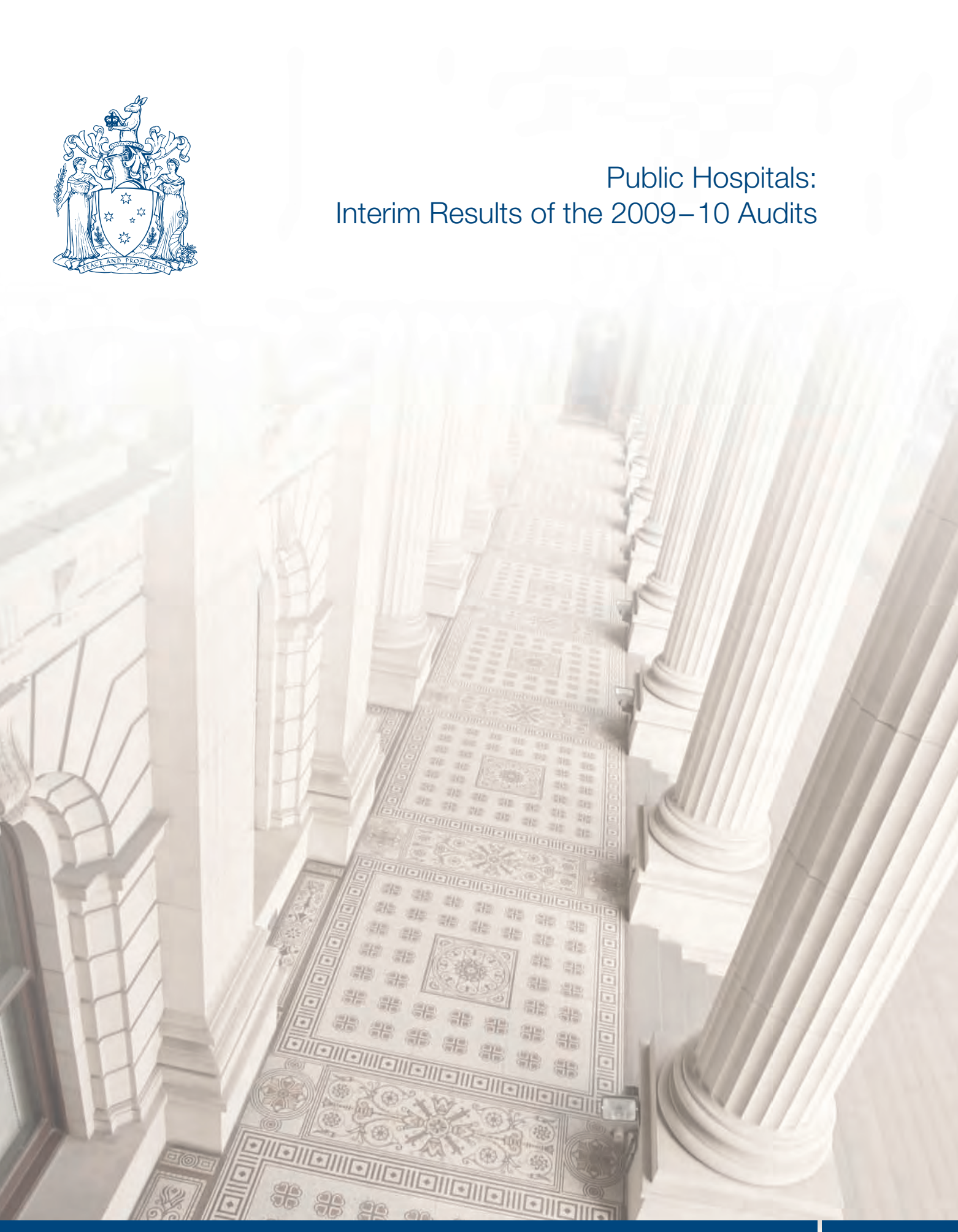
Public Hospitals: Interim Results of the 2009–10 Audits



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Victorian
Auditor-General

Public Hospitals: Interim Results of the 2009–10 Audits

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Victorian Auditor-General's Office

Auditing in the Public Interest

The Hon. Robert Smith MLC
President
Legislative Council
Parliament House
Melbourne

The Hon. Jenny Lindell MP
Speaker
Legislative Assembly
Parliament House
Melbourne

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report on *Public Hospitals: Interim Results of the 2009–10 Audits.*

Yours faithfully

D D R PEARSON
Auditor-General

1 September 2010

Contents

Audit summary

Background

This report informs Parliament about developments within the public hospital sector and internal control issues arising from our interim financial audit of 109 entities, comprising 87 public hospitals and the 22 entities they control.

All entities operate internal controls to maintain the reliability of their financial reporting, the efficiency and effectiveness of their operations and their compliance with all relevant laws and regulations. In our annual financial audit, we focus on the internal controls that relate to financial reporting. While it is not our responsibility to form an opinion on internal controls, we nevertheless raise with management any control weaknesses or breakdowns we identify.

This report comments on the effectiveness of internal controls supporting the preparation of the financial report and aspects of controls over leave and creditors.

At 24 August 2010, clear audit opinions had been issued on 39 per cent of public hospital and associated entities' financial statements for the financial year 30 June 2010.

Overall conclusion

Overall we found entity internal controls were adequate for financial reporting purposes. Nevertheless opportunities to strengthen internal controls were identified in relation to the preparation and review of key account reconciliations, the existence of core policies and procedures, and the adequacy of reviews for changes made to data on system masterfiles.

Controls over the management of leave were generally adequate, nevertheless there exists a number of opportunities to minimise the risks associated with the accumulation of excess recreation leave, and reduce the financial impact of sick leave absences.

Controls over the management of creditors could be further strengthened at almost all public hospitals, particularly relating to the development of comprehensive creditor management policies, more effective information systems, and enhanced monitoring of compliance and payment performance.

The Department of Health (DH) has not applied the government's fair payment policy to public hospitals. Consequently large metropolitan and regional hospitals are making over a third of their creditor payments outside the 30 day payment terms required under the government's fair payments policy.

Findings

Common internal control weaknesses

Internal control encompasses the policies, systems and behaviours established by entities to reliably and cost effectively meet their accountability and financial reporting objectives. Reliable internal controls are a prerequisite for effective and efficient delivery of reliable, accurate and timely external and internal reporting.

Public hospital internal control structures are adequate for financial reporting purposes, although the strength of these systems varied between public hospitals. We identified instances where important internal control mechanisms commonly needed to be strengthened. The incidence of weaknesses was generally consistent across metropolitan, regional and rural public hospitals.

A significant number of important internal control mechanisms commonly required strengthening:

- 20 per cent (17 of 87) of public hospitals had control weaknesses relating to the upgrade and implementation of new information systems
- information system security strategy, policies and system limitations were inadequate at 11 per cent (10 of 87) of public hospitals
- 34 per cent (30 of 87) of public hospitals were not independently reviewing masterfile standing data changes
- 39 per cent (34 of 87) of public hospitals had deficiencies in the preparation and review of key account reconciliations
- 29 per cent (25 of 87) of public hospitals had instances where core policies and procedures, such as over cash receipting or accounts payable processes, had not been established
- 16 per cent (14 of 87) of public hospitals had control weaknesses over the authorisation of supplier payments
- 23 per cent (20 of 87) of public hospitals had not appropriately addressed the requirements of Financial Reporting Direction 103D *Non-Current Physical Assets* regarding fair value assessments of non-current physical assets
- 31 per cent (27 of 87) of public hospitals had control weaknesses relating to payroll authorisation and management.

These matters, together with other audit findings and recommendations, were reported to the relevant hospital boards and their management teams in audit management letters.

In response to our 2009 review of investment management practices at public hospitals, DH is expected to promulgate its investment policy guidelines in August 2010.

Controls over leave

A review of the management controls within public hospitals over employee leave processes was undertaken as part of our cyclical assessment of internal controls relating to significant annual financial report balances and disclosures consistent with Australian Auditing Standards.

Total annual salary and related expenses for hospital staff are projected to be around $6.4 billion for 2009–10 ($6.0 billion, 2008–09), representing some 65 per cent of total public hospital expenditure. Of this amount, 16 per cent or $1.04 billion is expended on recreation, sick and long service leave entitlements each year. These costs arise from 74 300 equivalent full time staff employed by public hospitals at 31 March 2010 (71 400 at 30 June 2009).

While there are adequate controls over the management and monitoring of leave at public hospitals, there are a range of opportunities to strengthen controls.

Positive findings from our review included:

- 82 per cent (71 of 87) of public hospitals had an established leave policy which was generally comprehensive and making a positive contribution to leave management controls and arrangements
- 90 per cent of public hospitals had established arrangements to appropriately monitor leave balances to assist staff in complying with leave policies.

Leave management controls should, however, be strengthened in the following respects:

- nine per cent of public hospital employees have recreation leave balances in excess of 40 days at 31 March 2010
- 39 per cent (34 of 87) of public hospitals do not provide their boards with reports on leave management
- 60 per cent (52 of 87) of public hospitals had not included risks associated with the management of leave in the hospital's risk management register
- 89 per cent (48 of 54) of rural hospitals do not benchmark leave trends against external standards
- boards do not periodically perform a review over the adequacy of leave management practices at 76 per cent (66 of 87) of public hospitals
- 69 per cent (60 of 87) of public hospitals had not commissioned any internal audit projects in relation to their leave management practices within the last three years.

Ineffective controls over employee leave arrangements increase the likelihood of poor health and safety outcomes, additional costs associated with unplanned absences, and increased costs resulting from excess recreation leave accumulation.

Controls over creditors

Public hospitals are projected to spend around $2.6 billion on supplies and services in 2009–10 ($2.0 billion in 2008–09), representing around 26 per cent of total hospital expenditure. The total outstanding creditor balances were $209 million at 31 March 2010 ($246 million at 30 June 2009).

Given the substantial costs associated with creditors, and the considerable impact these payments have on operating cash flows for public hospitals and their creditors, we reviewed controls over creditors, including the effectiveness of established policies and practices, as well as monitoring arrangements.

In February 2006 the government extended its fair payment policy to apply to all major and significant public sector agencies. This requires agencies to pay for purchased goods and services of less than $3 million, on the lesser of supplier terms or 30 days from the date a correct invoice is received. The aim of this policy is to improve the cash flow certainty for Victorian small and medium sized businesses.

Under DH's funding and service agreements public hospital creditors are required to be paid within 60 days. The department has advised that it was not possible to comply with the government's fair payment policy due to the significant cash flow difficulties it would cause public hospitals. Consequently large metropolitan and regional hospitals are making over a third of their creditor payments outside the 30 day payment terms required under the government's fair payments policy.

The inconsistency between the supplier payment requirements outlined in the department's hospital funding agreements and the government's fair payment policy is yet to be resolved by the department. The government's fair payment policy as the overriding policy has been applied when assessing creditor payment performance.

Positive findings from our review included:

- 84 per cent (73 of 87) of public hospitals are monitoring creditor balances using an automated aged analysis facility
- electronic funds transfer is an effective and common payment method for public hospitals, with 53 per cent of total creditor payments made by this method
- at 49 per cent (43 of 87) of public hospitals where creditor management statistics were reported to the board, they commonly contained average payment terms achieved and, where applicable, comments and recommendations regarding areas of concern
- at 31 March 2010 less than eight per cent of creditor balances at rural public hospitals had been outstanding for more than 30 days, with one per cent outstanding for more than 60 days.

Controls over creditors should however be improved in the following respects:

- over 35 per cent of creditor balances at metropolitan and regional hospitals had been outstanding for more than 30 days, with five per cent outstanding for more than 60 days, at 31 March 2010
- 17 per cent (15 of 87) of public hospitals have experienced instances where creditor payments have been deferred due to cash shortages

- 68 per cent (59 of 87) of hospitals do not have mechanisms in place to capture and report on compliance with terms of trade
- 44 per cent (38 of 87) of public hospitals did not have an established creditor management policy
- 51 per cent of public hospital boards (44 of 87) do not include a supplier payment performance review as part of their regular board reporting
- 84 per cent (73 of 87) of public hospitals did not use external benchmarks to assess their aged creditor balances and payment terms achieved
- 69 per cent (60 of 87) of public hospitals had not included risks associated with the management of creditors and payment processing in the hospital's risk management register
- 61 per cent (53 of 87) of public hospitals had not completed an internal audit review of creditor management within the past three years
- 53 per cent (46 of 87) of public hospitals had not conducted a management review of creditor management practices and processes within the last three years
- 80 per cent (70 of 87) of public hospitals do not have a system in place whereby the board annually reviews the adequacy of creditor management policies.

Most public hospitals still need to develop more comprehensive creditor management policies, more effective management information systems and to enhance the monitoring of payment performance.

Recommendations

Recommendation	Pages
Public hospitals should assess their policies and procedures against the commonly identified internal control weaknesses to confirm they are operating in a reliable, efficient and cost effective manner.	15
Public hospitals should establish comprehensive leave monitoring arrangements, and hospital boards should require comprehensive leave management reports.	24, 25, 27
Public hospitals should improve the level of monitoring, review and oversight of sick leave absences.	33
The Department of Health should expedite resolution of the inconsistency between their service arrangements with public hospitals and the creditor payment terms required under the government's fair payment policy.	38
Public hospital boards should oversee the establishment of comprehensive creditor management policies and procedures, and receive detailed creditor payment and aged analysis reports to acquit their monitoring obligations.	41, 46
Public hospitals should investigate extending the use of computerised applications for processing creditors, establish comprehensive monitoring arrangements, and schedule periodic internal audits of creditor management practices.	46, 48

Submissions and comments received

In addition to progressive engagement during the course of the audit, in accordance with section 16(3) of the *Audit Act 1994* a copy of this report, or relevant extracts from the report, was provided to the Secretary of the Department of Health with a request for comments or submissions.

Agency views have been considered in reaching our audit conclusions and are represented to the extent relevant and warranted in preparing this report. Their full section 16(3) comments and submissions, however, are included in Appendix D.

Audit conduct

Audits were conducted in accordance with the Australian Auditing Standards.

The total cost of preparing and printing this report was $195 000.

1 Background

At a glance

Background

This report provides the interim results of the audit of the 2009–10 financial reports of 87 public hospitals and their 22 controlled entities.

Comment on the audit opinions issued for 2009–10, and the timeliness and accuracy of the preparation and finalisation of the financial reports will be included in the *Acquittal Report: Results of the 2009–10 Audits* report. That report will also include comment on public hospital financial sustainability.

Finding

At 24 August 2010, clear audit opinions had been issued on 39 per cent of public hospital and associated entities' financial statements for the financial year 30 June 2010.

1.1 Introduction

The state election is scheduled for 27 November 2010 with Parliament rising in early October 2010. This shortens our timelines for reporting on the annual financial statement audit of the public hospital sector. Accordingly, we have produced this interim report on the annual financial statements audits of the public hospital sector and will produce a final acquittal report in February 2011.

This report is the fourth of seven reports to be presented to Parliament covering the results of audits. Figure 1A shows the intended reports and time frames.

This report also comments on the effectiveness of internal controls and management controls relating to leave and creditors.

Figure 1A
VAGO reports on the results of audits

Report	Description
Portfolio Departments: Interim Results of the 2009–10 Audits (2010–11:1 tabled 28 July 2010)	Reported on the interim results of audits of the 11 portfolio departments. It examined the effectiveness of internal controls for IT systems; for identifying, declaring interests and managing conflicts; and for procurement. It also commented on financial reporting developments.
Local Government: Interim Results of the 2009–10 Audits (2010–11:3 tabled 11 August 2010)	Reported on the interim results of audits of 79 local governments, the 13 agencies they control and 12 regional library corporations. It examines the effectiveness of internal controls supporting the preparation of the financial reports, controls over conflicts of interests and IT change management.
Water Entities: Interim Results of the 2009-10 Audits (2010–11:4 tabled 11 August 2010)	Reported on the interim results of audits of 19 water entities. Examined the effectiveness of internal control supporting the preparation of the financial reports and aspects of how they manage capital projects and creditors.
Public Hospitals: Interim Results of the 2009–10 Audits (this report)	This report provides the interim results of audits of approximately 110 agencies in the sector. It will examine the effectiveness of internal control supporting the preparation of the financial reports and aspects of how they manage leave and creditors.

Figure 1A
VAGO reports on the results of audits – *continued*

Report	Description
Auditor-General's Report on the Annual Financial Report of the State of Victoria, 2009–10	The report will provide the results of the audit of the state's annual financial report. It will examine the quality and timeliness of financial reporting, explain significant financial results for the state and make observations on the status and financial implications of significant issues. *Scheduled for tabling in Parliament in October 2010.*
Acquittal Report: Results of the 2009–10 Audits	The report will provide the results of the annual financial statement audits of approximately 420 agencies across the portfolio departments and associated entities, and all other sectors, including local government, water entities and public hospitals. The report will include comment on the timeliness of their financial reporting and financial sustainability. *Scheduled for tabling in Parliament in February 2011.*
Tertiary Education and Other Entities: Results of the 2010 Audits	This report will provide the results of the annual financial audits of approximately 110 entities with financial year ends other than 30 June 2010. It will examine timeliness of their financial and performance reporting, the effectiveness of their internal control, their financial sustainability and aspects of how they manage creditors, employee costs and student fee revenue. *Scheduled for tabling in Parliament in May 2011.*

Source: Victorian Auditor-General's Office.

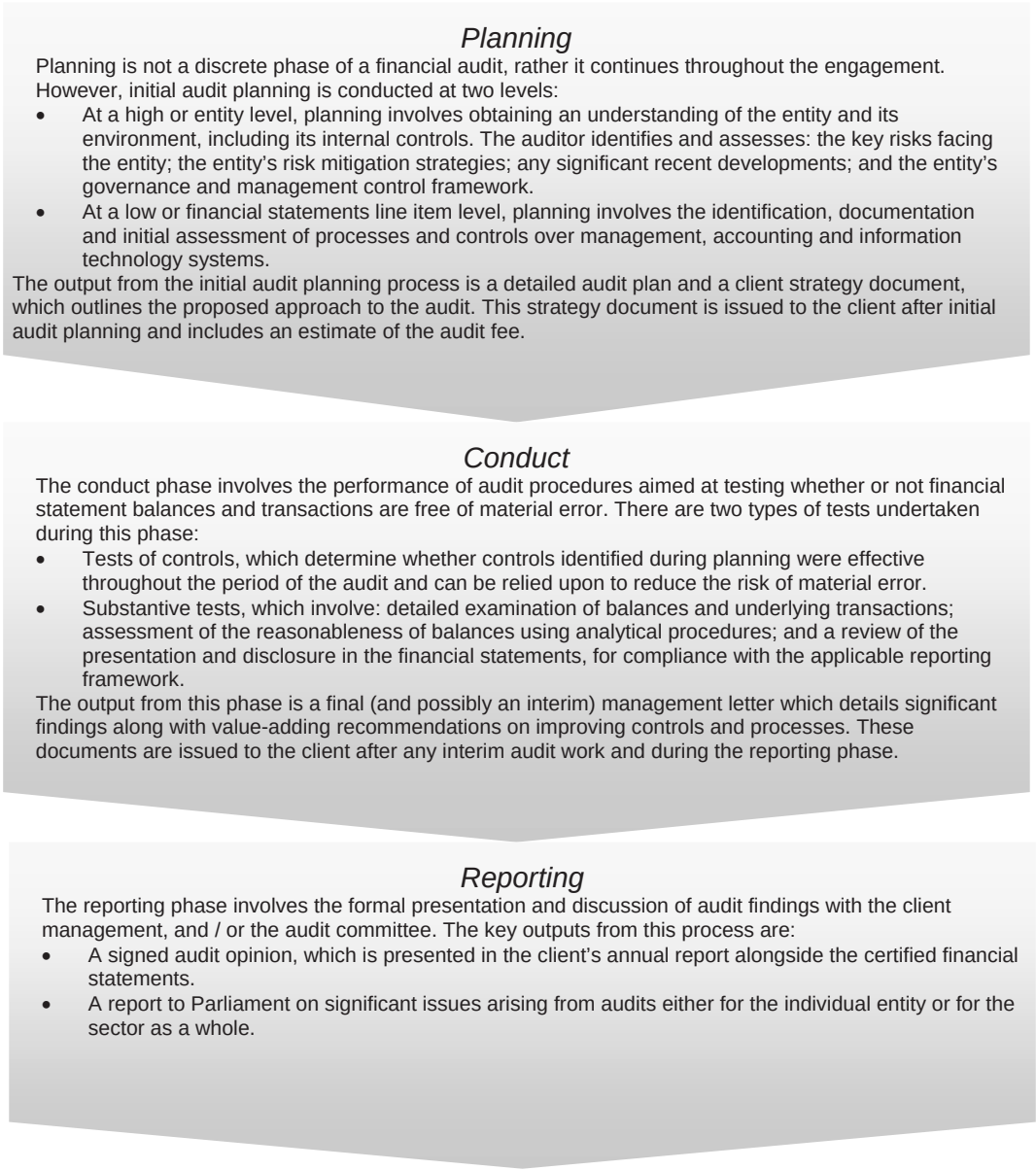
1.1.1 Financial audit framework

An annual financial audit has two aims:

- to give an opinion about whether financial statements are fairly stated, consistent with section 9 of the *Audit Act 1994*
- to consider whether there has been any wastage of public resources or any lack of probity or financial prudence in the management or application of public resources, consistent with section 3A(2) of the *Audit Act 1994*.

Figure 1B shows the three phases of a financial audit and details how the 2009–10 interim audits of the 87 public hospitals and the 22 entities they control were conducted.

Figure 1B
Financial audit framework



Source: Victorian Auditor-General's Office.

Audit of internal control

The assessment of an entity's internal controls is a basic part of a financial audit. 'Internal control' is how an organisation or entity can reasonably assure that its financial reporting is reliable, its operations are effective and efficient, and that it is complying with laws and regulations.

Australian Auditing Standard 315 *Understanding the Entity and Its Environment and Assessing the Risks of Material Misstatement* requires an auditor to understand and assess each entity's internal controls.

1.2 Scope

This report includes the results of our examination of internal controls related to the financial reporting responsibilities of 109 entities, comprising 87 public hospitals and the 22 entities they control, as set out in Figure 1C. Our audits are undertaken progressively. Internal controls are examined prior to financial year end to assess the reliance that can be placed on internal controls in the production of the financial report.

Figure 1C
Public hospitals and associated entities

Hospital category	2009	2010
Metropolitan:		
Public hospitals	18	18
Entities controlled by public hospitals	14	14
Regional:		
Public hospitals	15	15
Entities controlled by public hospitals	2	2
Rural:		
Public hospitals	55	54
Entities controlled by public hospitals	6	6
Other associated entities	4	0
Total	**114**	**109**

Note: Entities controlled by public hospitals generally comprise foundations and trusts, while associated entities are rural health information technology alliances.

Source: Victorian Auditor-General's Office.

Figure 1C shows that fewer entities were subject to our audit in 2010. These changes relate to:

- **Other associated entities**—The four rural health information technology alliances were restructured by the Department as unincorporated joint ventures and as such are not subject to the requirements of the *Financial Management Act 1994* (FMA) or the *Audit Act 1994*.
- **Public hospitals**—Robinvale District Health Services and Manangatang and District Hospital were amalgamated pursuant to section 115U(1)(b) of the *Health Services Act 1988*.

Public hospital services encompass prevention, early intervention and primary care, highly complex acute care, aged care and mental health services.

While metropolitan and regional public hospitals largely provide acute health services, they also provide a mix of mental health, sub-acute, community health services and aged care programs. Rural public hospitals generally offer a higher proportion of aged care and community health services.

1.3 Reporting framework

The 109 entities are required to prepare an annual financial report. The financial reports must be audited.

The principal legislation governing financial reporting by public hospital sector entities is the FMA. Eighty-eight of the 109 public hospitals and controlled entities prepare their financial reports in accordance with the FMA.

1.3.1 Financial reporting

The financial reports are prepared in accordance with Australian Accounting Standards, including the Australian Accounting Interpretations.

The main legislation governing financial reporting by public hospitals is the FMA with 88 of the 109 entities required to comply with the FMA. Fifteen entities prepare their financial reports in accordance with the *Corporations Act 2001* and one in accordance with the *Associations Incorporation Act 1981*. The remaining five do not report under a legislative framework. Appendix B details the legislative framework applying to each public hospital sector entity.

Financial Management Act 1994

Under the FMA, the Minister for Finance has the authority to issue directions in relation to financial administration and reporting issues. These directions set the minimum standards for public sector agencies to achieve sound systems of internal control to support financial management.

Public hospitals are also encouraged to comply with the requirements of the Financial Reporting Directions to achieve consistency in the application of accounting policies from a whole of government financial reporting perspective.

The FMA requires an entity to submit their annual report for tabling in the Parliament, within four months of the end of the financial year, including the financial report, which should be prepared and audited within 12 weeks.

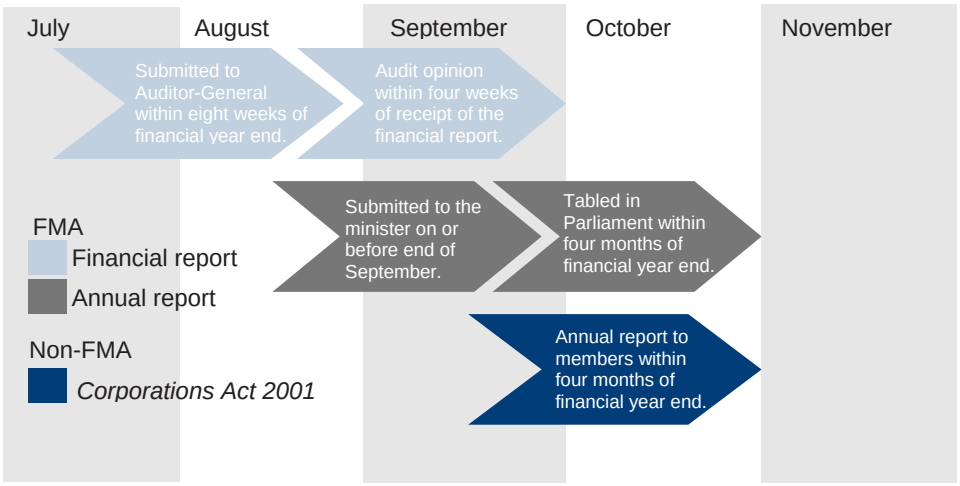
Corporations Act 2001

The *Corporations Act 2001* requires a company to report to their members within four months after the end of their financial year. However, as controlled entities of the state and to facilitate the preparation of the annual report of the State of Victoria, the provisions of the FMA require the financial report to be finalised within 12 weeks.

Legislated reporting time frames

Figure 1D summarises the legislated reporting time frames.

Figure 1D
Legislative reporting time frames



Source: Victorian Auditor-General's Office.

All public hospitals and controlled entities prepare their financial reports in accordance with Australian Accounting Standards, including the Australian Accounting Interpretations.

Audit opinions

Independent audit opinions add credibility to financial reports by providing reasonable assurance that the information is reliable.

At 24 August 2010, clear audit opinions had been issued on 39 per cent of public hospital and associated entities' financial statements for the financial year 30 June 2010. These have been detailed in Appendix C.

2 Common internal control weaknesses

At a glance

Background

In conducting financial audits, we assess internal controls that affect the reliability of financial reporting. Interim audits found instances where internal controls should be strengthened. Weaknesses found during an audit of a public hospital are brought to the attention of its management and audit committee.

Findings

Overall our assessment of the internal control structures is that they are adequate for financial reporting purposes, although the strength of these systems varied between public hospitals. We identified a substantial number of internal control mechanisms that required strengthening:

- 20 per cent (17 of 87) of public hospitals had control weaknesses relating to the upgrade and implementation of new information systems
- information system security strategy, policies and system limitations was inadequate at 11 per cent (10 of 87) of public hospitals
- 34 per cent (30 of 87) of public hospitals were not independently reviewing masterfile standing data changes
- 39 per cent (34 of 87) of public hospitals had deficiencies in the preparation and review of key account reconciliations
- 29 per cent (25 of 87) of public hospitals had instances where core policies and procedures had not been established
- 16 per cent (14 of 87) of public hospitals had control weaknesses over the authorisation of supplier payments
- 31 per cent (27 of 87) of public hospitals had control weaknesses relating to payroll authorisation and management.

In response to our 2009 recommendations to improve investment management practices, the Department of Health is expected to promulgate its investment policy guidelines in August 2010.

Recommendation

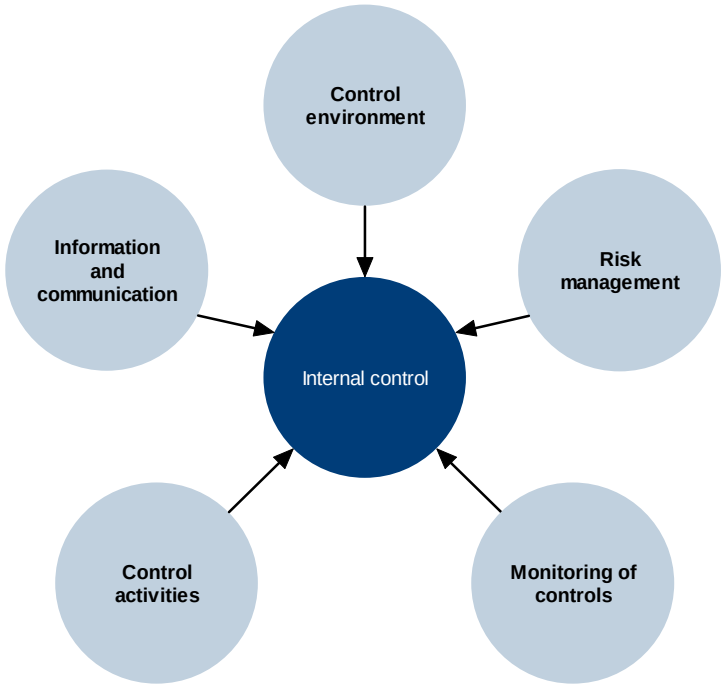
Entities should evaluate their policies and procedures against the commonly identified internal control weaknesses to assess if they are operating in a reliable, efficient and cost effective manner.

2.1 Introduction

Each entity's governing body is responsible for the development and maintenance of its internal control structure. Internal control refers to systems, processes and procedures that are established by the entity.

Figure 2A identifies the main components of an effective internal control framework. Sound internal controls provide an effective and efficient vehicle for the delivery of reliable, accurate and timely external and internal reporting.

Figure 2A
Internal control framework



Source: Victorian Auditor-General's Office.

In the diagram:

- the **control environment** provides the fundamental discipline and structure for controls and includes the governance and management functions and the attitudes, awareness, and actions of those charged with governance and management
- **risk management** involves identifying, analysing and mitigating risks
- **monitoring of controls** assess the effectiveness of internal controls in practise
- **control activities** are the policies, procedures and practices that management prescribes to help meet entity objectives
- **information and communication** involves communicating control responsibilities throughout the entity and providing information in a form and time frame that allows officers to discharge their responsibilities.

The annual financial audit results in our office forming an opinion on an entity's financial report. An integral part of this process, and a requirement of Australian Auditing Standard 315 *Understanding the Entity and Its Environment and Assessing the Risk of Material Misstatement*, is to assess the adequacy of the entity's internal control framework and governance processes as they relate to the accuracy, completeness and reliability of financial reporting.

Internal control weaknesses we identify during an audit will usually not result in a qualified audit opinion. A qualification is usually only warranted if weaknesses cause significant uncertainty about the financial information being reported. Often, an entity will have other compensating controls to mitigate the risk of material error. Weaknesses we identify during an audit of an entity are brought to the attention of the chairman, managing director and audit committee.

Section 16 of the *Audit Act 1994* empowers the Auditor-General to report to Parliament on the results of audits. This section of the report summarises the internal control weaknesses commonly identified during the financial audit for the year ended 30 June 2010.

Though it varied between public hospitals, an overall assessment of internal control at public hospitals and controlled entities was that the internal control systems and processes for financial reporting purposes were adequate.

2.2 Internal control

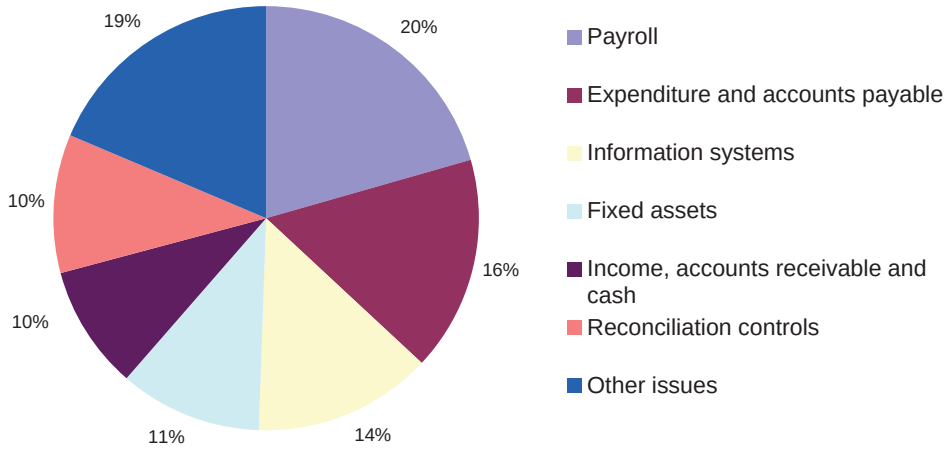
We identified instances where internal control mechanisms commonly needed to be strengthened. The incidence of weaknesses was generally consistent across public hospitals.

The significant and commonly identified areas for improvement were:

- upgrade and implementation of information systems
- information system security strategy, policies and system limitations
- review of masterfile standing data changes
- preparation and review of key account reconciliations
- existence of core policies and procedures
- authorisation of supplier payments
- fair value assessments of non-current physical assets
- payroll authorisation and management.

Figure 2B demonstrates the financial areas and systems that had the highest occurrence of weaknesses in 2009–10. Twenty per cent of findings were associated with payroll systems and processes, 16 per cent related to expenditure and accounts payable, and 14 per cent related to information systems.

Figure 2B
Issue occurrence by account balance and system



Source: Victorian Auditor-General's Office.

The following section outlines the common control weaknesses at public hospitals in 2009–10.

Upgrade and implementation of information systems

A significant number of regional and rural hospitals upgraded their information systems (IS) during the 2009–10 year.

The implementation of new or upgraded information systems can expose an entity to a breakdown of internal controls, particularly when processes and controls are not reviewed prior to implementation. Management should conduct a pre-commissioning review to assess whether the new controls and processes are adequate and effective.

Additionally, existing policies and procedures should be reviewed and updated to reflect the system upgrade and to confirm they remain relevant and effective in the new environment.

Twenty per cent (17 of 87) of public hospitals had the following weaknesses:

- a pre-implementation review was not undertaken to determine necessary changes to internal controls and processes that would eventuate as a result of the system upgrade
- assessments of the compatibility of the new system with existing procedures were not undertaken
- post implementation reviews of the system upgrade were not conducted.

Information system security strategy, policies and system limitations

Public hospitals should endeavour to have an IS security strategy in place that has appropriate controls to mitigate any IS risks or threats. The IS strategy should be based on a rigorous risk assessment so that relevant risks are identified and appropriately addressed.

The IS security policies that support the IS strategy should be regularly reviewed to deal with emerging risks and threats, particularly acceptable usage, password controls, confidentiality of information and the integrity of information. Classification of data within information systems should be based on a risk based methodology. Greater security over sensitive and confidential patient details would then be demonstrated and assured.

Reviews of information systems at public hospitals found instances at 11 per cent (10 of 87) of public hospitals where an IS security policy had not been established or was inadequate, or where the IS security policies were outdated and required updating.

Further, information systems at four public hospitals did not cater for all processing and reporting requirements, mainly due to systems being outdated.

Review of masterfile standing data changes

Financial systems, such as accounts payable, accounts receivable and payroll, rely on the maintenance of standing data on masterfiles to process individual payments. Masterfile data includes name, address, pay rates and bank account details.

It is important that all changes made to standing data on masterfiles are checked so that they are complete, accurate and legitimate. Otherwise subsequent processing errors can be repeated many times over. An independent review of masterfile standing data changes is important:

- for the detection and timely correction of unintentional or fraudulent changes
- to guard against payments to unauthorised suppliers or unauthorised adjustments to pay rates.

Thirty-four per cent (30 of 87) of hospitals were not independently reviewing periodic changes made to standing data on their system masterfiles.

Preparation and review of key account reconciliations

The majority of hospitals maintain subsidiary accounting systems, such as the accounts payable, payroll and fixed assets systems. These should be periodically reconciled to the general ledger to confirm they balance.

Timely preparation and independent review of reconciliations results in early detection and timely resolution of errors, and assures accuracy in financial reporting.

Thirty-nine per cent (34 of 87) of public hospitals had deficiencies in the preparation and review of reconciliations. Key reconciliations were either not being prepared and independently reviewed, or this was not occurring on a timely basis.

The majority of these deficiencies related to the preparation and review of bank account reconciliations, with a common issue being the occurrence of long outstanding unresolved variances. Given that the majority of an entity's transactions are processed through the bank account, it is imperative that this reconciliation be accurately prepared and independently reviewed on a timely basis.

Existence of core policies and procedures

Public hospitals should maintain up-to-date policies on the core areas of administration and governance. These policies are important in enabling boards and management to reliably communicate the responsibilities and accountabilities of staff. Documented policies and procedures also make it easier to identify control weaknesses or occurrences of non-compliance.

Twenty-nine per cent (25 of 87) of public hospitals had instances where policies and procedures, such as those governing cash receipting, accounts payable, accounts receivable, physical assets and fraud, were not established. Additionally, it was also noted that some public hospitals did not regularly review or update their policies and procedures.

Authorisation of supplier payments

Public hospitals have established controls around the processing of invoices, in particular:

- reviewing invoices prior to payment
- authorising invoices in accordance with the hospital's financial delegations.

A financial delegations manual should also be established by hospital boards to facilitate the approval of transactions commensurate with the efficient operation of the hospital and prudent financial governance. This is also a requirement of the Standing Directions of the Minister for Finance. Non-compliance with approved financial delegations increases the risk of inappropriately authorised payments and the misappropriation of assets.

In addition to complying with the financial delegations, payments processed via cheque and electronic funds transfer (EFT) are generally required to be authorised by two persons. This control is designed to reduce the risk of unauthorised or fraudulent payments, as one person cannot transfer funds without the authorisation of a second financial delegate.

Sixteen per cent (14 of 87) of public hospitals either did not comply with their established financial delegations, did not appropriately review invoices prior to payment or did not require dual authorisation for cheque and EFT payments.

Fair value assessments of non-current physical assets

Public hospitals are required by Financial Reporting Direction 103D *Non-Current Physical Assets* to report their non-current physical assets at fair value in their annual financial report.

In 2008–09 the majority of public hospitals performed this assessment, however, some hospitals did not document this process or did not consider the impact of the revaluation on the remaining useful lives of assets.

At 30 June 2010 a review of the movement in fair value of non-current physical assets was required. This should have involved the management at public hospitals considering the appropriateness of the assets' remaining useful lives based on the asset revaluation reports of 30 June 2009.

This assessment, as well as the valuation of the movements in the fair value of assets, should be documented so that there is appropriate and reliable evidence to support management's asset valuations and useful life assessments for financial reporting purposes.

Twenty-three per cent (20 of 87) of public hospitals had not addressed these requirements when they conducted managerial revaluation assessments of the movements in fair values of their non-current physical assets.

Payroll authorisation and management

Salaries and wages represent the most significant cost for public hospitals. Accordingly, adequate internal controls should exist over the processing and monitoring of salaries and related costs.

At 31 per cent (27 of 87) of public hospitals the following payroll related weaknesses were identified:

- inadequate authorisation of payroll payments
- staff with excess recreation leave entitlements
- no review of final payments to departing employees.

Audit management letters

These matters, together with other audit findings and recommendations, were reported to the relevant public hospital boards and their management team in individual audit management letters.

Recommendation

1. Public hospitals should assess their policies and procedures against the commonly identified internal control weaknesses to confirm they are operating in a reliable, efficient and cost effective manner.

2.3 Status of the 2009 review of public hospital investment management

Effectively managing investment funds is one of several critical factors for the ongoing financial viability of public hospitals. In 2009, as part of our cyclical approach to reviewing significant aspects of corporate governance and financial management, we conducted a review of the investment management practices and outcomes for the public hospital sector. The review outcomes were reported in the *Public Hospitals: Results of the 2008–09 Audits* (2009–10:2) report tabled in Parliament on 11 November 2009.

Our review of public hospital investment management practices found deficiencies in policy development, management practices and oversight arrangements across the public hospital sector. In addition, the sector had experienced investment losses as a consequence of the global financial crisis.

A key recommendation from the review was that the department should finalise, promulgate and monitor the application of investment policy guidelines for public hospitals.

This recommendation was accepted by the department, which advised that it had revised its draft investment policy guidelines, titled *Investment Policy Guidelines for Victorian Public Hospitals*. These guidelines are expected to be promulgated to the sector in August 2010.

3 Controls over leave

At a glance

Background

Public hospitals are projected to spend $6.4 billion on salaries and related costs in 2009–10, representing some 65 per cent of total public hospital expenditure. Of this amount 16 per cent or $1.04 billion will be spent on recreation, sick and long service leave entitlements. A review of the management controls within public hospitals over employee leave arrangements, processes and governance was undertaken as part of our cyclical assessment of internal controls.

Findings

Overall, leave management policies and practices were found to be adequate, although the following deficiencies were identified:

- management had not conducted a review of leave practices and processes at 61 per cent (53 of 87) of hospitals
- 89 per cent (48 of 54) of rural hospitals do not benchmark leave trends against external standards
- 39 per cent (34 of 87) of public hospitals did not provide their boards with any reports on leave management
- 69 per cent (60 of 87) of public hospitals had not commissioned any internal audit projects relating to their leave management practices within the last three years.

Notably, the five public hospitals with the lowest sick leave average had comprehensive leave management policies, practices and monitoring arrangements in place, demonstrating that significant cost savings are achievable for the broader public hospital sector.

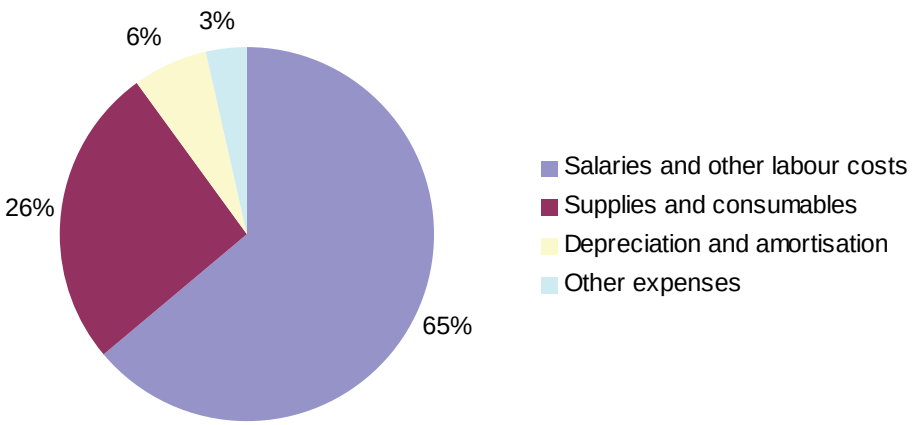
Recommendation

Public hospitals should establish comprehensive leave monitoring arrangements, and hospital boards should require comprehensive leave management reports to improve the level of monitoring, review and oversight of sick leave absences.

3.1 Leave management controls and processes

The largest proportion of public hospital outlays is on salaries and related costs. Figure 3A shows that this expenditure accounted for 65 per cent of total public hospital spending for the 9 month period ended 31 March 2010 (68 per cent for 2008–09).

Figure 3A
Public hospital spending for the period ended 31 March 2010



Source: Victorian Auditor-General's Office.

Total annual salary and related expenses in respect of hospital staff are projected to be around $6.4 billion for 2009–10 ($6.0 billion, 2008–09). Of this, 16 per cent or $1.04 billion is expended on recreation, sick and long service leave entitlements each year. These costs arise from the 74 300 equivalent full time staff employed by public hospitals at 31 March 2010 (71 400 at 30 June 2009).

At 31 March 2010 public hospitals had employee leave liabilities of $1.4 billion ($1.3 billion at June 2009). This represents some 52 per cent of total public hospital liabilities.

Given the financial significance of salaries and other labour costs for public hospitals, we reviewed the management controls and processes over public hospital expenditure and liabilities relating to employee benefits, in particular those around leave management and governance.

3.2 Employee leave arrangements

Figure 3B provides details of full time equivalents (FTE) and employee benefit expenditure by public hospital category. Metropolitan hospitals employ the most staff, and represent a substantial portion of the total employee benefit expenditure of all public hospitals.

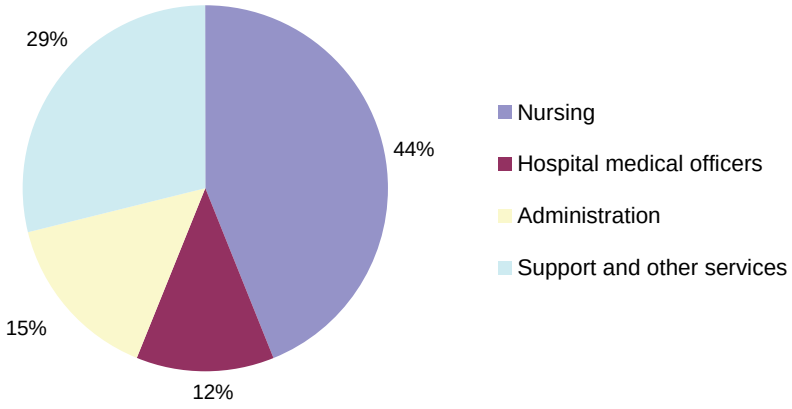
Figure 3B
Number of full time equivalent employees and employee benefit expenditure by category

Hospital category	Number of employees [(a)]	Percentage of employees	Employee benefit expenditure 2009–10 (estimate) $mil
Metropolitan hospitals	49 875	67	4 665
Regional hospitals	17 272	23	1 230
Rural hospitals	7 177	10	477
Total	**74 324**	**100**	**6 372**

Note: (a) FTE staff numbers were as at 31 March 2010.
Source: Victorian Auditor-General's Office.

As expected, nurses represent the greatest portion of these staff numbers, with 44 per cent of total public hospital employees, followed by support staff representing 29 per cent. Figure 3C shows the percentage of staff under each of the four classifications used in this report.

Figure 3C
Public hospital employee classifications



Source: Victorian Auditor-General's Office.

The majority of staff employed within the public hospital sector fall under the requirements of enterprise bargaining agreements (EBA), such as the Nurses Multiple Business Agreement 2007–2011 and the Health and Allied Services Certified Agreement 2006–2009. At the time of preparing this report an updated version of the Health and Allied Services Agreement was being completed, however leave entitlements are not expected to change.

Under the applicable EBAs, the main categories of employee leave entitlements are typically:

- 14 days sick/carer's leave per annum for staff with up to five years of service and 21 days for staff in excess of five years of service
- 25 days recreation leave for most nursing staff and generally 20 days recreation leave for other staff categories
- three months long service leave for each 10 years of service.

In accordance with these agreements, nurses are allowed to carry forward each year's entitlement of recreation leave for up to two years, whereas administrative and support staff are required to use each year's entitlement within six months of the accrual year, unless otherwise agreed with their employer.

As employee leave costs and provisions are financially significant, public hospitals should have an effective leave management framework in place. Effectively managing employee leave arrangements and entitlements should reduce the following strategic and operational risks:

- adverse impacts on patient requirements
- difficulties covering unplanned staff absences
- poor occupational health and safety outcomes for staff
- negative impacts on employee productivity
- additional costs associated with avoidable sick leave absences
- higher financial costs associated with accumulating excess recreation leave to be paid at higher rates of pay.

Effective leave management also promotes a healthy and productive workforce, and assists in minimising work disruptions caused by staff taking large blocks of outstanding recreation leave and avoidable sick leave.

3.3 Leave management framework

Under the *Health Services Act 1988*, the primary responsibility for implementing appropriate leave management controls resides with public hospital governing boards. Effective leave management requires boards to establish and monitor controls so that operational requirements are efficiently met, staff well-being is promoted and leave costs are controlled.

In establishing systematic control arrangements public hospitals should adopt a leave management framework with:

- comprehensive leave policies
- effective leave management practices, and
- appropriate governance and oversight arrangements.

Figure 3D outlines these key components of an effective leave management framework. This figure draws on Australian Public Service Commission's 2006 better practice guidelines detailed in the report *Fostering an Attendance Culture: A guide for APS agencies*. This framework assists entities to identify workplace absences and their possible causes, and improve each agency's capacity to address problems by implementing better practice strategies.

Figure 3D
Key elements of an effective leave management framework

Component	Key elements
Policy	Leave management objectives Compliance with EBA requirements Details of leave entitlements and limitations Outlines staff responsibilities and leave application requirements Specifies approval arrangements and delegations Nominates reporting frequencies and accountabilities Policies reviewed and approved by the board
Management practices	Adhering to leave management policies and EBA agreements Timely and efficient processing of leave applications Arrangements for monitoring leave balances and staff absences Analysing leave balances and staff absences, including benchmarking Developing action plans to address areas of concern Management review of policies, practices and processes Comprehensive and regular reporting to executive and board
Governance and oversight	Monitoring compliance with policy requirements Reviewing leave outcomes and benchmarked performance Periodic review of leave management policies Providing direction to management on areas of concern Assessing risks associated with leave arrangements and outcomes Engaging internal audit to review policy compliance and processes

Source: Victorian Auditor-General's Office.

We assessed the leave management frameworks of the 87 public hospitals by considering the elements outlined in the above table.

Overall, leave management policies and practices were found to be adequate, although there were a range of deficiencies in leave reporting systems and monitoring and oversight arrangements at many public hospitals.

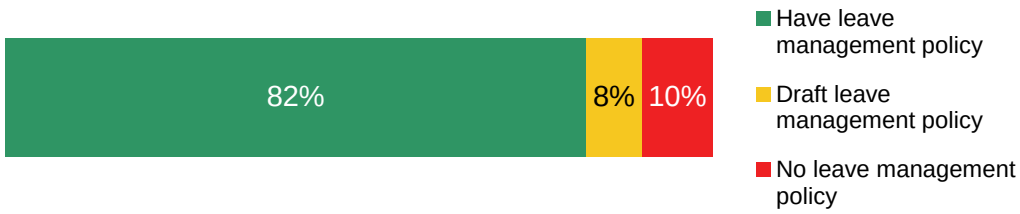
3.3.1 Leave policy

Comprehensive policies are important in allowing boards and management to communicate the responsibilities and expectations of staff, as well as aligning public hospital's operations with the strategic direction of the entity.

Existence of leave policies

Figure 3E sets out the proportion of public hospitals with leave policies.

Figure 3E
Public hospitals with leave policies at 31 March 2010



Source: Victorian Auditor-General's Office.

As at 31 March 2010, 82 per cent (71 of 87) of public hospitals had established leave management policies.

A further 8 per cent, or 7 hospitals, were in the process of drafting leave policies and the remaining 10 per cent, or 9 hospitals, did not have leave policies. These were mainly smaller rural hospitals that employed 4 763 staff at an estimated cost of $318 million per annum, or 5 per cent of total employee benefit costs for all hospitals.

Metropolitan and regional hospitals employ the largest proportion of staff and all but two of these hospitals had a policy in place to manage and control their employee leave processes.

Adequacy of leave policies

Very few public hospital's leave policies contained all of the desired elements set out in Figure 3D, however the vast majority of the policies reviewed did incorporate the following elements:

- leave approval arrangements and delegations in 89 per cent (63 of 71)
- who is to approve leave requests in 97 per cent (69 of 71)
- staff responsibilities and leave application requirements in 93 per cent (66 of 71)
- leave policy objectives in 96 per cent (68 of 71)
- leave entitlements and limitations for the different types of leave existed in 86 per cent (61 of 71)

- guidance for staff and management on accumulating recreation leave in 85 per cent (60 of 71)
- reference to the requirements of the relevant EBA or legislative requirements in 82 per cent (58 of 71).

Conversely, the following important elements were not included in the majority of the leave policies reviewed:

- details of risks associated with accumulating excess recreational leave in 63 per cent (45 of 71)
- reporting frequency in 62 per cent (44 of 71).

There was not a significant variation in the quality of policies across the metropolitan, regional and rural public hospitals. Overall leave policies established were comprehensive and were making a positive contribution to leave management arrangements.

Board approval of policy

Effectively managing employee leave costs and provisions is a core factor for the ongoing financial viability of public hospitals. The individual public hospital boards are responsible for oversighting leave arrangements, as per the *Health Services Act 1988*, while the related functions of the Secretary of the Department of Health under the Act include a performance monitoring role.

In discharging these legislative responsibilities policies relating to critical hospital functions should be reviewed and approved by the respective boards before they are implemented as the board is ultimately responsible for any deficiencies in policy setting.

Figure 3F sets out the proportion of public hospitals where leave policies had been approved by the board.

Figure 3F
Hospital leave policies approved by the board at 31 March 2010

Source: Victorian Auditor-General's Office.

Of the public hospitals with a leave management policy, 61 per cent (43 of 71) had a policy that was approved by the board of directors.

Recommendation

2. Public hospital boards should establish and periodically review comprehensive leave management policies.

3.3.2 Leave management practices

Compliance with policies and enterprise bargaining agreement requirements

To assure hospitals comply with leave management policies and the leave provisions contained within the relevant EBAs, the following procedures should exist at public hospitals:

- communicating leave entitlements and associated expectations to staff
- monitoring and authorisation of individual employee leave by direct line managers
- staff training for processing leave entitlements.

Ninety per cent (78 of 87) of public hospitals have appropriate arrangements in place to assist them in complying with the leave policies that were in place, and provisions contained within the EBAs.

Effectiveness of leave management systems

Management's ability to monitor leave costs and balances and process leave requests in a timely manner is dependent on having an efficient leave processing and recording system that interfaces with their financial reporting system.

It was noted that a number of the larger hospitals have recently implemented online leave management systems, such as the Employee Self Service software, which allows staff to apply for and monitor their leave balances online, instead of via manual leave forms.

These systems generally require timely approval to be provided online by an appropriate delegate, and allow managers to more easily monitor up to date leave balances. Software such as this also reduces the need for pay advices to be printed and mailed, as details are available online, thereby providing cost savings and environmental benefits.

While these systems may not be appropriate at all public hospitals, individual hospital boards and management should investigate whether productivity and financial gains are available from the implementation of an online leave management system.

Benchmarking leave outcomes and costs

Benchmarking of leave performance and costs through the use of comparisons with different hospitals or industry standards provides an objective reference point for management to establish their own targets and monitor their own performance and leave trends.

Benchmarking can also be used to assess whether sick leave trends are within normal parameters, recreation leave accruals are not excessive, and that the hospital is minimising the additional costs associated with the taking of unplanned leave.

Our review disclosed that at 76 per cent (66 of 87) of public hospitals there was no evidence of benchmarking leave trends and balances against external standards, with just 11 per cent (6 of 54) of rural public hospitals carrying out such an analysis. Where undertaken, the targets used for assessment were varied, with hospitals using benchmarks such as readily available but limited value public sector averages and departmental standards, through to more relevant results from comparable health services.

Management analysis of leave

Management should assess whether their established benchmarks are being met, and regularly review the need for remedial action in light of the actual leave outcomes experienced and current trends. This enables deficiencies relating to unfavourable leave outcomes to be identified and addressed in a timely manner.

Our review revealed that all metropolitan hospitals and almost 90 per cent (62 of 69) of both rural and regional public hospitals regularly assess the level of excess recreation leave accruals and sick leave absences.

Management review of practices and processes

Our review found that management were unable to demonstrate that they had conducted a review of leave practices and processes at 61 per cent (53 of 87) of hospitals. Such reviews are important to confirm practices and processes remain up to date following any changes in requirements that may arise due to modifications to EBAs, operational requirements, or to address areas of concern. They also allow for business improvements to be identified, for example, more effective reporting procedures or enhancing the use of computer software.

Recommendations

3. Public hospitals should have comprehensive leave monitoring arrangements, including benchmarking leave performance outcomes and costs.

4. Public hospital management should periodically review leave management practices and processes.

3.3.3 Governance and oversight

Monitoring of policy compliance and leave trends and balances

Public hospital boards are responsible for reviewing the adequacy of leave management procedures, assessing compliance with relevant internal policies, and monitoring leave trends in accordance with their responsibilities under the *Health Services Act 1988*. Accordingly, management should provide the board with appropriate, clear and regular reports on leave trends, outcomes and costs to facilitate effective monitoring.

Regular leave reports enable the board to identify areas of concern and direct management to implement appropriate remedial action in response to:

- increasing sick leave absences
- additional costs incurred from excess recreation leave or unplanned sick leave absences
- accumulation of excess recreation leave balances
- taking of leave in excess of entitlements
- unauthorised absences.

Thirty-nine per cent (34 of 87) of public hospitals did not provide their boards with any reports on leave performance outcomes. Where this reporting was performed, it was most commonly done either monthly or quarterly, which is considered appropriate.

For public hospitals that reported on their leave outcomes to the board, the quality of the reporting varied markedly. Two key elements lacking in the majority of leave management reports were details relating to sick leave absences or some form of benchmarking of the leave outcomes. Just over half of the reports reviewed contained a trend analysis of the accumulation of excess recreation leave.

Seventy per cent (37 of 53) of the reports provided to the board contained comments regarding areas of concern relating to leave, however only 28 per cent (15 of 53) of the reports exhibited better practice by including action plans to address the identified deficiencies.

Risk management

Leave management is an area of risk at all organisations which needs to be appropriately recognised and monitored. Low staff productivity, poor occupational health and safety outcomes, and significant additional costs can result if this leave is not managed effectively.

Sixty per cent (52 of 87) of public hospitals had not included risks associated with the management and processing of leave in the hospital's risk management register.

Internal audit

Internal audit should provide hospitals with greater comfort that their internal controls and processes are working as intended, and that they have an effective governance and risk management framework in place. Such reviews also assist hospitals in achieving their desired leave outcomes and appropriately manage the associated risks.

Over the past three years, 69 per cent (60 of 87) of public hospitals have not commissioned internal audit projects in relation to their leave management practices.

Specifically 61 per cent (11 of 18) of metropolitan hospitals, as well as 71 per cent (49 of 69) of both rural and regional hospitals, had not commissioned an internal audit of their leave management practices.

Periodic review of policies and procedures

Boards should periodically review leave management policies and procedures so that they continue to accurately reflect the operational direction and strategic position of the hospitals, and so that any areas of emerging concern can be proactively addressed.

Forty-one per cent, or 29 of 71 public hospital boards, had not reviewed their leave management policies for at least two years. This result was consistent across metropolitan, regional and rural public hospitals.

Furthermore it was evident that at 76 per cent (66 of 87) of public hospitals, the board had not been involved in a review over the adequacy of leave management practices.

Recommendations

5. Public hospital boards should require comprehensive leave management reports from management, including action plans for any adverse movements identified.

6. Public hospital boards should require periodic internal audit reviews of leave management practices and policy compliance.

7. Public hospital boards should periodically review their leave management policies and framework.

3.4 Recreation leave outcomes

Under the applicable EBAs hospital staff are entitled to either four or five weeks of recreation leave. The regular use of recreation leave promotes a healthy and productive workforce, and avoids work disruptions and additional costs associated with staff taking large blocks of outstanding leave.

Our report *Public Hospitals: Results of the 2008–09 Audits* (2009–10:2) noted that specific issues relating to employees with excess recreation leave entitlements had been identified and reported to management in 16 per cent (14 of 88) of public hospitals.

Hospitals effectively managing leave at an operational and strategic level should have policies and practices that reduce the accumulation of excess recreation leave and thereby avoid:

- adverse occupational health and safety outcomes for employees
- impacts on employee productivity and opportunities to take leave
- higher financial costs of accumulating excess recreation leave to be paid at higher rates.

Figure 3G shows the value of recreation leave balances at 31 March 2010 for all public hospitals. As metropolitan hospitals proportionately employ the most staff, they also have the largest portion of the total recreation leave balances for all public hospitals.

Figure 3G
Recreation leave balances by category

Hospital category	31 March 2010 $mil	30 June 2009 $mil
Metropolitan hospitals	314.8	314.9
Regional hospitals	103.2	102.7
Rural hospitals	50.5	49.9
Total	**468.5**	**467.5**

Source: Victorian Auditor-General's Office.

Under the applicable public hospital EBAs, recreation leave entitlements for nurses should be taken within two years after it is accrued, while administrative and support staff should take their entitlement within six months of the accrual year. Therefore, unless otherwise agreed, the maximum balance a public hospital employee may generally carry forward is 50 days for nurses and 30 days for other staff.

Given these varied parameters and the inability of 44 per cent of public hospitals to provide reliable information on a staff category basis, this review, recognising the mix of nursing and other staff, used leave balances in excess of 40 days as an indicator of the accumulation of excess recreation leave.

On this measure, Figure 3H shows the total number of staff with recreation leave per hospital type and the average days held in excess of 40 days by the employees.

Figure 3H
Excess recreation leave balances

Category	Number of staff with leave balances in excess of 40 days		Total days in excess of 40 days		Average days held in excess	
	31 March 2010	30 June 2009	31 March 2010	30 June 2009	31 March 2010	30 June 2009
Metropolitan	4 811	5 122	119 745	133 038	24.9	26.0
Regional	1 347	1 456	33 696	37 770	25.0	25.9
Rural	632	628	22 214	20 095	35.1	32.0
All hospitals	**6 790**	**7 206**	**175 655**	**190 903**	**25.9**	**26.5**

Note: This information was able to be obtained from 90 per cent (78 of 87) of hospitals, including all metropolitan hospitals.
Source: Victorian Auditor-General's Office.

Over 9 per cent of public hospital employees have recreation leave balances in excess of 40 days at 31 March 2010. Figure 3H shows a positive trend with the number of staff with excess leave balances having reduced since 2009 and the average excess leave balance having decreased slightly from 26.5 days at 30 June 2009 to 25.9 days at 31 March 2010.

Of the total number of public hospital employees with recreation leave in excess of 40 days, 78 per cent have excess leave balances of between one to 20 days, with the remaining 22 per cent having more than twenty days in excess of the 40 day benchmark.

Using this criterion, the accumulated value of excess leave balances for the 87 public hospitals in 2009–10 is approximately $49.4 million, ($53.4 million in 2008–09), as detailed in Figure 3I below.

Figure 3I
Estimated value of excess leave at public hospitals by category

Hospital category	31 March 2010 $mil	30 June 2009 $mil
Metropolitan hospitals	36.79	41.00
Regional hospitals	8.23	8.18
Rural hospitals	4.42	4.25
Total	**49.44**	**53.43**

Source: Victorian Auditor-General's Office.

Effectively managing recreation leave at public hospitals promotes the health and well-being of staff, their work-life balance outcomes and contains the cost of leave. This would provide benefits in the long term as staff are likely to be more productive at work, and reduce the risk of stress and exhaustion. While the overall results show a positive trend, there are opportunities to improve the management and monitoring of excess recreation leave at public hospitals.

Recommendation

8. Public hospitals should establish processes that encourage staff to take their recreation leave entitlements at planned intervals.

3.5 Sick leave outcomes

Hospital employees are generally allowed either 14 or 21 days sick leave depending on the length of their employment. Unused sick leave accumulates from year to year however these accumulated sick leave entitlements lapse on resignation or retirement, and are not paid out.

Figure 3J provides details of the average sick leave days taken by public hospital classification for the 2009 and 2010 financial years.

Figure 3J
Average sick leave taken per FTE by hospital category

Hospital category	30 June 2010[(a)] days	30 June 2009 days
Metropolitan hospitals	10.4	10.2
Regional hospitals	10.1	9.6
Rural hospitals	10.2	9.6
All hospitals	**10.3**	**10.0**

Note: (a) 2010 data was collected to 31 March 2010 and projected over twelve months.
Source: Victorian Auditor-General's Office.

The figure shows average sick leave of 10.3 days per FTE for 2009–10, between two and three of which were on average without a certificate. This is slightly higher than the average of 10.0 days taken in 2008–09.

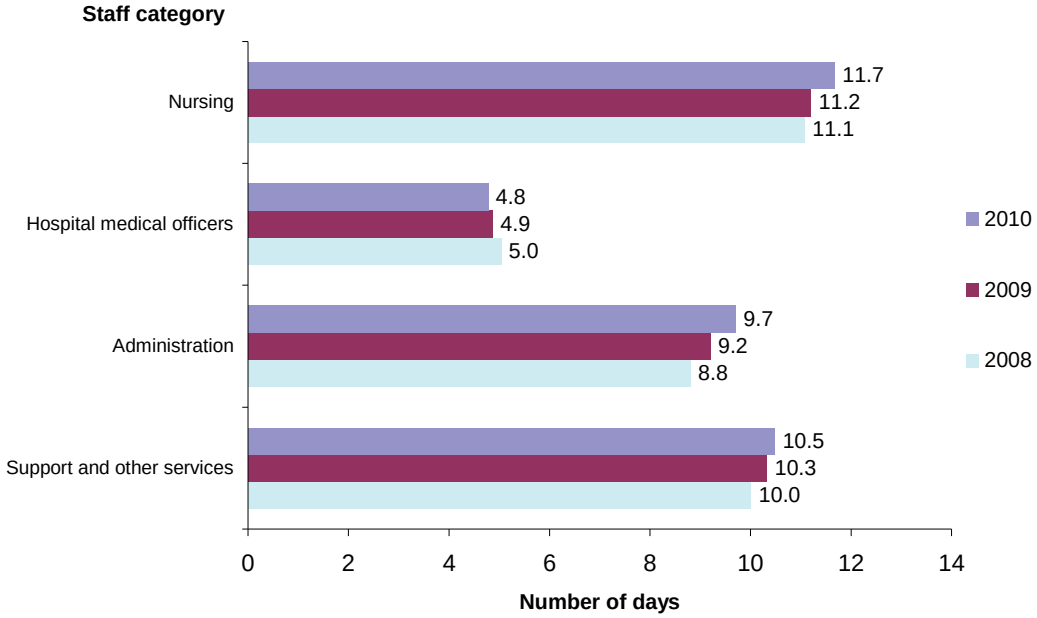
Given the different work performed by each type of hospital staff, reporting on the classifications individually would provide more useful information for management to monitor leave trends and balances, and tailor appropriate responses where undesirable movements are identified.

This review analysed sick leave taken by the four main types of employee classifications of nurses, medical officers, administrative and support staff.

However, it was noted that the payroll systems operating at a number of hospitals were unable to provide sick leave information classified into these established staff categories. Overall, 44 per cent (38 of 87) of hospitals were unable to provide this information, representing 33 per cent of total FTE staff in the sector. This was particularly evident for rural hospitals where 56 per cent (30 of 54) were unable to provide reliable sick leave information by staff category.

Notwithstanding, Figure 3K shows the average number of sick leave days over three years to the 30 June 2010 for the established categories of staff where this information was available. The figure shows that medical officers have taken an average of 4.8 days sick leave per annum, whereas nursing staff have taken an average of 11.7 days per annum in 2009–10. Average sick leave days taken has steadily increased for each staff category over the 3 year period, except for medical officers, which has decreased.

Figure 3K
Average number of sick days taken to 30 June by staff category



Note: 2010 data was collected to 31 March 2010 and projected over twelve months.
Source: Victorian Auditor-General's Office.

When nursing staff are on sick leave public hospitals' permanent or temporary staff are usually required to cover those shifts. In the absence of hospital estimates, audit estimated that across the public hospital sector these fill in shifts cost around $94 million per annum to fund. This excludes the higher pay rates associated with casual staff and overtime. On this basis, the number of sick leave days taken by nursing staff represents a considerable cost to the public hospital system. Therefore significant benefits can be gained from implementing better management programs, which should also lead to a consequential reduction in sick leave absences.

Medical staff and Hospital Medical Officers had taken on average 4.8 days of sick leave in 2009–10, which was considerably lower than nurses and support staff. Under the Hospital Specialists and Medical Administrators Award 2002 full time doctors are entitled to 28 days of sick leave per annum. The variances in leave taken by different categories of staff detailed in Figure 3K suggests that implementing payroll systems that enable reporting by staff category would allow management to more effectively monitor leave trends and balances. This information would also assist management in developing specific action plans to address any deficiencies that may be identified from utilising more detailed reporting.

Figure 3L provides a comparison of sick leave taken in hospitals with publicly available data for the Australian Public Service, public sector departments and better practice outcomes from Victorian public hospitals.

Figure 3L
Average sick leave taken per full time equivalent

Sector	Financial period	Sick leave days per FTE
Administrative staff		
Australian public service	2008–09	7.9[(a)]
Victorian public sector departments	2008–09	7.0
All hospital staff, including nurses		
Best performing public hospitals	2009–10[(b)]	6.3
Victorian public hospitals	2009–10[(c)]	10.3

Note: (a) State of the service report: State of the Service Series 2008–09, Australian Public Service Commissions, 2009.
(b) Calculated as the average of the five public hospitals with the lowest sick leave days taken per FTE in 2009–10. These were the Royal Women's Hospital, Peter MacCallum Cancer Centre, Albury Wodonga Health, Bairnsdale Regional Health Service, and Cobram District Hospital.
(c) Victorian public sector hospitals figure for 2009–10 has been extrapolated for the full 12 months from actual leave details provided by public hospitals from 1 July 2009 to 31 March 2010.
Source: Victorian Auditor-General's Office.

The average results of the five public hospitals with the lowest occurrences of sick leave days taken by staff has also been included in the table above, totalling 6.3 days in 2009–10. All five of these hospitals had comprehensive leave management policies in place and showed evidence of most of the better practice elements outlined in the leave management framework. Additionally, all but one of these hospitals regularly reported their leave trends to the board.

To assist in reducing the level of sick leave absences the public hospital sector should consider introducing the following initiatives, where they are not currently applied:

- providing counselling and support services to staff to assist with the management of substance abuse, depression and other related health issues
- the promotion of informal fitness clubs and gym memberships
- early intervention strategies to deal with stress management.

In 2006 the Australian Public Service Commission developed a better practice guide, *Fostering an attendance culture: A guide for APS agencies*, and a companion guide for line managers, *Turned Up and Tuned In: A manager's guide to maximising staff attendance*.

These guides assist entities to identify workplace absences and their possible causes, and improve their capacity to address problems through implementing better practice strategies such as:

- a reporting framework to assist management to monitor absences, identify patterns and trends and highlight areas for further investigation
- raising awareness of health and safety issues, health lifestyles promotion and prevention mechanisms
- providing more flexible working arrangements so that employees can better manage work-life balance
- establishing and communicating attendance expectations to staff
- providing support and training to line managers to build their confidence and capability in managing workplace absences.

While the management and oversight of unplanned leave at public hospitals has a number of characteristics, the increase in average sick days taken to 2009–10, and the variances in leave patterns of different types of hospital staff suggest that benefits can be achieved from enhanced monitoring of sick leave, and the promotion of health and welfare initiatives.

Enhancing management practices and board oversight should improve staff health, minimise adverse impacts on staff productivity, and reduce the financial consequences of unplanned leave.

Recommendation

9. Public hospitals should improve the level of monitoring, review and oversight of sick leave absences, including the establishment of systems that enable the reporting of leave trends for different categories of staff.

4 Controls over creditors

At a glance

Background

Public hospitals are projected to spend around $2.6 billion on supplies and services in 2009–10. Given the substantial costs and risks associated with creditor payments, we reviewed the effectiveness of controls relating to creditor management policies, practices and governance arrangements.

Findings

There are opportunities for improvement at almost all public hospitals, particularly relating to the development of comprehensive creditor management policies, more effective information systems, and enhanced monitoring of compliance and payment performance. The following deficiencies were noted:

- over 35 per cent of creditor balances at metropolitan and regional hospitals had been outstanding for more than 30 days at 31 March 2010, which contravenes the government's fair payment policy
- 17 per cent (15 of 87) of public hospitals have experienced instances where creditor payments have been deferred due to cash shortages
- 44 per cent (38 of 87) of public hospitals do not have an established creditor management policy
- 51 per cent of public hospital boards (44 of 87) do not include a supplier payment performance review as part of their governance responsibilities
- 84 per cent (73 of 87) of public hospitals did not use external benchmarks to assess their aged creditor balances and payment terms achieved.

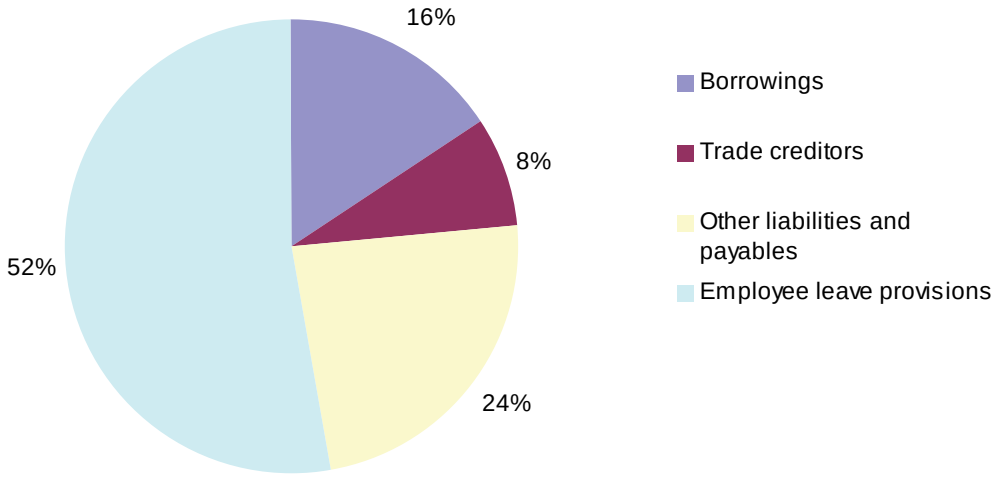
Recommendations

- The Department of Health should expeditiously resolve the inconsistency between their service arrangements with public hospitals and the creditor payment terms required under the government's fair payment policy.
- Public hospital boards should establish and periodically review comprehensive creditor management policies and procedures, and require creditor payment and aged analysis reports to acquit their monitoring obligations.
- Public hospitals should investigate extending the use of computer applications for processing creditors, establish comprehensive monitoring arrangements, and schedule periodic internal audits of creditor management practices.

4.1 Introduction

Total liabilities of public hospitals amounted to $2.7 billion as at 31 March 2010 ($2.9 billion at 30 June 2009). In balance sheet terms, Figure 4A shows that at 31 March 2010, eight per cent of liabilities relate to trade creditors.

Figure 4A
Composition of public hospital liabilities at 31 March 2010



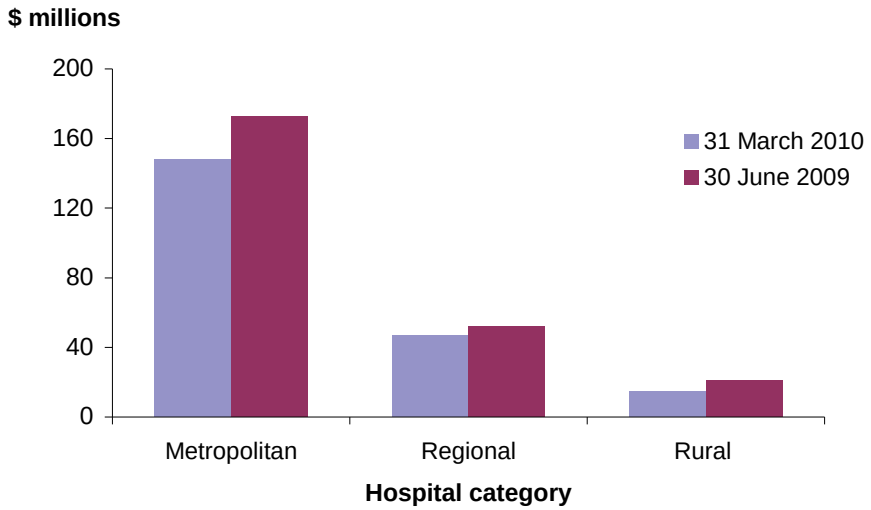
Source: Victorian Auditor-General's Office.

Given the financial significance of creditors for public hospitals, we reviewed the management controls and processes over public hospital expenditure and liabilities relating to trade creditors.

Our report, *Public Hospitals: Results of the 2008–09 Audits* (2009–10:2), included comment on public hospital financial sustainability. At 30 June 2009, 28 per cent (25 of 88) of hospitals, including 12 major metropolitan and regional hospitals, had cash holdings equivalent to less than 15 days operating cash outflows. Several hospitals had cash holdings of less than five days operating cash outflows. This report explores this matter further by addressing the control frameworks at public hospitals to meet the Department of Health's (DH) requirements for paying creditors, and reviews compliance with the government's fair payment policy.

Total expenditure on supplies and services by public hospitals was projected to be $2.6 billion for the financial year to 30 June 2010, up from $2.0 billion in 2008–09. Outstanding payments for supplies and services totalled $209 million at 31 March 2010 ($246 million at 30 June 2009). Figure 4B shows that metropolitan hospitals account for the largest proportion of this liability, followed by regional and rural hospitals respectively.

Figure 4B
Outstanding creditor balances by hospital classification



Source: Victorian Auditor-General's Office.

Creditor payment requirements

In November 2004, the government released the fair payment clause for inclusion in government contracts, requiring government departments to pay for purchased goods and services of less than $3 million, on the lesser of supplier terms or 30 days from the date a correct invoice is received. This commitment was extended to all major and significant public sector agencies in August 2006, as outlined in Victoria's Small Business Statement, *Time to Thrive: Supporting the changing face of Victorian small businesses*.

The aim of the fair payment policy was to improve the cash flow certainty for small and medium sized businesses, as late payments can place significant pressure on their operations and survival. It was also intended to promote prompt payment by large government contractors and grant recipients, as a way of demonstrating good corporate citizenship.

Where the fair payment policy applies and payments have been delayed, suppliers may claim penalty interest. The Attorney-General fixes the penalty interest rate under the *Penalty Interest Rates Act 1983* and it is regularly reviewed based on an appropriate institutional rate with an added penalty element.

Under DH's funding and service agreements, titled *Statement of Priorities*, for the major metropolitan and regional hospitals, public hospital creditors are required to be paid within 60 days. DH has advised that the government's fair payment policy was not applicable to the public hospital sector.

However, review of the documentation published in relation to the fair payment policy showed that there was a clear intent that it would apply to the larger metropolitan and regional public hospitals. Specifically, Victoria's August 2006 Small Business Statement states that 'the Victorian Government will extend to major and significant agencies the commitment to paying bills within 30 days'.

In June 2007 the Secretary of the Department of Innovation, Industry and Regional Development (DIIRD) wrote to the then Secretary of the Department of Human Services (DHS) requesting that, given the serious cash flow disruptions to small business caused by late payments, DHS set a timetable for hospitals and health services to comply with the fair payment policy, in accordance with the government's commitment.

The Secretary of DHS responded to this in August 2007 advising that the hospitals and health services would experience significant cash flow difficulties if their existing payment policy of 60 days were brought forward to 30 days. Further, hospitals were unable to comply with the fair payment policy without the injection of an additional cash flow, which they estimated to be approximately $130 million.

DHS subsequently advised DIIRD that it would consider implementing the fair payment policy in 2008–09 following their budget submission. At the date of this report there was no evidence that the department had made a budget submission or taken other action to implement the fair payment policy or to obtain an exemption.

The continuing non compliance with fair payment policy requirements in the department's hospital funding agreements is yet to be resolved.

Recommendation

10. The Department of Health should expedite resolution of the inconsistency between their service arrangements with public hospitals and the creditor payment terms required under the government's fair payment policy.

4.2 Creditor management controls and processes

Public hospitals need processes in place to enable the payment of creditor invoices by their due dates. This is necessary for public hospitals to meet the requirements of their service agreements, as a minimum, and to enable them to comply with internally established payment terms, as well as the government's fair payment policy.

We analysed the systems and processes forming the control framework over payments to creditors, which public hospitals had established to manage these functions. We examined the actual performance outcomes of public hospitals in paying their creditors.

Individual public hospital boards are responsible for managing creditors, consistent with the *Health Services Act 1988*.

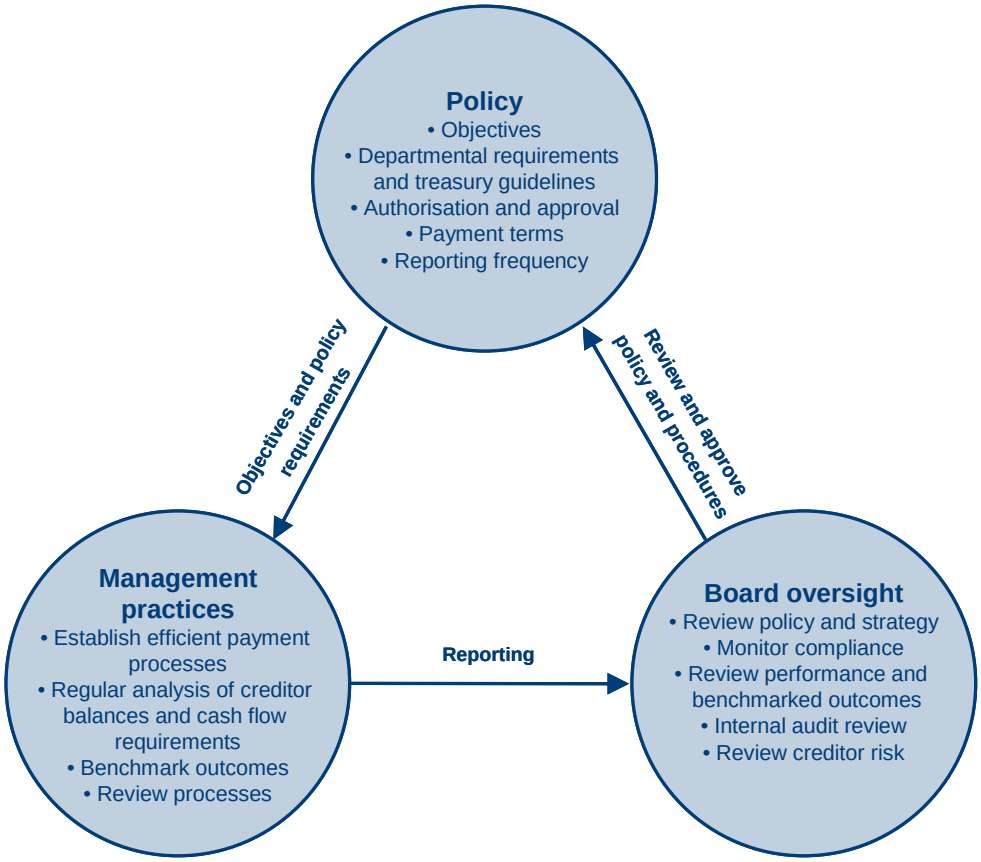
Establishing controls and monitoring their operation should promote prudent creditor management, as required under the Minister of Finance's Standing Directions pursuant to the *Financial Management Act 1994* (FMA). This should also lead to efficient cash flow management, assure compliance with government policy, and assist in meeting the payment requirements of DH.

Effective creditor management controls and processes include:

- comprehensive policies
- appropriate management practices, and
- sound governance and oversight arrangements.

Figure 4C further outlines the components of effective creditor management controls and processes. This better practice model was developed by reference to the Standing Directions of the Minister for Finance. These standing directions are mandatory requirements that should be followed by all public hospitals.

Figure 4C
Creditor management control cycle



Source: Victorian Auditor-General's Office.

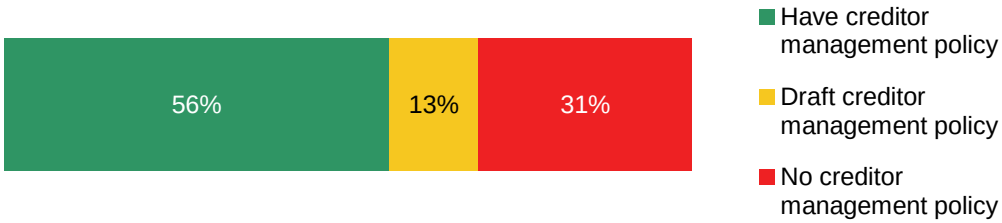
This creditor management control cycle encompasses the critical aspects relating to the management and payment of creditors, including payment terms, monitoring, performance management and board oversight arrangements. The establishment of such comprehensive creditor management processes would assist public hospitals in meeting their responsibilities more efficiently.

4.2.1 Policy

Creditor management policies

Figure 4D sets out the proportion of public hospitals that have established policies for managing their creditors.

Figure 4D
Public hospitals with creditor management policies



Source: Victorian Auditor-General's Office.

As at 31 March 2010, 56 per cent (49 of 87) of public hospitals had established a creditor management policy and collectively had creditors owing valued at $92 million. This represents 44 per cent of the total creditors held by the public hospital sector.

A further 13 per cent or 11 public hospitals were in the process of drafting creditor management policies and the remaining 31 per cent, or 27 hospitals, did not have documented creditor policies. These hospitals collectively had creditors owing valued at $117 million, or 56 per cent of the total creditors held by the sector.

One third of metropolitan hospitals did not have a creditor management policy. Creditor management policies did not exist at 40 per cent of regional hospitals and 48 per cent of rural hospitals.

Adequacy of policies established

While very few public hospital's creditor management policies contained all the elements identified in Figure 4C, the majority of the policies examined did incorporate the following important aspects:

- creditor management objectives were included in 84 per cent (41 of 49)
- authorisation and approval arrangements were contained in 90 per cent (44 of 49)

- staff responsibilities were specified in 86 per cent (42 of 49)
- reference to departmental and government requirements were included in 61 per cent (30 of 49).

Conversely, important elements not commonly included in the creditor management policies were:

- reporting frequency and accountabilities were not specified in 63 per cent (31 of 49)
- requirements on payment terms were not specified in 45 per cent (22 of 49)
- requirements for meeting supplier terms of trade were not specified in 45 per cent (22 of 49).

There was not a significant variation in the quality of policies across metropolitan, regional and rural hospitals. Overall there is scope for significant improvement in the existence and quality of documented creditor management policies across most public hospitals.

Board approval of policies

Governing boards have primary responsibility for ensuring the effective management of creditor payment functions at public hospitals, in accordance with the requirements of the *Health Services Act 1988*.

In discharging these legislative responsibilities the board should establish and periodically review policies, as they are ultimately responsible for any deficiencies in policy setting.

For the public hospitals that had established a creditor management policy, 41 per cent (20 of 49) of these policies had not been reviewed and approved by the board.

Recommendation

11. Public hospital boards should oversee the establishment and periodic review of comprehensive creditor management policies and procedures.

4.2.2 Management practices and systems

Efficiency of creditor payments processing

Administering creditor payments is an important responsibility of public hospitals, and the technology supporting this is constantly evolving. The more efficient systems have at least some of the following features; automatic ageing analysis, online purchasing, system-based matching of documents for authorisation, payment by electronic funds transfer, and the use of emails to raise orders and send remittance advices.

Some of these relatively new facilities present opportunities for efficiency gains, but can also pose a risk to the control framework, warranting continual attention both from management and boards.

Public hospitals are utilising some of these computerised technologies to make the processing of payments more efficient. These technologies save money, for example, by reducing the number of cheques that must be generated and mailed. They also allow public hospitals to more reliably control accounting and authorisation procedures.

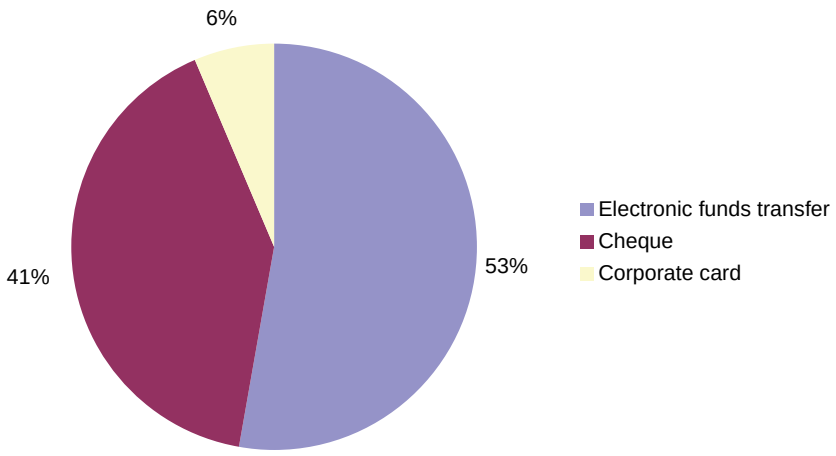
In determining whether public hospital creditor payment processes were performing efficiently and effectively we assessed if:

- systems could automatically produce creditor balance details and an ageing analysis
- electronic fund transfers were the preferred method of payment
- emails were used to communicate purchase orders and remittance advices to suppliers
- systems were capable of scheduling payments.

On this basis, of the 87 public hospitals, 84 per cent (or 73 hospitals) are using an automated aged analysis facility to effectively monitor creditor balances, including all metropolitan hospitals. However there are still opportunities to use other modern systems and technologies more extensively, which should result in cost savings.

For example, Figure 4E shows that at each hospital, on average, 53 per cent of creditor payments are made by electronic funds transfer. This was higher for metropolitan hospitals, which on average made 73 per cent of their payments by electronic funds transfer and lower for rural hospitals averaging 45 per cent.

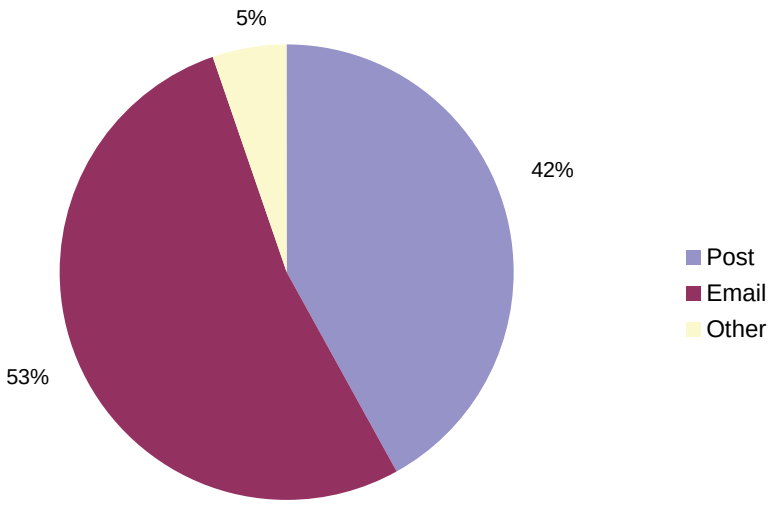
Figure 4E
Preferred payment methods at public hospitals



Source: Victorian Auditor-General's Office.

Figure 4F shows that 42 per cent of public hospitals still send remittance advice notices to suppliers via post. Therefore, although 70 per cent of hospitals surveyed are paying at least some of their accounts by electronic funds transfer, they are not receiving the full benefits from the adoption of this technology, as only 53 per cent of these send remittance advices by email. The extensive residual use of traditional mail to deliver remittance advices means these public hospitals are not gaining the efficiencies and substantial cost savings available through moving from post to email.

Figure 4F
Method of sending remittance advices at public hospitals



Source: Victorian Auditor-General's Office.

Eighty-four per cent (73 of 87) of public hospitals had systems capable of scheduling payments either on creditor terms of trade or on the hospital's preferred payment terms. However 68 per cent (59 of 87) of hospitals do not have mechanisms in place to capture and report on compliance with terms of trade.

At least 20 per cent of public hospitals were unable to determine the average days elapsed from invoice date to payment, and therefore are not able to effectively manage and monitor their payment performance. Furthermore, it was noted that hospitals are generally unable to capture the actual date of receipt of supplier invoices, instead using the invoice date for recording purposes. As a consequence, payment performance against due date is not able to be reliably measured against the requirements of the fair payment policy, which is based on the date a correct invoice is received by the agency.

Analysis of payment performance

As part of meeting their payment terms, hospital management regularly perform an aged analysis of creditors in 74 per cent (64 of 87) of hospitals. An important function of paying on terms of trade and managing creditor payments is monitoring the outcome.

This was achieved through monthly reporting on:

- late payment statistics, including invoices awaiting payment by age, number and value
- business management statistics detailing creditor payment performance and turnover for the current and previous months.

Benchmarking creditor payment performance

Benchmarking is an effective means of assessing each hospital's creditor management performance. It is important to use both external and internal benchmarks, and not just compare against the hospital's past performance, as this provides a more objective measure of the standard of performance achieved.

For the 87 public hospitals, 84 per cent (or 73 hospitals) did not use external benchmarks to assess their aged creditor balances and payment terms achieved, such as industry averages or departmental targets. Furthermore, no hospital had established benchmarks against which to monitor the performance of their accounts payable system, such as average processing cost, or average creditor payments made for each staff member engaged in these functions.

Payment performance outcomes

Hospitals did not generally pay on supplier terms unless this was an overriding supplier requirement. Generally hospitals' creditor policies included a range of payment terms which were often dependent on the various types of supply. Payment terms ranged from immediate up to 60 days payment.

The Minister for Finance requires public hospitals, which operate under the FMA, to have in place a system that is capable of paying all debts as and when they fall due and payable.

Figure 4G details the ageing of the hospitals' trade payables at 31 March 2010 compared with 30 June 2009. The analysis examined the number of days that have elapsed from the date of invoice.

Figure 4G
Ageing of creditors by hospital category

	31 March 2010 (%)				30 June 2009 (%)			
Category **Days**	**1–30**	**31–60**	**61–90**	**91+**	**1–30**	**31–60**	**61–90**	**91+**
Metropolitan hospitals	64.7	30.6	3.4	1.3	58.6	36.4	3.1	1.9
Regional hospitals	63.7	30.3	3.3	2.7	78.8	18.3	1.7	1.2
Rural hospitals	92.4	6.5	0.5	0.6	91.0	7.4	0.4	1.2
All hospitals	**66.4**	**28.8**	**3.2**	**1.6**	**65.6**	**30.1**	**2.6**	**1.7**

Source: Victorian Auditor-General's Office.

This analysis indicates that while hospitals are making most payments consistent with their funding agreements, they are generally not meeting the 30 day payment terms for invoices on hand at year end, with more than 33 per cent of the value of invoices exceeding 30 days from invoice date for the metropolitan and regional hospitals. Positively though, rural hospitals are paying 92 per cent of their creditors within 30 days.

To monitor hospital compliance with its funding agreements, the Department of Health regularly collects financial information from each of the major public hospitals, including details relating to the payment of creditors. This is measured monthly and shows the average number of days that a hospital takes to pay its suppliers. This demonstrates the poor payment performance of metropolitan hospitals. Substantial variances were noted across all major public hospitals, with over half regularly ranging from 40 days to 70 days, with five hospitals frequently in excess of 55 days.

The incidence of payments across the public hospital sector made outside of the 30 day requirements for major and significant agencies in the fair payment policy is substantial. The performance achieved indicates that suppliers may suffer cash flow difficulties as a result, contravening the aim of the government's fair payment policy.

Additionally, the review disclosed that 17 per cent (15 of 87) of public hospitals have experienced instances where creditor payments have been deferred due to cash shortages.

It is important that hospital management continues to monitor and assess creditor payments for compliance and to enable available efficiency gains to be realised. Our analysis also indicates that there is a need to improve payment times, particularly for metropolitan and regional hospitals.

To improve their performance, management should undertake a regular review of creditor management practices and processes. Fifty-three per cent (46 of 87) of public hospitals had not conducted a management review of creditor practices and processes within the last three years.

Recommendations

12. Public hospitals should investigate extending the use of computerised applications for processing their creditors, including online purchase orders, electronic funds transfer and sending remittance advices via email.

13. Public hospitals should confirm that processes are incorporated into their creditor payment functions to achieve the government's required payment terms.

14. Public hospitals should establish comprehensive monitoring arrangements their creditor management practices, including payment terms achieved, number of late payments, supplier complaints, number of active suppliers, and average processing costs.

4.2.3 Governance and oversight

Monitoring of policy compliance and payment performance

To assess the adequacy of each hospital board's oversight of their creditor functions, we reviewed whether the boards scrutinise this activity. We also examined the creditor information supplied by management for board review. Factors considered were whether:

- the age profile of creditors was regularly monitored
- performance targets for the accounts payable function were set and analysed
- creditor management performance statistics were reported to the board
- risks associated with the management of creditors had been documented.

Forty-nine per cent of public hospital boards (43 of 87) include a supplier payment performance review as part of their regular governance oversight. Where creditor management performance statistics had been supplied to boards this was most commonly performed monthly.

Of those hospitals that did have regular board reports, the quality of that reporting varied markedly. Management comments and recommendations regarding areas of concern were included in 70 per cent (30 of 43), and average payment terms achieved by the hospital were included in 53 per cent (23 of 43) of these board reports. Key elements not included in the majority of these reports were details of aged creditor balances and measuring performance against external benchmarks.

Risk recognition and management

Creditor management is a risk for all organisations. Inadequate payment systems can result in inefficient processing, duplicate payments and opportunities for staff to misappropriate funds. In addition, poor cash flow management may result in penalty interest expenses being unnecessarily incurred by the hospital for late payments, and increase supplier complaints.

Sixty-nine per cent (60 of 87) of public hospitals had not included risks associated with the management of creditors and payment processing in the hospital's risk management register. This was despite their obligations under their funding and service agreements with DH regarding the timeliness of creditor payments.

Internal audit

Most hospitals include creditor functions within the scope of internal audit examination. In some instances, external consultants are engaged to conduct compliance reviews of their control frameworks, including creditors. Several hospitals had also conducted compliance reviews using finance and administration staff.

Hospitals internally audit their creditor functions with varying frequencies. Some hospitals conduct these internal audits annually with others conducting cyclical audits.

Overall, internal audit coverage of the systems and processes relating to the payment of creditors was not strong. Half of the metropolitan hospitals had not completed an internal audit review of creditor management since 2007. There was also scope to improve internal audit coverage in regional and rural hospitals as no internal audit reviews had been completed at 67 per cent (10 of 15) of regional hospitals or at 63 per cent (34 of 54) of rural hospitals.

Periodic board review of creditor management policy and procedures

Creditor management policies and procedures should be approved by the board and regularly reviewed in accordance with the Standing Directions of the Minister of Finance, so that they accurately reflect the current operational and strategic position of the hospital.

For the 49 public hospitals that have a creditor management policy, 24 per cent (12 of 49) had not been reviewed for at least three years. This result was consistent across metropolitan, regional and rural hospitals.

Twenty per cent (17 of 87) of hospitals have a system in place where the board annually reviews the adequacy of creditor management policies and practices, resulting in greater alignment with the overall strategic and financial objectives of the hospital.

Overall conclusion

Payments for supplies and consumables represent a significant proportion of public hospital expenditure and accordingly management and the board should regularly review the policies, procedures and governance arrangements around creditor payments and information systems. This will assist management in recognising and addressing changes to financial risks, and complying with departmental and government requirements. Improved monitoring will also allow the hospital to take advantage of any opportunities for efficiency gains around the processing of supplier orders and payments.

There is potential for improvement at almost all public hospitals, particularly relating to the development of comprehensive creditor management policies, more effective information systems, and enhanced monitoring of compliance and payment performance.

Recommendations

15. Public hospital boards should review their creditor management policies and processes periodically.

16. Public hospital boards should receive comprehensive creditor payment and aged analysis reports, including benchmarked payment performance information, to acquit their monitoring obligations.

17. Public hospital boards should schedule periodic internal audit reviews of creditor management practices and related policy compliance.

Appendix A.
Acronyms and glossary

Acronyms

APS	Australian Public Service
DH	Department of Health
DHS	Department of Human Services
DIIRD	Department of Innovation, Industry and Regional Development
DTF	Department of Treasury and Finance
EBA	Enterprise Bargaining Agreement
EFT	Electronic Funds Transfer
FMA	*Financial Management Act 1994*
FTE	Full Time Equivalent
IS	Information System
VAGO	Victorian Auditor-General's Office

Definitions

Accountability

Responsibility of public sector entities to achieve their objectives, with regard to reliability of financial reporting, effectiveness and efficiency of operations, compliance with applicable laws, and reporting to interested parties.

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

An asset's useful life is the period over which it is expected to provide the entity with economic benefits. Depending on the nature of the asset, the useful life can be expressed in terms of time or output.

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.

Benchmarking

The process of assessing business outcomes against comparable measures to evaluate performance. This provides an objective reference point from which management can establish their own targets and monitor trends.

Depreciation

The apportionment of the capital value of an asset over its expected useful life. The amount of depreciation expensed takes account of normal usage, obsolescence or the passage of time.

Emphasis of matter

In certain circumstances, an auditor's opinion is modified by adding an emphasis of matter paragraph to highlight a matter affecting the financial report which is included in a note to the financial statements. The addition of such an emphasis of matter paragraph does not affect the auditor's opinion.

Employee leave liabilities

The liability recognised for employees accrued service entitlements, including all accrued costs related to employment comprising of wages and salaries, leave entitlements, redundancy payments and superannuation contributions.

Entity

Is a body whether corporate or unincorporated that has a public function to exercise on behalf of the state or is wholly owned by the state, including departments, statutory authorities, statutory corporations and government business enterprises.

Equity or net assets

Residual interest in the assets of an entity after deduction of its liabilities.

Expense

Outflows or other depletions of economic benefits in the form of liabilities incurred or depletion of assets of the entity, other than those relating to contributions by owners, that result in a decrease in equity during the reporting period.

Fair value

The amount for which a financial or non-financial asset could be exchanged between knowledgeable and willing parties in an arms-length transaction.

Financial delegation

A schedule that specifies the level of approval required for each transaction category to facilitate the execution of functions necessary for the efficient operation of the entity.

Financial report

Structured representation of the financial information, which usually includes accompanying notes, derived from accounting records and intended to communicate an entity's economic resources or obligations at a point in time or the changes therein for a period in accordance with a financial reporting framework.

Financial sustainability

An entity's ability to manage financial resources so it can meet spending commitments, both at present and into the future.

Financial year

A period of 12 months for which a financial report is prepared ending on 30 June each year for public hospitals and associated entities.

Going concern

An entity which is expected to be able to pay its debts as and when they fall due, and continue in operation without any intention or necessity to liquidate or otherwise wind up its operations.

Governance

The control arrangements in place at an entity that are used to govern and monitor its activities, in order to achieve its strategic and operational goals. It includes the oversight role of the board of management at public hospitals.

Internal control

A process effected by an entity's structure, work and authority flows, people and management information systems, designed to assist the entity accomplish specific goals and objectives. Internal control is a means by which an entity's resources are directed, monitored and measured. It plays an important role in preventing and detecting error and fraud and protecting the entity's resources.

Joint venture

A contractual agreement joining together two or more parties for the purpose of executing a particular business undertaking. All parties agree to share in the profits and losses of the enterprise.

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.

Masterfile

A database of entries containing data that does not often change (for example, address and bank account details).

Materiality

Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial report. Materiality depends on the size of the item or error judged in the particular circumstances of its omission or misstatement. Thus, materiality provides a threshold or cut-off point rather than being a primary qualitative characteristic which information must have if it is to be useful.

Material entity

Material entities represent those entities that are collectively deemed to have a significant effect on the transactions and balances reported in the state's annual financial report.

The selection of these entities follows a detailed analysis of the financial operations of all controlled entities and takes into account any major risk factors that are attached to specific entities or portfolios.

Modified audit report

The types of modified audit reports and the basis for issuing these reports are as follows:

- A 'qualified opinion' is expressed when the auditor concludes that an unqualified opinion cannot be expressed due to a disagreement with management, a conflict between applicable financial reporting frameworks or a scope limitation; however, the effect is not so material and pervasive as to require an adverse opinion or a disclaimer of opinion. The qualified opinion is expressed as being 'except for' the effects of the matter to which the qualification relates.
- A 'disclaimer of opinion' is expressed when a limitation of scope of the auditor's work exists and the possible effect of the limitation on scope is so material and pervasive that the auditor has not been able to obtain sufficient appropriate audit evidence and accordingly is unable to express an opinion on the financial statements.
- An 'emphasis of matter' is expressed in certain circumstances to draw attention to, or emphasise, a matter that is included in the note to the financial statements that is relevant to the users of the auditor's report but is not of such nature that it affects the auditor's opinion (i.e. the auditor's opinion remains unmodified).

Net result

The net result is calculated by subtracting an entity's total expenses from total revenue, to show what the entity has earned or lost in a given period of time.

Public sector entity

A department; a public hospital; a statutory body; an entity controlled by one, or more than one, department, public hospital or statutory body; or an entity controlled by an entity that is a public sector entity.

Qualification

A qualification is issued when the auditor concludes that an unqualified opinion cannot be expressed due to one of the following reasons:

- disagreement with those charged with governance
- conflict between applicable financial reporting frameworks
- limitation of scope.

A qualified opinion shall be expressed as being except for the effects of the matter to which the qualification relates.

Revenue

Inflow of funds, at public hospitals it is generally in the form of grants, private fees and charges. Can also include other savings in outflows of service potential, or future economic benefits in the form of increases in assets or reductions in liabilities of the entity.

Risk

The chance of a negative impact on the objectives, outputs or outcomes of the entity.

Unqualified audit opinion

An unqualified audit opinion is an expression by the auditor stating that the entity has followed all accounting rules appropriately and that the financial reports are an accurate representation of the entity's financial condition. Also referred to as a clear audit opinion.

Wage on-costs

The additional costs incurred as a consequence of employing personnel. Examples of wage on-costs include workcover, payroll tax and superannuation contributions.

Appendix B.
Public hospital entities listing

Figure B1
Legislative reporting framework

Entity	Audit Type
Metropolitan hospitals and associated entities	
Alfred Health	FMA
Austin Health	FMA
Calvary Health Care Bethlehem Ltd	C
Dental Health Services Victoria	FMA
Eastern Health	FMA
Melbourne Health	FMA
Evivar Medical Pty Ltd	C
Royal Melbourne Hospital Foundation Ltd	C
Mercy Public Hospitals Inc.	FMA
Northern Health	FMA
Northern After Hours Clinic Limited	C
Northern Health Research, Training and Equipment Foundation Limited	C
Northern Health Research, Training and Equipment Foundation Trust	O
Peninsula Health	FMA
Peter MacCallum Cancer Centre	FMA
Cell Therapies Pty Ltd	C
Peter MacCallum Cancer Foundation	FMA
Peter MacCallum Cancer Foundation Ltd	C
Queen Elizabeth Centre	FMA
Royal Children's Hospital	FMA
Communities That Care Limited	C
Royal Children's Hospital Education Institute Ltd	C
Royal Children's Hospital Foundation Trust Funds	C
Royal Victorian Eye and Ear Hospital	FMA
Royal Women's Hospital	FMA
Royal Women's Hospital Foundation Limited	C
Royal Women's Hospital Trust Funds	O
Southern Health	FMA
Kitaya Holdings Ltd	C
St. Vincent's Hospital (Melbourne) Limited	C

Figure B1
Legislative reporting framework – *continued*

Entity	Audit Type
Metropolitan hospitals and associated entities – *continued*	
Tweddle Child and Family Health Service	FMA
Western Health	FMA
Regional hospitals and associated entities	
Albury Wodonga Health	FMA
Bairnsdale Regional Health Service	FMA
Ballarat Health Services	FMA
Barwon Health	FMA
Bendigo Health Care Group	FMA
Central Gippsland Health Service	FMA
Echuca Regional Health	FMA
Echuca Regional Health Foundation	O
Echuca Regional Health Foundation Limited	C
Goulburn Valley Health	FMA
Latrobe Regional Hospital	FMA
Northeast Health Wangaratta	FMA
South West Healthcare	FMA
Swan Hill District Hospital	FMA
West Gippsland Healthcare Group	FMA
Western District Health Service	FMA
Wimmera Health Care Group	FMA
Rural hospitals and associated entities	
Alexandra District Hospital	FMA
Alpine Health	FMA
Bass Coast Regional Health	FMA
Beaufort and Skipton Health Service	FMA
Beaufort and Skipton Health Services Foundation Ltd	C
Beechworth Health Service	FMA
Benalla and District Memorial Hospital	FMA
Boort District Hospital	FMA
Casterton Memorial Hospital	FMA
Castlemaine Health	FMA
Cobram District Hospital	FMA
Cobram District Health Services Foundation	O
Cohuna District Hospital	FMA
Cohuna Community Nursing Home Inc.	FMA
Colac Area Health	FMA
Djerriwarrh Health Services	FMA
Dunmunkle Health Services	FMA

Figure B1
Legislative reporting framework – *continued*

Entity	Audit Type
Rural hospitals and associated entities – *continued*	
East Grampians Health Service	FMA
East Wimmera Health Service	FMA
Edenhope and District Memorial Hospital	FMA
Gippsland Southern Health Service	FMA
Heathcote Health	FMA
Hepburn Health Service	FMA
Hesse Rural Health Service	FMA
Winchelsea Hostel and Nursing Home Society	O
Heywood Rural Health	FMA
Inglewood and Districts Health Service	FMA
Kerang District Health	FMA
Kilmore and District Hospital	FMA
Kooweerup Regional Health Service	FMA
Kyabram and District Health Service	FMA
Kyneton District Health Service	FMA
Lorne Community Hospital	FMA
Maldon Hospital	FMA
Mallee Track Health and Community Service	FMA
Mansfield District Hospital	FMA
Maryborough District Health Service	FMA
Moyne Health Services	FMA
Moyne Health Services Inc.	A
Nathalia District Hospital	FMA
Numurkah District Health Service	FMA
Orbost Regional Health	FMA
Portland District Health	FMA
Omeo District Hospital	FMA
Otway Health and Community Services	FMA
Robinvale District Health Services	FMA
Rochester and Elmore District Health Service	FMA
Rural Northwest Health	FMA
Seymour District Memorial Hospital	FMA
South Gippsland Hospital	FMA
Stawell Regional Health	FMA
Stawell District Hospital Foundation	FMA
Tallangatta Health Service	FMA
Terang and Mortlake Health Service	FMA
Timboon and District Healthcare Service	FMA

Figure B1
Legislative reporting framework – *continued*

Entity	Audit Type
Rural hospitals and associated entities – *continued*	
Upper Murray Health and Community Services	FMA
West Wimmera Health Service	FMA
Yarram and District Health Service	FMA
Yarrawonga District Health Service	FMA
Yea and District Memorial Hospital	FMA

Note: Financial Management Act 1994 (FMA) audits are represented by FMA. Non-FMA audit types: A—*Associations Incorporation Act 1981*, C—*Corporations Act 2001* and O—other reporting framework.

Source: Victorian Auditor-General's Office.

Appendix C.
Completed audit listing

Figure C1
Completed audits with 30 June 2010 balance dates

Entity	Clear opinion issued	Auditor-General's report signed
Alexandra District Hospital	✓	23 Aug 2010
Alfred Health	✓	11 Aug 2010
Austin Health	✓	12 Aug 2010
Ballarat Health Services	✓	6 Aug 2010
Barwon Health	✓	6 Aug 2010
Benalla and District Memorial Hospital	✓	19 Aug 2010
Casterton Memorial Hospital	✓	19 Aug 2010
Dental Health Services Victoria	✓	19 Aug 2010
Dunmunkle Health Services	✓	20 Aug 2010
East Wimmera Health Service	✓	19 Aug 2010
Eastern Health	✓	11 Aug 2010
Heathcote Health	✓	20 Aug 2010
Hesse Rural Health Service	✓	13 Aug 2010
Heywood Rural Health	✓	24 Aug 2010
Latrobe Regional Hospital	✓	23 Aug 2010
Melbourne Health	✓	9 Aug 2010
Royal Melbourne Hospital Foundation Ltd	✓	6 Aug 2010
Moyne Health Services	✓	19 Aug 2010
Moyne Health Services Inc.	✓	19 Aug 2010
Northern Health	✓	17 Aug 2010
Northern Health Research, Training and Equipment Foundation Limited	✓	30 Jul 2010
Northern Health Research, Training and Equipment Foundation Trust	✓	30 Jul 2010
Peninsula Health	✓	23 Aug 2010
Peter MacCallum Cancer Centre	✓	13 Aug 2010
Cell Therapies Pty Ltd	✓	12 Aug 2010
Peter MacCallum Cancer Foundation	✓	16 Aug 2010
Peter MacCallum Cancer Foundation Limited	✓	16 Aug 2010

Figure C1
Completed audits with 30 June 2010 balance dates – *continued*

Entity	Clear opinion issued	Auditor-General's report signed
Portland District Health	✓	20 Aug 2010
Queen Elizabeth Centre	✓	18 Aug 2010
Royal Children's Hospital	✓	24 Aug 2010
Communities That Care Limited	✓	26 Jul 2010
Royal Children's Hospital Education Institute Ltd	✓	12 Aug 2010
Royal Children's Hospital Foundation Trust Funds	✓	13 Aug 2010
South West Healthcare	✓	24 Aug 2010
Southern Health	✓	11 Aug 2010
Kitaya Holdings Pty Ltd	✓	11 Aug 2010
Terang and Mortlake Health Service	✓	23 Aug 2010
Timboon and District Healthcare Service	✓	19 Aug 2010
West Wimmera Health Service	✓	17 Aug 2010
Western District Health Service	✓	18 Aug 2010
Western Health	✓	18 Aug 2010
Yarram and District Health Service	✓	23 Aug 2010

Source: Victorian Auditor-General's Office.

Appendix D.
Audit Act 1994 section 16—submissions and comments

Introduction

In accordance with section 16(3) of the *Audit Act 1994* a copy of this report was provided to the Department of Health with a request for comments or submissions.

The comments and submissions provided are not subject to audit nor the evidentiary standards required to reach an audit conclusion. Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Submissions and comments received

***RESPONSE* provided by the Secretary of the Department of Health**

Department of Health

Secretary

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e2031476

Mr D D R Pearson
Auditor-General
Level 24, 35 Collins Street
MELBOURNE 3000

Dear Mr Pearson

Thank you for your letter of 12 August 2010 inviting me to comment on the proposed audit report *Public Hospitals: Interim Results of the 2009-10 Audits*.

I can confirm that I am satisfied with the fairness and accuracy of the report which provides a number of opportunities for public hospitals to improve their internal controls.

I would like to include a succinct response to your findings and recommendations which is enclosed.

Yours sincerely

FRAN THORN
Secretary

Encl

Victoria
The Place To Be

***RESPONSE* provided by the Secretary of the Department of Health – continued**

General Comments

The Department welcomes audit advice that:

- The overall assessment of financial controls is that they are adequate for financial reporting purposes
- No weaknesses that could lead to significant uncertainty about the financial information being reported in the 2009/10 financial statements were found.

I note that audit further finds that a number of financial control practices related to account reconciliations, authorisation procedures and the like were variable and could be strengthened. Whilst these are mainly matters for health services and Boards to address I support the need to further improve financial controls.

I also noted that whilst health service creditor payment terms are 60 days, approximately two thirds of creditors are paid within 30 days and that the number of creditors paid within 30 days improved since the previous period.

Whilst this audit report focuses on financial controls, DH has put in place a number of measures to also address data controls such as the implementation of systematic and spot audits and the appointment of a Director of Data Integrity.

In regards to the specific summary recommendations I make the following comments:

Recommendation 1	Support
Recommendation 2	Support
Recommendation 3	Support The Health Service Management Innovation Council has sponsored work focused on improving sick leave management.
Recommendation 4	Support in principle
Recommendation 5	Support
Recommendation 6	Support

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Report title	Date tabled
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Taking Action on Problem Gambling (2010–11:2)	July 2010
Local Government: Interim Results of the 2009–10 Audits (2010–11:3)	August 2010
Water Entities: Interim Results of the 2009–10 Audits (2010–11:4)	August 2010

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