurement and contract management, just to make sure that they are working with the contract managers to make sure things are ridgy-didge.

Senator NASH—Okay. Thank you.

Ms KING—In light of the complexity of the environment that you operate within, do you think the Audit Office was a bit rough on you?

Mr Eccles—They are never rough on us, no!

Dr Nicoll—I thought it was well balanced.

Mr Eccles—I thought that there were some points that were well made. There is always scope for improvement, and the report highlighted for us that we have to try to get that balance right between allowing the people we fund to get on with the job and making sure that there is appropriate accountability for the taxpayer funding and that an obvious part. Maybe we had drifted a little bit. It is a matter of getting the balance right all the time. I think it is very important to recognise that the ANAO report did contain some positives. It certainly indicated that the platform was set and that there had been improvements. I do think some interpretation of it has been harsh—potentially harsher than might have been intended—but I think it was a fair and balanced review.

Mr Davies—I think it would be very foolish, dangerous and inappropriate for us to, if you like, play the health card and say, ‘We are health, it is complicated, go easy on us.’ I would much rather that we aspire to achieve the same levels of performance as audit colleagues expect of all public bodies. It is in the discussion of the shortfalls that the peculiarities of our environment may come into play, but I think we should not seek to be given an easier ride from audit colleagues.

Mr Eccles—And they did acknowledge that the department is well advanced in the guidelines and the training. Also, they did not find that there was anything improper and certainly, I think it is fair to say, that the way that we have administered our contracts has not adversely impacted on health outcomes or on getting the job done. It is more about administration documentation.

Ms KING—How many types of funding arrangements are you administering? I do not need the total number but just the types that you are doing.

Mr Davies—There are 6,000 contracts.

Mr Eccles—Which is not the question you asked, is it?

Ms KING—No.

Mr Eccles—Across the department or within primary care?

Ms KING—Within primary care. I just want to focus on this.

Mr Eccles—I would need to add up, but there would be in the order of 400 different agreements, but there are probably between 40 and 50 different initiatives, ranging from large ones to quite small ones.

Ms KING—Have they grown over the course of the last few years?

Mr Eccles—I think it has grown.

Mr Davies—It would have grown, yes.

Mr Eccles—I think, particularly through ‘Strengthening Medicare’. In some of the government initiatives over the last few budgets there have been new programs.

Mr Davies—Particularly in the rural health projects. Indigenous projects are managed through Richard’s division, but if you looked at how the mix had maybe changed over the last five or six years you would see a big push in those two areas, which has necessitated more contracts.

Ms KING—Particularly where the funding arrangement is with the one provider, whether it be a division of general practice, GPs, a hospital or a state, is there scope for consolidation into bigger, broader funding agreements?

Mr Eccles—There are a couple of answers to that. One is that COAG did discuss the importance of rationalisation and broadbanding, if you like, and that is something that we are actively looking at. We do look to do that. Having a single contract with multiple schedules is the ideal way, rather than having eight contracts with a particular division. We would have a single head contract with a number of schedules attached which outline the specific deliverables for that particular initiative. That is one way. We do it where we can. There are limitations, because not all programs neatly finish at the same time. But where it is possible it is something that we are looking at.

Ms KING—You outlined a couple of the initiatives that you are undertaking to implement the Audit Office’s recommendations. Do you want to list all of those so that we can get those on the record? Then I will ask Audit what their view of those are.

Mr Eccles—It is in a few areas. It is certainly in terms of the training that I alluded to earlier, and the training packages and the information sessions for staff have been tailored and adapted around some of the issues that were raised by the ANAO. There are the resources to make sure that they are up to date and make sure that they fully reflect the requirements. Another area is that there is increased vigilance by Ms Lucas’s unit in providing information, advice and training but also quality control to make sure that nothing comes to the delegate that has not been suitably assessed in terms of process.

Ms KING—Is that unit new since the audit?

Mr Eccles—No. That area has been around, but I think it is fair to say that its activities have been sharpened or made more targeted in light of the learnings from the report. They are probably the main areas. Is there anything else, Roz, that you can think of that we have done, other than the training?

Ms Lucas—No. I think the only additional area that the audit points out is the need for state and territory offices to have the additional support required. We are looking at rolling out the post-audit training and some support to our state and territory office colleagues.

CHAIR—On the questions that Ms King is asking, could you give us an idea of the implementation timeline? You said you welcomed the audit, you agree with the recommendations and you agree that there needs to be remedial action but if the Audit Office were to come back in a year would you be—

Mr Eccles—I would be confident if they came back in a year and looked at the contracts that had been entered into since probably even before the audit was finalised. I think it is fair to say that we started putting in place the changes that we are seeing before the audit was finalised.

CHAIR—While the audit was in progress?

Mr Eccles—We saw the draft and we started making changes.

CHAIR—That is good.

Mr Eccles—And we started doing a lot of the activities, and even these documents were well-developed by the time the final published version came through. I would be confident that if they came back now or in a year's time and had a look we would get a fairly glowing report.

CHAIR—Does the Audit Office want to comment on, first of all, Ms King's questions about the specific actions they are taking?

Mr Chapman—Without overstating it, as Philip suggested, it is a complex area of administration. We have looked to bring a balanced approach to the task. Certainly we have welcomed the cooperative working relationship and congratulate the department on its ability to manage the audit well to allow us to get on and achieve something positive out of it. At the end of the day, the issues that needed to be addressed are matters of good administration and good governance within the department and I think the department has responded quite appropriately. In terms of what might happen in the future, health generally features on our work program in some form and, while we are encouraged by what is occurring—

CHAIR—They can expect you back!

Mr Eccles—We do!

Mr Chapman—At some point in time.

Ms KING—This was the first time that primary care had been subject to an audit report for a long time, I think.

Dr Nicoll—That is correct.

Ms KING—A very long time.

Dr Nicoll—I must say, it was difficult to get into because, as Mr Davies has explained, there are a lot of different major projects and programs within it. We thought that if we focused on just this bit, it would not do justice to it. Finally we found a way, as is encapsulated in the report.

CHAIR—Thank you very much for that, and for coming along a bit earlier. That was most appreciated.

Resolved (on motion by **Senator Nash**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.48 pm