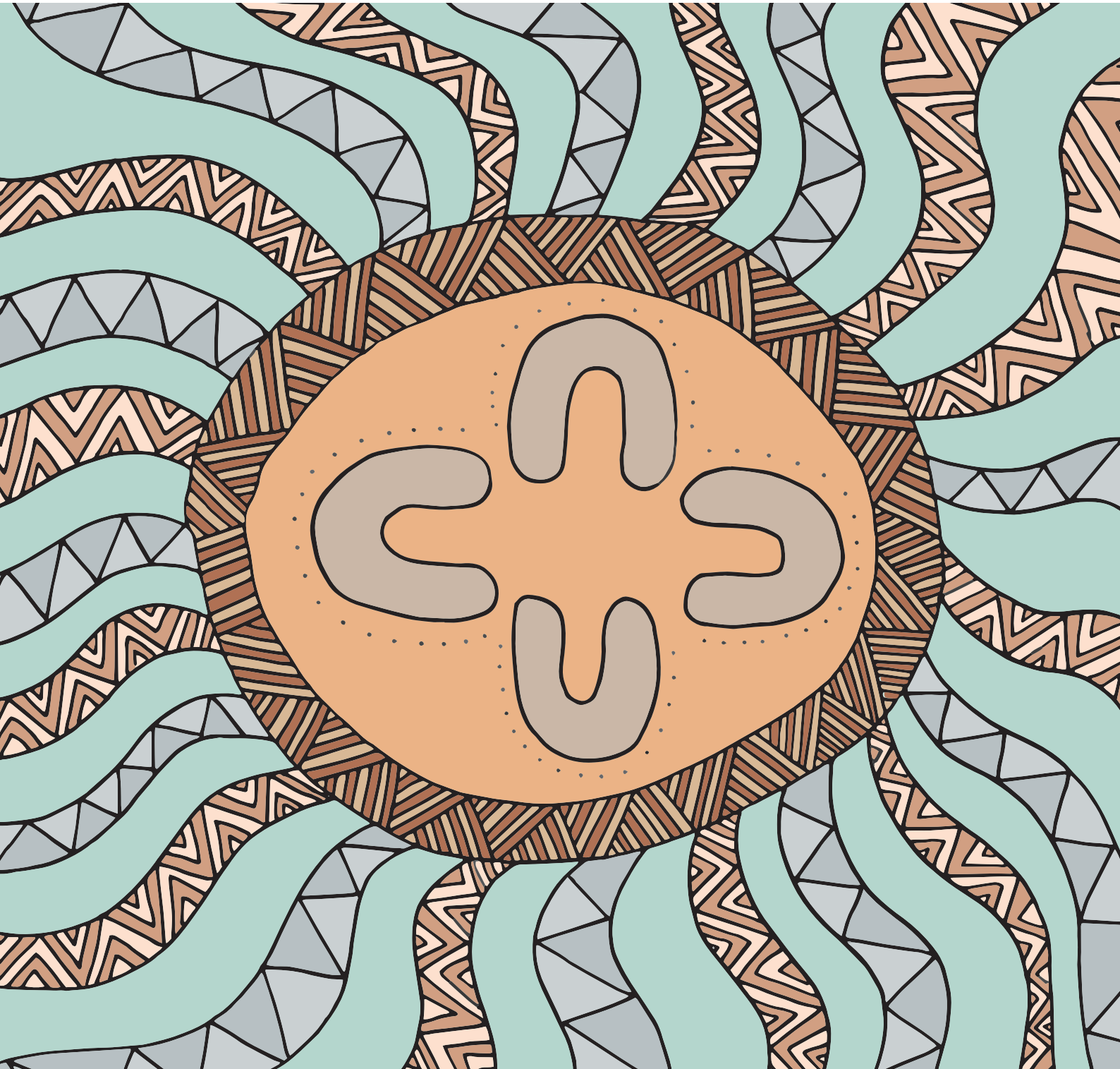


Is Funder Reporting Undermining Service Delivery?

Compliance reporting requirements of Aboriginal Community Controlled Health Organisations in Victoria

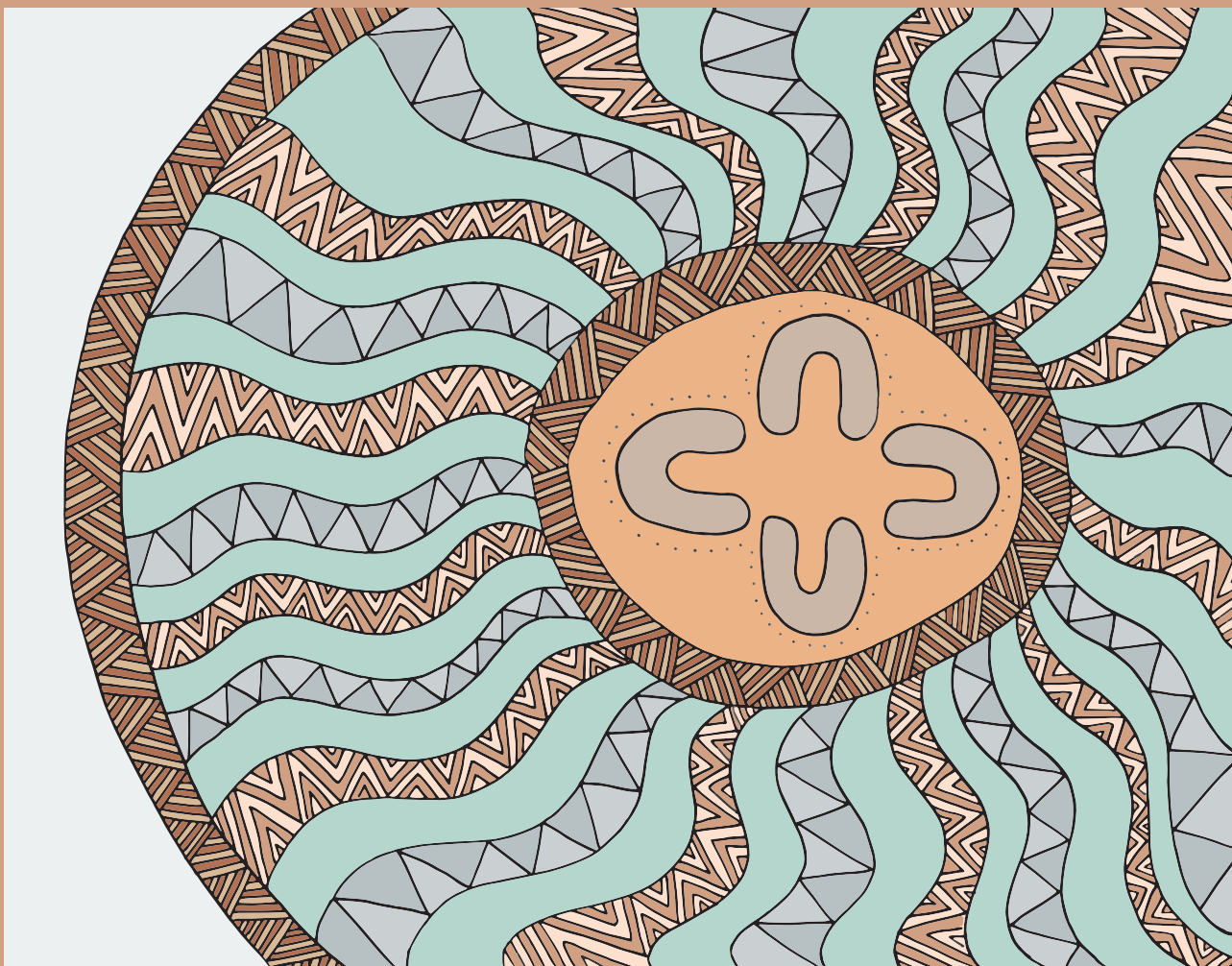
Kate Silburn, Alister Thorpe, Louise Carey, Yola Frank-Gray, Graeme Fletcher, Ken McPhail and Rumbalara Aboriginal Co-operative Ltd



Coming Together

Ms Shakara Montalto (Gunditjmara)

Hand drawn, digitised and coloured artwork



The symbols in the centre circle represent Aboriginal Community Controlled Health Organisations and government coming together in a yarning circle. It is symbolic for coming together, making agreements and building on their relationship to improve outcomes. The swerved lines radiating outward represent the ripple effect that these gatherings will have by impacting the Aboriginal community. The dots around the 'sitting symbol' represent the knowledge that both parties have and share with one another. The brown and blue tones used throughout represent meeting on traditional Aboriginal country, and the surrounding rivers and the oceans.

Is Funder Reporting Undermining Service Delivery?

Compliance reporting requirements of Aboriginal Community Controlled Health Organisations in Victoria

Kate Silburn

Alister Thorpe

Louise Carey

Yola Frank-Gray

Graeme Fletcher

Ken McPhail

and Rumbalara Aboriginal Co-operative Ltd



© The Lowitja Institute, 2016

ISBN: 978-1-921889-49-3

First published March 2016

This work is published and disseminated as part of the activities of the Lowitja Institute, Australia's national institute for Aboriginal and Torres Strait Islander health research, incorporating the Lowitja Institute Aboriginal and Torres Strait Islander Health CRC (Lowitja Institute CRC), a collaborative partnership funded by the Cooperative Research Centre Programme of the Australian Government Department of Industry, Innovation and Science.

This work is copyright. It may be reproduced in whole or in part for study or training purposes, or by Aboriginal and Torres Strait Islander community organisations subject to an acknowledgment of the source and no commercial use or sale. Reproduction for other purposes or by other organisations requires the written permission of the copyright holder.

Both a PDF version and printed copies of this report can be obtained from:

The Lowitja Institute

PO Box 650, Carlton South
Victoria 3053 AUSTRALIA

T: +61 3 8341 5555

F: +61 3 8341 5599

E: admin@lowitja.org.au

W: www.lowitja.org.au

Authors: Ms Kate Silburn (La Trobe University); Mr Alister Thorpe (The University of Melbourne); Ms Louise Carey, Ms Yola Frank-Gray, Mr Graeme Fletcher (VACCHO); Professor Ken McPhail (La Trobe University) and Rumbalara Aboriginal Co-operative

Managing Editor: Cristina Lochert

Editor: Cathy Edmonds

For citation: Silburn, K., Thorpe, A., Carey, L., Frank-Gray, Y., Fletcher, G., McPhail, K. and Rumbalara Aboriginal Co-operative 2016, *Is Funder Reporting Undermining Service Delivery? Compliance reporting requirements of Aboriginal Community Controlled Health Organisations in Victoria*, The Lowitja Institute, Melbourne.

Design and Layout: Carbon Media



Australian Government
**Department of Industry,
Innovation and Science**

Business
Cooperative Research
Centres Programme

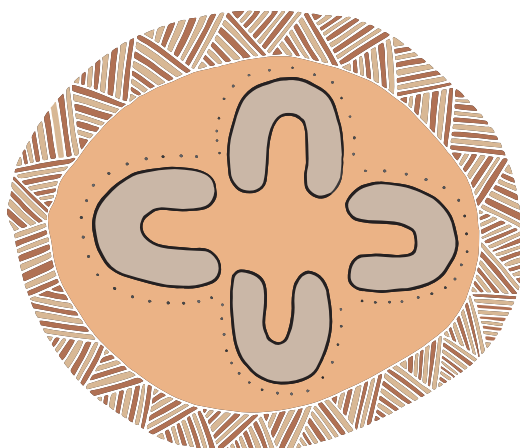
Contents

Background	v
Acknowledgments	v
Abbreviations	vi
Foreword	vii
Executive Summary	1
Introduction	5
Framing the regulatory function	5
Outline of this paper.....	7
The Compliance Environment of Victorian ACCHOs	9
Legal and financial requirements specified in statutes and through regulation.....	9
Quality and service standards.....	10
Performance reporting for funding provided by governments, including activity reporting and service agreement compliance.....	11
Funding Agreements and Reporting by Victorian ACCHOs	14
Study method	14
Case study: Rumbalara Aboriginal Co-operative Ltd	14
Discussion and Conclusion	24
Who benefits? Over-burdensome procedural accountability consumes significant resources and undermines service delivery.....	24
The service might be client centred, but what about the data?	24
Who is the boss? Increasing levels of vertical accountability reduces the time and resources available for community (horizontal) accountability.....	25
Might a focus on substantial, rather than procedural, accountability be useful?.....	25
How much evidence is required before there is a concerted, constructive and collaborative attempt to rethink how contracting between government and ACCHOs occurs?	26
In conclusion	26
References	28

Contents

Figures and Tables

Figure 1: Simplified representation of procedural and substantial accountabilities	6
Figure 2: Simplified representation of vertical and horizontal accountability	6
Figure 3: Representation of the numbers of funding agreements and associated reports for Rumbalara Aboriginal Co-operative.....	17
Table 1: Rumbalara Aboriginal Co-operative's service delivery areas and programs 2013–14	15
Table 2: Income from (non-reciprocal) State and Commonwealth grants in 2012 and 2013	16
Table 3: Number and frequency of reports for 2012–13 financial year	16
Table 4: Number of agreements and number of reports by funding source (2012–13 financial year)	17



Background

The Victorian Aboriginal Community Controlled Health Organisation (VACCHO) has long held concerns about the overburden of compliance reporting experienced by its member agencies. A particular issue is that the increasing administrative work required to meet these requirements is not adequately compensated, which means that organisations struggle to establish the corporate and operational functions adequate for dealing with them.

VACCHO has long advocated for significant change in the way Aboriginal Community Controlled Health Organisations (ACCHOs) are funded to ensure a strong, sustainable, thriving and highly effective Aboriginal community controlled sector in Victoria. At a minimum it considers that a higher administrative levy is required to enable organisations to function effectively and strengthen their viability in an environment of increasing compliance and reporting requirements.

VACCHO has sought to develop an evidence base to demonstrate the need for change so that members can

meet accountability requirements without compromising service delivery. VACCHO contributed to a Lowitja Institute-funded project— the Support Systems for Indigenous Primary Health Care Services Project— and approached the authors of the project report, *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services* (Silburn, Thorpe & Anderson 2011), to partner on this new work.

Rumbalara Aboriginal Co-operative was chosen as a case study site as it provides a wide range of health and community services and therefore enabled a comprehensive review of existing compliance and reporting arrangements. During the course of this review it became clear that it was not only the number of compliance and reporting requirements that contributed to the reporting burden, but also the complexities associated with the range of mechanisms required to do the reporting. This complexity creates significant challenges for ACCHOs in their efforts to deliver the scope of services needed by their communities.

Acknowledgments

This work would not have been possible without the generous contribution of senior managers and staff at Rumbalara Aboriginal Co-operative. We are grateful to them for sharing their knowledge and experience, particularly given their very demanding workloads. Thank you also to Ms Peggy Kerdo from the La Trobe University Law School for assisting us to understand different types of legislative requirements and to Ms Carolyn Renehan, Mr Paul Ryan, Ms Luella Monson-Wilbraham and Dr Michael Tynan for providing insightful comments on the draft report.

This project was funded by the Lowitja Institute. We are thankful to the Lowitja Institute for enabling both the conduct of research based on the needs of the Aboriginal community-controlled health sector and the collaboration between sector-based organisations and universities.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
AIHW	Australian Institute of Health and Welfare
CATSI Act	Corporations (Aboriginal and Torres Strait Islander) Act 2006
HPF	Aboriginal and Torres Strait Islander Health Performance Framework
IAS	Indigenous Advancement Strategy
LASN	Local Area Services Network
NGO	Non-Government Organisation
OATSIH	Office for Aboriginal and Torres Strait Islander Health
RAP	Risk Assessment Process
SAR	Service Activity Report
SDRF	Service Development Reporting Framework
SHIP	Specialist Homelessness Information Platform
SHOR	Specialist Homelessness Online Reporting
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service

Foreword

Rumbalara is in the process of reconfiguring services to ensure that the individual, the family and the community are at the centre of service delivery. The Rumbalara Heart of Community model of primary health care is a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status. We recognise that the community itself provides the most effective and appropriate way to address its main health problems. This type of model is based on individual, familial, community and cultural strength working in partnership with services and supports to play an active role in achieving their own optimal quality and standard of life.

Unfortunately, despite being very clear about what is the 'core business' of the Cooperative, and very prescriptive about what is and is not being purchased, there is a lot of activity that is solely focused on applying for, administering, complying with and reporting to various government funding departments.

There are significant issues associated with this regime of funding, reporting, compliance and renewal, which impact the ability to plan over the medium to longer term and demand that resources be specifically allocated to this function.

These performance and funding agreements are reviewed and adjusted every 12 to 36 months. They exist to ensure that we are able to address a life expectancy gap of 10 years between Indigenous and non-Indigenous peoples, that an Aboriginal and Torres Strait Islander child is twice as likely to die as any other child in the community and that Indigenous people are more than three times as likely to have diabetes than non-Indigenous people. Rumbalara is subject to 12 to 36 month funding, planning and political cycles while trying to achieve multi-generational targets.

Despite all the agreements and reporting requirements aimed at ensuring that the organisation remains compliant with the various vagaries of funding and performance agreements there is no direct line of sight between the identified needs and priorities of community, the service configuration, staffing and performance required to address those identified needs and the funding and performance agreements themselves.

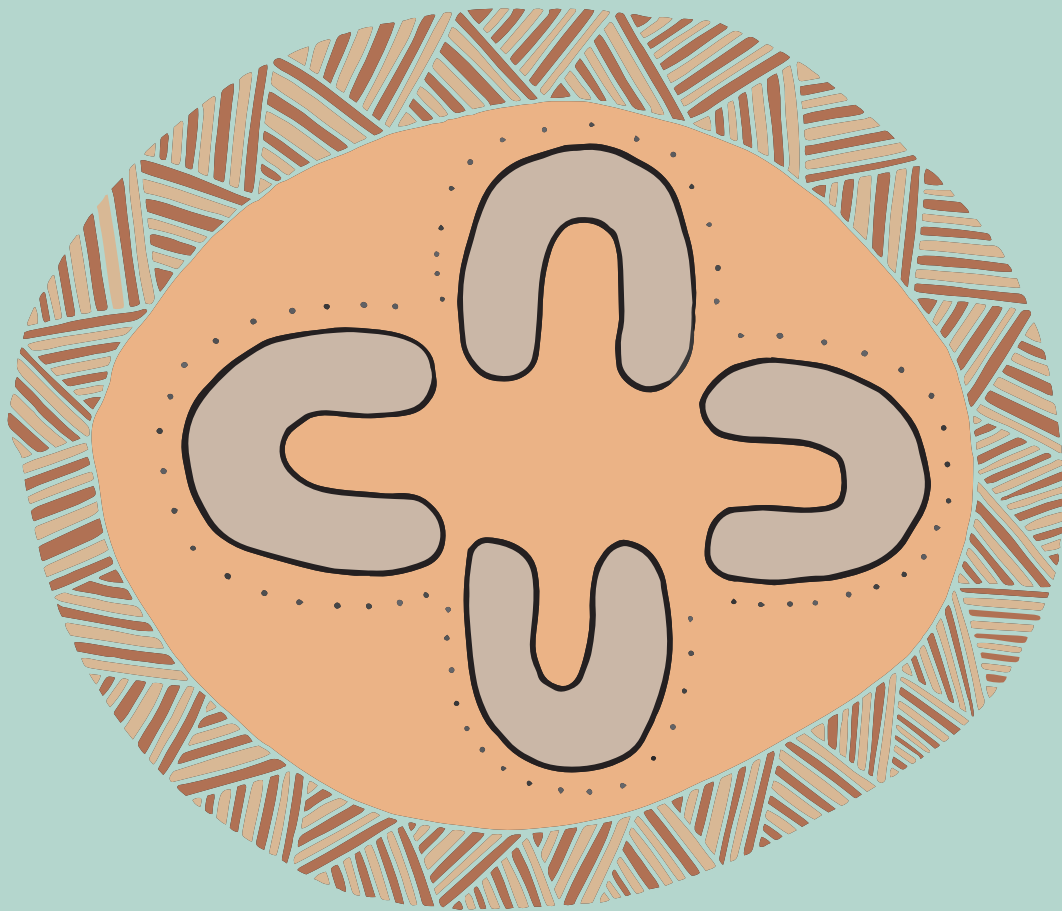
It would appear that our Aboriginal health and community services have been forced to conform to the needs of funding bodies, policy makers and political cycles and that the client who sits at the centre of our care actually lives in Canberra or Melbourne.

This regime of compliance and reporting is excessively onerous and generally based on activity rather than outcomes. Despite the rigour of this regime there are still issues with the management and operations of some ACCHOs across the nation, and in particular their financial and risk management and program performance.

One possible consideration could be that the regime of compliance and measurement is focused too narrowly. Rather than measuring outputs, how much attention is given to outcomes? Rather than micro-managing services through compliance and reporting regimes, have the governance structures and capability of the organisation been confirmed as being fit for purpose?

It is Rumbalara's position that if funded activities and services are accurately targeted to address identified and measurable needs in community, and delivered by culturally appropriate, skilled and resourced organisations then surely we can devote more time to achieving outcomes rather than outputs. This would enable us to lift our eyes to the horizon, towards addressing the multigenerational challenges that we all face and stop obsessing only on the frenetic activity of today.

Kemal (Kim) Sedick, CEO Rumbalara Aboriginal Cooperative, December 2015



Executive Summary

Aboriginal Community Controlled Health Organisations (ACCHOs) have been operating in Australia since the 1970s. They are governed by community-elected boards, vary in size and scope, and provide access to safe, appropriate and effective services for their communities. There are 27 ACCHOs across Victoria, all of which are members of the Victorian Community Controlled Health Organisation (VACCHO). Victorian ACCHOs range from small organisations with a limited number of core programs to large multi-million-dollar organisations providing an extensive range of health, wellbeing and community services. The latter obtain funding from a range of sources and have complex reporting requirements.

All organisations need to be accountable for their use of public funds. However, there are significant issues with the *form* of that accountability. In the case of Aboriginal and Torres Strait Islander health services, this has been described as a reporting *overburden* (Dwyer et al. 2009). To examine this further we make the distinction between *procedural* and *substantial* accountability and between *horizontal* and *vertical* accountability. Procedural accountability refers to accountability for activity, while substantial accountability refers to accountability for benefit. Vertical accountability tends to be rule bound and imposed by an external stakeholder (such as a funder), while horizontal accountability is enacted through strong mutual ties and relationships.

ACCHOs participate in (at least) two distinct forms of accountability. One is a vertical, formal, procedural and directly observable relationship with funders. The second is an accountability relationship with their communities and includes both formal and informal mechanisms and might be considered to be horizontal in nature.

Getting the balance and direction of accountability right is a crucial part of ensuring that organisations can achieve their objectives. Over-burdensome vertical and procedural forms of accountability can not only use up scarce resources but also impact negatively on organisational capacity to fulfil less formal, trust-based accountability relationships with clients and communities. Our concern is that current funding arrangements result in an over-burdensome amount of procedural accounting that can undermine the efforts of ACCHOs to deliver integrated, safe, comprehensive health and community services.

This paper describes a case study of the compliance and reporting requirements of a large Victorian ACCHO—Rumbalara Aboriginal Co-operative. We demonstrate that on top of the reporting overburden, incredible complexity is introduced when single organisations work across a range of health and community service sectors and consequently have to report in different ways, on different performance criteria, using different databases, for funding from different government programs. The irony is that while ACCHOs aim to build their service delivery capability in order to implement holistic responses to individual and community need, reporting to funders appears to work against this.

The broad compliance environment

Publicly funded non-government organisations have three main categories of compliance requirements: (1) legal and financial requirements, (2) quality and service standards, and (3) performance reporting for funding provided by governments and others. As community controlled organisations, ACCHOs also have significant reporting obligations to their communities.

Large Victorian ACCHOs are likely to have to comply with at least 70 pieces of legislation, including Commonwealth and state Acts pertaining to (1) being a company, co-operative or association, (2) how organisations in general must function and (3) the specific functions of the organisations. These organisations also have to undertake accreditation against service standards, with the majority of Victorian ACCHOs having to meet at least four different sets of accreditation standards. ACCHOs also report against individual funding agreements and provide additional data to Australian Government departments about their overall activity, risk profile and work relevant to the Aboriginal and Torres Strait Islander Health Performance Framework.

Study method

The focus of this work was to develop an understanding of the particular obligations associated with reporting against the types of funding agreements held by Victorian ACCHOs by conducting a case study with Rumbalara Aboriginal Co-operative. We were provided with data about funding agreements for the 2013–14 financial year. We interviewed nine executive managers about the processes associated with reporting against funding agreements and sought input from three VACCHO staff.

Case study: Rumbalara Aboriginal Co-operative

Rumbalara Aboriginal Co-operative grew from a settlement of Aboriginal people living on river flats between Mooroopna and Shepparton in the 1940s, and is now a large service with six service delivery areas providing a wide range of health and community services to the Aboriginal community in the Goulburn Valley and beyond. These service delivery areas are health, housing, justice, family, aged care and disability, and the Rumbalara Elder Facility. Funding is obtained in three main ways: (1) agreements negotiated with government for specified primary health care services, (2) fee-for-service arrangements and (3) competitive funding rounds. In 2012 Rumbalara Aboriginal Co-operative received \$15,396,760 from Australian and Victorian Government grants and in 2013 it received \$14,071,250 (Rumbalara Aboriginal Co-operative, 2013).

In 2013-14 Rumbalara Aboriginal Co-operative held 48 separate agreements with 12 agencies (five Victorian Government departments, three Australian Government departments, three government-funded not-for-profit agencies and one other agency) for services to be delivered in the 2013–14 financial year. This arrangement required 409 reports against 46 of these agreements, including reports to be provided annually ($n = 53$), half yearly ($n = 52$), quarterly ($n = 88$) or monthly ($n = 216$). A further two agreements required data be reported into databases that can be accessed at any time by the funder. The number of agreements per funding body ranged from one to 12 and the number of reports from one to 137.

Establishing systems for efficient and accurate data collection, along with implementing the processes for reporting data to funding agencies, requires significant time and expertise. Such a high number of service agreements across six programs creates a significant organisational risk. To help mitigate this risk the organisation has established a database—the Rumbalara Agreements Register—to record all information about reporting requirements and enable systematic co-ordination and monitoring of compliance with them.

Although the number of agreements and reports is high, the picture is significantly more complicated than the numbers suggest. Factors that create complexity include:

- the need for organisations to maintain multiple databases to report to different government programs (these databases often do not interface with each other)
- the need to sometimes report the same data for different purposes and in different ways (for example, data about homelessness-related services are reported to the funder and to the Australian Institute of Health and Welfare)
- where programs are funded by different levels of government, the need for organisations to report to both jurisdictions, not necessarily in the same format
- where programs are delivered across state borders, the potential need for organisations to report their activity to both jurisdictions
- different reporting frequencies for some programs for different elements of the work
- the range of ways organisations report data about their programs that are not technically formal compliance reports (such as through verbal reporting/ conversations with funders, committee meetings and steering groups)
- the necessity for paper-based records in some cases and the need to transfer data into an electronic form for reporting
- reporting requirements that are not always commensurate with the level of program or project funding
- the requirement by some programs to collect data that can be difficult or inappropriate to obtain
- changes to reporting requirements when there are changes in government departments and programs.

Obtaining additional services through brokerage funds or sharing clients (so that clients can obtain direct services not provided by Rumbalara Aboriginal Co-operative) introduces further complexity when data has to be shared between organisations that do not always have complementary databases.

Who benefits? Over-burdensome procedural accountability consumes significant resources and undermines service delivery

Victorian ACCHOs are committed to the provision of holistic, comprehensive (or 'wrap around') care for Aboriginal people. As a result of building their capacity to do this, ACCHOs are subject to increasingly complex funding arrangements and the burden is exacerbated by the specifications as to how data is to be recorded and reported. This imposes a high technical burden and introduces significant organisational risk. As the supporting infrastructure and processes become more complex, the capacity for organisations to innovate can be reduced—first, because the effort required to implement change across a number of platforms is substantial and, second, because the additional reporting burden associated with some funding opportunities outweighs the potential benefit of accessing those funds. Therefore current funding and reporting models have the potential to undermine service delivery and innovation. In addition, resources and effort that could otherwise be directed to service provision are being expended on compliance reporting. Significant attention needs to be directed to establishing new funding and reporting models that support, rather than hinder, the delivery of comprehensive client-centred services.

The service might be client centred, but what about data?

A consequence of accessing different funding streams is that clients utilising more than one service type have to provide information multiple times. This information is entered into multiple databases and extracted into multiple reports to be provided to different funders. This does not facilitate collation of data in a way that gives a comprehensive picture of either individual or community need. It also hinders the development of data systems that, with the right privacy and consent protections, might enable improved co-ordination of care for clients. Therefore, while ACCHOs are acutely aware of the need to collect and maintain excellent data so that they can plan, review and evaluate the services they deliver, current reporting requirements do not facilitate the use of data for these purposes. This is a significant barrier to ACCHOs in their efforts to improve the health and wellbeing of populations of Aboriginal people living in large catchment areas.

Who is the boss? Increasing levels of vertical accountability reduce the time and resources available for community (horizontal) accountability

ACCHOs are significant community organisations that put principles of community self-determination into operation. This means that horizontal forms of accountability enacted through strong mutual relationships between communities and their service providers are particularly important. Increasing levels of vertical accountability to funders potentially reduces the resources available for horizontal reporting. A key question is whether the burden of vertical accountability slowly erodes the capacity for community self-determination. If this is the case, who really is the boss? Certainly, if the burden of vertical accountability is reduced, additional resources may be able to be invested into strengthening and innovating in relation to community control.

Given that funders, ACCHOs and communities all want to achieve a common goal of improved outcomes for Aboriginal peoples, it might be useful to consider a system of horizontal (or what Dwyer et al. (2009) call 'relational') accountabilities between funders and service providers, and between service providers and their communities. In such a system all actors would have accountabilities to each other determined by the particular roles and responsibilities they play in contributing to achieving the shared goal.

Might a focus on substantial, rather than procedural, accountability be useful?

To reduce the impact of the complexities described in this report it would be worth considering a refocus from procedural accountability (that is, accountability for activity) to substantial accountability (that is, accountability for benefit). One means to achieve this would be for ACCHOs to develop catchment-based population health and community service plans, specify their proposed strategies to address identified needs and describe the benefits that would accrue. In this way, services could be organised around individual and family needs, rather than ACCHOs trying to fit individuals and families into a number of different programs and services that may be only partially appropriate. Careful consideration would need to be given to how accountability for benefit would be described, measured and reported so that organisations are only

held accountable for the things they can realistically influence. Any refocus on outcomes and results would need to be undertaken with the full participation of ACCHOs and their peak bodies.

How much evidence is required before there is a concerted, constructive and collaborative attempt to rethink contracting between government and ACCHOs?

Despite the growing body of evidence demonstrating the constraints imposed by current funding arrangements, the rhetoric about reducing 'red tape' and significant work undertaken by government departments to streamline reporting there is a need to rethink the way contracting for government-funded, third-party service provision is arranged. This report provides further evidence of the need to address this issue supports calls for the nature of the contract between ACCHOs and governments to be re-framed.

First funding mechanisms need to be developed to support a service system that can provide holistic, client-centred and co-ordinated care to people and communities. We endorse previous recommendations for arrangements that are relational or horizontal and focused on benefit for communities. In the meantime any new reporting requirements should only be introduced after consultation with services and after consideration as to whether there are existing reporting frameworks and databases that could be used for reporting on new programs. Similarly, duplication of effort related to meeting standards and obtaining accreditation should also be examined, with a particular focus on reducing the number of accreditation reviews organisations have to undertake and/or provision of recognition of equivalent standards to reduce workloads and cost.

In conclusion

There is ample evidence about the scope and nature of the compliance and reporting burden on ACCHOs. The effects of onerous reporting are real and do have the potential to compromise service delivery and impede innovation. The onus should be on governments to be more coordinated and insightful when considering how organisations should be held to account for the use of public funds. The focus must shift from procedural accountability for program activity to substantive, real accountability for outcomes in communities. Such a shift may enable organisations to increase the services they can provide and strengthen their capacity to deliver these in an effective, comprehensive and holistic way.

This would produce better outcomes for Aboriginal communities and for all Australian taxpayers. If there is not a move to establishing more purposeful and practical compliance regimes organisations will require additional funding to support the technical and administrative capacity to meet their increasing reporting requirements.

Government policy is explicit about the need to improve the health and wellbeing of Aboriginal and Torres Strait Islander peoples. ACCHOs share the goal of achieving the best possible outcomes for their communities. Transformation of the *nature* of the relationship between government and ACCHOs is required to ensure available resources are used to maximise the delivery of innovative, comprehensive, holistic services and are not expended on wasteful, over-burdensome reporting and compliance obligations.

Introduction

Aboriginal Community Controlled Health Organisations (ACCHOs) and services in Australia were established in the 1970s. They have a long history, based in the struggles of Aboriginal peoples for self-determination and for access to safe, appropriate and effective services. A key feature of ACCHOs is that they are governed by boards elected from their membership, the local Aboriginal community. There are ACCHOs in every state in Australia and they are important providers of health and wellbeing services to Aboriginal and Torres Strait Islander people. ACCHOs vary in size, scope, organisational composition and geographic location and include large, complex, multifunctional services in urban and regional settings and small services in remote communities. In 2014 ACCHOs across Australia provided 2.5 million episodes of care to approximately 342,000 people (NACCHO 2014).

The Victorian Aboriginal Health Service (VAHS), established in 1973, was the first in Victoria, and today there are 27 ACCHOs across the State. All Victorian ACCHOs are members of the Victorian Community Controlled Health Organisation (VACCHO), which both represents its members and works with them to build organisational capability and capacity across the sector. Victorian ACCHOs range from small organisations with a limited number of core programs to large multi-million-dollar organisations providing an extensive range of health, wellbeing and community services. Depending on the organisation, the range of programs might include health and wellbeing, housing, justice, family, home and community care, and aged care services. As well as providing a substantial volume of services to their communities, ACCHOs contribute significant social and community capital and provide important employment and training opportunities for Aboriginal and non-Aboriginal people.

Larger ACCHOs in Victoria are complex organisations that work to address many community and individual needs. As a result they obtain funding from a range of sources. The complexity of reporting arrangements and their significant administrative burden have been described previously (Dwyer et al. 2009, Productivity Commission 2010, Australian National Audit Office 2012, Moran et al. 2014), as has the inadequacy of funding for such a high administrative load (Australian Government Department of Finance and Deregulation 2009) and the associated risk to organisations (Australian National Audit Office 2012). Although government departments have introduced initiatives to streamline reporting, the burden is still significant. No matter how efficient ACCHOs are with their reporting, the resources dedicated to this task still represent funds that could otherwise be used for service delivery (Australian National Audit Office 2012).

Framing the regulatory function

ACCHOs, like any other organisations, have moral and legal obligations to be accountable for the funds they receive from governments or any other source. However, it is important to distinguish between the principle of accountability and the form that accountability takes (McKernan & McPhail 2012). Following from this, we consider two types of distinctions between different forms of accountability to help understand these challenges.

The first distinction is between procedural and substantial accountability. This is the difference between ways of giving an account that can be more or less effective in ensuring that the organisation fulfils its objectives. This distinction relates to the question of what the individual or organisation is accountable for.

-
1. Redfern Aboriginal Medical Service was the first of these services, established in Sydney in July 1971.
 2. For more information about the history of VAHS, see Victorian Aboriginal Health Service (n.d). For a history of Aboriginal community-controlled health services in Victoria see Hemingway, M. (n.d.).
 3. For more information about VACCHO see the organisation's website www.vaccho.org.au.
 4. ACCHOs are employers of large numbers of Aboriginal people, and in some communities are the main employers (Alford 2014). Along with other Aboriginal and Torres Strait Islander organisations, they contribute to social capital and play an important role in supporting, strengthening and sustaining communities (Australian National Audit Office 2012). The Productivity Commission (2010) noted a range of additional benefits that not-for-profit organisations contribute above their actual service delivery. These include benefits associated with: engaging members for a community purpose, added value to the community through how activities are undertaken (for example, through ensuring community participation), undertaking activities that would not be provided by for-profit or government sectors (whether due to lack of profitability, associated risk or lack of trust/relationships with clients) and impacts greater than those provided to clients (such as greater understanding and acceptance of specific groups of people).

Within the context of this report, the distinction might be construed as between undertaking procedures (and submitting reports about activity or services provided)

on the one hand and health and wellbeing on the other. A simplified representation of this is provided in Figure 1.

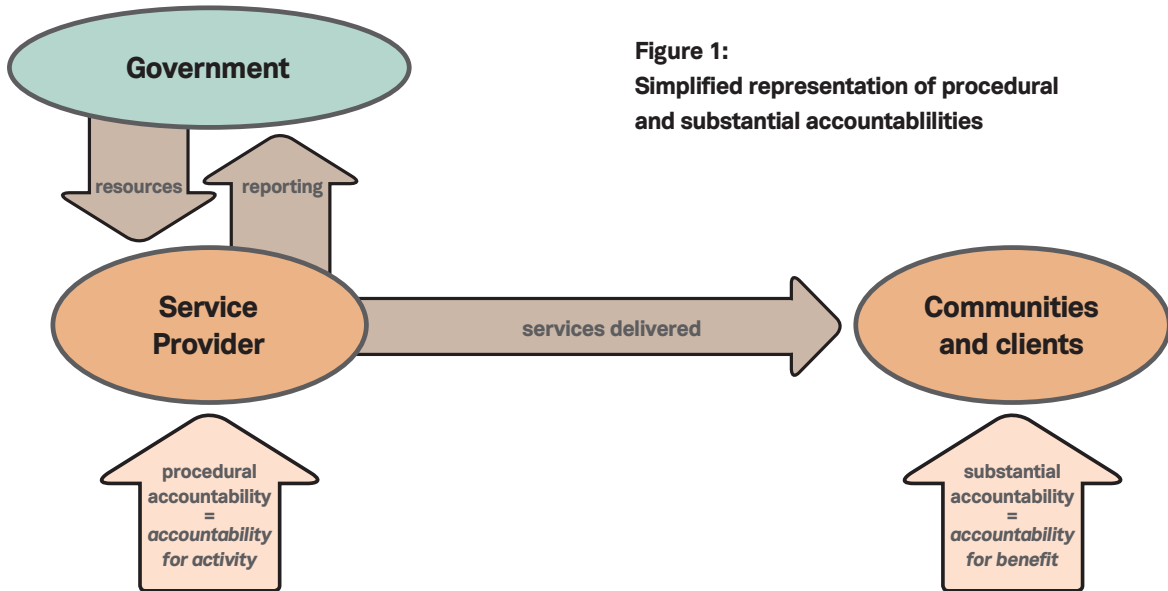


Figure 1:
Simplified representation of procedural and substantial accountabilities

The second distinction is between horizontal and vertical accountability. Vertical forms of compliance-based accountability often have explicit standards of performance imposed and enforced by an outside stakeholder; horizontal forms of accountability are those that are enacted through building strong mutual ties and relationships (Dixon et al. 2006). Lewis and Madon (2004:4) define vertical forms of accountability as 'rule-bound responses by organizations and

individuals who report to recognized authorities... in order to ensure that the resources they receive are used properly', while Dixon, Ritchie and Siwale (2006:409) explain that horizontal accountability 'relies upon wider situated relationships, and arises through diffused social networks whose governing norms may bring public honour and shame into accountability processes'. These types of accountability are represented in Figure 2.

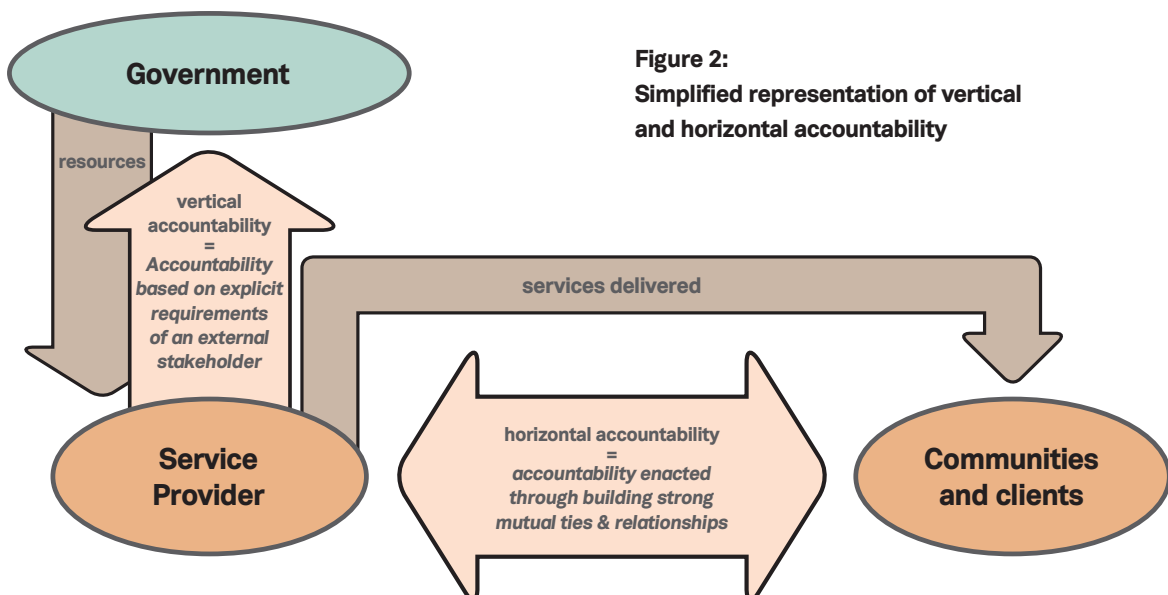


Figure 2:
Simplified representation of vertical and horizontal accountability

ACCHOs can be seen to participate in (at least) two distinct forms of accountability. One is a relationship with funders—which is vertical, formal, procedural and directly observable. The second is an accountability relationship with members/owners and the broader Aboriginal community from which the members come and to which services are provided (that is, the beneficiaries). The latter types of relationships are often informal and based more on trust and mutuality (Dixon et al. 2006, Gray 2010) and are of a horizontal nature. ACCHOs do have formal accountabilities to their members, who are sometimes only a small proportion of the whole community they represent and to whom they deliver services. These formal mechanisms, such as board meetings and annual general meetings, are only part of the overall social and cultural accountability of the organisation. There are also many less formal lines of accountability, including community meetings, newsletters, reports and feedback mechanisms. It is worth noting that just because relationships are informal, it does not mean they are less binding. ACCHOs are held to account by their communities and are expected to provide satisfactory explanations when services are changed or cultural protocols are not adequately followed.

As many commentators have noted, a focus on procedural forms of accountability is often mistaken for substantial accountability (Lehman 1999, Lehman 2001). Although ACCHOs are morally and legally accountable vertically to their funders, this is in no way superior to the (horizontal) obligation they owe to their communities and the beneficiaries of the services they provide. Indeed, self-determination may well be strengthened through the implementation of effective horizontal accountability through which communities can act as both advisors and arbiters on the quality and effectiveness of organisations engaged to meet their needs.

Getting the balance and direction of accountability right is a crucial part of ensuring that organisations can achieve their objectives. Tensions between hierarchical and horizontal accountability mechanisms have led to dysfunctional outcomes within the non-government organisation (NGO) sector (Dixon, Ritchie & Siwale 2006). This can be because pressures to increase the formal procedural reporting upward to funders can make it more difficult for organisations to fulfil informal, trust-based accountability relationships with clients and communities (Unerman & O'Dwyer 2006). It is therefore important to note that overbearing forms of procedural

accountability not only use up scarce resources but can also negatively impact the horizontal accountability relationship to beneficiaries.

This distinction between 'hard' forms of regulation through procedural forms of accountability and 'soft' forms of regulation through informal modes of accountability raises questions about whether and how increasing the voice and input of the beneficiaries into the accountability process might increase the efficacy of the services offered and reduce the need for procedural reporting.

The concern is that current funding arrangements result in an over-burdensome amount of procedural accounting that can undermine the efforts of ACCHOs to deliver integrated, safe, comprehensive health and community services. The nature and level of reporting imposes 'costs without commensurate benefits' and is often out of proportion to the size of the organisation or the scale of its work (Productivity Commission 2010). In addition, a significant proportion of government funding is provided under short-term, low-value funding agreements, and government has tended to try to mitigate risk by increasing monitoring and reporting (Productivity Commission 2010). The latter has contributed to more centralised decision making, a reduction in local discretion (Moran et al. 2014) and a focus on managing compliance rather than performance (Shergold 2013). Funding models focused around grants and service agreements also tend to force delivery of specific types of services into which people must fit, rather than enabling the development of services that fit people (Shergold 2013).

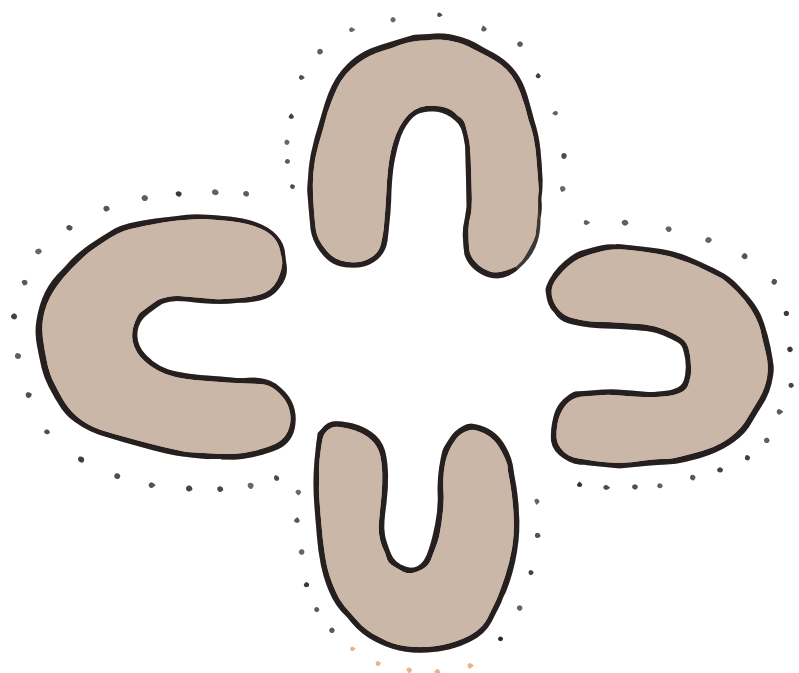
Outline of this paper

In this paper we aim to further elucidate the extent of the burden associated with reporting against funding agreements for ACCHOs in Victoria. Initially, we set out to develop an evidence base to support allocation of an adequate administration levy to enable ACCHOs to comply with legal, regulatory, statutory and financial requirements. The method was to include collecting detailed information about the procedures followed to meet all reporting requirements with the aim of using these data as the basis for a costing study (which was to be a second project and would have involved measuring the time taken on tasks associated with reporting). However, we encountered a significant challenge—collecting such data had the potential to further

compromise time dedicated to service delivery. For this reason, although we were able to obtain information about the volume of reporting requirements against funding agreements, information about procedures was only collected from a small number of programs.

We demonstrate that on top of the reporting overburden, incredible complexity is introduced when single organisations work across a range of health and community service sectors and consequently have to report in different ways, on different performance criteria, using different databases, for funding from different government programs. The irony is that while ACCHOs aim to build their service delivery capability so that they can implement holistic responses to individual and community need, reporting to funders appears to have become more fragmented and program-specific. Each time an organisation obtains a new funding stream to increase the services it can provide, the burden of reporting generally grows too.

Prior to describing the findings of our case study, we provide a brief overview of the compliance environment in which Victorian ACCHOs operate. This overview highlights that reporting associated with funding agreements is only part of the broader set of formal requirements that ACCHOs must meet. The remainder of the paper focuses on a case study of the reporting requirements of Rumbalara Aboriginal Co-operative for its service agreements over one financial year.



The Compliance Environment of Victorian ACCHOs

Publicly funded NGOs, including ACCHOs, have a range of requirements they must comply with in order to continue operating. These fall into three main categories:

- legal and financial requirements (specified in statutes⁵ and through regulations⁶)
- quality and service standards compliance
- performance reporting for funding provided by governments, including activity reporting and service agreement compliance (Breaking New Ground 2011).

Reporting and compliance requirements vary based on organisational status, operational activity and funding source.

It is essential to recognise that the fundamental principle of ACCHOs is community control. This means that organisations are governed by community-elected boards and communities play an important role in guiding how services develop. As such, obligations to actively involve, seek feedback from and report to communities could be considered an important, if not the primary, compliance requirement of these organisations. ACCHOs therefore have to maintain the vertical relationship with their funders and the horizontal relationship with their communities.

Legal and financial requirements specified in statutes and through regulation

In Australia organisations have to comply with legal and financial requirements, some of which are specified in Australian Government legislation and others in state or territory legislation. Such legislation can be associated with:

- being a company, co-operative or association
- how organisations (in general) must function (for example, meet certain occupational health and safety and equal opportunity obligations)

- the specific functions of an organisation (such as being an aged care provider or a provider of medical services).⁷

In *The Living Law*, the Aboriginal Health and Medical Research Council of New South Wales (2011) collated a set of common legislation with which its member agencies were likely to have to comply. This included 78 Commonwealth and state-based Acts pertaining to:

- administrative law
- business law
- civil and human rights law
- constitutional law
- health law
- industrial law
- intellectual property law
- occupational health and safety law
- privacy law
- tax law
- welfare law.

Although the specific state legislation is different, Victorian ACCHOs have to comply with a similar range (and number) of Acts.

In relation to their operation as business entities, ACCHOs are incorporated bodies governed by boards elected by the local community (VACCHO 2013a). Victorian ACCHOs are registered under one of four Acts⁸:

- *Associations Incorporation Reform Act 2012*,⁹ a Victorian Act administered by Consumer Affairs Victoria
- *Co-operatives Act 2006*, a Victorian Act administered by Consumer Affairs Victoria
- *Corporations Act 2001*, a Commonwealth Act administered by the Australian Securities and Investments Commission
- *Corporations (Aboriginal and Torres Strait Islander) Act 2006* (CATSI Act), a Commonwealth Act administered by the Office of the Registrar of Indigenous Corporations.

5. Statutes are pieces of legislation that have been passed through all Houses of Parliament in a jurisdiction.

6. Regulations give action to a statute; that is, they provide details about how legislation is to be put into action.

7. Thank you to Ms Peggy Kerdo, La Trobe University Law School, for assisting with this simplified description of legislative requirements.

8. Pro bono legal work for VACCHO is underway to compare each of these Acts and to clarify the benefits or disadvantages of each for Victorian ACCHOs.

9. This replaces the Associations Incorporation Act 1981/2009.

NACCHO has previously led work on sector governance and, in collaboration with VACCHO and Tony Lang, has developed a set of governance principles that organisations can use to check their governance processes (NACCHO & Lang 2012). VACCHO has developed a suite of resources to assist organisations in strengthening their work in this area.

As of July 2014 any organisation receiving \$500,000 or more from the Department of Prime Minister and Cabinet under the Indigenous Affairs Portfolio is required to be incorporated under a Commonwealth Act, with a specific requirement that Aboriginal and Torres Strait Islander organisations be incorporated under the CATSI Act.¹⁰

Quality and service standards

Quality improvement standards and accreditation processes are widely accepted across the health and community services sectors and most organisations have some form of accreditation. By 2011 there were more than 45 sets of standards for the community services sector in Australia (Breaking New Ground 2011). The result of this is that any organisation delivering different service types will have to meet, and be accredited against, multiple sets of standards (CRCAH 2008, Breaking New Ground 2011).¹¹ Some funders mandate accreditation against specific standards and these therefore represent a compliance requirement. Where accreditation is not mandated, organisations may choose to participate in an accreditation program for a range of reasons, including to ensure their services are

of high quality and to demonstrate the quality of their service to their communities. In the schema described previously, voluntary participation in accreditation processes could be considered a form of horizontal accountability.

In Victoria the majority of ACCHOs have to undertake at least four different types of accreditation. The four most common are:

- International Organization for Standardization (ISO) 9000 Standards or Quality Improvement Council (QIC) Health and Community Services Standards¹²
- Standards for General Practices¹³ (for ACCHOs with medical clinics)
- Home Care Standards (jointly developed by the Australian Government and state and territory governments¹⁴)
- Department of Human Services (DHS) Human Services Standards.¹⁵

Each set of standards assesses the governance, risk management, compliance management, financial processes, planning systems, client/patient experience and service delivery models of organisations under review and there is significant overlap in these domains (for example see Victorian Aboriginal Community Controlled Health Organisation 2013a).

10. See Department of Prime Minister and Cabinet (n.d.). For information about the sector response to this policy, see Victorian Aboriginal Community Controlled Health Organisation (2014).

11. There is a growing body of work on continuous quality improvement and accreditation in the community-controlled sector, including that led by NACCHO and its state- and territory-based affiliates. Some of the work in the sector is described by Wise et al. (2013).

12. These types of standards cover organisational systems, including governance, corporate systems, service delivery and external relationships. For more information on ISO standards see www.iso.org/iso/home/standards.htm and on QIC standards see www.qic.com.au/

13. These standards are developed by the Royal Australian College of General Practice. For more information see www.racgp.org.au/your-practice/standards/standards4thedition/

14. Community Care Common Standards were introduced to replace the Home and Community Care Standards and have now been re-named Home Care Standards. For more information see www.dss.gov.au/our-responsibilities/ageing-and-aged-care/home-care-standards-and-quality-reporting-documentation

15. The Department of Human Services in Victoria developed one set of standards to replace three program-specific sets of standards (for disability services in Victoria, registration standards for community service organisations and homelessness assistance services standards). Accreditation against these standards is mandatory for organisations receiving funding under the associated programs. For more information see www.dhs.vic.gov.au/

Other standards relevant to ACCHOs are:

- Australian Children's Education & Care Quality Authority National Quality Standard¹⁶
- Food Standards Code¹⁷
- National Safety and Quality Health Service Standards (standards one to six) of the Australian Commission on Safety and Quality in Health Care¹⁸
- Performance Standards for Registered Housing Agencies¹⁹
- Australian Skills Quality Authority standards²⁰
- Residential Aged Care Standards²¹
- Rainbow Tick Standards.²²

In 2014 in Victoria, 15 ACCHOs were required to meet at least four sets of accreditation standards, five had ten or more program areas subject to accreditation, and two had ten distinct sets of accreditation standards to meet (Frank-Gray 2014, personal communication).

Most accreditations are implemented on a cyclical basis (for example, over a three-year period) and include a mid-term review, but not all are co-ordinated or combined by accrediting bodies. This means that at any time an organisation might be in different phases of different accreditation cycles and be required to undergo assessments numerous times throughout the year.

Many mainstream health and community service organisations employ staff to oversee the numerous accreditation requirements and quality improvement processes. Some larger organisations have teams dedicated to ensuring compliance in these areas. In 2014 only six ACCHOs in Victoria had a staff member whose role it was to co-ordinate quality and accreditation (Frank-Gray 2014, personal

communication). Of these staff members, four were also employed to simultaneously manage their organisations' human resources, operational functions or infrastructure projects. In ACCHOs where this dedicated position is not financially feasible, staff are required to perform this role in addition to their main service delivery activities.

Performance reporting for funding provided by governments

Agencies receiving government funding are required to be accountable for the use of those funds. Both the Australian Government and the Victorian Government have undertaken initiatives to develop improved processes for collecting data about funded service delivery to Aboriginal and Torres Strait Islander communities. Some of these are described below.

It is important to note that many funding agreements focus expenditure on service delivery and limit the deduction of administrative levies. This puts significant strain on the capacity of organisations to undertake administrative and support functions.

Australian Government processes

The Australian Government is a significant funder of programs for Aboriginal and Torres Strait Islander peoples (Australian National Audit Office 2012).²³ The Office for Aboriginal and Torres Strait Islander Health (OATSIH) operated within the Australian Government department responsible for the health portfolio from 1995²⁴ to 2014. In 2014 OATSIH activities were re-allocated across two portfolios—the Department of Prime Minister and Cabinet and the Department of

16. For ACCHOs that provide child care services. For more information see www.acecqa.gov.au/national-quality-framework

17. All businesses that supply food must comply with this code and undergo audits. For more information see www2.health.vic.gov.au

18. For more information see www.safetyandquality.gov.au/

19. For ACCHOs that provide social housing, see www.housingregistrar.vic.gov.au

20. For registered training organisations, see www.asqa.gov.au/

21. For ACCHOs, such as Rumbalara Aboriginal Co-operative, that provide residential aged care services. For more information see www.aacqa.gov.au

22. Developed to support organisations to ensure that services are inclusive of gay, lesbian, bisexual, transgender and intersex people. For more information see www.qip.com.au/standards/rainbow-tick-standards/

23. It is estimated that in 2010–11 the Australian Government allocated \$A3.4 billion to programs to address Aboriginal and Torres Strait Islander disadvantage, with \$A1.34 billion provided as grants to Aboriginal and Torres Strait Islander organisations. Most of these funds were administered through three government departments (Australian National Audit Office 2012).

24. Although OATSIH was established in 1994, health functions were not transferred from the Aboriginal and Torres Strait Islander Commission until 1995. A summary of a range of initiatives associated with policy and program development and reporting through OATSIH is provided in the evaluation prepared by the Australian Government Department of Finance and Deregulation (2009).

Health (Indigenous Health Division). The following section covers the work of OATSIH prior to this restructure to provide a history of some of the initiatives associated with monitoring the work of ACCHOs and to add to the context in which services were operating when this report was written. It is not entirely clear whether the frameworks described here will be continued, although it is likely that some aspects of the OATSIH risk assessment process will be maintained.

OATSIH processes associated with compliance and quality

Prior to its abolition and the redistribution of its functions, OATSIH developed mechanisms to enable improved collection of data about the activity and impact of ACCHOs. These included the Service Activity Report or SAR,²⁵ the Service Development Reporting Framework or SDRF²⁶ (for non-financial reporting of activity against the Service Action Plans developed annually by services) and a Risk Assessment Process (RAP). OATSIH also undertook other initiatives to try to streamline funding and reporting processes and to improve the quality of their data collections.²⁷

The SAR questionnaire was completed annually and included information about service activity, independent of funding source. Its primary focus was access to primary health care and items included episodes of care, service population, clients served, staffing and health-related activities. Completing the SAR took significant time and views were mixed as to its usefulness in monitoring performance.²⁸

The SDRF was introduced to enable national consistency in reporting and was based on each ACCHO's Service Action Plan, which outlined activities, costs and performance measures for each year. SDRF reporting was developed to supplement the information provided

in the SAR and was required every six months. It was seen to be a useful performance monitoring tool by the majority of respondents in a government-conducted evaluation, although there was some duplication with SAR reporting (this included services having to report the same data in different ways) (Australian Government Department of Finance and Deregulation 2009).²⁹

There was also an initiative between OATSIH and state governments for the SDRF to be adopted as a common reporting framework by both levels of government.

The OATSIH RAP had to be completed only by organisations that were governed by an Aboriginal and/or Torres Strait Islander board and received more than \$400,000 from OATSIH. The RAP was undertaken every second year, except for services receiving a high or extreme risk rating (they had to complete more frequent RAPs). The process was conducted through onsite assessments by OATSIH staff until it was outsourced to an independent consulting group.³⁰ Its use was modified (to an internally conducted office process) in 2013 after a review determined it was not achieving its objective of identifying organisations that posed a risk to OATSIH funding and after negative feedback from the sector regarding the time and resources required to prepare for and undertake the assessment.

Aboriginal and Torres Strait Islander Health Performance Framework

In 2006 the Aboriginal and Torres Strait Islander Health Performance Framework (HPF) was developed under the auspice of the Australian Health Ministers' Advisory Council to enable collection of information about the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health and to assist with ongoing policy and planning. The HPF has three tiers, relating to (1) health status and health outcomes, (2) determinants of health and (3) health systems

25. The SAR was developed after an agreement signed between OATSIH and NACCHO in 1998. Separate Drug and Alcohol Service Reporting was developed for services that only provided these services and was implemented in 1999–2000 (Department of Finance and Deregulation 2009).

26. The SDRF was introduced in 2004 and was a requirement in OATSIH funding agreements.

27. Some of these are described in the evaluation prepared by the Department of Finance and Deregulation (2009).

28. See Department of Finance and Deregulation (2009). This report indicated that, annually, 50% of the services that responded to a survey on the topic took less than ten days to complete this report, almost 25% took between ten and 20 days, 17% took between 21 and 40 days, and the remainder took 41 days or longer.

29. The Australian Government Department of Finance and Deregulation (2009) also reported that 68% of survey respondents indicated that SDRF-related activities took less than 20 days a year in their service and 84% of respondents indicated that they thought the time taken was reasonable.

30. The process took between one and three days for the visit, with additional time required of services to prepare the documentation (Department of Finance and Deregulation 2009).

performance. Data for the HPF is derived from a range of sources including the Australian Institute of Health and Welfare (AIHW) and the Australian Bureau of Statistics (Australian Health Ministers Advisory Council 2006).

Victorian Government

The Victorian Government also provides significant funds to ACCHOs in the State and has undertaken work to reduce the reporting burden. This follows a report on how government works with ACCHOs (DHS 2006) and a review of ACCHO reporting requirements (Effective Change 2008). Most recently, it has developed a 'funded agency channel' where each agency funded by one of the collaborating departments can access a secure area in which information about their service agreements, as well as departmental policies, standards and guidelines, data collections and reporting mechanisms and relevant legislation, is kept.³¹

A note on relative cost of accreditation and reporting to funders

In a study that benchmarked resources allocated to back-of-house functions across 13 not-for-profit organisations in Victoria, the Nous Group (2012) considered four types of compliance activity—quality accreditation, financial audit and acquittal, reporting to funders and partnership activity (the latter was included because it was stipulated as a funding requirement in some funding and service agreements). Of these, reporting to funders consumed the highest proportion of resources used to meet compliance obligations (Nous Group 2012).

Caveat

At the time of writing this paper significant changes were occurring to the administrative structures associated with Aboriginal and Torres Strait Islander affairs at the Commonwealth level. Responsibility for more than 150 Aboriginal and Torres Strait Islander programs was transferred from different government departments to the Department of Prime Minister and Cabinet under the Indigenous Advancement Strategy (IAS), which has five program areas.³² When OATSIH was abolished, some of its programs were moved to the IAS and others were

incorporated into a newly constituted Indigenous Health Branch in the Department of Health. A new method for allocating funding for Aboriginal and Torres Strait Islander health is being developed by the Department of Health and will be implemented in 2015/16.

Despite increasing evidence of a need to change funding arrangements in Aboriginal and Torres Strait Islander affairs towards longer-term, partnership or alliance-based contracting that supports capacity development of Aboriginal and Torres Strait Islander organisations (Dwyer et al. 2009, Australian National Audit Office 2012), competitive tendering was the procurement process adopted for the first IAS funding round. Many submissions to the subsequent Senate Finance and Public Administration References Committee inquiry into the impacts of the funding process on service quality, efficiency and sustainability document serious concerns. For example, the VACCHO submission cites issues associated with the nature and design of the funding round, the process employed and its outcomes. Without reiterating these in detail, VACCHO points to a lack of consultation about the proposed changes and the limitations of funding rounds that promote competition between organisations with common interests. They raise concerns about the resources required to respond to the request for tender, the confusing procurement process and lack of information about it, and the limited time for submissions. VACCHO highlights examples that demonstrate poor design and implementation of the round and argues that there will be significant negative impacts for organisations, clients and communities as a result of the procurement decisions (VACCHO 2015).

Despite assertions that the changes to Aboriginal and Torres Strait Islander programs would reduce 'red tape', at the time of writing the effects in relation to compliance requirements and reporting were unclear. The data reported here should serve as a timely reminder for those designing new funding and reporting mechanisms of the importance of both understanding the consequences of their funding and compliance arrangements and also of simplifying and streamlining these.

31. For more information on this initiative see www.dhs.vic.gov.au/funded-agency-channel/home.

32. For more information see the Australian Government's websites www.indigenous.gov.au/ and www.dpmc.gov.au/pmc.

33. See www.health.gov.au/Indigenous.

34. See www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Commonwealth_Indigenous (n.d.) for the guidelines for this inquiry and a link to submissions to it. A report from the inquiry is due on 26 November 2015.

Funding Agreements and Reporting by Victorian ACCHOs

This project was conducted as a partnership between VACCHO, the Australian Institute for Primary Care and Ageing at La Trobe University and the Onemda VicHealth Koori Health Unit at The University of Melbourne. Ethics approval was obtained from the La Trobe University Faculty of Health Sciences Human Research Ethics Committee and the project was approved by the VACCHO Public Health and Research Unit.

As described in the introduction, ACCHOs must meet a range of legal, quality and performance obligations. The focus of this work was to develop an understanding of the performance reporting requirements associated with funding agreements held by Victorian ACCHOs by conducting a case study with one of these organisations. The key criteria for selecting the ACCHO for the case study was that it was a large organisation with a range of programs as this would provide a full understanding of the reporting requirements of Victorian co-operatives. Rumbalara Aboriginal Co-operative was identified and invited to participate by VACCHO.

Study method

Rumbalara Aboriginal Co-operative has developed a Rumbalara Agreements Register in which detailed information about funding agreements are entered. This database is continually being updated. We were provided with an extract from this database in Microsoft Excel file format on 19 February 2014. The content fields included the following: program (name and number); requirement summary; requirement frequency; requirement due date; responsible position; agreement execution date; agreement completion date; and whether the funding was recurrent.

We selected the financial year July 2013–June 2014 as the reporting period of interest. All reporting requirements outside this period were removed, as were requirements associated with meeting the legal and regulatory obligations of being a co-operative (such as dealing with board nominations, producing annual reports and reporting to the Australian Taxation Office). Accreditation and the compliances associated with meeting accreditation standards were not included as the focus was specifically on the additional compliance requirements incurred by organisations because of their funding agreements, rather than on compliance required to deliver specific types of services. Both activity and program specific financial reporting are included.

To develop a more in-depth understanding of the processes around reporting, we conducted face to face interviews with nine executive managers about the processes associated with reporting against funding agreements. This included asking:

- How is information about the activity for each funding agreement collected and recorded?
- How is data extracted, consolidated and reported?
- Are there other reports or compliances required?

We also discussed these questions with three staff from the VACCHO Sector Quality Improvement Unit in project meetings. Comprehensive notes were taken at all interviews and meetings. A thematic analysis of these qualitative data was undertaken to identify information pertaining to reporting requirements, including the processes and procedures followed, and opinions about the costs and benefits associated with current practice.

Initially, we had also planned to ask managers at Rumbalara Aboriginal Co-operative about who undertakes these tasks, the level of skill required and for an estimate of the time required to do them. However, this was not possible due to the very high workloads of managers and the limited time they had to participate.

Case study: Rumbalara Aboriginal Co-operative

Rumbalara Aboriginal Co-operative has a long history. The current service grew from a settlement of Aboriginal people living on river flats between Mooroopna and Shepparton in the 1940s. Eventually a small number of houses without amenities were constructed on this site as a temporary settlement for local Aboriginal people between their move from Cummeragunja Mission and into the broader community. This housing project was opened as Rumbalara (meaning 'rainbow') in 1958. Most of the families had been rehoused by 1969 and the site was closed. In the 1970s, after a significant struggle to obtain the site, the Goulburn Murray Aboriginal Co-operative established Rumbalara as a place where community people could meet for social and cultural activities and from where information, education and support could be provided (Rumbalara Aboriginal Co-operative n.d.a).

Rumbalara Aboriginal Co-operative is now a large service with six service delivery areas providing a wide range of health and community services to the Aboriginal

community living in the Goulburn Valley and beyond. These service delivery areas are health, housing, justice, family, aged care and disability, and the Rumbalara Elder Facility. There are also two administrative areas—administrative (corporate) services and planning and infrastructure services. In 2012–13 there were 195

employees³⁵ and 120 of these were Aboriginal and/or Torres Strait Islander people (Rumbalara Aboriginal Cooperative 2013).

A brief overview of each of the six service delivery areas and the programs run through these areas is provided in Table 1.

Table 1: Rumbalara Aboriginal Cooperative's service delivery areas and programs 2013–14

Area	2012	2013
Health services^A	Medical clinic <ul style="list-style-type: none"> • General practitioners • Community health nursing • Visiting specialist programs • Diabetes program • Women and children's health • Women's business information and referral • Aboriginal Health Workers 	Regional hearing program
	Oral health services (Wanya Centre)	Emotional and spiritual wellbeing program
Health services^B	Housing services <ul style="list-style-type: none"> • Housing and rental services • Supported Accommodation Assistance Program • Information & referral (accommodation issues) 	Drug and alcohol program
		Bringing Them Home program
		Traditional Healing Centre
Justice program^C	Aboriginal family violence program Youth Cultcha program Night patrol program Koori youth justice program	Healthy lifestyles <ul style="list-style-type: none"> • Aboriginal health promotion and chronic care • Physical activities, healthy eating and health education • Healthy for Life
		Homelessness assistance
		Innovative health services for homeless youth
		Financial counselling
Family services^D	Integrated family services Early intervention & parenting Kinship care program Extended care program Therapeutic foster care	Community work program
		Koori offender support and mentoring program
		Aboriginal community justice panel program
		Aboriginal family decision-making program
		Aboriginal family preservation
Rumbalara Elder Facility^E	30-bed facility High and low care and respite care One palliative care bed	Aboriginal in-home support program
		Cradle to kinder
Aged care and disability services^F	Aged care packages <ul style="list-style-type: none"> • Community Aged Care Package • Extended Aged Care at Home • Extended Aged Care at Home—Dementia 	Galnya Maya Program <ul style="list-style-type: none"> • Carer respite for people caring for those with mental health issues and/or disabilities
		Home and Community Care

^A Rumbalara Aboriginal Co-operative (n.d.b); ^B Rumbalara Aboriginal Co-operative (n.d.c); ^C Rumbalara Aboriginal Co-operative (n.d.d);

^D Rumbalara Aboriginal Co-operative (n.d.e); ^E Rumbalara Aboriginal Co-operative(n.d.f); ^F Rumbalara Aboriginal Co-operative (n.d.g)

35. Of these, 88 were full time, 74 were part time and 33 were casual.

Rumbalara Aboriginal Co-operative receives significant income in grants from both the Victorian Government and the Australian Government. In 2012 Rumbalara Aboriginal Co-operative received a total of \$15,396,760 from these sources and in 2013 it received \$14,071,250 (Table 2).³⁶

Table 2: Income from (non-reciprocal) State and Commonwealth grants in 2012 and 2013³⁷

	2012	2013
Australian Government	\$7,822,836	\$8,110,259
Victorian Government	\$7,573,924	\$5,960,991
Total government grants	\$15,396,760	\$14,071,250

Service agreement-related compliance requirements

In February 2014 Rumbalara Aboriginal Co-operative had 48 separate agreements for service provision for the July 2013–June 2014 financial year.³⁸ Agreements were held with 12 agencies—five Victorian Government departments,³⁹ three Australian Government departments, three government-funded not-for-profit agencies and one other organisation.

Funding is obtained in three main ways. The first is an historical arrangement where a set amount is provided through service and funding agreements negotiated with government departments on an annual or tri-annual basis for delivery of specified primary health

care services. Most of these agreements, across both levels of government, cover delivery of multiple projects or programs. The second is through fee-for-service arrangements, such as payments for medical services through Medicare, and the third is through competitive processes, such as requests for tenders or applications to funding rounds.

This arrangement required 409 reports against 46 of these agreements. Of these, there were 53 annual reports, 52 half-yearly reports, 88 quarterly reports and 216 monthly reports (Table 3; Figure 3). The task of meeting these reporting requirements is further complicated because not all quarterly reports are required on the same dates.

Table 3: Number and frequency of reports for 2012–13 financial year

Reporting frequency	Number of Reports
Yearly*	53
Half yearly	52
Quarterly	88
Monthly	216
Total	409

* One agreement can contain two annual reports if the agreement includes funding for different projects or programs. When a final report for a program is to be submitted within 2013–14, this is included in the count as a once-per-year report.

36. This was the latest publicly available information on grant income at the date of writing this report. It is included to provide an indication of the income received through the agreements for which the reporting requirements are discussed in this report.
37. Data from Rumbalara Aboriginal Co-operative (2013). In 2012 the total revenue was \$22,947,210 (which included a capital grant of \$5,381,875) and in 2013 it was \$15,966,856. Therefore income from non-reciprocal State and Commonwealth grants makes up the majority of the organisation's funding base.
38. This number is likely to be an under-report as some agreements for the 2013–2014 financial year had not yet been included in the database. This does not mean that they are not being reported on, but rather that the information is in the process of being collected from managers and entered into the database.
39. Post the federal election in 2013 in which the Liberal government came to office in Australia, there have been significant changes to administrative and funding arrangements for Aboriginal and Torres Strait Islander health and community services. This study reports on arrangements in place in February 2013, which was prior to changes coming into effect.

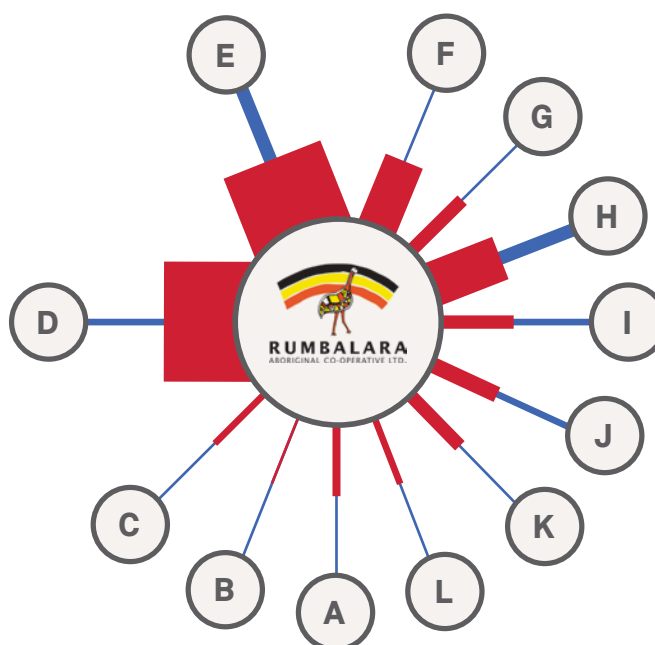
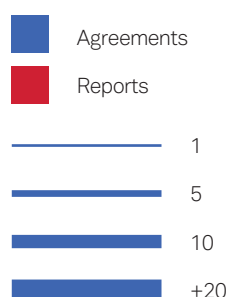
The number of agreements per funding body ranged from one to 12 and the number of reports from one to 137 (Table 4). The proportion of reports to agreements is particularly high for some funding sources for a range of reasons. For example, one agreement pertained to three types of service delivery across a number of regions with monthly reporting for each region for each service delivery type. Another included a program where regular reports were required for different kinds of data (for example activity data, staffing data, finance data) and another included an agreement for multiple programs, each with separate reporting requirements.

Table 4: Number of agreements and number of reports by funding source (2012–13 financial year)

Funding source	Number of agreements	Number of reports
A	2	5
B	1	1
C	1	5
D	5	137
E	10	111
F	1	38
G	1	12
H	12	47
I	5	18
J	7	20
K	2	10
L	1	5
Total	48*	409

* While there are 48 agreements, the number of reports pertains to 46 of these as two agreements had 'ongoing' reporting, which meant that data entered into a database could be accessed by the funding agency at any time, rather than there being set reporting dates.

**Figure 3:
Representation of the numbers of
funding agreements and associated reports
for Rumbalara Aboriginal Co-operative**



* Each funder is represented by a circle containing a letter. The number of funding agreements between Rumbalara Aboriginal Co-operative and that funder is represented by a blue line, where the width of the line indicates the number of funding agreements held. The red lines indicate the number of reports required to comply with those funding agreements.

Establishing systems for efficient and accurate data collection, along with implementing the processes for reporting data to funding agencies, requires significant time and expertise. Data pertaining to direct service provision to individuals is routinely collected and recorded in either paper-based or electronic client records.⁴⁰ Information from paper-based records is entered into an electronic database. Each service delivery area has a process for checking the accuracy of data prior to it being extracted for reporting.⁴¹ Data required for financial purposes (either for claiming or reporting) is extracted and forwarded to the Finance Manager.

For some programs additional information is required. This can include the number of staff (and/or Aboriginal and Torres Strait Islander staff), staff productivity, waiting lists and provision of support services (such as transport). For community-based activities, workforce development projects and one-off projects, a range of reporting is required, including written reports containing both qualitative and quantitative information. In some cases a requirement to participate in an external evaluation is built into funding agreements, which could be considered an additional form of compliance.

Having such a high number of service agreements across six programs creates a significant organisational risk. To address this, Rumbalara Aboriginal Co-operative has established two overarching co-ordination/governance mechanisms. The first is regular internal monitoring and reporting by program managers, who liaise with the Finance Manager and report monthly to the Chief Executive Officer, who reports to the Board. The second is the establishment of a Microsoft Access database—the Rumbalara Agreements Register—to record all information about reporting requirements and enable systematic co-ordination and monitoring of compliance with them.

The Rumbalara Agreements Register was developed with assistance from Jawun Indigenous Corporate Partnerships⁴² and took between two and three years to develop. It is maintained by the Rumbalara Aboriginal Co-operative Corporate Projects Officer, who ensures that all reporting requirements for each agreement are entered into this database (and that updates are made when there are changes to the program or reporting), provides reminders to program managers about reporting dates and monitors compliance with reporting requirements. The Corporate Projects Officer also reviews reporting requirements in potential funding submissions so that the decision about whether to pursue the funding opportunity can include an assessment of reporting burden relative to potential income.

It's not just the number of reports...

Although the number of agreements and reports is high, the picture is significantly more complicated than the numbers suggest. In the following section factors that contribute to this complexity are described. These factors principally emerged from the thematic analysis of interview data from Rumbalara Aboriginal Co-operative managers and VACCHO Sector Quality Improvement Unit staff, but they pertain to many ACCHOs operating in Victoria, so this section is not specific to Rumbalara Aboriginal Co-operative.

Multiple service delivery areas—multiple databases

Different service delivery areas obtain funding from at least one government department under one or more programs, each with their own reporting requirements and often with a requirement to report via a specific database (or type of database). As a result, organisations delivering across multiple service delivery areas are likely to have to maintain multiple databases. As an example, for its six service delivery areas, Rumbalara Aboriginal Co-operative has to work with ten different databases (eight of these were reported by Dean and Renehan nd).

40. Keeping accurate client records is part of normal service delivery and is therefore not considered as contributing to the reporting burden.

41. Generally, this includes auditing a sample of records and ongoing work with staff to ensure data is accurately entered and checked. In some instances additional checks are built into databases and systems. For example, one database on services to clients experiencing homelessness rejects incomplete records, which then have to be checked and missing data entered. In other cases, where program staff can access sensitive client information from an external source, the external agency might conduct spot checks to check that those accessing these data have client consent to do so.

42. For more information about Jawun see the organisation's website www.jawun.org.au

These are:

- Communicare⁴³ (incorporating PenCAT⁴⁴ and OCHREStreams⁴⁵)
- Titanium⁴⁶ for dental services
- Specialist Homelessness Information Platform (SHIP)⁴⁷
- Specialist Homelessness Online Reporting (SHOR)⁴⁸
- Integrated Reports and Information System (IRIS)⁴⁹
- Alcohol and Drug Information System (ADIS)⁵⁰
- Client Relationship Information System for Service Providers (CRISSP)⁵¹
- Client Relationship Information Service (CRIS)⁵²
- The Care Manager⁵³
- Quarterly Data Collection and reporting—disability services (QDC).⁵⁴

Databases pertaining directly to one service delivery area are often not compatible with each other. This can make it difficult to compile data to form an overall picture of

the health service utilisation (and health service needs) of community members.

This not only adds to the complexity of compliance reporting and the organisational risk associated with it, but also imposes a significant technical burden in having to maintain and update databases and train and support service delivery staff in their use.

Data for different purposes

Sometimes the same data are reported for different purposes. Interviewees reported that data on services for people experiencing homelessness is reported in two ways. The first is to the funder about service delivery and the second is to AIHW for reporting on the Council of Australian Governments' performance indicators. Staff working with homeless clients enter data into SHIP. Organisations then extract data from SHIP, save it and upload it to SHOR. Agencies can also use extracts from SHIP for their own use and can download AIHW

43. Communicare is an electronic health and practice management system. For more information see www.communicaresystems.com.au

44. PenCAT is software that enables medical practice staff to extract clinical patient information to support quality improvement in information management and service delivery. It is a tool that can integrate with a range of patient information systems utilised in Australian general medical practices. For more information see www.clinicalaudit.com.au

45. OCHREStreams is a web portal that, when used in conjunction with PenCAT, enables organisations providing health services to Aboriginal and Torres Strait Islander people to electronically extract data from their clinical software and submit it as de-identified information required for reporting to the Australian Government Department of Health (and to the AIHW for reporting against National Key Performance indicators). Information can also be extracted by services for continuous quality improvement purposes, including for participation in collaboratives or other sector or jurisdiction-wide initiatives. OCHREStreams was developed with the aim of reducing the amount of reporting for service providers. For more information see the OCHREStreams website at www.ochrestreams.org.au/pages/welcome.aspx

46. Titanium is dental service-specific software for data collection, records and practice management.

47. SHIP replaced the Supported Accommodation Assistance Program management and reporting tool called SMART in July 2011. It can store client information (including case notes, case plans and client goals). More information about SHIP can be found on the AIHW website at www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129543495

48. SHOR is a secure website hosted by the AIHW and was designed to support data collection to report on Council of Australian Government performance indicators. Information about the use of, and interface between, SHIP and SHOR is at Australian Institute of Health and Welfare n.d.a.

49. IRIS was developed for agencies funded by the Victorian and Tasmanian Departments of Human Services to enable their funded agencies to provide electronic reports. See the IRIS website <http://www.irissoftware.com.au>

50. ADIS is a records and reporting database for State-funded drug treatment services in Victoria; see www.health.vic.gov.au/mhdr-info/downloads/adis-user-manual-v4.pdf

51. CRISSP is a client information and case management system and enables recording of client data and electronic reporting. Further information can be found at www.dhs.vic.gov.au/funded-agency-channel/information-technology/client-relationship-information-system-for-service-providers-crissp

52. This is an online directory containing information about Victorian community-based support services. It is therefore not a database for reporting purposes, but needs to be maintained with up-to-date information about services; see the CRIS website at <http://cris.crisisservices.org.au>

53. The Care Manager is software for aged and community care services; see <http://healthconnex.com.au/solutions/tcm/features>

54. QDC is an information system that aims to streamline reporting requirements across Department of Human Services Victoria program areas. These include Psychiatric Disability Support Services, and Home and Community Care data collections; more information can be found at www.dhs.vic.gov.au/for-service-providers/disability/service-quality-and-improvement/disability-services-performance-reporting/quarterly-data-collection-and-reporting-disability-services

Statistical Summary Reports for their agency from SHOR. Reports are produced by the AIHW quarterly, half yearly and yearly. Funding does not necessarily reflect the trends described in these reports.

A second example of data reported in two ways is where data from the Youth Support Program is also provided to SupportLink, which is a database to assist with monitoring and supporting referral of clients between police and support agencies.⁵⁵ Police also use the database to refer clients to ACCHOs and other service providers.

Programs with multiple funders

Responsibility for provision of funding is split between the State and Australian governments in some programs. This can lead to organisations having to provide reports to both jurisdictions, not necessarily in the same format. For example, some ACCHOs have reported having one program in which there are two workers—one funded by the State and one by the Australian Government. Service activity data entered into the program database can be sent directly to one jurisdiction, but needs to be extracted into a Microsoft Excel spreadsheet for the other. Programs with multiple funders also generally have to provide separate financial statements for each funder.

Programs delivered across state borders

Similarly, when programs are delivered across state borders (such as in Victoria and New South Wales), reporting can be required to both jurisdictions. In the case of aged care services, Victorian ACCHOs delivering services into New South Wales need to be registered as 'foreign co-operatives' in that state.

Brokerage and externally provided services

Enabling clients to access some services requires ACCHOs to apply to a broker – either for funds to provide services, or for delivery of services they do not provide. ACCHOs might work with a number of different brokering organisations. An example of this type of arrangement is where young people transitioning from care to independent living can receive services through the Transition to Independent Living Allowance,⁵⁶ but the services must be purchased by a supporting organisation, rather than the allowance going directly to the client. These kinds of arrangements often entail

provider organisations collecting and forwarding information about each client prior to the approval of funds, organising and/or providing the service/s and reporting to the broker about service provision. The broker then reports this information to the funder. Therefore, these arrangements are not technically ACCHO compliance requirements, but nonetheless entail a degree of reporting to the brokering organisation.

In some types of services, such as aged care facilities, reporting is also required for professional services to clients from external providers. This might include hours of service provided by visiting doctors, mental health workers, health workers, counsellors, dental services, traditional healing services and allied health professionals. This means that the facility must collect and report this information even though the client record will be held by the respective service provider.

Programs with multiple reporting frequencies

The way some programs are funded means there can be multiple reporting frequencies. For example, in one program there is a 'main bucket of money', with reporting twice a year (on a set date in February and October), plus 'supplementary' funds, for which reporting is quarterly. Some funding agreements also require information to be provided on request. This can mean responding to requests for data and/or stories for a range of purposes, including for inclusion in ministerial briefings and other government documents. In some programs requests for additional information or extra reporting might occur several times a year.

Committees, meetings and verbal reports

There are various ways organisations report about their programs that are not technically formal compliance reports. These include verbal reporting—for example, through telephone conversations with government officers and other funders, visits to the service from funders, and participation in regional, state-based or Commonwealth-level committees or steering groups (which might include reporting on activity). Generally, ACCHOs value good working relationships with their funders, so these are seen as important and positive mechanisms to enable this to occur; however, they can also represent an additional form of reporting, as well as time away from service provision.

55. For further information see www.supportlink.com.au/overview.aspx

56. Further information about the Transition to Independent Living Allowance can be found at www.fostercare.org.au

An example of a regional-level committee is the Victorian Local Area Services Networks (LASNs), which includes representatives of housing and support agencies providing homelessness services. Each LASN is charged with making sure the homelessness service system in its area is as effective as possible and organisations can be asked to provide additional reports by the LASN. At a regional level there is also the Loddon Mallee Aboriginal Reference Group, which consists of elected members who provide advice to Aboriginal organisations, mainstream organisations and government departments.⁵⁷ At a state-wide level there are many forums where reports and updates are provided. These include the Aboriginal Justice Forum and other program-specific forums such as those for social and emotional wellbeing and the Aboriginal health promotion and chronic care initiative. VACCHO also holds tri-annual members meetings, where information on programs and activity can be exchanged.

Working with partners can create some data issues

Although partnerships with mainstream agencies are often important to ACCHOs, particularly if they are unable to provide specific services to their communities and need to develop collaborative arrangements (such as shared care), these arrangements can create significant work, including in relation to compliances. For example, while data for Koori Maternity Services clients in Victoria are entered into participating ACCHO patient information and referral systems, hospital staff use a different database. In order to keep a complete record and maintain an accurate picture of the health of the community (and report appropriately), data about client care may have to be extracted from one organisation's database and manually entered into the partner organisation's database.

Paper and electronic records

Over the past decade or so there has been a move from paper-based to electronic records, a process that has not always been smooth. In some instances staff may consider that it is still important to keep paper-based records as a back-up. In other circumstances staff may deliver services outside the physical location of the organisation and, unless they have access to portable devices, need to first record information on paper. Sometimes clients are uncomfortable with

workers typing directly into a computer or even having an electronic device with them, which can make it difficult for workers to have conversations with clients and means they are more likely to record information on paper. In any of these scenarios, time is required to transfer records from paper to electronic form.

Activity reporting and financial reporting

In many organisations, financial information is tracked and monitored against each project or program and monitored to ensure there is no over- or under-spending, with financial acquittals being undertaken at the end of each project and/or the end of each financial year. Many programs have a requirement to be externally audited with an independent acquittal, although one funder (the Department of Human Services in Victoria) has introduced a system where there is one audit for all its funded programs. Sometimes a lot more time is spent on reconciling smaller projects than larger projects. There can be different timeframes for acquittals—most fall on 30 September, but some are at the end of July and some are at the end of October.

Reporting to community

ACCHOs have significant obligations associated with engaging with their communities, and reporting on service delivery is one of them. A range of mechanisms can be put in place to enable this reporting, including via the Board of Governance, through community meetings, and through advisory committees, newsletters and events.

Keeping abreast of program changes

Changes to government departments (such as through restructuring) or to programs can result in changes to reporting and compliance requirements. One way that ACCHOs can keep abreast of these changes (and problem solve related issues) is to have good relationships with their funding bodies, particularly the Australian Government and state governments. Public service downsizing has the potential to disrupt these relationships, including making it more difficult for government officers to have the time to discuss issues with service providers.

Accountability and continuous quality improvement

Program managers were clear about the need to be

57. See www.bdac.com.au/pages/lmarg.html for further information on the Loddon Mallee Aboriginal Reference Group.

both accountable and transparent and were committed to developing the skills and capacity within their organisations to report effectively. They also wanted to collect data that would enable them to track the effectiveness of their services so that they could build an evidence base, use data to assist with continuous quality improvement and be able to demonstrate the contribution their service delivery makes to key issues for their communities. Program managers tended to see accreditation processes and requirements not only as being about ensuring continuous quality improvement, but also as being part of their compliance regime, particularly if accreditation was a mandated requirement to receive funding (which it is for a number of Australian and state government-funded programs).

Ensuring high-quality data

Significant time is invested by ACCHO program managers to ensure data is entered into databases correctly. This includes training and supporting staff (some of whom will have had limited access to information technology), checking data and/or doing regular audits of data quality, and following up incomplete or missing information. In some service areas a staff member has the specific responsibility of monitoring data quality.

In some instances managers considered that service activity tended to be under-reported by staff, and that significant training was required to help them understand the breadth of their work and that all activity needed to be recorded. For others, accurate reporting on activity was about 'changing the culture of our mob to take time out every day to put stuff in the database' (ACCHO program manager) —an objective perhaps made difficult by having an oral culture and/or by staff members not wanting to take time for administrative work when they could see that community members needed services.

In some areas facilitating improved data collection involved finding methods that would help staff collect and record data. One example was the development of a paper chart/spreadsheet and a process whereby an administration worker sat with each service provider once a week to talk about their work. Although the organisation that implemented this strategy considered that it promoted a form of reflective practice, the double handling of data was also noted.

Some reporting requirements are too difficult and sometimes inappropriate

Some reporting requires collection of data that can be difficult or inappropriate to obtain. An example of this is where a funder requires the number, age and gender of all people attending community events to be reported. These data can be difficult to collect when large numbers of people, including many children, attend these events. It may also be inappropriate for workers to ask Elders (or anyone from their community) their age when the information is not relevant to the reason they are attending (for example, a community event rather than a health service) and may dissuade people from returning to the organisation for other services, such as health care.

Limits to usefulness of quantitative data

Although quantitative data is useful for reporting on activity and against the bottom line, it may not provide an accurate picture of what is happening on the ground and may therefore have limited applicability for planning and other purposes. Some workers considered it was important to collect qualitative information to help understand the meaning of quantitative information and to better understand the nuances of working in a community with complex needs.

Reporting is not always commensurate with program or project funding

Some programs have very small amounts of funding (for example, \$50,000) but still require almost as much reporting as much larger projects. This has meant that, in some cases, ACCHOs have not applied for funding (or have chosen to cease delivering a program) because the reporting burden relative to resources available is too high. In other cases, ACCHOs have sought funding for small amounts of money for programs that are highly valued by the community, but have had to stretch their resources to ensure reporting requirements can be met.

Individuals provide the same data many times

ACCHOs in Victoria provide a wide range of services, so community members are likely to receive more than one type of service. This means that they have to tell their story, and provide the same data (such as demographic information), multiple times, which can be very confusing and frustrating. A consequence of this is that data pertaining to one individual might be reported to multiple

funding agencies. The Department of Human Services in Victoria has introduced the 'funded agency channel' to try to address some of these issues⁵⁸.

No existing database

Some programs do not have a specified database and in some cases program managers have had to develop their own. One program manager reported having to enrol in an education course to enable her to do this.

Similarly, many ACCHOs cannot afford expensive databases to keep track of and monitor their reporting requirements. Most ACCHOs therefore continue to manage compliance and reporting manually through the use of spreadsheets and text documents.

58. The Funded Agency Channel is an inter-departmental site in Victoria (encompassing the Departments of Human Services, Health, Education and Early Childhood Development) which aims to support partnerships with their funded agencies. Each agency can access a secure area in which information about their service agreements as well as departmental policies, standards and guidelines, data collections and other reporting requirements and relevant legislation. See www.dhs.vic.gov.au/funded-agency-channel/home for more information.

Discussion and Conclusion

Who benefits? Over-burdensome procedural accountability consumes significant resources and undermines service delivery

Victorian ACCHOs are committed to the provision of holistic, comprehensive (or 'wrap around') care for Aboriginal people living in or visiting the catchment in which they operate. Many ACCHO clients have complex needs and require a range of service types, such as health, housing, family and justice services. Delivering these services appropriately requires implementation of client-centred, well-co-ordinated or integrated models of care. To facilitate development of such models, some ACCHOs have grown into multifunction organisations that provide a suite of services and/or collaborate with other organisations to ensure their clients obtain the services required.

As most funding is attached to separate programs and projects ACCHOs delivering comprehensive models of care are subject to increasingly complex funding arrangements. Multiple funding streams must be accessed and relevant activity reported for each stream, which necessitates the use of multiple databases and reporting processes. This imposes a high technical and staff training burden and introduces significant organisational risk.

Increasing the complexity of the supporting infrastructure and processes can reduce the capacity for organisations to innovate, including in the delivery of new models of integrated care. This is because organisations are challenged by the substantial effort required to implement change across a number of platforms and the additional reporting burden associated with some funding opportunities can outweigh the potential benefit of accessing those funds.

Clearly, current funding and reporting models have the potential to undermine service delivery and innovation. In addition, resources and effort that could otherwise be directed to service provision are being expended on compliance reporting. Significant attention needs to be directed to establishing new funding and reporting models that support, rather than hinder, the delivery of comprehensive, client-centred services.

The service might be client centred, but what about the data?

A further consequence of organisations reporting against different funding streams is that client data are not captured and reported in a way that enables service providers or governments to gain a useful understanding of the overall needs of clients and families. To illustrate this point, consider one person accessing an organisation such as Rumbalara Aboriginal Co-operative, with co-existing health conditions (say, diabetes and oral health issues) and requiring housing, justice and family services. Data about the client and their diabetes-related care will be entered into a patient reminder and recall system (Communicare) and then extracted into a form appropriate for reporting to the Australian Government or for claiming from Medicare. Dental records will be entered into a database maintained by Dental Health Services Victoria (Titanium). Housing data will be entered into the Specialist Homelessness Information Platform (SHIP) and also extracted and uploaded into the Specialist Homelessness Online Reporting (SHOR) platform for the AIHW. Depending on the nature of the justice and family services required, data will be reported into other databases—such as the Victorian Government's Integrated Reports and Information System (IRIS).

Databases designed for reporting for different programs generally do not interface with each other. Not only will clients have to provide information about themselves multiple times, but these data will have to be entered multiple times and extracted into multiple reports to be provided to several Australian and state/territory government departments. This does not facilitate collation of data in a way that gives a comprehensive picture of either individual or community need. It also hinders the development of data systems that, with the right privacy and consent protections, might enable improved co-ordination of care for clients.

While ACCHOs are acutely aware of the need to collect and maintain quality data so that they can plan, review and evaluate the services they deliver, the way data are reported for compliance purposes does not facilitate its use for these purposes. This situation is contrary to recommendations from a number of investigations, including that conducted by the Australian Government's

Department of Finance and Deregulation (2009), which indicated that reported data should be both meaningful to the funder for monitoring how the organisation is meeting its objectives and to the service for the purposes of service development.

Continuing to add further procedural reporting requirements for new funding streams simply increases the administrative burden on services. It does nothing to contribute to the capacity of organisations to access accurate data for planning and evaluation purposes. This is a significant barrier to agencies like Victorian ACCHOs that aim to improve the health and wellbeing of populations of Aboriginal people living in large catchment areas.

Who is the boss? Increasing levels of vertical accountability reduces the time and resources available for community (horizontal) accountability

ACCHOs are significant community organisations that put principles of community self-determination into operation. This means that horizontal forms of accountability enacted through strong mutual relationships between communities and their service providers are particularly important. ACCHOs maintain horizontal accountabilities in many ways, including through formal means (such as community-elected boards, community meetings, community events, and communication with communities through newsletters and media) and through less formal means (such as conversations with community members). Increasing levels of vertical accountability to funders potentially reduces the resources available for horizontal reporting. In addition, vertical reporting requirements are designed to meet the needs of funders and data reported may not be the most useful information for engaging communities.

A key question is whether the burden of vertical accountability slowly erodes the capacity for community self-determination. A related question is whether authority and control is increasingly transferred to funders through the vehicle of over-burdensome compliance requirements. If this is the case, who then is really the boss? Certainly, if the burden of vertical

accountability was reduced, additional resources could be invested in strengthening governance and enhancing innovation in relation to community control.

Given that funders, ACCHOs and communities all want to achieve a common goal of improved outcomes for Aboriginal and Torres Strait Islander peoples, it might be useful to try to conceive of a system of horizontal (or what Dwyer et al. 2009 call 'relational') accountabilities between funders and service providers, and between service providers and their communities. In such a system all actors would have accountabilities to each other determined by the particular roles and responsibilities they play in contributing to achieving the shared goal.

Might a focus on substantial, rather than procedural, accountability be useful?

To reduce the impact of the complexities described in this report, it would be worth considering a refocus from procedural accountability (that is, accountability for activity) to substantial accountability (that is, accountability for benefit). This would require ACCHOs to develop catchment-based population health and community service plans that specify strategies to address identified needs and describe the benefits that would result. In this way services could be organised around individual and family needs, rather than ACCHOs trying to fit people into a number of different programs and services that may be only partially appropriate. Careful consideration would need to be given to how accountability for benefit would be described, measured and reported so that organisations are only held accountable for the things they can realistically influence. Any refocus on outcomes and results would need to be undertaken with the full participation of ACCHOs and their peak bodies. This approach would represent a significant change and support and training for organisations to develop the capacity to plan, deliver and demonstrate accountability for outcomes would be required.

This idea is similar to that described by Dwyer et al. (2009) who propose that ACCHOs be provided with long-term contracts to deliver 'core services'. In their schema, there would also be flexibility for local priority setting, which would be described in a plan, and monitoring would be based on performance and outcome measures. One limitation here is that although there has been some

work on describing core functions for comprehensive primary health care services (for example, see Tilton & Thomas 2011, Silburn & Sieh 2013) and some initiatives focused on catchment-based planning to meet the needs of Aboriginal populations, to our knowledge there are no frameworks that describe the full suite of core health and community services Aboriginal populations should have access to.

How much evidence is required before there is a concerted, constructive and collaborative attempt to rethink how contracting between government and ACCHOs occurs?

Despite the growing body of evidence demonstrating the constraints imposed by current funding arrangements, the rhetoric about reducing 'red tape' and some work by some government departments to streamline reporting there remain significant issues with the way contracting for government-funded, third-party service provision is arranged. This report provides further evidence of the need to address this issue and therefore we support calls made by others for the nature of the contract between ACCHOs and governments to be re-framed.

First, funding mechanisms need to be developed to support a service system that can provide holistic, client-centred and co-ordinated care to people and communities. As described above, this is likely to require mechanisms for undertaking population-based planning and then funding integrated service delivery commensurate with need. While streamlining programs and allocating funding through competitive funding rounds (such as happened under the current federal government's Indigenous Advancement Strategy) might result in reducing the number of contracts held by government (and therefore the 'red-tape' with which government has to deal), this kind of strategy is not conducive to ensuring a planned approach to service delivery so that communities have access to a suite of services that meet their needs. It also does little to change the nature of the accountability relationship between government and service providers.

Second, we endorse recommendations by previous authors for funding and accountability mechanisms to be relational or horizontal and focused on benefit for communities (and therefore be substantive rather than procedural). In the meantime we suggest that when introducing new programs and/or reporting processes, governments consult with service providers to determine what will work in practice. To minimise duplication consultation should also occur between government departments and levels of government to identify existing databases and reporting frameworks that could be used (or reviewed, strengthened or broadened) for reporting on new programs. These actions could greatly reduce the reporting burden for ACCHOs and reduce the pressure on, and cost of, administrative functions.

Similarly, duplication of effort related to meeting standards and obtaining accreditation should also be examined. In the ACCHO sector, most organisations are engaged in continuous quality improvement processes and participate in accreditation programs (some of which are mandatory). However, this means that ACCHOs often have to meet multiple sets of standards and where these contain common elements, duplicate the work required for evidence and reviews. Funding and accrediting bodies should work towards reducing (rather than continually increasing) the numbers of accreditation reviews organisations have to undertake, and/or provide recognition of equivalent standards to reduce workloads and cost.

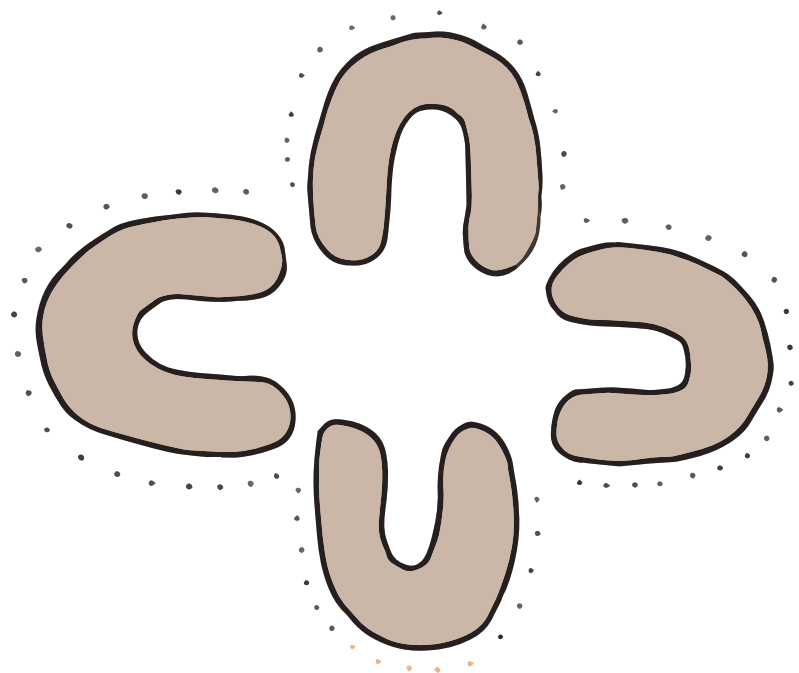
In conclusion

There is ample evidence about the scope and nature of the compliance and reporting burden on ACCHOs. The case study of Rumbalara Aboriginal Co-operative paints a picture of the impact of this overburden for service providers. The effects of onerous reporting are real and do have the potential to compromise service delivery and impede innovation.

There is currently a focus by governments to further reduce administrative costs and redirect them to frontline services. Too often policy changes have resulted in increased rather than decreased compliance burdens on ACCHOs. There must be a shift in mechanisms for engagement, funding and compliance at a government level to produce improved compliance frameworks at the service delivery level. We acknowledge the complexities for both governments and ACCHOs if this is to be achieved.

The onus should be on governments to be more coordinated and insightful when considering how organisations should be held to account for the use of public funds. The focus must shift from procedural accountability for program activity to substantive, real accountability for outcomes in communities. Such a shift may enable organisations to increase the services they can provide and strengthen their capacity to deliver these in an effective, comprehensive and holistic way. This would produce better outcomes for Aboriginal communities and for all Australian taxpayers. If there is not a move to establishing more purposeful and practical compliance regimes organisations will require additional funding to support the technical and administrative capacity to meet their increasing reporting requirements.

Government policy is explicit about the need to improve the health and wellbeing of Aboriginal and Torres Strait Islander people and communities. ACCHOs share the goal of achieving the best possible outcomes for their communities. Transformation of the nature of the relationship between government and ACCHOs is required to ensure available resources are used to maximise the delivery of innovative, comprehensive, holistic services and are not expended on wasteful, over-burdensome reporting and compliance obligations.



References

- Aboriginal Health and Medical Research Council of New South Wales (AH&MRC) 2011, *The Living Law: An Interactive Resource to a Selection of Statutes*, compiled by P. A. Richards, AH&MRC, Sydney.
- Alford, K. 2014, *Economic Value of Aboriginal Community Controlled Health Services*, NACCHO, Canberra.
- Australian Health Ministers Advisory Council 2006, *Aboriginal and Torres Strait Islander Health Performance Framework*. Canberra, Australia, Office of Aboriginal and Torres Strait Islander Health, Australian Government Department of Health, Canberra.
- Australian Institute of Health and Welfare n.d.a, *From SHIP to SHOR*, AIHW, Canberra. Accessed 2 October 2014 www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737422566.
- Australian National Audit Office 2012, *Capacity Development for Indigenous Service Delivery*, Australian Government, Canberra.
- Breaking New Ground 2011, *The Cost of Quality Service Standards: Assessment and Compliance Reporting for the Not-for-profit Sector*, Breaking New Ground, Bradfield Nyland Group and BNG NGO Services Online. Accessed 5 May 2015 www.ngoservicesonline.com.au/files/pdf/bng-report-costofstandards-july2011.pdf.
- Cooperative Research Centre for Aboriginal Health (CRAH) 2008, *Aboriginal and Torres Strait Islander Health Sector Accreditation and Quality Standards Project*, prepared by P. Duncan & M. Gooda CRAH, Darwin.
- Dean, F. & Renehan, C. n.d., Rumbalara Aboriginal Co-operative Ltd—Presentation to the Victorian Aboriginal Community Controlled Health Organisation at VACCHO, July 2013
- Department of Finance and Deregulation 2009, *Evaluation of Primary Health Care Funding to Aboriginal and Torres Strait Islander Health Services*, Australian Government, Canberra.
- Department of Human Services (DHS) 2006, *Improving the Way We Work with Aboriginal Community Controlled Organisations—How the Department of Human Services Can Assist in Improving Service Delivery Outcomes for Aboriginal Victorians*, DHS, Melbourne.
- Department of Prime Minister and Cabinet (n.d.), 'Strengthening organisational governance to support effective services for Indigenous Australians', Australian Government. Accessed 5 May 2015 www.dpmc.gov.au/indigenous-affairs/incorporation-requirements.
- Dixon, R., Ritchie, J. & Siwale, J. 2006, 'Microfinance: Accountably from the Grassroots', *Accounting Auditing and Accountability Journal*, vol. 19, no. 3, pp. 405–27.
- Dwyer, J., O'Donnell, K., Lavoie, J., Marlina, U. & Sullivan, P. 2009, *The Overburden Report: Contracting for Indigenous Health Services*, Cooperative Research Centre for Aboriginal Health, Darwin.
- Effective Change 2008, *Review of DHS Reporting Requirements for Aboriginal Community Controlled Organisations*, DHS, Victoria.
- Gray, R. 2010, 'Is Accounting for Sustainability Actually Accounting for Sustainability... and How Would We Know? An Exploration of Narratives of Organisations and the Planet', *Accounting, Organizations and Society*, vol. 35, no. 1, pp. 47–62.
- Hemingway, M. n.d., *The Long Journey: Colonialism, Community-Control and Indigenous Autonomy*, VACCHO, Melbourne. Accessed 1 July 2014 www.vaccho.org.au/vcwp/wp-content/uploads/2011/03/Michael-Hemingway-Thesis-History-of-VACCHO.pdf.
- Lehman, G. 1999, 'Disclosing New Worlds: A Role for Social and Environmental Accounting and Auditing', *Accounting Organizations and Society*, vol. 24, no. 3, pp. 217–42.
- Lehman, G. 2001, 'Reclaiming the Public Sphere: Problems and Prospects for Corporate Social and Environmental Accounting', *Critical Perspectives on Accounting*, vol. 12, no. 6, pp. 713–33.
- Lewis, D. & Madon, S. 2004, 'Information Systems and Nongovernmental Development Organizations: Advocacy, Organizational Learning, and Accountability', *The Information Society*, vol. 20, pp. 117–26.
- McKernan, J. & McPhail, K. 2012, 'Accountability and Accounterability', *Critical Perspectives on Accounting*, vol. 23, no. 3, pp. 177–82.
- Moran, M., Porter, D. & Curth-Bibb, J. 2014, *Funding Indigenous Organisations: Improving Governance Performance through Innovations in Public Finance Management in Remote Australia*, Closing the Gap Clearinghouse, Canberra.

National Community Controlled Health Organisation (NACCHO) & Lang, T. 2012, *NACCHO Governance Code: National Principles and Guidelines for Good Governance*, NACCHO, Canberra.

Nous Group 2012, *Not-for-profit Back-of-house Function Benchmarks, 2010–2011, 25 July 2012—Public Summary Report*, Nous Group, Melbourne. Accessed 10 October 2014 www.nfpbenchmarking.com.au/sites/default/files/NFP%20Back-of-house%20function%20benchmarks%202010-2011%20-%20summary%2025%20Jul%202012.pdf.

Parliament of Australia n.d., 'Commonwealth Indigenous Advancement Strategy Tendering Processes'. Accessed 29 May 2015 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Commonwealth_Indigenous.

Productivity Commission 2010, *Contribution of the Not-for-Profit Sector, Productivity Commission Research Report*, Productivity Commission, Canberra.

Rumbalara Aboriginal Co-operative Ltd 2013, Annual General Meeting Report 2012–2013, Rumbalara Aboriginal Co-operative Ltd, Shepparton, Vic.

Rumbalara Aboriginal Co-operative n.d.a, 'About us'. Accessed 11 February 2014 www.rumbalara.org.au/about-us.php.

Rumbalara n.d.b, 'Health Services'. Accessed 19 May 2014 www.rumbalara.org.au/programs.php?id=ID1363830256&l=Health%20Services.

Rumbalara n.d.c, 'Housing Services'. Accessed 19 May 2014 www.rumbalara.org.au/programs.php?id=ID1363830291&l=Housing%20Services.

Rumbalara n.d.d, 'Justice Program'. Accessed 19 May 2014 www.rumbalara.org.au/programs.php?id=ID1363830328&l=Justice%20Program.

Rumbalara n.d.e, 'Family Services'. Accessed 19 May 2014 www.rumbalara.org.au/programs.php?id=ID1363830275&l=Family%20Services.

Rumbalara n.d.f, 'Rumbalara Elder Facility'. Accessed 19 May 2014 www.rumbalara.org.au/programs.php?id=ID1372040335&l=Rumbalara%20Elder%20Facility.

Rumbalara n.d.g, 'Aged Care and Disability Services'. Accessed 19 May 2014 www.rumbalara.org.au/programs.php?id=ID1363830349&l=Aged%20Care%20and%20Disability%20Service.

Shergold, P. 2013, *Service Sector Reform: A Roadmap for Community and Human Services Reform*, Victorian Council of Social Service, Melbourne.

Silburn, K., Thorpe, A. & Anderson, I. 2011, *Taking Care of Business: Corporate Services for Indigenous Primary Health Care Services—Overview Report*, The Lowitja Institute, Melbourne.

Silburn, K. & Sieh, K. 2013, 'Is better population health data the answer? A model for planning primary health care in rural areas', presentation to the Health Services Research Association of Australia and New Zealand conference, Wellington, New Zealand, December.

Tilton, E. & Thomas, D. 2011, *Core functions of primary health care: A framework for the Northern Territory*, The Lowitja Institute, Melbourne.

Unerman, J. & O'Dwyer, B. 2006, 'Theorising accountability for NGO advocacy', *Accounting Auditing and Accountability Journal*, vol. 19, no. 3, pp. 349–76.

Victorian Aboriginal Community Controlled Health Organisation (VACCHO) 2013a, Governance review: A comparison of RAPT, ISO, QIC and ACCHO governance standards. Melbourne, VACCHO, Melbourne.

Victorian Aboriginal Community Controlled Health Organisation (VACCHO) 2013b, *VACCHO 2013–16 Strategic Plan*, VACCHO, Melbourne. Victorian Aboriginal Community Controlled Health Organisation (VACCHO) 2014, 'New Government Policy Set to Discriminate and Reduce Services', media release, 4 September. Accessed 10 October 2015 www.vaccho.org.au/assets/01-RESOURCES/TOPIC-AREA/NEWS-MEDIA/MEDIA-RELEASES/2014/2014-09-04-VACCHO-Media-release-ORIC-final-23.pdf.

Victorian Aboriginal Community Controlled Health Organisation (VACCHO) 2015, 'Response to Finance and Public Administration References Committee Inquiry into Indigenous Advancement Strategy Tendering Processes', Parliament of Australia, Canberra.

Victorian Aboriginal Health Service (VAHS) n.d., 'History VAHS'. Accessed 5 May 2014 www.vahs.org.au/history-vahs.

Wise, M., Angus, S., Harris, E. & S. Parker 2013, *National Appraisal of Continuous Quality Improvement Initiatives in Aboriginal and Torres Strait Islander Primary Health Care*, The Lowitja Institute, Melbourne.



the
Lowitja
Institute

Australia's National Institute for Aboriginal and
Torres Strait Islander Health Research

The Lowitja Institute

PO Box 650, Carlton South
Victoria 3053 AUSTRALIA

T: +61 3 8341 5555

F: +61 3 8341 5599

E: admin@lowitja.org.au

W: www.lowitja.org.au

 [@LowitjaInstitut](https://twitter.com/LowitjaInstitut)