Queensland Audit Office

Results of audit: Hospital and Health Services entities 2012–13

Report to Parliament 8 : 2013–14

Queensland Audit Office

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Queensland Audit Office

November 2013

The Honourable F Simpson MP
Speaker of the Legislative Assembly
Parliament House
BRISBANE QLD 4000

Dear Madam Speaker

Report to Parliament

This report is prepared under Part 3 Division 3 of the *Auditor-General Act 2009*, and is titled Results of audit: Hospital and Health Services entities 2012–13.

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

Yours sincerely

Andrew Greaves
Auditor-General

Contents

Summary

This report summarises the results of our 2012–13 financial audits of the 17 Hospital and Health Services (HHSs) established on 1 July 2012 to provide public health services in Queensland.

HHSs are statutory bodies governed by a Hospital and Health Board and are accountable to their local community and to the Parliament. The annual report of each HHS is the primary accountability document to its stakeholders and users of its services. It sets out the HHS's operational and financial performance and financial position.

Legislation requires the annual report to include audited financial statements, with the accompanying audit opinion providing readers of the financial statements with added assurance that the financial statements are reliable.

This report summarises the results of our financial audits, the timeliness and quality of financial reporting and the systemic issues with internal controls identified during our audits. We have also analysed indicators of financial performance and sustainability with which each HHS can be assessed.

Conclusions

Unmodified audit opinions have been issued for all 17 HHSs for 2012–13. This means that their financial statements were prepared in accordance with the requirements of legislation and relevant accounting standards.

Their financial statements were timely, with all HHSs meeting the two-month legislative time frame of 31 August 2013 to have statements audited and certified. As this was the HHSs' first year of operation and HHSs' financial reporting processes are still developing, this was a good result.

All 17 HHSs were in a sound financial position at year end, with all generating operating surpluses in 2012–13. There are no significant concerns about their long term financial sustainability, primarily because no HHS has long term debt and the construction of major infrastructure assets is funded by the Department of Health (DoH).

Key findings

Audit results

All 17 HHSs performed well in discharging their financial reporting obligations in their first year. All financial statements were timely and generally of good quality. Processes for preparation of financial statements were satisfactory, but quality review of draft financial statements could be improved in ten HHSs.

Internal control weaknesses and control breakdowns were found at all HHSs but none were serious enough to require a qualified audit opinion.

We assessed preparation processes of HHSs' financial statements against accepted better practice. The processes of 13 of the 17 HHSs were high quality and six of these performed exceptionally well. These six prepared a good draft set of financial statements for audit that required no significant changes before audit certification occurred.

Nonetheless, material adjustments and changes to note disclosures of financial statements were required to ten of the 17 HHSs' financial statements before audit opinions were issued. Better quality review of financial statements during the preparation process would improve the accuracy of these HHSs' financial statements.

Internal controls

Because it was the HHSs' first year of operation, it was not surprising that internal controls were not yet well established across all financial processes. During 2012–13, we identified 159 significant control weaknesses across the 17 HHSs. The weaknesses occurred because HHS personnel did not always comply with the policies and procedures to protect assets and to ensure reliable accounting records.

The most common weaknesses we found were in procedures designed to prevent potential problems occurring or to detect problems which do occur and allow corrective action to be taken:

- monitoring of DoH processing activities not performed effectively at 14 HHSs
- key reconciliations not promptly prepared or independently reviewed at 12 HHSs
- financial delegations not complied with at nine HHSs
- poor patient billing controls at four HHSs
- inadequate segregation of duties at four HHSs.

Other areas where adequate controls still need to be established by HHSs are:

- financial management practice manuals which were not completed by 13 HHSs
- risk management frameworks which were not yet finalised by 13 HHSs.

All control weaknesses we identified have been reported directly to each HHS concerned for management action. Remedial action by all HHSs to address these deficiencies has occurred or is in progress.

Internal audit, audit committees and chief finance officer (CFO) statements of assurance have been introduced as monitoring controls in HHSs. These functions need to improve in some HHSs before they are fully effective and reliable to management:

- 11 of 17 HHSs have an internal audit function to perform key monitoring functions and are still developing their processes; the other six were still in the process of establishing this capability
- all 17 HHSs have an audit committee, but six audit committees could improve their processes by establishing an annual work plan setting out the activities to be covered by the committee during the year
- 12 of the 17 HHSs prepared CFO statements of assurance. Of these, only seven provided adequate assurance to the health service chief executive (CE) and the board. Improvements in the CFO assurance process would provide CEs with a greater level of confidence over the control environment and the accuracy and completeness of the financial statements.

Financial performance, position and sustainability

The financial performance of each HHS is measured primarily by its operating result. The target operating result for the HHSs was break even or a surplus. All 17 achieved the target and made operating surpluses in 2012–13.

As expected, the most significant cost to HHSs was in employee expenses which were $6.70 billion in 2012–13. These costs represent nearly 70 per cent of HHSs' total spending in 2012–13 of $9.68 billion. Staff reductions made this year through employee redundancy programs should reduce employee costs by $326 million next year.

From a financial sustainability perspective:

- over the short term, the ratios we calculated show that HHSs are in a favourable position with positive operating cash flows and have adequate liquidity to meet their liabilities as they fall due
- over the long term, all HHSs are in a sound position because of the current funding arrangements for HHSs. No HHSs have long term debt because major infrastructure assets are constructed and funded by DoH and, when completed, transfer to HHSs at no cost.

While the cost of backlog maintenance could be a potential threat to HHS sustainability, it is predominantly funded by DoH.

HHSs are primarily funded by Commonwealth and state grants as the main source of revenue. There is opportunity for the HHSs to grow their own source revenue (OSR) by focusing more effectively on identifying and billing private patients using the public health system. OSR can provide the support for sustainability and increased patient health care services.

Operational effectiveness

Under the new Activity Based Funding (ABF) model, HHSs have a transitional period until 30 June 2014 to improve the cost efficiency of the health services they provide to the community.

After this date, the Commonwealth's share of funding will be based on the National Efficient Price (NEP) per Weighted Activity Unit (WAU). The state will continue to fund its share but will be responsible for also funding any remaining price inefficiencies in the public health system. With the cost of providing services rising, our analysis indicated HHSs will need to continue to implement cost and productivity improvements if they are to meet the benchmarks in place from 1 July 2014.

Reference to comments

In accordance with section 64 of the *Auditor-General Act 2009*, a copy of this report was provided to the Minister for Health; the Director-General, Department of Health; and the Board Chairs and Chief Executives of Hospitals and Health Services with a request for comments.

The agencies' views have been considered and are represented to the extent relevant and warranted in preparing this report.

A fair summary of the comments received are included in Appendix A of this report.

1 Context

1.1 Financial reporting requirements

On 2 August 2011, the Council of Australian Governments (COAG) signed the National Health Reform Agreement leading to major reforms across Australia in the funding and delivery of public health services. Changes for Queensland included the establishment on 1 July 2012 of 17 Hospital and Health Services (HHSs) across the state as the principal providers of public health services.

HHSs are statutory bodies under the *Hospital and Health Boards Act 2011* and each is independently and locally controlled by a Hospital and Health Board. As statutory bodies, HHSs are subject to the requirements of the *Financial Accountability Act 2009* (FAA).

The Department of Health (DoH) retains responsibility for overall management of the public health system, including the oversight of each HHS's performance. As required by the *Hospital and Health Boards Act 2011,* a service agreement between DoH and each HHS establishes the hospital, health and other services to be provided by the HHS, funding provided for the provision of these services and key performance indicators.

The hospital and health services performance framework, which is part of the service agreement, describes how DoH monitors and manages HHSs' performance for the delivery of public health services. Current service agreements cover the period from 1 July 2013 to 30 June 2016.

This is the first year that HHSs have prepared financial statements. Each HHS prepares general purpose financial statements in accordance with the Australian Accounting Standards. As statutory bodies, HHSs are required, when preparing their annual financial statements, to have regard to the minimum reporting requirements contained in the financial reporting requirements for Queensland government agencies issued by Queensland Treasury and Trade.

The Financial and Performance Management Standard 2009 (FPMS) requires draft financial statements of each HHS to be provided for audit by an agreed date. This allows sufficient time to conduct the audit and to complete the audit opinion which is no later than two months after the end of the financial year to which the statements relate—that is, by 31 August.

The chairperson and the executive responsible for financial administration at each HHS must certify compliance with legislative requirements around establishing and keeping the accounts and that the financial statements present fairly the transactions for the financial year and the financial position.

The FAA requires that audited financial statements are included in the annual report of each HHS. It also requires that the annual report is given to the Minister by a date which allows the report to be tabled in Parliament by the Minister within three months after the end of the financial year to which the report relates. No HHSs' annual reports were tabled in Parliament by 30 September 2013 as the Minister extended the tabling period as authorised by the FPMS. All annual reports were tabled in Parliament by 5 November 2013.

1.2 Audit responsibilities

Section 40 of the *Auditor-General Act 2009* requires the Auditor-General to audit the annual financial statements of all public sector entities, including those of statutory bodies and to prepare an auditor's report about the financial statements.

The auditor's report, which includes the audit opinion, provides assurance about the reliability of the financial report, including compliance with legislative requirements. In accordance with Australian Auditing Standards, one or more of the following audit opinion types may be issued:

- an **unmodified opinion** is issued where the financial statements comply with relevant accounting standards and prescribed requirements
- a **qualified opinion** is issued when the financial statements as a whole comply with relevant accounting standards and legislative requirements, but with particular exceptions
- an **adverse opinion** is issued when the financial statements as a whole do not comply with relevant accounting standards and legislative requirements
- a **disclaimer of opinion** is issued when the auditor is unable to express an opinion as to whether the financial statements comply with relevant accounting standards and legislative requirements.

An emphasis of matter paragraph may be included with the audit opinion to highlight an issue of which the auditor believes the users of the financial statements need to be aware. The inclusion of an emphasis of matter paragraph does not modify the audit opinion.

The *Auditor-General Act 2009* requires that, after the audit opinion has been issued, a copy of the certified statements and the auditor's report must be provided to the chief executive of the HHS and the Minister for Health.

As an integral part of the financial audit, the main components of each HHS's internal control framework are assessed to determine if the financial reporting controls in place are operating effectively as well as the extent of compliance with legislative requirements. Significant issues identified during the audit and recommendations for improvement are reported to the health service chief executive.

The *Auditor-General Act 2009* also requires that the Auditor-General reports to Parliament on each financial audit conducted. The report must state whether the audit has been completed and the financial statements audited. It must also include details of significant deficiencies where financial management functions were not performed adequately or properly. This report satisfies these requirements.

1.3 Structure of the report

The report is structured as follows:

- Chapter 2 provides the audit results of HHSs, including significant financial reporting issues and timeliness and quality of their financial statements
- Chapter 3 assesses the key internal controls over the reliability of financial reporting
- Chapter 4 assesses the financial performance and position and examines the financial sustainability of HHSs
- Chapter 5 assesses the operational efficiency of HHSs
- Appendix A contains comments from entities subject to this audit
- Appendix B contains the status of the 2012–13 financial statements
- Appendix C outlines better practices for preparation of financial statements
- Appendix D describes financial sustainability measures
- Appendix E contains a map of the areas covered by HHSs
- Appendix F contains a glossary of terms.

2 Audit results

In brief

Background

The seventeen Hospital and Health Services (HHSs) are located throughout Queensland in rural and urban areas. All HHSs were required to prepare financial statements for 2012–13 and include them in their annual reports.

Conclusions

Unmodified audit opinions were issued for all 17 HHSs and they all met their two-month legislative timeframe for finalising their financial statements. Since this was their first year of operation, this is a commendable achievement. Their financial statements were timely but, for some, the quality of their report preparation processes can be improved.

Asset valuation issues and capturing and recording the subsequent transfer of newly completed assets constructed by DoH are a challenge for HHSs, given the value that these assets represent.

Key findings

- All 17 HHSs' financial statements were certified by management and audit by 31 August 2013 and were issued with unmodified audit opinions.
- The preparation processes for financial statements were satisfactory for 13 HHSs while four HHSs needed to improve.
- Material adjustments were made to the draft financial statements for ten of the 17 HHSs.
- Seven HHSs required no material adjustments to their financial statements and six of these HHSs also had high quality preparation processes for financial statements.
- The transfer of assets and liabilities to establish the HHSs on 1 July 2012 was orderly.
- Legal ownership of land and buildings is yet to transfer to the HHSs.

2.1 Background

Seventeen Hospital and Health Services (HHSs) were established on 1 July 2012 and were required to prepare financial statements for the first time this year.

The HHSs have a 30 June balance date and are required by the Financial and Performance Management Standard 2009 (FPMS) to have their financial statements finalised and audited by 31 August each year.

2.2 Conclusions

All HHSs met the two-month legislative time frame for finalising their financial statements, which is commendable in this first year of operation. The effective management by HHSs of the timing of the preparation processes for financial statements through early agreement with audit of timeframes and deliverables contributed to this result.

We identified scope to improve reporting processes, including the need to strengthen year-end financial statements' processes; to identify and resolve significant accounting issues earlier in the year; and to complete revaluations of land and buildings before balance date.

There was an orderly establishment of the HHSs and transfer of existing assets and buildings from the Department of Health (DoH). Asset valuation issues and capturing and recording the subsequent transfer of newly completed assets constructed by DoH are a challenge for HHSs, given the value that these assets represent.

2.3 Audit opinions

Unmodified audit opinions were issued for all 17 HHSs. An unmodified audit opinion confirms that the financial statements have been prepared in compliance with relevant accounting standards and prescribed requirements.

2.4 Timeliness of financial statements

The time taken to produce financial statements is an essential characteristic for ensuring financial statements are useful and relevant for the oversight of public sector accountability and government decision making. The later the financial statements are produced and published after their balance date, the less useful they may become.

The legislative timeframe for the preparation and audit of HHSs' financial statements by 31 August 2013 was met. The dates the financial statements were signed by management and the audit opinion issued are in Appendix B.

To achieve this result, strategies were broadly adopted across the HHSs to complete parts of the planning and preparation process for financial statements prior to 30 June. Strategies adopted included:

- ensuring bank and other ledger reconciliations were completed and long outstanding reconciling items were cleared
- identifying and addressing emerging financial risks and accounting issues with management review
- completing asset stocktakes.

Figure 2A shows that seven HHSs did not meet the timetable they agreed with us for providing the initial draft version of their financial statements, including providing their supporting working papers. The reasons included:

- inadequate experience in preparation of financial statements, especially meeting compliance with minimum reporting requirements
- delays in the implementation of a financial statements' software product
- unplanned staff absences and resignations.

Figure 2A
Timeliness of key financial statements' milestones

Milestone	Who	Number of HHSs achieving milestone
First draft of financial statements completed by agreed date	HHS	10
Financial statements certified by management by agreed date	HHS	5
Audit opinion issued by 31 August 2013	QAO	17

Source: QAO

Not meeting these agreed interim time frames placed additional pressure on the finalisation process for financial statements and increased the risk of untimely financial reporting and non-compliance with reporting obligations.

2.5 Quality of draft financial statements

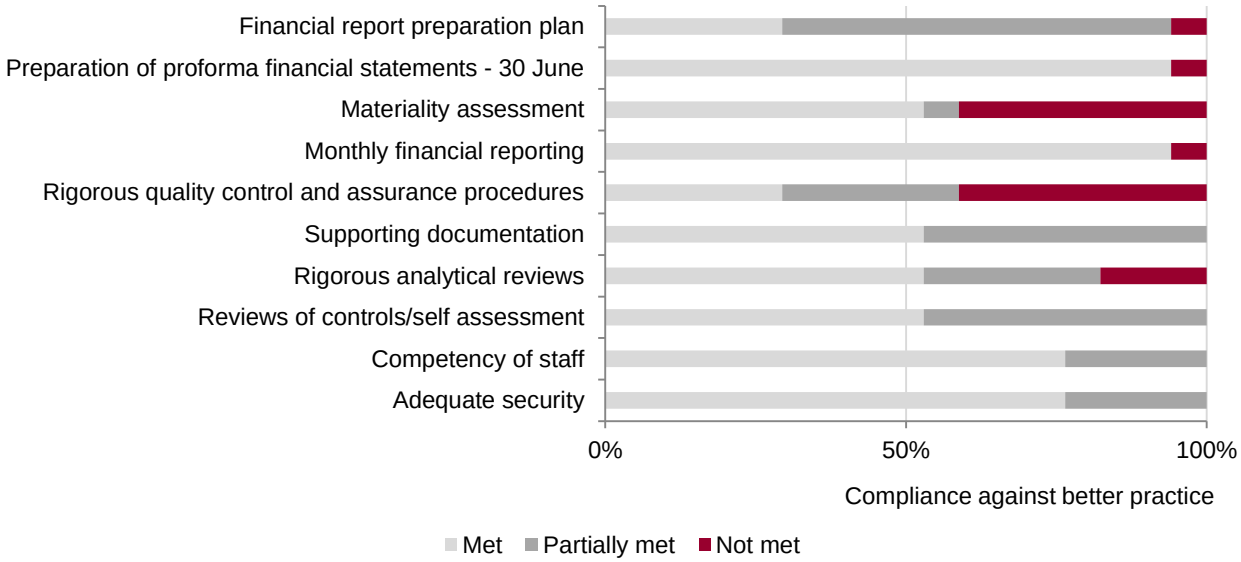
The overall quality of HHSs' financial statements and supporting work papers provided was satisfactory.

2.5.1. Process quality

The processes of the 17 HHSs to prepare financial statements were benchmarked against recognised better practices provided in Appendix C. The processes of 13 HHSs to prepare financial statements were assessed as satisfactory while processes in four HHSs need improvement.

Figure 2B shows our combined assessment of the preparation processes of all HHSs' financial statements against better practice.

Figure 2B
Combined assessment of preparation processes for financial statements



Source: QAO

Better practice elements that were implemented well across the 17 HHSs in their first year of operation included:

- the competency of finance staff
- robust monthly financial 'close' and reporting practices
- preparation of pro forma financial statements prior to the reporting date.

Scope for improvement exists in the areas of:

- planning for the preparation of the financial reporting
- more rigour in quality control checks over the financial statements and supporting work papers.

2.5.2. Adjustments

Before being given to audit, financial statements should be subject to appropriate internal quality assurance checks to establish that they are complete, materially accurate and compliant with reporting and disclosure requirements.

Ideally, only one set of financial statements should be prepared by management with no adjustments required; the frequency and size of errors identified in the draft financial statements that required adjustment are direct measures of their quality.

Any errors we detect in the draft financial statements are raised with management. Material errors require correction so that an unqualified audit opinion can be issued. The entity itself may also change its draft financial statements after submitting them to audit if their quality assurance procedures subsequently identify that reported information is incorrect or incomplete.

Broadly, there are two types of adjustments:

- adjustments to financial statements—changes to the amounts being reported
- disclosure adjustments—changes to the commentary or financial note disclosure within the financial statements.

Material adjustments initiated by management or arising from audit examination were made to draft financial statements before audit opinions were issued for 2012–13 for 10 HHSs.

No material adjustments were made to seven HHSs' financial statements and six of these HHSs were assessed also as meeting better practice in processes to prepare financial statements, demonstrating the benefits gained when robust processes are implemented.

Figure 2C shows the combined material adjustments made to financial statements by component.

Figure 2C
Combined material adjustments made to financial statements by component

Financial statements' area	Number of adjustments	Amount $ m
Income	3	3.80
Expenses	8	16.34
Assets	6	51.00
Liabilities	6	12.34
Other comprehensive income	6	130.10
Net result	16	129.30
Equity	3	36.36

Source: QAO

The nature of the material adjustments to financial statements included late identification or recognition of:

- creditors and accruals at three HHSs totalling $10 million
- asset revaluation adjustments at four HHSs totalling $124.76 million
- assets transferred from DoH at one HHS totalling $28.47 million.

Of the 10 HHSs with material adjustments to their financial statements, three were assessed also as needing improvements in their processes to prepare financial statements. One of the three HHSs was not timely in meeting the timetable for providing the initial draft version of its financial statements.

In addition to the changes made to the reported figures, adjustments were made to the notes to the financial statements to comply with disclosure requirements of HHS accounting policies, accounting standards and the Queensland Treasury and Trade financial reporting requirements.

Key changes led to enhanced disclosures about:

- the accounting policies adopted
- land and buildings valuation assumptions
- key executive remuneration
- opening balances and first time accounting disclosures
- equity injections and withdrawals.

2.6 Significant financial reporting issues

Significant financial reporting issues were identified during the financial year that required resolution prior to forming an audit opinion on the financial statements.

2.6.1. Control and consolidation of HHSs

A significant issue we identified when the HHSs commenced on 1 July 2012 was whether they met the criteria to be controlled entities of DoH. If the HHSs were controlled entities, the financial results of all HHSs would be required under Australian Accounting Standards to be consolidated with the financial results of DoH.

The key criteria examined that led to a conclusion that the HHSs are not controlled entities of DoH were:

- DoH has limited ability to govern policies or direct decision making at the HHS for the benefit of DoH
- DoH's role is that of system regulator responsible for setting system-wide strategy, policy and standards and for monitoring performance
- HHSs do not operate for the direct benefit of DoH
- HHSs and DoH have significantly different roles and objectives
- each HHS is administered by a separate management team and governed by an independent Hospital and Health Board
- although the service agreement between each HHS and DoH determines the funding provided and the activities funded, the HHS has the discretion to determine how to deploy its resources and whether to accept resources from DoH
- DoH has no power to direct the day to day activities of any HHS or influence the operational decision making process of the Hospital and Health Board.

The exception to this is the Torres Strait and Northern Peninsula HHS, which has been administered by the Director-General, DoH since it was established on 1 July 2012. As such, it meets the controlled entity criteria and is included in DoH financial statements although the HHS is required also to prepare and publish its own separate financial report. The results of the audit of the Torres Strait and Northern Peninsula HHS are included in this report.

2.6.2. Transfer of assets and liabilities to HHSs

Transfer of closing balances

The establishment of HHSs on 1 July 2012 required the asset and liability closing balances at 30 June 2012, previously held by the former health service districts, to be transferred to the HHSs. This was done for nil consideration. Transfer notices were authorised by the Minister for Health and the transfers designated as a contribution by owners through the contributed equity account.

Figure 2D shows the total assets and liabilities transferred to HHSs on 1 July 2012.

Figure 2D
Combined total assets and liabilities transferred to HHSs on 1 July 2012

Assets and liabilities	Balance $ m
Cash and cash equivalents	78.75
Receivables	213.64
Inventories	72.98
Other current assets	9.07
Intangible assets	4.60
Property, plant and equipment	5 409.56
Other non-current assets	0.18
Trade payables	(294.96)
Employee benefits	(0.50)
Other current liabilities	(0.37)
Other non-current liabilities	(0.30)
Net assets transferred	**5 492.65**

Source: QAO

Land and buildings recognised by HHSs

The Minister for Health approved the transfer of land and building assets through a three-year concurrent deed of lease, representing the HHSs' right to use the assets.

While DoH retains legal ownership, effective control of these assets was transferred to the HHSs as the HHSs have full exposure to the risks and rewards of owning the assets.

To support the asset recognition and disclosure of the land and buildings assets in the HHSs' financial statements, the Minister for Health provided the following assurance on 16 July 2013:

> *…It is intended that legal title of land and buildings is transferred when both the Department of Health and Hospital and Health Boards have mutual confidence that the HHSs have the capacity and capability to be effective asset managers. In the event that this does not occur prior to the expiration of the Deed of Lease arrangements, the term of the Deed of Lease arrangements will be extended…*

The transfer of legal ownership of the land and building assets of certain HHSs during 2013–14 is currently under consideration by DoH.

2.6.3. DoH contribution to the Sunshine Coast University Private Hospital

During 2012–13, the Sunshine Coast HHS paid an initial fee of $50.07 million and reported in its financial statements indicative future cash outflows of nearly $300 million under the terms of an agreement with a private health provider. Under the agreement, the provider will make the Sunshine Coast University Private Hospital available to ensure that service capacity is available for and supplied to public patients in the facility once it is operating.

The Sunshine Coast University Private Hospital operations are scheduled to commence in December 2013 and the facility will provide health care services to public patients over the next five years. After the five-year service term, the provider will continue to operate the entire facility as a private provider of health care services for a further 45 years. At the end of the 50-year period, the building will be transferred to the Sunshine Coast HHS.

In 2012–13, the HHS received funding from DoH for the same amount as the fee paid to the private health provider.

The terms of the agreement required further consideration to determine how the fee paid to the private health provider and the building should be recognised by the HHS in its financial statements. We concluded that the fee paid was an operating expense of the HHS and no building asset was required to be recognised in the financial statements.

3 Internal controls

In brief

Background

Internal controls include the systems, policies and activities established by HHSs to ensure the effectiveness and efficiency of their operations, reliability of financial reporting and compliance with applicable legislation. As part of the financial audit, we assess key internal controls over the reliability of financial reporting, with any weaknesses identified raised with management for its corrective action. An integrated system of internal control reduces the risks an entity must overcome to achieve its objectives.

Conclusions

Control activities ensure risks identified by management are addressed properly and in a timely manner. The number of control activity weaknesses reported across HHSs indicates that improvement is needed to ensure controls are operating effectively.

This is the first year of operation for the HHSs. While monitoring controls, such as internal audit, audit committees and chief finance officer (CFO) statements of assurance have been established, improvement is needed before these become fully effective.

It is crucial that each HHS understands its responsibilities and risks under service provider arrangements with DoH for financial processing. HHSs should have appropriate monitoring controls in place to confirm the material accuracy and the validity of transactions posted to their ledgers by DoH.

Key findings

- There were 159 significant control weaknesses reported across HHSs during 2012–13. However, none were serious enough to result in a modified audit opinion.
- Thirteen HHSs had not finalised the adoption of the Department of Health (DoH) financial management practice manual (FMPM) due to tailoring requirements for local practices.
- The risk management framework at 13 HHSs is still developing. The monitoring of DoH financial processing activities was not entirely effective at 14 HHSs.
- Eleven of 17 HHSs had internal audit functions independent of management, reported directly to the audit committee and resourced with qualified and experienced staff.
- All 17 HHSs have established an audit committee in line with good practice principles. However, further improvements to committees' structures and processes are required.
- Five of 12 HHSs that prepared CFO statements of assurance did not provide adequate assurance to the health service chief executive (CE) and the board. Of these, four HHSs identified opportunities for improvements in their CFO statements of assurance.
- The monitoring controls by 14 HHSs were not entirely effective throughout 2012–13 over all DoH service provider activities.

3.1 Background

The *Hospital and Health Boards Act 2011* provides that HHSs are statutory bodies under the *Financial Accountability Act 2009* (FAA). The FAA imposes significant responsibilities on statutory bodies, including the duty to manage the statutory body efficiently, effectively and economically and to establish and maintain appropriate systems of internal control and risk management.

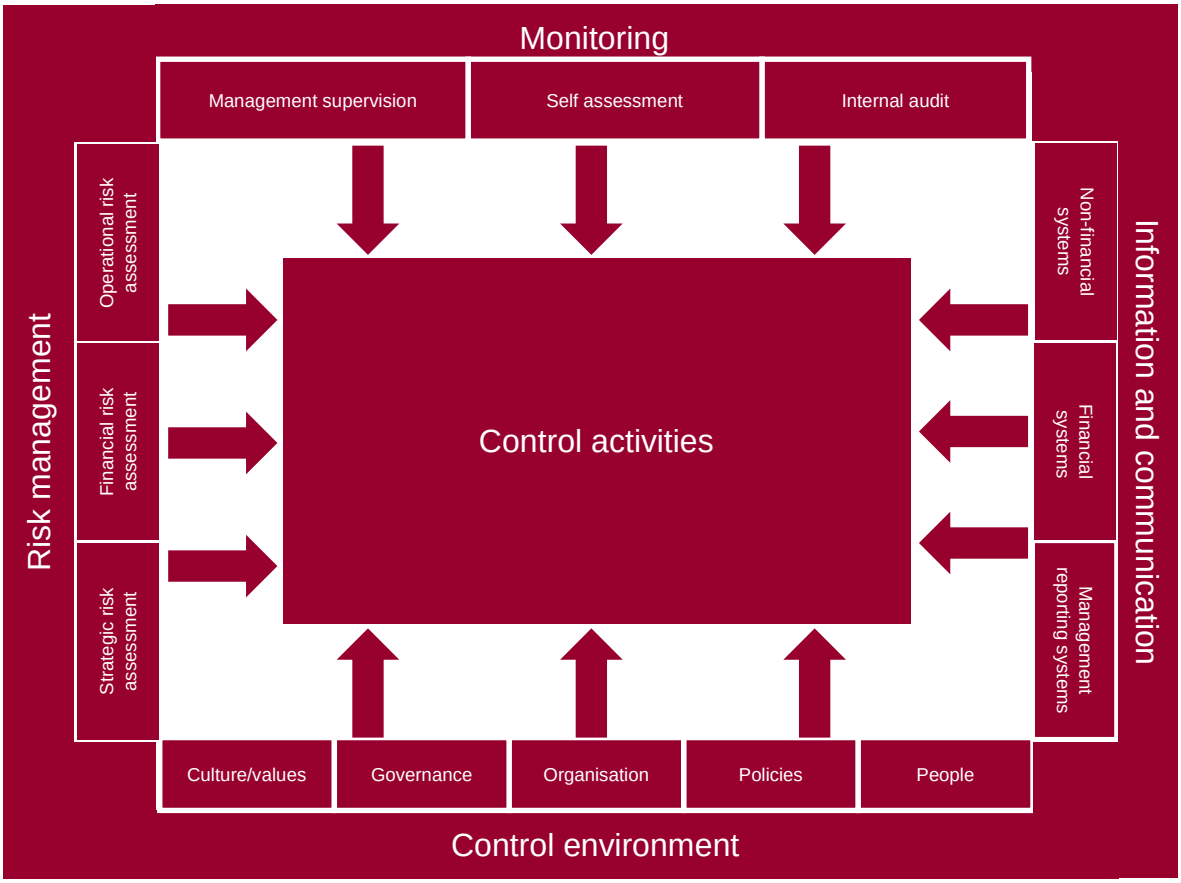
Internal controls are processes (including policies, procedures and systems) that are established, operated and monitored by management of an entity to provide reasonable assurance to management and to its governing body about the achievement of the organisation's objectives.

An integrated system of internal control reduces the risks an entity must overcome to achieve its objectives. Internal controls cannot eliminate risk altogether. They operate to provide reasonable assurance to management about:

- the effectiveness and efficiency of their operations
- the reliability of internal and external financial reporting
- compliance by the entity with laws and regulations.

Figure 3A illustrates the components of an internal control framework.

Figure 3A
Components of an internal control framework



Source: QAO adapted from Internal Control: Integrated Framework - Committee of Sponsoring Organizations of the Treadway Commission, American Institute of Certified Public Accountants, 2011

In Figure 3A the five core elements of a system for control are:

- **control environment**—management's actions, attitudes, policies and values that influence day to day operations—factors include management's integrity and operating style; organisational culture and values, structure and assignment and delegation of authority; and processes for sourcing and developing qualified and skilled employees
- **risk management**—management's processes to consider risks to achieve an organisation's objectives, forming a basis for how the risks should be managed
- **control activities**—the policies and procedures implemented that help ensure management directives are carried out and that necessary actions are taken to address identified risks; operating at all levels and in all functions, control activities include approvals, authorisations, verifications, reconciliations, reviews of operating performance, security of assets, and segregation of incompatible duties
- **information and communication**—the systems used to provide information in a form and time frame that allows employees to discharge their responsibilities and the way that control responsibilities are communicated throughout the entity
- **monitoring of controls**—the methods management employs to oversee and assess the operating effectiveness of control activities in practice. This may be achieved through ongoing supervision, periodic self assessments and separate evaluations.

3.2 Conclusions

The number and nature of control weaknesses reported indicate that, across the HHSs, control activities implemented need improvement to ensure management identified risks are addressed properly and in a timely manner.

This is the first year of operation for the HHSs. While monitoring controls, such as internal audit, audit committees and chief finance officer (CFO) statements of assurance have been established, more improvement is needed before these monitoring controls become fully effective.

3.3 Internal control framework

Each HHS is responsible for developing ways to manage risks to which their operations are exposed. These include maintaining an adequate system of internal controls to ensure that financial records and other information are complete and accurate, assets are safeguarded and errors and other irregularities are prevented or detected.

As part of the financial audit, assessment is made of key internal controls over the reliability of financial reporting and any weaknesses identified are raised with management for corrective action.

Across the HHSs, we have reported 159 significant control weaknesses to management during 2012–13. All 17 HHSs had significant control weaknesses.

These significant issues have been analysed against the components of the internal control framework in Figure 3A and the number of issues are reported in Figure 3B.

Figure 3B
Significant control weaknesses reported across HHSs

Element	Number of issues
Control environment	24
Risk management	4
Controls activities	117
Monitoring	14
Combined significant control weaknesses	**159**

Source: QAO

3.3.1. Control environment

Planning and accountability documents outline the goals, strategies and policies for implementing an organisation's vision, managing finances, ensuring information system security and achieving sustainable management of infrastructure. Effective policies and plans allow management to reinforce relevant legislative requirements and organisational priorities and are a cornerstone in establishing a good control environment.

The Financial and Performance Management Standard 2009 (FPMS) requires HHSs to prepare and maintain a financial management practice manual (FMPM) as the paramount policy manual covering financial management and operations. The FMPM is the initial point of reference for staff at HHSs for financial policy, guidelines and procedures.

All HHSs initially adopted the Department of Health's (DoH) FMPM, which required changes to suit local practices. Thirteen of the 17 HHSs have not finished updating their FMPM to better reflect their operations.

3.3.2. Risk management

Risk management involves establishing and maintaining an effective system to identify, analyse and mitigate risks to an entity from unacceptable costs or losses associated with its operations and managing those risks that may affect the ability of the entity to continue to provide services. Risk management policies and risk registers identify the major risk exposures and the control measures adopted to mitigate or manage those risks.

The management of fraud risk and business continuity planning are two crucial elements of a robust risk management framework.

The Auditor-General's Report 9 for 2012–13 on fraud risk management, tabled in Parliament in March 2013, reported that HHSs were still evolving their approaches to fraud and provided recommendations around a better practice fraud control program. The lack of maturity in HHSs' risk management systems increases the risk of undetected fraudulent activities.

Business continuity planning includes recognising that a level of risk is unavoidable; for example, responding to natural disasters through the preparation of contingency plans to maintain business operations. The flood emergency and outbreak of Legionnaires' disease in 2013, both requiring the transfer of patients to alternate hospital facilities, are prime examples of the need for crisis management plans to maintain essential health services.

The risk management framework at 13 of the 17 HHSs is still developing, as indicated particularly by risk management policies not being adopted and risk registers being incomplete.

Failure to identify and document appropriately the significant and emerging risks considerably diminishes the effectiveness of the HSS at managing risks to its financial position and its ability to deal with unexpected events.

3.3.3. Control activities

Control activities are the specific procedures established to protect assets, ensure reliable accounting records, promote efficiency and encourage adherence to the organisation's policies. Effective controls provide early warning of weaknesses or susceptibility to error, support for timely reporting and early identification of irregularities.

The more common control weaknesses that occurred across HHSs related to:

- ineffective or partially effective monitoring of service provider processing at 14 HHSs
- key account reconciliations not prepared in a timely manner or independently reviewed at 12 HHSs
- financial delegations not complied with at nine HHSs
- poor controls over patient billing at four HHSs
- inadequate segregation of duties at four HHSs.

Each HHS has entered into service provider arrangements with DoH whereby DoH undertakes significant accounts payable and payroll expenditure processing and payment, property, plant and equipment accounting, journal processing and general ledger reconciliations on behalf of HHSs.

DoH has the responsibility for ensuring the accuracy over processing and quality of services provided and, as owner of the financial system used by each HHS, is also responsible for the maintenance of the system and associated controls.

It is crucial that each HHS does not lose sight of its responsibilities under these arrangements and understands the risks of absolute reliance on DoH for correct processing. There should be a clear understanding by the HHS that it is accountable for the accuracy and validity of transactions processed to its ledgers. Accordingly, HHSs should have appropriate monitoring controls in place to confirm the material accuracy and the validity of transactions posted to their ledgers by DoH.

The monitoring controls by 14 HHSs were not entirely effective throughout 2012–13 over all DoH service provider activities.

The HHSs are continuing to develop processes to monitor and verify adequately the activities undertaken by DoH. This includes developing their own reporting systems, such as payroll reports provided by DoH which HHSs considered were not useful for adequate monitoring and verification of costs.

3.3.4. Monitoring

Monitoring activities evaluate whether the components of the system of internal controls are in place and operating effectively, with a view to detecting and remediating any control deficiencies.

An internal audit function and an audit committee are two key monitoring and review activities over HHSs' systems of internal controls. Another effective mechanism for gaining a high level of assurance about the operation of key financial controls is a CFO statement of assurance.

The Hospital and Health Boards Regulation 2012 requires HHSs to establish an audit committee and identify its functions. The FPMS specifies that a statutory body must have an internal audit function if directed by the appropriate Minister, or if the statutory body considers it is appropriate to establish the function.

The Minister has not directed HHSs to establish an internal audit function; however, in the absence of an internal audit function, it would be difficult for an audit committee to fulfil its role and responsibilities.

Internal audit function

Internal audit is an integral part of the internal control framework in providing assurance that appropriate internal controls exist and operate effectively, risks are managed and operations are run economically.

Although it is the intention of HHSs to establish an internal audit function, only 11 of the 17 HHSs had established one during 2012–13. Those six HHSs without an internal audit function were in the process of establishing this function.

Five of the 11 HHSs established their internal audit function more than six months after the start of the 2012–13 financial year. Of the 11 HHSs with internal audit functions, ten HHSs outsourced significant audit activities to external service providers.

Of the 11 HHSs with internal audit, three had not prepared an internal audit charter outlining their roles and responsibilities while, for one HHS, the internal audit plan setting out the audits to be carried out during 2012–13 was not presented to the audit committee.

To assess broadly how well the internal audit functions of the 11 HHSs were progressing in their early stage of development, we examined the framework underpinning how the internal audit function was established and whether it was:

- independent from operational functions and processes
- resourced adequately by professionally qualified and suitably experienced staff.

In all instances, we found that the internal audit function was independent of management, reporting directly to the audit committee and was resourced appropriately by qualified and experienced staff.

Those HHSs without an audit function have indicated their intention to establish one to provide its important role in monitoring the health of the internal control structure.

In continuing to develop an effective internal audit function, all HHSs should ensure that they have comprehensive charters governing their establishment and operations and timely annual internal audit plans. Both the charter and plan should be approved by the health service chief executive (CE), with regard to recommendations of the audit committee. Ideally, annual internal audit plans are approved before the start of the year to which they relate with processes in place for the review and update of audit plans throughout the year, usually during audit committee meetings.

Audit committee

The role of audit committees is to operate independently of management and to assist the CEs of HHSs to discharge their responsibilities for the efficient, effective and economical use of public resources. This is achieved by a committee providing independent oversight and reporting to the health service CE about governance and internal control frameworks, financial reporting and compliance with relevant legislation.

All 17 HHS have established an audit committee.

The attributes of a good audit committee are grouped into five elements:

- Operating principles—audit committees underpin their operations with a robust charter and comprehensive annual work plan
- Committee structure—audit committees have the right balance of skills and industry experience so members appropriately challenge management and provide impartial views
- Key responsibilities are performed—audit committees provide financial oversight; review and monitoring of internal controls, internal audit, external audit; and self assessment
- Relationship with audit—audit committees engage actively and robustly with both internal and external audit
- Proceedings—audit committees demonstrate good planning and conduct regular meetings.

Generally, HHSs ' audit committees demonstrated these five attributes in their establishment and operations.

All 17 audit committees operate under a charter that is subject to annual review. Six audit committees did not have an annual work plan that outlines the activities that are to be covered at committee meetings during the year. The number of members ranges from two to six. Ideally, audit committees should comprise membership between three and six members with at least half the number of members being independent appointees. All committees met, at a minimum, on a quarterly basis.

CFO statement of assurance

The *Financial Accountability Act 2009* (FAA) requires the CFO of state government departments to give the accountable officer a statement each year about whether financial internal controls are operating efficiently, effectively and economically.

While the FAA does not require the CFO of a statutory body to prepare a statement of assurance for the health service CE and the board, 12 of the 17 HHSs adopted this as better practice.

Where there is a robust framework to support the preparation of the CFO statement of assurance, the CE and the board can gain a high level of assurance about the operation of key financial controls during a financial year. Importantly, the framework and CFO statement of assurance can provide a greater sense of comfort that HHSs are more likely to be effective in identifying and correcting material control weaknesses. This reduces the risk of material misstatement in their financial statements.

The form of the CFO certification as outlined in the FPMS includes statements about:

- whether the financial records have been properly maintained throughout the financial year in accordance with the prescribed requirements
- whether the risk management and internal compliance and control systems relating to financial management have been operating efficiently and effectively throughout the financial year
- since the balance date:
  - whether there have been any changes that may have a material effect on the operation of the risk management and internal compliance and control systems
  - if there have been any changes—details of the changes
- whether external service providers have given assurance about their controls.

We undertook an audit of the CFO statements of assurance of HHSs to establish what underpinned each CFO statement of assurance and to gauge the level of assurance being provided to the CE and the board about the efficient and effective operation of key financial internal controls.

In forming our conclusions, our assessment considered:

- design—the risk and control assurance framework adopted
- application—the implementation of the framework over the period
- reporting—the form and content of the annual certification and supporting documentation.

To form a positive conclusion, we expected to find that, in terms of:

- design—there was a clear, early understanding between the CE, the board and the CFO about the significant risks; the controls being examined; the approach to be used to test these controls; and the desired level of assurance expected to be obtained from these tests
- application—there was sufficient and appropriate evidence obtained and documented to demonstrate that the controls were tested in operation
- reporting—the certificate provided was in the form required by the FAA and FPMS and the accompanying report contained reference to, or was supported by, the evidence obtained.

The assurance framework is an integrated set of activities that links the strategic plans, risk management processes, internal audit function, external audit process and self assessment of internal controls. The framework allows each HHS to assess the effectiveness, efficiency and economy of financial internal controls, culminating in a statement of assurance from the CFO to the CE and the board.

DoH provided its CFO assurance framework to HHSs as a guide for preparing their CFO statements of assurance.

We concluded that five of the 12 HHSs that prepared CFO statements of assurance did not meet our expectations for a positive result in key requirements. This increases the risk of the CEs and boards of these HHSs having a false sense of comfort from the CFO statements of assurance about the operational effectiveness of their internal financial controls.

Nonetheless, being the first year of operation for HHSs, the results were encouraging overall for those HHSs that prepared CFO statements of assurance. With some improvements, CEs and boards can gain a high level of confidence from the CFO statements of assurance. Importantly, four HHSs identified opportunities for improvements to the process in their CFO statements of assurance.

Areas that require most attention include:

- early discussions, ideally at the beginning of each year and agreement between the CFO, CE and audit committee about the assurance framework to be used
- identification of the nature of controls to be tested, the assessment process to test these controls, inclusion of the nature of controls tested and the control weaknesses in the CFO statements of assurance
- strengthening of the assessment of the controls at DoH
- identification of financial reporting risks.

DoH performs a range of significant financial functions on behalf of HHSs and provides information systems support for financial and patient management systems. Under these service provider arrangements, DoH annually provides HHSs with a report on controls at DoH, giving assurance that it has established and maintained appropriate controls to ensure accurate and timely processing.

It is crucial that HHSs take an active and lead role in this assurance process early in the year rather than, as occurred in 2012–13, solely relying on DoH to define a generic scope of the assurance process—particularly, the controls to be confirmed and reported in the assurance report. Early engagement with DoH will provide each HHS with an understanding of the planned assurance process and an opportunity to address HHS-specific financial risks and to request the necessary assurances over key DoH internal controls.

Once the annual assurance report is received, the CFO should assess the report to determine whether sufficient detail is provided to enable an assessment of the exact nature and extent of the assurance being provided and the effect of this assurance on the control environment of the HHS. If internal control issues are identified at DoH, the CFO should undertake further assessment of the effect on relying on the controls at DoH and the need for further testing.

A risk register establishes a sound basis for documenting the CFO's understanding and analysis of significant financial risks, including financial reporting risks. Areas one would expect to see in this type of register would include:

- identification of material account balances, transactions or disclosures in the financial statements
- identification of management assertions in relation to those items (such as valuation, completeness, accuracy)
- assessment of the inherent risk of material misstatement by assertion
- identification of key controls that mitigate the risk of material misstatement of those items
- identification of responsibility for the key controls operating effectively and the methods to be used to obtain a high level of assurance over those controls throughout the year (such as transaction testing).

4 Financial performance, position and sustainability

In brief

Background

The annual financial statements of Hospital and Health Services (HHSs) provide a measure of their financial performance and net assets, allowing an assessment of whether they generated sufficient surpluses during the year to meet current and future financial obligations. To remain sustainable, HHSs must manage future financial and funding risks and, at the same time, maintain quality and expected levels of public health care services.

The target operating result for all 17 HHSs was to break even or achieve a surplus.

This chapter provides an assessment of the financial sustainability of HHSs through an analysis of key financial performance indicators based on 2012–13 financial results.

Conclusions

All HHSs are in a sound, long term financially sustainable position because of the current arrangements between the Department of Health (DoH) and HHSs, with HHSs having no long term debt.

We identified opportunities to improve asset valuation processes which can reduce the risks of valuation errors from incomplete and inconsistent information on assets and costs used by the valuers. It can also reduce delays in finalising the annual valuation process.

Key findings

- All 17 HHSs achieved operating surpluses for the year, resulting in aggregate operating surpluses of $159.56 million for the HHS sector. Revenue budget increases totalling $461.43 million were made principally to cover unplanned expenditure for employee redundancy programs and functions devolved from DoH.
- Nine of the 17 HHSs exceeded their final approved expense budgets by a total of $40 million.
- HHSs spent $9.68 billion in 2012–13, with employee costs representing 69.4 per cent ($6.72 billion) of all costs.
- Staff reductions through employee redundancy programs are estimated to achieve savings of $326 million in 2013–14.
- HHSs had total assets of $6.67 billion and liabilities of $0.64 billion at 30 June 2013.
- All HHSs had adequate liquidity to meet their short term liabilities as they fall due.

4.1 Background

The financial performance of Hospital and Health Services (HHSs) is reported annually in their statements of comprehensive income. The financial position of HHSs is measured annually in their statements of financial position by reference to their net assets —- the difference between each HHS's total assets and total liabilities. A service agreement between the Department of Health (DoH) and each HHS establishes the hospital, health and other services to be provided by a HHS, the funding provided for the provision of these services and the key performance indicators to measure the delivery of these services.

4.2 Conclusions

All HHSs have the present capacity to meet their current and future expenditure obligations as they fall due and to absorb foreseeable changes and emerging financial risks without significantly changing revenue and expenditure policies.

Short term ratios for all HHSs are favourable, with all achieving positive operating cash flows. Long term financial sustainability is also favourable. No HHS has long term debt, particularly because major infrastructure assets are constructed and funded by DoH and transferred to HHSs at no cost. Specific funding from DoH will also be provided for backlog maintenance.

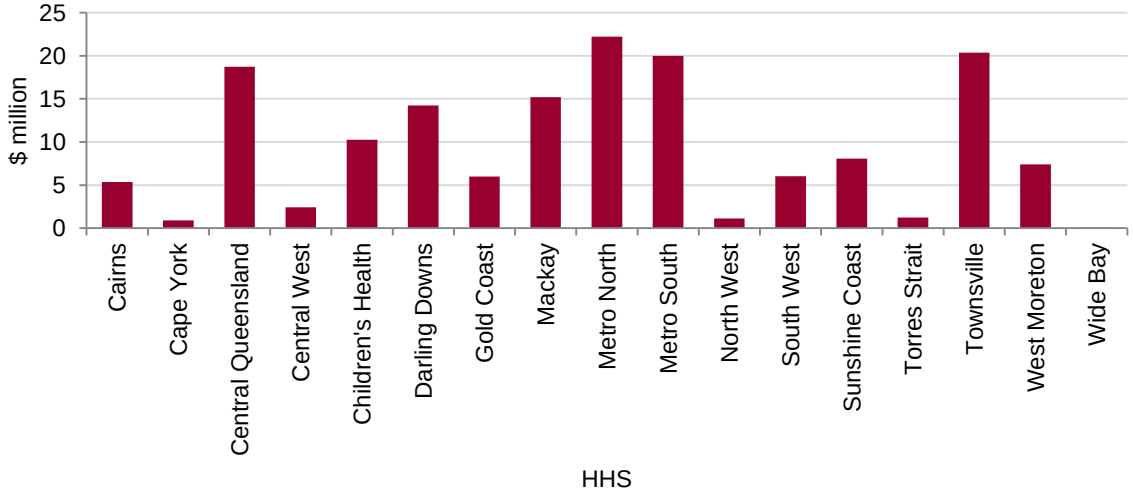
4.3 Financial performance

Financial performance is measured primarily by the operating result—the difference between operating revenue inflows and expenditure outflows. The target specified in each HHS's service agreement is that the operating result should be break even or in surplus.

4.3.1. Operating results

Figure 4A shows the operating surpluses achieved by all 17 HHSs for the year. In aggregate, operating surpluses were $159.56 million for the HHS sector.

Figure 4A
Operating result for 2012–13



Source: QAO

Operating revenues

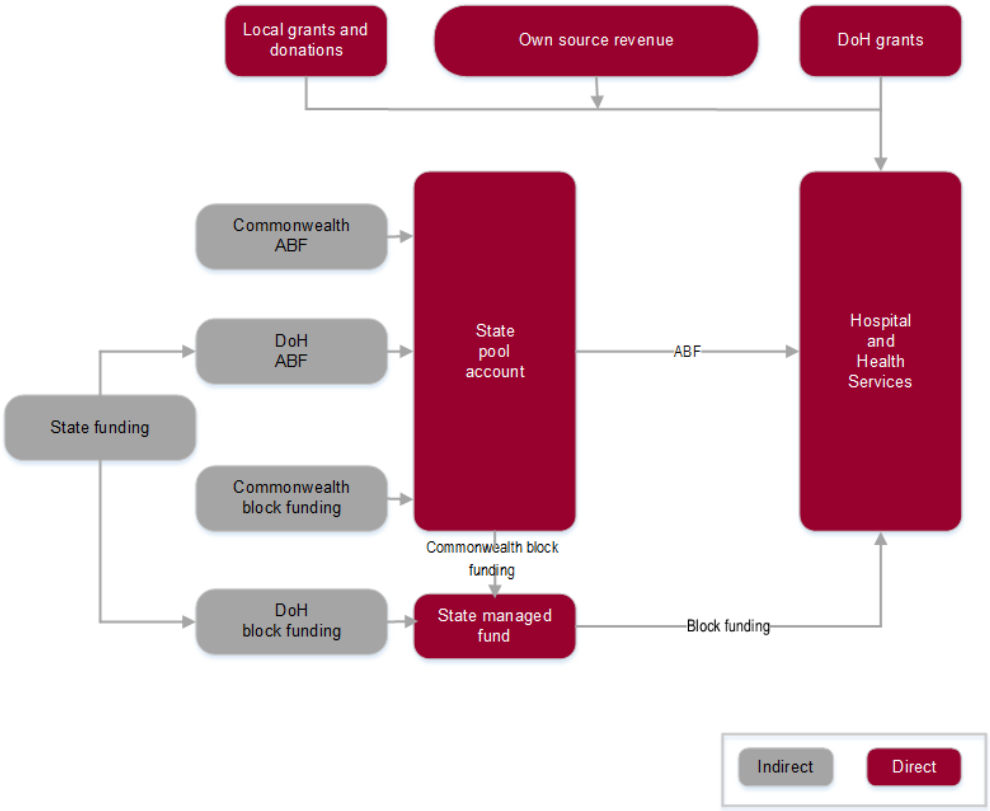
The activities of HHSs are primarily funded by Commonwealth and state grants.

The Commonwealth and state grants for activity based funding (ABF) are pooled and allocated through a state pool account. The Commonwealth and state contributions for block funding and training, teaching and research funds are pooled and allocated through a state managed fund.

HHSs also generate revenue from other grants and donations and from individual HHS activities which is known as own source revenue (OSR). OSR includes private, interstate and residential aged care patient fees, reimbursement of pharmaceutical benefits and sales of goods and services.

Figure 4B shows the revenue sources flow for HHSs.

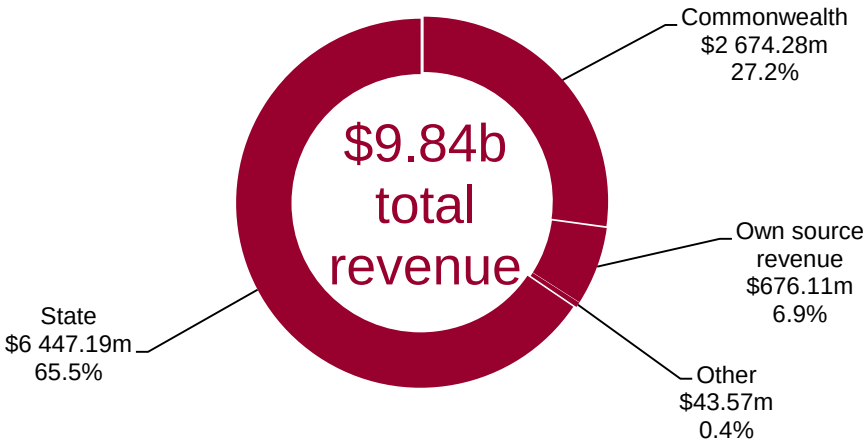
Figure 4B
Revenue flows to HHSs



Source: QAO and DoH

Figure 4C shows that 65.5 per cent of total revenue of $9.84 billion in 2012–13 was derived by HHSs from state government sources, while Commonwealth funding comprised 27.2 per cent.

Figure 4C
Revenue by source



Source: QAO

The main components of state and Commonwealth funding was ABF and block funding, comprising 64 per cent ABF and 13 per cent block funding. Additionally, ABF represented 60.8 per cent of the total revenue for the 13 HHSs that received ABF.

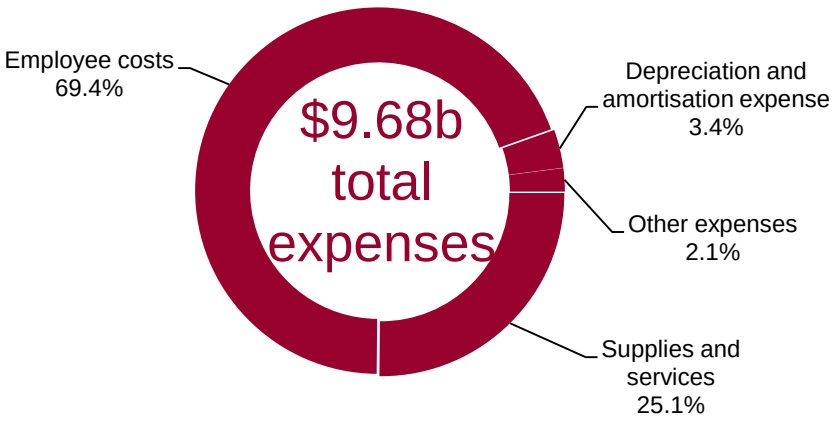
Revenue for the four HHSs that did not receive ABF was primarily by block funding (58.5 per cent) and DoH grants (33.2 per cent). The four HHSs that do not receive ABF are Cape York, Central West, South West and Torres Strait and Northern Peninsula HHSs.

Operating expenses

HHSs spent $9.68 billion in 2012–13, with employee costs in delivering health services representing 69.4 per cent of all costs.

Figure 4D shows the major expenses by nature incurred by HHSs in 2012–13.

Figure 4D
Expense composition



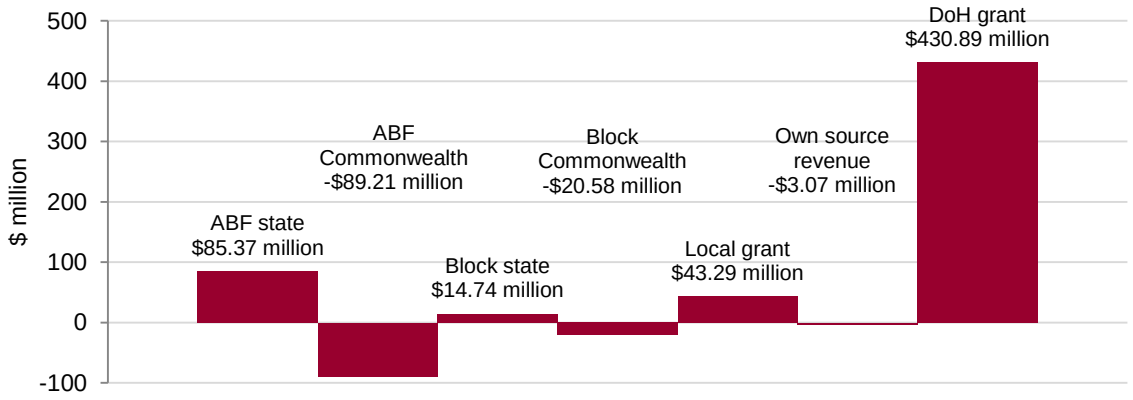
Source: QAO

Performance against annual budget

A key focus of HHSs for 2012–13 included improving efficiency in the delivery of public hospital and health care services while, at the same time, achieving a favourable financial result, primarily through cost reductions. All HHSs achieved operating surpluses for the year.

Figure 4E shows the changes to the original revenue budgets. The original budget allocated $9.23 billion of funding to the HHSs. In November 2012, the Commonwealth decreased its funding due to lower than expected population growth requiring HHSs to make additional cost savings to meet the reduction in Commonwealth funding. The significant increase in state funding was to meet principally unplanned expenditure for employee redundancy programs and the devolution of other functions and costs from DoH, which were not identified in the original budget.

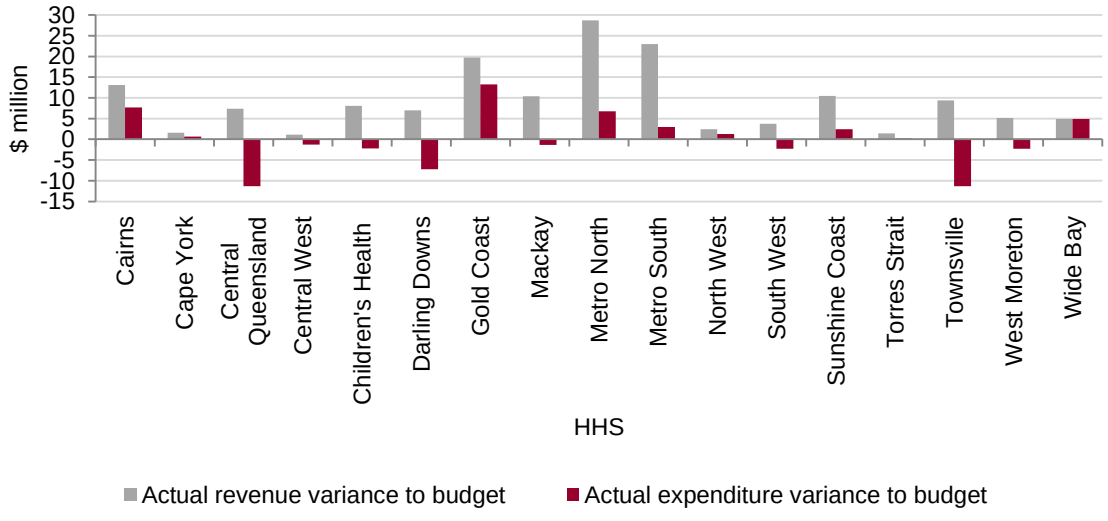
Figure 4E
Changes to 2012–13 original revenue budgets



Source QAO

The final revenue budgets increased by $461.43 million (4.8 per cent) from the budgets originally approved for 2012–13. The final budgeted revenue exceeded budgeted expenditure for the sector by less than $1 million. Nine of the 17 HHSs exceeded their final approved expense budget by a total of $40 million. Figure 4F provides an analysis of the variance between the actual revenue and expenditure of all HHSs against their original budgets for 2012–13.

Figure 4F
Actual revenue and expenses variance to original budget



Source QAO

4.3.2. DoH health service employee costs

Employee costs arose from executive employees appointed directly by HHSs ($23.24 million) and health service employees provided by DoH ($6 70 billion). The analysis in this section refers to the core health care employees, who are the DoH employees.

Under the *Hospital and Health Service Boards Act 2011*, DoH retains responsibility for those health service employees provided to each HHS under a service agreement. Each HHS reimburses DoH for the full cost of these services.

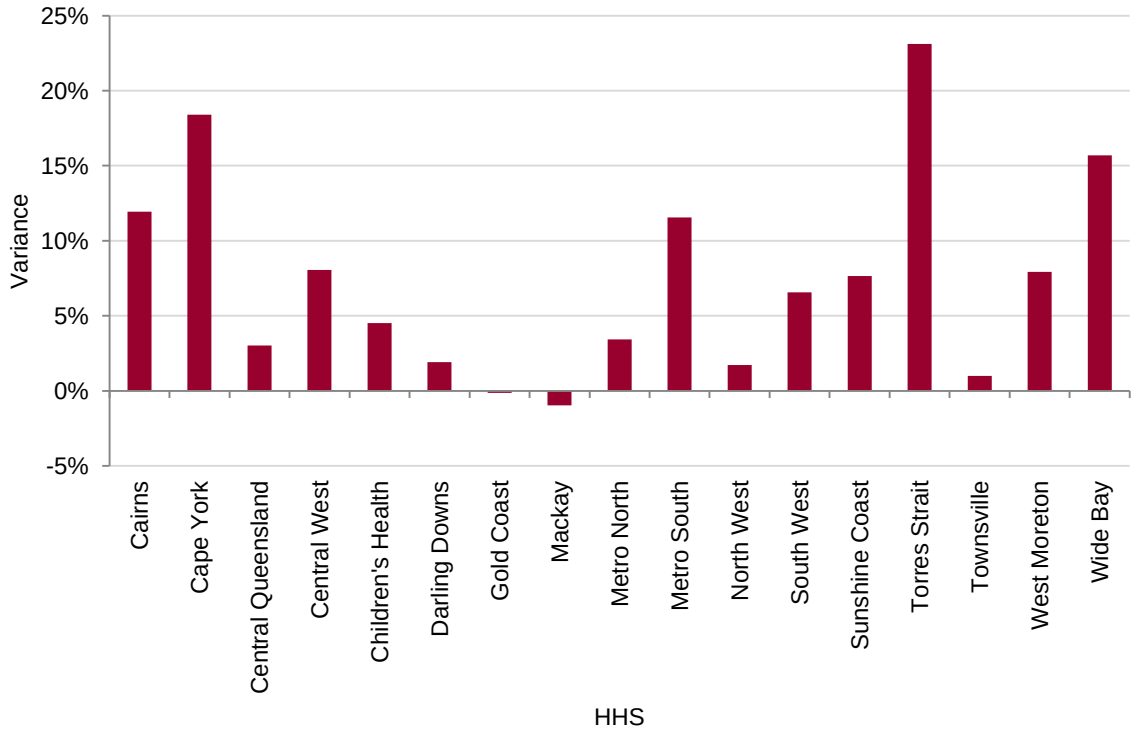
Salaries and wages paid to DoH health service employees totalled $5.62 billion for 2012–13 for approximately 57 905 full time equivalent (FTE) employees. This salaries and wages amount differs from the employee costs reimbursed to DoH because these costs include employee related on-costs such as payroll tax, workers compensation and superannuation contributions as well as annual leave and long service leave central scheme levies payable to DoH. The annual leave and long service leave liabilities for health service employees are managed centrally by the Queensland Government and are not required to be recognised in the balance sheets of the HHSs.

Comparison to budget

The total DoH health service employee costs exceeded the original budget for 2012–13 by $376 million or 5.93 per cent.

Figure 4G shows for each HHS the variance between actual employee costs compared to the original estimate.

Figure 4G
Variance of actual employee costs compared to original estimate

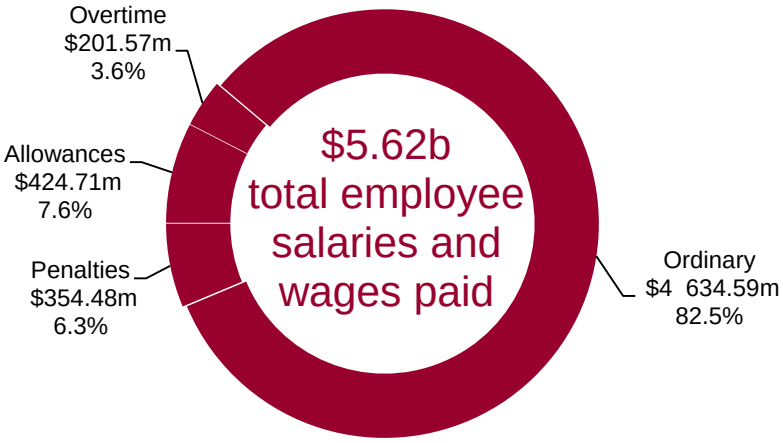


Source: QAO

Composition of DoH health service employee costs

Each HHS incurred significant costs for employee overtime, allowances and penalties. In 2012–13, payments made to DoH employees for these totalled $980.76 million—17.5 per cent of the total amount paid to employees. Figure 4H shows the composition of the employee costs by pay type.

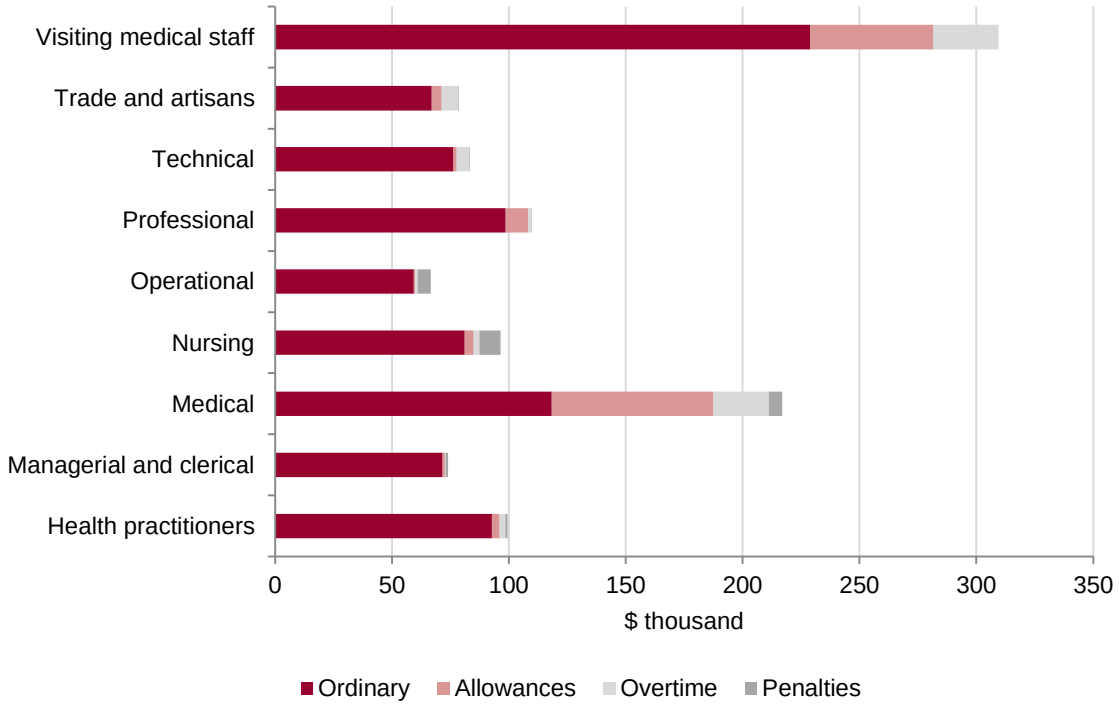
Figure 4H
Composition of employee costs by pay types



Source: QAO

Figure 4I shows average pay for a FTE employee by pay stream and pay type.

Figure 4I
Average pay composition by pay stream

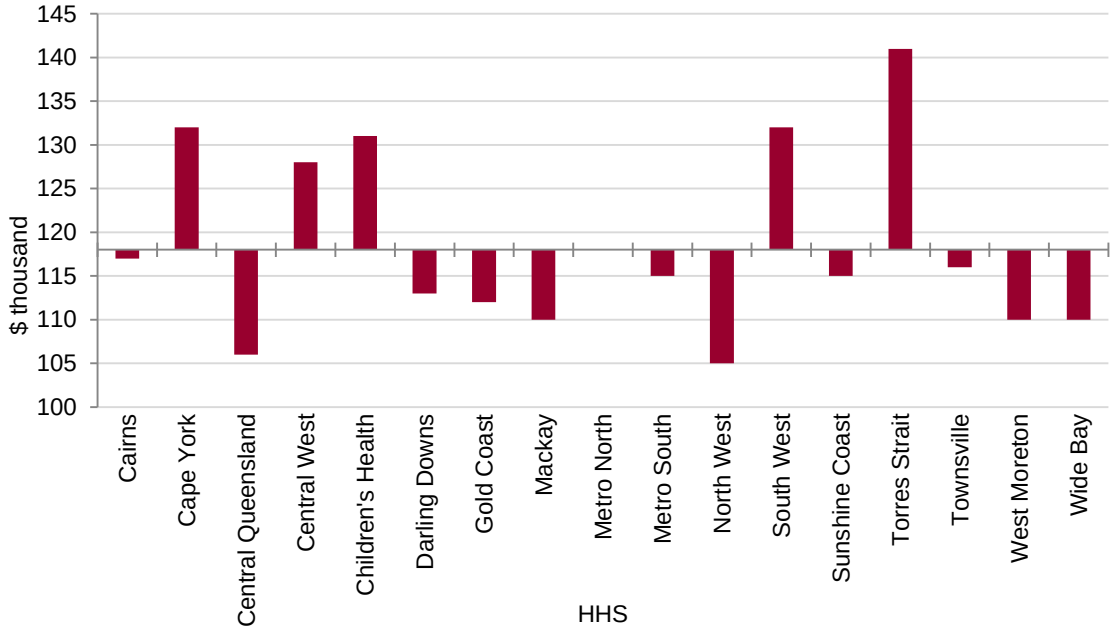


Source: QAO

Ordinary or base pay

Base pay for the sector totalled $4.63 billion and comprised 82.5 per cent of the gross pay earned. The nursing pay stream accounted for 42.3 per cent and the medical pay stream accounted for 17.2 per cent of total ordinary pay. The average base pay for medical staff across all HHSs was $118 366 per FTE. Figure 4J shows higher than average base pay for medical staff was noticeable in the more rural and remote HHSs, apart from North West HHS which had the lowest average medical ordinary pay of $104 947 per FTE.

Figure 4J
Average ordinary pay per medical FTE compared to overall HHSs medical average pay

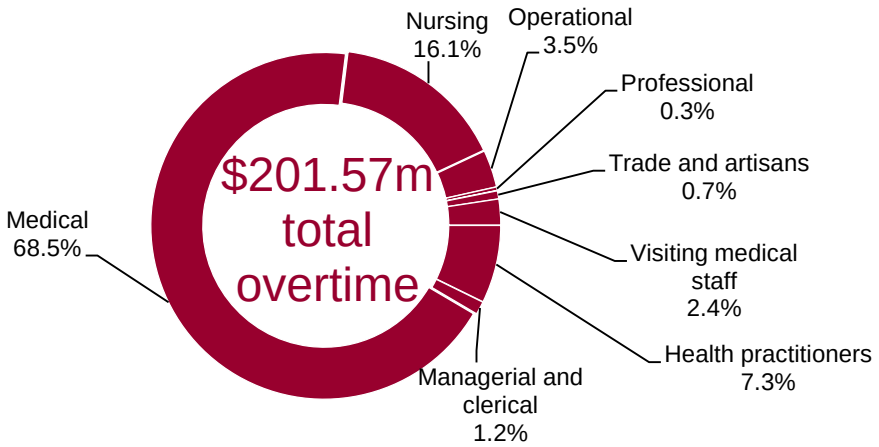


Source: QAO

Overtime

Figure 4K shows $201.57 million paid in overtime in 2012–13. The medical stream earned more than two-thirds of total overtime paid—$138.09 million, while nursing staff received $32.38 million.

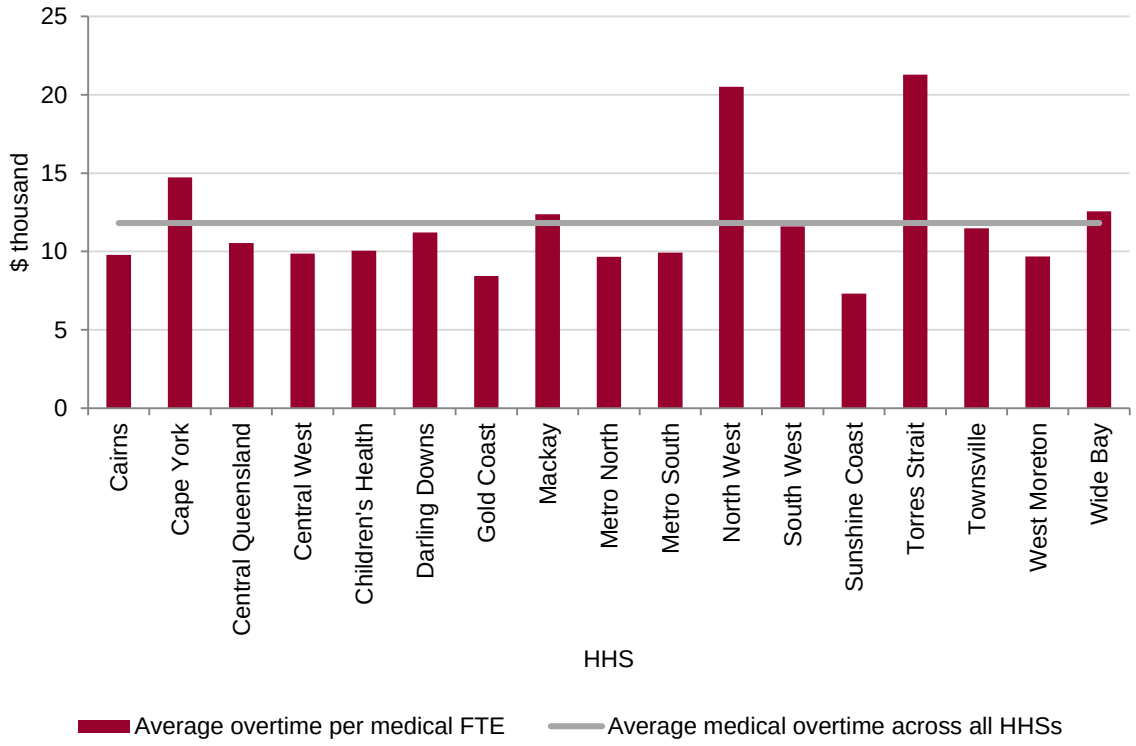
Figure 4K
Overtime costs by pay stream



Source: QAO

Figure 4L shows that higher than average overtime was paid to medical staff particularly in the more remote hospitals.

Figure 4L
Average overtime per medical FTE



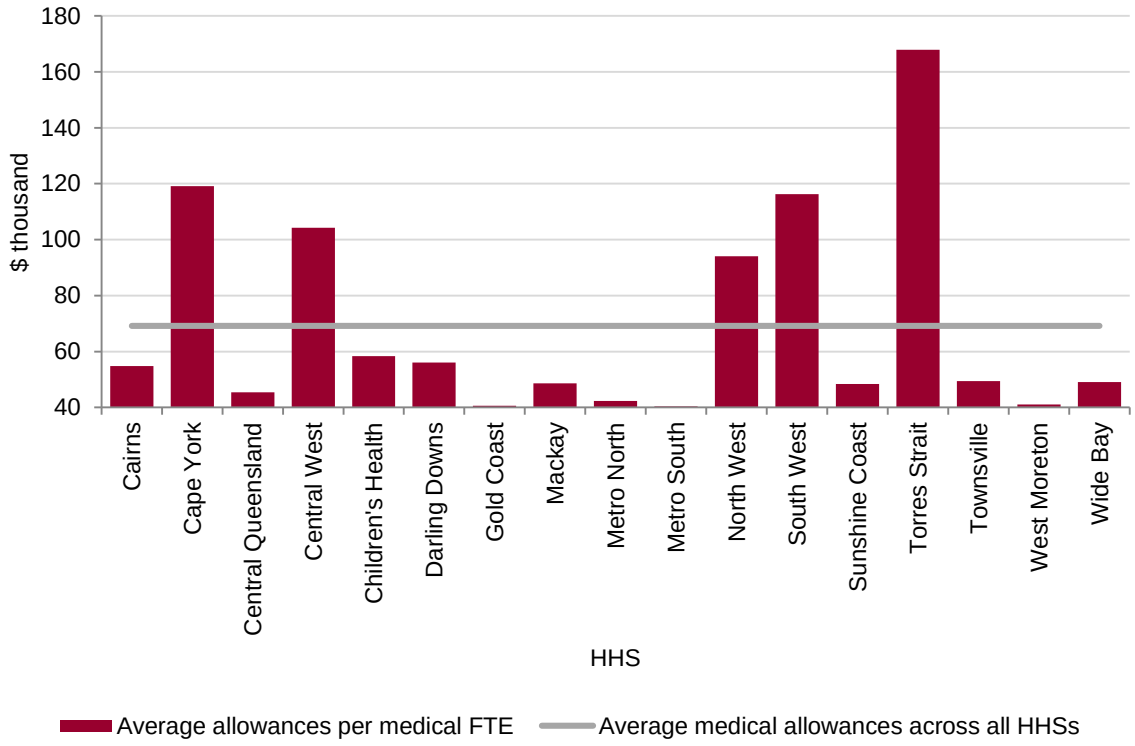
Source: QAO

Allowances

Across the sector, $424.71 million was paid in allowances: $319.09 million (75.1 per cent) of which was paid to medical staff. Allowances paid included the right of private practice—$192.71 million; professional development allowances—$48.93 million; motor vehicle allowances—$32.51 million; and on call allowances—$27.33 million. Nursing staff received a total of $65.53 million in allowance payments.

Figure 4M shows higher than average allowances are paid to medical staff in the more remote locations. This was because a higher proportion of those senior medical officers receive the right to private practice allowance as well as an inaccessibility (or locality) allowance.

Figure 4M
Average allowances per medical FTE



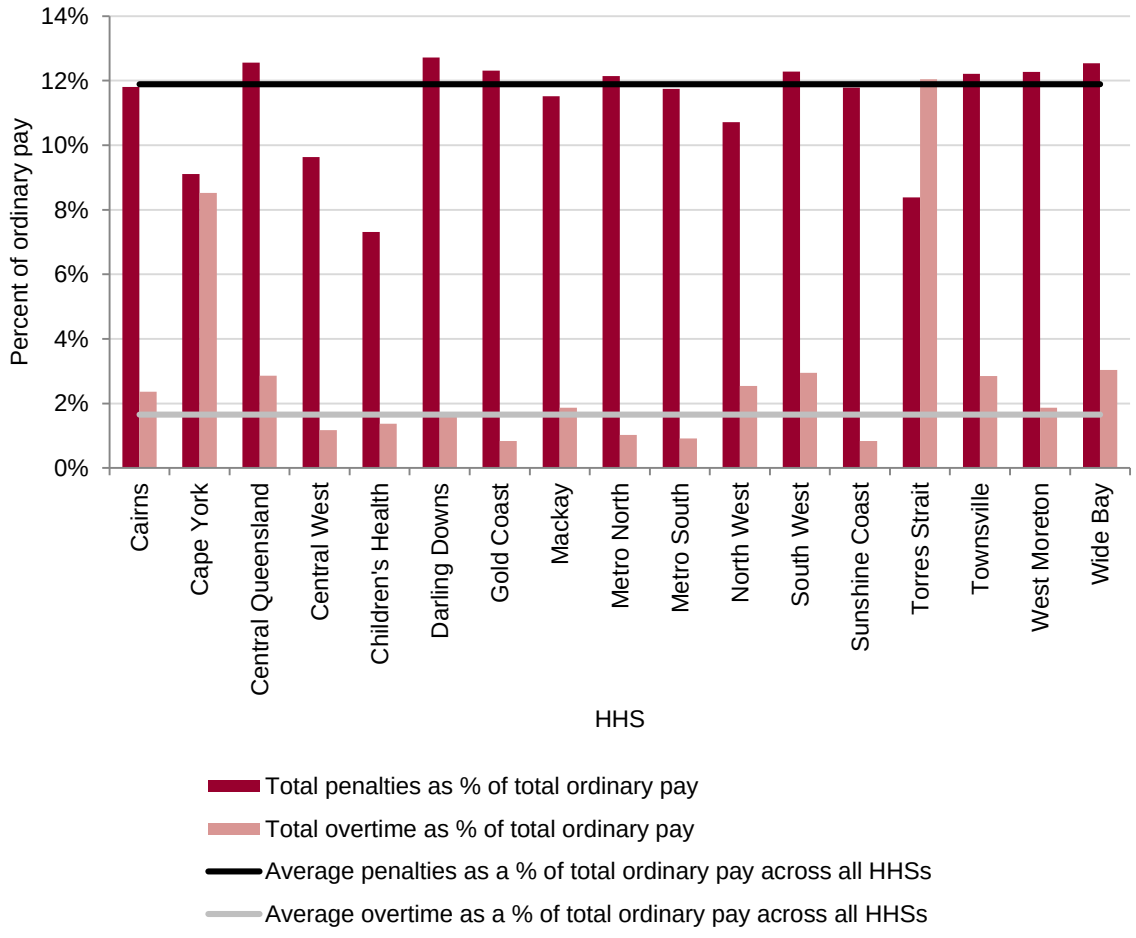
Source: QAO

Penalties

Across the sector, $354.48 million was paid in penalties with nurses paid $233.40 million for working weekends, nights and afternoon shifts. On average, penalties represented 12 per cent of total nursing pays but overtime represented only 1.65 per cent of payments made to nurses.

Figure 4N shows that, although the cost of penalties for nursing staff at Torres Strait and Northern Peninsula and Cape York HHSs was lower than the state average of 12 per cent, this was offset by significantly higher than average overtime costs. Nursing overtime costs as a percentage of base pay at Torres Strait and Northern Peninsula and Cape York HHSs were more than seven and six times the state average respectively. Children's Health Queensland HHS achieved a lower proportion of penalties to base pay for nurses, due to fewer inpatients on weekends and from reduced penalties that arise from shift changeover times.

Figure 4N
Penalties and overtime paid to nurses as a percentage of ordinary pay



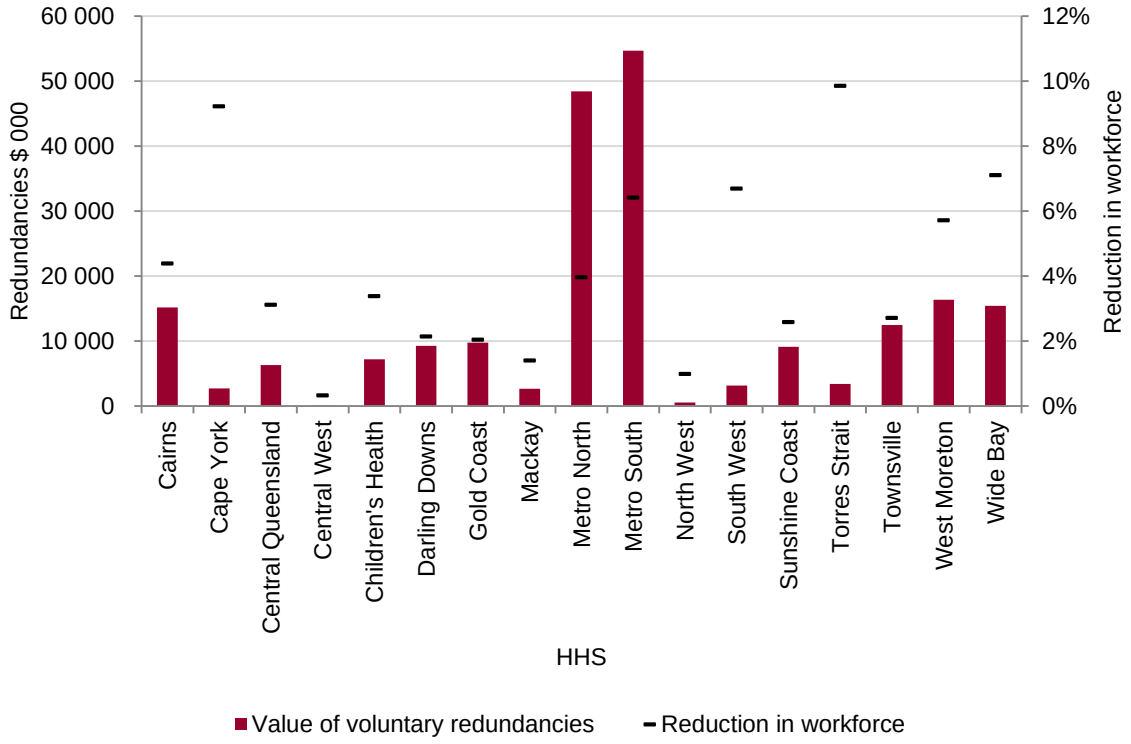
Source: QAO

FTE reductions through voluntary employee separations

Employee redundancy programs were implemented by DoH in consultation with the HHSs. During 2012–13, 2 362 FTE employees received redundancy packages costing approximately $157 million.

Figure 4O shows by HHS the cost of redundancies and the percentage reduction in the HHS workforce.

Figure 4O
Cost of employee redundancies and effect on workforce



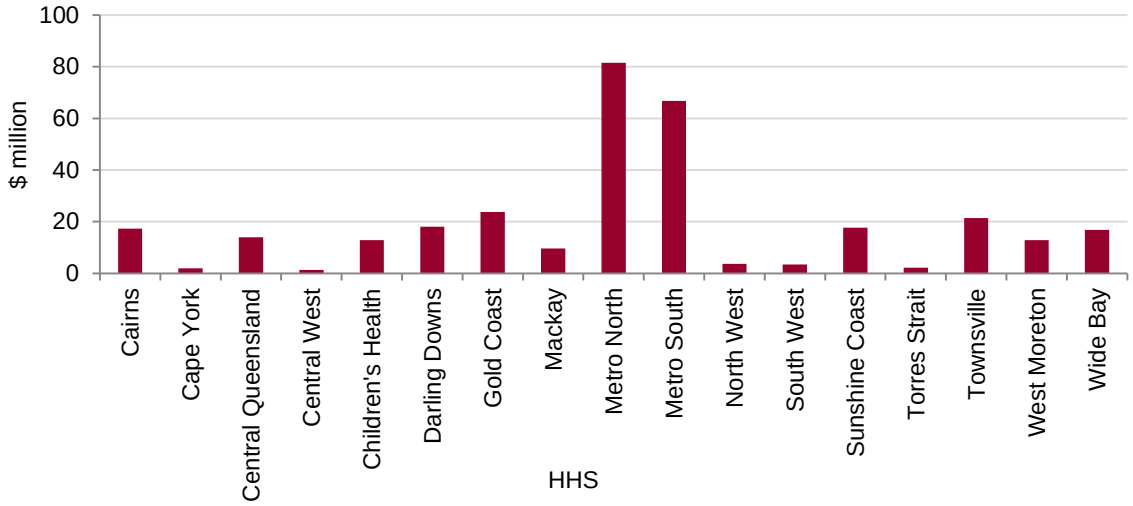
Source: QAO

The estimated reduction of 1 537 FTE employees across the HHS sector are set to deliver employee cost savings of $326 million in 2013–14. Targets were set for workforce FTE reductions, as measured by the Minimum Obligatory Human Resource Information (MOHRI).

The initial FTE targets were revised up by 558 FTE employees or 1.0 per cent. Fourteen HHSs achieved the final end of year FTE targets. Three HHSs did not achieve the FTE targets, but only exceeded their targets by less than three per cent.

Figure 4P shows the estimated 2013–14 salary and wages savings from 2012–13 reductions in FTE employee numbers.

Figure 4P
Estimated 2013–14 salary and wages savings from 2012–13 FTE employee reductions

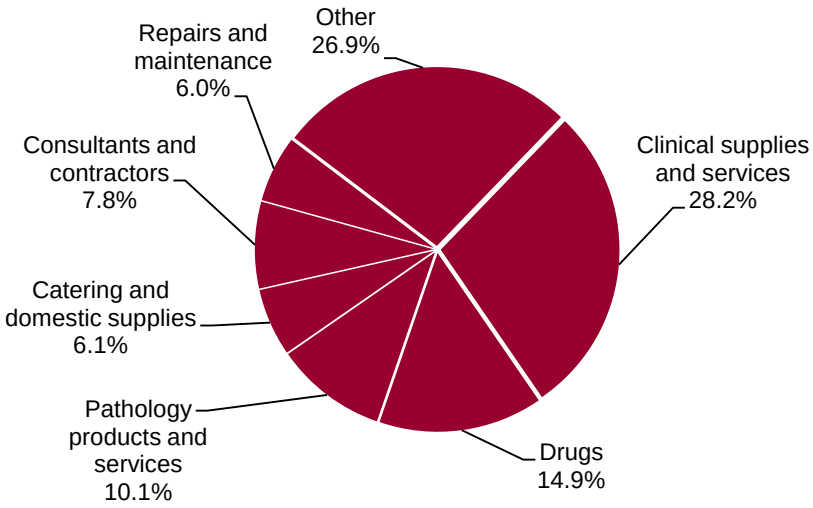


Source: QAO

4.3.3. Supplies and services expenses

Supplies and services costs totalled $2.44 billion, which represents approximately one-quarter of total expenses of the HHSs. Figure 4Q shows the percentage that different supplies and services contributed to the total cost.

Figure 4Q
Supplies and services composition for 2012–13



Source: QAO

Clinical supplies

On average, costs for clinical supplies in 2012–13 as a percentage of total supplies and services were 22 per cent higher at the major hospitals. Major hospitals provide a range of complex and high cost services such as intensive care, cardiology, neurosurgery and obstetrics. The greater the complexity of services provided, the greater the use and proportionate cost of clinical supplies.

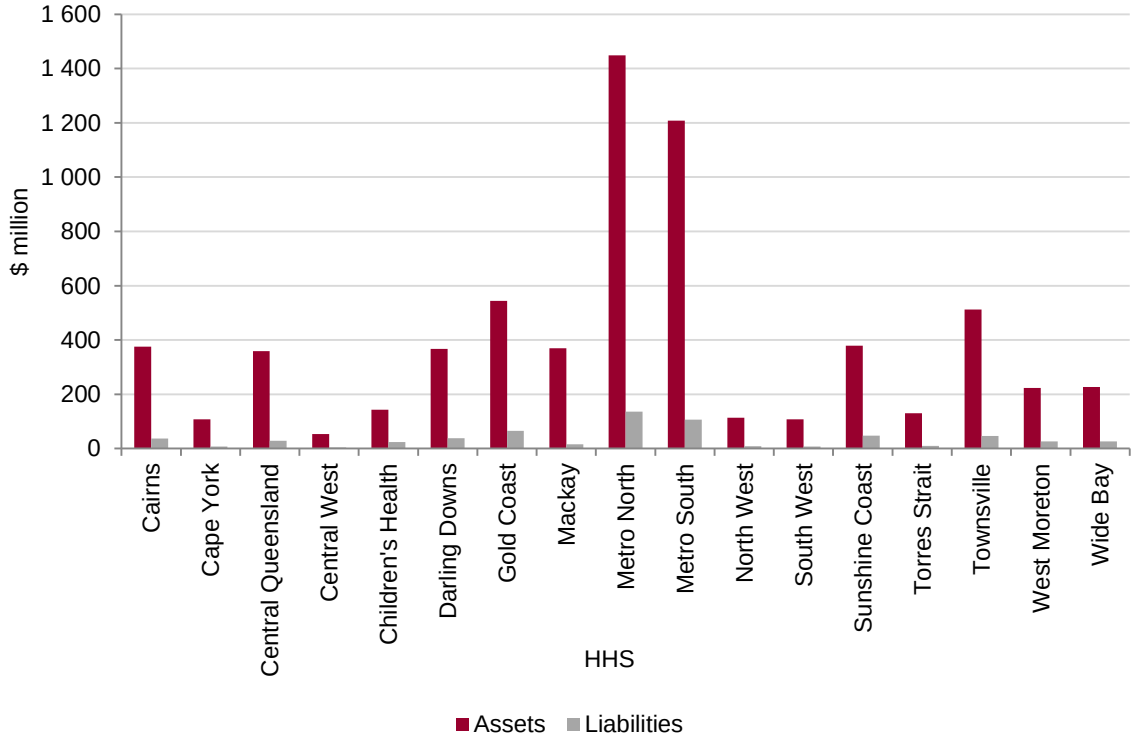
4.4 Financial position

The financial position of HHSs is generally measured by reference to their net assets—the difference between total assets and total liabilities.

HHSs hold significant physical assets in the form of land, buildings and medical equipment which require significant funds to meet operating costs, repairs, maintenance, replacement and renewal.

Figure 4R shows HHSs had total assets of $6.67 billion and liabilities of $0.64 billion at 30 June 2013.

Figure 4R
Financial position—total assets and liabilities



Source: QAO

On 1 July 2012, DoH transferred net assets of $5.49 billion to the HHSs. HHSs collectively had net assets of $6.03 billion at 30 June 2013, an overall net increase of $539.31 million. The net increase was primarily due to increases in cash of $476.13 million, receivables of $51.03 million and property, plant and equipment values of $344.04 million, offset by an increase in liabilities of $339.58 million.

4.4.1. Assets

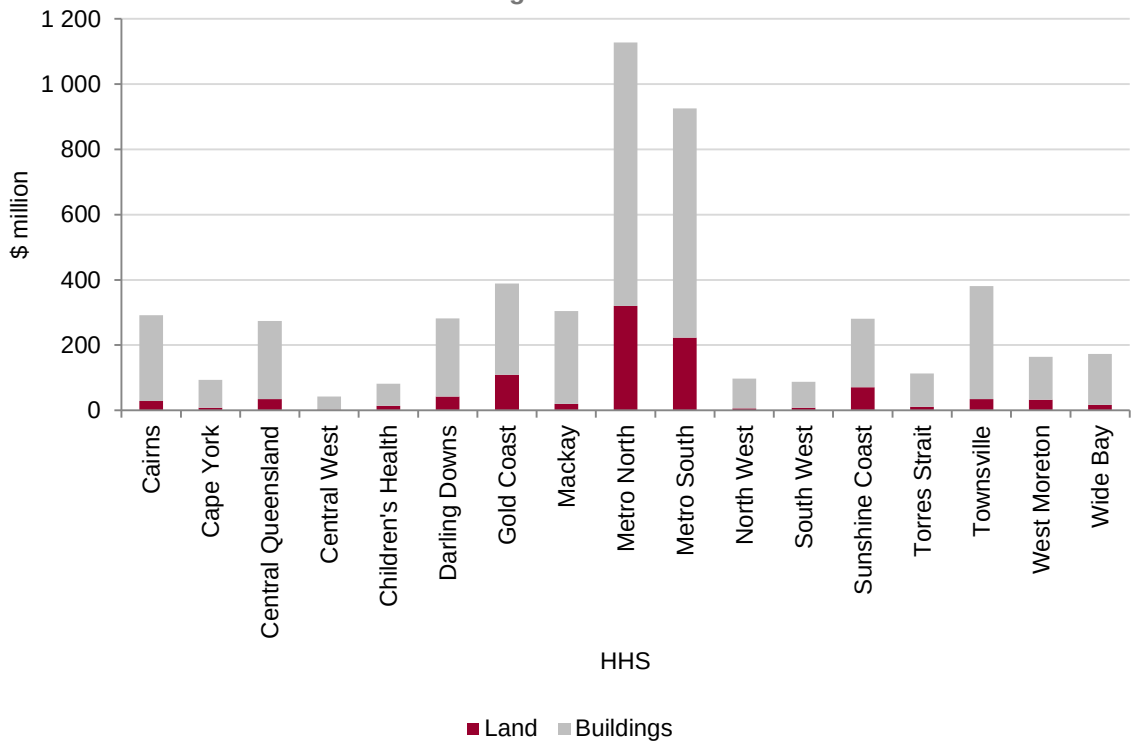
Land and buildings

Land and building assets comprised $5.11 billion (76.6 per cent) of the total reported assets of the sector at 30 June 2013.

Depreciation on HHSs' buildings for the year totalled $212.43 million, representing 5.1 per cent of the value of the buildings portfolio. This rate of depreciation indicates that the overall HHSs' buildings portfolio had an average remaining useful life of around 20 years.

Figure 4S shows the value of land and buildings at 30 June 2013 by HHS.

Figure 4S
Land and buildings values at 30 June 2013



Source: QAO

Revaluations of land and buildings

Land and buildings were stated at their fair value at 30 June 2013 in accordance with AASB 116 *Property, Plant and Equipment.* To ensure that asset values remain current, each HHS is required to annually assess its assets for fair value, either by using experts such as professional valuers or quantity surveyors or by applying an appropriate price index.

Land assets controlled by HHSs were valued by the State Valuation Service. The valuation was based on a market survey of all local government areas and consultation with local government and industry groups. Overall, the movement in the fair value of land was flat across all HHSs.

Buildings controlled by HHSs were externally valued by a professional valuer using the depreciated replacement cost (DRC) method. DRC is used as an alternative to market value where assets cannot be bought and sold on the open market. This method takes into account the cost of replacing the asset, based on its current use and adjusted for the condition of the asset and the remaining useful life.

Revaluations of land and building assets resulted in a net increase in values across the HHS sector of nearly $100 million, comprising the value of land declining by $5.37 million or 0.6 per cent while building values increased by $102.89 million or 2.5 per cent.

As this was the first year of operation for HHSs, no asset revaluation reserves had been established on 1 July 2012. Any decreases in values in 2012–13 were counted as an expense, directly affecting the operating results of the HHS.

We identified improvement opportunities in the valuation process which can reduce the risks of valuation errors from incomplete and inconsistent information on assets and costs used by the valuers and can reduce delays in finalising the annual valuation process:

- early finalisation of the valuation process, preferably by 30 April
- oversight of the process by the audit committee
- preparation of a valuation plan identifying specific assets to be subject to full valuation or use of valuation indices
- ensuring valuation estimates are supported by complete and accurate documentation
- consideration and endorsement of valuation results by the HHS's board.

Asset transfers from DoH

Under the current arrangements between DoH and HHSs, DoH is responsible for the funding and construction of all major infrastructure assets. Once completed, the asset is transferred at no cost to the HHS, through a transfer notice approved by the Minister for Health.

When assets are received by an entity for no monetary or other consideration, they may be recognised at their fair value and as a revenue inflow in the statement of comprehensive income; however, as allowed under Queensland Government accounting practices, the Minister has authorised and prescribed that assets transferred to HHSs are to be recognised as an equity transfer in the balance sheet, rather than through the statement of comprehensive income.

Figure 4T shows the value of the material assets transferred during the year (>$10 million) and DoH's capital works in progress at 30 June 2013 (>$30 million).

Figure 4T
Material completed and in progress projects

HHS	Completed assets transferred > $10 m $ m	DoH capital works > $30 m $ m
Cairns and Hinterland	21.90	197.69
Central Queensland	12.50	66.34
Children's Health Queensland	—	779.31
Gold Coast	—	1 414.38
Mackay	188.54	51.59
Metro North	64.60	41.79
Metro South	30.13	81.18
Sunshine Coast	17.70	111.02
Torres Strait and Northern Peninsula	28.61	—
Townsville	20.01	133.69
West Moreton	—	69.94
Total	**383.99**	**2 946.93**

Source: QAO

The value of all completed assets transferred to HHSs in 2012–13 totalled $434.68 million. DoH's total capital works in progress balance at 30 June 2013 of $3.10 billion includes assets that will be transferred to HHSs when projects are completed.

Completed assets transferred by DoH to HHSs during 2012–13 included:

- hospital redevelopments in Cairns, Rockhampton, Townsville, Mackay and Mount Isa
- enhancements to mental health services in Mackay, Caboolture and Logan
- upgrades to emergency departments in Logan, Caboolture, Ipswich, Redlands, Prince Charles Hospital and QEII Hospital.

Debtors

At 30 June 2013, HHSs were owed a total of $264.66 million; an increase of $51.03 million from the balance transferred to HHSs on 1 July 2012. Of this balance, $127 million was due to expected grant funds not yet received with the remainder being primarily unpaid patient accounts.

The most common reasons for long outstanding patient debts were that these were incurred by international travellers or students with no medical insurance, patients who absconded without payment and disputes over the services rendered or the price charged.

During 2012–13, $12.82 million of debts were written off as bad debts (2012:$20 million) while overall, HHSs have estimated that it is doubtful that 7.5 per cent ($19.99 million) of total debts owed to HHSs will be collected.

4.4.2. Liabilities

Total liabilities at 30 June 2013 were $635.70 million, an increase of $339.58 million from the balance of liabilities transferred to HHSs on 1 July 2012. Of the total liabilities, $341.15 million were owed by HHSs to DoH for salaries and wages costs of the health service employees.

The HHSs have reported $623.97 million in expenditure commitments over the next five years. Generally, a commitment arises when a decision is made to incur a liability through a purchase contract (or similar arrangement). Reported operating commitments for Sunshine Coast HHS were 81.5 per cent of the total of all HHS commitments. HHSs' commitments included $508.25 million to procure public health services from private health providers.

HHSs are required under Queensland Treasury and Trade's financial reporting requirements to disclose information on cases subject to litigation. At 30 June 2013, 146 cases are filed with the courts across the HHSs. Litigation is underwritten by the Queensland Government Insurance Fund. The HHSs' maximum financial exposure under this scheme is up to $20 000 for each insurable event.

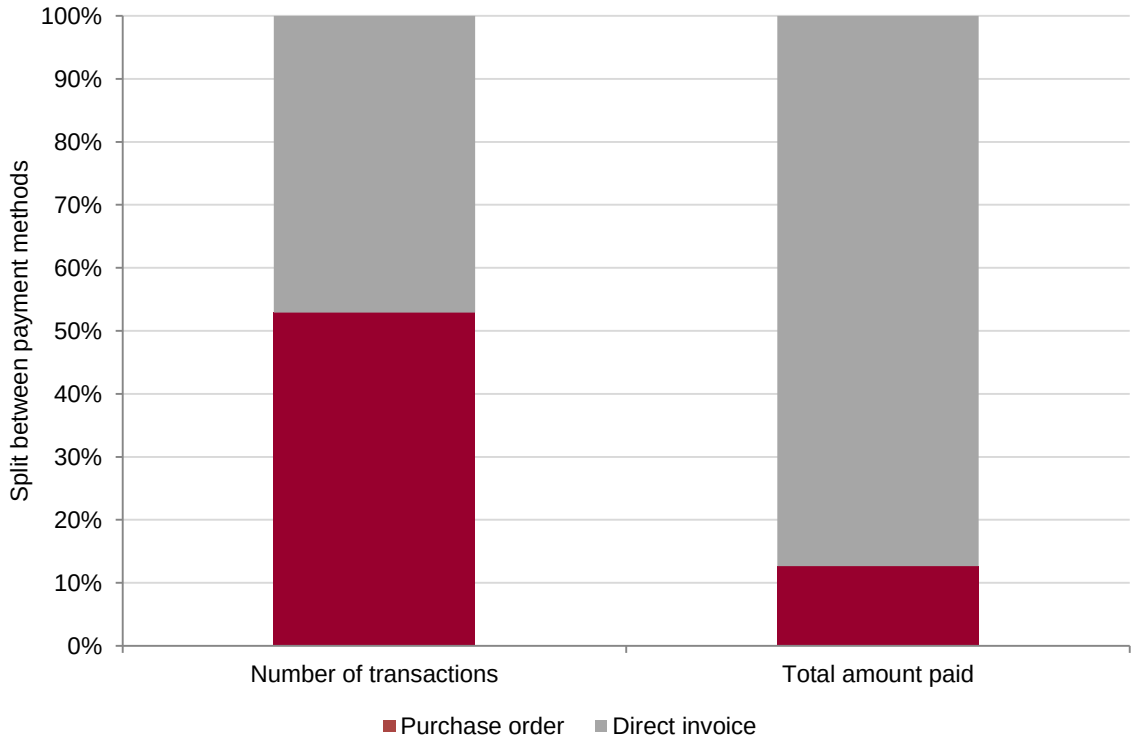
Accounts payable

More than one million expenditure transactions were processed in the HHS sector during the year. Supplies and services costs totalled $2.44 billion for 2012–13.

The two most common forms of purchasing and paying for goods and services across HHSs are by direct invoice and by order/invoice where a purchase order is raised and approved for every transaction. Ordinarily, there is stronger control in confirming the validity and accuracy of purchases when an invoice can be agreed with a purchase order. HHSs address the risk around direct invoices by requiring authorisation by three independent delegated officers.

Figure 4U shows that, while only 47.1 per cent of transactions were made by the direct invoice method, these purchases represent 87.4 per cent of the total value of all goods and services purchased.

Figure 4U
Expense payment methods—number and value



Source: QAO

Purchases of goods and services by corporate credit card accounted for 0.15 per cent of the value of expense transactions across HHSs, with the average value of credit card transactions being $247.

South West HHS uses corporate cards as its preferred method of paying for low risk and low value goods and services. South West HHS had more than one and a half times the average number of corporate card transactions. Mackay HHS had more than one and a half times fewer corporate card transactions than the HHS average. Generally, the rural and remote HHSs had a higher proportion of their suppliers paid by corporate card, reducing the need to forward documentation to DoH processing centres and avoiding delays in making payment to local suppliers.

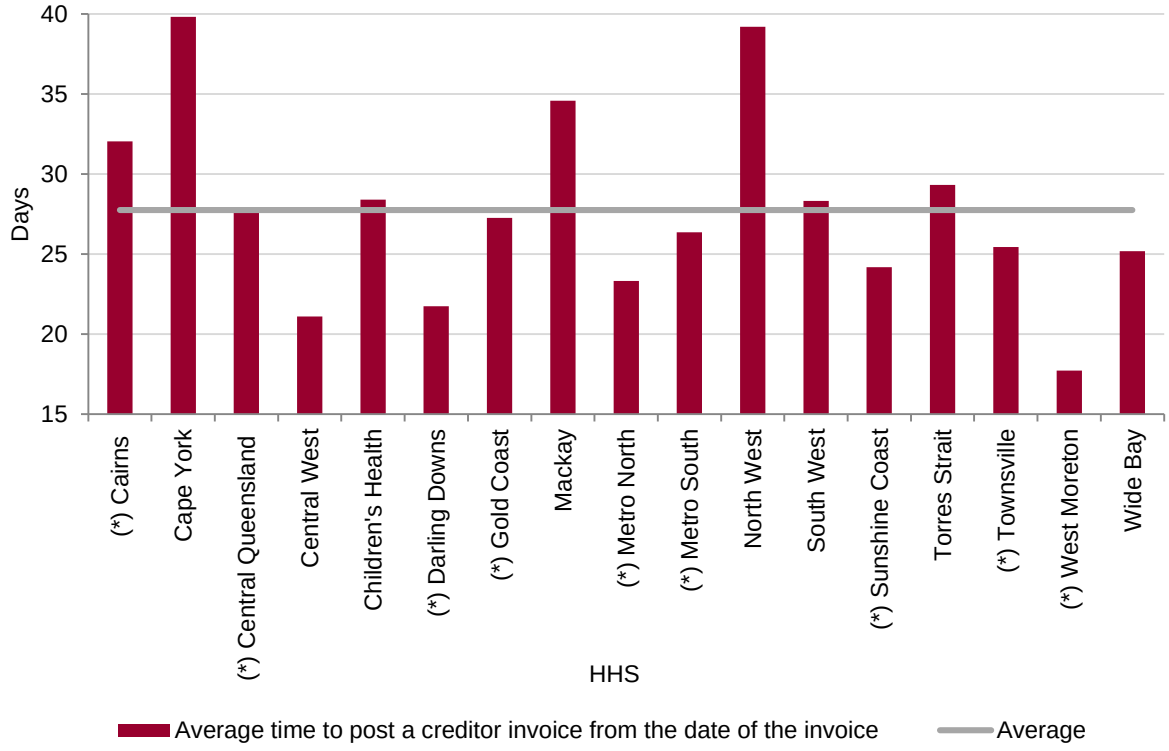
The use of corporate cards as the preferred payment method for low risk and low value goods and services requires further consideration by all HHSs as processing and other costs are considerably lower than other payment methods.

The terms by which HHSs pay their creditors are disclosed in their annual financial statements, including the length of time it takes to pay. Fewer than half of the HHSs have terms of 30 days or less and three HHSs have terms of 60 days or more.

Across HHSs, the average time taken from the creditor invoice date to when the invoice is processed into the financial system is 27.8 days. It can take longer when the HHS is not located near a DoH processing site. DoH performs the invoicing processing and payment function for all HHSs when the required supporting documentation is provided by the HHS.

Figure 4V shows, by HHS, the average time between invoice date and processing date.

Figure 4V
Elapsed time (days) between creditor invoice date and processing date



(*) Denotes where a DoH processing centre is located

Source: QAO

Also contributing to processing delays is the time taken to obtain the manual authorisations for invoice processing and payment from the required three independent delegated officers, when these officers may be located at different facilities within the HHS region. In 2012–13, DoH successfully piloted an automated accounts payable system at West Moreton HHS with results showing that invoices were processed for payment ten days earlier than the average. This automated accounts payable system reduces the delay around manual authorisations and the wait by DoH for the supporting documents for processing.

On 1 July 2013, the government introduced the late payment policy for small businesses. Under this policy, invoices must be paid within 30 days or interest will accrue on the amount owing. This applies to contracts up to $1 million submitted correctly on undisputed tax invoices. Small businesses with fewer than 20 employees at the contract date are eligible for late payment interest.

This late payment policy does not presently apply to HHSs; however, it provides a reasonable creditor payment benchmark for HHSs to achieve.

4.5 Financial sustainability

Financial sustainability examines the capacity of HHSs to meet current and future expenditure as it falls due and to absorb foreseeable changes and emerging risks without significantly changing their revenue and expenditure policies.

Short term indicators assess the ability of HHSs to maintain a positive operating cash flow and adequate cash holdings and to generate an operating surplus.

Long term indicators assess whether there is adequate funding available to cover long term debt and for spending on asset replacement. Long term financial sustainability around these aspects has not been assessed because all HHSs are in a sound position under current arrangements.

Currently, no HHS has loan borrowings, particularly because major infrastructure assets are constructed and funded by DoH and transferred to HHSs at no cost to HHSs. While HHSs are responsible for the maintenance of infrastructure assets, HHSs will be provided with specific funding during 2013–14 to fund backlog maintenance. During 2012–13, each HHS was also funded specifically for the depreciation expense in respect of its non-current physical assets.

Appendix D describes in more detail the financial sustainability ratios we used to assess HHS sustainability.

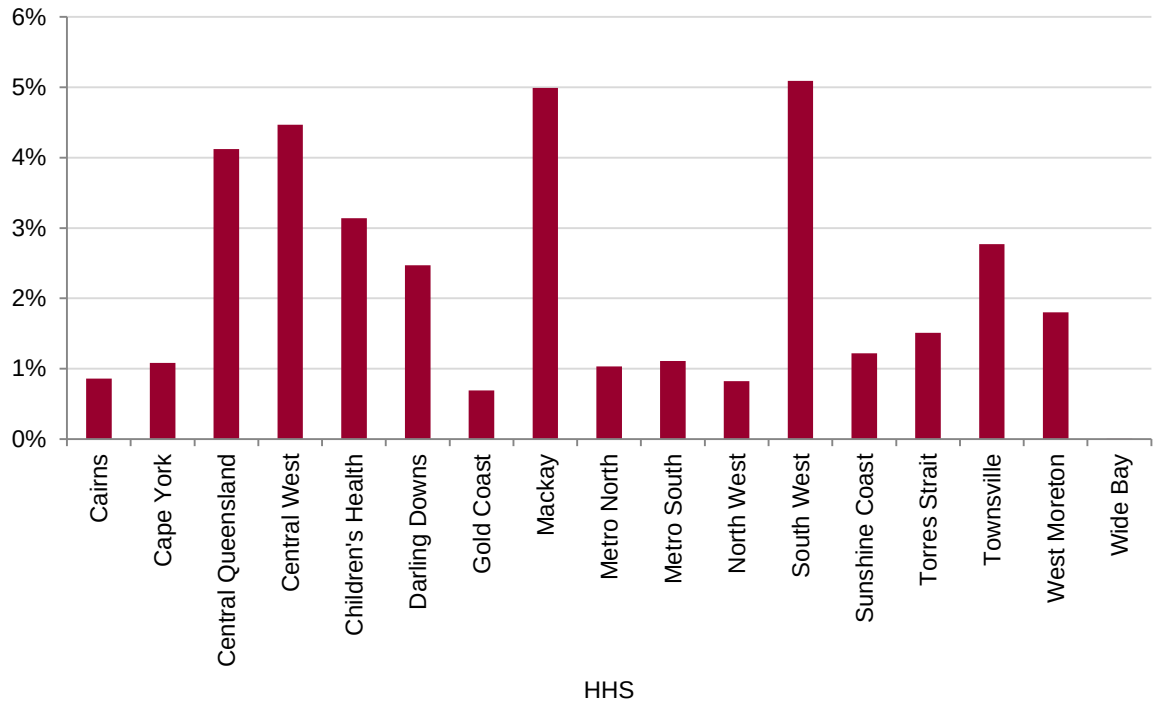
4.5.1. Short term financial sustainability indicators

Operating ratio

The operating ratio indicates the extent to which operating revenue covers operating expenses. A higher ratio indicates a better growth capacity to meet current and future operating and capital expenditure obligations.

Figure 4W shows the operating ratios as at 30 June 2013 achieved by each of the 17 HHSs in the first year of operation.

Figure 4W
Operating ratio



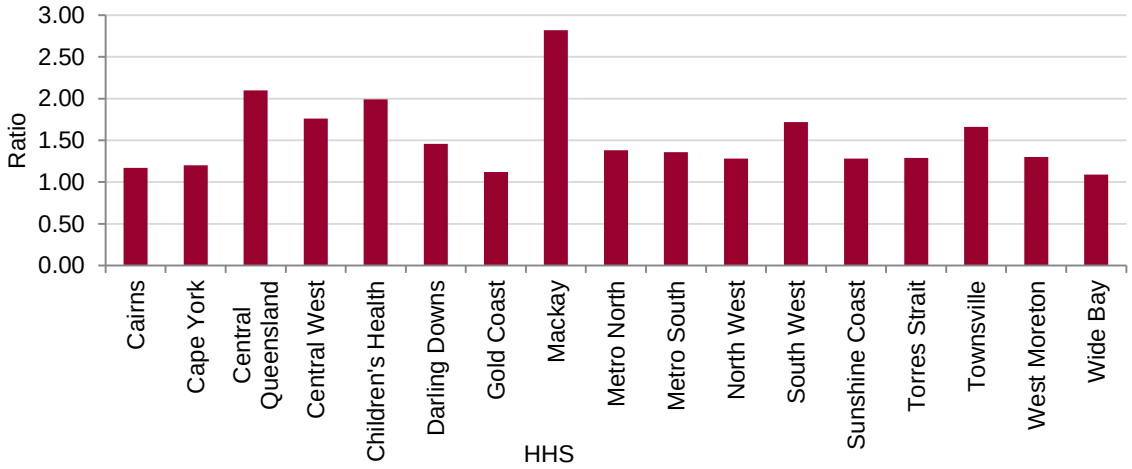
Source: QAO

The target for each HHS as specified in the service agreement is a balanced or surplus operating result. All HHSs have achieved this result, reflecting a favourable short term position for all HHSs.

Current ratio

The current ratio measures the ability to pay existing short term liabilities with current liquid assets (cash, inventories, receivables). A ratio of one or more means there is more cash and liquid assets than short term liabilities. The higher the current ratio, the more capable the HHS is of paying its obligations. Figure 4X shows that all HHSs have adequate liquidity as at 30 June 2013 to meet their short term liabilities as they fall due.

Figure 4X
Current ratio

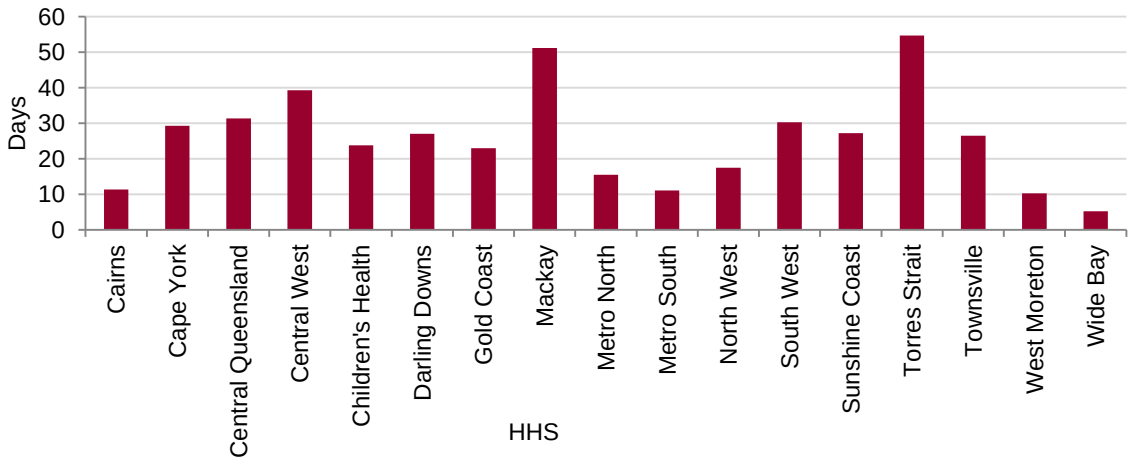


Source: QAO

Number of days cash available indicator

Each HHS is responsible for its own cash management. However its ability to manage its cash prudently is significantly affected by its dependency on the fortnightly funding payments from DoH. Figure 4Y shows the number of days HHSs could meet operating expenses with current available unrestricted cash without further revenue at year end. Good financial management supports HHSs having unrestricted cash holdings equivalent to at least 14 days of operating cash outflows.

Figure 4Y
Number of days that cash is available



Source: QAO

Thirteen HHSs had sufficient cash available to cover more than two weeks of operating costs and five could cover 30 days or more.

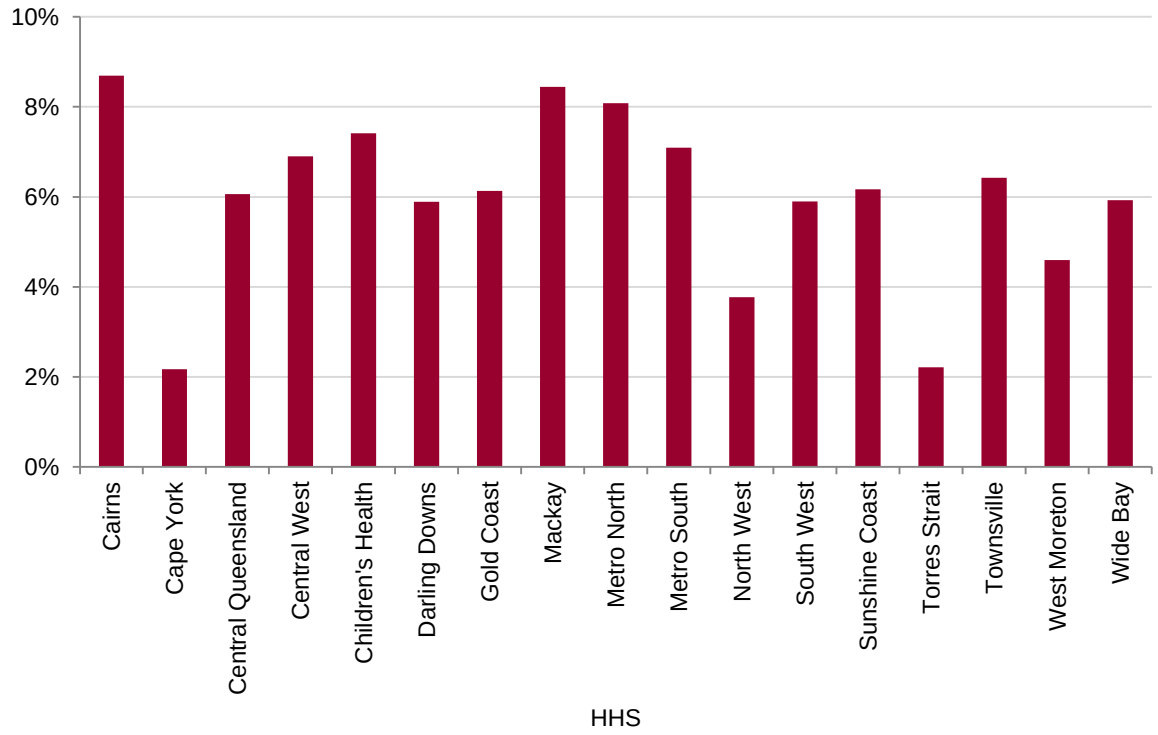
Own source revenue

Own source revenue (OSR) arises from the billing of those patients who come into the public system and elect to be treated as private patients. DoH has directed more effort and attention be given to increasing OSR across HHSs through more effective identification of those patients with health or other relevant insurance for billing as private patients.

Increasing the level of OSR provides additional support for the maintenance and further development of health services and financial growth and sustainability.

Figure 4Z provides a comparison of each HHS's OSR revenue as a percentage of its total revenue. The greater the percentage, the higher the billing of private patients fees against health services provided.

Figure 4Z
Own source revenue as a percentage of total revenue



Source: QAO

5. Operational efficiency

In brief

Background

The operational efficiency of Hospital and Health Services (HHSs) is measured by how well they have used their financial resources to deliver health care services to the community. The services to be delivered are agreed between each HHS and the Department of Health (DoH) and are included in a service agreement. The service agreement includes specific benchmarks against which services delivered are monitored to improve the timeliness, quality, safety, cost efficiency and volume of services provided to the community.

Conclusions

The importance of hospital efficiency is emphasised by the new Activity Based Funding (ABF) model because, by improving operational efficiency within hospitals, there is an opportunity to fund additional services.

The key challenges facing HHSs to achieve operational performance efficiencies include increasing the number of health care services without compromising quality and measuring performance by the achievement of patient targets rather than the efficient use of resources.

Challenges will also arise around funding the public hospital system if the cost of services continue to increase at the current rate. Continuous improvement in operational effectiveness in cost and productivity is essential for HHSs to be able to continue to deliver the required quality and level of health care services.

Key findings

- With the implementation of the ABF model, funding will be provided for most public hospital services based on an agreed number of patient health care services at a price determined by the Commonwealth.
- ABF is in a transitional phase until 1 July 2014, providing HHSs with the time to develop capabilities to monitor activities, to implement robust systems and controls to capture reliable and complete patient activity data and to achieve efficiencies to reduce the cost of delivering health care services in the public hospital system.
- The costs to fund operations is significant and increasing with a growing and ageing population, placing increasing pressure to deliver the same or improved health care services if not matched by proportionate funding growth.
- Generally across the 13 HHSs receiving ABF, the 2013–14 KPIs' targets are higher than achieved in 2012–13.
- Six of the 13 HHSs were less efficient when measured against the Queensland Efficient Price (QEP).

5.1. Background

Under the National Health Reform Agreement in August 2011, the states and territories committed to major changes in the way that health services are funded and governed. These changes took effect from 1 July 2012.

The key objectives of the Agreement are to achieve improvements in the efficiency and capacity of public hospitals to deliver health care services and to ensure the sustainability of the health system throughout Australia. The Commonwealth's intention is to increase its funding contribution for public hospital services and to be the major funder of public hospital services over the long term. The challenge facing the state is to maximise this contribution and the efficient and cost effective use of this funding.

The core driver of the Agreement's objectives is the introduction of Activity Based Funding (ABF), whereby funding for most public hospital services will be based on an agreed number of patient health care services at a price determined by the Commonwealth.

Eligible public hospital services within all HHSs will continue to be funded through block grants, or a combination of block grants and ABF to ensure HHSs have the appropriate capacity to deliver the expected services. The Agreement recognises that some eligible public hospital services and hospitals in regional, rural and remote communities will be better funded through block grants particularly where the services would not be financially viable under ABF. Block grants are not based on levels of public health care activity.

The funding to four HHSs that do not receive ABF—Cape York, Central West, South West and Torres Strait and Northern Peninsula HHSs—will continue, primarily with block funding.

While the Commonwealth's activity based funding to the state for the two financial years, 2012–2014, is provided as ABF grants, the amount is calculated on the funding framework used in previous years. These two transitional years provide the opportunity to improve public hospital efficiencies in the delivery of the number and cost of services provided. From 2014–15, the majority of Commonwealth funding for eligible public hospital services will be provided under the ABF mechanism.

The Independent Hospital Pricing Authority (a Commonwealth statutory authority) determines the hospital health care services (activities) eligible for funding and the national efficient price (NEP) by which these activities across Australia will be funded. Consequently if the cost at which the HHS provides its services is greater than this NEP, the HHS either reduces its number of activities or the state increases its funding to support the HHS to remain financially sustainable. Conversely, if any HHS can deliver activities at a lower price than the NEP, more hospital services may be provided across the state.

A service agreement between each HHS and DoH defines the hospital, teaching, research and other health services that are to be provided by the HHS and the funding to be provided for the delivery of these services. The service agreement also defines the key performance indicators (KPIs) and their associated targets that the HHS will be required to meet for the provision of services.

The KPIs cover HHSs' performance across four health service delivery areas:

- Effectiveness—safety and quality
- Equity and effectiveness—access
- Efficiency—efficiency and financial performance
- Effectiveness—patient experience.

As the overall manager of public health system performance and to ensure delivery of services in line with the service agreement, DoH has implemented a Hospital and Health Services performance management framework which sets out the systems and processes that DoH will employ to fulfil its responsibilities. These processes include assessing and rating HHSs' performance and the monitoring and managing of this performance. DoH publishes information about HHSs' performance on its website.

5.2. Conclusions

Improving operating effectiveness involves implementing strategies to deal with the challenges of achieving lean and efficient operations without compromising the quality of services. The challenges of sustainably financing the cost of public hospital systems will be greater without productivity and efficiency improvements in the delivery of health care services.

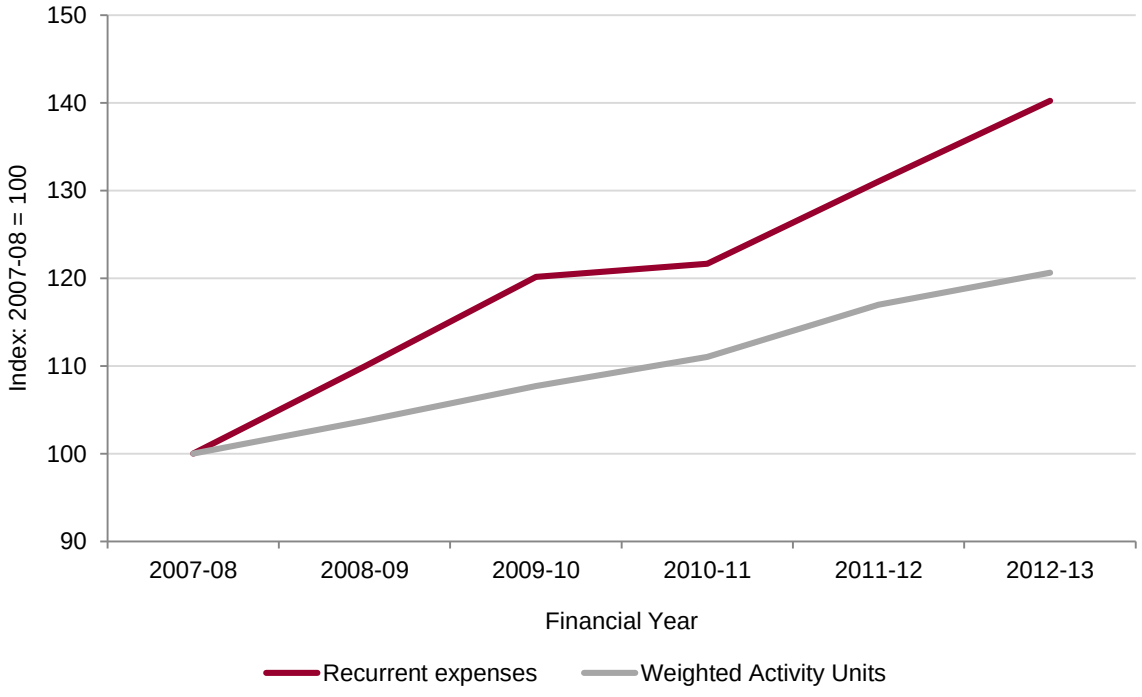
Strategies by HHSs and DoH to reduce costs, including by workforce reductions, are in place. The government has identified six key productivity targets for 2013–14. All HHSs will require operational performance and efficiency improvements to achieve these targets.

5.3. Cost of health care services

Public hospitals are a fundamental part of the state's health care system. The costs to fund operations is significant and increasing with a growing and ageing population, placing increasing pressure to deliver the same or improved health care services if not matched by proportionate funding growth.

Figure 5A shows that public hospital expenditure increased 40.2 per cent between 2007-08 and 2012–13, yet activity only increased by 20.7 per cent.

Figure 5A
Queensland public hospital expenditure and activity trends



Source: DoH

Challenges will arise around funding of the public hospital system if the cost of services continues to increase at the current rate. Continuous improvement to operational effectiveness in cost and productivity is essential for HHSs to be able to continue to deliver the required quality and level of health care services.

In February 2013, the state government released its Blueprint for better healthcare in Queensland as its action plan to improve the productivity, care and efficiency in public hospitals across the state, with the objective to meet and surpass national benchmarks. This document included six key statewide health service KPIs, primarily for the 13 HHSs receiving ABF, with the intention to make these HHSs more accountable for their performance in these areas.

The six KPIs are aimed at achieving:

- shorter stays in emergency departments
- shorter waits for elective surgery
- shorter waits for specialist outpatient clinics
- increased support for families with newborns
- fewer hospital acquired infections
- better value for money.

From 1 July 2013, there will be regular monitoring and assessment for these six KPIs of performance against targets, with quarterly public reporting by HHSs. These and other financial and service KPIs are included in the service agreement.

Generally across the 13 HHSs, the 2013–14 Blueprint KPIs' targets are higher than achieved in 2012–13. HHSs face a challenge to meet specified efficiency performance targets while, at the same time, maintaining the overall quality and achieving cost efficiencies in the delivery of health care services.

5.4. Activity based funding

One of the objectives of the HHSs' service agreement is to facilitate the progressive implementation of a purchasing framework under the ABF mechanism. ABF is in a transitional phase until 1 July 2014, providing HHSs with the time to develop capabilities to monitor activities, to implement robust systems and controls to capture reliable and complete patient activity data and to achieve efficiencies to reduce the cost of delivering health services.

Annually, the Independent Hospital Pricing Authority determines the NEP for public hospital services based on an analysis of data on actual activity and costs gathered from public hospitals throughout Australia. NEP is basically the average cost of providing a range of public hospital services.

The Independent Hospital Pricing Authority pricing model also includes establishing the National Weighted Activity Unit (NWAU) for hospital services. Basically, NWAU provides the unit of measure of hospital services. While the average hospital service may be worth one NWAU, more intensive and expensive activities are worth multiple NWAUs. Conversely, simpler and less expensive activities are worth fractions of a NWAU.

The price of a hospital service is then determined by multiplying the NEP by the total number of weighted activity units. The Commonwealth will provide its funding based on this calculation.

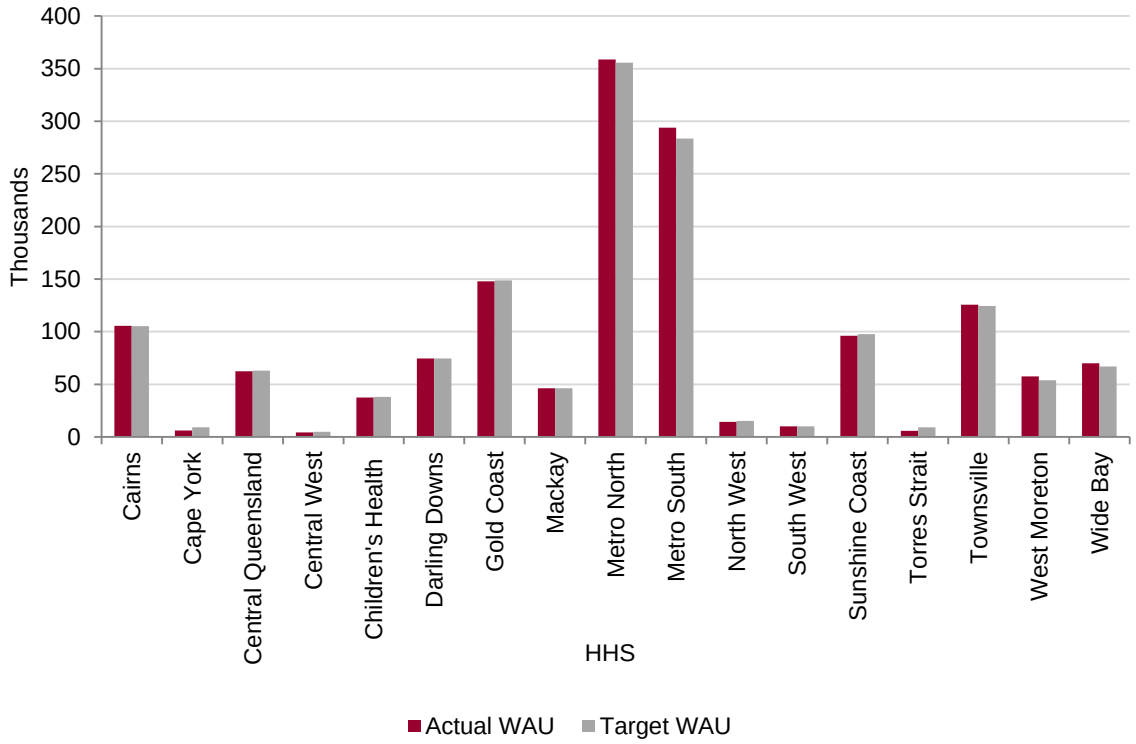
For DoH's monitoring function, HHSs determine their actual number of weighted activity units (WAU) achieved in six categories for comparison to the KPIs' WAU targets recorded in the service agreement of each HHS.

Hospital functions are grouped into the following six categories of KPIs:

- Emergency department and emergency services
- Outpatients (non-admitted)
- Sub and Non-Acute Patients (SNAP)
- Mental health
- Acute care
- Critical care.

Figure 5B compares the total 2012–13 actual weighted activity units of the six categories to the key performance indicator targets for each HHS.

Figure 5B
Total actual weighted activity unit compared to key performance indicator targets



Source: DoH

Total actual weighted activity units for all HHSs was 1.52 million, which was 0.7 per cent higher than the total key performance indicator target of 1.51 million. Six of the 13 HHSs under the ABF model failed to achieve their total target. The greatest variances were West Moreton HHS which exceeded its target total by seven per cent and North West HHS which was below its target total by six per cent. The four block funded HHSs failed to achieve their total target.

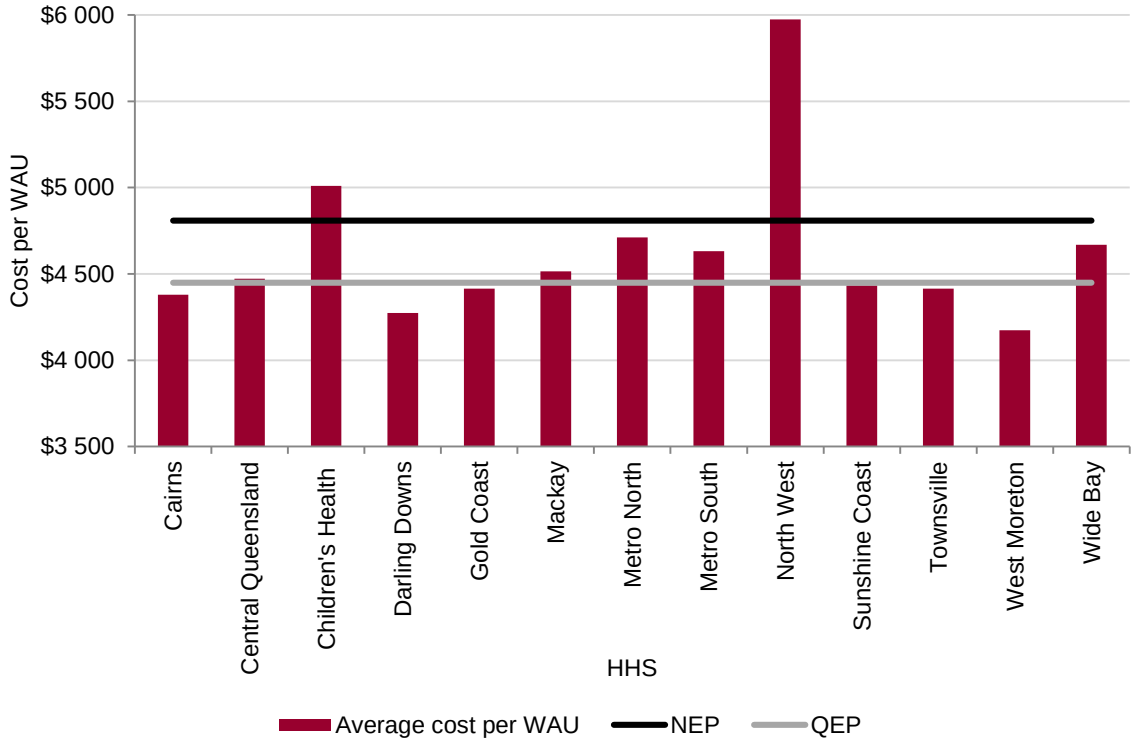
Only two categories' totals—mental health and critical care—were below the key performance indicator total targets, by 2.1 per cent and 5.8 per cent respectively. No HHS met its targets in all six categories.

To maximise the benefit of funds received under ABF requires HHSs to achieve cost efficiencies in the delivery of health services. The lower the cost compared to NEP, the more funding that remains to deliver additional services across the state.

Figure 5C compares, for 2012–13, the actual average cost per weighted activity unit for each HHS to NEP and to a Queensland efficient price for those 13 HHSs that will be funded under the ABF model. DoH prepares a Queensland efficient price (QEP) to exclude some components of the NEP that are borne by DoH rather than HHSs to provide a better comparison of an average price that HHSs need to achieve. The QEP for 2012–13 was $4 450 and is a key performance indicator target recorded in the service agreements.

Figure 5C shows that six of the 13 HHSs were less efficient when measured against QEP. The consequences for inefficiencies under ABF will mean the state will be required to provide additional funding to maintain essential health care services, rather than the Commonwealth.

Figure 5C
Average cost per weighted activity unit comparison



Note: The 2012–13 NEP per NWAU was $4,808 (2013–14: $4,993).

Source: DoH

A key objective of the ABF model is to provide financial incentives to achieve efficiencies in the delivery of public hospital services. The challenge for HHSs is to maintain sustainable health services under ABF. To achieve this, it is crucial that HHSs ensure systems and controls are in place that record health care activity data and costs accurately and completely to form the basis for ABF provided.

Appendices

Appendix A—Comments

Auditor-General Act 2009 (Section 64)—Comments received

Introduction

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

Responses were received from

- Children's Health Queensland Hospital and Health Service
- Darling Downs Hospital and Health Service
- Metro North Hospital and Health Service
- Sunshine Coast Hospital and Health Service.

These views have been considered and are represented to the extent relevant and warranted in preparing this report. Responsibility for the accuracy, fairness and balance of the comments rests with the head of these entities.

A fair summary of the comments received within 21 days is included in this Appendix.

Comments received

Response provided by the Chief Executive, Darling Downs Hospital and Health Service on 14 November 2013:

> *…3.3.4 Monitoring - CFO statement of assurance: The HHS notes that a statement of assurance was provided to the Board Chair as the responsible officer to sign the management certificate on behalf of the Board rather than the Chief Executive.*
>
> *4.5 Financial sustainability: The HHS notes the need for future capital replacements. However currently the Department's funding principals of HHSs are that the HHS should not fund major capital replacement but break even on operating expenses.*
>
> *4.3.2 DoH health service employee costs: The report mentions that DoH health service employee costs exceeded the original budget for 2012-13 by $376 million. This is largely due to significant devolution of functions previously held by DoH as well as redundancies paid by HHSs reimbursed by Treasury.*
>
> *5.4 Activity based funding: There is a general theme that ABF funding means that HHSs can invest in additional services if they are deemed to be efficient. For example there is a comment that "The lower the cost compared to NEP, the more funding that remains to deliver additional services …'. However HHSs are historically funded through the transition payment, meaning that any difference between actual efficiency and NEP cannot automatically be invested in new services. Put simply, cost efficient services like Darling Downs Hospital and Health Service (DDHHS) have their revenue under ABF discounted by the Department of Health limiting the ability to provide additional services..*
>
> *5.4 Activity based funding: The chart (Figure 5B) refers to all WAU not just ABF facilities. The chart (Figure 5C) refers to ABF WAU costs. This may confuse the reader…*

Response provided by the Chair, Metro North Hospital and Health Board on14 November 2013:

> *…3.3.3 Control activities: Metro North agrees with the statements made and would like to add that the HHS and DoH need to work closely to develop processes to monitor and verify activities undertaken by DoH on behalf of the HHS. DoH is the system/process owner and the HHS is the user of the outcomes. In some instances the monitoring of DoH processing has been a challenge for Metro North due to the lack of reporting and data that is made available to the HHS.*
>
> *2.2 Conclusions: Metro North would also state that a challenge has been that the transfer process in itself had been a challenge due to delays in information provision and timeliness of the transfers.*
>
> *4.4.2 Liabilities – Accounts payable: Metro North can influence the time it takes to make payment to a creditor, however cannot be solely responsible for this as DoH provide the accounts payable function to the HHS. Metro North and DoH have been working together to make this process as efficient as possible.*
>
> *4.5.1 Short term financial sustainability indicators - Number of days cash available indicator: As noted, the HHS's cash balance is dependent on the fortnightly funding payment from DoH. It should also be noted that the cash balance is intrinsically linked to the service agreement and amendments of the service agreement. Delays in agreeing to amendments could impact the cash position…*

Response provided by the Chief Executive, Sunshine Coast Hospital and Health Service on 14 November 2013:

> *…5.3 Cost of health care services: This section and the accompanying graphic (Figure 5A) are significantly misleading as there is no reference to EB increases that applied throughout those years, nor is there any assessment of the costs devolved to HHS by Department of Health in areas such as IT, depreciation increase, nor non-ABF hospital based Initiatives funded by both the State and Commonwealth. These should have been assessed and factored into the equation…*

The response provided by the Chair, Children's Health Queensland Hospital and Health Service on 13 November 2013 has been addressed in finalising this report.

Appendix B—Status of HHS financial statements

Figure B1
2012–13 audit opinions

Audit	Financial statements signed	Opinion issued	Opinion	Certified by 31 August legislated timeframe
Cairns and Hinterland Hospital and Health Service	28.08.2013	30.08.2013	U	✓
Cape York Hospital and Health Service	29.08.2013	30.08.2013	U	✓
Central Queensland Hospital and Health Service	23.08.2013	30.08.2013	U	✓
Central West Hospital and Health Service	22.08.2013	29.08.2013	U	✓
Children's Health Queensland Hospital and Health Service	29.08.2013	30.08.2013	U	✓
Darling Downs Hospital and Health Service	27.08.2013	29.08.2013	U	✓
Gold Coast Hospital and Health Service	28.08.2013	30.08.2013	U	✓
Mackay Hospital and Health Service	30.08.2013	30.08.2013	U	✓
Metro North Hospital and Health Service	27.08.2013	30.08.2013	U	✓
Metro South Hospital and Health Service	27.08.2013	29.08.2013	U	✓
North West Hospital and Health Service	23.08.2013	30.08.2013	U	✓
South West Hospital and Health Service	29.08.2013	30.08.2013	U	✓
Sunshine Coast Hospital and Health Service	30.08.2013	30.08.2013	U	✓
Torres Strait and Northern Peninsula Hospital and Health Service	30.08.2013	30.08.2013	U	✓
Townsville Hospital and Health Service	26.08.2013	28.08.2013	U	✓
West Moreton Hospital and Health Service	26.08.2013	28.08.2013	U	✓
Wide Bay Hospital and Health Service	27.08.2013	30.08.2013	U	✓

Opinion key:

U = unmodified

Q = qualified

A = adverse

E = emphasis of matter

D = disclaimer

Source: QAO

Appendix C—Better practice for preparation of financial statements

Figure C1
Selected better practice—preparation of financial statements

Key area	Better practice
Financial report preparation plan	Establish a plan that outlines the processes, resources, milestones, oversight and quality assurance practices required in preparing the financial report
Preparation of pro forma financial statements	Prepare pro forma financial statements before 30 April and provide to the auditors to enable early identification of amendments, minimising the need for significant disclosure changes at year end
Materiality assessment	Assess materiality, including quantitative and qualitative thresholds, at the planning phase in consultation with the audit committee; the assessment assists preparers in identifying potential errors in the financial report
Monthly financial reporting	Adopt full accrual monthly reporting to assist in preparing the annual financial report; this allows for the year end process to be an extension of the month end process
Rigorous quality control and assurance procedures	Require a review of the supporting documentation, data and the financial report itself by an appropriately experienced and independent officer prior to providing to the auditors
Supporting documentation	Prepare documentation of a high standard to support and validate the financial report and provide a management trail
Rigorous analytical reviews	Undertake rigorous and objective analytical review during the financial report preparation process to help to improve the accuracy of the report
Reviews of controls/self assessment	Establish sufficiently robust quality control and assurance processes to provide assurance to the audit committee on the accuracy and completeness of the financial report
Competency of staff	Require that staff members preparing the financial report have a good understanding and experience in applying relevant accounting standards and legislation; require that they also have project management and interpersonal skills
Adequate security	Protect and safeguard sensitive information throughout the process to prevent inappropriate public disclosure

Source: Australian National Audit Office (ANAO), Victorian Auditor-General's Office (VAGO) and QAO

Appendix D—Financial sustainability measures

The measures reflecting short term sustainability are detailed in Figure D1.

Figure D1
Short term sustainability measures

Measure	Formula	Description	Target
Current ratio	Current assets / current liabilities	Measures the ability to pay existing liabilities in the next 12 months	A ratio of 1 or more (more current assets than short term liabilities)
Operating ratio	Operating result / total operating revenue	The higher the ratio, the higher the capacity to meet current and future operating and capital expenditure obligations, as operating revenues more than cover operating expenses	A positive ratio (surplus operating result)
Average number of days cash available	Unrestricted cash / (total annual operating cash outflows / 365 days)	Measures the number of days of operating expenses that an entity could meet with its cash on hand at 30 June; unrestricted cash includes cash equivalents, but excludes cash held where the use has been restricted such as special purpose funds or patient money	30 days' cash supply for operating expenses
Own source revenue	Own source revenue / total revenue	Own source revenue is revenue generated by a HHS's own activities such as the billing of private patients	Maximise revenue through robust revenue identification and billing practices

Source: QAO

Appendix E—Queensland HHS areas

Figure E1
Hospital and Health Services by Queensland Health facilities

Source: DoH

Appendix F—Glossary

Figure F1
Glossary

Term	Definition
Accountability	Responsibility on public sector entities to achieve their objectives about the reliability of financial reporting, effectiveness and efficiency of operations, compliance with applicable laws, and reporting to interested parties
Australian Accounting Standards (AAS)	Australian accounting standards, including interpretations, are set by the Australian Accounting Standards Board (AASB) to be applied by: • entities required by the *Corporations Act 2001* to prepare financial reports • governments in preparing financial statements for the whole of government and the General Government Sector • entities in the private or public for profit or not for profit sectors that are reporting entities or that prepare general purpose financial statements
Australian Accounting Standards Board (AASB)	An Australian Government agency that develops and maintains financial reporting standards applicable to entities in the private and public sectors of the Australian economy
Acquisition	Establishing control of an asset, undertaking the risks and receiving the rights to future benefits, as would be conferred with ownership, in exchange for the cost of acquisition
Appropriate	Measures or indicators are appropriate if they provide users with sufficient information to assess the extent to which an entity has achieved a pre-determined target, goal or outcome
Asset	A resource controlled by an entity as a result of past events and from which future economic benefits are expected to flow to the entity
Asset useful life	The period over which an asset is expected to be available for use by an entity; the useful life of an asset may be different to the period of its physical life
Asset valuation	The process of determining the fair market value of an asset
Auditor-General Act 2009	An Act of the State of Queensland that establishes the responsibilities of the 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
Auditor's opinion	Positive written expression within a specified framework indicating the auditor's overall conclusion on the financial report based on audit evidence obtained
Cost benefit	Weighing the total expected costs against the total expected benefits of one or more actions in order to determine the best option
Depreciation	The systematic allocation of a fixed asset's capital value as an expense over its expected useful life to take account of normal usage, obsolescence, or the passage of time
Effectiveness	The achievement of the objectives or other intended effects of activities at a program or entity level
Efficiency	The use of resources so output is optimised for any given set of resource inputs or input is minimised for any given quantity and quality of output

Term	Definition
Expense	Outflow of cash or other assets from an entity to another person, company or entity
Financial Accountability Act 2009	An Act of the State of Queensland that establishes the accountability for the administration of the state's finances and for financial administration of departments and statutory bodies, as well as annual reporting to Parliament by departments and statutory bodies
Financial report	Structured representation of the financial information, which usually includes accompanying notes, derived from accounting records and is intended to communicate an entity's economic resources or obligations at a point in time or the changes for a period in accordance with a financial reporting framework
Financial and Performance Management Standard 2009 (FPMS)	Legislation of the State of Queensland that provides a framework for an accountable officer of a department or a statutory body to develop and implement systems, practices and controls for the efficient, effective and economic financial and performance management of the department or statutory body
Financial reporting requirements	Queensland reporting requirements for annual financial statements provided to assist departments and statutory bodies in the preparation of their financial statements: the requirements provide updates on new and revised accounting policies and standards and additional guidance and advice on the application of such policies and standards
Financial sustainability	An entity's ability to manage financial resources so it can meet its spending commitments both at present and into the future
Financial year	The period of 12 months for which a financial report is prepared
Fraud	An intentional act by one or more individuals among management, those charged with governance, employees or third parties involving the use of deception to obtain an unjust or illegal advantage
Fraud risk factors	Events or conditions that indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud
Going concern	Means an entity is expected to be able to pay its debts as and when they fall due and continue to operate without any intention or necessity to liquidate or wind up its operations
Governance	The control arrangements in place at an entity that are used to govern and monitor its activities to achieve its strategic and operational goals
Hospital and Health Services (HHS)	Entities established as statutory bodies under the *Hospital and Health Boards Act 2011* which are independently and locally controlled by a Hospital and Health Board
Hospital and Health Boards Act 2011	An Act of the State of Queensland which sets out financial reporting and annual reporting requirements for Hospital and Health Boards
Information system	A component of internal control that includes the financial reporting system, and consists of the procedures and records established to initiate, record, process and report entity transactions (as well as events and conditions) and to maintain accountability for the related assets, liabilities and equity
Internal control	The process designed, implemented and maintained by those charged with governance, management and other personnel to provide reasonable assurance about achieving reliability of financial reporting, effectiveness and efficiency of operations and compliance with applicable laws and regulations; internal controls play an important role in preventing and detecting error and fraud and protecting the entity's resources

Term	Definition
Internal audit	An appraisal activity established or provided as a service to the entity, internal audit functions include examining, evaluating and monitoring the adequacy and effectiveness of internal control and reporting deficiencies to management
Legislative time frame	The date prescribed by legislation for a public sector entity to finalise its financial statements or annual report
Liability	A present obligation of the entity arising from past events, the settlement of which is expected to result in an outflow of resources from the entity
Machinery of government change	A significant change to the interconnected structures and processes of government, such as the functions and accountability of departments
Materiality	Depends on the size or nature of the item or error judged in the particular circumstances of its omission or misstatement; information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements
Misstatement	A difference between the amount, classification, presentation or disclosure of a reported financial report item and the amount, classification, presentation or disclosure that is required for the item to be in accordance with the applicable financial reporting framework; misstatements can arise from error or fraud
Net assets	Total assets less total liabilities
Net result	Calculated by subtracting an entity's total expenses from its total revenue to show what the entity has earned or lost in a given period of time
Net operating balance	Measure of the ongoing sustainability of the ordinary operations of government, net operating balance is determined as the excess of revenues over expenses; it excludes capital expenditure, but includes non-cash costs such as accrued employee entitlements and depreciation—by including all accruing costs, including depreciation, it encompasses the full cost of providing government services
Prescribed requirements	Requirements prescribed by an Act or a financial management standard; prescribed requirements do not include the requirements of a financial management practice manual
Probity	The standards of ethical behaviour (such as honesty, integrity) expected of public servants charged with the stewardship of public funds and the protection of assets
Qualified audit opinion	Opinion issued when the financial statements as a whole comply with relevant accounting standards and legislative requirements, with the exceptions noted in the opinion; exceptions could be the effect of a disagreement with those charged with governance, a conflict between applicable financial reporting frameworks or a limitation on scope that is considered material to an element of the financial report
Revenue	Income received from normal business activities
Risk	The chance of a negative effect on the objectives, outputs or outcomes of the entity
Risk management	The systematic identification, analysis, treatment and allocation of risks, the extent of risk management required will vary depending on the potential effect of the risks
Unqualified audit opinion	Opinion issued when the financial statements comply with relevant accounting standards and prescribed requirements

Term	Definition
Voluntary separation program	A program providing employees with severance pay based on length of service if they choose to separate from employment and agree to the rules of the program
Written down value	The value of an asset after accounting for depreciation or amortisation, written down value is calculated by subtracting accumulated depreciation or amortisation from the asset's original value and reflects the asset's present worth from an accounting perspective

Source: QAO

Auditor-General Reports to Parliament

Tabled in 2013–14

Report number	Title of report	Date tabled in Legislative Assembly
1	Right of private practice in Queensland public hospitals	July 2013
2	Supply of specialist subject teachers in secondary schools	October 2013
3	Follow up—Acquisition and public access to the Museum, Art Gallery and Library collections	October 2013
4	Follow up—Management of offenders subject to supervision in the community	October 2013
5	Traffic management systems	November 2013
6	Results of audit: Internal control systems	November 2013
7	Results of audit: Water sector entities 2012–13	November 2013
8	Results of audit: Hospital and Health Services entities 2012–13	November 2013

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