The Auditor-General
Audit Report No.5 2002–03
Performance Audit

# The Strategic Partnership Agreement between the Department of Health and Ageing and the Health Insurance Commission

## Department of Health and Ageing
## Health Insurance Commission

Australian National Audit Office

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Australian National
Audit Office

Canberra ACT
23 August 2002

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Ageing and HIC in accordance with the authority contained in the *Auditor-General Act 1997.* I present this report of this audit, and the accompanying brochure, to the Parliament. The report is titled *The Strategic Partnership Agreement between the Department of Health and Ageing and the Health Insurance Commission.*

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

Yours sincerely

P. J. Barrett
Auditor-General

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

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# Contents

# Abbreviations

| | |
|---|---|
| ACIR | Australian Childhood Immunisation Register. |
| ANAO | The Australian National Audit Office. |
| BIP | Business Improvement Program. |
| BMMS | Better Medication Management System—a system which correlates data on prescriptions from providers, patients and pharmacists. |
| Finance | The Commonwealth Department of Finance and Administration. |
| GPII | General Practice Immunisation Incentives Program. |
| Health | The Commonwealth Department of Health and Ageing—lead agency in the Health and Ageing Portfolio. |
| HIC | The Health Insurance Commission, established under the *Health Insurance Commission Act 1973*. |
| IME | Improved Monitoring of Entitlements—a scheme designed to ensure that PBS benefits are paid to eligible patients. |
| MBCC | Medicare Benefits Consultative Committee. |
| MBS | Medicare Benefits Scheme, incorporating the Medicare Benefits Schedule. |
| MOU | Memorandum of Understanding. |
| MSAC | Medicare Schedule Advisory Committee. |
| OPA | Output Pricing Agreement under the SPA. |
| ORC | Output Review Committee—one of HIC's key management groups. |
| PBAC | Pharmaceutical Benefits Advisory Committee. |
| PBS | Pharmaceutical Benefits Scheme, incorporating the Pharmaceutical Benefits Schedule. |
| PIP | Practice Incentives Program. |
| PRD | Program Review Division—a Division of HIC which analyses Medicare data for anomalies in claiming/servicing patterns. |
| SPA | Strategic Partnership Agreement between the Commonwealth (represented by Health) and HIC—made under section 8JA of the *Health Insurance Commission Act 1973*. |

# Summary and Recommendations

# Summary

## Background

**1.** The Department of Health and Ageing (Health) and the Health Insurance Commission (HIC) share responsibility for the effective and efficient implementation of a range of health programs, including Medicare and the Pharmaceutical Benefits Scheme (PBS). Both agencies have stated that they recognise the importance of working together, as partners in their respective roles, to maximise their performance in the achievement of health portfolio outcomes and to discharge their respective responsibilities. This joint commitment is embodied in a written agreement—called the **Strategic Partnership Agreement** (SPA)—between Health (representing the Commonwealth) and HIC.

**2.** Health and HIC are part of the Commonwealth Health and Ageing Portfolio. Services provided by the Health and Ageing Portfolio are delivered through nine portfolio Outcomes.[1] The first three Outcomes reflect the core business of the portfolio, and are described in the 2002–2003 Health Portfolio Budget Statements as:

- Outcome 1—Promotion and protection of the health of all Australians and minimizing the incidence of preventable mortality, illness, injury and disability;
- Outcome 2—Access through Medicare[2] to cost-effective medical services, medicines and acute health care for all Australians; and
- Outcome 3—Support for healthy ageing for older Australians and quality and cost-effective care for frail older people and support for their carers.

**3.** Health is a Department of State, with the roles and responsibilities of the lead agency in the Health portfolio. Essentially, Health provides policy advice, manages programs and delivers some services directly to the community. Health engages other agencies in the portfolio to deliver a range of services to the community, on Health's behalf.

**4.** The Health Insurance Commission is a statutory authority, created by the *Health Insurance Commission Act 1973*, whose roles and responsibilities are outlined in Commonwealth legislation. HIC manages legislated functions,

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1 Portfolio Budget Statements 2002–03. Health and Ageing Portfolio. p. 7.

2 Outcome 2 includes the Medicare Benefits program, the Pharmaceutical Benefits Scheme and the Australian Health Care Agreements for public hospital services. The scope of this audit does not extend to the Australian Health Care Agreements. That program is the subject of a separate ANAO performance audit.

processes claims, pays benefits under the Medicare and PBS programs, and delivers services in connection with a range of other health programs.

**5.** The SPA documents arrangements for HIC to deliver services and administer a number of Health portfolio programs (across several portfolio Outcomes), including:

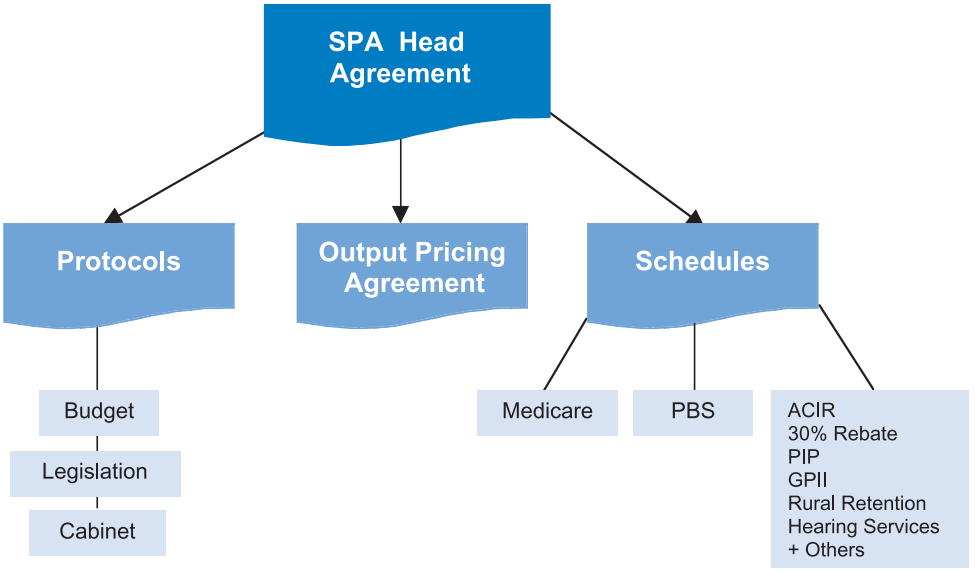
- Medicare Benefits Scheme (MBS);
- Medicare Compensation Recovery Program;
- Pharmaceutical Benefits Scheme;
- 30 Per Cent Private Health Insurance Rebate Scheme;
- Australian Childhood Immunisation Register (ACIR);
- General Practice Immunisation Incentives Program (GPII);
- Practice Incentives Program (PIP);
- Hearing Services Claim Payment System;
- Rural Retention Program; and
- Australian Organ Donor Register.

**6.** The SPA sets out principles to guide the relationship between Health and HIC, along with various undertakings by both parties and provisions relating to the operation of the Agreement. The broad structure of the SPA is represented in Figure 1. The SPA consists of a **Head Agreement** and several other parts, specifically:

- **Schedules**—containing details of particular functions, programs or services, for example, Medicare or the Pharmaceutical Benefits Scheme;
- **Protocols**—outlining processes for consulting on Budget, Cabinet and legislation issues; and
- an **Output Pricing Agreement** (OPA)—which defines the basis of pricing on which Health purchases the outputs supplied by HIC.

## Figure 1

**Broad structure of the Health-HIC Strategic Partnership Agreement**

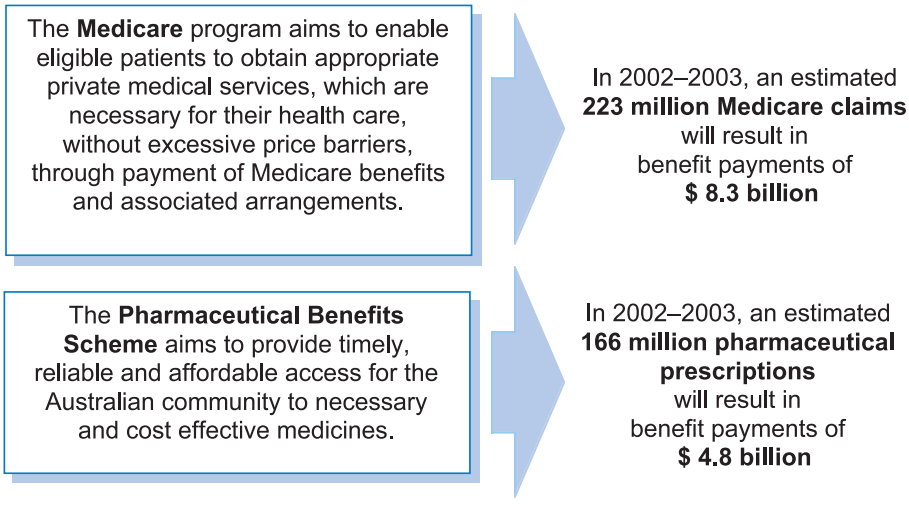



Source: ANAO

7. This audit concentrated on arrangements between Health and HIC for the implementation of Medicare and the PBS, as these two programs account for $13 billion of the portfolio's annual appropriation of $30 billion. Figure 2 illustrates the key dimensions of Medicare and the PBS.

## Figure 2

**Medicare and PBS estimates for 2002–2003.[3]**




[3] Figures are sourced from the Health Portfolio Budget Statements 2002–03. p.19, 20 & 92.

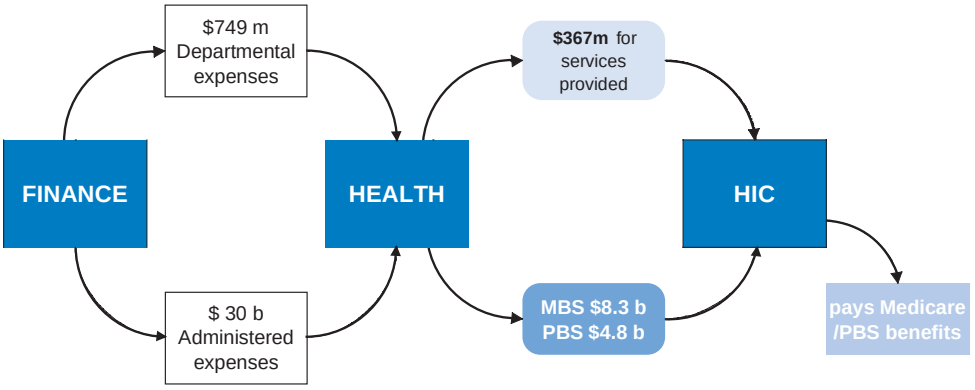
**8.** According to the Health Portfolio Budget Statements, the department will manage a total budget of $30.8 billion in 2002–2003. Of this total, the department will administer $30 billion, to fund the operation of various health programs, and $749 million in departmental expenses.[4] From its departmental appropriation of $749 million, Health will pay HIC an estimated $367 million in 2002–2003 to deliver the range of health services covered by the SPA. Under their Output Pricing Agreement, Health will pay HIC a specific amount of money for each Medicare claim processed. Other services delivered under the SPA, such as processing PBS prescriptions, maintaining the ACIR and making PIP payments, are also costed on a 'per service' basis. The $367 million is calculated using estimates for the number of services HIC is expected to deliver in 2002–2003, under each program.[5]

**9.** The estimated $367 million in payments from Health will represent approximately 90 per cent of HIC's estimated total income of $418 million in 2002–2003. HIC will spend over $300 million of the $367 million in delivering Medicare and the PBS.

**10.** Figure 3 illustrates the flow of funds between the Department of Finance and Administration, Health and HIC, in relation to funding Medicare and the PBS.

## Figure 3

**Flow of funds.** Amounts refer to estimates for the 2002–2003 financial year.




Source: ANAO

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[4] Source: Health Portfolio Budget Statements 2002–03, p. 18.

[5] Under a Memorandum of Understanding between Health and Finance, if HIC delivers more services than estimated in a particular year, Health will receive additional funds from Finance to pay for the additional HIC services. Conversely, should HIC not be required to deliver the estimated number of services, and therefore, Health not be required to pay HIC the entire $367 million, the difference is returned to Finance. This MoU covers the Medicare, PBS, Compensation Recoveries, ACIR and 30% PHIR programs. Hearing Services, PIP, GPII and Rural Retention programs are not specifically covered by the MoU and in theory Health bears a risk should actual service volumes exceed estimates.

**11.** Medicare and the PBS are key elements in Australia's public health system. The SPA has operated for four years as a basis for Health and HIC's shared responsibility for these programs. Against this background, the ANAO considered it timely to examine the implementation of the SPA and supporting arrangements within the two organisations.

## Audit objective and methodology

**12.** The objective for the audit was to form an opinion on the administrative effectiveness of arrangements between Health and HIC in relation to Medicare and PBS, and the implementation of their Strategic Partnership Agreement.

**13.** The focus for this audit was on the partnership between Health and HIC to achieve a shared goal. The audit looked at the respective roles of Health and HIC, as documented in their Strategic Partnership Agreement, and how the exercise of these roles facilitates a coordinated approach to the delivery of Medicare and PBS programs.

**14.** The audit team examined relevant documents and files held by Health and HIC, interviewed a total of some 40 staff within the agencies, and reviewed the suite of documents which comprise the SPA, Commonwealth Budget papers, the agencies' annual reports and other public documents. Members of the ANAO financial statements audit team undertook fieldwork in relation to financial matters within the scope of the audit.

## Overall conclusion

**15.** The ANAO concluded that administrative arrangements between Health and HIC, including their Strategic Partnership Agreement, generally act to support a co-ordinated implementation of Medicare and the Pharmaceutical Benefits Scheme.

**16.** The SPA incorporates essential elements of a governance framework for the relationship, including joint management structures, a performance monitoring and reporting framework, and protocols for communication between the policy agency and the administrative agency. ANAO also concluded that administrative arrangements supporting the provision of funding for Medicare and PBS benefit payments are sound.

**17.** However, ANAO considers that the Health-HIC relationship would benefit from a greater clarity of each agency's accountability obligations. In particular, the Health-HIC relationship would benefit from a more explicit treatment and understanding of Health's obligations for ensuring the efficient, effective and ethical expenditure of departmental resources, which fund the majority of HIC's operations.

**18.** ANAO also concluded that a program of external benchmarking of HIC's services would enable the partners to more clearly demonstrate that the Health-HIC business arrangements deliver value for money to the Commonwealth. Such a program of external benchmarking was envisaged in the SPA, and has been considered by both agencies, but has not yet taken place.

# Key Findings

## Role definition

**19.** ANAO found that the SPA adequately documents respective roles for Health and HIC in the implementation of health programs, such as Medicare and the PBS.

**20.** The SPA indicates that Health's role reflects its policy focus and its role in promoting, developing and funding health services. Health formulates estimates of Medicare and PBS expenditure and monitors expenditure relative to the Budget estimates. Health also produces and maintains the Medicare Benefits Schedule and the Pharmaceutical Benefits Schedule.[6]

**21.** HIC's role is described in the SPA as that of program administration, that is, maintaining the Medicare Enrolment file, producing and issuing Medicare cards, assessing claims for Medicare and pharmaceutical benefits and making payments of benefits to eligible claimants. The core function of HIC is the Medicare function, conferred by the *Health Insurance Commission Act 1973*.

**22.** The SPA refers to, but does not recite, HIC's statutory functions, which are detailed in legislation such as the *Health Insurance Commission Act 1973*, *Health Insurance Act 1973* and *National Health Act 1953*. However, where the activities to be performed by HIC are not made explicit in legislation, such as data exchange with Health and reporting requirements, the Schedules to the SPA contain a description of the required activities.

**23.** ANAO found that Schedules to the SPA typically address matters such as management arrangements, financial arrangements, undertakings of each organisation, monitoring and feedback arrangements, including the identification of performance indicators and data and reporting requirements. In addition to the Schedules, a number of Protocols have been agreed by Health and HIC, to guide their relationship at an operational level. Protocols address communication and consultation processes in relation to Budget, Cabinet liaison and the maintenance of legislation.

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[6] Not to be confused with Schedules under the SPA, the Medicare Benefits Schedule and Pharmaceutical Benefits Schedule referred to here arise from the legislative instruments in which Medicare or pharmaceutical benefit items, item numbers and scheduled fees are detailed (such as the Health Insurance (General Medical Services Table) Regulations 2001).

## Implementation of the SPA

**24.** ANAO found that Health and HIC have implemented the majority of arrangements and undertakings envisaged in their SPA. However, ANAO also found that a number of undertakings included in the SPA Head Agreement have not been fully implemented by Health and HIC.

**25.** The SPA Head Agreement envisages that arrangements for the delivery of each significant program will be included in a separate Schedule. ANAO found that a Schedule for the Medicare Benefits program has not yet been executed, and that the Schedule for the PBS program has expired and has not yet been renewed.

**26.** Health and HIC have not yet conducted a program of external benchmarking of HIC's service delivery activities, as required by the SPA Head Agreement. ANAO noted that some internal benchmarking has occurred within HIC and that a number of corporate service areas within HIC have been benchmarked, but that key program delivery elements, as envisaged in the SPA, have not been subjected to external benchmarking.

**27.** While acknowledging the difficulties associated with successful benchmarking, the latter would permit a comparison of HIC's costs with other private or public sector organisations engaged in similar service delivery activities. Benchmarking would also enable Health and HIC, but in particular HIC, to develop an insight into aspects of better practice which HIC might adopt or adapt in order to achieve improved performance. This is important in the context of the Health-HIC relationship as Medicare and PBS services are not contested in the marketplace. HIC is the sole provider of Medicare and PBS services, and these functions are conferred on HIC by legislation.

**28.** HIC has recently embarked on a four-year Business Improvement Program, within which HIC will evaluate and re-engineer many of its business processes. ANAO suggests that external benchmarking, of the type envisaged in the SPA, should be conducted in conjunction with HIC's Business Improvement Program.

## Financial arrangements

**29.** ANAO found that Health and HIC have established sound administrative arrangements for the transfer of resources to fund Medicare and PBS benefit payments. Health and HIC have also established a system whereby resources from the special appropriations that fund the payment of Medicare and PBS benefits, are transferred from Health's bank accounts to HIC's bank accounts, on a daily basis and sufficient to meet demand. The two organisations reconcile data on the volume of transactions.

## Accountability

**30.** ANAO found that the nature of the business relationship between Health and HIC reflects many characteristics of a purchaser-provider arrangement. The SPA specifies the services to be delivered by HIC, the price to be paid by Health for each service, and service standards to be achieved. It envisages a performance monitoring framework and reporting arrangements.

**31.** ANAO found that Health monitors the volume of services provided by HIC, and pays HIC according to the volume of services delivered. Health also accepts a large amount of program data from HIC (de-identified Medicare and PBS claim information) to inform its policy advisory functions and to monitor program trends and expenditure against Budget estimates. However, ANAO found that Health does not regularly endeavour to inform itself of the quality of services provided by HIC. Health informed the ANAO that it saw its role as providing *funding* for the delivery of health services, rather than *purchasing* health services. Consequently, Health has not positioned itself to exercise the latter role.

**32.** A degree of tension exists between Health's accountability for departmental expenses used to fund HIC's operations, and Health's perceived role simply as a 'funder' of health services. Prior to 1999–2000, the majority of HIC's operational funding appeared as a one-line entry in Health's budget, under administered items. Since that time, the resources have been provided to Health as departmental funds. Typically, an agency manages administered items on behalf of the Commonwealth and has little or no discretion over the expenditure of administered items, while departmental items are controlled by the agency in producing its outputs.

**33.** ANAO found that Health does not have the same discretion in the expenditure of departmental expenses used to fund HIC under the SPA, as it does in the expenditure on other departmental items. This is because the estimated $367 million Health will pay HIC is 'quarantined' by Health. The tension arises in that Health views its role as a funding conduit to HIC, with little discretion in the application of departmental resources involved. However, the *Financial Management and Accountability Act 1997* obliges the Secretary of the Department to be accountable for the efficient, effective and ethical expenditure of departmental resources.

## Review of HIC funding arrangements

**34.** At the time of preparing this audit report,[7] ANAO became aware that the Department of Finance and Administration is to assess the financial needs of

[7] May–June 2002.

HIC and analyse whether the current purchaser-provider model operating between Health and HIC is the most appropriate mechanism. This review will be conducted with the assistance and involvement of Health and HIC. A range of issues raised in this report will be relevant to the proposed review.

# Recommendations

**Recommendation No. 1 Para 2.28**

The ANAO recommends that Health and HIC, taking account of relevant legislation, clarify each agency's accountability requirements in relation to expending and reporting on departmental resources under the SPA. Health and HIC should then amend the SPA to reflect respective accountability obligations.

***Joint Health-HIC Response:*** Agreed.

**Recommendation No. 2 Para 3.18**

The ANAO recommends that Health and HIC:

- finalise and execute a SPA Schedule for the Medicare program; and
- review and renew the current SPA Schedule for PBS.

***Joint Health-HIC Response:*** Agreed.

**Recommendation No. 3 Para 3.25**

The ANAO recommends that, consistent with the SPA Head Agreement, and in concert with the HIC's Business Improvement Program, Health and HIC reconsider a program of external benchmarking for a range of HIC's program elements and services delivered under the SPA.

***Joint Health-HIC Response:*** Agreed.

# Audit Findings and Conclusions

# 1 Introduction

*This chapter describes the background to the Strategic Partnership Agreement, its structure, purpose and the broad role of each organisation, under the Agreement. It also briefly describes funding arrangements for the delivery of Medicare and PBS, and concludes with a description of the audit approach.*

## Background to the Strategic Partnership Agreement

**1.1** At some time in their lives, all Australian citizens are likely to access the Medicare system and the Pharmaceutical Benefits Scheme (PBS). Two Commonwealth entities share primary responsibility for the effective and efficient implementation of Medicare and PBS—the Department of Health and Ageing (Health) and the Health Insurance Commission (HIC).

**1.2** In 2002–2003 HIC will process an estimated 223 million Medicare claims and make payments of around $8.3 billion. In addition, HIC will process claims for more than 166 million pharmaceutical prescriptions and pay an estimated $4.8 billion in benefits. The Department of Health and Ageing provides policy advice and manages funding for these programs. In addition, Health will pay HIC approximately $367 million in 2002–2003 to deliver a range of health services, including Medicare and PBS services, to citizens and health industry professionals.

**1.3** Both agencies have stated that they recognise the importance of working together, as partners in their respective roles, to maximise their performance in the achievement of health portfolio outputs and outcomes and to discharge their respective responsibilities. This joint commitment is embodied in a written agreement, called the Strategic Partnership Agreement (SPA), between Health (representing the Commonwealth) and HIC.

**1.4** HIC was established in 1974 to administer Medibank, Australia's Universal Health Insurance Scheme, which commenced in July 1975. In October 1976, HIC was restructured to conduct two distinct programs—Medibank Standard and Medibank Private (a private health insurance fund, competing in the marketplace). Two years later Medibank Standard was abolished and HIC's sole function was the administration of Medibank Private.

**1.5** In May 1983, HIC was given responsibility for administering Medicare, which commenced in 1984. In 1985, the Government transferred responsibility for medical fraud and over-servicing aspects of Medicare from the Department of Health to HIC and, in 1989, administration of the PBS was transferred from the Department of Community Services and Health to HIC. In 1998, as part of

the broader reform of the health insurance sector, Medibank Private became a discrete Commonwealth owned company and separated from HIC.

**1.6** Therefore, HIC has a 28 year history of administering health insurance/health benefits programs. The Department of Health has traditionally provided policy advice to Government and managed the overall implementation of universal health programs. Against this background, the Strategic Partnership Agreement between the two organisations was designed to deliver a coordinated, effective and efficient implementation of a wide range of Government health programs.

## Purpose and structure of the SPA

**1.7** The SPA, made under section 8JA of the *Health Insurance Commission Act 1973*, was signed on 5 June 1998[8] by the Secretary of the (then) Department of Health and Family Services, as delegate of the Minister for Health and Family Services, and the Managing Director of the Health Insurance Commission.

**1.8** Section 8JA of the *Health Insurance Commission Act 1973* (HIC Act) provides:

> The Minister may, on behalf of the Commonwealth, enter into an agreement with the Commission about the performance of the Commission's functions and the exercise of the Commission's powers.

**1.9** The stated purpose of the Strategic Partnership Agreement is to:

- clarify respective roles and relationships in implementing the Government's health and family services programs;
- articulate and commit to principles guiding the strategic partnership between Health and HIC;
- define services to be provided by HIC and provide a framework for dealing with specific functions or programs;
- outline performance monitoring procedures to ensure that services meet policy requirements of the Government and outline measures to improve performance;
- define the financial arrangements between Health and HIC; and
- establish procedures and mechanisms to form the basis for improving the collaborative relationship between Health and HIC, particularly in relation to consultation and information sharing.

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[8] The SPA was originally signed by the Secretary in February 1998. Legal advice suggested that version of the SPA may have been invalid. An instrument of delegation was developed, through which the Minister formally delegated power to enter into an agreement under s8JA, to the Secretary. The document was then re-executed in June 1998, with the Secretary acting as the formal delegate of the Minister.

**1.10** The SPA documents arrangements for HIC to deliver services and administer a number of health portfolio programs, including:

- Medicare Benefits Scheme (MBS);
- Medicare Compensation Recovery Program;
- Pharmaceutical Benefits Scheme;
- 30 Per Cent Private Health Insurance Rebate Scheme;
- Australian Childhood Immunisation Register (ACIR);
- General Practice Immunisation Incentives Program (GPII);
- Practice Incentives Program (PIP);
- Hearing Services Claim Payment System;
- Rural Retention Program; and
- Australian Organ Donor Register.

**1.11** The SPA also sets out principles to guide the relationship between the department and HIC, along with various undertakings by both parties and provisions relating to the operation of the Agreement. The SPA consists of a **Head Agreement** and several other parts, specifically:

- **Schedules**—containing details of particular functions, programs or services, for example, Medicare or the Pharmaceutical Benefits Scheme;
- **Protocols**—outlining processes for consulting on Budget, Cabinet and legislation issues; and
- an **Output Pricing Agreement** (OPA)—which defines the basis of pricing on which Health funds HIC to provide certain services. The OPA is supported by a separate Memorandum of Understanding (MOU) between Health and the Department of Finance and Administration.

## Roles described in the SPA

**1.12** The SPA Head Agreement cross-references the Corporate Plan and Mission Statement of each agency, to describe their respective roles. At the time of signing the agreement, Health's 1997–98 corporate plan defined its mission as:

> We lead the development and implementation of health and family services policy according to Government objectives and directions.

In the 2000–01 Health Corporate Plan, the department's mission is stated as:

> To lead the development of Australia's health and aged care system.

**1.13** HIC's Corporate Plan of 1997–98 stated HIC's mission as:

> We exist to support the delivery of quality health care to all Australian residents. We provide the Australian community with convenient and easy access to government benefit payments…

HIC no longer publishes a mission, but rather defines its purpose:

> Our purpose is clear: to improve Australia's health through payments and information.

**1.14** The SPA Head Agreement expands on these broad roles and ascribes a set of responsibilities to each agency.

**Figure 4**

**General Roles and Responsibilities described in the SPA**

Throughout the **SPA Head Agreement** the following general roles and responsibilities are documented:

*Health is responsible for:*

- overall policy advice and implementation;
- promoting, developing and funding health services;
- providing funding to HIC for the services delivered; and
- consulting with HIC, where appropriate, on policy issues that will impact on their (HIC's) products or services.

*HIC is responsible for:*

- administration of programs;
- managing legislated functions;
- delivering the agreed services detailed in the Schedules to a required standard of performance;
- providing necessary assistance, financial and program data to enable Health to conduct its business;
- designing, implementing and managing large scale payment and registration systems and those programs involving the flow or analysis of data; and
- developing activity-based costings for programs and services to demonstrate cost.

**1.15** Essentially, Health's role reflects a policy focus and its work in promoting, developing and funding health services.[9] Health provides policy advice to

[9] SPA Head Agreement, Clause 6.1—Roles and functions of the Department.

Government, manages programs and delivers some services directly to the community. Health engages other agencies in the portfolio to deliver a range of services to the community, on Health's behalf.

**1.16** HIC is primarily responsible for the day-to-day administration of programs—including the processing of claims and the payment of benefits. HIC discharges this role through the delivery of Medicare and Pharmaceutical Benefit services to the public through a number of channels including a national network of 226 Medicare offices and increasingly via electronic communication channels including telephone, fax and the Internet.

**1.17** The primary responsibilities and functions of Health and HIC in relation to Medicare and the PBS, are described in the following legislation:

- *Health Insurance Commission Act 1973 (HIC Act);*
- *Health Insurance Act 1973 (HI Act); and*
- *National Health Act 1953 (NH Act).*

**1.18** This body of legislation provides direction for HIC,[10] in terms of day-to-day administration of the Medicare and PBS programs and delivery of related services.

## Funding the delivery of Medicare and the PBS

**1.19** Funding for Medicare and PBS benefits is sourced via special appropriations by the Australian Parliament.[11] Health treats these funds as administered items.[12] Funds provided to Health to support HIC's delivery of Medicare and PBS services are treated as departmental items.[13]

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[10] The HIC Act, HI Act and NH Act confer a significant number of statutory powers and functions on the Managing Director of HIC, and on the Commission itself.

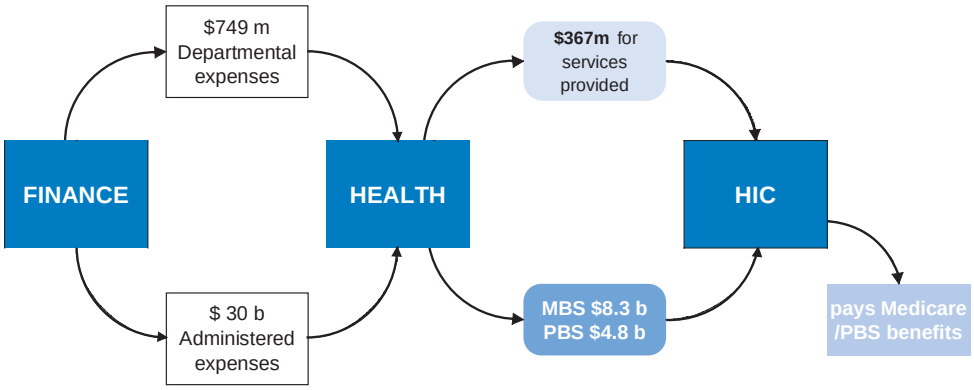
[11] The *2001–2002 Health and Aged Care, Portfolio Budget Statements* (Appendix 3) defines the terms as follows: ***Special appropriations***—Moneys appropriated by Parliament in an Act separate to the annual Appropriation Act, where the payment is for a specified amount. Special appropriations are not subject to Parliament's annual budget control, unlike annual appropriations; ***Standing appropriations***—These are very similar to special appropriations, except that instead of an amount being specified in the appropriation, the Act provides for an automatic payment of funds where an entitlement exists… The terms special and standing are often used interchangeably.

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

[13] ibid. ***Departmental items***—Assets, liabilities, revenues and expenses which are controlled by the agency in providing its outputs. Departmental items would generally include computers, plant and equipment assets used by agencies in providing goods and services and most employee expenses, supplier costs and other administrative expenses incurred.

**Figure 5**

**Flow of funds.** Amounts refer to estimates for the 2002–2003 financial year.




Source: ANAO

**1.20** In 2000–01, HIC received over 90 per cent of its funding from Health.[14] HIC's income under the OPA provides funding for operational expenditure as well as the cost of maintaining and replacing HIC's capital asset base.

**1.21** In addition to the flow of departmental funds from Health to HIC, Health also makes available to HIC the $13 billion of administered funds for the payment of Medicare and PBS benefits to citizens and health industry professionals. Health provides these funds to HIC on a daily basis, and sufficient to meet the expenses incurred by HIC throughout the previous day. The mechanisms through which Health makes administered funds available to HIC, for the payment of benefits is described in more detail in Appendix 1.

## The audit

### Audit objective

**1.22** The objective for the audit was to form an opinion on the administrative effectiveness of arrangements between Health and HIC in relation to Medicare and PBS, and the implementation of their Strategic Partnership Agreement.

**1.23** In order to achieve the objective, the audit addressed three major criteria to determine whether:

- Health and HIC have documented roles in relation to Medicare and PBS, consistent with relevant legislation and government policy directives;
- Health and HIC discharged their roles, as documented; and

[14] Financial statements in HIC's Annual Report for 2000–2001 reveal that HIC received $361.5 million from Health in a total income from 'Sale of Services' of $389.9 million.

- funding arrangements supporting the delivery of Medicare and PBS services reflected sound administrative practice.

## Audit scope

**1.24** The audit involved the Department of Health and Ageing and the Health Insurance Commission. Within Health, audit activity was concentrated in various Branches in the Health Access and Financing Division. Within HIC, audit activity was concentrated in the Medicare and PBS Branches of the Program Management Division.

**1.25** Activity associated with the third audit criterion—funding arrangements—was undertaken by the ANAO's financial statements audit team with particular responsibility for Health and HIC. This work sourced information from the Finance areas within each organisation. Additional information was sought from the Department of Finance and Administration.

**1.26** The focus for this audit was on the partnership between Health and HIC—how the two agencies employ their strategic relationship to achieve a shared goal, that of Outcome 2 in the Health Portfolio Budget Statements—Access to Medicare (Outcome 2 includes access to pharmaceutical benefits).

**1.27** It is important to note that this was not an audit of Medicare or PBS, but rather an audit of the respective roles of Health and HIC, as documented in their Strategic Partnership Agreement, and how the exercise of these roles facilitates a coordinated approach to the delivery of Medicare and PBS programs. Other programs are delivered by HIC under separate Schedules to the SPA. These include the Practice Incentives Program, the Australian Childhood Immunisation Register and the Private Health Insurance Rebate Program. This audit concentrated on Medicare and PBS, as these two programs account for over $13 billion of the $20 billion of administered appropriations (for Outcome 2) managed by Health in 2002–2003.

## Audit methodology

**1.28** The audit examined the suite of documents comprising the SPA—the Head Agreement, selected Schedules and Protocols, the Output Pricing Agreement and Memorandum of Understanding between Health and Finance. It also examined relevant documents and files held by Health and HIC, including minutes of joint management committee meetings, annual performance reports on the operation of the SPA, legal advice and information papers presented to senior management groups within both agencies, Commonwealth budget papers, enabling legislation, the agencies' annual reports and other public documents, such as Corporate Plans and Mission Statements.

**1.29** A total of some 40 staff within the agencies were interviewed during the course of the audit.

**1.30** Audit fieldwork was conducted over the period December 2001 to May 2002. The audit was conducted in accordance with ANAO auditing standards at a cost of $245 000.

## Other relevant audits

**1.31** ANAO published Audit Report No.30, 1998–99, *The Use and Operation of Performance Information in Service Level Agreements*, in January 1999. The report examined the operation of a Strategic Partnership Agreement between Centrelink and the Department of Family and Community Services (then the Department of Social Security), as well as the Service Arrangement between Centrelink and the (then) Department of Employment, Education, Training and Youth Affairs. The audit explored the respective roles of those involved in a purchaser-provider relationship and, in particular, whether the performance assessment framework specified in the agreements enabled an adequate assessment of achievements under purchaser-provider arrangements.

**1.32** ANAO published Audit Report No.42, 1999–2000, *Magnetic Resonance Imaging Services—effectiveness and probity of the policy development processes and implementation,* in May 2000. Among other things that audit found that both organisations had been working, through strategic partnerships and memoranda of understanding towards improving liaison at both the strategic and at the operational level. However, it was apparent that liaison at the operational level could have provided greater assurance that risk treatments were being monitored and managed in a disciplined manner.

**1.33** ANAO published Audit Report No.47, 2001–2002, *Administration of the 30 Per Cent Private Health Insurance Rebate*, in May 2002. The 30 Per Cent Private Health Insurance Rebate Scheme is another program administered by HIC under the SPA. While the current audit focussed on the SPA in relation to Medicare and PBS, and did not specifically address arrangements for the 30 Per Cent Private Health Insurance Rebate Scheme, some findings of Audit Report No.47, 2001–2002 are relevant. In particular, Audit Report No.47, 2001–2002 comments on the roles and responsibilities of Health and HIC, and the use of performance information, in the management and administration of the Scheme.

**1.34** In 2001–2002, ANAO commenced an audit of the quality of HIC client service. The objective of this audit, which is currently in progress, is to form an opinion on whether the HIC takes adequate measures to deliver quality client service to the Australian public as clients of Medicare. The audit will examine three areas of client service in HIC:

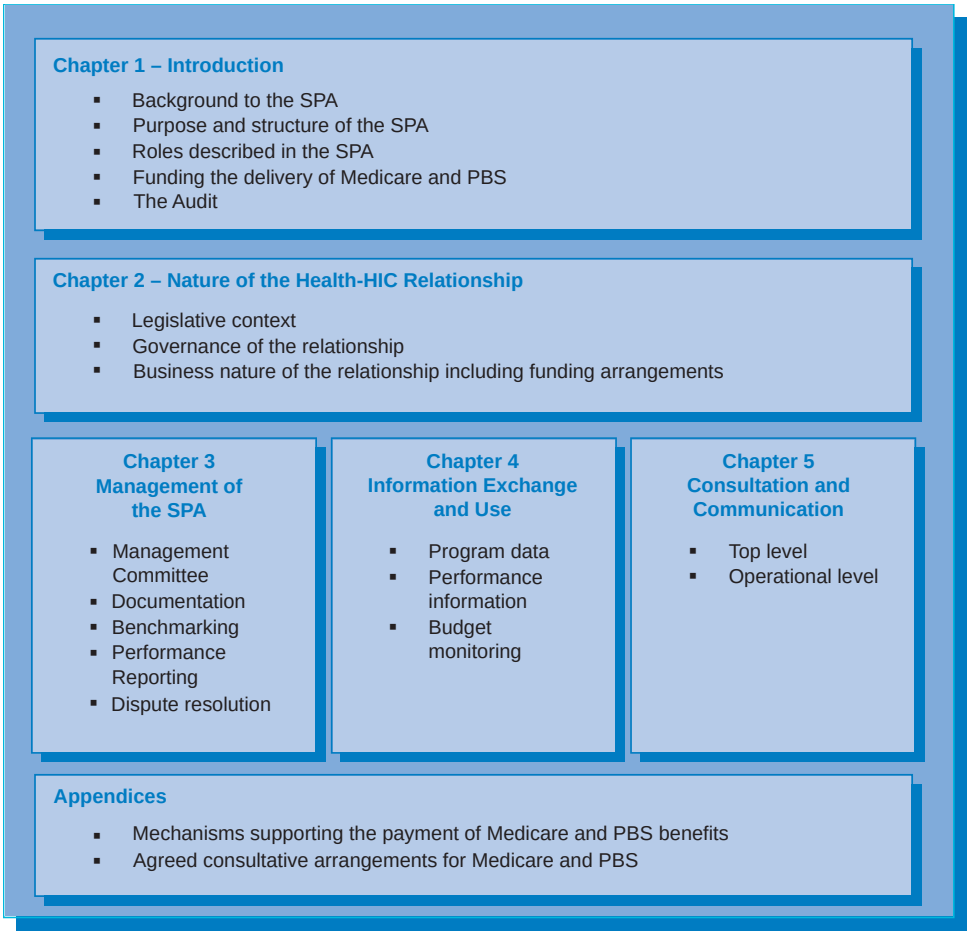
- management of the client service process;
- continuous improvement of client service; and
- whether HIC is meeting good practice client service standards.

The ANAO expects to table a report of this audit in September 2002.

## Structure of the report

**1.35** Figure 6 illustrates the structure of this report.

**Figure 6**
**Structure of the audit report**



# 2. Nature of the Health–HIC Relationship

*This chapter discusses the legislative context within which the SPA operates and outlines the governance arrangements for the SPA. It also addresses the nature of the business relationship between Health and HIC, including the funding arrangements under their Output Pricing Agreement.*

## Legislative context

**2.1** As a Commonwealth Department of State, the Department of Health and Ageing operates within an established legislative framework. Of particular interest, in the context of this audit are the *Public Service Act 1999* and the *Financial Management and Accountability Act 1997*.

**2.2** Among other things, the *Public Service Act 1999* (PS Act) defines the powers, functions and responsibilities of Agency Heads within the Australian Public Service.[15] The PS Act is not prescriptive in terms of accountability and responsibility, but rather confirms in general terms, the lines of accountability and responsibility consistent with the framework of responsible government. The PS Act imposes a general responsibility on public servants to 'use Commonwealth resources in a proper manner' and establishes Agency Heads as key players in the management of, and having responsibility for, the use of Commonwealth resources.

**2.3** The *Financial Management and Accountability Act 1997* (FMA Act) outlines the responsibility and accountability obligations of Commonwealth public servants, and establishes a framework for the use and stewardship of Commonwealth resources. Part 7 of the FMA Act details the special responsibilities of Chief Executives in the APS.[16]

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[15] Section 7 of the Act defines *Agency Head* as: (a) the Secretary of a Department; or (b) the Head of an Executive Agency; or (c) the Head of a Statutory Agency. Section 57 of the PS Act details the responsibilities of Secretaries:

(1) The Secretary of the Department, under the direction of the Agency Minister, is responsible for managing the Department and must advise the Agency Minister in matters relating to the Department.

(2) The Secretary of a Department must assist the Agency Minister to fulfil the Agency Minister's accountability obligations to the Parliament to provide factual information, as required by the Parliament, in relation to the operation and administration of the Department.

[16] Section 5 defines a Chief Executive as 'including a person who is Secretary of an Agency for the purposes of the *Public Service Act 1999*'. Section 44 of the FMA Act requires that Chief Executives promote the efficient, effective and ethical use of Commonwealth resources. Subsection 44(1) states:

A Chief Executive must manage the affairs of the Agency in a way that promotes proper use of the Commonwealth resources for which the Chief Executive is responsible…*proper use* means efficient, effective and ethical use.

**2.4** The Health Insurance Commission is a statutory authority within the Commonwealth Health and Ageing Portfolio. The Commission is established by the *Health Insurance Commission Act 1973*, which sets out the functions of the Commission as follows:

> *Section 5: The Commission has the following functions:*
> a) *the* **medicare functions** *mentioned in section 6;*
> b) *the* **service delivery functions** *mentioned in section 7;*
> c) *the* **spare capacity functions** *mentioned in section 8;*
> d) *the* **additional functions** *mentioned in section 8AA;*
> e) *to do anything incidental to or conducive to the performance of any of the above functions.*

**2.5** Specific functions, including those associated with the PBS and Medicare schemes are detailed in the *National Health Act 1953 (Part VII)* and *Health Insurance Act 1973 (Part II)* respectively. For example, in relation to Medicare, HIC is responsible for the processing and payment of claims, the issue of Medicare Cards and the registration of Medicare eligible persons.

**2.6** As a Commonwealth authority, HIC operates subject to the *Commonwealth Authorities and Companies Act 1997* and associated regulations and orders (CAC Act). The CAC Act obliges directors[17] of Commonwealth authorities and companies to meet a set of core reporting and auditing requirements. For example, directors are required to prepare an annual report of the operations of the authority, which addresses both the efficiency and effectiveness of those operations, in producing its principal outcomes.[18]

**2.7** The CAC Act also requires that directors keep the responsible Minister informed of the operations of the authority, comply with general policies of the Commonwealth Government and to exercise their powers and discharge their duties with reasonable care and diligence.

**2.8** Technically, the SPA is an agreement under section 8JA of the HIC Act, between the Commonwealth—represented by the Minister—and HIC, about how the Commission should perform its functions and exercise its powers. The Minister has formally delegated the power to enter into such an agreement to the Secretary of Health. Therefore, as a signatory to the SPA, the Secretary is exercising a power under the HIC Act, delegated by the Minister, on behalf of the Commonwealth.

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[17] In the case of HIC, each of the Commissioners is a director for purposes of the CAC Act.

[18] Clause 10 of the *Commonwealth Authorities and Companies Orders 1998.*

## Governance of the relationship

**2.9** The Department of Health and Ageing is the lead agency in the Commonwealth Health and Ageing Portfolio. Within the Government's outcomes/output framework, Health has identified nine portfolio outcomes.[19] Outcome 2—Access to Medicare, is described as 'Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians'.[20] The 2002–2003 Portfolio Budget Statements state that Health pursues the achievement of portfolio outcomes in association with other agencies in the portfolio. The Portfolio Budget Statements also indicate that the Health Insurance Commission contributes to Outcome 2—Access to Medicare, through a service agreement with the department.

**2.10** In any arrangement where there is joint responsibility for managing and administering programs, a clear governance framework, including accountability and reporting arrangements, which define the roles and responsibilities of participants, is essential.

**2.11** Governance has been described as being about how an organisation is managed—its corporate and other structures, its culture, its policies and strategies, and the ways in which it deals with its various stakeholders.[21] It is concerned with structures and processes for decision-making and with the controls and behaviour that support effective accountability for performance outcomes/results. Key components also include business planning, risk management and performance monitoring.

**2.12** In this audit, ANAO focussed on governance arrangements for the Health-HIC relationship, as defined by the SPA, rather than governance arrangements of the individual agencies.

### Audit findings

**2.13** The SPA Head Agreement establishes a joint, senior Management Committee, explicitly tasked with the overall management of the SPA. This Committee exercises a leadership role and, reporting to the Secretary of Health and the Managing Director of HIC, represents a key corporate structure in the governance framework for the Health-HIC relationship. Chapter Three of this report discusses the role, responsibilities and functioning of the Health-HIC Management Committee.

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[19] Portfolio Budget Statements 2002–2003. Health and Aged Care Portfolio. p. 16.

[20] ibid., p. 17.

[21] PJ Barrett, 2000. Corporate Governance in an Environment of Devolved Authority. Presentation to the Canberra Evaluation Forum, 17 August 2000, Section 2—Creating a Sound Governance Framework. Available on ANAO's website: <www.anao.gov.au>.

**2.14** The various Schedules to the SPA include performance monitoring and reporting arrangements. Schedules detail the nature of services to be provided by HIC and identify expected quality standards. These vary across Schedules and are specific to the program defined by each Schedule. The structure and content of Schedules for Medicare and PBS are explored throughout this report.

**2.15** The SPA also commits the two organisations to exchange data and information about the various health programs that will allow each organisation to conduct its business. For example, HIC provides a large amount of information on Medicare and PBS claims to Health, which Health analyses in support of the department's policy advisory role. Various Schedules identify the data requirements, along with the frequency of exchange. Chapter Four of this report considers the exchange and use of information.

**2.16** The SPA incorporates a number of policies and strategies designed to ensure coordination and collaboration on critical functions. For example, Protocols have been developed under the SPA, describing agreed processes in relation to consultation between Health and HIC on Budget, Cabinet and legislative issues. Communication and consultation is discussed in more detail at Chapter Five of this report.

**2.17** Each of the above elements contributes to the governance framework for the Health-HIC relationship. ANAO found that the governance framework, envisaged in the SPA, generally acts to support the co-ordinated delivery of Medicare and PBS services to users.

## Business nature of the relationship including funding arrangements

**2.18** While essentially a partnership between two Commonwealth entities, for the purpose of achieving a co-ordinated delivery of Government health programs, the Health-HIC business relationship reflects many characteristics of a purchaser-provider arrangement. That is, an arrangement whereby Health purchases services from HIC, akin to but not identical to, a contractual relationship between two bodies for the provision of goods and or services by the provider to the purchaser.[22]

[22] Legal advice provided to Health suggests that the SPA was not intended to create legally enforceable obligations between HIC and the department, and concludes that the SPA does not represent a contract between the two organisations.

**2.19** The SPA Head Agreement contains the following statement as to the *Purpose of the Agreement*:[23]

> *This Agreement is made in order to:*
>
> - *clarify our roles and the relationship between the Department and HIC in implementing the health and family services programs of the Government;*
> - *articulate and commit to principles which will guide the strategic partnership between the organisations;*
> - *define the services to be provided by HIC and provide a framework for dealing with specific functions or programs (in Schedules to this Head Agreement);*
> - *outline performance monitoring procedures to be used to ensure that the services provided meet the policy requirements of the Government and outline measures to improve performance;*
> - *consistent with legislative requirements, define the financial arrangements between the Department and HIC; and*
> - *establish procedures and mechanisms which will form the basis for improving the collaborative relationship between the Department and HIC, particularly in relation to consultation and information sharing.*

**2.20** The first, second and sixth dot points above go to establishing a partnership between the two organisations, in which roles and responsibilities are shared. The third, fourth and fifth relate more closely to a traditional relationship, involving one organisation providing services for an agreed fee, to another organisation which stipulates the services to be provided, the standard to which those services should be delivered and the arrangements to be employed in monitoring the performance of the service provider.

**2.21** Health and HIC have entered into an Output Pricing Agreement (OPA). This Agreement, an element of the SPA, sets out the services to be performed by HIC and the associated revenue HIC will receive from Health for performing these services. The OPA is structured such that Health pays HIC a specified amount for each service delivered—for example, each Medicare or PBS benefit paid to an eligible claimant. Hence the more benefits HIC process the more departmental revenue it receives. The revenue from the OPA covers all costs of performing these services including direct and overhead costs and, as indicated earlier, in 2002–03 is expected to total some $367 million—representing approximately 90 per cent of HIC's revenue.

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[23] SPA Head Agreement—Part 1, Clause 3, p. 5–6.

**2.22** Prior to 1999–2000, the majority of operational funding was provided as a one-line direct appropriation to HIC, and treated as an administered item within Health's budget.[24] From 1 July 1999, these funds were appropriated as part of Health's total departmental budget.

## Audit findings

**2.23** The SPA operates within a legislative context, and as noted previously, legislation relevant to Health and HIC outlines accountability obligations for the efficient, effective and ethical expenditure of Commonwealth resources. HIC is accountable for the expenditure of special appropriation funds—i.e. funds that enable Medicare and PBS benefit payments. HIC must ensure that benefit payments are made accurately and that the expenditure of Commonwealth funds on benefit payments is appropriately accounted for. HIC is also accountable for the expenditure of income derived from all sources, including departmental funds received from Health. ANAO found that the SPA recognises HIC's accountability obligations.

**2.24** However, ANAO found that the SPA does not provide a similar degree of clarity in relation to Health's accountability obligations for the expenditure of departmental resources. For example, as the Health-HIC relationship reflects many aspects of a purchaser-provider arrangement, the purchaser—Health—would be expected to inform itself regarding the quality of services delivered by the provider—HIC. ANAO found that Health monitors the volume of services delivered by HIC, and uses the information gained to calculate payments to HIC. Health also receives a significant amount of program data, such as the type of Medicare services claimed, benefits paid, trends in Medicare item usage and the like, but Health does not monitor the quality of service delivered by HIC to its customers.[25]

**2.25** ANAO acknowledges Health's stated position that the department is not legally responsible for HIC's day-to-day administration of health programs such as Medicare and the PBS—that such responsibility is conferred on HIC under legislation. ANAO is not suggesting that Health should attempt to become involved in the day-to-day administration of programs—rather that Health adequately inform itself, through information readily available,[26] of the quality of services delivered by its service provider. By doing so, Health and HIC would be in a stronger position to demonstrate value for money in their joint delivery of portfolio outcomes.

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[24] Health's budget—Division 343-1 *For Expenditure under the Health Insurance Commission Act 1973.*

[25] For example: achievements in relation to Medicare claims processing standards, Medicare Office customer service standards or telephone enquiry service standards.

[26] Chapter Four of this report deals with the availability of business performance information.

## Conclusion

**2.26** ANAO concluded that the SPA, together with relevant legislation, adequately documents a set of arrangements for the co-ordinated delivery of Medicare and PBS services. The SPA defines broad roles and responsibilities for Health and HIC, specifies services to be delivered, and service standards to be achieved, includes pricing arrangements and a performance monitoring framework, establishes protocols for communication and consultation between the policy agency and the agency administering the programs, and establishes governance and reporting arrangements to guide and monitor the partnership.

**2.27** ANAO also concluded that Health and HIC should clarify accountability requirements, in respect of departmental resources, allocated to Health for the purpose of funding the majority of HIC's operations.

## Recommendation No. 1

**2.28** The ANAO recommends that Health and HIC, taking account of relevant legislation, clarify each agency's accountability requirements in relation to expending and reporting on departmental resources under the SPA. Health and HIC should then amend the SPA to reflect respective accountability obligations.

*Joint Health-HIC Response:* Agreed. Following the outcome of the current Department of Finance review of HIC funding arrangements, HIC and Health will review the SPA and its subordinate agreements with a view to amending the SPA to reflect any changes to accountability obligations that may arise from that review.

## Review of HIC funding arrangements

**2.29** At the time of preparing this audit report, ANAO became aware that the Department of Finance and Administration, in conjunction with HIC and Health, is to assess the financial needs of HIC and analyse whether the current purchaser-provider model operating between Health and HIC is the most appropriate mechanism. A range of issues raised in this report will be relevant to the proposed review.

# 3. Management of the Strategic Partnership Agreement

*This chapter examines the roles and achievements of a joint Management Committee, established to oversee and report on the operation of the SPA.*

**3.1** The SPA Head Agreement incorporates a set of overarching principles describing how Health and HIC will conduct business together. It outlines general roles and responsibilities for both parties and consists of four parts, as follows:

*Part 1—Overview*
*Part 2—Working together –roles and principles to guide the relationship*
*Part 3—Undertakings*
*Part 4—Definitions and the operation of the Agreement*

**3.2** While the SPA notes that, broadly speaking, Health is responsible for policy and HIC for implementation, it states that the demarcation line between policy and administration is often blurred, and recognises that neither can operate in a vacuum, one divorced from the other[27]. The overriding principle articulated in the Head Agreement to the SPA is that of cooperation—an open, collaborative partnership and joint commitment to implement Government health programs.

## Establishment of the Health-HIC Management Committee

**3.3** The SPA Head Agreement establishes a joint Management Committee, with representation of senior officials from both agencies, and which has the following functions:

- to consider strategic issues and provide a forum for consultation and coordination on major policy issues, matters of principle, and major operational issues affecting the relationship between the two organisations;
- to oversee the operation of the Agreement, including reporting to the Secretary and the Managing Director as required;
- to oversee the benchmarking of programs and services;
- to oversee performance monitoring requirements, including the preparation of the Performance Report;
- to oversee the review of the Head Agreement, the Protocols and Schedules; and
- to assist in resolving any disputes referred to the Management Committee.

[27] SPA Head Agreement, paragraph 7.3.

**3.4** Membership of the Management Committee was to include up to five senior executive level managers from each organisation and meetings were to be held every two to three months. The SPA Head Agreement envisages that the Management Committee will be chaired on a rotational basis by the General Manager of Program Management Division (HIC) and the First Assistant Secretary of Health Benefits Division (Health), now called Health Access and Financing Division.

### Audit findings

**3.5** ANAO found that the joint Health-HIC Management Committee was established in accordance with Clause 11 of the SPA Head Agreement. The Management Committee met for the first time on 8 May 1998 and again in June 1998. It has met regularly since that time, with five meetings occurring in each of 1998–1999, 1999–2000 and 2000–2001.

**3.6** ANAO's analysis of the minutes of meetings held over the period 1999 to 2001, reveals that the Management Committee regularly considered matters of strategic importance to the Health-HIC relationship. For example, the introduction of major new health programs, which would involve HIC delivering a range of services to or on behalf of Health, was discussed. These included the 30 per cent Private Health Insurance Rebate Scheme and the Rural Retention Program.

**3.7** The Management Committee also played a key problem-solving role, in particular, in respect of difficulties encountered during a Health Information Technology outsourcing initiative and in the calculation and finalisation of budget estimates for Medicare and other health program expenditure.

## Maintenance of SPA documentation

**3.8** The Health-HIC Management Committee is responsible for ensuring the development, review and renewal of elements of the SPA, such as Schedules, Protocols and the Head Agreement.

### Audit findings

**3.9** The 1997–1998 Performance Report indicates that the following elements of the SPA were formally executed during that year:

- SPA Head Agreement—23 February 1998, re-executed 5 June 1998;
- Schedule for Practice Incentives Program—15 June 1998;
- Schedule for General Practice Immunisation Incentives Program—15 June 1998;

- Schedule for Certification of Non-Entitlement to Medicare Benefits—

  3 April 1998, re-executed 3 July 1998; and

- Schedule for Australian Childhood Immunisation Register—3 July 1998 *(although this date falls outside the 1997–1998 financial year).*

The 1997–1998 Performance Report also noted a delay in finalising the Output Pricing Agreement and a delay in the commencement of work on the Schedules for Medicare and the PBS.

**3.10** The 1998–1999 Performance Report indicates that the following elements of the SPA were formally executed during that year:

- Output Pricing Agreement—14 December 1998;
- Legislation, Cabinet and Budget Protocols—4 December 1998;
- Schedule for Hearing Services Claim Payment System—25 June 1998 *(although this date falls outside the 1998–1999 financial year);* and
- Amended version of the Schedule for General Practice Immunisation Incentives Program—30 December 1998.

The 1998–1999 Performance Report acknowledges that Schedules were still to be developed for the two largest programs under the SPA—Medicare and the PBS.

**3.11** The 1999–2000 Performance Report indicates that the following element of the SPA was formally executed during that year:

- Schedule for PBS—December 1999.

That Performance Report also noted that the Output Pricing Agreement (OPA) expired on 30 June 2000 and that negotiation on a replacement agreement was not finalised by the due date. The Committee agreed that the terms and conditions of the first OPA would continue to apply until the second OPA was finalised.

**3.12** The 2000–2001 Performance Report indicates that the following elements of the SPA were formally executed during that year:

- Schedule for Rural Retention Program—July 2000;
- Schedule for Australian Organ Donor Register—December 2000;
- Schedule for Vietnam Veterans' Children Support Program—April 2001;
- Schedule for the 30 per cent Rebate on Private Health Insurance—April 2001; and
- OPA2—introduced from 1 July 2000.

**3.13** At the time of conducting this audit the Schedule for the Medicare program, required by the SPA Head Agreement, had not yet been finalised. The most recent draft of a proposed Schedule was dated 9 June 1999 and was still subject to negotiation between relevant staff in Health and HIC.

**3.14** The ANAO recognises that HIC has been responsible for the administration of the Medicare program since 1984, and that the program and systems developed and employed by HIC over that time might reasonably be considered mature and robust. ANAO understands that, at the time of executing the SPA Head Agreement in 1998, both agencies might well have been satisfied with the administration of the Medicare program at that time.

**3.15** Notwithstanding, the absence of a formally executed Schedule, relating to the Medicare program, reduces the overall value of the Strategic Partnership Agreement. Given the significance of the Medicare program to both organisations and to the Government, and considering the monetary value of administered expenses in respect of Medicare, the finalisation of a Schedule for Medicare should be given priority by both agencies.

**3.16** The ANAO found that the Term of the Schedule for PBS had expired on 30 June 2000, and that the Schedule had not yet been formally renewed as at March 2002. The ANAO notes that the Schedule for PBS continued to operate beyond the documented expiry date.

**3.17** The ANAO is aware that the Health-HIC Management Committee noted, at its 9 February 2001 meeting, work recently undertaken by staff reviewing existing Schedules and developing new Schedules. The Management Committee should pursue the completion of work already under way, and should employ the results of this work during the implementation of the following recommendation.

## Recommendation No. 2

**3.18** The ANAO recommends that Health and HIC:

- finalise and execute a SPA Schedule for the Medicare program; and
- review and renew the current SPA Schedule for PBS.

*Joint Health-HIC Response:* Agreed. HIC and Health are currently working on procedures for the development of new and maintenance of existing Schedules. This includes a Schedule template with standard clauses and format. HIC and Health will also be reviewing and updating all existing Schedules over the next six months to reflect as appropriate the standard clauses and format developed, as well as make changes to content. This will include developing an MBS Schedule and reviewing the PBS Schedule as recommended.

## Benchmarking

**3.19** The SPA Head Agreement commits HIC and Health to internal and external benchmarking of programs, under the direction of the Management Committee, but with the majority of the work to be coordinated by HIC. The Head Agreement deals with the issue of HIC and Health operating within an environment of increasing contestability of services, and contains the following entry:

> HIC and the Department recognise the importance of demonstrating publicly that value for money is being obtained for services which are not contested. HIC agrees to develop activity based costing for all programs and services to demonstrate the cost of programs and services, and to undertake internal and external benchmarking of programs. … Under the direction of the Management Committee, HIC and the Department will agree on mechanisms and timeframes for the sharing of costing information and the internal and external benchmarking of programs.

### Audit findings

**3.20** The ANAO reviewed the minutes of Management Committee meetings and interviewed staff in both organisations regarding the matter of benchmarking. The February 2000 meeting of the Management Committee was advised that a report of a benchmarking scoping study, undertaken by an external management consultancy firm, had been finalised but that the report indicated that benchmarking many of HIC's activities would be difficult. The ANAO was informed that this view was essentially accepted by HIC and Health—i.e., that benchmarking HIC's program delivery activities would be difficult and the outputs of any such benchmarking would likely be of limited value in comparison to the resources required for the task.

**3.21** The SPA Head Agreement notes that while it may not be appropriate to benchmark entire programs, it may be possible to market test certain elements of programs such as card production, printing, advertising and distribution activities. It also envisages comparing HIC's costs with those of other service providers—presumably Commonwealth Government service providers.

**3.22** The ANAO recognises that some of the activities mentioned above, such as card production and advertising, are currently outsourced by HIC. As such, market testing is conducted as each contract is offered for tender. ANAO also recognises that HIC has benchmarked a range of corporate support services, such as human resource management and information technology (also outsourced). These corporate support services contribute to the total overhead costs of the organisation, which are recovered in the full cost model established by the OPA. Nevertheless, benchmarking key process elements and service

delivery procedures has the potential to provide HIC with additional insights and information that could be used to enhance the efficiency of HIC's current processes.

**3.23** HIC has alerted the ANAO to the fact that the organisation has recently embarked upon a Business Improvement Program (BIP), which is likely to involve a major re-engineering of many of HIC's business processes. Furthermore, HIC has suggested that it would be inappropriate to commence an external benchmarking program at this time, given that many business processes will be modified over the next three to four years.

**3.24** Taking into consideration the matters of timing and cost associated with benchmarking, ANAO considers that the type of benchmarking envisaged in the SPA Head Agreement[28] remains a relevant and important issue for the Health-HIC Management Committee to pursue. ANAO also recognises that benchmarking HIC's service delivery processes might prove more valuable to the partnership, if conducted toward the end of HIC's BIP.

## Recommendation No. 3

**3.25** The ANAO recommends that, consistent with the SPA Head Agreement, and in concert with the HIC's Business Improvement Program, Health and HIC reconsider a program of external benchmarking for a range of HIC's program elements and services delivered under the SPA.

*Joint Health-HIC Response:* Agreed. We note that HIC regularly undertakes benchmarking of its activities and has market tested a number of key processes and support elements as part of outsourcing arrangements. Health and HIC will continue to monitor opportunities for benchmarking its processes as the Business Improvement Program progresses.

*ANAO comment:* To ensure clarity when interpreting this recommendation, ANAO makes the distinction between benchmarking corporate support activities, which is noted above—and benchmarking key service delivery processes—which the recommendation calls for.

## Annual Performance Report

**3.26** Another function of the Management Committee is to oversee performance monitoring requirements, including the preparation of an annual—*Performance Report.* The Performance Report is to cover each organisation's performance under the obligations of the Head Agreement, the Protocols and Schedules, over the preceding financial year.

[28] Concentrating on service delivery activities rather than corporate support activities.

**3.27** The Head Agreement sets particular requirements in relation to the Performance Report[29]. The report is to be prepared within three months of the end of the financial year and it is to be referred through the Management Committee to the Secretary of Health and Managing Director of HIC by 30 September of each year.

### Audit findings

**3.28** Documents provided to ANAO indicated that the Performance Report for 1997–1998 was finalised on 1 October 1998; that for 1998–1999 on 12 May 2000; that for 1999–2000 on 6 August 2001; and that for 2000–2001 on 28 March 2002.

**3.29** Therefore, the ANAO found that none of the four Performance Reports met the 30 September target date, although the first—that for 1997–1998—exceeded the target by only one day. The 1999–2000 Performance Report was finalised almost a full year after the target date.

**3.30** The first Performance Report acknowledged that it essentially represented a progress report on the implementation of the SPA and reflected the fact that, at that stage, the SPA Head Agreement had been in place for a relatively short period of time. Subsequent Performance Reports employed a relatively consistent format, comprising an Executive Summary, information and commentary on the operation of the agreement, a financial statement and information and commentary on each of the major programs delivered under the SPA.

**3.31** Rather than offer a recommendation in relation to the timing of the Performance Reports, ANAO suggests that the Management Committee consider whether or not the 30 September deadline mentioned in the SPA Head Agreement is both desirable and achievable. If it is decided to inform the Secretary of Health and the Managing Director of HIC of the operation of the SPA by 30 September each year, the Management Committee should then consider developing a reliable mechanism to ensure the timely production of the annual Performance Report.

## Dispute resolution

**3.32** The SPA Head Agreement also outlines a role for the Management Committee in the resolution of disputes, should any such disputes not be resolved informally, or at the program manager level.

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[29] Clause 10.2 of the SPA Head Agreement outlines the requirements in relation to the production of the annual Performance Report.

**3.33** The 1998–1999 Performance Report illustrated a number of contentious issues considered by the Committee during that year and indicated an active involvement by the Committee to assist in resolving these as follows:

> The challenge for the SPA Management Committee in the year ahead is to come up with innovative ways to tackle these problems, identify possible solutions and seek sponsorship from the CEOs in support.[30]

**3.34** The most recent Performance Report recognises that:

> Designing, developing and implementing new work, such as Budget measures or significant changes to established programs, continues to be a difficult aspect of the partnership. … During the year HIC and Health drafted a New Business Protocol designed to address some of these difficulties and to formalise our joint approach to new business development. Consultation on the Protocol will continue during 2001–02.[31]

## Audit findings

**3.35** ANAO found that the Health-HIC Management Committee has played an effective role in dispute resolution and in the identification of strategic solutions for difficulties encountered in the introduction of new business into the partnership.

## Conclusion

**3.36** The SPA establishes a joint Management Committee to oversee the operation of the SPA and to report on each agency's performance annually. ANAO concluded that the Health-HIC Management Committee fulfilled a key role in the Health-HIC relationship governance framework, and dealt effectively with strategic and major operational issues affecting the relationship.

**3.37** ANAO also concluded that the review and maintenance of SPA documentation could be improved. The Health-HIC Management Committee should pursue a program of external benchmarking for aspects of HIC's service delivery. ANAO also considered that the annual Performance Report, prepared by the Health-HIC Management Committee, provided a valuable source of performance information for the Secretary of Health and the Managing Director of HIC.

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[30] Performance Report 1998/99 under the Strategic Partnership Agreement between the Health Insurance Commission and the Department of Health and Aged Care, Part 1—Executive Overview.

[31] Performance Report 2000–2001, Strategic Partnership Agreement between the Health Insurance Commission and the Commonwealth (represented by the Department of Health and Aged Care), Executive Summary, under the heading—Working Together.

# 4. Information Exchange and Use

*This chapter analyses the manner in which information and data are exchanged and used by both organisations. The use of program data to inform health policy decisions is discussed along with business performance information and data used to monitor budget expenditure against estimates.*

**4.1** The SPA documents a joint commitment of Health and HIC as follows:

> *Collaboration and openness between the organisations, exhibited by:*
>
> - *a real effort to share relevant information;*
> - *the ready access to, and provision of, information about policy, product design and service delivery processes as required by each organisation to effectively conduct its business ; and*
> - *the ready access to, and provision of, program and financial information and data.*

**4.2** The Schedules to the SPA specify the precise data to be exchanged between HIC and Health for each program. The information falls into three broad categories:

- raw, line item data from the programs[32]—such as Medicare and PBS claims processed by HIC;
- performance information—on business performance, service delivery standards and budget expenditure; and
- notification of changes in policy/operations that will impact on one another's business.

**4.3** As two of the largest population-wide health programs in Australia, Medicare and PBS generate a significant amount of valuable data. Health and HIC have at their disposal an extremely rich data source of medical and commercial significance. HIC creates and maintains data on all Medicare claims and pharmaceutical records processed. Line item data on both programs flows from HIC to Health on a daily basis, along with monthly and quarterly summary reports.[33]

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[32] Line item data refers to the details of individual Medicare claims and PBS benefits processed by HIC. De-identified data (i.e. claimant's personal information removed) is provided by HIC to Health on a daily basis.

[33] While this audit did not include a detailed examination of the quality assurance procedures associated with Medicare and PBS data entry, storage and extraction, it touched lightly on the issues of data validation and integrity. The audit did not involve an assessment of the veracity or reliability of data quality assurance processes—it simply noted that the issue of quality control appeared to be considered by each agency and that some activity was undertaken to internally verify data quality.

**4.4** Performance information includes business performance indicators, permitting an assessment of performance against certain targets such as service level standards and budget. This information is used by HIC for a variety of purposes, including internal monitoring, external and annual reporting.

**4.5** Each category of information is capable of being used by Health and HIC in the achievement of their business objectives. The following sections discuss how the first two categories of information are used and shared between the organisations. The third category of information—notification of changes to existing policy/operations—will be considered in the following chapter, Communication and Consultation.

## Use of program data

**4.6** As the administrator of Medicare and PBS, HIC produces and holds a range of data on all Medicare and PBS benefits processed. However, HIC's legislated role extends beyond a data generation and storage capacity. In accordance with legislation[34], one of HIC's functions is the prevention, detection and investigation of inappropriate practice and fraud.

**4.7** A division within HIC, the Program Review Division (PRD), has primary responsibility for this area and for encouraging appropriate practice through the consistent interpretation of items and policy. The PRD examines provider data for anomalous patterns that may indicate over-servicing, fraud or misapplication of items in the Medicare Benefits Schedule or the Pharmaceutical Benefits Schedule. PRD conducts investigative audits of specific providers that are not, or may not be, complying with legislative requirements.

**4.8** The results of such analyses are conveyed to Health, where appropriate (with due consideration to matters of privacy and the protection of personal information), and may prompt Health to initiate a review of the relevant policy framework, for example, a review of individual items or group of related items in the Medicare Benefits Schedule.

**4.9** HIC also analyses line item data to identify changes in claiming patterns and/or frequencies, across States and particular postcode regions. This analysis assists HIC to better target service delivery and to consider the most appropriate service delivery channel mix for particular regions or service types.

**4.10** Health uses de-identified line item data to:

- monitor the implementation of programs to ensure they are consistent with government policy;

[34] *Health Insurance Act 1973*, *Health Insurance Commission Act 1973* (Part IID: Investigative Powers of HIC) and Regulation 3 of the *Health Insurance Commission Regulations.*

- stimulate debate with the medical profession and other industry stakeholders that may lead to health policy development and review;
- formulate Budget estimates and review expenditure relative to Budget; and
- inform program administration, in particular, in relation to maintaining the Medicare and Pharmaceutical Benefits Schedules.

**4.11** Most of the Medicare data is provided directly to the Medicare Estimates and Statistics section of the Financing and Analysis Branch of Health. Subsequent analysis produces a number of reports that are distributed to relevant policy areas and the department's Executive.

**4.12** Some examples of the regular reports include:

- monthly briefing to Executive on performance against budget;
- individual reports to departmental areas on items bulkbilled by service type/State/month; and
- statistical reports to Committees.

**4.13** The Pharmaceutical Access and Quality Branch (PAQB) in Health receives de-identified PBS line item data on a daily basis from HIC. PAQB aggregates and analyses this PBS data and disseminates the results to policy areas within Health. A monthly report on PBS expenditure trends is produced for the department's Executive and appropriate Branch staff. In addition to the internal reports generated from HIC data, Health produces publications for external readers: for example, the quarterly Medicare Statistics and Expenditure and Prescriptions PBS publications.

**4.14** Reports generated by Health, from HIC line item data, provide input to a range of consultative committees managed by Health. These include a variety of Medicare Benefits Consultative Committees (MBCC), the Pharmaceutical Benefits Advisory Committee (PBAC), and more specialist subcommittees like the Pathology Statistics Committee, MRI Committee, and the Diagnostic Imaging Monitoring Information Group.

**4.15** Within these forums, the data and information analysed by Health are used to validate findings, confirm suspected trends, facilitate discussions with the medical profession and stimulate debate that may lead to policy refinement.

**4.16** Health's Medicare Benefits Branch is primarily responsible for the production of the Medicare Benefits Schedule[35], the book that lists the item

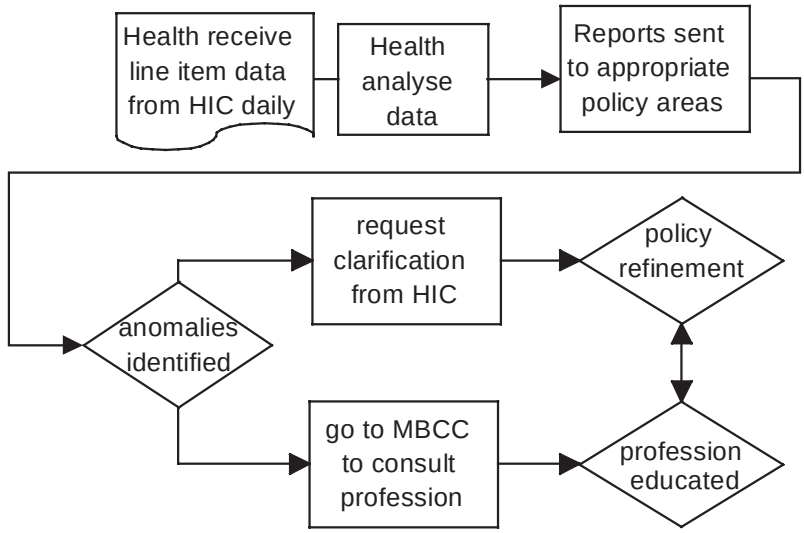
[35] Not to be confused with the Schedule under the SPA, the Medicare Benefits Schedule referred to here arises from the legislative instruments in which Medicare benefit items, item numbers and scheduled fees are detailed (such as the Health Insurance (General Medical Services Table) Regulations 2001).

numbers, item descriptors and scheduled fees for the various medical services that are funded by Medicare. A new edition is published in November each year, with a supplement produced each May. Review of the items in the Schedule is an ongoing process and the Branch utilises the data from HIC to monitor usage patterns of Medicare items.

**4.17** Analysis of the data may reveal irregular statistical trends for a particular Medicare item, such as an unexpected increase in the use of a particular item or group of related items. Health first attempts to clarify matters with HIC, to determine whether a surge or marked decline reflects a genuine change in trend. Health and HIC determine the causal factors behind the change and, depending on the reason behind the irregularity, a review may be initiated. Reviews often lead to the removal, addition or amendment of items and their accompanying descriptors in the Schedule. Health informed ANAO that changes to the Medicare Benefits Schedule are almost always affected on a cost-neutral basis. Figure 7 illustrates this process.

## Figure 7

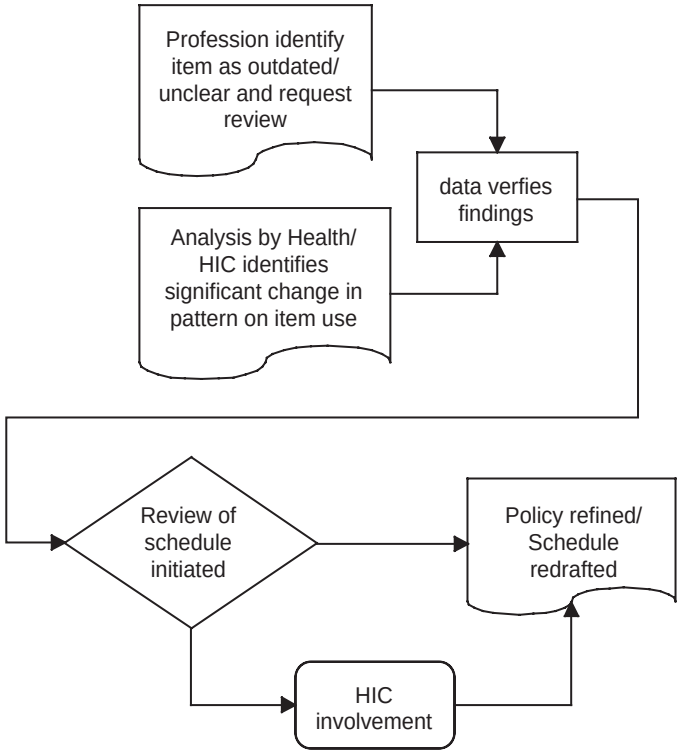
**Data analysis informs Health's policy advice function**




Source: ANAO

**4.18** Figure 8 illustrates how a review of the Medicare Benefits Schedule is often initiated. The ANAO examined a number of instances of recent changes to the Medicare Benefits Schedule in order to test application of this model.

**Figure 8**
**Review of the Medicare Benefits Schedule**




Source: ANAO

## Audit findings

**4.19** The ANAO found that Health effectively uses the line item data, provided by HIC, to inform the department's policy development activities and to support consultation with the medical profession and industry stakeholders.

**4.20** The ANAO found that HIC employs the analysis of line item (program) data to assist in the discharge of its legislative responsibilities for the prevention, detection and investigation of inappropriate practice and fraud. Further, the ANAO found that HIC employs the analysis of program data to better inform decisions about its service delivery mechanisms.

**4.21** The following case study illustrates how Health's analysis of HIC's data assists in health policy development and refinement.

**Case Study 1: Health employs HIC's data in policy development**

**PBS - Improved Monitoring of Entitlements (IME)**

Improved Monitoring of Entitlements (IME) is an initiative that forms part of the PBS program. IME aims to ensure pharmaceutical benefits are provided only to those members of the community who are eligible to receive them. The system operates by using a Medicare number to determine a patient's eligibility for pharmaceutical benefits.

IME operated from January 2001 in a transitional form. It required pharmacists to ask customers, at the time of dispensing a prescription, for their Medicare number and to include this information in the pharmacy's claim to HIC. IME commenced full implementation on 1 May 2002 and thereafter required the mandatory provision of Medicare numbers. HIC payments are subject to the pharmacist providing the patient's Medicare number as part of the pharmacist's claim to HIC, and the number supplied matching the number held by HIC for that patient.

HIC monitors the occurrence and accuracy of Medicare numbers supplied in the PBS claims and provides this information to Health. HIC produces a fortnightly report for Health that summarises the volume of prescriptions accompanied by Medicare numbers, reasons for rejection/warning (often due to a name mismatch) and where special Medicare numbers have been used.

This information is used by Health in discussions with industry stakeholders, to provide evidence of common errors that pharmacists may be making. Health and HIC then formulate strategies to resolve issues of concern: for instance, where a lack of awareness may exist, a re-education or communication campaign may result. Alternatively HIC may conduct an investigation or Health may revise policy to bring about changes in practice. HIC information has assisted the policy development process.

## Use of business performance information

**4.22** As a customer focussed organisation, HIC's public commitment is to make payments as efficiently as possible and to provide accurate and reliable information when it is needed for health decision-making. HIC uses performance information to monitor and measure its business achievements against these targets.

**4.23** A key forum for considering performance within HIC is the Output Review Committee (ORC). ORC is one of four senior management committees in HIC. It meets on a monthly basis to discuss HIC's business performance against a number of indicators including HIC Charter of Care and the indicators specified in the Schedules to the SPA. ORC is chaired by the Deputy Managing Director and comprises all General Managers, all State Managers, the Manager Associate

Government programs, the Manager Health Programs and the National Program Manager.[36]

## Audit findings

**4.24** The ANAO examined a range of reports, which constitute standing agenda items, presented to recent ORC meetings[37]. These included the following documents:

- Reports by output (i.e. program, including Medicare and PBS):
  - — Part one of this report deals with 'deviations from our promised SPA obligations';
  - — Part two relates to financial and volume performance analysis for the previous month; and
  - — Part three discusses business and strategic issues/policy issues.
- ORC Scorecard
  - — The Scorecard reports against four perspectives including customer, financial, staff and internal business and processes. The report details actual performance against targets, the variance, attention required and year-end outlook.
- State scorecard reports against the same four perspectives on a State by State basis.
- Performance against Charter of Care standards.
  - — Presented on a program-by-program basis against targets of payment times/call handling performance. Graphs are used to illustrate historical movements by State and explanations for any deviations accompany the charts.
- National scorecard
  - — A summary of corporate performance against key performance indicators. Charts accompany the tables to show trends over time.

**4.25** The ANAO found that HIC uses information to monitor its performance against a number of business targets. Reports identify actual performance against targets, provide explanations as to why anomalies have occurred and, where appropriate, discuss possible remedial action. Any failure to meet obligations under the SPA is reported on an exception basis.

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[36] HIC Annual Report 2000–01, p. 21.

[37] ANAO examined papers for 24 October 2001, 21 November 2001 and 20 February 2002 ORC meetings.

**4.26** HIC informed the ANAO that significant issues identified at ORC are raised with the Commission's Board and, where appropriate, a dialogue is established with Health. The Board receives monthly reports on corporate performance and the scorecard results are incorporated into the Deputy Managing Director's business report to the Commission's Board. The Secretary of the Department of Health and Ageing is a member of the Board and, as such, receives this performance information.

**4.27** The suite of reports presented to ORC represents a sound basis for reporting organisation-wide performance. The Scorecard's four perspectives of customer, financial, staff and internal business and processes are a useful basis to examine and assess business performance. HIC's capacity to publicly demonstrate accountability for its service delivery standards is also enhanced by use of the Charter of Care measures, which are published in HIC's annual report.

## Monitoring expenditure against Budget estimates

**4.28** Under the SPA, Health has responsibility for developing Budget estimates for Medicare and PBS expenditure.[38] Health involves HIC in this activity, while retaining carriage of the task and negotiating with the Department of Finance and Administration.

**4.29** As previously noted, the statistics area within HIC produces monthly reports for HIC's Output Review Committee. These reports include statistics on volume and cost measures for each of the programs administered by HIC. HIC also provides Health with a range of Medicare and PBS data on a daily basis.

### Audit findings

**4.30** Health aggregates the de-identified line item data for Medicare and PBS, supplied by HIC, to monitor expenditure against Budget estimates. Health analyses statistics on claims processed and reconciles expenditure through the banking system.

**4.31** The Medicare Estimates and Statistics Section of the Financing and Analysis Branch within Health informs the department of Medicare expenditure

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[38] ANAO notes that section 34 of the HIC Act states that *The **Commission** shall prepare budget estimates, in such form as the Minister directs, relating to the Commission's performance of its Medicare function for each financial year …* However, the SPA is an agreement between the Minister and the Commission about the performance of the Commission's function and exercise of its powers, and the OPA states that ***Health** will prepare budget estimates including output volumes in consultation with HIC and Finance.*

patterns. A monthly report titled Medicare Benefits Schedule Item Utilisation—Financial Year to Date Comparisons, is provided to Health's Executive and other relevant staff. That report identifies key areas of change in the number of Medicare services and benefits claimed over the course of the financial year as well as a comparison of expenditure relative to budget.

**4.32** The Special Access and Coordination Section of the Pharmaceutical Access and Quality Branch within Health produces a monthly report on PBS expenditure trends. The report is distributed to members of the Health Executive and other relevant staff. The PBS expenditure report includes:

- Forecast vs Actual expenditure;
- comparison of scripts and government costs—by patient category;
- comparison of scripts and government costs—by major drug group;
- comparison of scripts and government costs—by major drug group and generic drugs; and
- special reports on specific drugs such as Cox II inhibitors, Glivec and Zyban.

**4.33** The report is prepared in conjunction with the Financing and Analysis Branch's Modelling Team. It presents a month-by-month breakdown as well as a cumulative total of PBS expenditure. Comparisons with similar reporting periods for the previous financial year are also included. Statistics on volumes of prescriptions processed and total costs are presented.

## Provisions for reconciling Medicare and PBS expenditure between agencies

**4.34** During the conduct of the audit, ANAO noted that each agency operated an independent system by which it monitored expenditure of administered funds. ANAO observed that Health and HIC compared statistics on the base level data, i.e. the line item Medicare and PBS claim data. For example, they compare aggregate Medicare benefit and volume statistics on a monthly basis. However, ANAO's analysis of annual reports reveals that reconciliation of figures between the two organisations, at a whole of program level, is less than optimal.

**4.35** The OPA envisages a system by which HIC regularly informs Health about administered revenue and expenditure.[39]

> *The HIC will provide Health (Financial Reporting Section) with a financial statement in the format shown at Attachment C:*
>
> *(i) each month, within 10 working days after month end; and*
>
> *(ii) each year, within 30 days after year end, together with a statement from the ANAO that the relevant accounts and records are free from material misstatement.*

## Audit findings

**4.36** The information required by Attachment C of the OPA includes the identification of cash figures, for the month in question and the year-to-date, along with accruals estimates, such as estimates of the value of unpresented cheques, benefits processed but unpaid and a provision for outstanding claims. The form requires this information for each program under the SPA.

**4.37** This system also requires HIC to provide a statement by the ANAO that the relevant accounts and records (supporting the Attachment C) are free from material misstatement. The ANAO is not aware of HIC ever requesting such a statement to be completed. As ANAO currently audits the financial statements for HIC, it is not clear what additional value such a statement would deliver to HIC or Health. Also, if such activity were requested in addition to ANAO's annual financial statement audits, it would normally constitute an 'audit by arrangement'.

**4.38** The ANAO examined the annual reports, published by each agency, for the four years 1997–1998 to 2000–2001. Both agencies report expenditure on Medicare and PBS within their annual reports. ANAO noted, and Health and HIC confirmed, that there are no directly comparable figures disclosed in the Health and HIC financial statements included in annual reports. The format and content of financial statements for annual reports is determined by legislation. Health and HIC prepare financial statements to meet slightly different legislative and government requirements, and where expenditure might be disaggregated in one agency's report, when disclosing cash expenditure against appropriations, it may be aggregated in the other agency's report, when disclosing accrual expenditure.

**4.39** Therefore, while both agencies may have reconciled figures for the expenditure of administered items, it is not clear to the reader of their annual reports that this has occurred. ANAO recognises that both agencies are subject

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[39] OPA Clause 31.

to particular annual reporting requirements and that the preparation of financial statements is governed by legislation. Nevertheless, ANAO encourages Health and HIC to seek opportunities to include comparable or reconciled figures, for expenditure on major programs such as Medicare and PBS, in their annual reports. Health and HIC might consider incorporating such reporting into the body of their annual reports, rather than in their financial statements.

**4.40** Health and HIC advised ANAO that they have recently implemented processes to ensure there are no differences between reported figures that do not arise from different legislative and reporting requirements, or that an explanation of any differences is provided in their annual reports.

## Conclusion

**4.41** The exchange of data on Medicare and PBS programs is of fundamental importance in the Health-HIC SPA. Both organisations utilise the information gleaned from the analysis of program data in the conduct of their business—HIC to monitor service standards and fulfil legislated responsibilities, and Health to inform its policy development and advisory functions. ANAO concluded that business performance information is used more extensively by HIC, while Health focuses on program performance information.

# 5. Consultation and Communication

*This chapter examines the mechanisms established by Health and HIC to foster effective consultation and communication between the agencies.*

**5.1** As partners, Health and HIC have committed to work together to deliver portfolio outcomes. To successfully achieve this, the SPA recognises the importance of a productive and cooperative working relationship between the two organisations. The SPA commits Health and HIC to consult regularly and promptly on matters of mutual interest.

**5.2** Table 1 outlines the consultative arrangements between Health and HIC. A discussion of the operation of these mechanisms follows.

**Table 1**

**Consultative mechanisms established by the SPA**

| Consultation arrangements outlined in SPA | Frequency |
|---|---|
| Top level<br>• Health-HIC Management Committee established as a joint forum for coordination on major policy issues, matters of principle and major operational issues affecting the relationship. | Every 2-3 months |
| Operational level<br>• Protocols<br>  • Outlines consultation in specific operational matters including Cabinet, Budget and Legislation.<br>• Schedules - Program-level<br>  • Outlines consultation in matters including:<br>  - proposed variations to policy or development of new policy;<br>  - involvement in forums including working parties, task forces, consultative committees;<br>  - development and implementation of new work<br>  - encouraging regular working contacts at officer-level. | Ongoing<br>As required |

Source: ANAO summary, drawn from entries throughout the SPA Head Agreement.

## Top-level consultation arrangements

**5.3** The SPA Head Agreement establishes a joint Management Committee[40] as discussed in Chapter Three of this report. This Committee oversees operation of the Agreement as a whole. It operates in conjunction with other joint management/operational committees, including those established to oversee activities described in individual Schedules and Protocols.

## Operational level consultation

### Protocols

**5.4** Three protocols under the SPA outline the agreed procedures for Legislation, Budget and Cabinet consultation. These Protocols provide practical guidance and direction regarding the consultation process.

**5.5** The Budget consultation Protocol documents the consultation process in relation to all budget matters, covering initiatives developed by the department and HIC, and well as providing comment on initiatives from other departments and agencies.

**5.6** The Legislation consultation Protocol documents arrangements for consultation on legislative matters, including administrative functions conferred by the HIC Act, while the Cabinet consultation Protocol documents the guidelines and procedures applying to consultation between Health and HIC on Cabinet matters.

### Audit findings

**5.7** The annual Performance Report for 1999–2000 comments on the application of the Protocols. It notes that, in most cases, the organisations had followed the agreed arrangements and that processes dealing with Cabinet related material ran smoothly. However, consultation on Budget matters was reported as less successful.

**5.8** The ANAO recognises, that in its most recent Budget cycle, Health, with HIC's co-operation, has been working to prepare a joint submission to the Department of Finance and Administration. A joint Health-HIC Budget Information Group has been established to provide for regular consultation on Budget matters.

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[40] Clause 11.2 of the SPA Head Agreement.

## Program level consultation arrangements

**5.9** Consultation arrangements for individual programs are outlined in Schedules. A summary of agreed consultation processes included in the draft Medicare Schedule and the PBS Schedule is at Appendix 2.

**5.10** The ANAO examined evidence of consultation under the following categories:

- policy development activities;
- development and implementation of new work; and
- officer-level communication.

### *Policy development activities*

**5.11** The SPA recognises that it is less than optimal to conduct policy development activities in isolation from the administrative context. Under the SPA Head Agreement,[41] Health is expected to:

> consult with and involve HIC at an early stage to ensure that policies likely to impact on products or services of HIC can be effectively and efficiently implemented by HIC.

**5.12** This process involves providing HIC with relevant and timely information on proposed changes to the Medicare and PBS programs, in order to allow HIC to enhance or redesign its information technology and other systems, prior to implementation.

**5.13** Additionally, HIC is expected to:

> keep the Department regularly informed of any innovations being pursued by HIC in customer service delivery. This includes any changes to services and products which are likely to impact on any policy outcomes or the delivery of programs.

## Audit findings

**5.14** ANAO found that HIC is a regular participant in policy forums, in which it offers input and insight in relation to technical, operational and implementation issues. Representatives from the department, HIC and relevant professional/industry bodies are members of the Medicare Schedule Advisory Committee (MSAC)[42]. A similar arrangement applies in the PBS area, with the peak

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[41] Clause 11.3.7.

[42] The main function of the Medicare Schedule Advisory Committee is to assess the safety and effectiveness of medical services and products prior to listing on the Medicare Benefits Schedule.

consultative groups[43] attended by representatives from both Health and HIC. In addition there are numerous working groups, standing committees and subcommittees with Health-HIC representation, including the Diagnostic Imaging Management Committee and its associated Monitoring Information Group, the Pathology Statistics Committee, the MRI[44] Committee and Better Medication Management System (BMMS) taskforce.

**5.15** ANAO found that both agencies participate in formal consultation with medical industry groups on health policy matters. However, the ANAO found that Health and HIC could benefit from a closer cooperation in the implementation of policy changes. For example, HIC staff expressed a view that HIC often received insufficient notice of project deadlines or were not involved at a sufficiently early stage in discussions with Health about how policy changes might be best implemented. This was seen to create unnecessary difficulties, particularly when the changes were likely to impact directly on HIC's operations. On some occasions, in order for HIC to meet implementation deadlines, a major re-ordering of its work program was required.

**5.16** HIC recognised that, in many cases, Health was required to respond to urgent political imperatives, often arising from Budget announcements, the achievement of which imposed very short timeframes on both agencies. The ANAO understands that the New Business Protocol, currently under development by the Health-HIC Management Committee, will address these issues.

**5.17** Closer cooperation between the organisations is also necessary for HIC and Health to enjoy a shared understanding of the policy and its intended application. For instance, item descriptors in the Medicare Benefits Schedule may be subject to different interpretations by HIC, Health and the medical profession. The following case study illustrates the importance of ensuring an appropriate and ongoing dialogue between policy makers and program administrators.

[43] Such as the Pharmaceutical Benefits Advisory Committee (with HIC as an adviser) and the Agreement Management Committee (for the Third Community Pharmacy Agreement).

[44] Magnetic Resonance Imaging.

***Case Study 2: The importance of communication***

**Interpretation of particular item descriptors in the Medicare Benefits Schedule**

In the second half of 2001, HIC noted an anomaly in *chemotherapy device access* item use in one State and, based on its interpretation of the various item descriptors, placed a restriction on the payment of the benefit. HIC has the authority to place such restrictions on item use in order to arrest apparent leakage of Medicare funds associated with inappropriate use. In this case HIC did not notify Health of the restrictions imposed. HIC and Health held different interpretations of the item descriptors, specifically in relation to the use of the subject items in connection with other items.

Practitioners subsequently lodged a series of complaints with Health. Health then advised HIC to remove the restriction, pending determination of the matter following consultation with the profession. HIC expressed the view that, often, such consultations take considerable time and that, in the interim, HIC is unable to arrest the flow of Medicare funds and that recovery of benefits cannot be sought for retrospective determinations.

As a matter of course, HIC now consults Health before placing such restrictions on Medicare item use. This process enables Health to clarify the interpretation of an item by reviewing documentation relating to the initial industry consultation and subsequent definition of the item.

**5.18** The above example is one of a number of matters to do with day-to-day administration of the Medicare Schedule, now addressed through a recently established, Health-HIC monthly liaison meeting. The group is coordinated by the Medicare Benefits Branch in Health. The group deals in a systematic manner with queries about the Medicare Benefits Schedule, and in particular with clarification of the interpretation of item descriptors and their applicability.

**5.19** Similarly, with regard to the PBS program, regular meetings between the Assistant Secretaries and /or Managers of PBS branches[45] in Health and HIC are conducted every six weeks, with the intent of ensuring effective communication on matters of importance to either (and therefore both) organisation(s).

[45] There are three branches: Pharmaceutical Benefits, Pharmaceutical Access and Quality and the Better Medication Management System taskforce.

### *Introduction of new work*

**5.20** An example of successful communication in the introduction of a new program is the Better Medication Management System (BMMS). BMMS is a joint Health-HIC project announced in the May 2000 Budget. BMMS aims to create a new electronic patient medication record that lists prescriptions written by different doctors and/or dispensed by different pharmacists. Patients will be able to obtain copies of their records and authorise access to them by doctors and pharmacists. The system is intended to enable better informed prescribing and supply of medications.

**5.21** BMMS is currently in the trial stage. Health is responsible for policy development, evaluation and stakeholder relations. HIC takes responsibility for administration, building and maintaining a central database and specifying system modifications for third party software vendors. As a separate program to the PBS[46], it is intended that BMMS will eventually be covered by a new Schedule under the SPA.

## Audit findings

**5.22** The ANAO found that, in designing the BMMS, Health and HIC employed an effective communication framework consisting of:

- a BMMS Development Group consisting of general practitioners, pharmacy and consumer stakeholders and government representatives;
- a BMMS Steering Committee. Meetings held monthly, at a senior level (Division Heads, Assistant Secretaries) acting as a decision making body, to discuss critical issues including budget and risk management; and
- numerous working groups and a project team which meet on a weekly basis. These meetings facilitated information sharing and ensured both agencies were kept up-to-date about the proposal.

### *Consultation at officer level*

**5.23** During the course of the audit, ANAO was informed that much of the most useful communication takes place between Health and HIC at officer level. For example, staff in Health and HIC with day-to-day responsibility for specific aspects of the Medicare or PBS program or data production and analysis, indicated that they enjoyed a productive working relationship with their counterpart(s) in the other organisation.

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[46] BMMS is included as a discrete section in the Health-HIC annual Performance Report 2000–2001.

**5.24** While a small number of staff reported to the ANAO that they were unclear about the identity of an appropriate contact point in the other agency, the annual Performance Reports describe a general improvement in the amount and quality of communication between the two organisations.

## Conclusion

**5.25** ANAO found that the SPA establishes an agreed set of procedures aimed at ensuring appropriate communication and consultation between Health and HIC, on matters important to their business and strategic relationship. ANAO concluded that Health and HIC have demonstrated effective communication and consultation on matters of strategic importance to the relationship.

**5.26** Both organisations have recognised the need to focus additional effort in some areas, such as the interpretation of item descriptors in the Medicare Benefits Schedule, and have established operational level consultative mechanisms to achieve improved communications.

**5.27** The Health-HIC Management Committee has recognised that the processes involved in the introduction of new work into the SPA would operate more smoothly if the organisations could refer to a Protocol, such as those employed to ensure effective communication on Budget, Cabinet and legislative matters. ANAO notes that the New Business Protocol has been drafted and should be finalised during 2002–2003.

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Canberra ACT
23 August 2002

P. J. Barrett
Auditor-General

# Appendices

## Appendix 1

# Mechanisms supporting the payment of Medicare and PBS benefits

### *Medicare*

**1.** Claimants may submit a Medicare claim to HIC via:

- a Medicare Office - presenting the claim in person;
- the electronic transmission of bulk-billing claims[47];
- facsimile transmission;
- dedicated telephone booths;
- claiming electronically from doctors' surgeries; or
- mailing the claim to HIC.

**2.** These claims are processed within HIC's common assessing function, which involves validating the Medicare, Provider and Item Fee Numbers against the information contained in HIC's standing data files. Once the claim has been validated, the payment is processed and payment is made. Payments are made in one of three ways: cash from a Medicare Office; electronic funds transfer (EFT); or cheque.

**3.** HIC receives funding from Health for these payments after the payments are presented for collection. At the beginning of each day, HIC's bank accounts stand at zero. EFT payments are made by sending the relevant payment information to the Reserve Bank of Australia (RBA). After the payment has been paid to the relevant bank account, it triggers a reduction in HIC's bank account. At the end of each day, HIC's bank accounts are in a negative balance position. The accounts are then swept back to zero using funds from Health bank accounts.

**4.** Cheque payments are processed and cheques are sent to the claimants (or to the Medicare provider in the case of claims for unpaid accounts). However payment will not be made to HIC until the cheque is presented at the bank for collection. After a cheque has been presented for payment, it will also trigger a reduction in HIC's bank account. At the end of each day, HIC's bank account, which is in a negative position, is swept back to zero using funds from the Health bank account.

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[47] In the process known as bulk-billing, the patient assigns the right to the Medicare benefit to the treating doctor. The doctor then makes the claim and receives the benefit payment from HIC.

**5.** Cash payments are made at Medicare Offices. HIC is funded by Health to make the payments. When a Medicare Office requires cash, a request is made to a security company, which delivers the cash. The cash required is funded from the Branch Office Reimbursement account, which reduces to negative and is swept back to zero by Health at the end of each day.

**PBS**

**6.** PBS benefits are claimed by pharmacies when they lodge their claims either by sending the information on a computer disk or HIC staff manually entering claim details. HIC staff then validate the information by checking it against their standing data files. Once information has been processed the claim is normally paid by an EFT payment. HIC sends the information to the RBA, where payments are made into the relevant bank accounts. After payments are made it triggers a reduction in HIC's bank account. At the end of each day, the bank account is swept back to zero using funds from Health's bank account.

## Appendix 2

# Agreed consultative arrangements for Medicare and PBS

1. Consultation and information-sharing arrangements outlined in the draft SPA Schedule for the **Medicare** program are summarised below.

2. The Department agreed to:

   - consult with HIC about proposed variations to policy or administrative requirements particularly where systems development or changes are required;
   - ask HIC to participate in relevant discussions with the Privacy Commissioner; and
   - invite HIC to be represented on any relevant consultative committees or working parties.

3. HIC agreed to:

   - consult with Health about introducing any significant changes to the MBS program which may affect the delivery of services or alter the costs of operations;
   - provide input to policy matters, if requested by the Department; and
   - provide input to discussion with Privacy Commissioner.

4. The Department and HIC both agreed to:

   - share information and provide assistance to enable each organisation to perform its roles and functions, within the limits of legislation and agreements under which they operate; and
   - consult on Budget, Cabinet and Legislation matters in accordance with agreed procedures as set out in the relevant Protocols.

5. Consultation and information-sharing arrangements outlined in the **PBS** Schedule include the following.

6. The Department agreed to:

   - consult with HIC about variations to policy or administrative requirements for the PBS; and
   - invite HIC to be represented on any relevant consultative committees or working parties.

**7.** HIC agreed to:

- obtain agreement from Health prior to introducing any significant changes to current arrangements which may affect the delivery of services or alter the costs.

**8.** The Department and HIC both agreed to:

- share information to enable each organisation to perform its roles and functions, within the limits of legislation and agreements under which they operate; and
- consult on Budget, Cabinet and Legislation matters in accordance with agreed procedures as set out in the relevant Protocols.

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