AGPN's submission to the Productivity Commission's Issues Paper: Contribution of the Not-for-profit Sector April 2009

June 2009

Executive Summary

The not-for-profit or 'third' sector makes a major contribution to Australian society through the action of volunteers and the many and varied health, community and welfare services it delivers on behalf of governments.

The Australian General Practice Network (AGPN) is the peak national body for divisions of general practice, comprising 111 divisions across Australia as well as state based organisations (SBOS). Network members (AGPN, SBOs and divisions) are individually and independently governed by a board of directors and are not-for-profit small businesses whose core activities are the delivery and organisation of primary care through general practice and broader primary health care teams. Locally, Network members deliver a range of services to their communities including health promotion, early intervention, general practice, after hours and allied health services.

The following is a summary of AGPN's recommendations pertaining to the some of the key issues canvassed in the Commission's Issues Paper:

Enhancing efficiency and effectiveness: including responses to issues of human and financial resources and how current regulations for not-for-profit organisations (NFPs) can impact on these and on innovation

- AGPN recommends that funding contracts between government funders be developed in a flexible manner that does not constrain cross-program integration and coordination. Effective recruitment and project/program sustainability can often involve linkage and integration with other (new or existing) contracts. AGPN also recommends that project contracts include adequate funds for impact and outcome evaluations and for developing sustainability plans.

- AGPN recommends that all Divisions are deemed as charitable businesses for the purposes of payroll tax and FBT.

Service Delivery: including discussion of delivery of government funded services, with a particular emphasis on the impact of contractual arrangements, accountability and reporting frameworks

- AGPN recommends less stringent requirements in government contracts regarding the accrual of working capital in order to better financially manage the cash deficit issues that can arise from contract timing issues with funders.

- AGPN recommends that to maximise efficiency, contracts from the same funding agency should be legally equivalent, and standardised and streamlined as much as possible. AGPN also recommends that contracts from the same funder or government department be audited as part of an overall audit and not require individual audits. Allowance should also

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be made in funding agreements or other resourcing for NFPs to seek legal and/or accounting advice to better manage the diversity of contracts that currently exist.

- AGPN recommends that future funding contracts with government take into account the real market rate for employee salaries including realistic consideration of CPI and rises in competing employment awards.

- AGPN recommends that budget breakdowns in contracts for services have the flexibility to be assessed on a case-by-case basis where necessary, to take into account the diversity of locations and local factors across Australia. AGPN further recommends that code of conduct specifications for staff employed under contracts are determined by the contract holder and not the funder.

Measurement and contribution – with reference to AGPN's own experience with its required reporting framework.

AGPN recommends that national performance or indicator systems for NFPs remain flexible enough to reflect and measure responsiveness, particularly for organisations acting locally. AGPN also recommends that performance systems are devised with meaningful realistic indicators that encourage improvement over time.

Background to AGPN and this submission

The Australian General Practice Network (AGPN) welcomes the opportunity to make a submission to the Productivity Commission Issues Paper on the Contribution of the Not- for profit (NFP) sector.

AGPN recognises that the NFP sector makes an enormous contribution to the health, wellbeing and productivity of the Australian community. This occurs through action by volunteers and through the many and varied health, community, welfare and vocational services delivered on behalf of governments.

AGPN is the peak national body of the divisions of general practice, comprising 111 divisions across Australia, as well as eight state based organisations (SBOs). Approximately 90 percent of GPs and an increasing number of practice nurses and allied health professionals are members of their local division. Network Members (divisions, SBOs and AGPN) are essentially not-for profit small businesses (each member organisation operates as a small-to-medium-sized enterprise[1] or SME) whose core activities are the delivery and organisation of primary care through general practice and broader primary care teams. Ultimately the Network is designed to deliver primary health care outcomes for the Australian population. These outcomes are achieved through the delivery of population health programs, health services and other activities that support:

- their members (general practices and, in some cases, practice nurses and allied health providers)
- their local communities, and
- the larger general practice network via contributions to policy advice and feedback on policy initiatives.

Through this work the Network plays a pivotal role in ensuring all Australians can access a high quality health system.

Every Network Member (Divisions, SBOs and AGPN) are individually governed by a board of directors. Since 2005, AGPN has also been required to report annually on a set of national performance indicators (NPIs) as part of the Department of Health and Ageing's (DoHA) National Quality and Performance System (NQPS) for the Network.

Many programs implemented by Network Members at the local level are funded through the Australian Government Department of Health and Ageing. These programs include aged care, mental health, practice nursing, immunisation, rural palliative care, quality use of medicines, chronic disease management and eHealth. Many of these programs are supported at the SBO level through state networks and/or are coordinated at the national level through AGPN.

At a local level there are numerous instances of other innovative individual divisional programs that add value to the health system. Funding for these programs may be through a variety of means: state or area health funding brokered either directly or through the SBOs, community grants, or private enterprise funding negotiated at a local level. In fact, Network Members are increasingly sourcing funding from alternative sources.

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[1] An SME is an organisation defined as having fewer than 200 employees. Small enterprises: 5 to 19 employees medium enterprises: 20 to 200 employees. CSIRO Small and Medium Enterprise Engagement Centre: http://www.csiro.au/solutions/SMEEngagement.html#3 Last accessed May 2009

The range of services that the Network delivers requires ongoing engagement with an immense array of stakeholders at many different levels - local, state and national. Two important aspects to the work of the Network are therefore collaboration and linkage as well as consumer and community engagement.

Collaboration and linkage across the health sector helps patients experience a more unified system as they move between general practice and other parts of the health and social welfare system. It also helps with efficiencies – through shared resources, streamlined approaches and funds pooling (where several different sources of small local funds are combined to provide larger amounts to contribute to a positive community outcome).

Network Member's engagement and linkage with their communities is vital not only to ensure that services delivered are consumer focused, but also to ensure best use of government and other funds through the effective implementation and uptake of services at the local level.

AGPN's response to the Issues Paper

AGPN commends the Commission on its detailed Issues Paper and notes the twenty four questions contained within it. AGPN agrees with the Commission's broad definition of NFPs. It also agrees with the Commission's proposed approach to the study whereby the Study intends to narrow its focus to a smaller group of NFPs for sections two (*Enhancing efficiency and effectiveness*) and three (*Service delivery*) of the paper. AGPN also supports the proposed focus on the suggested issues within each of these areas. Although AGPN is not familiar with all of the studies outlined on page 15 of the Issues Paper, AGPN supports drawing on other studies where these are relevant to inform the Commission's understanding and recommendations regarding NFPs.

Many of the Paper's questions and areas of focus are pertinent to AGPN as a national network of NFP organisations delivering government funded services to its local communities. While every question will not be answered individually, AGPN's response aims to broadly cover the various issues contained within all questions. Overall, AGPN's response will be divided into the following four sections:

1. Enhancing efficiency and effectiveness: including responses to issues of human and financial resources and how current regulations for NFPs can impact on these and on innovation.
2. Service Delivery: including discussion of delivery of government funded services, with a particular emphasis on the impact of contractual arrangements, accountability and reporting frameworks.
3. Measurement and contribution – with reference to AGPN's own experience with its required reporting framework.

Section 1: Enhancing efficiency and effectiveness: *including responses to issues of human and financial resources, and how current regulations for NFPs can impact on these and on innovation.*

Staffing and human resources:
The Network relies on a skilled and effective workforce to support the complex needs of primary health care and to engage with the broader health care sector. Staffing includes the executive and administrative staff required in any business, but additionally specific health program and clinical staff. These staff include nurses, dieticians, psychologists, occupational therapists, health educators and many others who have the special skills required to deliver and/or coordinate health programs, provide health promotion, or directly provide services to consumers. Divisions also employ, as well as support, GPs although employment is often on a sessional basis. The total number of staff employed across the Network is about 2,637 staff (representing 1,615 FTE).[2]

Staffing issues that arise for the Network as an NFP organisation are often related to the nature of its contracts with governments. This area is also discussed in section 3. Although Network Members (Divisions, SBOs and AGPN) receive core funding for certain activities, various additional services are funded through specific program or project funding on a contract basis. These contracts are often short-term with no certainty of renewal. They are also often under priced in comparison to equivalent services in the for-profit sector and/or do not keep pace with increases in state or commercial payment awards for similar services. This leads to difficulty both attracting and retaining good staff because wages cannot be offered commensurate to the for-profit sector and public sector and there is lack of job security – tenure cannot be offered. To some degree, the Network can overcome the wage issues through salary packaging options available to NFPs through their charitable status and FBT exemptions, however it can still be difficult to attract staff when advertising lower wages, especially where NFPs, the public sector and For Profits are competing for the same workforce. There is also a legitimate view that even with salary packaging, salaries are generally not on a par with market rates and that ideally, salaries should be determined at real commercial rates, irrespective of salary packaging options.

Staffing can also be affected through project or program contracts that offer capacity to finance part-time positions. It is particularly difficult in rural and remote areas to employ people on this basis which can mean that some communities, including those most in need, can potentially miss out on vital services. Divisions attempt to overcome this by 'pooling' funds from different programs so that funding for an FTE can be achieved while preserving the ability to be accountable for the separate funding streams. However in some cases the guidelines for certain programs are so specific that this is very difficult, if not impossible to accomplish.

Short-term, one-off project funding can mean that essential services that have been made available to the community are withdrawn when project funding ceases even though community expectations have been raised. Ideally, projects need to have both evaluation and sustainability components built into contracts as a standard, funded clause. This is not currently the case. Within the Network, sustainability of effective projects can be a key area of innovation, often involving linkage with other agencies or new/existing projects. Broad based, outcome driven contracts that provide flexible funding best enable Network Members (and presumably other NFPs) to achieve this. Again, contracts that are very specific in how and where funds can be spent can obstruct useful linkages, funding use, innovation and local relevance. See Box 1 for an example around regional health services funding.

[2] PHC RIS ASD 2006-2007. This figure represented a 10% increase on the previous year – and without any increase to members' core funding

Box 1: Regional health services funding[3]

The regional health services funding program was set up to assist small rural and remote communities of less than 8000 people to access health services. Access to health providers in such areas is often extremely difficult and the funds enable employment of health practitioners to help address this issue. A number of Divisions successfully applied for funding. North and West Queensland primary health care (NWQPHC) - one such Division – has a long history of health care provision in remote Australia and understands that the successful recruitment of health professionals to remote areas relies on providing them with reliable peer support. Without such support available, recruitment to remote areas is more difficult. The Division addressed this issue by basing a critical mass of staff funded through a variety of programs, including the regional health services contract, in Mt Isa from which outreach programs, as well as services in Mt Isa itself, could be run. Mt Isa is a large regional centre with a population of about 19,000 people. NWQPHC's regional health service contract provided them with funding to supply subsidised health care to some of the small remote communities outlying Mount Isa such as Richmond, Julia Creek, Hillendon, Normanton and others. Many of the people from these areas regularly come to Mt Isa to shop (it is the only large shopping area in the region). Although it would have made sense for people from these communities to access the subsidised health services available through the additional funding when they were in Mt Isa – and many of them were keen to do so – technically the contract made this impossible as it stipulated that service provision had to be in communities of less than 8000 people.

AGPN recommends that contracts are developed in a flexible manner that does not constrain cross-program integration and coordination. Effective recruitment and project / program sustainability can often involve linking with other (new or existing) contracts. AGPN also recommends that project contracts include adequate funds for impact and outcome evaluations and for developing sustainability plans.

Financing:

Financing issues that arise for the Network as NFP organisations include inconsistencies between jurisdictions over tax regulations and ambiguities in tax law relevant to NFPs, particularly inconsistencies in the application of tax and other financial regulations to different types of NFP organisations. (The business structure of member organisations within the Network varies, with the result that not all are eligible for the same benefits).

This variation and inconsistency adds complexity and administrative burden to organisations such as those within the Network whose resources are often already stretched and so do not have the time or money to seek all the necessary legal / financial advice they may need. Deductable Gift Recipient (DGR) status is a useful example. An overview is provided in Box 2.

[3] This case study describes guidelines in place prior to July 2009. Changes made to regional health service funds in the recent budget may have led to changes in these guidelines.

Box 2. Deductible Gift Recipient (DGR) status: Is it worth it?
DGR can be a useful way for NFPs to attract funds as organisations with DGR status can offer a tax incentive to certain grant makers and philanthropic bodies that provide the NFP with funds. However, there are almost 50 different DGR categories. Each category of DGR has certain 'eligibility criteria' that an organisation must meet in order to be endorsed by the Australian Taxation Office (ATO.) Each different category generally also has varying conditions attached to it. Organisations must comply with these conditions as well as comply with the record-keeping and reporting requirements that come with being a DGR. Determining whether to apply for DGR status is therefore burdensome and complex, not only because of the variety of DGR categories that exist but because the onerous or restrictive criteria that come with being a DRG can outweigh the potential advantages of attracting greater funds[4].

While AGPN recognises it is a State tax, we would note that issues can also arise in relation to payroll tax treatment of NFPs within the Network and variation in their charitable or other NFP status. Payroll tax is a tax payable to the state by an employer, based on the total wages paid to all employees. Employers are only liable for payroll tax when their total Australian wages exceed a certain threshold. However, thresholds vary between states. Certain organisations including public benevolent institutions, public or non-profit hospitals, non-profit non-government schools and charitable organisations are often exempt from payroll tax, even if they reach the threshold, provided specific conditions are satisfied. The exemption helps such organisations make their often stretched resources go further. Again, requirements for specific conditions also vary between states - for an Australia-wide infrastructure funded under a national initiative such as the Divisions of General Practice Program, it also adds to inequity between individual agencies. For example, a Network Member in one State/Territory may be eligible for payroll tax exemption while in another it is not, even though both organisations fulfil the same functions and provide the same services.

Further, payroll tax exemption can be linked to an organisation's charitable status. This in turn can be linked to Fringe Benefits Tax (FBT) eligibility which can have major implications for what NFP organisations like those in the Network can offer staff in terms of benefits such as salary packaging. Determination of these issues can lead to financial imposts on the organisation itself as well as impacting on their ability to recruit staff.

Appeals to challenge tax exemptions and / or charitable status can be made, but are costly both in time and money. This again places further burden on NFP organisations that are often already under-resourced. An example of an appeal that occurred within the Network (Central Bayside Division) is provided in Box 3.

[4] Australian Taxation Office (ATO) Gift Funds: Frequently Asked Questions http://www.ato.gov.au/nonprofit/content.asp?doc=/content/32068.htm&page=4&H4. Last accessed May 2009.

Box 3: Central Bayside v Commissioner of State Revenue re payroll tax
Central Bayside General Practice Association Limited[5]– now known as Bayside General Practice Network (BGPN) - was set up in 1993 with Commonwealth Department of Health funding (as part of the National Health Care Scheme), to encourage general practitioners to work together to promote the quality of local health care. BGPN was one of 123 Divisions that operated across Australia at that time.

In 2005, BGPN, sought exemption under sub section 10 (1) (bb) of the *Payroll Tax Act* 1971 (Vic) from payment of payroll tax as it was a charitable body engaged exclusively in the work of a charitable nature. The Victorian Civil and Administrative Tribunal determined that BGPN was not exempt from pay roll tax (on wages) as it was too close to being an arm of government to be an organisation whose objects come within the concept of charity. BGPN's appeal to the Supreme Court of Victoria was dismissed.

On appeal to the High Court of Australia, a decision was handed down on 31 August 2006 that BGPN was entitled to a payroll tax exemption because its constitution and purposes brought it within the legal definition of a charity. The High Court found that although BGPN, like many charities, had a purpose shared by the Commonwealth, this did not alter its essential character as a charity, even though the government was the source of its funds and even though BGPN consented to conditions being attached to those funds.[6]

The Central Bayside case set a precedent for Divisions regarding payroll tax and charitable status but involved significant time and financial costs. Had regulations about charitable status and payroll tax been clearer and more consistent at the outset, such funds could have been put towards providing the services that BGPN was set up to do – promoting the quality of health care through general practice.

AGPN recommends that jurisdictional differences in payroll tax legislation need to be addressed as part of the COAG regulatory reform agenda (including general reduction in red tape associated with payroll tax). AGPN also recommends that all Network members are deemed as charitable businesses for the purposes of payroll tax and FBT.

Impact on Innovation:
One of the Network's major contributions to health service delivery is its ability to be agile and responsive at the local level - to customise care, delivered through general practice and primary care services, so that it is aligned with the identified needs of its diverse communities. One of the main ways in which the Network achieves this is through its linkage with a variety of health, business, community and other agencies at all levels – local/regional, state and national. This is a key way in which the Network operates and innovates.

As a result, the Network has achieved significant outcomes with modest funding in a range of areas. These outcomes include the successful translation of national initiatives into relevant services at the local level as well as the development of local projects to meet community needs that occur from the ground up. AGPN's 2006 report, *The Value of the Network*, captures many examples of this innovation and AGPN refers the Commission to that publication: http://www.agpn.com.au/site/content.cfm?page_id=46497&current_category_code=106&leca=16

[5] Formerly known as Central Bayside Division Of General Practice Ltd
[6] ATO Non-Profit News Service No. 0151 – High Court decision in Central Bayside Division of General Practice Ltd http://www.ato.gov.au/nonprofit/content.asp?doc=/Content/77820.htm Last Accessed May 2009

Certain issues however hamper the Network from further innovation, particularly in relation to competitive tendering situations. These include:

- The narrow focus of the Network and similar NFPs on a single stream of funding – essentially Government contracts. The single funding stream means Divisions are often at a disadvantage in contestable environments. Staff are employed to run the organisation, make essential local linkages and deliver services. They do not always have the resources or expertise to submit winning tenders, even though their practical ability to deliver services and know their communities is excellent and competitive.
- The barriers to Network Members borrowing funds can also constrain innovation and successful contestability for additional funding sources. Technically, NFPs/Network members are able to do this (their business structures do not prevent this) but government contracts do place some limitations on this.
- The nature of the work that the Network does on the ground, which involves linkage and collaboration with local agencies and often "in-kind" contributions can also add difficulty to competitive processes. For one program, a local agency may be a partner, in another they may be a competitor.

Many of these matters are related to the nature of the Network's contracts with government[7] and these are addressed further in the next section.

Section 2. Service Delivery: Delivery of government funded services:

including discussion of delivery of government funded services, with a particular emphasis on the impact of contractual arrangements, accountability and reporting frameworks.

The benefit of Divisions as not-for-profit organisations in service delivery

Not for profits need opportunities to be innovative to meet local needs. Even when national, government funded programs are implemented, there is still a real requirement for them to be tailored to local differences. The Network is a prime example of how national initiatives in primary health care service delivery can be implemented with local innovation. Examples can be seen in any number of the Network's programs. Many of these are showcased in various publications, such as *Dynamic Divisions* and *What Divisions Do*, available on the AGPN website at: http://www.agpn.com.au/site/index.cfm?display=458 A specific example, based on the More Allied Health Services Program (MAHS) is provided in Box 4.

[7] For Profit organisations also face the same issues with government contracts. However, For Profits' greater diversification of funding streams mean that the impacts of government contract issues are less overall.

BOX 4: National initiatives, local innovation: The role of NFPs and the Network
More Allied Health Services (MAHS) is a government funded program that enables rural Divisions to employ allied health providers (such as physiotherapists, dieticians, psychologists, nurses and the like) in areas where they are typically often hard to recruit. The broad based funding of MAHS means that allied health providers can be engaged according to local need. For example, in the Kimberley Division there is a high indigenous population, with high levels of diabetes and other associated health issues. To help target these needs, this Division uses MAHS funds to employ two fulltime dieticians as well as to support podiatry services.

In West Vic division, the profile is very different. Here, a priority health need has been identified as providing an efficient mental health counselling service to local general practice patients. In this instance, the Division has combined MAHS with other mental health funding to provide a single referral pathway, through GPs, for patients needing counselling and psychological services. The flexible nature of MAHS funding in particular means that counsellors can be recruited from social workers, psychologists or eligible private counsellors. Having a wider workforce pool to recruit from is extremely valuable in rural and remote areas where available workforce is already limited. In both instances (the Kimberley and West Vic) services through these initiatives are provided at no or only low cost to patients, making them accessible both physically and financially.

MAHS is a good example of how a flexible, broad based contract supports local innovation and individualised responses in specific regions. A number of the Network's service delivery contracts with government have a degree of flexibility in them to allow for such innovation. This is to be encouraged as it enables innovation and responsiveness to need at the local level. There are still issues, however, that arise in contracts with government that constrain the Network's innovation and prevent it from maximising its contribution in the NFP sector. These include:

- **Short extension times to contracts and lack of certainty about contract renewal** even less than one month before the contract is due to expire. This has significant industrial relations implications (such as redundancy provisions and meeting the legally required timeframes for termination notification). It also impacts on staff retention and service continuity. As a result of contract uncertainty, many good quality staff are lost to the Network, even though the contract may eventually be renewed and the work continued. As a result, new staff need to be recruited, oriented and trained in the role, corporate knowledge is lost and additional resources (time and money) are expended that could have been saved or put to better community use if assurance about the contract was provided earlier.

- **Timeliness of funding as well as timing of funding** provided through assured contracts can also be problematic. Although NFPs can, in theory, develop surplus funds, they are limited, especially when their main funding is through government contracts, from accruing too much. This inability to build up a cash buffer (working capital) can work against good financial management in relation to contract timing issues. Firstly, in circumstances when funders of guaranteed contracts are delayed in sending through payments, lack of working capital can place Network Members under considerable financial pressure - to the point of temporary insolvency - as they have only limited reserves available to them to cover the late payment period. This situation is compounded by Members' inability to attain overdrafts. Furthermore, many contracts have tight timeframes. To deliver these contracts on time, timely recruitment of project staff and arrangements with subcontractors/other partner agencies is required. Delays in sending through funding in such situations cause

not only financial stress but also threaten relationships with partners/subcontractors and the ability to recruit/retain staff.

Secondly, some government contracts specify that payments to the main contract holder are amortized over the life of the program, while subcontractors, other partners or subcontracted Network members will typically require a frontloaded payment on project commencement. Again, lack of access to an adequate cash buffer to tide over payments until they come through from principal funders (either because they are delayed or because they fall due outside of subcontractor payment times) creates significant financial stress on Divisions – and on other NFPs.

AGPN recommends less stringent requirements from government regarding the accrual of working capital to better financially manage the cash deficit issues that will inevitably flow from contract timing issues with funders.

- **The diversity of contracts** that applies to Network members. Many NFPs administer contracts from a variety of funders – local, state and national government as well as from other non-government sectors. Although there may be little that can be done about contracts with different agencies, improvements could be made to improve consistency in contracts generated by the same funding agency. For example, Network members each have individual contracts with the DoHA. These generally follow the form whereby core funding is provided through a multipurpose agreement with DoHA to which schedules which relate to the delivery of specific programs are attached. In addition, there are also often separate individual program and/or project contracts. AGPN recognises the need for accountable use of Government funds. However, reporting against the various contracts is administratively burdensome and in some cases can mean duplication of effort. There are also legal and financial implications in managing and responding to a raft of different and diverse contracts: often, individual contract details vary significantly, even in contracts from the same funder. Legal and other advice often needs to be sought for new / differently formatted contracts. Again, this can be costly in terms of time and money. Additionally, separate audits are generally required for each contract, even though they are all from the same government department. In theory this means that they should be able to come under the one audit process.

AGPN recommends that to maximise efficiency, contracts from the same funding agency should be legally equivalent, and standardised and streamlined as much as possible. AGPN also recommends that contracts from the same funder or government department be audited as a single entity and not require individual audits. Allowance should also be made in funding agreements or other resourcing for NFPs to seek legal and / or accounting advice to better manage the diversity of contracts that currently exist.

- **Indexation:** Government contracts are often not indexed and even when they are, they are not indexed to the level of CPI. This can impact on general project budgets and the capacity to offer wage justice resulting in overall negative impact on both service delivery capacity and on staff recruitment and retention. When contracts are not indexed or indexed below CPI, NFPs cannot keep pace with rises in State or other employment awards. Although Network Members use innovative approaches to employment and can offer some other non-financial benefits to staff (more autonomy and flexibility than government sectors for instance) good staff are lost by the inability of Network Members' funds to

match salaries at realistic market rates. This will become an increasing issue for the Network as it moves further towards a service provider model. Network Members must be able to offer salaries at market rates if they are to be viable into the future.

AGPN recommends that future funding contracts with government take into account the real market rate for employee salaries including realistic consideration of CPI and rises in competing employment awards.

- **Intellectual property (IP) issues:**

Ownership barriers: IP ownership can be a significant barrier to effective knowledge sharing for NFPs. When funders, rather than NFPs own the IP of work they have been supported to develop, the inability to share learnings, knowledge and resources can lead to duplication, rather than streamlining of effort, with the result that government or other agencies' initial investment is not maximised, especially where the same work is then refunded and undertaken by another organisation, or not linked to forerunner work. This is true for knowledge sharing both across different organisations and between agencies within the same umbrella organisation, such as the Network.

At the national level AGPN has overcome this to some extent by negotiating an agreement with its main funder whereby AGPN, as part of its core funding agreement, owns the IP of any work it develops. This ownership is passed down to other AGPN program areas in various schedules to this agreement. It can also be passed on to subcontractors through licensing agreements. Although this does not always guarantee that information can be shared (on occasion, AGPN has been prohibited from sharing project findings despite this clause), it does for the most part assist in knowledge and information sharing. It also helps maximise efficiencies by preventing duplication.

An example from AGPN of how IP clauses can assist knowledge sharing and efficiency is provided in Box 5.

Box 5: Intellectual Property issues: *Reset your life.*

Reset your life is a program for diabetes prevention for people with pre-diabetes aged 40-49 years. It was developed by nutrition and physical activity experts at the Baker IDI Heart and Diabetes Institute in partnership with the Australian General Practice Network (AGPN). The program aims to prevent or delay people from developing Type 2 diabetes. The program can be implemented by qualified providers. On referral from GPs, patients can access the program at low or no cost as part of the Government's Prevention of Type 2 Diabetes Program. (The program is an accredited program under this initiative).

Funding for the program was provided by the Australian Government DoHA. AGPN owns the IP of the *Reset your Life* program and has provided Baker IDI with a licensing agreement for its use. Other agencies have also approached AGPN to access the program. Access has been achieved through a similar licensing mechanism. This has saved reinvention of similar programs by other agencies and maximises the exposure of *Reset your life* and the funders' initial investment, which in turn has saved time and funds.

Control barriers: IP clauses can still however hamper innovation and improvement at a local level. For Divisions, Departmental funding contracts give the Division ownership but take an unlimited right to distribute or amend any work, so removing much of the value in the Division's IP ownership. The same approach also extends to subcontractors engaged by a Division. This hinders innovation and progress. For example, improving an existing divisional

program can involve engaging a subcontractor to amend some existing technology / resource they own but that is used by the Division. Before undertaking the improvement work, the contractor must agree to the Department having unrestricted rights to the IP. Understandably, commercial operators from the for-profit sector are reluctant to give up potential revenue derived from their own R&D by giving such rights to the Department. This is a major barrier to engaging subcontractors and hinders improvement.

- **Inflexibility in contracts and program guidelines:** Certain government contracts stipulate an administrative versus operational cost ratio which can be problematic for practical program implementation. For example, allied health service delivery funds for the national youth mental health program – ***headspace*** – implemented through a number of divisions, specifies that budgets contain no more than 15 percent on administration and the rest on operational (service delivery) costs. Any associated travel involved in service outreach by health providers is included in the administrative costs for this program. This is the same in all ***headspace*** contracts, irrespective of geographical location. In remote areas of Australia however, travel costs are significantly greater than elsewhere. This is not taken into account in the contracts – but can be a significant burden on the administrative component of the budget for rural/remote Divisions.

A further restriction that has sometimes occurred in contracts is specification of how people employed under the contract should conduct themselves or their business. For example, one government contract implemented through the Network stipulated that staff employed under it should act as if employed by the Australian Public Service (APS). This was untenable for the employees – and for the Divisions – who as independently governed private businesses, have their own code of conduct. This level of specification is unnecessary. It can make partnership arrangements extremely difficult and can put pressure on collaborative relationships - a key mechanism by which NFP organisations operate.

AGPN recommends that budget breakdowns in contracts have the flexibility to be assessed on a case-by-case basis where necessary, to take into account the diversity of locations and local factors across Australia. AGPN further recommends that code of conduct specifications for staff employed under the contract are determined by the contract holder and not the funder.

Section 3: Measurement and Contribution

The Commission's Issues Paper proposes a framework for measurement of the whole NFP sector. While AGPN appreciates the intent behind such an aim, we do not support such an approach.

Firstly, the size of the not for profit sector is difficult to quantify. This has implications for measuring the contribution of the whole sector if the sector size itself cannot be measured.

Secondly, the diversity of types of NFPs is such that it would be difficult to develop meaningful indicators to address the whole sector.

Thirdly, AGPN's own experience with the introduction of the government's national performance indicators (NPIs) highlight the challenges in measuring the contribution even within one type of NFP organisation. AGPN believes that attempting to measure the whole sector would amplify this difficulty further[8].

[8] AGPN also draws the Commission's attention to the existing National Health Performance Framework and the work of the Australian Institute of Health & Welfare developing indicators across the whole health and aged care system.

In outlining AGPN's own experience with NPIs (see also Box 6) AGPN highlights several further points:

- The nature of much of the work that NFPs do is not easily amenable to quantitative measurement such as contributing to building the capacity of member organisations and influencing policy. Even when indicators are put into place, the collaborative way in which NFPs work make it difficult to attribute the outcomes directly to the NFP. This is even more difficult in relation to health care as Divisions are an intermediary in a chain of other factors that impact on the final health outcome of an individual – or more importantly a population. Some process measures may be more amenable to measurement, such as whether more services are in place, but actual change in health outcomes is harder to measure as a direct cause of Divisional involvement. This does not mean that Divisions should not attempt to improve population health outcomes – indeed they are funded to assist in this aim - but they should not be directly measured on this alone.

- Imposing NPIs can confound innovation. When NPIs become the yardstick by which an NFP is measured, effort often goes into achieving the indicators and reporting successfully against them at the expense of putting resources into other areas that may be more pressing locally. This effect is compounded when funding is linked to NPIs.

- There are intangible spinoffs and benefits that occur from the way that NFPs work, especially in relation to collaboration and partnership that are not factored into initial measurement systems as they are often unknown. This is particularly true for factors such as relationships with other organisations or with particular subsections of the community. The effort taken in building up a relationship with or within a community or a local agency can take significant time but can be invaluable to the successful implementation of a future project or program (for example, figures of up to two years or more have been suggested by some Network members as the time taken to build a collaborative and trusting relationship with Aboriginal health services).

AGPN acknowledges the need for accountability of government funds. At the same time, to help AGPN and the broader Network maximise its contribution to health care within the community, accountability frameworks need to ensure capacity to respond to local need. AGPN endorses a continuous quality improvement approach to service delivery and primary health care. Performance systems that assist measurement of improvement over time – that are educative rather than punitive - are more likely to be of use in assisting the Network to maximise its contribution as a NFP.

AGPN recommends that national performance or indicator systems for NFPs remain flexible enough to allow local responsiveness. AGPN also recommends that performance systems are devised with meaningful realistic indictors that encourage improvement over time.

Box 6: Governance, accountability and performance measurement: The Network experience with the NQPS. As a recipient of funding from the Australian Government Department of Health and Ageing, the Network has been the subject of a number of external reviews, the most recent of which was the Phillips Review in 2003[9]. Since 2005, as a result of the Phillips Review recommendations, network members have worked within a National Quality and Performance System (NQPS) to promote continuous improvement and responsible use of its Government funding. From 2006-08, the NQPS included 51 National Performance Indicators (NPIs) across the following nine main domains of performance: prevention and early intervention | chronic disease management | access (to health care) |(health) workforce | general practice support | quality support | integration | consumer focus | governance. Governance indicators were to be replaced over time by evidence that Network members were accredited with an eligible accreditation agency. Economic penalties were to be applied to Network members who did not meet the accreditation criteria within 12 months. The NQPS also included some optional local indicators whereby Divisions could report on innovative programs they had developed locally.

The NQPS mainly collected qualitative data and as a result it was difficult to monitor improvements over time for the same Network member. Benchmarking against other members was also difficult – although because of the diversity of Network member communities, benchmarking at those levels was not very meaningful. All Network members did undergo accreditation as a result of the NQPS, although this has proved a costly process for most members – average accreditation costs are $5000.

After two years, in response to feedback from the Network, the NPIs have been reduced to 10. All Network members report against the same NPIs, including the SBOs and AGPN. The abbreviated number of NPIs is an improvement and has more focus on health outcomes. However, there are still issues in finding ways of capturing all that the Network does, including measuring local innovation and finding meaningful ways of measuring the contribution from different levels of the Network. (Arguably, AGPN needs to be measured on different NPIs than Divisions). AGPN is in discussion with the DoHA about useful revisions to the NPIs. AGPN has also developed its own draft set of performance measures that specifically capture the breadth of work that the Network does and that can be used to help Network Members embrace more of a continuous quality improvement approach to performance monitoring.

[9] Phillips, R. 2003. The Future role of the Divisions network: Report of the review of the role of the Divisions of General Practice, Commonwealth of Australia, Canberra.