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**title** Improving the reporting efficiency for Aboriginal Community  
Controlled Health Organisations: progress over a decade

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## Executive summary

This issues brief examines the evolution of the reporting requirements of Aboriginal Community Controlled Health Organisations (ACCHOs) over the last ten years, with a particular focus on programs funded by the Australian Government Department of Health (the Department). With one exception, the issues brief examines key initiatives implemented by the Department, up to the end of 2013, in an attempt to improve reporting arrangements for ACCHOs. It also examines the impacts of these changes on reporting efficiency. The exception is the Healthy for Life Program. The program is included here because it pioneered Continuous Quality Improvement and outcomes based reporting and as such influenced subsequent reporting developments.

The key initiatives are:

- the Service Development and Reporting Framework (SDRF) (2005 to 2011);
- the Healthy for Life program (2005 and continuing);
- the Indigenous and Rural Health Division (formerly Office for Aboriginal and Torres Strait Islander Health) Risk Assessment Process (2008 to 2013);
- developments in Information Technology and Information Management, with a particular focus on the OCHREStreams web-based reporting tool (2011 and continuing); and
- a multi-year funding agreement (2011 and continuing).

These initiatives have brought about some significant improvements in reporting efficiency, including:

- standardisation of reporting requirements across several programs under the SDRF, with a consequent reduction in reporting complexity and effort and adoption of a more strategic cross-program approach to planning and reporting;
- a shift to outcomes based planning and reporting as part of a continuous quality improvement cycle, and an increase in the data management skills and systems needed to support continuous quality improvement;
- progressive move to independent risk assessment that focused primarily on governance and financial management, which has driven improvements in the quality of financial reporting;
- the development and roll-out of a web-based reporting tool that allows ACCHOs to submit organisational and service activity data, as well as data for national Key Performance Indicators; and
- further standardisation of reporting requirements under the Department's multi-year funding agreement.

Despite these improvements, ACCHOs still face a complex and resource intensive reporting load. Current reporting requirements are discussed in some detail, along with a range of possible improvements that could be made with the aim of avoiding unnecessary reporting yet maintaining information flows for policy and programme design implementation and review supporting the accountability requirements of public funds and supports continuous quality improvement in the sector. These include:

- working with other funders, particularly the states, to coordinate and standardise reporting requirements, with a possible extension of OCHREStreams to enable it to be used by states for some aspects of reporting;

- reviewing the extensive data reporting-related requirements with a view to removing those that are of least value to the Commonwealth and the sector; and
- where formal accountability requirements permit, moving progressively away from reporting on inputs and throughputs in favour of outcomes-based reporting, with possible use of targets and benchmarks to enable organisations to track performance.

The identified improvements provide a framework for continuing to work towards maximising reporting efficiency which will help to address a range of strategic outcomes including the Aboriginal and Torres Strait Islander Health Plan (2013–2023) priorities.

It should be noted that whilst this issues brief references only arrangements until the end of 2013, there have been considerable reporting changes and initiatives since that time.

## Introduction

### Purpose

The purpose of this issues brief is to address the following research question:

How has the reporting efficiency for Aboriginal Community Controlled Health Organisations (ACCHOs) improved as a result of changes made by the Australian Government Department of Health?

In responding to the research question, the issues brief provides contextual information about reporting requirements for ACCHOs, and an overview of work by the Australian Government Department of Health (the Department) in the last 10 years to improve reporting arrangements. It highlights improvements resulting from these initiatives, and discusses ongoing reporting-related challenges that might be amenable to further improvement.

The paper describes reporting requirements up to the end of 2013. The reporting requirements have changed since then.

### What is reporting efficiency?

Meeting reporting and accountability requirements is sometimes referred to as a burden by ACCHO staff. Considerable effort is required by ACCHOs to meet their reporting obligations and staff are sometimes concerned that this effort would be better spent on improving client outcomes.

ACCHOs do acknowledge the need to be accountable to the wider community, funders and Parliaments, and they also see that reporting processes and outputs—data, information, analysis—return real benefits in terms of more targeted service management and planning, and long term strategic planning – all critical to improve service delivery to their clients.

Clearly, a balance is required between reporting effort on the one hand, and the benefits derived from that effort on the other. The evidence obtained in interviews for this report and from a 2013 survey of 21 ACCHOs<sup>1</sup> suggests that the balance is not yet right.

Respondents to the 2013 survey highlighted some of the current challenges. Qualitative analysis of the ACCHO interviews found that they thought that:

- too much effort was invested in managing the volume of reports that funders require;
- there was duplication across reports, particularly between those required by the Australian Government and those required by the states;
- processes were unnecessarily complex and there was an apparent lack of coordination among program administrators; and
- there were problems with the extent of performance and financial reporting, and in some cases the value of it—a concern directed at both Australian Government and state requirements.

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<sup>1</sup> Haynes E, M Holloway, A Boxall, S C Thompson, *Reducing the Burden of Reporting in Aboriginal Health Services: An Assessment of Progress*, June 2013, Deeble Institute and the Combined Universities Centre for Rural Health, University of Western Australia.

In this issues brief, the term ‘reporting efficiency’ is used instead of ‘reporting burden’ and ‘efficiency’ is used in a broader rather than technical sense (and there is no attempt at quantification). The term is used to refer to such things as reducing processing complexity for a given reporting product, or extending with minimal effort the range of reporting outputs for which a given input (data, for example) is used. But the term is also used to capture a sense of greater return on effort such as may be derived, for example, from an increase in the value or benefit to the organisation of a reporting process or output.

An efficiency improvement might thus involve one or more of the following:

- a. less effort required to produce the same reporting outputs (data, information, reports);
- b. fewer or shorter reports; and
- c. reports and underlying data collections that had greater value for the organisations producing them.

### *Scope and method*

The issues brief examines changes to reporting requirements and improvements in reporting efficiency over the last ten years, a timeframe sufficient to capture significant changes to the Department’s approach to accountability. The planning processes used by ACCHOs and their evolution over the last decade are also discussed as these have often had a strong bearing on reporting obligations. Some of the main changes discussed here include:

- streamlining and standardising funding agreements along with their planning and reporting requirements;
- a progressive movement away from paper based reporting to online reporting;
- greater use of IT for information and data management; and
- process and relationship changes as they relate to reporting efficiency.

The issues brief is based primarily on desk-top research focussing on published and unpublished information provided by the Department, program reviews and evaluations, the websites of peak bodies and government agencies, as well as relevant work undertaken by independent researchers. A number of interviews were held with staff involved in the administration of Indigenous health programs in the central and state offices of the Department.

In addition to funding from the Department, the ACCHO sector receives funding from other sources to deliver programs that are not health-related. The paper focuses primarily on reporting as it relates to health programs for which the Department provides funding. However, where information has been available the wider range of Australian Government and state/territory funded programs and their reporting requirements have been considered, though the discussion is illustrative rather than systematic.

Extensive use was made of a compilation of the results of a survey of 21 ACCHOs in all states on the topic of reporting that was undertaken in 2013 by the Deeble Institute and the Combined Universities Centre for Rural Health at the University of Western Australia.<sup>2</sup> The survey and report were commissioned by the Department. ACCHO staff were not consulted in the development of this Brief given the recency of existing data sources.

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<sup>2</sup> Ibid.



### *Structure of the paper*

The remaining sections of this paper are as follows:

- An overview of the ACCHO sector

- Past problems with reporting

- Progress towards more efficient reporting

  - Initiative 1: Service Development and Reporting Framework

  - Initiative 2: Healthy for Life

  - Initiative 3: Risk assessment

  - Initiative 4: Web-based reporting—OCHREStreams

- Reporting requirements for ACCHOs in 2013

- What further improvements could be made?

## An overview of the ACCHO sector

### *Establishment, role and funding*

Aboriginal Community Controlled Health Organisations (ACCHOs) are established under the Corporations (Aboriginal and Torres Strait Islander) Act 1975 (CATSI Act) or the Corporations Act 2001 and, where relevant, equivalent state legislation. They are independent, not-for-profit, corporate entities that operate under the governance of boards of management, and are accountable to the local community and to funders. Their principal purpose is to provide comprehensive primary health care and population health services, but many also provide a range of community and other services. ACCHOs' clients are mainly but not exclusively Aboriginal and/or Torres Strait Islander.

ACCHOs are diverse in terms of their service scope, client base and funding sources. The variation largely reflects differences in the needs and size of the organisations' local Indigenous populations, local service mix, jurisdictional policies, and community and board decisions on service configuration.

In 2012–13 there were around 180 ACCHOs delivering health services in Australia. They operate in all Australian states and territories in very remote communities through to major cities. Total client numbers are difficult to estimate; however, an analysis by the Australian Institute of Health and Welfare (AIHW) of 2012–13 data provided by Indigenous-specific primary health care organisations indicates that the sector provides health services to an estimated 316,000 clients.<sup>3</sup> The client base for all programs (not just primary health care) is significantly larger.

ACCHOs are funded by federal, state and territory and local governments, as well as Non-Government Organisations (NGOs).<sup>4</sup> In 2008, when data on funding from all sources was last systematically collected, governments were by far the majority funder, contributing 99 per cent of total ACCHO funding. The Australian Government provides approximately 80 per cent of total funding, with the states providing 19 per cent and local governments and NGOs the remaining one per cent.<sup>5</sup> The proportion of funding received from different funding organisations varies across ACCHOs.

In 2008, the principal Australian Government funder was the Department of Health; however, other Australian Government departments provide program or project funding for non-health related purposes.<sup>6</sup> With the exception of the one Tasmanian ACCHO, organisations received health funding from state health authorities, and may have also received funding for other purposes from state departments with responsibilities for community services, education, housing and juvenile justice.<sup>7</sup>

According to the most recent systematically collected data on funding from all sources, dating from 2008 or earlier, approximately 71 per cent of total funding is for health purposes, 20 per cent is for

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<sup>3</sup> Australian Institute of Health and Welfare, 2014, *Aboriginal and Torres Strait Islander health organisations: Online Services Report – key result 2012-13s*, Cat. No. IHW 139, Canberra, AIHW, p28.

<sup>4</sup> NGOs that have provided funding to ACCHOs include the Pharmacy Guild, The Menzies School of Research, The George Institute, among others.

<sup>5</sup> Dwyer J, K O'Donnell, J Lavoie, U Marlina, P Sullivan, *The Overburden Report: Contracting for Indigenous Health Services*, 2009, Finders University and Cooperative Research Centre for Aboriginal Health, p32.

<sup>6</sup> These include the Department of Social Services, the Department of Education, Employment and Workplace Relations and the Attorney General's Department, and the Department of the Prime Minister and Cabinet.

<sup>7</sup> Dwyer et al, op cit., pp29-36.

community and social programs, and nine per cent is for information and communications technology and other infrastructure and support services, educational and incentive programs for health workers, or is paid as grants to cover operating costs and management services.<sup>8</sup>

Although the Department is the majority funder for health related purposes, the states, through various government agencies, tend to provide more funding for non-health related purposes.<sup>9</sup> While the states fund many programs in the ACCHO sector, the funding amounts tend to be smaller than those provided by the Australian Government.

There are some instances, for example, in the Northern Territory, where some Australian Government and state health funding to ACCHOs is pooled.

### *Primary health care services provided by ACCHOs*

The Department provides core or base funding for the provision of comprehensive primary health care services under the Primary Health Care (PHC) program. These services comprise clinical services, population health services and health promotion activities.<sup>10</sup>

The PHC program also funds Healthy for Life, Improving Indigenous Access for Health Care Services, Sexual Health, Quality and Accreditation, and Information and Communication/Information Management.

### *Government administration*

Machinery of government changes following the 2013 federal election saw national policy responsibility for Indigenous health move from the Department of Health to the Department of the Prime Minister and Cabinet. However, policy responsibility for Indigenous health programmes such as Primary Health Care, New Directions, Closing the Gap in Chronic Disease and Tackling Indigenous Smoking remained within the Department. Policy for Substance Use and Social and Emotional Wellbeing programmes moved to PM&C.

### *Peak bodies*

The National Aboriginal Community Controlled Health Organisation (NACCHO) and its state affiliates represent individual member ACCHOs. Part funded by the Department, NACCHO and affiliates assist ACCHOs by providing support for accreditation, workforce recruitment, retention and training, initiatives promoting greater access and equity to health care, strengthening information and communication technology infrastructure management (ICT/IM) systems, corporate and clinical governance, and creating smoke-free workplaces. They also play a strong role in advocacy and representing the interests of communities and community organisations.

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<sup>8</sup> Dwyer et al, op cit, p p32.

<sup>9</sup> Ibid, p32.

<sup>10</sup> Clinical health services include: management of diabetes and other chronic illness, shared care for chronic conditions, management of cardiovascular disease, diagnosis and treatment of illness/disease, antenatal shared-care arrangements, and discharge planning between services and hospital and dental care. Population health services and health promotion activities include: child and adult immunisation, child and maternal health programs, well-persons' screening (diabetes, sexually transmitted disease, blood pressure), health promotion (nutrition, immunisation, physical activity, sexual health, blood borne virus, social and emotional well-being, substance use, women's health services, men's health services, harm and injury reduction programs), access to secondary and tertiary health services, client and community assistance, and advocacy on health-related matters.

## Past problems with reporting

Given the multiple funding sources and the wide range of services provided through ACCHOs, it is not surprising that organisations have diverse and complex reporting obligations. Indeed, it has been claimed that ACCHOs are required to be more accountable than other similar sized service providers in the health sector.<sup>11</sup>

In 2004, ACCHOs were funded through a multitude of funding agreements with Australian Government departments, state and territory government departments and other authorities.<sup>12</sup>

Funding agreements from the Australian Government generally covered one financial year. The relatively short term nature of these contracts created funding uncertainty for ACCHOs and meant they had to spend a disproportionate amount of time securing funding for the future. It also made it hard for ACCHOs to plan for the future and to put in place the data and information management systems needed to support performance measurement and reporting.

A decade ago, the reporting problems experienced by ACCHOs were becoming more apparent. Funders, peak bodies and organisations began holding discussions about improving the planning and reporting process, but change was likely to be difficult as there were longstanding inconsistencies in the way funding agreements and their reporting requirements were framed. Some programs funded by the Australian Government and state governments had the same or similar purposes, which meant organisations frequently had to report on the same or similar service domains more than once. In instances where funding was for health programs, there were issues of inconsistency such as different reporting periods and submission dates, different data items and measures, and used different data definitions.

Reporting was mostly paper-based, and neither the sector nor its funders had consistent, integrated approaches to information and data management.

These fragmented reporting arrangements meant that funders could not conduct an evidence-based, whole-of-service analysis of the activities undertaken by ACCHOs, nor could they assess the impacts of their activities on health outcomes. It was difficult for ACCHOs to properly account for funding, and government policy-makers found it difficult to use the information provided by organisations in policy development.

The following section describes key initiatives over the last ten years to the way the Department administers health programs provided by ACCHOs. It focuses on the impacts of these changes on reporting requirements, and in particular on improvements in reporting efficiency.

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<sup>11</sup>Dwyer et al, op cit, p44.

<sup>12</sup> The snapshot of reporting arrangements presented in this section is derived from discussions with Department of Health officers and from Dwyer et al, op cit.

## Progress towards more efficient reporting

### *Initiative 1: Service Development and Reporting Framework*

#### What is it?

The Service Development and Reporting Framework (SDRF)<sup>13</sup> was developed and trialled in 2004. It aimed to:

- improve service planning so that it facilitated a systematic and integrated approach to planning across health programs funded by the then Office of Aboriginal and Torres Strait Islander Health (OATSIH)(now, the Indigenous and Rural Health Division); and
- standardise non-financial program reporting requirements.

The SDRF, which was fully rolled out by 2008, encompassed the OATSIH funded PHC program (as described above).

Once the SDRF was rolled out, the Department's initial emphasis was on helping services do more systematic program planning. After 2008, the emphasis shifted to performance measurement and reporting.

The centrepieces of the SDRF were:

- an Action Plan, which organisations were required to develop annually; and
- a Progress Report against the Action Plan, which was required every six months.

To finalise the Action Plans, ACCHOs typically had to have discussions with contact officers in the Department's state offices, get approval from their board of management and approval from the Department's delegate. After this, the plan was appended to the funding agreement (then called the OATSIH Funding Agreement) as a schedule. Reports against the Action Plan followed a similar trajectory.

Action Plans included financial and non-financial components, both of which were reported on in the six monthly Progress Reports. The financial component was not standardised across all ACCHOs—the minimum requirement was for organisations to submit audited financial statements. The non-financial (or program) component included information on service delivery, management, linkages and coordination, and community involvement for its various comprehensive primary care services.

The Department provided a template for the non-financial or program component (Table 1 below), but it was not mandatory to use it. If ACCHOs chose to use the template it had to be completed for each activity area of the PHC program. ACCHOs had some discretion as to how they grouped various clinical services provided under the PHC program for separate planning and reporting purposes. Some chose to use the template as a high level strategic plan, in which case there was a small number of broad groupings, with a correspondingly smaller reporting load; others chose to use the template to develop a detailed business plan, in which case the reporting load was greater.

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<sup>13</sup> The discussion of the SDRF is derived from the Department's SDRF guidelines, *Action Planning and Reporting: Service Development and Reporting Framework*, 5<sup>th</sup> edition, April 2008, and from interviews with officers of the Department of Health.

**Table 1: SDRF Action Plan template**

1. Area	2. Aim	3. Strategies	4. Measures	5. Timeframe	6. Estimated cost
Service delivery					
Management					
Linkages and coordination					
Community involvement					

ACCHOs could also include non-program elements in the template such as supporting the board, resource management, financial management, and staff development. If they did, it meant they also had to report against them.

ACCHOs were encouraged to develop their own performance measures for non-financial program components included in the Action Plan and to develop the internal systems and processes they needed to collect required data.

The template also required an estimate of the cost of each element included in the Action Plan, the sum of the identified costs of the included elements being the total allocation of funds. The intention was twofold: to inform the Department of how the organisation was distributing its funds, and to encourage organisations to identify activities for which funding was not available, but which might be funded in the future. The latter were to be detailed—and costed—in a separate part of the Action Plan.

In the initial years of the SDRF, the Department provided grants of \$10,000 to help organisations with the costs of preparing Action Plans. These grants, which were intended to support capacity development in planning and information management, ceased in 2007 at the end of the roll out period.<sup>14</sup>

The SDRF ceased in 2011; however Departmental grant officers continued to receive Actions Plans for all programs. In some instances, organisations still report on these Action Plans, for example, Tackling Indigenous Smoking activities. In addition, requirements also remain for some organisations that have a medium or high risk rating to report in a narrative form in a Performance Report.

### What was achieved, what wasn't?

The main achievement of the SDRF was that it standardised planning and reporting processes across OATSIH funded programs by:

- encouraging ACCHOs to carry out integrated program review, planning, and performance assessments;
- reducing the effort required to undertake planning and reporting by bringing together disparate planning and reporting activities under a single framework; and
- increasing the value of performance information generated by linking it to program aims, strategies and resources.

<sup>14</sup>DOHA, 2008, *Action Planning and Reporting: Service Development and Reporting Framework*, 5<sup>th</sup> edition.

Because the template was only used to report against elements of the PHC Program, ACCHOs still had to maintain separate planning and reporting regimes for other Indigenous-specific programs funded by the Department, each of which had its own distinct requirements. These programs included Bringing Them Home, COAG Mental Health Counsellor Positions, Healthy at Home Plus Nurse Home Visits, and Healthy for Life.

In addition, ACCHOs had to separately submit a Service Activity Report (SAR) and the Drug and Alcohol Service Activity Report (DSAR), both of which were required under the OATSIH Funding Agreement.<sup>15</sup> Most programs funded by state governments, particularly those state programs focused on non-health related community needs, also had to be planned and reported separately from the SDRF. However, in some states, collaborative efforts by Aboriginal Health Forums—comprising federal and state officials, peak representatives, and experts in Aboriginal health, health service design, and data management—resulted in state health authorities adopting the SDRF Action Plan and Progress Reports as the vehicles for planning and reporting on state health programs. When they did, it reduced the variability in planning and reporting instruments, and the effort involved in the preparation of reports.

The SDRF is recognised by ACCHOs and funders as making an important contribution to capacity building, particularly in the area of information and data management. ACCHOs valued the opportunity to develop their own indicators for the PHC program elements because it helped build skills and allowed them flexibility to adapt measures to local circumstances, such as data availability. However, the flexibility also had a downside. It created problems for organisations that chose to share data for the purpose of comparing performance. It meant that organisations using different indicators for similar program activities were unable to make any meaningful comparisons. It also significantly reduced the utility of the information for funders because it confined its use to the contract management function at the level of individual organisations.

The flexibility given under the SDRF to develop the Action Plan template as a high level strategic document or as a detailed business plan also had consequences for reporting efficiency—for both ACCHOs and the Department. The more detailed plans required more detailed Progress Reports, so ACCHOs had to put in more effort to prepare them. In the view of some Departmental interviewees, the more highly detailed reports provided more information than was needed for its own accountability and program planning purposes, and the variability between reports made it difficult to obtain a sector wide view.

Financial reporting also remained problematic under the SDRF. Periodic financial statements provided six-monthly by ACCHOs were of variable quality, and the information contained within them was often inconsistent across organisations. In many cases, the transparency of actual financial performance at the program and organisation levels was impaired, not only to funders but to the organisations themselves. The amount of effort and time required of both Departmental contact officers and ACCHOs to arrive at an acceptably transparent, accurate and meaningful product was often considerable.

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<sup>15</sup> The SAR and the DSAR were the means by which organisations contributed to a national data collection on activity (for example, patients seen, occasions of service, operational and clinical and non-clinical staff numbers by PHC service) within the ACCHO sector, and a national collection specifically on throughput and resourcing in ACCHOs for drug and alcohol services.

## Initiative 2: Healthy for Life

### What is it?

The Healthy for Life program (HFL) was announced in the 2005–2006 Federal Budget. It aimed to improve the capacity of Indigenous primary health care organisations to deliver high quality maternal and child health services and chronic disease care. The program—which commenced in 2007 and continues to date—takes a population health approach to improving Indigenous health outcomes. It emphasises the need to assess health impacts and outcomes for the client population, and to plan service delivery to influence these outcomes. It is an evidence-based approach for which data and evaluation are essential elements.

Not all ACCHOs provide HFL; less than one third of ACCHOs are currently funded to deliver it. Nonetheless, HFL is discussed here because it has played a significant role in driving the early uptake of Continuous Quality Improvement (CQI) within the sector and the development of information systems needed to support it.<sup>16</sup> The program is also noteworthy because it was one of the first administered by the Department to move to outcome focused monitoring and reporting. As a 2009 evaluation of the HFL program found:

*“HFL is the first (non-pilot) Program funded by OATSIH that has had a central focus on CQI. It is also the first Program where there has been significant investment in setting up systems and processes to collect and report on health outcome data, taking it beyond service activity reporting”.<sup>17</sup>*

There are around 100 HFL funded indigenous-specific primary health care organisations at 57 sites in urban, regional and remote areas across the country. Approximately 70 per cent of HFL funded organisations are ACCHOs.<sup>18</sup>

At the commencement of the program, with funding from the Department, Menzies School of Health Research, the Australian Institute of Health and Welfare and SRA Information Technology, implemented the Support, Collection, Analysis and Reporting Function (SCARF) of the HFL program, which was hosted by the AIHW to support HFL service delivery and to build capacity in CQI and reporting activities. The SCARF had the following objectives:<sup>19</sup>

- Develop and support a web-based information system, which was to become known as OSCAR, the OATSIH Service Collection Analysis and Reporting tool.
  - Services entered the data onto the OSCAR. These data were transmitted to the AIHW electronically. The AIHW worked with services to improve data quality. Final Individual service level reports were uploaded onto OSCAR where they could be

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<sup>16</sup> It is important to note that CQI initiatives were also being undertaken at the state level at roughly the same time as the national Healthy for Life program was being phased in and that these had a major impact on the uptake of CQI across the Indigenous-specific primary health care sector. For an evaluation of CQI in the Indigenous-specific primary health care sector in the Northern Territory see Allen and Clarke, 2013, *Evaluation of the Northern Territory Continuous Quality Improvement (CQI) Investment Strategy: Summary report*, Department of Health, Canberra. CQI methodologies were also a key feature of the mainstream Primary Health Care Collaboratives Program, which commenced in 2005. For a brief overview see L Farmer, *The National Primary Care Collaboratives Program—Involving consumers in new and innovative service delivery in primary care*, The Australian Health Consumer, Number 3, 2005-2006 <https://www.chf.org.au/pdfs/ahc/ahc-2005-3-primary-care-collaboratives-program.pdf>

<sup>17</sup> URBIS Pty Ltd, 2009, *Evaluation of the Healthy for Life Program: final report*, Canberra, DOHA, p6.

<sup>18</sup> Commonwealth Department of Health website, [www.health.gov.au/healthyforlife](http://www.health.gov.au/healthyforlife) (accessed 13 May 2014). See also AIHW, *ibid*, p6.

<sup>19</sup> This description of SCARF is derived from Australian Institute of Health and Welfare, 2013, *Healthy for Life: results for July 2007-June 2011*, Cat no. IWH 84, Canberra, AIHW, and URBIS, *op cit*, and from URBIS Pty LTD, *op cit*.



accessed by services. In addition, two National reports a year were uploaded on OSCAR (unpublished reports) commencing in June 2007 until June 2010. Three National Summary reports were also made available on OSCAR for periods June 2009, Dec 2009 and June 2010 (also not published reports).

- OSCAR operated between 2007 and 2011 and was superseded by OCHREStreams (discussed below).
- Provide training and support to HFL sites.
  - This involved capacity development to extract, collate and report indicator data, use OSCAR and interpret reports and was led by the Menzies School of Health Research, which established a help desk, and networks of support officers and regional coordinators.
- Refine and develop data and indicator specifications.
  - This component was led by the Australian Institute of Health and Welfare (AIHW), working with a Data Development Reference Group.
  - Undertake analyses of organisations' data and reports. This component was available to participating organisations, the program evaluator and to central users and was managed by the AIHW.

In 2013, the AIHW published a national report containing comprehensive analysis of HFL data over the period 2007–2011.<sup>20</sup>

A range of reporting indicators were developed for HFL organisations. The indicators covered three broad domains:

- service profile—episodes of care, clients, staffing, staff qualifications;
- organisational infrastructure—accreditation, governance, leadership and management (staffing, service operation, QI, community development), information capability (use of information systems, recall systems and training); and
- health priorities—access, services provided and management in relation to maternal health, child health and chronic disease.

In relation to the health priorities, 11 Essential Indicators of outcomes or processes associated with outcomes were developed for HFL reporting. Individual organisations provided qualitative and quantitative data annually for eight of the Essential Indicators and data were collected every six months for three.<sup>21</sup> In May 2010, separate MBS items: Child Health Checks (MBS Item 708) and Adult Health Checks (MBS Item 710) were combined into a single MSB Item (MBS Item 715). This change was subsequently reflected in the Essential Indicators, reducing the number from 11 to 10, seven of which were reported annually.

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<sup>20</sup> AIHW, *ibid.*

<sup>21</sup> These Essential Indicators and their reporting frequencies were: 1. Timing of first antenatal visit (annual), 2. Average birth weight (annual), 3. Low and high birth weight babies (annual), 4. Risk factors identified in during pregnancy (annual), 5. Child health checks (annual), 6. Child immunisation rates (annual), 7. Adult health checks (annual), 8. Chronic disease management plans (annual), 9. HbA1c (Glycosylated haemoglobin) blood tests for clients with Type II diabetes (biannual), 10. Blood pressure tests for clients with type II diabetes (biannual), and 11. Blood pressure tests for clients with coronary heart disease. Source: URBIS Pty Ltd, 2009, *op cit*, Appendix E: Summary of HFL Essential Indicators at June 2008 and December 2008.

In 2008, the Council of Australian Governments agreed to introduce 24 national Key Performance Indicators (nKPIs) for Indigenous-specific primary health care services.<sup>22</sup> The nKPIs were to be developed by the Department in partnership with state and territory health departments, and in cooperation with the AIHW. The period ending 30 June 2011 was the last for which Essential Indicators were collected as the HFL Essential Indicators have now been superseded by the nKPIs. The nKPI indicators were built on the success of the HFL with the initial subset being the same as those implemented for HFL.

### What was achieved, what wasn't?

Many organisations that received HFL funding faced considerable challenges in establishing the skill sets, information systems and data management processes needed to meet the HFL reporting requirements. However, when the program was evaluated, most organisations thought that, on balance, the effort put into capacity building was worth it because it improved knowledge of how to improve health outcomes.

*“Most of the services that are ‘on the other side’ of this data system improvement process now consider themselves to be in a much better position to understand the impact of their activities on the health outcomes of their community, and to make CQI a reality in their service.”<sup>23</sup>*

In relation to the Essential Indicators, the evaluation found that:

*“the HFL Essential Indicator data has already been useful to some sites in their CQI process, and is likely to be increasingly useful to a growing number of sites as the number of sites increases and data quality improves.”<sup>24</sup>*

These evaluation findings were confirmed more recently by the AIHW. Focussing specifically on CQI and the data management practices that underpin it, the AIHW reported that:

*“The Australian Government’s investment in the Healthy for Life program and the SCARF Project provided a significant impetus in the development of health service-level CQI programs designed to improve the quality of care and health outcomes. The Aboriginal and Torres Strait Islander primary health care sector is now a leader in the application of CQI through these initiatives and funding.”<sup>25</sup>*

The main benefits of the CQI process and use of the Essential Indicators, supported by the training and data development elements of SCARF, seem to be that they focused organisations’ effort on collecting data that were linked to outcomes, and were consistent across HFL organisations. This made reporting more valuable to ACCHOs, funders and the wider community. As the AIHW notes:

*“The project provided both the Australian Government and local health services with data that could be used to inform regular cycles of decision-making to improve health service delivery (at both local and national levels), program management and policy, and support health services to build capacity to use the data.”<sup>26</sup>*

The value of the data, and hence the value of ACCHOs’ HFL reports, was further enhanced as data quality improved. This was facilitated in part by OSCAR which had an inbuilt data validator and by the work of the AIHW as data custodian and the Data Reference Group.

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<sup>22</sup> Council of Australian Governments, National Indigenous Reform Agreement, 2008, p F-74.

<sup>23</sup> URBIS Pty Ltd, op cit, p45.

<sup>24</sup> Ibid, p45.

<sup>25</sup> AIHW, op cit, p6.

<sup>26</sup> AIHW, op cit, p6.

OSCAR had built in basic validation checks for many of the Essential Indicators, and alerted organisations to errors in the data as they are entered. AIHW staff performed more detailed data validation, and organisations were provided with interim reports identifying errors and inconsistencies. Health services could recheck the data and make corrections as required.

These significant improvements in reporting efficiency were confined to organisations receiving HFL funding. However HFL-funded ACCHOs were also still required to report on other Australian Government health programs through the SDRF process, and non-health programs through other processes. Some duplication resulted; similar information on service and organisational indicators needed to be submitted twice—once for HFL reports and a second time for the Service Activity Report (SAR).<sup>27</sup> As discussed below, this duplication has since been removed. With the inclusion of a service activity reporting module in OCHREStreams, a web-based reporting tool for performance indicator and activity data, and the cessation of SAR as a separate report, ACCHOs receiving HFL funding now only need to report service activity once.

### *Initiative 3: Risk assessment*

#### **What is it?**

The OATSIH Risk Assessment Process (ORAP) commenced in 2006. It aimed to systematically identify risks to the Australian Government when investing in Aboriginal and Torres Strait Islander health service provision, and to support capacity development in the areas of governance and financial management.

In late 2013, the Department removed the requirement for an on-site risk assessment and adopted a single approach to managing and assessing risk for all grant holders using sources of information already available through current reporting arrangements. The comments below relate mostly to the ORAP before the changes were introduced.

ORAP comprised two elements:

- Risk assessment—the process by which organisations' governance and financial management present risks to the Australian Government are assessed, and
- Risk mitigation and management—the development and implementation of risk mitigation strategies and risk mitigation plans to address risks identified in a risk assessment.

Organisations that received more than \$300,000 a year in funding through an OATSIH funding agreement and were governed by a board were required to undergo a risk assessment.

In the early years of the ORAP, contract managers in state offices carried out risk assessment. It was a desktop process focussing on financial reports and information provided in Service Activity Reports. However, the poor quality of the financial reports in particular gave OATSIH an unreliable view of the level of risk in organisations. To remedy this, on site assessments were instituted and were initially undertaken by departmental officers. More recently, assessments were carried out by independent assessors who used a standard tool—the Risk Assessment Profile Tool (RAPT)—that aligned with the Australian/New Zealand Risk Management Standards ISO 31000: 2009.

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<sup>27</sup> URBIS Pty Ltd, op cit, p45.

The RAPT was an extensive instrument that included standards on management structure; management standards; control, monitoring and reporting; and accountability and financial management. In all, there were 41 indicators across the four standards.

Organisations with ratings of either 'low' or 'medium' risk on all standards were required to have a risk assessment every two years. Those with ratings of 'high' or 'extreme' on one or more of the standards were scheduled to have an assessment every 12 months. There was an option for the Department to require organisations to undertake a risk assessment at any time if something happened that posed risk to the Australian Government—for example, if there was significant unexpected turnover in an organisation's senior management.

A rating of 'medium' on one of the standards triggered a requirement to submit a Risk Mitigation Strategy (RMS). State office contract managers were then responsible for working with the organisation to finalise the strategy and to ensure that organisations made progress in removing the risk.

Organisations rated 'high' and 'extreme' on one or more of the standards were required to submit a Risk Management Plan (RMP)—a more extensive document than the RMS. The RMP was negotiated by the state office contract manager with the organisation and then submitted to the OATSIH Central Office Risk Delegate for review and approval. State office contract managers monitored all RMPs.

### What was achieved, what wasn't?

Under ORAP (pre and post the 2013 changes), organisations were required to put in considerable effort to achieve and maintain the standards, prepare for periodic assessments and complete reporting requirements.

An organisation's reporting load increased with the level of risk identified in its assessment. Those required to use the RMP (those with a rating of high or extreme on one of the standards) needed to report regularly and provide evidence that identified risks were being addressed.

Reporting was less onerous for organisations using the RMS (those with a rating of 'low' and 'medium') as documents were relatively high-level. Where no risk had been identified, compliance with standards for governance and financial management was covered at quarterly discussions with state office contacts.

While the effort required of an organisation to report on risk is broadly aligned to the level of identified risk in the organisation, further refinements have been suggested. Some argue that the trigger for a Risk Management Plan—a rating of 'high' on one of the standards—imposes a reporting obligation that in some instances is disproportionate to the identified problem. Some ACCHOs also argue that the automatic reduction of the term of the funding agreement to one year following a finding of 'high' risk on one standard can be counterproductive because it requires organisations to complete and comply with a RMP, concentrates other reporting requirements into a shorter period of time, and diverts effort into re-establishing a longer funding period.

The ORAP, however, was viewed by many ACCHOs and the Department as delivering benefits in capacity building. The assessment instrument and associated documentation have helped organisations to identify financial management and governance gaps and develop comprehensive plans for improvement. Support services provided by state affiliates to help organisations to set up

risk management processes and practices and to maintain them once they are in place have had a beneficial effect. In many cases potential risks were identified and resolved early, allowing organisations to avoid the expense and effort of formal mitigation and associated reporting.

As noted above, changes in 2013 have seen the removal of on-site assessments using a RAPT and implementation of a department wide standard process. Assessments are now based on information already provided to the Department, resulting in a reduction of effort for organisations and the Department.

#### *Initiative 4: Web based reporting—OCHREStreams*

##### **What is it?**

The Online Community Health Reporting Environment (OCHREStreams) has its origins in a 2008 Council of Australian Governments (COAG) agreement that stipulated “a web-based reporting system be progressively developed and provided to Indigenous primary health care services”.<sup>28</sup> The development of OCHREStreams was funded by the Department of Health, which is the lead agency on the project.

The primary original purpose of OCHREStreams was to collect data from Indigenous primary health care services including ACCHOs for reporting against nKPIs. The key feature of the system was to allow services to automatically extract data from Patient Information Recall Systems (PIRS) using the Pen computer Systems Clinical Audit Tool (PenCAT) to upload to OCHREStreams. OCHREStreams has been progressively enhanced and now performs a range of other functions that help support ACCHOs and other Indigenous primary health care services internal program-related information management needs as well as some external reporting obligations. Extending the scope of OCHREStreams was in partial fulfilment of a 2009 Australian Government commitment to reduce the reporting burden for federally funded Indigenous-specific health organisations, including ACCHOs.

As part of this expansion of scope, OCHREStreams includes an Online Services Report (OSR) module, which allows organisations to submit data and information that for the most part had previously been submitted in paper format through the Service Activity Report (now discontinued). In addition, the OSR collects data previously collected in paper format for the Drug and Alcohol Services Report (DSAR) (also discontinued) and Bringing Them Home collection (discontinued), noting the questions from the three surveys were streamlined in the process.

The OSR module in OCHREStreams collects data in the following categories:

- Organisational profile;
- Clinical services;
- Social and Emotional Wellbeing Program;
- Link Up;
- Standalone substance use;
- Training (if a registered organisation);
- Health Promotion;
- Corporate services and infrastructure;

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<sup>28</sup> Council of Australian Governments, National Indigenous Reform Agreement, 2008, pF-74.

- Advocacy, knowledge and research, policy and planning; and
- Community engagement.

The OCHREStreams project was rolled out in stages, with the following organisations performing key roles in both development and ongoing management:

- The Improvement Foundation was engaged by the Department to project manage the development, and has since operated and managed the website hosting the database and maintains data security on behalf of the Department.<sup>29</sup>
- The AIHW was engaged by the Department to extract nKPI and OSR data from OCHREStreams, perform validation checks and analysis, prepare confidential organisation level reports, which are given to the organisation, and national reports for publication.
- A Technical Working Group was established to advise on the nKPIs data and indicator specification. Its membership included the Department, AIHW, and representatives of state/territory government agencies, NACCHO and Affiliates, the Improvement Foundation and organisations that have well established indicator collections relevant to primary health care.

OCHREStreams reporting commenced in March 2012 with an initial trial collection of indicator data involving 80 organisations funded under the Healthy for Life program. The first live collection was in June 2012 with 90 organisations submitting data for 11 nKPIs, which had replaced the HFL Essential Indicators in 2012. OCHREStreams has since been enhanced to allow reporting of 19 nKPIs from June 2013 and 21 from December 2014. Implementation and reporting of the remaining three indicators is expected to be finalised by December 2015.

OCHREStreams started collecting OSR data in July 2012, with further upgrades released in June 2013 with the introduction of a revised OSR (following a review undertaken in 2012–13), improved functionality and to enable automatic data extraction from organisations' Patient Information Recall Systems (PIRS) to populate some fields. This involved the development of the Pen Computer Systems Clinical Audit tool (PENCAT) (already used to extract data for the nKPIs), to enable organisations to upload information from their PIRS directly to OCHREStreams.

In summary, OCHREStreams:

- enables organisations to electronically lodge nKPI (biannually) and OSR data (annually) required under funding agreements;
- includes functions and tools that can be used locally between reporting times and outside of reporting processes that enable organisations to generate and view a wide range of reports and charts which can be used to initiate/participate in CQI programs, projects and other data quality initiatives; and
- enables organisations to readily analyse the quality, completeness and integrity of their own data and monitor trends over time and in comparison with other services.

### What was achieved, what wasn't?

Uptake of OCHREStreams has been relatively rapid and almost universal.

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<sup>29</sup> The Improvement Foundation is a not-for-profit organisation specialising in quality improvement consultancy and training services.

At the time of writing this issues brief, the nKPI data has been collected for three reporting periods after the initial trial with 80 HFL organisations. Organisations reporting nKPI data include ACCHOs, state and local government organisations, non-government organisations, auspiced organisations and Medicare Locals. The nKPI data for the December 2013 collection was provided by 207 primary health care organisations, and the remainder were organisations with other governance arrangements.

In 2011–2012, 290 out of 292 services (99%) receiving federal funding for Indigenous-specific primary health care, Social and Emotional Wellbeing counselling (Bringing Them Home and Link-up) and Substance Use rehabilitation services provided valid data for the OSR. 98 per cent of services reported by the due date. This was a 60 per cent improvement on previous years (2009–2010 and 2010–2011) when the paper-based report was used. In 2012–2013, all organisations that received federal Indigenous-specific health funding responded to the OSR collection.

The rapid uptake of OCHREStreams strongly suggests that the system is meeting both a need for efficient delivery of data for nKPI and OSR reporting purposes, as well as some of ACCHOs' internal needs. According to those interviewed, the strong response is likely also due in some, if not all, states to the strong support provided by NACCHO and affiliates. It is also due to the initial and ongoing support provided by the Improvement Foundation, the Department and the AIHW in familiarising organisations with the system and its data requirements, and in feeding value added data back to organisations.

State government funders do not currently use OCHREStreams as a means of collecting data for their health programs. ACCHOs must continue to meet their reporting obligations to states through separate processes. At the time of writing, the Department expected consultations to commence in 2014 and anticipated that Indigenous primary health care services funded by states and territories could begin collecting nKPI data using OCHREStreams in the 2014–2015 financial year. If the outcome of the discussions is that the states accept nKPI data as delivered through OCHREStreams as at least partially meeting state reporting requirements, a further reduction in the volume of ACCHOs' reporting load could result.

Data collected through OCHREStreams can also be used in a variety of other ways, making it considerably more valuable to ACCHOs and government. The AIHW uses the nKPI data to prepare analyses and commentary for two reports:

- A report for publication in which performance against each nKPI is analysed separately at the national, state and regional levels. The first report covering the June 2012, December 2012 and June 2013 reporting periods was published in May 2014.
- A report at the organisation level, which is provided to each organisation on a confidential basis.

The public report provides essential information for assessing progress towards 'Closing the Gap' in Indigenous health and as such is useful for policy purposes.

The confidential individual reports compare organisations' nKPI performance with national and state performance outcomes, and provide analyses of organisational factors associated with better health outcomes. As such they provide an essential input to ongoing CQI activities within the organisation. Over time as the number of data points increases and data quality problems are addressed, the value of both the public and the confidential reports will increase.

In addition the AIHW also publishes the Online Services Report, which provides statistical analyses of program and organisational data submitted through the OSR.

### *Initiative 5: Multi-year funding agreements*

#### **What is it?**

On 1 July 2011, the Department commenced the progressive introduction of a new multi-year funding agreement covering all programs funded by OATSIH, now the Indigenous and Rural Health Division (IRHD). Organisations funded under the OATSIH Funding Agreement were transitioned to the new funding agreement as their OATSIH agreement approached expiry.<sup>30</sup>

The standard term (or Project Period) of the new agreement is three years, although the term is reduced to one year if 'high' or 'extreme' risk is identified in a risk assessment. This differs from arrangements under the SDRF where organisations were required to demonstrate their suitability for a three-year term in an application.

Action Planning established under the SDRF is continued under the multi-year funding agreement, but the scope is expanded to include all Indigenous-specific health programs funded by the Department.

To further standardise planning and reporting, organisations do not have as much discretion as they did under the SDRF in determining categories for planning and reporting. The Action Plan template mandates categories (or Business Themes) for planning and requires organisations to provide information at the Business Theme level on aims, core services, strategies, performance measures, timeframe and, for most Business Themes, estimated costs.

The Business Themes are as follows:

- Primary Health Care;
- Child and Maternal Health;
- Closing the Gap in Chronic Disease;
- Substance Use;
- Social and Emotional Well-being;
- Remote Service Delivery; and
- Workforce.

Several of the Business Themes are made up of subthemes. Thus, for example, the Primary Health Care Business Theme comprises:

- Primary Care Base (clinical services);
- ICT/IM (clinical and management IT systems, communications technology);
- Quality and Accreditation;
- Sexual Health; and
- Healthy for Life.

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<sup>30</sup> The discussion of the multi-year funding agreement is based on discussions with officers of the Department of Health, and from *The Funding Agreement Book*, Version 4, 30 June 2013, which is prepared by the Department to provide guidance to departmental contact officers. It is also distributed to funded organisations. The book can be found at: [http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih\\_funding-agreement-book~introduction~overview-fa](http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih_funding-agreement-book~introduction~overview-fa) (accessed on 21 May 2014).



The Action Plan also includes a separate template on organisational management, which requires information on aims, strategies, progress measures, and timeframes for three themes: governance and management, linkages and coordination and community involvement.

Organisations are required to submit Budgets for the Project Period. The Project Period is three years, unless a risk assessment has resulted in a shorter term pending remediation of the risk. Annual updates are required.

In general, the Department requires budgets to include separate budget lines for each Business Theme, unless accountability at the subtheme level is required. Administrative expenditures are to be treated separately from program expenditures, and all income, including income from state governments and other federal departments, is to be included in the Budget, with the Departmental funding separately identified.

Reporting obligations under the multi-year agreement are as follows:

- Organisations funded to provide primary health care services and New Directions: Mothers and Babies services must complete the OSR annually. This requires qualitative and quantitative input for the organisational management element of the Action Plan, and for all of the Business Themes and the majority of the subthemes.
  - Some of the quantitative input is uploaded automatically from organisations' Patient Information and Recall Systems (PIRS).
- Organisations must provide nKPI data bi-annually. The majority of data are extracted automatically.
- Organisations were required to participate in comprehensive quarterly conversations with contract managers in state offices, however this requirement has been reduced since 2013, with the number of conversations based on an assessment of risk, that is, the higher the risk rating the more frequent the conversation. Progress against Business Theme and subtheme service delivery aims and measures is reviewed, as are budget performance and organisational management.
  - The quarterly conversations replace the six monthly Progress Reports required under the SDRF.
- Organisations must report on performance against budget at the quarterly conversations. The budget for the Project Period is updated annually and the update is discussed at the appropriate quarterly conversation.

The quarterly conversations follow a comprehensive checklist. Organisations are not required to prepare a formal report, but are expected to provide the following:

- Action Plan;
- Acquittals;
- Risk Assessment Profile (RAPT);
- Risk Management Plan/ Risk Mitigation Strategy (if applicable);
- Remediation Plan (If applicable); and
- Accreditation/ Certification Certificate (where applicable).

After each quarterly conversation, the Department prepares a detailed report, which is sent to the organisation for CEO and board approval.

### What was achieved, what wasn't?

The multi-year funding agreement takes the standardisation process commenced under the SDRF a few steps further. The scope of Action Plans is greater under the multi-year agreement than under the SDRF, and the range of permissible variation has been reduced through the stipulation of Business Themes and subthemes for planning and program reporting. Organisations benefit from a reduction in the number of separate reporting requirements, and from a greater level of clarity about their planning and reporting obligations. State office contract managers benefit from the increased level of consistency across Action Plans.

Some programs covered by the Action Plan still require separate reports. These are generally new programs funded through recent Budget appropriations that are subject to specific accountability requirements, especially during implementation.

The introduction of quarterly conversations has been received well by many organisations, as it relieves them of the task of preparing lengthy six monthly Progress Reports. However, according to some of those interviewed for this report, other organisations question whether the replacement of six monthly written reports by quarterly conversations amounts to a significant gain in reporting efficiency. An interviewee argued that the effort required to prepare for quarterly conversations is about the same as that required for written six monthly Progress Reports.

Some organisations value the direct contact with state office staff afforded by the quarterly conversations. They claim that contract managers' feedback is more immediate, and that the conversational format allows for an exchange of ideas, and provides an opportunity to discuss local factors that affect service delivery and performance. However, views on this are mixed, with other organisations maintaining that the conversations are too focussed on financial management and on performance as measured by indicators, and do not give due regard to the circumstances in which an organisation operates.

The planning and reporting arrangements under the multi-year agreement have had little effect on organisations' reporting obligations to other funders. As noted earlier, some headway was made through State Indigenous Health Forums to adapt planning and reporting under the SDRF to meet state requirements, and a number of state health authorities adopted the SDRF for some programs, thus reducing to an extent duplication of reporting. However, the momentum for better coordination appears to have been lost with the cessation of the SDRF and the introduction of the multi-year funding agreement with its reliance on quarterly conversations.

State office staff report that the quality of the information in financial reports has improved since the SDRF, and has further improved under the multi-year agreement. This is due in part to the requirements being specified in greater detail under the new funding agreement, but may also reflect increased financial management capabilities resulting from the Risk Assessment Process and its focus on financial management standards.

The Department is moving to a new Standard Funding Agreement, which aims to eliminate multiple individual funding agreements being offered to service providers by using a single set of Terms and Conditions that will be consistently used across the Department.

## Reporting requirements for ACCHOs in 2013

The following table (Table 2 below) provides an overview of ACCHOs' reporting obligations in 2013. The reporting requirements are divided into four broad groups.

1. Corporate or organisational reporting (blue): As corporations under the CATSI Act or equivalent state legislation, ACCHOs must meet certain statutory reporting obligations. These include audited financial accounts and notifications of such things as changes to statutory office holders. ACCHOs established under the CATSI Act are required to report to the Office of the Registrar of Indigenous Corporations on any changes to board membership and statutory officers. Reports are required annually and can be completed online.  
  
This category also includes organisational-level reporting required by the Department, such as financial reporting, reporting associated with risk management and accreditation, and the Organisational Management element of Action Plans.
2. Program reporting (red): This covers the mandatory Business Themes (discussed in the previous section), which include Primary Health Care and a range of other programs.
3. National Key Performance Indicators (black): All ACCHOs that provide primary health care and New Directions services are required to report data for nKPIs. Reporting is through OCHREStreams.
4. Other agencies' reporting requirements (green): This includes reports required by other federal departments and state government departments and authorities in relation to health, community and social programs. The programs and their reports are not specified here; their number varies between jurisdictions, and in some cases may exceed twenty for a single organisation.<sup>31</sup> This category may also include reporting requirements of NGOs, though the number of ACCHOs receiving funding from NGOs is likely to be very small. As noted above, NGOs provide no more than one per cent of funding (based on a 2009 estimate).

It should be noted that the table represents a maximum reporting requirement. There are many ACCHOs that are not required to report against all of the categories. For example, some ACCHOs do not receive funding from state departments and therefore do not have to meet state reporting requirements. Similarly the majority of organisations have not been found to present a risk to the Australian Government under the risk assessment process; such organisations have no obligation to report against a Risk Management Plan or a Risk Management Strategy.

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<sup>31</sup> Haynes et al, op cit, p6.

**Table 2: Overview of reporting requirements as at December 2013**

	Reporting domain	Reports	Recipient	Frequency
ORGANISATIONAL REPORTING	Statutory obligations	Audited financial statements and if incorporated under the CATSI Act, ORAC report	Incorporating authority	Annual
	Accreditation	Accreditation renewals	Accrediting authority	Annual
		Accreditation status	DOH	Annual
	Risk assessment	Reports against Risk Assessment Strategy or Risk Assessment Plan, depending on risk rating.	DOH	Biennial unless otherwise required
	Organisational profile Registered Training Program Corporate Services / Infrastructure Advocacy, knowledge and research, policy and planning Community Engagement, control and cultural safety	Online Services Report and Quarterly conversations	DOH, AIHW for annual confidential and published reports, through Improvement Foundation	Annual OSR reporting plus Quarterly conversations with contract managers
	Organisational finances	Online Services Report and Quarterly conversations	DOH	Annual
	Organisation management	Online Services Report and Quarterly conversations	DOH	Annual
NKPIs	Outcomes – nKPI	OCHREstreams nKPI submission	AIHW for national reporting	Biannual
PROGRAM REPORTING Business Themes	Primary Health Care Child and Maternal Health Closing the Gap in Chronic Disease Substance Use Social and Emotional Well-being Remote Service Delivery Workforce	Online Services Report, Quarterly conversations, financial reports at Business Theme level, acquittals.	DOH/PM&C	Quarterly conversations (for activity under Business Themes); Biannual financial reporting; Annual acquittals.
OTHER AGENCIES	Non-health federal programs	Various	Various	Depends on funding agreement
	State government health program	Various	Various	Depends on funding agreement
	State government non-health programs	Various	Various	Depends on funding agreement

## What further improvements could be made?

The 2013 survey of Aboriginal Community Controlled Health Organisations conducted by the Combined Universities Centre for Rural Health as part of the Centre's inquiry into reporting efficiency revealed that ACCHOs staff and managers felt that further improvements in reporting efficiency could be made. At the same time, survey respondents were clear that reporting effort is both necessary and in many respects beneficial to organisations.

This section provides an overview of surveyed organisations' views of the benefits of reporting and suggested further improvements, drawn from the 2013 survey and from the research undertaken for this Issues Brief.

### *Organisations' views of the benefits of reporting*

ACCHO staff and managers appreciate the need for accountability to funders, Parliament and the broader community and the value of the secondary uses of the data they generate for research and for statistical analyses of the kind published by the AIHW. They also value the information generated to meet reporting requirements for internal program and business management purposes. In the 2013 survey, respondents reported that reporting and accountability:

- supports the Continuous Quality Improvement cycle;
- helps identify program and service needs and service gaps and thus supports development of short-term action plans at the clinical management and individual level and longer-term strategic planning at the program and organisational levels;
- supports program evaluation by helping to determine whether program goals are being met and reasons for underachievement;
- supports reporting to boards and the community:
  - "Information gained is useful for strategic planning and predictions for the next three years. Some of this information is needed for the board. The Medical Director in particular finds the information of interest in mapping health trends, health changes and emerging disease patterns."<sup>32</sup>
  - "Much of the information collected is used to inform the community of what is being achieved and whether health outcomes are improving or not;"<sup>33</sup>
- can be useful in advocacy:
  - "We share the data with VACCHO—then they can use it to advocate at the national level";<sup>34</sup>
- supports on the job learning about the organisations' service environment; and
- supports staff accountability and helps identify staff training needs by identifying service gaps and shortfalls.

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<sup>32</sup> Haynes at al, op cit, p66.

<sup>33</sup> Ibid, p67.

<sup>34</sup> Ibid, p67.

### Further improvements

Notwithstanding this appreciation of the value of reporting, it is clear from Table 2 above that ACCHOs still manage a large and complex reporting load.

The following discussion identifies some possible further improvements with the aim of avoiding unnecessary reporting yet maintaining information flows for policy and program design and implementation and review, supporting the accountability requirements of public funds and supports continuous quality improvement in the sector. As noted in the introduction, improvement in reporting efficiency can in principle be brought about by one or more of the following:

- a. a reduction in the effort required to produce the same reporting outputs (data, reports),
- b. an increase in the value to organisations of their reporting outputs (data, information, reports),
- c. a reduction in reporting outputs.

The suggested improvements are grouped under these headings.

### Reducing effort for the same outputs

Despite the significant improvements discussed above, respondents to the 2013 survey claimed that they still need to complete “a multiplicity of reports”, many of which require the same or similar data. The multiplicity of reports reflects the multiplicity of funding sources, suggesting an opportunity for efficiencies through better coordination. A reduction in reporting effort may be possible through:

- better coordination between funders of their requirements by making use, for example, of State Indigenous Health Forums, as was done under the SDRF, and
- the adoption by other funders of OCHREStreams, particularly the OSR module, as reporting tool.

Improved coordination between federal and state funders could address the problem reported by ACCHOs of duplication or partial overlap of purpose of some funding streams and the resulting confusion over accountability and duplication of reporting. Where the same or similar data are required for a range of reports for different funders, efficiencies could be achieved by ensuring alignment of reporting periods and submission dates, and adoption of common data definitions where possible.

Survey respondents also claimed that their reporting effort is unnecessarily high because of a lack of clarity around communication lines and responsibilities within departments. Better coordination may be needed at the time reporting requirements are being framed to ensure processes and communication lines are consistent, clear and reduce duplication, and once a reporting requirement has been put in place, to ensure an efficient reporting process for ACCHOs. The optimum time for alignment of reporting periods, submission dates and data definitions is, of course, before reporting requirements have been set.

A challenge with this proposal is that some ACCHOs receive some funding through competitive processes, which comes with particular reporting requirements. In these cases, it would not be equitable to exempt ACCHOs from requirements other organisations must meet as a condition of funding.

Unnecessary effort appears to result from system incompatibilities, with some respondents reporting a need to extract and manipulate data from as many as four separate systems. Such a process often requires resource intensive and error-prone recourse to manual handling of data by way of spread sheets. Addressing such issues can be costly and require long lead times, but the extent of the problem could be scoped in intergovernmental discussions on the broader issue of reporting efficiency.

Reductions in reporting effort could be achieved by ACCHOs subcontracting data management functions, including preparation and submission of required reports, to specialist providers of data management services, as is done in the hospital and other health sectors. Economies for smaller organisations could be achieved through group purchasing of such services. Affiliates could also play a greater role in supporting services with data capability and capacity.

### Increasing the value to organisations of their reporting outputs

Respondents to the 2013 survey felt that:

- performance information should focus more on outcomes and less on inputs and throughputs,
- much of the information they provide is not of great value to funders and their contract managers who appear to be solely focused on financial performance and
- much of the quantitative service activity information they provide is narrowly program-focused and does not afford a clear picture of complex and holistic nature of health issues faced by many clients.

Some respondents also want to see targets and benchmarks included in the reporting process to enable them to track progress against an objective standard.

Moving to targets and benchmarks is a complex policy matter that raises issues of reliable comparability and attribution of responsibility for variations in performance over time and across and within regions. Nonetheless, the respondents' comments do indicate an appetite—perhaps stimulated by the AIHW's value added confidential returns—for high-value, outcomes focussed and service relevant data for both planning and reporting purposes.

That need could at least in part be met through partnership arrangements between organisations in which data resources are pooled and processed into reports covering the areas in which the partner organisations operate, as well as the regular mandatory reports required by funders.

We understand models for this kind of arrangement already exist and could be further explored to assess feasibility of broader roll out of application.

On a more modest level, the value of reporting information could also be increased through feedback that is timelier, better informed of organisations' circumstances, and includes performance comparisons with peer organisations.

Respondents also want more opportunity for narrative reporting. Although this may result in additional effort, provision of narrative information to contextualise quantitative performance outcomes would increase funders' understanding of the circumstances in which health services are provided. An interest in narrative reporting by some organisations needs to be balanced by the burden it would impose on all organisations and by the funder's ability to read and review the

reports and to provide feedback. If funders are not able to adequately respond to these reports, there is no value in their generation.

While some of these options would be desirable, especially outcomes based reporting, attribution to funding is often difficult and the requirements established by the Department must align with overall Government directions in grant management (that is, lighter touch approaches).

### Reducing reporting outputs

The OSR (submitted through OCHREStreams) is a large collection that appears to give a comprehensive and very detailed picture of an organisation and its activity. It is also a collection that expands as new modules are added to enable reporting of recent program elements.

While a review in 2012 led to significant changes in the OSR structure and content (in consultation with the sector), regular reviews could identify items that add least value to funders' understanding of organisations, are not essential for accountability purposes, and are of least value to organisations themselves.

It is, however, acknowledged that the implications of the Australian Government's recently released Indigenous Advancement Strategy for the community controlled Indigenous health sector have yet to play out. Any review of ACCHOs' accountability should be carried out in the context of the expectations that are placed on ACCHOs in the new policy environment. The above recommendations should be considered in light of the impact of the Government's consolidation of programs.