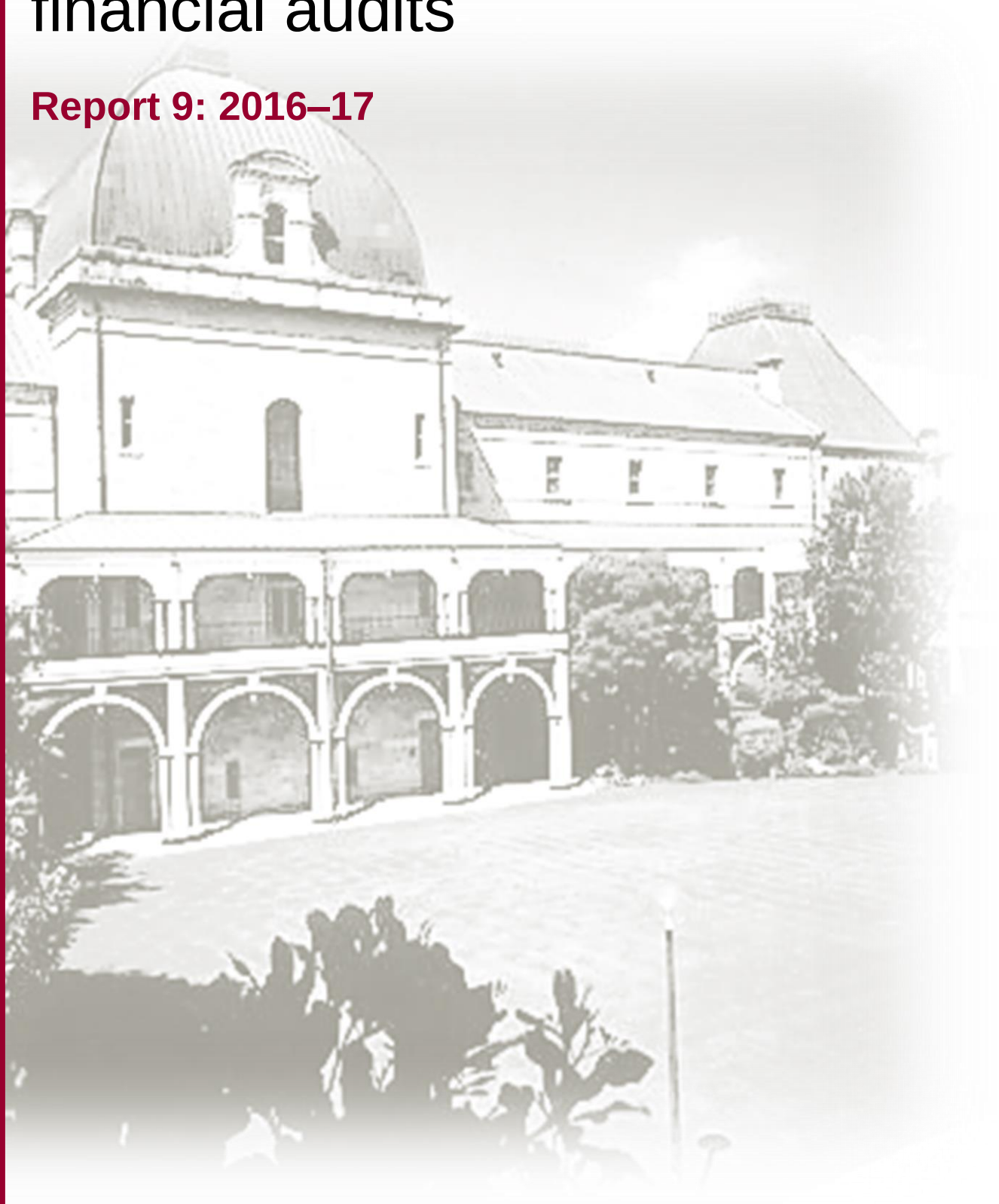
Queensland Audit Office
better public services

Hospital and Health Services: 2015–16 results of financial audits

Report 9: 2016–17



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Queensland Audit Office
better public services

31 January 2017

The Honourable P Wellington MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

Dear Mr Speaker

Report to Parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled *Hospital and Health Services: 2015–16 results of financial audits* (Report 9: 2016–17).

In accordance with s.67 of the Act, would you please arrange for the report to be tabled in the Legislative Assembly.

Yours sincerely

Anthony Close
Auditor-General (acting)

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The Queensland Audit Office

The Queensland Auditor-General, supported by the Queensland Audit Office, is the external auditor of the Queensland public sector. We provide independent audit opinions about the reliability of financial statements produced by state and local government entities.

We provide independent assurance directly to parliament about the state of public sector finances and performance. We also help the public sector meet its accountability obligations and improve its performance. This is critical to the integrity of our system of government.

The auditor-general must prepare reports to parliament on each audit conducted. These reports must state whether the financial statements of a public sector entity have been audited. They may also draw attention to significant breakdowns in the financial management functions of a public sector entity.

This report satisfies these requirements.

The Queensland Audit Office has a unique view across the entire Queensland public sector of matters affecting financial and operational performance. We use this perspective to achieve our vision of better public services for all Queenslanders by sharing knowledge, providing comprehensive analysis, and making well-founded recommendations for improvement.

Contents

Summary

Introduction

Most public sector entities prepare annual financial statements. The Queensland Auditor-General is responsible for providing parliament with independent assurance of the financial management of public sector entities by auditing these financial statements.

This report summarises our financial audit results of the 16 Hospital and Health Services. The Hospital and Health Services provide health services across the metropolitan, regional, and rural areas of Queensland.

The results of all other health sector entities, including the Department of Health (DoH) and other health sector statutory bodies, are included in our report *Queensland state government: 2015–16 results of financial audits* (Report 8: 2016–17). An overview of all health-related public sector entities in Queensland and their responsibilities is located in Appendix A.

Results of our audits

We provided unmodified audit opinions on all 16 Hospital and Health Service (HHS) financial statements within the statutory deadline of 31 August. This confirms that their financial statements were prepared according to requirements of legislation and Australian accounting standards, and can be relied upon.

We evaluated the processes that support accurate and timely preparation of draft financial statements and found that HHSs improved quality, but reduced timeliness, this year. Fourteen HHSs made no adjustments to key balances in their draft financial statements before we certified them, which demonstrates higher quality. But only nine HHSs provided a complete draft of their financial statements to us by agreed dates. HHSs should focus on two key areas of their year end process—earlier finalisation of asset valuations, and preparation of early draft financial statements. This will assist HHSs in improving the timeliness of financial reports.

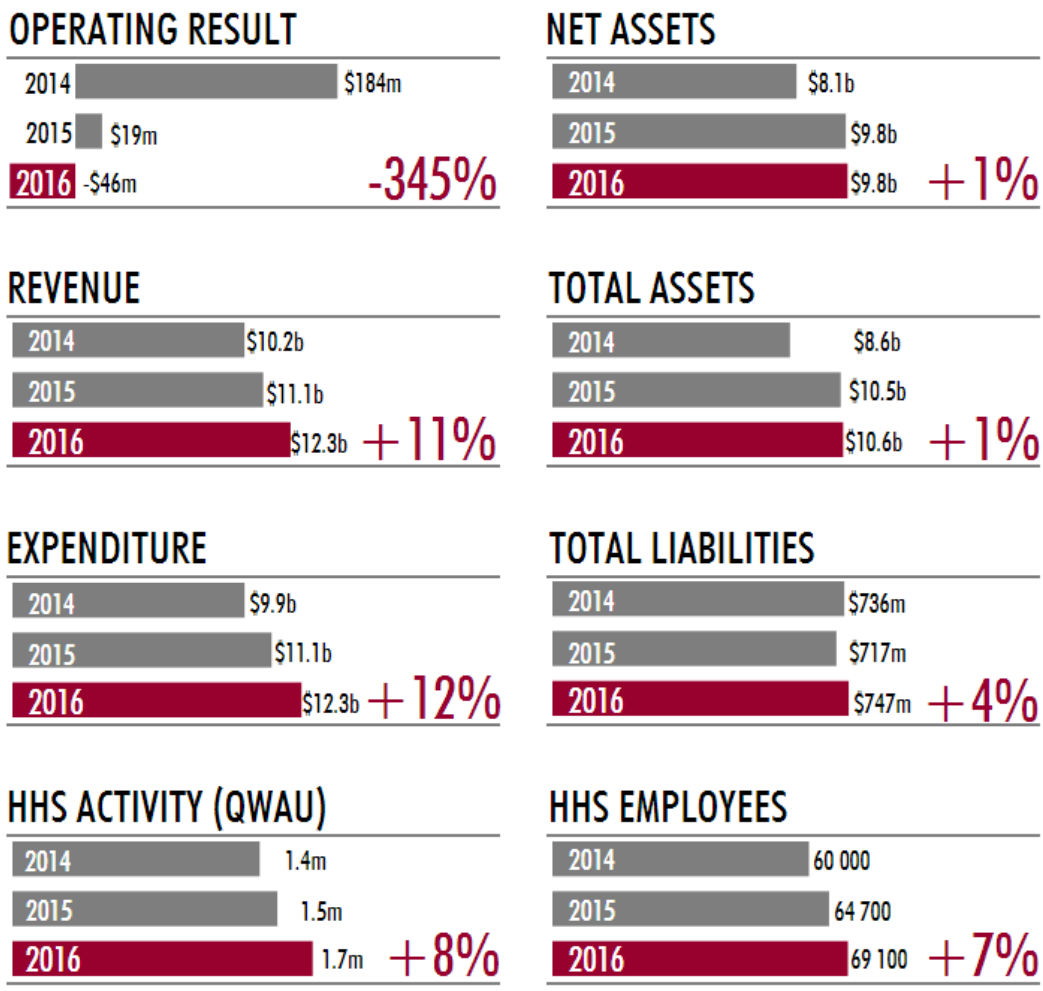
For the 2016–17 financial year, we encourage HHSs to complete valuations of all material assets by no later than 31 May 2017, with a view to achieving a target of 31 March in 2018.

Financial performance, position, and sustainability

The collective financial performance of the HHSs has deteriorated over the last year, recording its first deficit of $46 million (representing 0.4 per cent of total revenue). The result for the Queensland health system, which includes the HHSs and DoH, was a surplus of $51 million in 2015–16.

Most HHSs spent more on delivering services in 2015–16 compared to the previous year. However, the price DoH paid them to deliver these services did not always cover the costs of those services. For the 13 HHSs that are funded based on their level of clinical activity, three HHSs—Gold Coast HHS, Sunshine Coast HHS, and North West HHS—had an average cost per activity that was higher than DoH funding received, meaning they needed to use other sources of revenue or surpluses from prior years to cover the difference. Three HHSs—Cairns and Hinterland HHS, North West HHS, and Wide Bay HHS—are showing signs of financial stress, with their financial sustainability ratios below generally accepted benchmarks. In our review of DoH's actions for Cairns HHS, we found that DoH, as the manager of the public health system in Queensland, regularly monitors HHS performance and has proactive processes for working with HHSs to improve financial sustainability.

Figure A
2015–16 financial snapshot—all Hospital and Health Services



Source: Hospital and Health Services financial statements 2015–16; Department of Health

Demand for health services continues to rise, and HHSs delivered more clinical activity than they had agreed to deliver with DoH. Delivering more than the agreed clinical activity is allowed but is only funded at 45 per cent of the efficient price for that service. This means HHSs need to find other sources of revenue, reduce their costs, or use surpluses from prior years to make up any shortfall to the incremental cost of delivering extra activity. Continued increases in demand for health services may impact HHS sustainability unless they can improve their efficiency or find additional revenue sources.

HHSs' implementation of digital hospitals is a significant investment across the sector that may put additional pressure on future financial operations. Digital hospitals use electronic rather than paper records that integrate with digital medical devices to enable clinicians to easily review and update patient information. In 2015–16, the two lead HHSs that implemented digital hospitals experienced significantly higher costs than originally budgeted.

HHSs are aware of the challenges presented by the rising demand for health services, and are looking for ways to increase capacity in public hospitals and reduce costs while also improving the quality of care.

Queensland hospitals have continued to improve their performance in terms of reducing the length of a patient's stay in hospital, with four more HHSs meeting the national average for selected diagnosis related groups this year. Patient access has also improved, with HHSs reporting more outpatients seen within the clinically recommended time and increased levels of elective surgery procedures performed.

Internal controls

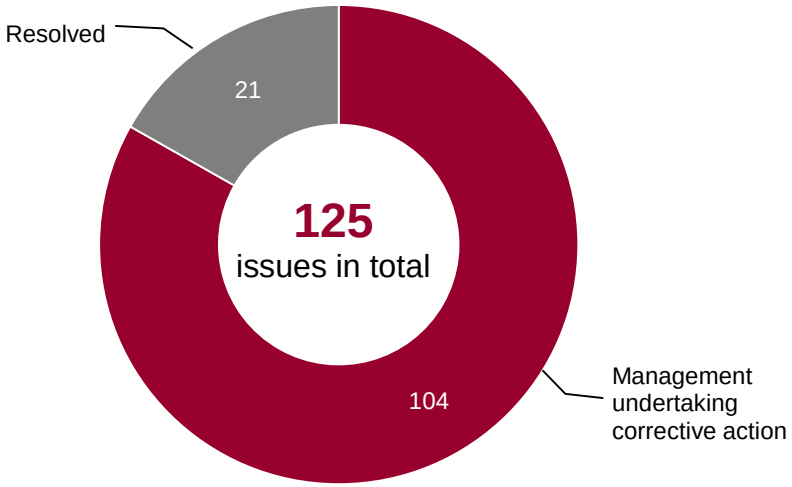
Good internal controls provide reasonable assurance that an entity is achieving its objectives relating to operations, reporting, and compliance.

We assess financial controls used by public sector entities against the Committee of Sponsoring Organizations of the Treadway Commission (COSO) internal controls framework. This framework is widely recognised as the benchmark for designing and evaluating internal controls using five key elements, including:

- control environment—actions, attitudes, and values that influence daily operations
- risk assessment—processes for identifying, assessing, and managing risk
- monitoring activities—oversight of internal controls for existence and effectiveness
- control activities—policies, procedures, and actions taken to prevent or detect errors
- information and communication—systems to inform staff about control responsibilities.

We did not identify any significant deficiencies (high risk matters) in internal controls. We found 125 lower risk internal control weaknesses. These deficiencies affected the risk assessment, control activities, and control environment COSO elements. As part of our audit, we provide internal control deficiencies to management for resolution.

Figure B
Number of 2015–16 internal control weaknesses at 31 August 2016



Source: Queensland Audit Office

HHSs are not resolving audit issues in a timely manner. Fifty-five per cent of internal control deficiencies reported in 2015–16 were also reported in prior years. These were mainly deficiencies in the control environment and control activities, such as out-of-date financial management practice manuals and inappropriate approval of financial transactions. HHSs need to resolve these issues promptly, as delays may expose the HHSs to increased risk of fraud or error.

We reviewed the risk management processes of four HHSs and identified that three HHSs' information technology (IT) disaster recovery planning processes and procedures were immature. This means that, if there were a disaster, HHSs might be challenged in recovering critical IT systems.

We did not identify any deficiencies in the HHSs' information and communication processes. However, we continue to note that HHSs' financial system, provided by the DoH, is no longer supported by the vendor. A replacement financial system project is underway, with a likely implementation in 2017–18. In the meantime, DoH has taken steps to minimise the risk of system failure in the existing system.

Recommendations

As part of each audit we make recommendations to individual HHSs about how to improve their financial management.

We recommend that Hospital and Health Services:

1. assess the maturity of their IT disaster recovery capabilities to identify areas for improvement, and initiate plans to implement these improvements.

In addition, we recommend that the Department of Health:

2. finalises its service level agreement with all HHSs for accounts payable processing.

Reference to comments

In accordance with section 64 of the *Auditor-General Act 2009,* we provided a copy of this report to the Minister for Health and Minister for Ambulance Services, the Director-General, Department of Health, and the Board Chairs and the Chief Executives of the HHSs for comment.

A response was received from The Department of Health. The response is in Appendix B.

Report structure

Chapter	
Chapter 1	provides the background to the report and the context needed to understand the audit findings and conclusions.
Chapter 2	evaluates the audit opinion results, timeliness, and quality of reporting.
Chapter 3	analyses the financial performance, position, and sustainability to enhance accountability and transparency of transactions and events during the year.
Chapter 4	assesses the strength of the internal controls designed, implemented, and maintained by the HHSs.

Report cost

The cost of this report was $240 000.

1. Context

Legislative framework

A Hospital and Health Service (HHS) is a statutory body under the *Hospital and Health Boards Act 2011.* Hospital and Health Boards are responsible for the operations of each of the HHSs. Each board is accountable to the Minister for Health and the Minister for Ambulance Services.

HHSs prepare their financial statements in accordance with the following legislative framework and financial reporting deadline:

Entity type	Entity	Legislative framework	Financial audit deadline
Statutory bodies	Cairns and Hinterland HHS Central QLD HHS Central West HHS Children's Health QLD HHS Darling Downs HHS Gold Coast HHS Mackay HHS Metro North HHS Metro South HHS North West HHS South West HHS Sunshine Coast HHS Torres and Cape HHS Townsville HHS West Moreton HHS Wide Bay HHS	▪ *Financial Accountability Act 2009* ▪ Financial and Performance Management Standard 2009	31 August 2016

Source: Queensland Audit Office

Accountability requirements

The *Financial Accountability Act 2009* applicable to the Hospital and Health Services requires statutory bodies to:

- achieve reasonable value for money by ensuring the operations of the statutory body are carried out efficiently, effectively, and economically
- establish and maintain appropriate systems of internal control and risk management
- establish and keep funds and accounts that comply with the relevant legislation, including Australian accounting standards.

Queensland state government financial statements

Each year, most Queensland state public sector entities are required to table their audited financial statements in parliament.

These financial statements are used by a broad range of parties including parliamentarians, taxpayers, employees, and users of government services. For these statements to be useful, the information reported must be relevant and accurate.

The auditor-general's audit opinion on these entities' financial statements assures users that the statements are reliable and comply with accounting standards.

The department's role in health services

The Department of Health (DoH) and HHSs work as a system to deliver health services to Queenslanders. DoH is responsible for the overall management of the public health system in Queensland under the *Hospital and Health Boards Act 2011*. DoH has established a performance framework that outlines how the department monitors and assesses the performance of HHSs in delivering public health services in Queensland.

DoH negotiates service agreements annually with each HHS. These agreements outline the services that DoH purchases from the HHS and how much it will pay for those services. They also include the performance measures that DoH will assess each HHS against.

Figure 1A shows key responsibilities in the health system that relate to expenditure, payroll, and asset management.

Figure 1A
Health system responsibilities

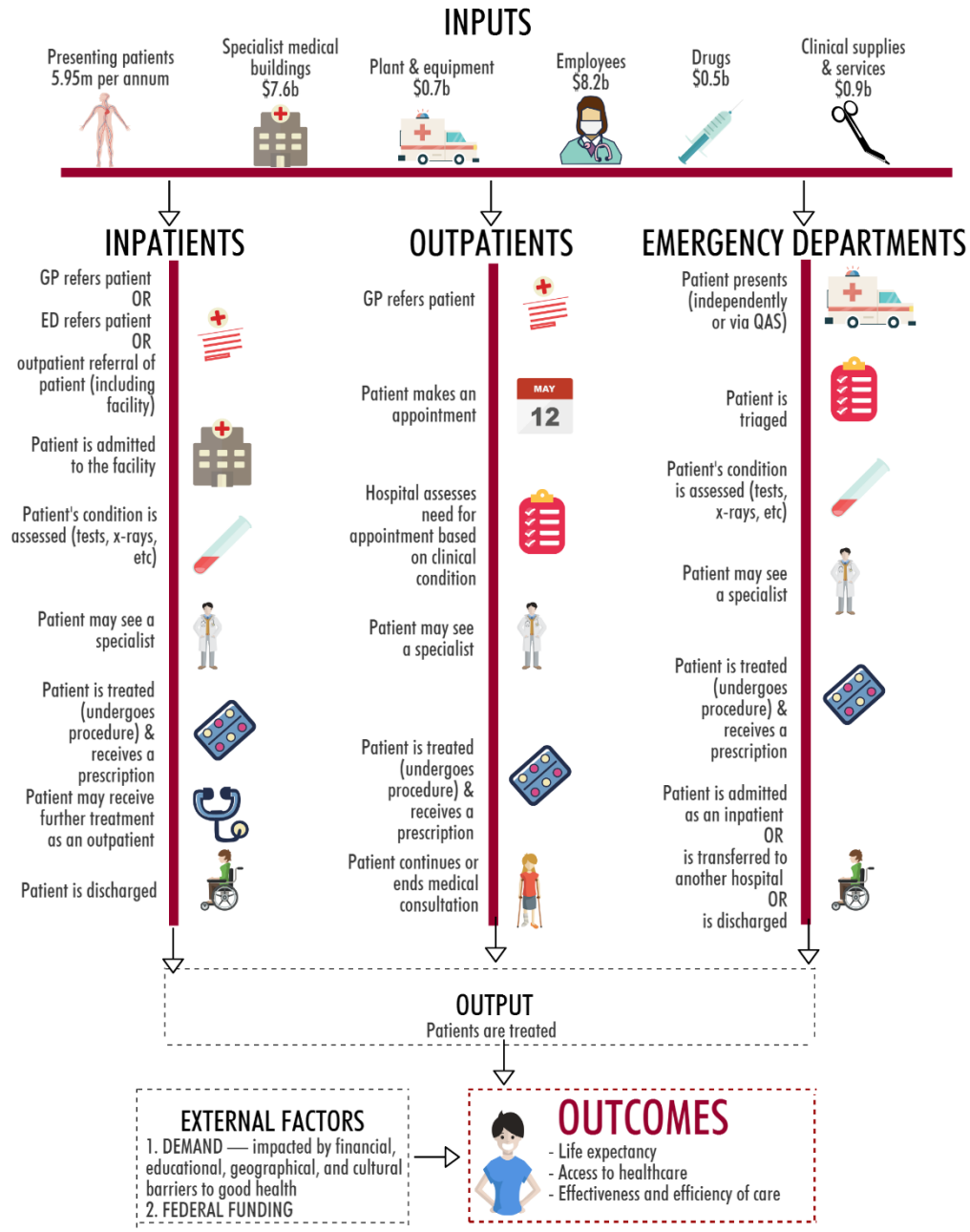
Area of responsibility	DoH	HHS
Staffing		
Employing HHS executive staff and senior medical officers	–	X
Employing junior medical staff, nurses, and other staff	X	X
Assets		
Control and maintenance of physical assets	–	X
Delivery of major construction projects	X	–
Systems		
Provision of Information Technology systems—patient administration and finance system	X	–
Processing of payroll and expense transactions	X	–

Note: The DoH employs the majority of staff for Cairns and Hinterland, Central Queensland, Central West, Darling Downs, Mackay, South West, Torres and Cape, and Wide Bay HHSs. Remaining HHSs employ the majority of their staff directly.

Source: Queensland Audit Office

The Queensland health supply chain comprises a wide range of services and uses a significant amount of resources. Figure 1B details the key inputs, activities, outputs, and outcomes for the sector.

Figure 1B
Function level inputs, processes and activities, outputs, and outcomes



Note: QAS—Queensland Ambulance Service.

Source: Queensland Audit Office

HHS funding arrangements

HHSs receive most of their funding through three sources:

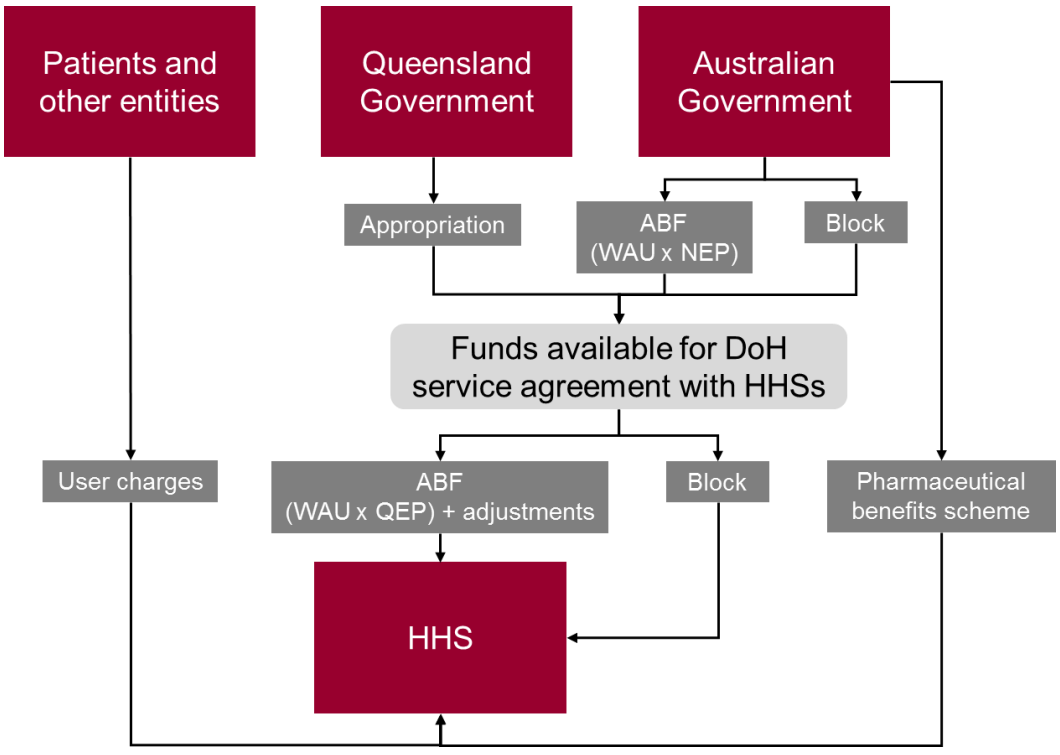
- activity based funding from the Australian and Queensland Governments
- block funding from the Australian and Queensland Governments
- user charges from patients, private health insurers, and other entities, and pharmaceutical benefits scheme reimbursements from the Australian Government.

The amount of activity based funding a HHS receives is a combination of:

- the volume of clinical activity purchased by DoH, measured by the number of weighted activity units (WAU)
- the price paid for each WAU, called the National Efficient Price (NEP) for payments by the Australian Government to Queensland, and the Queensland efficient price (QEP) for payments by DoH to HHSs
- adjustments, either positive or negative, arising from the service agreement between DoH and each HHS.

Figure 1C provides a conceptual diagram of the funding that HHSs receive.

Figure 1C
HHS funding sources



Source: Queensland Audit Office

In 2015–16, DoH set the Queensland efficient price at $4 597 per WAU (2015: $4 676).

HHSs may deliver more or less than the activity purchased by DoH. When HHSs deliver:

- less than the activity purchased—they may have their funding reduced
- more than the activity purchased—they are funded for the additional activity at 45 per cent of the Queensland efficient price, meaning HHSs must meet any remaining funding shortfall to the incremental cost of delivering extra activity.

Block funding supports teaching and research in public hospitals and funds small rural and regional hospitals. Central West, South West, and Torres and Cape HHSs are fully block funded and do not receive activity based funding.

2. Results of our audits

Chapter in brief

We audit the financial statements of each Hospital and Health Service (HHS) annually and provide assurance that the reports are reliable and comply with accounting standards.

Main findings

- We issued unmodified opinions on the financial statements for all 16 HHSs in the 2015–16 financial year as they complied with Australian accounting standards and relevant legislative requirements.
- We issued all audit opinions on all financial statements within their legislative time frame.
- Fourteen HHSs required no changes to the values reported in their draft financial statements, compared to 12 last year.
- Nine HHSs provided their draft financial statements to us within the agreed time frame, down from 12 last year.
- Finalising asset valuations and preparing early draft financial statements were the two year end processes that were most often not completed on time.

Audit conclusions

The overall quality and timeliness of financial reporting continues to be appropriate for all HHSs.

HHSs can further improve their year end financial reporting processes by completing valuations of their material assets and early draft financial statements well before 30 June.

Introduction

This chapter details the reliability of the information reported by each Hospital and Health Service (HHS) that was subjected to audit.

Our audits provide confidence in the financial statements of HHSs for intended users. We express an *unmodified* opinion when the financial statements are prepared in accordance with the relevant legislative requirements and the Australian accounting standards. We *modify* our audit opinion where financial statements do not comply, and are not accurate and reliable.

Sometimes we include an *emphasis of matter* in our audit reports to highlight an issue that will help users better understand the financial statements. They do not change our audit opinion.

The purpose of our analysis is to increase accountability and transparency in financial reporting by scrutinising the quality and timeliness of reporting.

Conclusion

Readers can rely on the results in the audited financial statements of all 16 HHSs because we issued unmodified audit opinions for each entity.

We completed all audits within the legislative time frame of 31 August, even though fewer HHSs met their agreed time frame for completing financial statements ready for audit.

HHSs can improve their year end financial reporting processes by bringing forward key steps well ahead of the 30 June balance date. Half of the HHSs did not complete their asset valuations or prepare their draft financial statements by dates they agreed with us.

The quality of HHSs' financial statements continued to improve this year. The majority of HHSs provided draft financial statements to us that required no amendments to values reported. Most HHSs also continued to simplify their financial statements, making them more readable and useful to the users of these statements.

Audit opinion results

All HHSs met their legislative deadline of 31 August (2014–15: 100 per cent). Figure 2A details the audit opinions we issued for the 2015–16 financial year.

Figure 2A
Audit opinions issued for the 2015–16 financial year

Entity	Date audit opinion issued	Type of audit opinion issued
Cairns and Hinterland HHS	31.08.16	Unmodified
Central QLD HHS	29.08.16	Unmodified
Central West HHS	26.08.16	Unmodified
Children's Health QLD HHS	30.08.16	Unmodified
Darling Downs HHS	31.08.16	Unmodified
Gold Coast HHS	29.08.16	Unmodified
Mackay HHS	29.08.16	Unmodified
Metro North HHS	31.08.16	Unmodified
Metro South HHS	25.08.16	Unmodified
North West HHS	31.08.16	Unmodified
South West HHS	31.08.16	Unmodified
Sunshine Coast HHS	25.08.16	Unmodified
Torres and Cape HHS	25.08.16	Unmodified
Townsville HHS	29.08.16	Unmodified
West Moreton HHS	30.08.16	Unmodified
Wide Bay HHS	30.08.16	Unmodified

Source: Queensland Audit Office

Financial statement preparation

Entities that adopt effective financial reporting practices throughout the year should be able to produce a set of high quality financial statements in a timely manner.

To assess the financial statement preparation process we considered:

- the year end close process—whether outcomes were delivered by agreed dates
- timeliness—whether we received a complete draft financial report by an agreed date
- quality—the extent of adjustments made to total revenue, expenditure, and net assets, during our audit.

The following sections of this report detail the improvements required in financial statement preparation. Our assessment criteria and our detailed assessment by entity are outlined in Appendix C.

Year end close process

Based on better practice guidance issued by the Queensland Under Treasurer in January 2014, we identified five outcomes for entities to achieve before 30 June 2016. Early completion of these items means an entity has less risk that a financial report is not cleared in time for board signature, and certification by audit is achieved within statutory deadlines.

We found that eight HHSs completed all five of these outcomes by the agreed dates. The remaining eight HHSs completed at least three outcomes within agreed time frames. HHSs need to improve the timely completion of both their asset valuations and preparation of early draft financial statements.

Due to the size and complexity of infrastructure assets held by HHSs, it is important that valuations are completed well before 30 June to allow for sufficient internal and external review of calculations, judgements, and assumptions. For 2016–17, HHSs should aim to complete their asset valuations by 31 May, with a view to achieving the target of 31 March in 2018.

The early completion of draft financial statements provides the HHSs with an opportunity to seek timely feedback from their auditors and their audit and risk committees on the format and content of the financial statements.

Timeliness of financial statements

An entity's ability to prepare timely draft financial statements is an indicator of the strength of the entity's financial management processes. Financial statements are timely when they provide information for decision-makers in time to influence their decisions. As timeliness diminishes, the statements are less relevant and useful to users of financial statements.

Nine HHSs provided draft financial statements by agreed dates (2014–15: 12), and a further six provided their draft financial statements within two days of the agreed date.

While all HHSs did not provide their financial statements to us by agreed dates, we provided audit opinions for all HHSs financial statements by the 31 August legislative time frame.

Quality of draft financial statements

The extent of adjustments made to a draft financial report indicates the effectiveness of the entity’s internal review processes to identify and correct errors before providing reports to audit.

This year, two HHSs made adjustments of less than one per cent between their draft and final financial statements (2014–15: 4) including:

- additional funding from the state for the provision of health services
- an additional expense not originally identified by the HHS
- asset valuation adjustments not processed correctly.

Simplified financial statements

HHSs continued to reduce the size of their financial statements—a process they started last year. Ten HHSs achieved an average decrease of 14 per cent in the number of note disclosures in their financial statements compared to the prior year. The remaining six HHSs either had no change or increased the number of note disclosures by no more than two notes.

Over the last two years, HHSs achieved an average decrease of 24 per cent in the number of note disclosures by adopting the following simplification strategies:

- removing disclosures that are not required by users of the financial statements to make informed decisions
- revising the presentation of the financial statements to make information clearer
- using plain language to improve readability and understanding of complex accounting matters.

We encourage other HHSs to adopt these simplification strategies to improve the readability and usefulness of their financial statements for users.

Audit reporting changes

The Australian Auditing and Assurance Standards Board (AUASB) has adopted the international standard ISA 701 *Communicating Key Audit Matters in the Independent Auditor's Report*.

QAO will formally adopt this standard for financial statements prepared at 30 June 2017.

The new form of audit reporting will aid transparency by disclosing our audit response to the areas in the financial report that we consider require significant audit attention.

The new-look audit report will continue to include our audit opinion on the financial report, and will now also include a section on key audit matters—those areas that, in our professional judgement, pose a higher risk of material misstatement of the financial report. These matters will mostly relate to major events and transactions that occur during the period, and those areas requiring significant judgement and estimation.

We will report on why we considered the key audit matter to be significant and give an overview of the key procedures we performed to address the matter.

We prepared an example key audit matter for the HHSs on the valuation of complex buildings this year. We presented this example to the respective HHSs and their audit committees for their information.

Related party disclosures

Amendments to the Australian Accounting Standard Board (AASB) standard 124 *Related Party Disclosures* extend the scope of the standard to include not-for-profit public sector entities from 1 July 2016. The amended standard also provides additional guidance on applying the definition of *key management personnel* to not-for-profit public sector entities.

The objective of this accounting standard is to draw the attention of users of financial reports the possibility that the financial position and profit or loss may have been affected by the existence of related parties (and by transactions and outstanding balances with such parties). This standard is designed to increase transparency in financial reporting.

Who are related parties?

The definition of a *related party* covers persons and entities related to the reporting entity.

Related persons include the key management personnel of the entity and their close family members. Close family members are those people able to influence, or be influenced by, key management personnel in their dealings with the entity.

Related entities can include any subsidiary, joint venture, or associate of an entity. It can also include any entity controlled by the key management personnel or their close family members.

Attention is directed to the substance of the relationship rather than its legal form when identifying a related party relationship.

Who are key management personnel?

Key management personnel (KMP) are those persons with the authority and responsibility for planning, directing, and controlling the activities of an entity—directly or indirectly.

The KMP of a HHS will include chief executives and their direct reports, and board members. The standard also considers ministers to be part of the KMP of their departments and, potentially, of other agencies in their portfolio.

Impact on financial statement disclosures

HHSs already disclose remuneration of KMP. However, the amended standard may require entities to make additional disclosures of transactions with related parties, and relationships between parent and controlled entities.

HHSs should already have started to collect the necessary information to report on the 2016–17 financial year. Key steps will include identifying who are related parties and the types of transactions that may be entered into with those related parties. HHSs will also need to determine the information required to identify these relationships and transactions, and assess their capability and capacity for collecting it.

3. Position, performance, and sustainability

Chapter in brief

This chapter details the major transactions and events that affected the 2015–16 financial statements of each Hospital and Health Service (HHS). We alert users to future challenges, including existing and emerging risks for the sector, and analyse the sustainability of entities.

Main findings

- The HHSs collectively achieved an operating deficit of $46 million in 2015–16. This is the first collective deficit since the establishment of the HHSs in 2012–13. The result for the Queensland health system, including the Department of Health (DoH) as the system manager, was a surplus of $51 million in 2015–16.
- Three HHSs have exhausted accumulated surpluses built up in prior years. These HHSs are showing signs of financial stress, with short-term financial sustainability ratios below generally accepted benchmarks.
- Three of the 13 HHSs receiving activity based funding had an average cost per unit of activity that was higher than the funding received from DoH. Only one HHS was below the Queensland efficient price compared to 10 in 2014–15.
- In aggregate, HHSs delivered eight per cent more activity than DoH originally agreed to purchase this year. Twelve of the 13 activity based funded HHSs received additional funding for delivering levels of clinical activity above the 2015–16 targets set in their agreements.
- Eight HHSs did not meet their expenditure targets for building maintenance and three HHSs were behind in their backlog maintenance remediation programs.
- Collectively, HHSs reported improvements in operational performance, with a decrease in the number of patients waiting longer for a specialist outpatient appointment and reductions in the average length of stay in hospital.
- Actual costs for the implementation of *digital hospitals* at two HHSs were significantly higher than the budgets approved.

Audit conclusions

The financial performance and position of the HHS sector deteriorated in 2015–16. Demand for health services continues to increase, but costs are increasing faster than revenue.

Providing additional health services (which are only partially funded by the Australian Government) increases the financial pressure on HHSs to fund these services from alternate revenue sources or to reduce costs.

HHSs need to focus on managing costs and finding efficiencies to build financial sustainability in the short term.

Introduction

The information in the financial statements describes the main transactions and events for the year. Over time, financial statements also help users to understand the sustainability of each Hospital and Health Service (HHS) and the health system. Metrics, such as ratio analysis, allow users to understand organisational performance.

The purpose of our analysis is to help users understand and use the financial statements by clarifying the financial effects of key transactions and events in 2015–16.

Additionally, our analysis alerts users to future challenges, including existing and emerging risks faced by HHSs.

Performance framework

Under the *Hospital and Health Boards Act 2011*, the Department of Health (DoH) is responsible for monitoring the performance of HHSs and taking remedial action when performance does not meet the expected standard. DoH publishes a Hospital and Health Service Performance Management Framework (the framework) that sets out the system and processes they use to monitor public health system performance. The framework ensures delivery of services is in line with DoH's service agreements with HHSs. DoH annually reviews and updates the framework in consultation with HHSs.

In this chapter, we assess the position, performance, and sustainability of HHSs.

Conclusion

The overall financial performance of most HHSs deteriorated in 2015–16. Most HHSs had sufficient financial resources to meet their day-to-day operational needs this year, but some required additional financial support from DoH. Three HHSs—Cairns and Hinterland HHS, North West HHS, and Wide Bay HHS—are showing signs of financial stress, with their financial sustainability ratios below generally accepted benchmarks. DoH increased the level of performance monitoring over these HHSs after each HHS identified challenges with their financial performance. While all HHSs need to exercise prudent financial management, immediate focus is required for these three HHSs.

Demand for health services continued to increase across the health system, with HHSs delivering eight per cent more clinical activity in 2015–16 compared to the previous year. However, HHSs total expenses increased by 12 per cent, mainly due to a 12 per cent increase in staff related expenses this year.

Of the 13 HHSs that receive activity based funding, three had an average cost per activity that was higher than the price paid by DoH for the agreed level of activity.

When HHSs deliver more clinical activity than purchased by DoH, they receive additional revenue from the Australian Government, but only at 45 per cent of the efficient price for that service. Only one HHS delivered their activity at an average cost that was below the efficient price. HHSs need to ensure their incremental cost of delivering additional activity is below the funding provided or find additional revenue sources. Not doing so increases the risk that higher demand for services will further deteriorate their financial performance.

The actual costs of Metro South and Cairns and Hinterland HHSs' digital hospital implementations were significantly higher than each budgeted. This suggests that these HHSs may not have included all costs when developing their budgets—a consideration for other HHSs implementing the digital hospital program in the future.

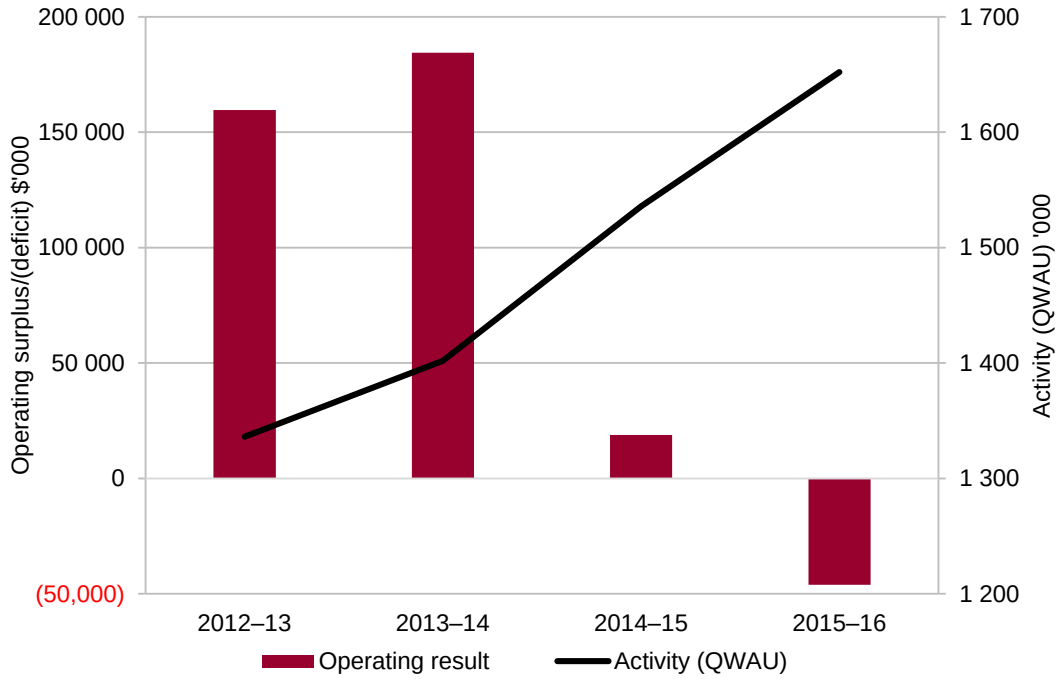
The maintenance of hospital buildings and health facilities is critical to the delivery of health services, but some HHSs did not meet their expenditure targets for building maintenance this year. While an under-investment in maintenance for one or two years is not cause for concern, continuing to defer maintenance is likely to result in corrective maintenance activities that are more costly than regular preventative maintenance. This will not only affect the ability of HHSs to support current service levels but also their ability to meet future demand for services.

Understanding financial performance

The net operating result is used by public sector entities to measure financial performance. It shows the difference between revenue and expenses incurred from day-to-day operations.

The financial performance of HHSs declined in 2015–16. In aggregate, the HHSs realised a deficit of $46.1 million compared to a surplus of $18 million in 2014–15. This result is due in part to a deliberate HHS strategy from 2014–15 to use prior year surpluses to deliver additional health services. Figure 3A shows the decline in HHS operating results against increasing clinical activity, measured in Queensland weighted activity units (QWAU), since 2012–13.

Figure 3A
HHSs operating result versus clinical activity



Note: Excludes mental health activities as the administrative discharge of long-term mental health patients in the patient administration system increased a proportion of other activities recorded in 2015–16 and they represent less than one per cent of the movement in total activity.

Source: Queensland Audit Office

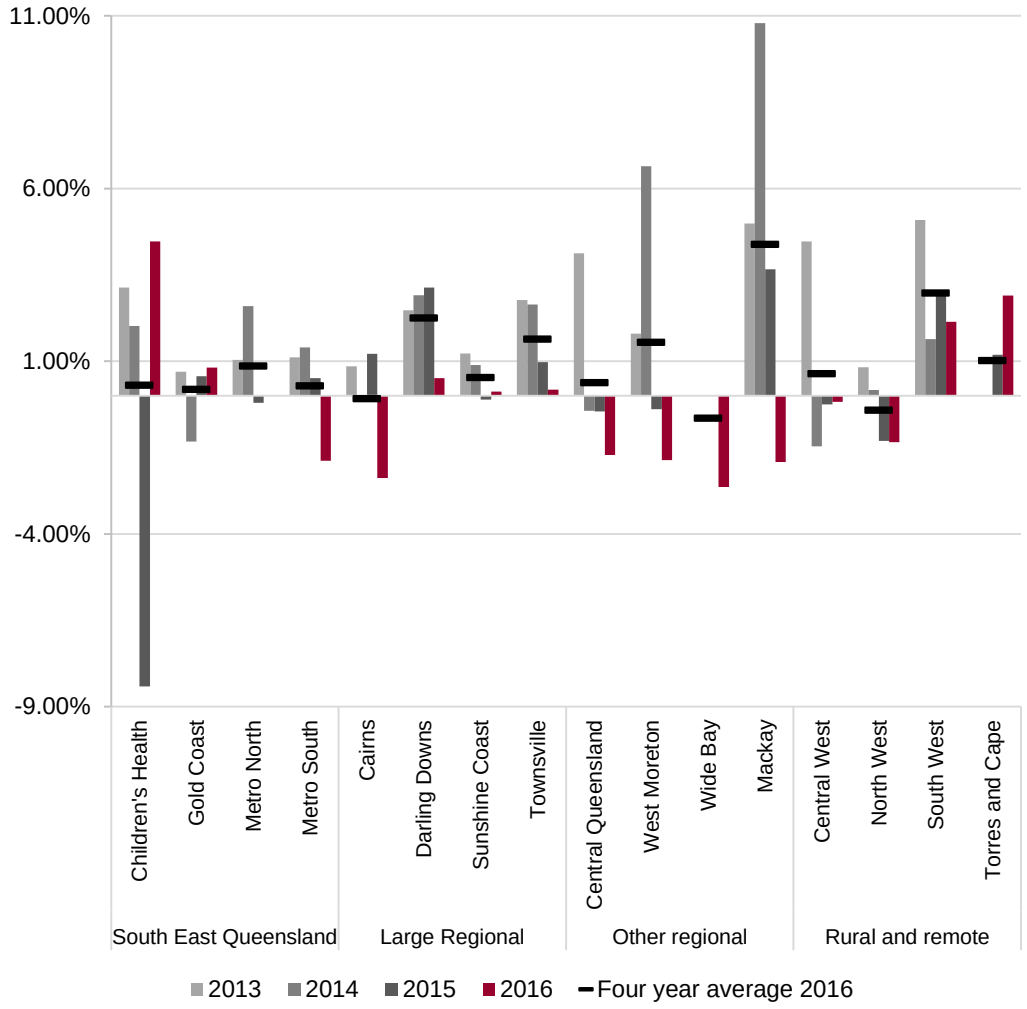
Although the HHSs combined made a deficit in 2015–16, DoH, as the system manager, returned approximately $94.0 million to Queensland Treasury and recorded a $2.8 million operating surplus in 2015–16. The collective result for the Queensland health system was a surplus of $51 million. Some of the money returned to Queensland Treasury related to under-spending in HHS specific programs, such as backlog maintenance (under-spent by $35 million).

Operating surplus ratio

An operating deficit in any one year is not a cause for concern if, over the long term, the HHS achieves a balanced result or a small surplus. However, continuous deficits may indicate that a HHS is not financially sustainable.

We use the operating surplus ratio to measure the extent to which revenue covers operational expenses. A positive ratio indicates that the HHS's revenues exceeded their expenses. We calculate the ratio as a four-year average to assess the HHSs' long-term financial sustainability. Figure 3B shows the HHSs' annual operating ratio since 2012–13 and their four-year average.

Figure 3B
HHS operating surplus ratio 2012–13 to 2015–16



Source: Queensland Audit Office

Three HHSs—Cairns and Hinterland HHS, North West HHS, and Wide Bay HHS—have exhausted their surpluses built up over previous years (evidenced by a negative four-year average).

These three HHSs also underperformed against the following financial sustainability measures, which are important indicators of short-term liquidity:

- current ratio—measures the ability of a HHS to pay existing short-term debts with current assets (benchmark is greater than one)
- cash available (days) ratio—the number of days available to cover HHS cash outflows (benchmark is greater than 14 days).

When DoH identifies a HHS performance issue, it considers the need for support and the likelihood of continued adverse performance. The level of further support depends on the nature and severity of the issue, and DoH's assessment of the capacity for the HHS to resolve the issue themselves.

DoH increased its performance monitoring of four HHSs under the performance framework during 2015–16. This was due to their full-year forecast operating position varying unfavourably from their budget by more than one per cent. The HHSs were:

- Cairns and Hinterland HHS
- Central Queensland HHS
- North West HHS
- Wide Bay HHS.

Our assessment criteria and our detailed assessment for all HHSs are included in Appendix D. Further analysis on the three HHSs that have recorded four-year average negative operating surplus ratios is provided below.

Cairns and Hinterland HHS

Cairns and Hinterland HHS's average four-year operating surplus ratio is negative 0.08 per cent. Cairns and Hinterland HHS had an accumulated deficit at 30 June 2016 of $5.9 million, down from a $14.1 million surplus at 30 June 2015. Its current ratio as at 30 June 2016 is less than one (0.8) for the first time in four years. This result indicates that without additional funding, Cairns and Hinterland HHS may have insufficient current assets to meet its short-term debts. Cash available days has declined below the 14-day benchmark for a second year to minus 2.5 days, meaning Cairns and Hinterland HHS was in overdraft at 30 June 2016. This result may be due to the timing of cash inflows and outflows, but it may also indicate that they have insufficient cash to meet expected expenditure outflows.

In 2015–16, Cairns and Hinterland HHS reported an operating deficit of $20 million. The implementation of additional clinical services and the associated staffing costs in the latter part of 2015–16 were the key contributors to the reported operating deficit. This result included DoH funding of $31 million for the digital hospital implementation, which was $15 million more than budgeted, and an additional $13.4 million of non-recurrent funding.

The following case study outlines actions DoH took when Cairns and Hinterland HHS's performance against this measure deteriorated during 2015–16.

Case study 1

DoH system management in action

Context

In October 2015, the Director-General of DoH wrote to the Cairns and Hinterland HHS Chief Executive on a number of performance issues, including:

- improving emergency department performance
- addressing long waiting outpatients, particularly ear, nose, and throat patients
- discussing additional investment from DoH to help achieve these outcomes
- increasing the frequency of performance meetings from bi-monthly to monthly for a six-month period beginning December 2015.

At this time, Cairns and Hinterland HHS was experiencing demand for services above targets agreed with DoH, particularly for admitted patients and attendances at emergency departments.

During 2015–16, Cairns and Hinterland HHS experienced significant business change processes as it rolled out the digital hospital program at Cairns Hospital. This was a major undertaking in terms of staff training, equipment costs, and additional staff to help with the implementation and transition to a digital hospital. Cairns Hospital went live with the digital hospital in February 2016.

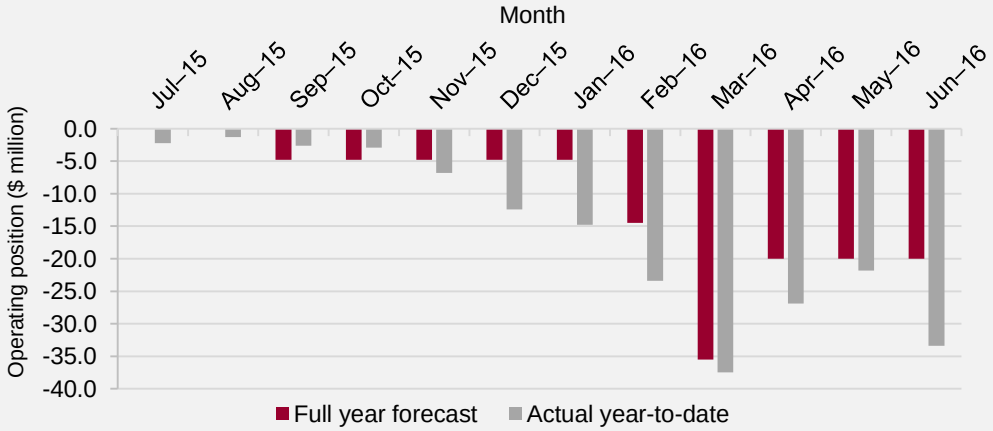
Monthly performance meetings

During each monthly meeting, DoH and Cairns and Hinterland HHS reviewed the HHS's performance under the framework. Attendees at the monthly performance meetings included the director-general, other senior executives of DoH, and the chief executive and other senior executives of Cairns and Hinterland HHS.

Each month, DoH prepared a performance report that included Cairns and Hinterland HHS's full-year forecast operating position, year-to-date actual financial results, operating performance measures, and activity delivered. The HHS specific performance reports did not include reporting of full-time equivalent staffing levels; however, overall HHS staffing levels formed part of DoH's system-wide performance reporting on a monthly basis.

The monthly performance reports for Cairns and Hinterland HHS identified the full-year forecast operating position and year-to-date actual financial results as shown in the chart below.

Figure 3C
2015–16 full-year forecast and actual financial position of Cairns and Hinterland HHS



Source: Department of Health monthly performance reports

Actions from December 2015 to February 2016

The year-to-date actual operating position of the Cairns and Hinterland HHS began to deteriorate from December 2015. At the time, DoH thought this was the result of Cairns and Hinterland HHS incurring expenditure in the lead up to going live with the digital hospital program, for which $16 million of funding had been approved but not yet provided.

DoH system management in action

From December 2015 to February 2016, the performance meetings between DoH and Cairns and Hinterland HHS focused primarily on operating performance (such as emergency department and outpatient waiting times), rather than financial performance. Once the full-year forecast operating position of Cairns and Hinterland HHS deteriorated during February 2016, greater attention turned to the financial performance of this HHS.

Actions from March to June 2016

Initially, Cairns and Hinterland HHS attributed the forecast deficit to the additional costs of delivering the digital hospital program above that initially funded by DoH. However, Cairns and Hinterland HHS also advised in March 2016 that they commenced a number of services in 2015–16 that they sought to fund primarily from their retained surpluses, supplemented by funding from DoH. The cost of these services exceeded what Cairns and Hinterland HHS had originally forecast. DoH and Cairns and Hinterland HHS assessed the full-time equivalent staffing levels at the HHS, the driving factors behind the deficit position for 2015–16, and the recurrent outlook for 2016–17.

Cairns and Hinterland HHS held an extraordinary board meeting in April 2016 to identify the cause of their worsening financial position. It engaged a consultant to perform a rapid financial and operational assessment and to ensure there was no evidence that fraud was contributing to the deficit. The draft report in May 2016 attributed 55 per cent of the forecast 2015–16 deficit to the digital hospital program and 39 per cent to unfunded projects. The consultant did not identify any evidence of fraud. Between April and June 2016, DoH agreed to fund additional costs Cairns and Hinterland HHS incurred for the digital hospital program, plus an additional $13.4 million, which reduced the recorded deficit.

The April 2016 monthly performance meeting focused on the significant increase in full-time equivalent staffing at Cairns and Hinterland HHS, which was above the budgeted level, and the costs of operating the additional beds it had opened to increase service provision. The June 2016 performance meeting noted that Cairns and Hinterland HHS had commenced these additional services without the appropriate funding required to sustain them into the future.

Actions after June 2016

In July 2016, Cairns and Hinterland HHS engaged an external consultant to conduct an independent assessment of their 2016–17 budget. It publicly released the external consultant's report on 14 October 2016, which forecast an $80 million deficit in 2016–17 if Cairns and Hinterland HHS took no action to reduce costs or find or negotiate additional revenue with DoH. The report identified the largest contributor to the 2016–17 forecast deficit was the full-year impact of the new services that Cairns and Hinterland HHS introduced in the latter part of 2015–16.

DoH has revised its 2016–17 performance framework and performance measures in its service agreements with HHSs to include a new measure for the number of full-time equivalent staff compared to budgeted levels. This was previously monitored as part of the system-wide performance reporting each month. DoH will also determine a performance rating for each HHS and escalate responses depending on that rating.

North West HHS

The North West HHS's average four-year operating surplus ratio is negative 0.42 per cent. North West HHS had an accumulated deficit as at 30 June 2016 of $3.4 million, a $2.1 million deterioration from 30 June 2015. Its current ratio at 30 June 2016 shows that it has sufficient current assets to meet short-term debts; however, its cash available days declined below the 14-day benchmark for the first time in four years (4.9 days).

North West HHS experienced expense increases due to the cost of converting contract-based medical officers to a new enterprise agreement and wage increases for doctors and nurses. Increased costs of externally provided radiology services also contributed to its operating deficit.

Wide Bay HHS

Wide Bay HHS's average four-year operating surplus ratio is negative 0.65 per cent. It had an accumulated deficit of $13.9 million as at 30 June 2016. Its operating results for the previous three years were balanced, meaning there was little financial capacity to fund any current year deficit.

At 30 June 2016 Wide Bay HHS's current ratio fell to 0.5 for the first time in four years, suggesting they may need additional financial support to pay their debts. Its cash available days has been historically below the 14-day benchmark since its establishment in 2012–13. But this year its cash available days declined to minus 3.3 days, meaning they were in overdraft at 30 June 2016.

In 2015–16, Wide Bay HHS delivered more clinical activity than DoH agreed to purchase, and earned more revenue (up 6.5 per cent). However, expenses were greater than revenue (up 9.3 per cent), with increases in:

- employee expenses—due to employing additional staff, and wage increases under enterprise agreements
- supplies and services expense—due to high cost hepatitis C drugs, and new outsourced ophthalmology and cardiology services.

Expenditure

Figure 3D
Total expenditure for all HHSs by type in 2015–16

Source: Hospital and Health Services financial statements 2015–16

In 2015–16, HHSs spent $12.3 billion purchasing goods and services and employing people to provide health services to Queenslanders, an increase of $1.3 billion or 12 per cent compared to 2014–15. The most significant expense for all HHSs is their staff costs, representing $8.2 billion or 67 per cent of total expenses.

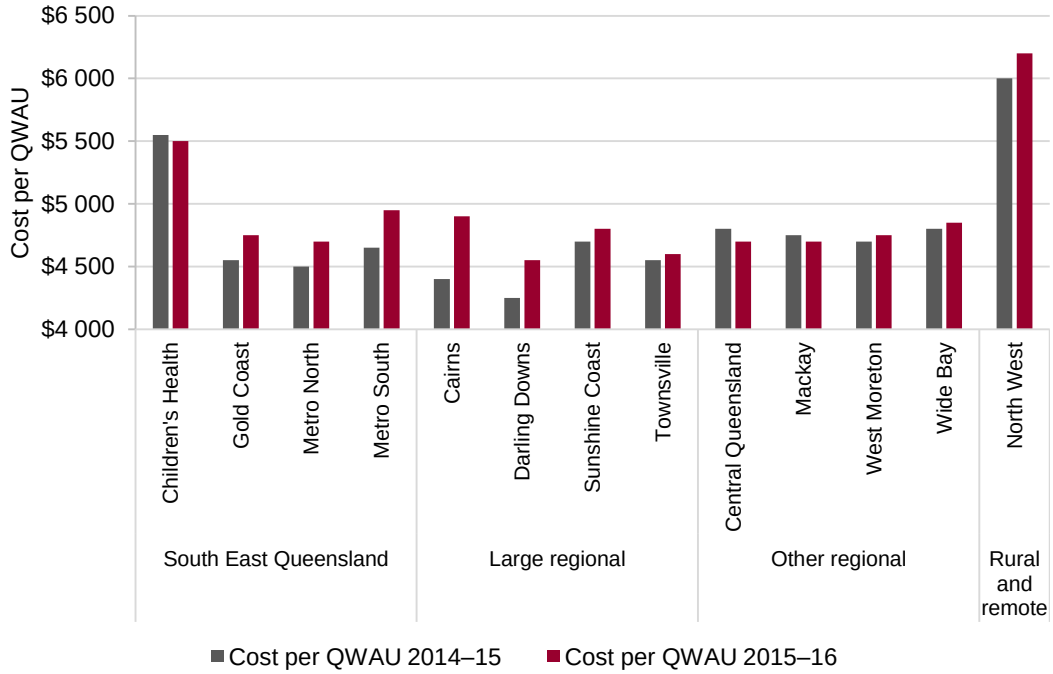
HHSs spent $3.5 billion purchasing goods and services. Drugs and clinical supplies represent 40 per cent of this expense.

Events and transactions affecting expenditure this year

Cost of HHS activity

DoH measures HHSs that receive activity based funding against the average cost of delivering one unit of clinical activity (Queensland weighted activity unit or QWAU). Figure 3E below shows the actual average QWAU cost for each HHS that received activity based funding in 2014–15 and 2015–16.

Figure 3E
Cost per QWAU for activity based funded HHSs



Note: The 2015–16 calculation model has been applied to the 2014–15 figures to provide a valid comparison.

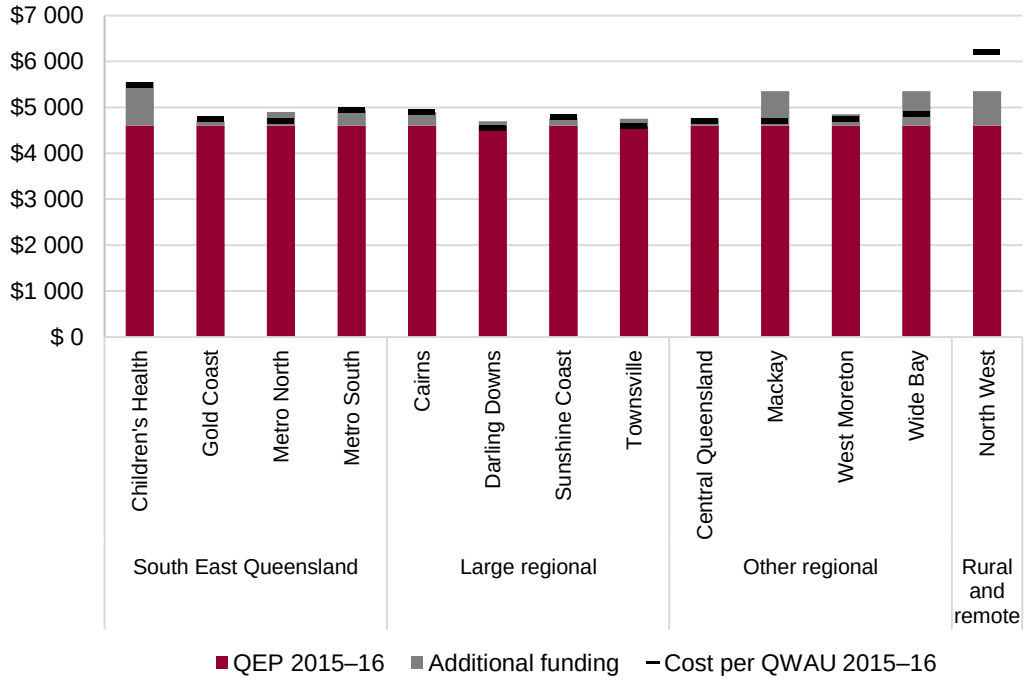
Source: Queensland Audit Office

In 2015–16, 10 HHSs cost per QWAU increased between one per cent and 11 per cent, and three HHSs cost per QWAU decreased between one percent and two per cent. This shows an average increase of three per cent across the sector. These results are in contrast to our previous report *Hospital and Health Services: 2014–15 financial statements* (Report 5: 2015–16), where we noted that in 2014–15 most HHSs had reduced their cost per QWAU compared to the prior year. The use of high cost drugs that were introduced to the Pharmaceutical Benefits Scheme in April 2016 has contributed to the increase in costs for some HHSs.

The Queensland efficient price is a benchmark of the efficient cost of providing public hospital services. The average QWAU cost of an efficient HHS should be at or below the Queensland efficient price.

HHSs can negotiate for additional funding from DoH to cover their costs in excess of the Queensland efficient price. When DoH assesses a HHS's cost per QWAU performance, it uses the Queensland efficient price plus any additional funding received by the HHS. Figure 3F compares the HHSs' average cost per QWAU against the funding received from DoH in 2015–16. Only Darling Downs HHS achieved an average cost below the Queensland efficient price in 2015–16, compared to 10 HHSs in 2014–15. Despite the additional funding from DoH, three HHSs delivered activity at an average cost above their funding level in 2015–16. The difference between funding received and cost per QWAU ranged from $50 for Sunshine Coast HHS and Gold Coast HHS to $850 for North West HHS.

Figure 3F
HHS QWAU cost versus funding received 2015–16



Source: Queensland Audit Office

DoH considers HHS performance is unfavourable when the cost per QWAU is more than three per cent higher than the funding they receive. In 2015–16, North West HHS is the only HHS above this benchmark, with a 14 per cent difference between funding received and cost per QWAU.

North West HHS is the only rural and remote HHS funded for activity based funding. It services patients in a remote location with a proportionally high Indigenous population. In 2015–16, North West HHS also received $34.2 million in block funding from DoH to assist in meeting its costs.

Employees

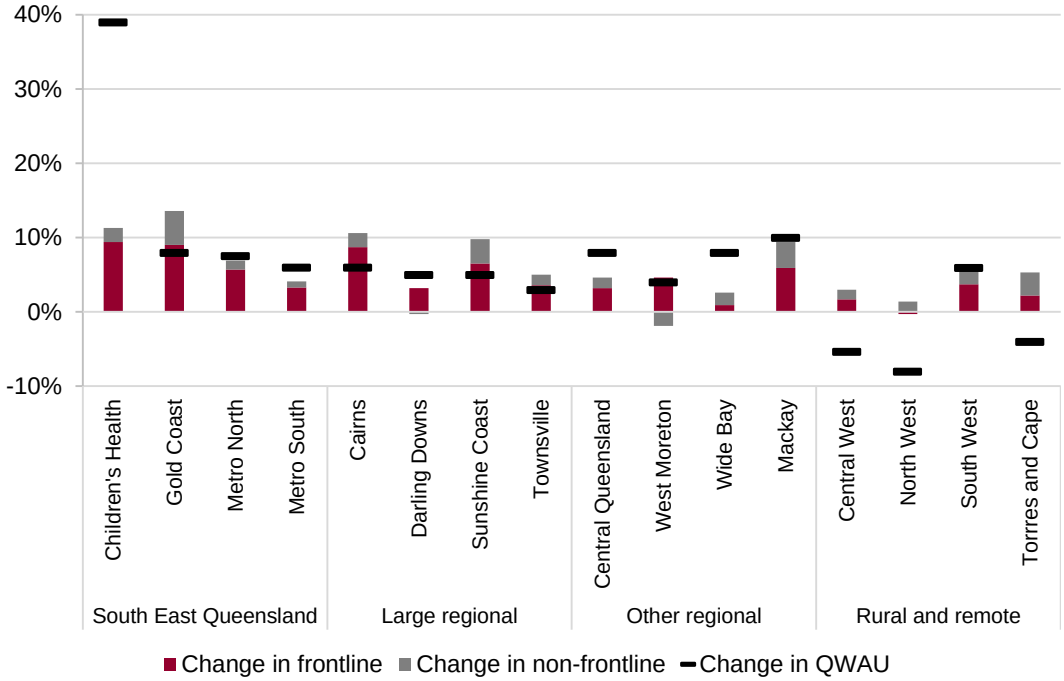
Employee expenses increased by 12 per cent compared to 2014–15. This increase was due to:

- the HHSs hiring more people—in aggregate, the number of full-time equivalent employees (FTE) increased by seven per cent to 69 100 employees
- the impact of changes to employee pay due to the re-establishment of an industrial agreement for senior doctors and a broader wage increase of 2.5 per cent for doctors and nurses.

Across the health sector, the majority of FTE growth occurred in frontline positions, which increased by 3 300 employees (six per cent) compared to 2014–15. Non-frontline employees provide operational and administration support in the HHSs. The number of non-frontline employees increased by 1 000 employees (nine per cent) compared to 2014–15.

With the majority of growth in frontline positions, we looked to see if the increases in staff translated to increases in HHS activity. Figure 3G shows the change in health service activity between 2014–15 and 2015–16, measured in QWAU, compared to the change in FTE (permanent and temporary, but excluding locums and other contracted staff) between 30 June 2015 and 30 June 2016.

Figure 3G
Change in activity versus change in FTE



Source: Queensland Audit Office

In some cases, the growth in activity has exceeded growth in FTE, for others the growth is commensurate, and for others the growth in FTE has been higher than increases in clinical activity. HHSs that have experienced FTE growth of 10 per cent or greater and was not commensurate with activity were:

- Children's Health Queensland HHS—the 39 per cent growth in activity arose due to the 2014–15 activity representing approximately seven months of activity following the commissioning of the Lady Cilento Children's Hospital in November 2014. The FTE increase of 11 per cent in 2015–16 reflects the increase in services in the hospital's first full year of operation.
- Gold Coast HHS—the increase in FTE at Gold Coast HHS of 14 per cent occurred due to the introduction of new services and the extension of existing services to meet the continuing growth in the demand for healthcare. In addition, frontline FTE increased to comply with the nurse–patient ratio legislation that came into effect on 1 July 2016.
- Cairns and Hinterland HHS—the increase in frontline FTE of nine per cent occurred to grow clinical activity and the two per cent increase in non-frontline FTE occurred primarily in staff for the digital hospital project. The increase in frontline FTE occurred in the last quarter of 2015–16, meaning the additional staff were recorded as FTE at year end but only a portion of the increases in activity was realised.
- Sunshine Coast HHS—frontline FTE increased by seven per cent as it prepares for the opening of Sunshine Coast University Hospital. Sunshine Coast HHS will retain some services at Nambour Hospital and bring additional employees online for Sunshine Coast University Hospital. Non-frontline staff increased by three per cent, primarily in project staff as Sunshine Coast HHS plans and prepares for the opening of Sunshine Coast University Hospital.

In the rural and remote HHSs, clinical activity at Central West HHS, North West HHS, and Torres and Cape HHS was not commensurate with the increase in FTE. These results are not unexpected as:

- rural and remote HHSs have a small staff cohort. A movement of less than 10 FTE can result in a significant percentage change
- some of these HHSs are actively attempting to convert contract staff (such as locums not on the payroll system) to full time permanent employees, which shows above as a change in FTE, but does not change the total workforce required to deliver health services
- activity levels fluctuate due to a transient workforce and visitors.

Across the sector, the increase in FTE is one of the factors contributing to the reported improvements in health sector performance including:

- the increase in health service activity with HHS delivering eight per cent more QWAU compared to prior year
- more outpatients seen within the clinically recommended time. The number of outpatients waiting longer than the clinically recommended time for a specialist appointment decreased by 23 600 (29 per cent) patients since June 2015
- more elective surgery procedures performed, with the number of elective surgery procedures provided increasing by 4 107 (3.1 per cent) procedures compared to 2014–15
- the average length of stay for patients at the 13 HHSs funded by activity based funding reduced, with 10 HHSs meeting the national average for all diagnosis groups as determined by the National Health Performance Authority compared to six in 2014–15.

Future challenges and emerging risks

Queensland's health sector faces a number of challenges in delivering health services.

Growing demand for and the increasing cost of health services

Demand for healthcare has increased across all HHSs, growing by 26 per cent to 1.2 million hospitalisations in the four years to 2015–16. Population growth, the ageing population, and the increase in admission rates are factors that drove this growth and are drivers for future demand for health care. Specifically:

- Queensland's population has grown by six per cent over the past four years and is projected to increase by a further 18 per cent by 2026.
- Hospital admission rates are increasing due to changing disease profile and improvements in medical treatments and procedures.
- The proportion of Queensland's population aged 65 years and older is projected to increase to 17 per cent by 2026.

Australian and Queensland Government funding for health care has increased by 20 per cent over the last four years. The challenge for HHSs is to meet the growing demand for health services while managing their costs.

Nurse–patient ratio

From 1 July 2016, HHSs introduced minimum nurse–patient ratios. This means that acute medical and surgical wards in HHSs will have a minimum of one nurse to every four patients for a day shift and one nurse to every seven patients for a night shift. Nine HHSs have identified that they will collectively employ an additional 172 full-time equivalent nurses at a cost of $20.5 million in 2016–17 to satisfy their nurse–patient ratio. HHSs need to fund these additional nurses from their existing budgets, meaning that HHSs need to find further savings.

Sunshine Coast University Hospital

The Sunshine Coast University Hospital is Queensland's first public hospital public–private partnership (PPP). The construction of Sunshine Coast University Hospital was completed in November 2016, with commissioning in April 2017. This presents a number of challenges for the Sunshine Coast HHS, including:

- recruiting a large workforce—in 2016–17 total FTE at Sunshine Coast HHS will increase by 45 per cent to 5 700 FTE, with employee expenses rising by 39 per cent to $637 million. Sunshine Coast University Hospital will employ 3 500 staff when it opens, approximately 70 per cent will be new staff, with the remaining staff transferred from Nambour Hospital.
- managing the transformation of services—health services across Sunshine Coast hospitals will be reconfigured between the existing hospitals and Sunshine Coast University Hospital. Following the opening of Sunshine Coast University Hospital, both Nambour and Caloundra hospitals are scheduled for refurbishment.
- managing the public-private partnership—Exemplar Health (the PPP partner) will maintain Sunshine Coast University Hospital buildings, equipment, car parks, and grounds for 25 years and will be entitled to payments of $2.5 billion over the life of the agreement.

Integrated care

Integrated care has the potential to reduce the rising demand, and cost, on the public hospital system. It seeks to better coordinate the care for an individual across primary and preventative care, mental health, and specialist and hospital care. With these different tiers of the health system working together to provide the right care for the patient, unnecessary tests and hospitalisations can be minimised.

Nationally, the Australian Government's Health Care Homes pilot commences in 2016–17, with the Brisbane North region selected as the only Queensland site.

Independent of this initiative, all but one HHS has integrated care projects planned or in progress. We have selected two projects as examples of the work that is underway.

Case study 2

Integrated care

Gold Coast Integrated Care

Gold Coast Integrated Care (GCIC) was jointly developed between the Gold Coast HHS and Gold Coast General Practitioners (GPs). GCIC established partnerships with 15 Gold Coast GP clinics, which encompasses more than 110 GPs and 130 000 patients, representing about 25 per cent of the Gold Coast population.

GCIC aims to streamline the provision of care for people suffering chronic conditions such as heart disease, chronic obstructive pulmonary disease, kidney disease, and diabetes. It brings together teams within the Gold Coast Hospital, general practice, and community-based care providers, including non-government organisations. Central to the care coordination is a shared patient record that is accessible by all care providers (including GPs, Gold Coast Hospital staff, and community pharmacists), allowing ready access to the latest patient interactions with the health system. Access to this information maximises the coordination of care, and avoids duplication of services, such as blood tests or X-rays.

The integrated patient information enabled GPs to identify around 1 500 patients at higher risk of hospitalisation. A tailored care strategy was developed for each patient, involving either hospitalisation and/or ongoing monitoring/management of their condition outside of hospital.

GCIC is conducting a formal evaluation of the program's objectives to measure the anticipated benefits in the following areas:

- reduced presentations to the emergency department
- decreased admission rates (especially unplanned admissions)
- reduced length of stay where admission is required
- improved capacity of specialist outpatients
- improved clinical outcomes for patients with complex and chronic conditions.

The evaluation of the program is due to be finalised in December 2018.

Metro North QCAT project

Some elderly and vulnerable patients, or those with complex care needs, may lack a care-giver or guardian to make informed decisions on their behalf. These patients often remain in acute inpatient beds in Queensland public hospitals as they wait for guardianship matters to be heard by the Queensland Civil and Administrative Tribunal (QCAT).

Hospital evidence indicates that these people routinely experience extended lengths of inpatient stay that are medically unnecessary and make it harder to free up beds for patients requiring acute care.

The Metro North QCAT project aims to reduce the time patients wait for guardianship hearings.

The pilot phase aimed to cut the average waiting time for a hearing by more than 50 per cent, by:

- funding additional QCAT hearing days
- centralising management of QCAT applications across all Metro North
- working with QCAT to better coordinate processes between entities.

Metro North HHS has reported the following preliminary outcomes from the pilot:

- 47 per cent reduction in average hearing waiting times (from 66 days to 35 days, reaching a low of 24 days in September 2016)
- reduction in average length of hospital stay for QCAT patients by 37 days.

Digital hospital implementations

In 2015–16 both Princess Alexandra Hospital (Metro South HHS) and Cairns Hospital (Cairns and Hinterland HHS) went live as digital hospitals. In both cases the actual implementation costs were more than originally budgeted as shown in Figure 3H.

Figure 3H
Budget versus actual cost of digital hospital implementation

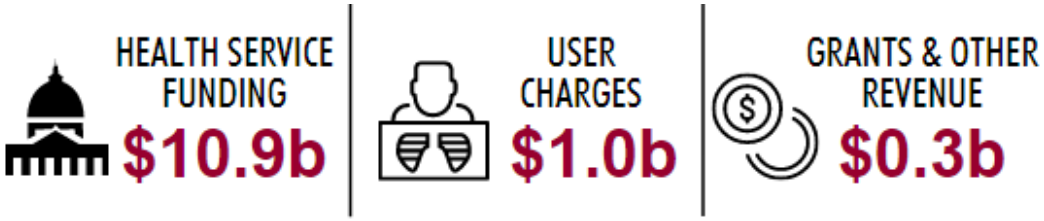
Hospital	Budget $ million	Actual $ million	Over budget $ million
Princess Alexandra Hospital	18	30	12
Cairns Base Hospital	16	31	15

Source: Metro South HHS, and Cairns and Hinterland HHS

In 2016–17, Princess Alexandra Hospital will implement additional functionality to manage medication, and a further five digital hospital implementations will commence or continue at Townsville, Mackay, Children's Health Queensland, Redcliffe Hospital (Metro North HHS), and Logan Hospital (Metro South HHS). The experiences at Princess Alexandra and Cairns should be considered in developing and managing budgets for other digital hospital implementations.

Revenue

Figure 3I
Total revenue for all HHSs by type in 2015–16



Source: Queensland Audit Office

In 2015–16, HHSs received revenue totalling $12.2 billion, an increase of $1.1 billion or 11 per cent from 2014–15. HHSs received $10.9 billion of their revenue from the Australian and Queensland Governments, including $7.9 billion in activity based funding and $1.2 billion in block funding for the provision of health services, an increase of 10 per cent from 2014–15. Revenue from user charges increased by 25 per cent to $1.0 billion in 2015–16.

Events and transactions affecting revenue this year

Additional funding from DoH above Queensland efficient price

DoH agreed with HHSs in 2015–16 to provide additional activity based funding above the Queensland efficient price. HHSs used this additional funding to help meet the increased costs they incurred during the year. Figure 3F shows the amount of additional activity based funding per QWAU provided to each HHS.

Across all HHSs, DoH contributed a total of $490.2 million in additional activity based funding in 2015–16, more than doubling the additional activity based funding of $146.8 million in 2014–15.

Growth in services delivered

In 2015–16, DoH agreed to purchase approximately 1.4 million QWAU from the 13 HHSs that receive activity based funding. In 2015–16, these HHSs delivered approximately 1.5 million QWAU, an increase of six per cent above the amount purchased.

Twelve of the HHSs exceeded their activity target for 2015–16. For these HHSs, the Australian Government provided additional growth funding of $192.2 million, an increase of $82.7 million or 75 per cent compared to 2014–15. North West HHS had its funding reduced by $0.8 million for not meeting its 2015–16 activity target.

For each QWAU delivered above the target, HHSs receive funding of only 45 per cent of the Queensland efficient price. In 2015–16 only one HHS delivered their activity at an average cost below the Queensland efficient price. To be financially sustainable, HHSs need to deliver additional activity at an incremental cost below the additional funding the Australian Government provides, otherwise they need to fund any difference from alternate sources.

Growth in pharmaceutical benefits scheme reimbursements and private patient receipts

Reimbursements from the Australian Government through the pharmaceutical benefits scheme increased by $134.1 million or 56 per cent to $371.5 million in 2015–16. This was largely caused by the March 2016 listing on the scheme of high cost drugs to treat hepatitis C. HHSs' drug costs increased in similar proportions.

Hospital fees increased by $55.5 million or 13 per cent to $474.1 million in 2015–16 for two main reasons:

- increased receipts of $37.1 million from private health insurers and Medicare-ineligible patients using public health facilities
- a change in the funding arrangements for worker's compensation patients with HHSs now billing Workcover Queensland directly, where previously DoH billed on their behalf ($18.5 million).

Contribution from DoH to Children's Health Queensland HHS

DoH provided a non-cash contribution of $35 million in 2015–16 to Children's Health Queensland HHS. The contribution restored Children's Health Queensland HHS's accumulated surplus, which was eroded in 2014–15 due to the write-down in the value of the former Royal Children's Hospital buildings at Herston.

Future challenges and emerging risks

Changes in HHS funding from the Australian Government

In 2016–17, the Australian and Queensland Governments will spend $12.6 billion purchasing health services from HHSs, an increase of 8.6 per cent compared to the 2015–16 budget. The increase in funding will help expand and grow services to meet local demand.

In April 2016, the Australian Government and the states and territories agreed to continue activity based funding as the national funding model until 30 June 2020. From 1 July 2017 the Australian Government will fund 45 per cent of efficient growth in public hospitals, subject to a national cap of 6.5 per cent growth per year. This means that 2016–17 is the final year for HHSs to earn growth funding in an uncapped environment.

Other changes to health funding announced by the Australian Government in the 2016–17 Federal Budget affecting the HHSs include:

- ceasing funding for the National Partnership Agreement on Supporting Mental Health Reform on 30 June 2016, resulting in a reduction in funding of $10.4 million across Queensland
- changing the Child Dental Benefits Scheme and the adult dental National Partnership Scheme, which will reduce funding for public dental services. These changes were scheduled to commence on 1 July 2016 but are now delayed as the legislation has not yet passed.

Understanding financial position

Financial position is measured by HHS net assets—the difference between total assets and total liabilities. Over time, financial position can indicate whether financial health is improving or deteriorating. A growing positive net asset position indicates that a HHS has greater capacity to meet an increase in future service demands. As at 30 June 2016, the combined net asset position of HHSs totalled $9.8 billion, which is similar to the result achieved in 2014–15.

HHSs do not hold any debt, apart from short-term debts to suppliers. The key risk to HHSs is the maintenance of a large portfolio of buildings.

Assets

Figure 3J
Total assets for all HHSs by type in 2015–16

Source: Queensland Audit Office

In 2015–16, the HHSs reported total assets of $10.56 billion, of which 89 per cent is property, plant, and equipment.

Events and transactions affecting assets this year

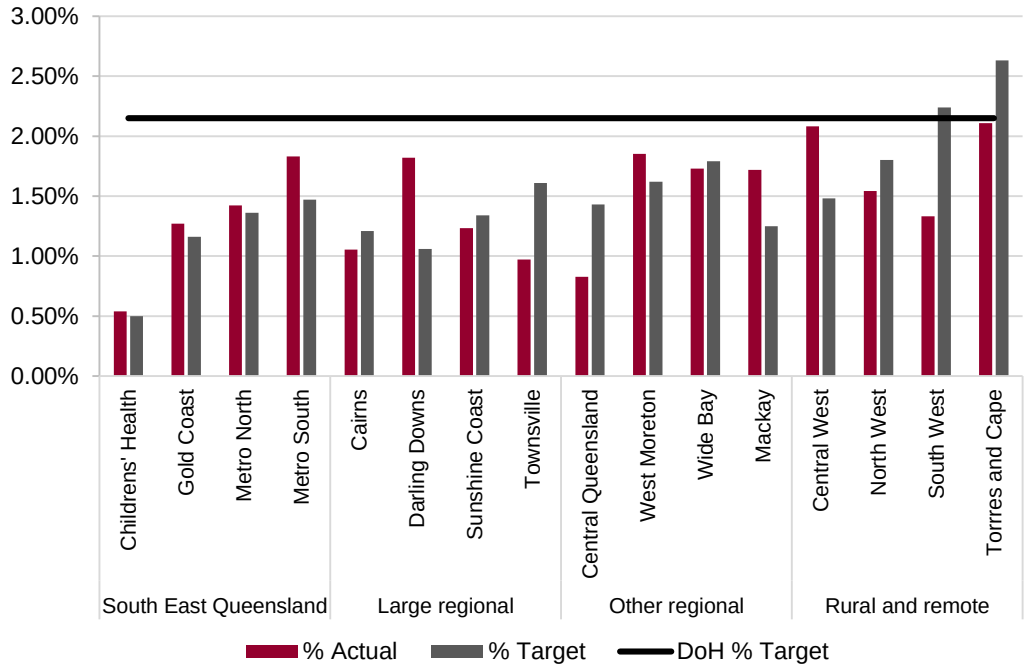
Maintenance of buildings

As at 30 June 2016, HHSs are the custodians of land valued at $1 billion and buildings valued at $7.6 billion. Effective planning for the replacement, refurbishment, and maintenance of these assets is critical for HHSs to continue to deliver high quality health services to Queenslanders into the future and to ensure the safety of patients and staff.

The service agreement between DoH and the HHSs provides funding for the regular maintenance of buildings. DoH sets a target for maintenance expense of 2.15 per cent of the building value. However, the HHSs can nominate their own target level for asset maintenance in their approved annual maintenance plans.

Figure 3K shows that all HHSs (except for Torres and Cape HHS, and South West HHS) have set maintenance targets that are below the DoH target for 2015–16. Eight HHSs did not achieve their own lower asset maintenance targets. Ideally, HHSs should set their asset maintenance targets based on the age and condition of their buildings. For example, Children's Health Queensland HHS currently has the lowest asset maintenance target. This is expected as it has the newest hospital in Queensland.

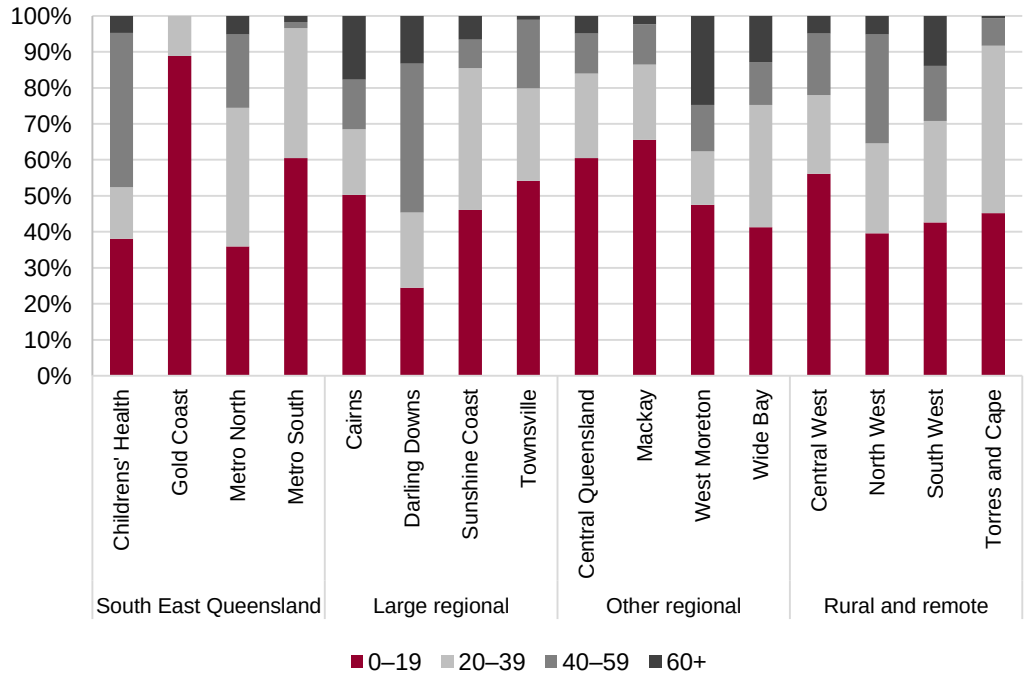
Figure 3K
2015–16 building maintenance expense—actual versus target as a % of asset value



Source: Queensland Audit Office

We expected HHSs with much older assets to set higher asset maintenance targets as older assets require greater levels of maintenance. However, this does not appear to be the case for all HHSs. Figure 3L shows Darling Downs HHS has the largest proportion of buildings over 20 years of age (75 per cent) yet has the second lowest asset maintenance target as disclosed above. Despite its low target, Darling Downs HHS has exceeded its target by more than any other HHS.

Figure 3L
HHS buildings by age



Source: Queensland Audit Office

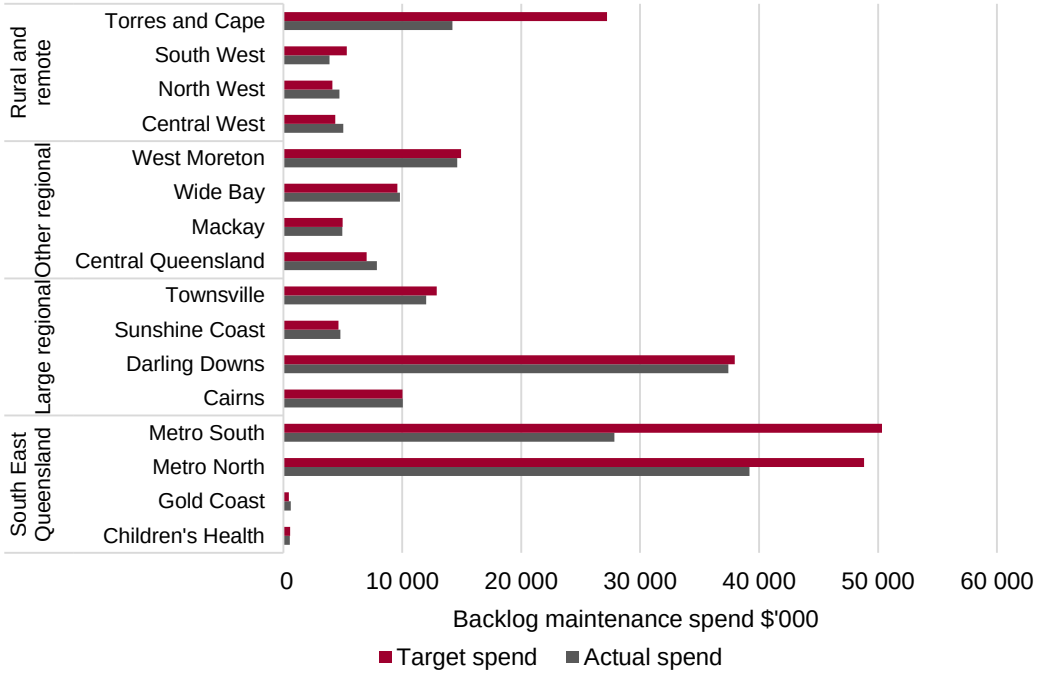
The rural and remote HHSs also have a large number of older buildings. While their asset maintenance targets are some of the highest across the HHSs, most of the rural and remote HHSs have fallen well short of meeting their targeted maintenance spend.

HHSs should ensure that they consider the age and condition of their buildings when determining their asset maintenance targets in the future.

Under-expenditure in maintenance for one or two years is not an immediate cause for concern. However, if maintenance continues to be deferred, this may result in available funds being used for corrective maintenance tasks rather than being applied for preventative maintenance that maintains the life of the asset. This will not only affect the ability of the HHS to support current service levels but also its ability to meet future demand for services.

An outcome of under spending in regular building maintenance is the build-up in backlog maintenance requirements. The government announced the backlog maintenance remediation program in the 2013–14 Queensland Budget to address the under investment in asset maintenance in HHSs. Figure 3M shows that after the third year of the program, 13 HHSs are essentially on track in achieving their cumulative spend on backlog maintenance against their targets.

Figure 3M
HHS cumulative backlog maintenance spend for the three years to 2015–16



Source: Department of Health

The HHSs that are currently furthest behind in their backlog maintenance spend are:

- Metro North HHS—has funds earmarked to demolish a building as part of the program but needs to find additional funding from its own sources to relocate the services currently being provided in that building before demolition can commence. The HHS also has another major project requiring further negotiation with the Commonwealth before being able to proceed
- Metro South HHS—has a number of large projects that are in progress and scheduled for completion by June 2017
- Torres and Cape HHS—has been hampered by the lack of capacity and capability within the HHS to deliver the program. The HHS has committed to complete the program of work by the end of the 2016–17 year.

Future challenges and emerging risks

Long-term asset planning

There are significant challenges for all HHSs to determine the correct level of asset maintenance required to achieve the maximum life and service potential of their buildings. HHSs need to perform a rigorous evaluation of the asset portfolio to ensure that it supports their planned service delivery objectives. This evaluation includes current and future plans to improve, replace, dispose, and maintain assets.

For HHSs with limited resources, striking the right balance between maintenance requirements and the provision of clinical services to those in need is an ongoing challenge.

4. Internal controls

Chapter in brief

This chapter details our assessment of the strength of the internal controls designed, implemented, and maintained by entities to ensure reliable financial reporting.

We assess financial controls using the Committee of Sponsoring Organizations of the Treadway Commission (COSO) internal controls framework, which is widely recognised as a benchmark for designing and evaluating internal controls.

Main findings

- We reported 125 internal control deficiencies in 2015–16; 55 per cent of these relate to deficiencies that were reported in prior years but not resolved.
- We did not identify any significant deficiencies (high risk matters).
- There is an absence of service level agreements and tailored financial management practice manuals within the control environment of Hospital and Health Services (HHSs).
- For risk management, we identified that three of the four HHSs we reviewed had immature information technology (IT) disaster recovery planning processes and procedures.
- We identified deficiencies for control activities about managing contracts, approving transactions, and monitoring expense reports.
- The HHSs' finance system is no longer maintained by the supplier, with a project to replace the system underway and scheduled for implementation in 2017–18.

Audit conclusions

Generally, we assessed that HHSs had control environments that were suitable for us to rely on for ensuring complete and accurate financial reporting. Upon testing the effectiveness of these controls, we found they were reliable in most cases, except for some lower risk deficiencies in both manual and IT controls.

The high number of internal control deficiencies that remain unresolved from prior years increases the risk that fraud or error will not be detected.

Introduction

This chapter evaluates the effectiveness of internal controls maintained by each Hospital and Health Service (HHS), whether these controls are operated by the HHS, or the Department of Health (DoH) as their service provider. The purpose of these controls is to mitigate risks that may prevent an entity from achieving reliable financial reporting, effective and efficient operations, and compliance with applicable laws and regulations.

As part of our audit, we assess the design and implementation of these controls and, where we identify controls that we intend to rely on, we test how effectively these controls are operating.

If we assess an entity's internal controls as not being well designed, not operating as intended, or missing controls that should be in place, we are required to communicate these deficiencies to management.

The DoH is responsible for processing the payroll and accounts payable financial transactions of the HHSs, and for managing the financial information systems that HHSs use. HHSs rely on their own controls and those of DoH to minimise the risk of fraud or error in their financial statements. In assessing the effectiveness of HHS controls, we consider the controls of the service provider as well.

By reporting on our analysis we aim to promote a stronger control environment, and to mitigate financial losses and damage to public sector reputation by initiating effective responses to identified control weaknesses.

We have provided a summary of our control assessments in Appendix C.

Conclusion

We did not identify any significant deficiencies (high risk matters) in the HHSs' controls, and their control environments support reliance on their internal control systems.

The risk of undetected errors within financial systems and consequently, financial reports, has increased compared to the previous year. We reported 125 internal control deficiencies this year—55 per cent of these were deficiencies not resolved from last year. HHSs expose themselves to a higher risk of error or fraud by not addressing internal control deficiencies in a timely manner.

Our review of information technology (IT) disaster recovery planning at four HHSs, found three with immature disaster recovery planning processes and procedures. This means that these HHSs may not be able to recover critical systems within an acceptable time frame in the event of a disaster.

We did not identify any deficiencies in the HHSs' information and communication processes. However, we continue to note that HHSs' financial system, provided by DoH, is no longer supported by the vendor. A replacement financial system project is currently underway, with a likely implementation in 2017–18. In the meantime, DoH has taken steps to minimise the risk of system failure in the existing system.

Internal controls at the HHSs complement the internal controls at DoH—their service provider—as they relate to the HHSs financial transactions. While there were some weakness in DoH's internal controls over payroll and accounts payable processing, these weaknesses did not affect the reliability of reported financial results at HHSs.

Internal control framework

We assess internal controls using the Committee of Sponsoring Organizations of the Treadway Commission (COSO) internal controls framework, which is widely recognised as a benchmark for designing and evaluating internal controls.

The framework defines five components to a successful internal control system. These include the control environment, risk management, monitoring of controls, control activities, and information and communication.

All the components need to be present and operating together as an integrated system of internal control. When this is the case, entities increase the likelihood of achieving their objectives.

Selecting internal controls to test

We assess the design and implementation of each entity's controls to assist us in determining the nature, timing, and extent of testing to be performed.

Where we believe the design and implementation of controls is effective, we select the controls we intend to test further by considering a balance of factors including:

- significance of the related risks
- characteristics of balances, transactions, or disclosures (volume, value, and complexity)
- nature and complexity of the entity's information systems
- whether the design of the controls facilitates an efficient audit.

Our initial assessments indicated that we could rely on financial controls in place at each HHS. Once we test whether the controls are operating effectively, we update our assessment across each COSO element. Our assessment of the controls at the HHSs is detailed in Appendix C.

Our rating of internal control deficiencies

Significant deficiency *(high risk matters)****:*** a deficiency that either alone or in combination with multiple deficiencies may lead to a material misstatement. They require immediate management action and are reported to those charged with governance.

Deficiency: occurs when internal controls are missing or are ineffective. Deficiencies may lead to an environment that is not supportive of high quality financial reporting.

We assess all internal control deficiencies based on their potential to cause a material misstatement in the financial statements—either individually or in combination with other control deficiencies.

Our ratings allow management to gauge relative importance and prioritise remedial actions.

We increase the rating to a significant deficiency from deficiency based on the risk of material misstatement in the financial statements, the potential to cause financial losses, or an event causing major business interruptions.

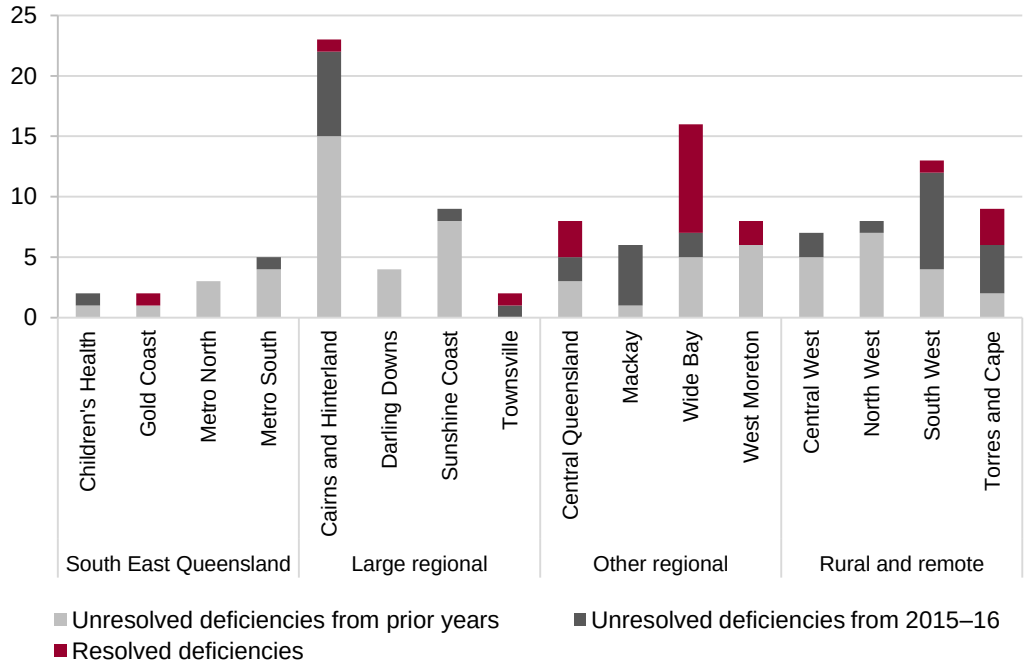
The following sections of this report detail the control deficiencies we identified by COSO element. We also consider the appropriateness and timeliness of remedial action undertaken to resolve audit matters identified.

Status of internal control deficiencies

In 2015–16, we did not identify any significant deficiencies in the HHSs.

During 2015–16 we identified and communicated to HHSs a total of 125 internal control deficiencies. Figure 4A outlines the current status of the control issues identified.

Figure 4A
Status of internal control deficiencies reported to management in 2015–16



Source: Queensland Audit Office

Of the deficiencies raised this year, 69 (55 per cent) were matters originally raised in the previous year, but not resolved by the HHSs by 31 August 2016. This means that some HHSs are taking more than 12 months to implement action to address their internal control weaknesses. The lack of timely action on internal control deficiencies exposes the HHSs to an increased risk of error or fraud.

Unresolved issues principally fall into two COSO elements:

- control environment issues—relating to delays in agreeing complete service level agreements with DoH as the shared service provider, and the tailoring of financial management practice manuals for HHS contemporary financial practices
- control activity issues—relating to deficiencies in managing contracts, approving expenditure transactions, and monitoring of expenses.

Control environment

- Cultures and values
- Governance
- Organisational structure
- Policies
- Qualified and skilled people
- Management's integrity and operating style

The control environment is defined as management's actions, attitudes, and values that influence day-to-day operations. As the control environment is closely linked to an entity's overarching governance and culture, it is important that the control environment provides a strong foundation for the other elements of internal control.

We identified deficiencies at HHSs relating to:

- absence of service level agreements with DoH
- absence of tailored financial management practice manual.

We reported last year, as a deficiency, the absence of a service level agreement between HHSs and DoH as their shared service provider. HHSs and DoH have established formal service agreements for payroll and IT services this year. However, we found that HHSs continue to negotiate the final conditions on service levels and reporting requirements for accounts payable services provided by DoH.

We also continued to raise the absence of financial management practice manuals as a deficiency this year. These manuals describe the policies and procedures that relate to the financial management of the HHSs, including internal controls. Seven HHSs have not updated their manuals for their contemporary financial practices. This means that internal controls at these HHSs may not be consistently applied, increasing the risk of fraud or error.

Risk assessment

Risk assessment relates to management's processes for considering risks that may prevent an entity from achieving its objectives, and agreeing how the risks should be identified, assessed, and managed.

Appropriate management of business risks can be achieved either by management accepting the risk, if it is minor, or mitigating the risk to an acceptable level through the implementation of appropriately designed controls. Risks can also be eliminated entirely such as by choosing to exit from a risky business venture.

This year, in addition to our annual review of HHS general risk management processes, we conducted an in-depth review of IT disaster recovery planning (DRP) at four HHSs. The purpose of the review was to assess whether HHSs had appropriate controls in place to completely recover their IT systems and data within an acceptable time frame in the event of a major disruption or disaster. Delivery of health services depends on IT systems, and the rollout of the digital hospital program only increases the level of reliance on IT, emphasising the need for timely and effective recovery of systems when required.

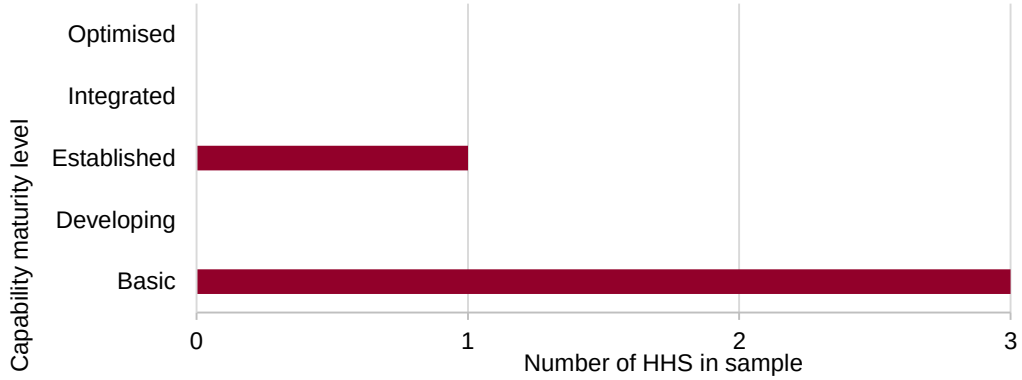
For this review, we selected one HHS from each of the following HHS groups:

- South East Queensland—Metro South HHS
- Large regional—Cairns and Hinterland HHS
- Other regional—Mackay HHS
- Rural and remote—South West HHS.

We used a capability maturity model to assess how well HHSs' disaster recovery planning supports critical IT processes. The maturity ratings are described in Appendix E.

Figure 4B shows the maturity of each HHS that we reviewed. Only Metro South HHS has an established disaster recovery capability. This means that the HHS has a comprehensive disaster recovery plan covering all its critical processes and this plan is reviewed and tested annually. With the greater reliance on IT capability associated with digital hospital implementations, being able to recover these services in the event of a disaster is increasingly important.

Figure 4B
IT disaster recovery—sampled HHS maturity assessments



Source: Queensland Audit Office

The remaining three HHSs were assessed as having basic processes for identifying and documenting their IT disaster recovery requirements and managing risks relating to their IT assets. We found that:

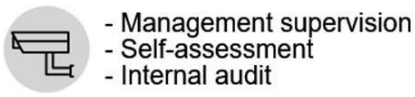
- the HHSs did not conduct business impact assessments to identify how long it would take to recover their systems, where they will do this, and what is an acceptable period for sustaining an outage
- IT DRP documentation maintained by the HHSs were not comprehensive, as they did not cover all the facilities located in the HHS and all IT systems and services that they manage
- the HHSs did not conduct annual testing of their DRP or, if they did test, did not document the results of testing performed.

We also found that the service agreements between the HHS and DoH were not updated to reflect the IT systems supported by DoH. For example, the agreement with Metro South HHS and Cairns and Hinterland HHS did not include the IT systems implemented by the digital hospital program. The service agreements also did not define the level of service that will be provided by DoH in the event of a disaster.

These deficiencies mean that there is an increased risk that HHSs may not be able to recover critical IT systems within an acceptable time frame in the event of a disaster.

While our review only sampled four of the 16 HHSs, we recommend that all HHSs assess the maturity of their IT disaster recovery capabilities, identifying areas for improvement, and initiate plans to implement these improvements.

Monitoring activities



Monitoring activities are the methods management uses to oversee and assess whether internal controls are present and operating effectively. This may be achieved thorough ongoing supervision, periodic self-assessments, and separate evaluations. They also concern the evaluation and communication of control deficiencies in a timely manner to effect corrective action.

Typically, the internal audit function and an independent audit and risk committee are responsible for overseeing the implementation of controls and the resolution of control deficiencies. These two functions work together to ensure that internal control deficiencies are identified and resolved in a timely manner.

The extent of unresolved issues from the prior year suggests that audit and risk committees need to take a more active role in monitoring the timely resolution of control deficiencies.

Control activities

Control activities are policies and procedures that help ensure management directives are carried out and that necessary actions are taken to address identified risks. These activities operate at all levels and in all functions, and can be designed to prevent or detect errors entering financial systems.

The mix of control activities can also be categorised into manual control activities and IT system controls.

Manual control activities

Manual controls contain a human element, which can provide an opportunity to assess the reasonableness and appropriateness of transactions. These controls may also be less reliable than automated controls, because they can be more easily bypassed or overridden.

Manual controls include activities such as approvals, authorisations, verifications, reconciliations, reviews of operating performance, securing of assets, and segregation of incompatible duties. Manual controls may be performed with the aid of IT systems.

Nearly half the control deficiencies we identified during 2015–16 (45 per cent) relate to manual control activities. We identified deficiencies in:

- approving expenditure, inventory, and payroll transactions by an appropriate financial delegate
- managing contract processes, which includes maintaining contract registers, monitoring of actual spend against contract values, and monitoring the performance of suppliers
- monitoring of payroll costs by cost centre managers.

In all cases, management's proposed actions were reasonable and we encourage them to resolve the deficiencies in a timely manner.

The department has several information system projects underway that may reduce the reliance on manual controls.

IT system controls

IT system controls are the control activities that relate to the maintenance and operational capability of the entity’s IT systems.

IT system controls can enhance the timeliness, availability, and accuracy of information through applying predefined business rules. They can enable the performance of complex calculations in processing large volumes of transactions, and improve the effectiveness of financial delegations and segregation of duties.

Effective controls over IT systems can reduce the risk that controls will be circumvented, and maintain the integrity of information and data security.

Conversely, poorly managed IT system controls can increase the risk of unauthorised access, which may result in the destruction of data or recording of non-existent transactions.

HHSs rely on IT systems provided by DoH for their operational and financial activities. Our testing of DoH IT system controls identified no deficiencies.

Service providers

Queensland public sector entities use a variety of service providers to outsource some or all of the activities to process transactions on behalf of the entity. Service providers can deliver cost efficiencies and also provide an effective layer of control. They also present risks to the participating entities due to the lack of visibility over controls at the service provider.

Most service providers engage an auditor to prepare an assurance report on their controls. This report provides assurance that the control activities at the service provider are suitably designed and implemented, and are operating effectively. The report also describes the controls tested by the auditor and the results of those tests.

DoH is a service provider, delivering a range of services to the HHSs. These services include accounts payable, payroll, and information system services. This year DoH engaged us to prepare two assurance reports. Figure 4C shows the period of coverage and scope of each report.

Figure 4C
Service provider assurance reports

Report	Coverage period	Scope
Type 2	01.07.15 to 31.03.16	Assurance over the design, implementation, and operating effectiveness of controls. It highlights the rate of deviations in the transactions tested.
Type 1	As at 30 June 2016	Assurance over the design and implementation of controls. It highlights matters identified through observation and inquiry.

Source: Queensland Audit Office

Results of our audits

DoH received a modified audit opinion for the Type 2 assurance report due to deficiencies being identified in selected payroll and accounts payable controls at six of the 11 DoH service centres. Although deficiencies in controls were identified, the impact on the HHSs was minimal as the transactions affected were either not material or the HHS had compensating controls in place.

The Type 1 report was unmodified, meaning that we were able to confirm, by observation and inspection of documents, that DoH controls were implemented at 30 June.

HHSs cannot solely rely on these assurance reports for the adequacy of their internal controls. Typically, controls are also necessary at the HHSs both:

- when the transaction is initiated—such as approval by a HHS officer with the appropriate financial authority
- after transactions are processed—such as reviewing cost centre reports.

These 'complementary' HHS controls are required to monitor performance of the service provider and ensure the overall internal control strength is maintained.

Information and communication

Information and communication controls are the systems used to provide information to employees and the ways that control how responsibilities are communicated.

This aspect of internal control also considers how management generates financial reports, and how they are communicated to internal and external parties to support the functioning of internal controls.

A continuing issue exists at DoH in relation to the finance system used to process transactions and produce annual financial statements for all 16 HHSs.

DoH's Finance and Materials Management Information System (FAMMIS) finance system is an early generation SAP product that is 19 years old. The system has been out of vendor maintenance for ten years, and is experiencing performance and stability issues.

The database and operating system, which are critical components for operating the finance system, have also reached end of life and do not have vendor support. DoH cannot upgrade these critical components because the finance system may not be compatible with newer versions.

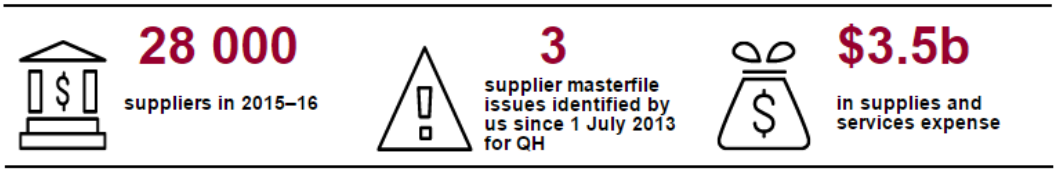
A cancelled attempt at replacing the finance system in 2014–15 cost an estimated $36.56 million.

There is a current financial system renewal project that will provide DoH and the HHSs with a contemporary SAP finance solution. The project has been allocated $105 million in the 2016–17 Queensland Budget over three years.

DOH has also provided $2.7 million in seed funding for the new project between 2014 and 2017.

The project team is evaluating a system prototype and planning the implementation in accordance with Queensland Government Chief Information Officer ICT investment governance framework.

Fraud awareness



Source: Queensland Audit Office

Management are responsible for the systems of internal control designed to prevent and detect fraud within their entities.

Annually, we review the controls operating over the integrity of supplier data. Suppliers often change bank account details. The subsequent payments to these suppliers is significant.

The scam

During the financial year, a malicious fraud scheme targeted public and private sector entities. The scam used fraudulent documents to change an existing suppliers' bank account details and divert payments to illegitimate bank accounts.

Management's responsibilities

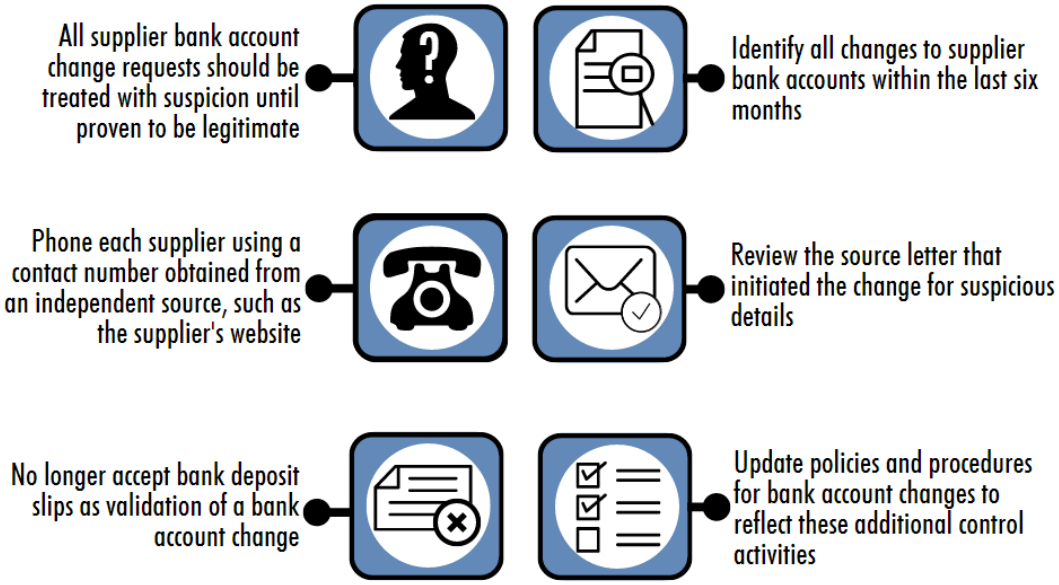
DoH and HHSs are responsible for ensuring that controls over the integrity of supplier data are in place and operating as expected.

Our responsibilities

During an audit, we assess the risk of material misstatement due to fraud and respond by developing specific audit procedures to address the risks identified.

Our response

In response to the identified fraud scam this year, we asked all entity chief finance officers of DoH and the HHSs to independently verify their supplier bank account details. We recommended entities exercise increased vigilance over new requests to change supplier bank account details.



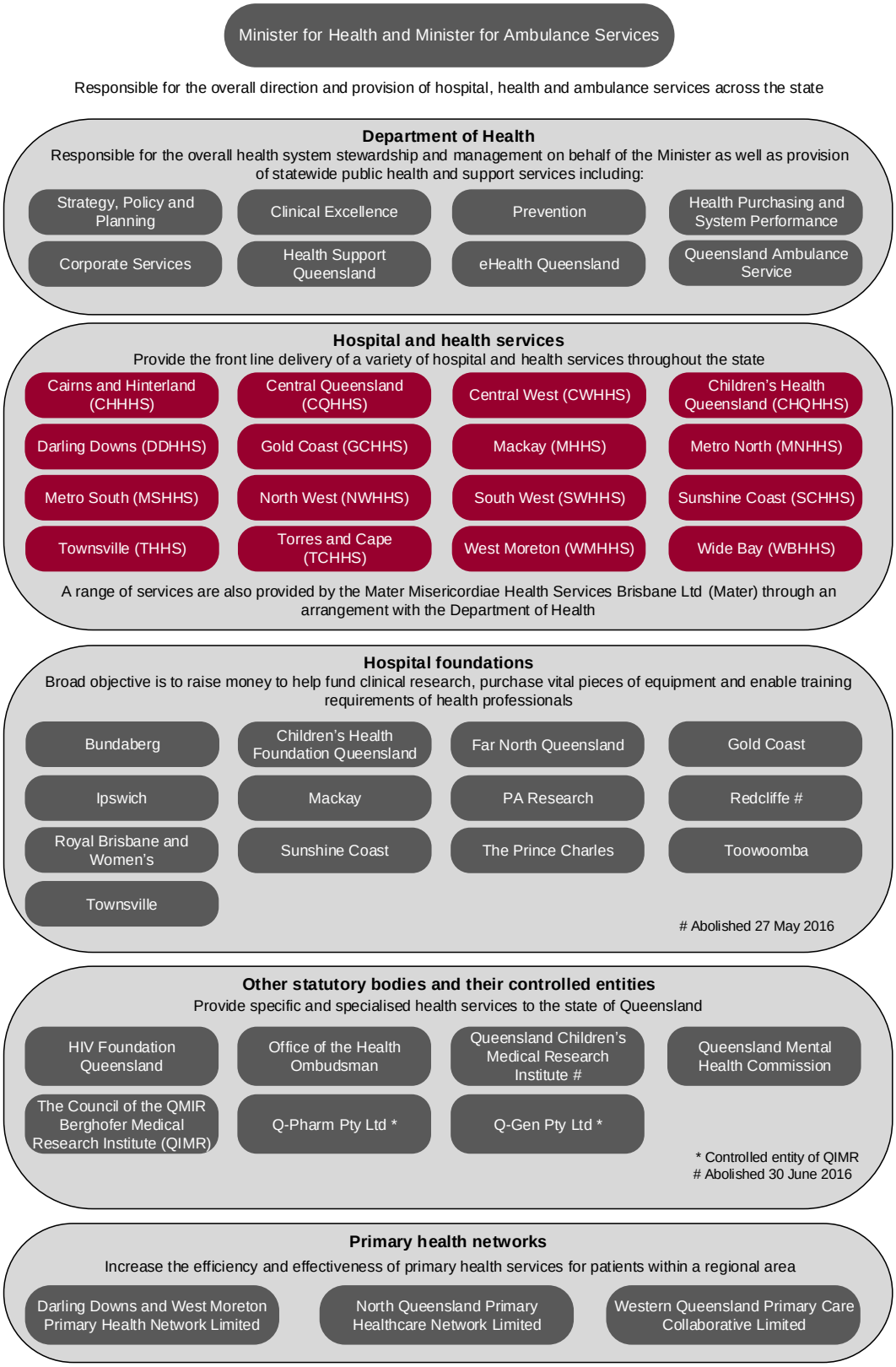
HHSs use a common supplier system that DoH manages and maintains. DoH is responsible for ensuring that controls over supplier changes are implemented and operating effectively. We worked with DoH to identify and target higher risk bank account changes.

Our testing of internal controls at DoH found that controls over suppliers' bank account changes were operating effectively, and appropriate supporting documentation was maintained. Our testing did not identify any instances of fraud.

Although no fraudulent payments were detected, the HHSs and DoH need to remain on high alert to this, and other fraudulent schemes, and allocate sufficient resources to their support staff to properly interrogate of documents requesting changes to bank account details.

Appendices

Appendix A—Queensland public health entities



Source: Queensland Audit Office

Appendix B—Full responses from agencies

In accordance with section 64 of the *Auditor-General Act 2009*, we gave a copy of this report with a request for comment to all 16 Hospital and Health Services and the Department of Health.

The heads of these organisations are responsible for the accuracy, fairness, and balance of their comments.

This appendix contains their detailed responses.

Comments received from Director-General, Queensland Health

Queensland Government

Enquiries to: Mr Alistair Luckas
Senior Director
Statutory and Advisory Services
Finance Branch
Corporate Services Division
Telephone: 3199 3494
File Ref: DG082494

24 JAN 2017

Mr Anthony Close
Acting Auditor-General
Queensland Audit Office
PO Box 15396
CITY EAST QLD 4002

Dear Mr Close Anthony

Thank you for your letter dated 9 December 2016, regarding the Queensland Audit Office's (QAO) proposed report to Parliament titled *Hospital and Health Services: 2015-16 results of financial audits*.

I acknowledge receipt of the report and the contents proposed to be included in the QAO's report to Parliament. I am responding on behalf of both the Department of Health (the Department) and the 16 Hospital and Health Services (HHSs) such that there is a single Health system response to your report rather than potentially 17 separate responses.

It is pleasing to note in your proposed report that all 16 HHSs received an unmodified audit opinion on their financial statements for 2015-2016 within the statutory deadline of 31 August 2016, with no significant deficiencies (high risk matters) in internal controls identified.

2015-2016 Financial Results

Overall our health system reported a surplus of $51 million in 2015-2016. Whilst the HHSs reported a net $46 million deficit, if allowance is made for the reinvestment of $66 million of retained earnings, then the HHSs actually recorded an underlying net surplus of $20 million for the year.

This outcome reflects disciplined cost management across HHSs. I note the report shows a 3% year-on-year increase in the cost per Queensland Weighted Activity Unit (QWAU). As about 1% of this was attributable to increased expenditure on high cost drugs (for which a 100% rebate was received) the underlying cost per QWAU increase was 2%, that is, in line with wage and salary rate increases and general inflation.

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Comments received from Director-General, Queensland Health

2015-16 Activity and Operating Performance

It is important to consider the financial results in the context of the HHSs delivering increased output (7.3% activity above contracted levels) in response to increasing demand for services including:

- an increase of 49,226 (or 2.9%) in emergency department presentations in 2015-2016 compared with 2014-2015; and
- 3.1% more elective surgery procedures undertaken as at 30 June 2016 when compared to the prior year.

Mention is made a number of times in the report that HHSs receive 45% of the Queensland Efficient Price (QEP) for delivering QWAUs above contracted levels. HHSs take into consideration the incremental cost of incremental activity as a matter of course when making decisions about over delivering on their contract. This ensures such decisions are financially sustainable.

I would also like to note that HHSs have delivered against key performance priorities including:

- in 2015-2016, achieving 78.4% of emergency department patients being discharged or admitted to hospital with four hours;
- 97.6% of category 1 patients (target 98%), 94.7% of category 2 patients (target 95%) and 98.4% of category 3 patients (target 95%), treated within clinically recommended timeframes; and
- a reduction of more than 23,000 (or 29%) as at 30 June 2016, compared to 30 June 2015, the number of patients waiting longer than clinically recommended for an outpatient appointment.

Addressing financial challenges

The financial performance of each HHS is routinely monitored by both the HHS and the Department. If a HHS indicates to the Department they are facing financial challenges and/or the Department has concerns about a HHS's financial performance, they work jointly to address the issues. This open and collaborative approach serves our health system well.

During 2015-2016, the Department worked with four HHSs who indicated they were facing financial challenges – Cairns and Hinterland, North West, Central Queensland and Wide Bay – to develop and implement remediation strategies to improve financial performance. Whilst these HHSs still ended up reporting deficits in 2015-2016, I am pleased to advise that the Wide Bay and Central Queensland HHSs continue to gain traction on their financial remediation strategies and are both expecting to deliver surpluses in 2016-2017. The Department is also still working closely with the Cairns and Hinterland and the North West HHSs to support their financial recovery efforts.

Maintenance of Buildings

The report highlights the significant challenge faced by HHSs to determine and fund the correct level of asset maintenance required to achieve the maximum life and service potential of buildings. I agree that in a health system with significant funding constraints and cost pressures it is no easy task to strike the right balance between maintenance requirements and the provision of clinical services to those in need. Short term benefits must be weighed up against longer term risks. This is an area which is receiving increased focus from both the Department and HHSs.

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Comments received from Director-General, Queensland Health

Information Technology Disaster Recovery Plans

Regarding the report's recommendation in relation to HHS Information Technology (IT) disaster recovery plans (DRPs), the Department, through eHealth Queensland, is working on strategies to support the HHSs in development of their DRPs. This includes progressing actions to the recommendations in your final report, to management for the Department's 2015-2016 Financial Statements Audit. In particular a disaster recovery management function will be created to provide a central point of contact for HHSs to liaise with in regards to their IT disaster recovery planning and development of a DRP template and work instructions in collaboration with three HHSs and Health Support Queensland that can be used across all HHSs and the Department to achieve standardisation and economies of scale.

Accounts Payable Service Level Agreements

With respect to the report's recommendation about finalising service level agreements (SLAs) for accounts payable documents have been developed by the Department in consultation with HHSs and were distributed on 22 November 2016. No material concerns have been raised and four HHSs have already signed. In the meantime, the Department continues to provide services in accordance with the agreements, and which are also reflected in the accounts payable systems descriptions of key internal controls operated by the Department and are reviewed by the QAO as part of the ASAE 3402 assurance work each year.

Financial System Renewal Project

I was pleased to note that no deficiencies in the HHSs' information and communication processes were identified. In relation to the existing financial and materials management system (FAMMIS) in use across the health system, the Financial System Renewal Project has received Governor-in-Council project commencement approval. In the meantime, significant steps have been taken to mitigate identified risks relating to FAMMIS.

Addressing outstanding internal controls issues

All HHSs will continue, with the support of the Department, to work through outstanding internal controls issues to ensure actions to address deficiencies and mitigate risks are implemented in a timely and efficient manner. This includes the finalisation of accounts payable SLAs (which presumably makes up 16 of the 125 deficiencies identified in 2015-2016 – one for each HHS) and updating policies and procedures in Financial Management Practice Manuals (which makes up a further seven deficiencies).

Annual Financial Statements process improvements

The Department and HHSs will also continue to work with the QAO to implement strategies to improve processes in the preparation of the annual financial statements. The focus will be on achieving better practices in financial reporting, including the completion of valuations of material assets and early draft financial statements well before 30 June 2017.

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Comments received from Director-General, Queensland Health

Should you or officers of your Department require further information, the Department of Health's contact is Mr Alistair Luckas, Senior Director, Statutory and Advisory Services, Finance Branch, Corporate Services Division, on telephone

Yours sincerely

Michael Walsh
Director-General
Queensland Health

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Appendix C—Our assessment of financial governance

Auditing internal controls

In conducting an audit, we assess the design and implementation of internal controls to ensure they are suitably designed to prevent, detect, and correct material misstatements. Where the audit strategy requires it, we also test the operating effectiveness to ensure the internal controls are functioning as designed.

Internal controls

Our assessment of internal control effectiveness is based on the number of deficiencies and significant deficiencies identified during the audit.

We have categorised each deficiency against five elements of internal control under the internationally recognised Committee of Sponsoring Organizations of the Treadway Commission (COSO) framework. These elements are:

- control environment—management's actions, attitudes, and values that influence day-to-day operations
- control activities—policies and procedures that help ensure management directives are carried out, and that necessary actions are taken to address identified risks
- risk assessment—management's processes for considering risks that may prevent an entity from achieving its objectives, and for forming a basis as to how the risks should be identified, assessed, and managed
- information and communication controls—the systems used to provide information to employees and the ways that control responsibilities are communicated
- monitoring activities—the methods management employs to oversee and assess whether internal controls are present and operating effectively.

A deficiency occurs when internal controls are unable to prevent, detect, or correct errors in the financial statements or where internal controls are missing.

A significant deficiency (high risk matter) is a deficiency that either alone, or in combination with multiple deficiencies, may lead to a material misstatement in the financial statements. They require immediate management action and are reported to those charged with governance.

The following table outlines the ratings we use to assess internal controls:

Rating	Internal controls assessment
● Effective	No deficiencies identified in internal controls
● Generally effective	Deficiencies identified in internal controls
● Ineffective	Significant deficiencies identified in internal controls

The deficiencies detailed in this report were identified during the audit and may have been subsequently resolved by the entity. They are reported here because they impacted the overall system of control during 2015–16.

Financial statement preparation

Year end close process

State public sector entities should have a robust year end close process to enhance the quality and timeliness of their financial reporting processes. In January 2014, the Queensland Under Treasurer recommended the completion of five key areas before 30 June each year, to enable a timely audit clearance of the financial statements at year end:

- finalising non-current asset valuations by 31 March
- preparing complete pro forma financial statements by 30 April
- resolving accounting issues by 30 April
- completing hard or soft close processes
- concluding all asset stocktakes by 30 June.

The extent of these key processes and the actual planned dates to perform these processes can vary on the needs for each entity. The target date for completion of these processes should be documented in a financial report preparation plan.

To be effective, year end processes need to be performed in accordance with the financial report preparation plan and supporting documents made available to audit in a timely manner.

Rating	Year end close process assessment
● Effective	All five key processes were completed by the planned date.
● Generally effective	Three of the five key processes were completed within two weeks of the planned date.
● Ineffective	Less than three of the five key process were completed within two weeks of the planned date.

Timeliness of draft financial statements

To assess timely draft financial statement effectiveness, we have compared the financial report preparation plan's target date to prepare the first draft financial statements against the actual date acceptable draft financial statements were received by audit.

Rating	Timeliness of draft financial statements assessment
● Effective	Acceptable draft financial statements were received on or prior to the planned date.
● Generally effective	Acceptable draft financial statements were received within two days after the planned date.
● Ineffective	Acceptable draft financial statements were received more than two days after the planned date.

Quality of draft financial statements

We calculated the difference between the first draft financial statements submitted to audit and the final audited financial statements for the key financial statement components of total revenue, total expenditure and net assets. Our quality assessment is based on the percentage of adjustments across each of these components.

Rating	Quality of draft financial statements assessment
● Effective	No adjustments were required.
● Generally effective	Adjustments for any of the three financial statement components were less than five per cent.
● Ineffective	Adjustments for any of the three financial statement components were greater than five per cent.

Result summary

This table summarises the results of each Hospital and Health Service (HHS) against our assessments of internal controls and financial statement preparation.

	Internal controls[1]					Financial statement preparation[2]		
	CE	RA	CA	IC	MA	YE	T	Q
Cairns and Hinterland HHS	●	●	●	●	●	●	●	●
Central QLD HHS	●	●	●	●	●	●	●	●
Central West HHS	●	●	●	●	●	●	●	●
Children's Health QLD HHS	●	●	●	●	●	●	●	●
Darling Downs HHS	●	●	●	●	●	●	●	●
Gold Coast HHS	●	●	●	●	●	●	●	●
Mackay HHS	●	●	●	●	●	●	●	●
Metro North HHS	●	●	●	●	●	●	●	●
Metro South HHS	●	●	●	●	●	●	●	●
North West HHS	●	●	●	●	●	●	●	●
South West HHS	●	●	●	●	●	●	●	●
Sunshine Coast HHS	●	●	●	●	●	●	●	●
Torres and Cape HHS	●	●	●	●	●	●	●	●
Townsville HHS	●	●	●	●	●	●	●	●
West Moreton HHS	●	●	●	●	●	●	●	●
Wide Bay HHS	●	●	●	●	●	●	●	●

[1] CE = Control environment; RA = Risk assessment; CA = Control activities; IC = Information and communication; MA = Monitoring activities.

[2] YE = Year end close processes; T = Timely preparation; Q = Quality of preparation.

Appendix D—HHS financial health

Financial sustainability examines the ability of each Hospital and Health Service (HHS) to meet current and future expenditures as they arise and their capacity to absorb foreseeable changes and emerging risks. We assess the financial sustainability of HHSs by examining four metrics.

Operating result

This metric measures the HHSs' full year operating result against their forecast. HHSs set a target operating result that is balanced, or in surplus. HHSs may forecast an operating deficit in agreement with Department of Health (DoH). The ratings below are consistent with DoH's Performance Framework for HHSs.

Rating	Measure of operating result
● Green	Balanced, surplus or an agreed non-recurrent deficit.
● Amber	Between 0% and 1.0% unfavourable variance to budget.
● Red	Greater than 1.0% unfavourable variance to budget.

Operating surplus ratio

This ratio measures the extent to which revenue covers operational expenses. A positive ratio indicates that the HHS is able to generate surplus to help fund additional activity or capital projects. We calculate the ratio as a four-year average when assessing the HHSs.

Rating	Measure of operating surplus ratio
● Green	Greater than 0% over four years.
● Red	Less than 0% over four years.

Current ratio

This ratio measures the ability of a HHS to pay existing short-term debts with current assets. A ratio of one or more indicates a HHS has sufficient current assets to meet its short-term debts as they fall due.

Rating	Measure of current ratio
● Green	Greater than 1.1:1
● Red	Less than 1:1

Number of days cash available

This metric measures the number of days a HHS has cash available to cover cash outflows. The desired benchmark is 14 days in line with the timing of funding payments from DoH.

Rating	Measure of the number of days cash available
● Green	14 days or more days of cash available.
● Red	Less than 14 days of cash available.

HHS financial performance and ratios

This table summarises the financial performance and financial sustainability ratios of the 16 HHS. The arrows indicate the change in results compared to the previous financial year.

HHS	Operating surplus/(deficit) $ million	Average four year operating surplus ratio	Current ratio	Cash available (days)
Cairns and Hinterland HHS	-$20.00 ↓	-0.08% ↓	0.80 ↓	-2.50 ↓
Central QLD HHS	-$8.88 ↓	0.38% ↓	1.2 ↓	10.97 ↓
Central West HHS	-$0.12 ↑	0.64% ↑	1.1 ↑	11.48 ↑
Children's Health QLD HHS	$30.82 ↑	0.30% ↑	1.0 ↑	13.72 ↓
Darling Downs HHS	$3.47 ↓	2.26% ↑	2.8 ↑	43.10 ↓
Gold Coast HHS	$10.55 ↑	0.19% –	1.3 –	18.78 ↑
Mackay HHS	-$7.05 ↓	4.38% ↓	4.1 ↓	62.43 ↓
Metro North HHS	$0.16 ↑	0.86% ↓	1.6 ↓	11.17 ↓
Metro South HHS	-$40.83 ↓	0.28% ↓	1.2 ↓	15.62 ↓
North West HHS	-$2.14 ↓	-0.42% ↑	1.3 ↑	4.90 ↓
South West HHS	$2.84 ↓	2.98% ↑	2.5 ↑	52.47 ↑
Sunshine Coast HHS	$0.96 ↑	0.53% ↑	1.9 ↑	31.50 ↑
Torres and Cape HHS	$5.75 ↑	1.02% ↑	2.1 ↑	43.74 ↑
Townsville HHS	$1.49 ↓	1.64% ↓	1.9 ↓	23.06 ↓
West Moreton HHS	-$9.06 ↓	1.55% ↓	1.5 ↓	30.95 ↓
Wide Bay HHS	-$14.06 ↓	-0.65% ↓	0.5 ↓	-3.30 ↓

Appendix E—IT disaster recovery maturity

We use a capability maturity model to assess how well the disaster recovery planning at a Hospital and Health Service (HHS) would support critical business processes in terms of:

- analysing the impact of losing critical computer systems on business operations
- planning, monitoring, supervising, and automating the disaster recovery activities
- testing and reviewing the plans
- considering continuous service when entering into agreements with vendors and major suppliers
- enhancing and aligning their information technology (IT) disaster recovery plan (DRP) with continuous service planning and business need.

The maturity ratings are described below.

Maturity rating
5—Optimised
HHS has in place a disaster recovery program that is leading edge. The program enables automation and continuous improvement. It enables the HHS to anticipate future disaster recovery risks, resources, demands, and capabilities. There is a provisional recovery site, with little exposure to common threats, which is tested regularly.
4—Integrated
HHS has in place a disaster recovery plan which enables effective recovery of critical processes and systems. The planning process is in response to changing business needs and external factors. Recovery expectations and delivery are aligned with continuous service testing and updating of plan.
3—Established
HHS has in place a disaster recovery plan that is adequate in meeting most of the needs of the critical processes. Business impact analysis is conducted for each key process. Roles and responsibilities are defined and plans are reviewed and tested annually.
2—Developing
HHS has in place a disaster recovery plan that meets some of the needs of the critical processes. Some business impact analysis has been done. Management processes support event response and some of the planning has been reviewed. Limited testing is done.
1—Basic
HHS has in place a basic disaster recovery plan that does not support critical processes.

Source: Australian National Audit Office (ANAO) Better Practice Guide June 2009, Gartner (September 2010) and Queensland Audit Office

HHSs need to determine the appropriate level of IT DRP maturity for their business as the cost of achieving an optimised IT DRP maturity may outweigh the benefit of doing so. In some cases, an integrated or established IT DRP maturity may be more appropriate.

Appendix F—Queensland HHS areas

Appendix G—Glossary

Term	Definition
Accountability	Responsibility of public sector entities to achieve their objectives in reliability of financial reporting, effectiveness and efficiency of operations, compliance with applicable laws, and reporting to interested parties.
Auditor-General Act 2009	An Act of the State of Queensland that establishes the responsibilities of the Queensland Auditor-General, the operation of the Queensland Audit Office, the nature and scope of audits to be conducted, and the relationship of the Auditor-General with parliament.
Australian Accounting Standards	The rules by which financial statements are prepared in Australia. These standards ensure consistency in measuring and reporting on similar transactions.
Capital expenditure	Amount capitalised to the balance sheet for contributions by an entity to major assets owned by the entity, including expenditure on: ▪ capital renewal of existing assets that returns the service potential or the life of the asset to that which it had originally ▪ capital expansion which extends an existing asset at the same standard to a new group of users.
Financial sustainability	The ability to meet current and future expenditures as they arise and their capacity to absorb foreseeable changes and emerging risks.
Deficiency (lower risk)	Occurs where we have assessed the control is designed or implemented in such a way that it is unable to prevent, or detect and correct, misstatements in the financial statements in a timely basis, or where that control is missing.
Significant deficiency (higher risk)	A deficiency in internal control, or combination of deficiencies in internal controls, that in our professional judgement, may lead to a material misstatement in the financial statements. Significant deficiencies require immediate management action and are always of sufficient importance to merit the attention of those charged with governance.
Weighted activity unit (WAU)	A unit of measure used to compare different health services based on the level of resource utilisation. The Independent Hospital Pricing Authority (IHPA), an Australian Government body, determines the value of a national weighted activity unit (NWAU). The Queensland Department of Health determines the value of a Queensland weighted activity unit (QWAU).

Auditor-General reports to parliament

Reports tabled in 2016–17

Number	Title	Date tabled in Legislative Assembly
1.	Strategic procurement	September 2016
2.	Forecasting long-term sustainability of local government	October 2016
3.	Follow-up: Monitoring and reporting performance	November 2016
4.	Criminal justice data—prison sentences	November 2016
5.	Energy: 2015–16 results of financial audits	November 2016
6.	Rail and ports: 2015–16 results of financial audits	November 2016
7.	Water: 2015–16 results of financial audits	December 2016
8.	Queensland state government: results of financial audits	December 2016
9.	Hospital and Health Services: 2015–16 results of financial audits	January 2017

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