V E R I F E D V E R S I O N

PUBLIC ACCOUNTS AND ESTIMATES COMMITTEE

Inquiry into the Impact on Victorian Government Service Delivery of Changes to National Partnership Agreements

Melbourne — 19 November 2015

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Witnesses

Mr Tom Symondson, Chief Executive Officer, and

Ms Weif Yee, Policy Adviser, Victorian Healthcare Association.

The CHAIR — I declare open the public hearings for the Public Accounts and Estimates Committee inquiry into the impact on Victorian government service delivery of changes to national partnership agreements. All mobile telephones should now be turned to silent. I would like to welcome Mr Tom Symondson, chief executive officer of the Victorian Healthcare Association, and Ms Weif Yee, policy adviser.

All evidence is taken by this committee under the provisions of the Parliamentary Committees Act, it attracts parliamentary privilege and is protected from judicial review. Any comments made outside the hearing, including on social media, are not afforded such privilege. The committee does not require witnesses to be sworn, but questions must be answered fully, accurately and truthfully. Witnesses found to be giving false or misleading evidence may be in contempt of Parliament, and subject to penalty.

All evidence given today is being recorded by Hansard. You will be provided with proof versions of the transcript for verification as soon as it is available. Verified transcripts, any PowerPoint presentations and hand-outs will be placed on the committee's website as soon as possible. Witness advisers may approach the table during the hearing to provide information to the witnesses if requested, by leave of myself. However, written communication to witnesses can only be provided via officers of the PAEC secretariat. Members of the public gallery cannot participate in the committee's proceedings in any way.

I would now like give the witness the opportunity to make a very brief opening statement of no more than 10 minutes. This will be followed by questions from the committee.

Mr SYMONDSON — The national partnership agreements that relate to health have generally stemmed, apart from a few small exceptions, out of the national health reform agreement that was agreed between the states, territories and the commonwealth in 2011. The intention of the national health reform agreement and the NPAs that came out of it was to provide sustainability and certainty of funding to health providers and to the states and territories themselves, because they replaced a system that was felt not to have that sustainability and certainty.

What we have tended to see instead are changes to those national partnership agreements that are generally unilateral and are either seeing funding reduced and terms cut short, or when they are successful, even if they do complete their term, there is no process for replacement of the money that was going into services, and that is even the case where there is evidence that it was doing good — and significant good in some cases. What has eventuated is a situation where a national partnership agreement is no longer seen as certainty or to give confidence to health providers. That is what it was supposed to do.

From the perspective of the health sector, what we would like to see is a true partnership approach where if a partnership is actually signed, it is allowed to serve out its time, and there should be a process, if it is successful, for replacing the funding that flows through that NPA. That is absolutely not what we have seen in a number of fairly high-profile cases. That is our broad view. I am obviously happy to take any questions.

The CHAIR — I bring you back to your submission, and heading 2.6, 'National partnerships for infrastructure and capital improvements', and I note the third dot point, East Grampians Health Service dialysis unit. While clearly a dialysis unit is a very important piece of equipment, I just wonder whether from your perspective, one unit going into one regional health service, an NPA would be an appropriate mechanism to fund that piece of equipment. Do you have any background or context around that or views on that?

Mr SYMONDSON — Interestingly, because of the constitutional implications of the commonwealth directly funding state services, the framework of national partnership agreements has been used to jointly fund projects. Sadly, they are the most successful part of the NPA program, because they tend to work and people tend to agree on them and they tend to see the funding flow. But what that means is that you do see things like the Colac Area Health youth hub, which is a very important project, and the East Grampians Health Services dialysis unit, again a very important project, used under a national partnership agreement because that is the only mechanism that is available. It is a positive thing, but it is a sad indictment that the only national partnership agreements we have complete confidence in are the very small-scale ones that provide capital money that is generally match funded between the state and the commonwealth.

The CHAIR — I will just tease that out a little bit more. From your perspective — leaving aside the dollar sum here — do you think that capital projects tend to lend themselves better to NPAs because you start a process, it is very clear what the unit price of the product will be, there is an agreement in advance that it is

50-50 or two-thirds, one-third or whatever, but it is a one-off payment, it is fixed, it is known, it is defined, people go into it with their eyes open and then they are done, as opposed to some of the more complex arrangements where you have operational expenditure being funded for a period of time, and then there is a question mark as to once that project ends, who picks up the slack, or do you terminate the project?

Mr SYMONDSON — NPAs were designed for the latter — for the more complex arrangements — but what has ended up happening is that because of exactly what you describe, it is easy to measure, there is generally strong agreement up-front that the project is required and both sides say, 'We will put in X amount of dollars', it is a relatively easy agreement to conclude. With more complex arrangements what has ended up happening is that, particularly where governments change or ministers change or whatever happens, people's view of what they are trying to achieve sometimes changes halfway through the NPA. That is what we have seen.

The CHAIR — If I can bring you back to page 1 of your submission, under 'Impact of changes', the final paragraph, you talk about 'successful arrangements should be extended in a manner that allows health services to plan for any changes to their workforce and service provision arrangements', and this is in the context of how you are trying to fund these agreements going forward. Do you have any insights from your perspective, given the limitations of vertical fiscal imbalance, on what you think the preferred or optimum model might be for funding in the future in terms of health services?

Mr SYMONDSON — One of the things that we were pinning quite a lot of hope on was the national health reform agreement, because the increases in funding that were projected from 2017–18 onwards would have gone a long way to reducing the need for these kinds of direct payments. The national partnership agreements that we have seen have generally been put in place in a targeted way, so they are on closing the gap or they are on workforce changes or whatever, because of the inadequacy of the general funding pool.

What we have always advocated for is for the states and the commonwealth to agree on a level of funding that allows health services to do what they need to do. National partnership agreements, whilst it is a positive principle, tend to cover up for a gap in funding elsewhere. So our preferred option would be that a national agreement was reached — we did have one; we now do not have one — which allows for those gaps to be mended and for health service delivery to keep up with demand. This is a fix and it is a way of allowing governments to put money into things that are priorities at the time, but because of the inherent lack of certainty, they are not the best mechanism, and we have seen that play out.

Mr MORRIS — I guess the challenge I am seeing emerge with all this picks up the point you were just making, Tom, that governments change and their priorities change. I do not think anyone on this side of the table would argue that governments should not be able to change priorities when elected, no matter how painful it might be for those whose policies are being set aside, but the related issue of course is how far you go beyond the forward estimates. A lot of the conversation, particularly around health funding, relates to money that was identified beyond the forward estimates, not necessarily in the NPAs but in general terms. I certainly see that as an issue, because in terms of making this framework effective, whether it is reasonable to go beyond the forward estimates period or not, that sort of plays out in terms of particularly the preventive health one, I guess, which was to be extended to 2018 and then a change of policy effectively set that aside. In part as well it could be as a result of the way these agreements are being used as a substitute for an appropriate funding framework, I guess. In terms of the NPs that have been in place and in the context of what I think we all think they should be used for, which is to address specific problems or prove up a theory, are there any that you would say have worked really well?

Mr SYMONDSON — Yes.

Mr MORRIS — And on the converse side, what has been one that has been less than adequate?

Mr SYMONDSON — Of the ones that have worked really well, leaving out whether they had ended early or whatever has happened with them, one in fact that worked spectacularly well was the dental NPA on reducing public waiting lists, because obviously states put a significant amount of their own money into public dental waiting lists, but we are never able to keep up with demand. The national partnership agreement on reducing those public dental waiting lists saw something like a 30 per cent reduction in waiting times. It saw 25 per cent additional people being treated over its term.

Victoria was extremely successful, partly because we have the infrastructure to deliver those kinds of services through our community health services and our rural hospitals and all of those, which other states do not benefit from. We saw waiting times as much as halved and in some places completely disappear. People who had been waiting five years for a public dental appointment were then waiting no time at all; they could be seen the following month. That success was almost stopped in its tracks when that NPA ended, so immediately that money was taken away. We have seen waiting lists return almost to where they were, in fact in some places higher than they were, or longer than they were prior. So there is sort of a double-edged sword on that one.

Another one that was successful but in a less easily quantifiable way was the preventive health NPA. That established Healthy Together Victoria in a number of local government areas across the state. The reason for that partnership agreement, apart from the fact that prevention is important, was to provide an evidence base for prevention actually working. One of the things that is generally thrown at people who advocate preventive health is, 'Where's the evidence?'. Because generally speaking preventive health has a long-term dividend — 10 years later that person who has received that support does not end up in an ED — it is fairly difficult to prove that. So the partnership agreement on prevention was intended to develop an evidence base around behavioural change, which you can measure much more quickly — is this impacting people's behaviour?

That is one that built fantastic partnerships across the state with organisations that would not necessarily previously have seen health as their business. So you saw councils really wholeheartedly supporting preventive health, which is not something we ever expected to see. Certainly five years ago you would not have seen it. The difference between areas that have a Healthy Together Victoria and areas that do not is marked. So those are very successful.

One of the areas that is less successful, or has been less successful, was the NPA on improving public hospital services, which was a large amount of money — it was $821 million for Victoria — but was linked to a set of targets on things like emergency access and times of waiting in emergency departments and for elective surgery, which drove a particular kind of response. This is the old adage that if you measure it, it will do it. What we found with that particular NPA is that it drove states to deliver services in a way that was necessary under the NPA rather than what you might actually do if you were planning the system to do what it needed to do. So you end up with slightly perverse outcomes with that kind of partnership agreement, which is where the commonwealth comes along and says, 'We don't think your emergency waiting times are good enough, so here's some money to change that', but because that is not a development from the hospital level or from the state level — it is something that is done to providers — you tend to find a slightly different response. So those we would say have probably been slightly less successful.

But generally speaking NPAs are successful, and that is why it is so difficult when they either come to an end or there is a renewal that is not enacted or whatever eventuates. Your comment about policy changing is absolutely true — and providers in the health sector deal with that and they are fine with that — but over the long term you only get improvement if you have sustained effort, and probably in health and education that is much more obvious than in other areas. So when you ramp things up, particularly with an expensive and complex workforce like the one in health care, you employ people to spend money. The dental one is a good example: you employ dentists and then the money disappears, you lose them and you cannot get them back again. We actually had a three-month gap between the end of one NPA on dental and the beginning of another one. Three months is more than long enough to lose dentists. We accept the right of governments to change policy, but governments also need to accept that public health provision is not that flexible.

Mr MORRIS — Just briefly on the dental one, it seems to me that if it worked, as it apparently did, then rather than simply extending the agreement, the better approach would be, if you could get policy agreement — and I do not think we need to go into whatever the reasons were that it was not funded — then presumably having proved up the concept, a better vehicle would be ongoing funding rather than renewing every four years, or whatever, an NPA.

Mr SYMONDSON — We would absolutely agree. We all probably accept that NPAs, as I said, are a way of filling a gap. The reality is that for something like dental funding, oral health is one of the most important indicators of someone's overall health, and the people who are eligible for public dental are generally our most vulnerable communities and often people who have not been to a dentist in 10, 15 or 20 years and have really, really serious problems, so we would want to see a funding model that actually allowed for that. But we do not have that, and what tends to happen is we get a little bit of initiative-itis. We sort of say, 'We've got an initiative

that will for three years or for a year and a half provide a boost to public dental services', and then when it ends everybody sort of says that should be mainstreamed now, but nobody has the money or the willingness to do that.

In the dental one — a great example — the money actually caused services to ramp up in a way that caused more people to join the waiting lists, because suddenly they saw that there was the ability to get onto that list and be seen, and then the money went, so now we have got an even more difficult problem than we had prior. Nobody is suggesting that having seen extra people is a bad thing, but what it showed is that that short-termism just does not work in an area like that.

Mr MORRIS — Yes, so you need some either agreed process at the top of the structure or something built into each agreement in terms of — —

Mr SYMONDSON — A trigger.

Mr MORRIS — Where you go at the end of the cheque.

Mr SYMONDSON — Absolutely. If the partnership agreement itself had some sort of description of what would happen afterwards — because they do not tend to have that — that would be very positive. Whilst the NPAs are what we have got, we should make them true and real and build that partnership in a way that does not end up acrimoniously, which is also what happens.

Mr MORRIS — Exactly.

Mr T. SMITH — The Chair has already mentioned the vertical fiscal imbalance and how we have a unique method of funding particularly hospitals in this country. My question goes to whether or not there are other international jurisdictions with a similar constitutional set-up as ours that perhaps do this better, because I think getting to the heart of what we are discussing here today is: were we writing the constitution today, we probably would not fund the health system as it was envisaged that we would 100 years ago. The idea of a public health system did not actually really exist 100 years ago. It is what it is, and the Public Accounts and Estimates Committee of Victoria are not going to change that here today, but if you could give us some insights as to what you have learnt internationally, I would really appreciate that.

Mr SYMONDSON — The first point to make is that there really is not anywhere that has the same constitutional arrangements as us, which makes it very difficult — —

Mr T. SMITH — Canada is similar.

Mr SYMONDSON — It is similar, but the way that they fund health is very different. In Canada what you find is that the provincial ministry of health is fairly hands off. That is the first point. Hospitals are fairly heavily devolved and held very accountable for the way that they spend the money, which is quite different to what we have here, but there has been an ongoing agreement that health will be funded in a way that is relatively transparent. If you take other examples of places like the UK, because there is not a state level of government, what tends to happen is that you have to have a partnership approach between providers because local government provides a lot of what our health system provides here. You end up with a partnership approach that pools money in a way that we find very difficult in Victoria.

I think our international experience has not been fantastically helpful in coming up with an alternative that would work for us, but the best option that we can see is to come up with a formula or a framework that to an extent takes the choice for governments out of where funding sits, because it is based on evidence, it is based on where demand is or it is based on what governments actually want to achieve in terms of outcomes rather than widgets. What we actually have in Australia is an activity-based funding model for our hospitals, so we fund people to do things. We actually need to fund people to achieve outcomes. It is very difficult, but it is something that we should be aiming for. In answer to your question, we have not found another system that would translate really easily without a very significant change in the relationship between states and the federal government, sadly.

Mr MORRIS — A very quick follow-up on that one. Funding outcomes — is there anyone in the world who does that and does it effectively?

Mr SYMONDSON — There are places that do it. There are lots of places that attempt it. Australia attempts at. There are some places that are having greater success. They are generally in northern Europe and in fact the UK, apparently. You are going to have to explain that one.

Ms YEE — The UK has introduced a system which they call best practice tariffs, which aims to bundle best practice of care for vulnerable patients, in particular people with fractured hips, for example, ensuring that the bundle of care that they receive is evidence based according to best practice evidence and is not just about purely medical outcomes but also the provision of care coordination, for example, and ensuring that there is holistic care in that instance.

Mr MORRIS — Thank you; that is useful.

Mr SYMONDSON — They tend to be small scale, because it would be very difficult to do this at a system level, particularly given that we do not actually know what works in terms of measurement. Pilots are important. Trying things is important, and we would advocate for more of that in Victoria, but it is also difficult when most of your funding comes through an activity model.

Mr DIMOPOULOS — On page 4 of your submission, under 'Dental health' it states:

> Regarding the Victorian context, the revised NPA represented an approximate $11 million reduction in commonwealth dental funding to Victoria.

Just as a sense of perspective for us, before that NPA, or before the original NPA, what level of funding was coming to dental health through the commonwealth, whether directly or because the health providers had a bit more sway over the dollar that was provided? I am just trying to understand: the $11 million reduction is off what base? You are obviously talking of the most immediate, previous NPA, but generally in terms of the commonwealth spend on dental health.

Mr SYMONDSON — Prior to the 2014 NPA, funding to public dental, as far as I remember, was not consistent. So this was the first time that there was an allocation of money. There have been partnership agreements and there have been provisions of money from the commonwealth before, but this was the first time that there was a dedicated pool of money of a significant size that was to augment the existing state allocation.

In terms of numbers, I think you were seeing — I do not have the dollars in front of me in terms of what the state amounts are — something like 300 000 patients per year being seen, and the NPA increased that to 400 000 or something in that order, so it is a very significant increase. The $11 million reduction is off the NPA amount of $155 million. What we had expected to see was a continuation of that at its same level. We did not see that. We saw a continuation of that combined with another program at the same amount, so we essentially saw it cut. So $11 million might not sound like very much, and actually it is not that much, because at least we are still getting the NPA itself. We did have that gap between March, when the previous one finished, and July, when the new one was supposed to come into effect, although I understand that the money may not even be flowing yet. It is one thing to see it in budget papers but quite another thing to see it flow. That is a significant sum of money, and it is making a big difference.

Mr DIMOPOULOS — Just a quick follow-up. Thank you for that. I am just thinking that if you are the commonwealth Treasurer and you are looking at the spend that the commonwealth government has given to Victoria for health generally, and the NPAs would be a very small fraction of that, do you have a sense of, over a similar period of time, has the funding generally increased in any other aspect of health through your normal recurrent funding arrangements? Do you know what I mean? We are targeting an area because that is the purpose of this inquiry about NPAs, but you could theoretically have in the same period as the $11 million reduction a $400 million increase in health spend from the commonwealth to Victoria.

Mr SYMONDSON — Yes, and I think that is why dental is important, because dental is not funded through other commonwealth mechanisms because it is not part of Medicare, it is not part of the hospital funding agreement, so — —

Mr DIMOPOULOS — So that $11 million is actually a genuine reduction in dental.

Mr SYMONDSON — It is not a reduction to the overall health spend, because of course that never goes down in dollar terms, even if does in real terms, but to dental that is a specific ring-fence amount. We have a

royal dental hospital in Melbourne which does receive commonwealth funding for its acute services, but in terms of this is mainly community dental provided through community health services and hospitals, that is not funded that way.

Mr D. O'BRIEN — Thank you, Tom. Following up on questions from Mr Smith and Mr Morris, the comment on the first page of your submission that as a minimum NPAs should not be changed unilaterally during their agreed term et cetera, and particularly what Mr Dimopoulos was just talking about regarding public dental services, is the problem with NPAs themselves or is the problem with governments not sticking by the terms? If so, is there a better way of doing the NPAs, or is it better to scrap them and move on with something else?

Mr SYMONDSON — In legal terms NPAs are not a contract, so either party can essentially change, walk away or do whatever it likes, and there is not really a penalty except a political or public opinion penalty or, from our perspective, a community penalty because people cease receiving service. The difficulty is that generally the commonwealth is providing the lion's share of the money in an NPA, so if they walk away, what tends to come back to the state is, 'Well, you should pick it up if you think it is so good', and the state is left picking up a very large proportion. Even with relatively small NPAs, it will still be the lion's share coming from the commonwealth.

How you change that I do not know. What I would like to see is an approach to partnership that actually makes that word mean something. What we have tended to see is not just have NPAs been changed unilaterally but there has been no discussion about what that is going to mean. There has been no approach between a commonwealth minister and a state minister to say, 'We can't afford this anymore', or 'Our priorities have changed. What should we do?'. You just read it in the newspapers, or you find it in the forward estimates of the commonwealth budget, and that leads to the kind of acrimony that we tend to see. It almost makes it easy. Instead of that it would be great to see some sort of conversation take place. That does not happen. The national health reform agreement, whilst it is not strictly speaking an NPA, has all of the hallmarks of an NPA; it is exactly the same. There are a range of views as to why the commonwealth chose to do what it did with the funding formula in the way that it did, maybe to force action from the states or whatever, but it was not something that people expected. It came out of the blue, and it then leaves people running around trying to work out what they are going to do.

From the perspective of a health provider, whilst it is a public health provider, it is very difficult when you are finding yourselves embroiled in a political argument because you are actually working for the government of the day, whoever that is, and you do not want to get yourself in the crossfire; you want to continue to deliver services. A methodology that took some of that stress out of the system would be great. I am afraid I do not know what it would look like because it does ultimately come down to two sovereign governments agreeing to do something and staying the term rather than deciding not to do it halfway through. Governments have that right. We would like to see something that did not result in that.

Mr O'BRIEN — Has there been any evidence either in Victoria or elsewhere that you might be aware of where it has been the state that has unilaterally walked away from it, or is it predominately the commonwealth?

Mr SYMONDSON — I am not aware of any evidence in Victoria — I cannot speak for other states — where states have walked away. As I have pointed out, they are generally providing a smaller amount of the money, so generally it is not going to be in their interests to do so, particularly if you look at some of the big ones. The one I mentioned on health performance was $800 million out of the commonwealth; it was a significant sum. The one on workforce was something like $100 million from the state and $400 million from the commonwealth, so you are generally getting $4, $5, $6 or $7 per dollar invested. It is not sensible for the states to walk away.

Dr CARLING-JENKINS — Thank you very much for coming in today. We really appreciate it. I want to commend you on your submission as well; it was excellent, and it has been extremely helpful for the committee. I just want to follow up on a question around workforce capacity. You have alluded to that under the dentist NPA, and I note that on the first page of your submission you commented that if state and territory governments are not prepared to fill funding gaps, or presumably are not able to fill those gaps, health services are left with little option but to reduce capacity or service delivery. That is a real concern to me, the unstable funding meaning that we are losing qualified health professionals. You mentioned dentists before and that just a three-month gap meant it was extremely difficult. Can you tease that out a little bit more regarding your

concerns around workforce capacity and that long-term impact that you have seen with NPAs finishing, particularly when they finish early as well, and what impact that has had on the Victorian health sector?

Mr SYMONDSON — The easiest one to demonstrate is the dentists because they are not funded through another mechanism. What tends to happen is that public providers see that there is an NPA coming. They have to ramp up. Particularly around dental there is a capital cost. You have to put in more chairs, and a chair cost something like $500 000 because it is not just the chair, it is the room and the clinical systems et cetera. Then they have to recruit a dentist and a hygienist or a dental assistant or whatever else they have to have. If you are in rural or regional Victoria, that is very tough in the first place. Public dentists tend not to be particularly well paid, so it is difficult to recruit into that sector anyway. Sometimes the only way to increase your capacity is to provide vouchers for the private system for people to seek their treatment in a private facility because there simply is not the capacity in the public system to spend the money and deliver that treatment. Private dentists, however, are not particularly interested in peaks and troughs in their capacity, so you see two problems.

When the money stops, if they are private dentists, you can no longer provide the funding for service, and for public dentists you can no longer afford to pay them, so they go very quickly. What we have seen with the NPAs in dental is that even when the commonwealth has said, 'We're going to give you the money, but you're going to have to wait another three months', the state has picked up the tab to ensure that does not happen, but it can only do that for a short period of time without very significantly blowing out its dental budget. The same is true in other, particularly allied health, professions. Because remember if it is nursing or if it is medical, it is funded in a different way. You might find that you have struggled to get a dietitian or a speech therapist into a small rural town, and if the funding mechanism changes you can only afford to pay them two days a week instead of the four, or four and a half or five that you got them there under the pretence of. That makes it difficult for that person to survive, so really at a very human level changes in funding of this nature make it very difficult, firstly, to recruit, and secondly, to retain, staff that you would otherwise just not have because they are not funded adequately through the other mechanisms that the government has.

Dr CARLING-JENKINS — Particularly that problem is in the regional areas, so you are finding people will just pack up and come back into the city where they can get two days a week here and three days a week there?

Mr SYMONDSON — That is exactly right. For some professions in rural Victoria there will only ever be one or two days of work; because of the greater density of services in the city or because of the higher flow through they are able either to get a full-time job in a metro service or they can mix and match. That is much more difficult when the nearest service is 1½ hours or 2 hours away or whatever. We are seeing approaches in rural Victoria where health services are trying to go in partnership and say, 'We will do two days and you can do two days and we have got our full-time or our four day a week job', which is more sustainable.

But it is very difficult to retain those people. When the wages in the first place are not great, a reduction in your hours can have a really material impact. That is why we talk about certainty all the time. It is not just certainty for the provider. The health service as an entity will cope. It will find a way around it, whether it is a reduction in services or whatever. The individuals do not have that option.

Mr MORRIS — One of the issues that emerged on Tuesday, particularly from a couple of departmental secretaries who appeared, related to the issue of increasingly onerous obligations for reporting. We heard that with the very early NPs in 2008 there was little reporting required, but fairly soon afterwards the hurdles were raised, which was viewed by the witnesses on Tuesday as an unnecessary obligation. I am just wondering how that type of issue plays out with your members and whether that has been an issue in terms of passing information up to the state departments to pass on to the feds.

Mr SYMONDSON — It is fair to say that health would be one of the most heavily regulated sectors there is anywhere and public health is the most heavily regulated part of health, and any additional burden is exactly that — it is a burden. There tends to be duplication in the first place, so people are already employing staff just to report, which is not what any of us really want to see. We want to see safe and quality health services, but reporting for its own sake nobody agrees with, or accreditation for its own sake.

With NPAs, the one I mentioned earlier around improving public hospital services where you ended up with targets that potentially drove perverse outcomes, you have got exactly that issue where people are calling on you to report on something in order to get the reward payments or to get the funding full stop, which is indeed onerous, requiring you to set up completely new systems and, potentially, if you are a large service, put in place

new staff just to measure and to record, and then the money disappears. It is absolutely true. The difficulty for the commonwealth of course is that if it is providing money, it wants to ensure that money is being spent on what it wants to achieve. But, again, it does put a bit of a lie behind the partnership word, so we tend to feel on delivery of some NPAs — not all — that the burden of reporting is almost because there is an assumption that we were not going to do the right thing with it or that we were not able to achieve what we said we were able to achieve.

Anything that can streamline that is absolutely something we would want to see, and particularly for health providers where they are already reporting on hundreds of pieces of data to both state and federal and other bodies, and different departments of state and different departments of federal, you do it because you need the money and want to provide the service, but it is not desirable and it does have an impact.

Mr MORRIS — Going back to the commonwealth issue again, the only significant piece of work that we have been able to find that the Australian National Audit Office has done was on a program around homelessness. Four recommendations came out of that report. Three of them were about increasing the level of reporting. Given that we have probably got the ANAO looking at it, the Victorian Auditor-General's Office looking at it, is there any best practice accountability? Obviously it is public money, so we need that transparency and accountability. I guess what I am asking in shorthand is: are you aware of a better way of achieving that accountability without loading up the unnecessary reporting requirement side of it?

Mr SYMONDSON — Speaking very broadly, because I am not aware of a specific piece of work on this, but what we have advocated for is: if you just remove the duplication of reporting, you would go quite a long way to fixing the problem. If you take something like accreditation of hospitals, obviously hospitals have to be accredited because we want to know that they are safe and we want the public to know that their hospital is safe or to pick up if it is not. You are accredited by one accreditor to do your acute health standards, another one on aged care, which will also accredit some of the same things, and you have to report on that. You have got one for your radiography, one for your cancer treatment, one for this, one for that, and they are generally accrediting the specifics of that service delivery, but they are also looking at your governance, looking at your financial models, looking at your back office, looking at all of the things multiple times. The same is true with reporting of data. You tend to find that the state might ask for a piece of data for its own purposes, and then the commonwealth will come along and ask for the same piece of data in a slightly different format with a different form for a different purpose. This is also true within government.

Mr MORRIS — This committee has been guilty of exactly that.

Mr SYMONDSON — And it is very difficult to avoid. However, we have to try. If you are a community health service reporting some data on your company structure — because you are a company — to the federal government through ASIC or the ACNC, the state department will come along and ask you for exactly the same data when they could have gone to ASIC or ACNC or had some sort of MOU or whatever. That is just a tiny example, but if we were aware across each level of government and between levels of government what data was already being collected, I would say that a large proportion of the data requirements that are placed on services when an NPA comes into place were already being collected anyway or they might have been being collected in a slightly different way and we can change that so that they fit their needs.

Nobody is doing that work, because what tends to happen is you get somebody who comes along. They are responsible for the delivery of the NPA in the federal department, and they do not talk to the person in the other department or down the road who is collecting the same data for a different purpose. The state and federal governments are just as guilty as each other on this, and, whilst we accept it is very difficult to fix because these are big bureaucracies, big organisations, the burden ends up not being on governments. It ends up being on that service provider.

Mr MORRIS — Thank you; that is good.

The CHAIR — I would like to thank you, Mr Symondson and Ms Yee, for attending today. There were no questions taken on notice, so we will not be requiring to be in touch with you. Thank you very much for your time and for your insights.

Witnesses withdrew.