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Victorian Auditor-General's Office

Results of 2016–17 Audits: Public Hospitals

November 2017

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Results of 2016–17 Audits: Public Hospitals

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VAGO
Victorian Auditor-General's Office

The Hon Bruce Atkinson MLC
President
Legislative Council
Parliament House
Melbourne

The Hon Colin Brooks 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 *Results of 2016–17 Audits: Public Hospitals*.

Yours faithfully

Andrew Greaves
Auditor-General

29 November 2017

Contents

Acronyms

AASB	Australian Accounting Standards Board
ABF	Activity-based funding
DHHS	Department of Health and Human Services
FMA	*Financial Management Act 1994*
HPP	Health Purchasing Policies
HPV	Health Purchasing Victoria
KMP	Key management personnel
PPP	Public private partnership
VAGO	Victorian Auditor-General's Office

Audit overview

Victoria's public hospital sector is made up of 86 hospitals and 23 controlled entities.

This report outlines the results of our financial audits of these entities, and our observations, for the year ended 30 June 2017. We also analyse the financial results and outcomes of the sector.

Conclusion

The financial reports of entities in the hospital sector are reliable. The Parliament and community can have confidence in these reports.

Overall, the sector is operating within its funding envelope, and the rate at which new assets are being added to its asset base exceeds the rate at which existing assets are being consumed, as measured by annual depreciation.

Findings

Results of audits

Financial report audit opinions

To date, we have issued 108 clear audit opinions to Victoria's 86 public hospitals and 22 of their 23 controlled entities, for the financial year 2016–17. This positive outcome, consistent with last year, means the financial reports of the sector continue to be materially correct and reliable.

Also consistent with last year, all but one of the reports were finalised within legislated time frames. This shows that the sector is continuing to prepare its financial reports in a timely manner. This year, Bendigo Health Care Group missed the deadline, because it needed to finalise the complex accounting treatment and disclosures related to its new hospital.

The audit opinion for The Royal Children's Hospital Foundation Trust Funds remains outstanding. This is because we are conducting an ongoing review of the trust funds' audit reporting requirements.

Key audit themes

In 2016–17, we identified three common key financial reporting risks across the 86 public hospitals:

- implementation of the new requirement for public sector entities to disclose significant related-party transactions under Australian Accounting Standard AASB 124 *Related Party Disclosures*
- the ongoing challenge of valuing non-current physical assets using current replacement cost methodologies
- the accuracy of employee expenses and the valuation of employee leave entitlements due to the complexity of awards and terms and conditions of employment.

Our audit procedures addressed these risks, and we are satisfied that they have been mitigated.

Internal control issues

In our financial audits, we consider the internal controls relevant to financial reporting and assess whether entities have appropriate controls to manage the risks that their financial reports will not be complete and accurate.

Overall, hospitals' internal controls remain adequate for ensuring reliable financial reporting. However, we also continue to find instances where important internal controls are weak and need improvement.

This year, we identified 34 new control issues that we rated as either extreme or high risk, across 11 hospitals. The relevant hospitals have accepted these issues and are actively working to resolve them.

At the start of the 2016–17 financial year, there were 151 unresolved internal control issues across the sector. We raised these issues with hospital management in earlier audit cycles. During the year, hospitals resolved 69 per cent of these issues. There are seven unresolved prior-year high-risk issues, across six hospitals. Management at these hospitals is proactively managing the risks arising from these control weaknesses while they work to address the original issue.

We remain concerned that—in line with prior periods—most of the control weaknesses we find relate to IT system environments, payroll, and expenditure and accounts payable areas. These issues increase the risk of data in public hospital systems being lost, stolen or inaccessible. They also increase the risk of undetected fraudulent payments.

Compliance with the Health Purchasing Policy framework

Health Purchasing Victoria (HPV) was set up by the state government to work with hospitals to:

- strengthen their procurement policies and frameworks
- provide training to improve procurement functions
- negotiate with suppliers to deliver goods and services to public hospitals through collective purchasing arrangements.

In 2014, HPV implemented the Health Purchasing Policy (HPP) framework to help achieve these aims. As part of our 2016–17 financial audits, we assessed compliance with each of the five policies under the HPP framework across the 76 public hospitals that were required to comply. These policies are:

- HPP 1 *Procurement Governance*
- HPP 2 *Procurement Strategic Analysis*
- HPP 3 *Market Approach*
- HPP 4 *Contract Management and Asset Disposal*
- HPP 5 *Collective Purchasing.*

By fully implementing the HPP framework, public hospitals can improve their procurement governance, processes and management. This will help them to achieve best value when purchasing supplies and services.

Overall, hospitals comply with most elements of the HPP framework. However, the rate of compliance was higher on some policies than others. We found hospitals had implemented the requirements of HPP 4 and 5 the best.

More work is required for hospital management to fully comply with all elements of the framework. Weaknesses we identified included:

- lack of a finalised procurement governance framework
- poor strategic analysis of procurement needs, including a lack of complexity and capability assessments
- multiple or decentralised contract registers, which weaken contract oversight
- not obtaining an exemption from HPV to enable the use of alternative suppliers for goods and services.

Financial sustainability

We analysed the financial sustainability of the public hospital sector using audited data for the past five financial years. We used two key indicators:

- net result—measures the surplus or deficit as a percentage of the total revenue generated in the financial year
- physical asset replacement—measures new assets acquired as a percentage of depreciation expenditure in the financial year.

Sector level

This year, the sector generated a combined net surplus of $493.9 million (compared with a $114.8 million deficit in 2015–16). This equated to 3.1 per cent of the sector's revenue (−0.8 per cent in 2015–16). This surplus for the sector was because of the significant capital income received by the Bendigo Health Care Group for its new hospital.

The funding model for public hospitals is mainly activity-based—it is set up so that the cost of providing services to the public is constrained to the funding provided to the sector. This break-even model means that the net result—the difference between income and expenditure—will typically be close to zero.

Over the past five years, the net result for the sector has been +/−5 per cent of break even. This indicates that, in the longer-term, the funding model is operating as intended, as the sector is generally working within its means.

Although the sector results are positive, they can vary considerably between individual public hospitals and over time.

For the 2016–17 financial year, 55 public hospitals nearly broke even, spending within 5 per cent of their total generated revenue. However, 20 hospitals generated a deficit of greater than 5 per cent of revenue. The hospitals generating a surplus or deficit vary from year to year, and individual results are influenced by factors such as capital funding for large projects.

The sector also needs to fund the renewal and replacement of its physical assets in a timely way. Run-down assets may affect the quality of service that patients receive and can result in higher long-term costs.

The sector acquired $1.5 billion of new or replacement assets in 2016–17 ($1.9 billion in 2015–16). Over the past five years, the sector spent on average $1.59 on new or replacement assets for each $1 of recorded depreciation. This indicates the sector has a low financial sustainability risk when it comes to its service delivery assets.

Responses and submissions

We have consulted with the Department of Health and Human Services (DHHS), HPV and the public hospitals named in this report, and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report to those agencies and asked for their submissions or comments. We also provided a copy of the report to the Department of Premier and Cabinet.

The following is a summary of those responses. The full responses are included in Appendix A.

The Department of Health and Human Services has provided a response for inclusion in this report, noting our findings.

Responses from Austin Health, Eastern Health, The Royal Women's Hospital and Timboon and District Healthcare Service provide additional information regarding their management letter issues. All of the hospitals state that they have resolved or are resolving the issues.

Health Purchasing Victoria comments on our findings of the sector's compliance with the Health Purchasing Policy framework. Also, Austin Health, Beaufort and Skipton Health Service and Northern Health provide additional information regarding their compliance with the Health Purchasing Policy framework.

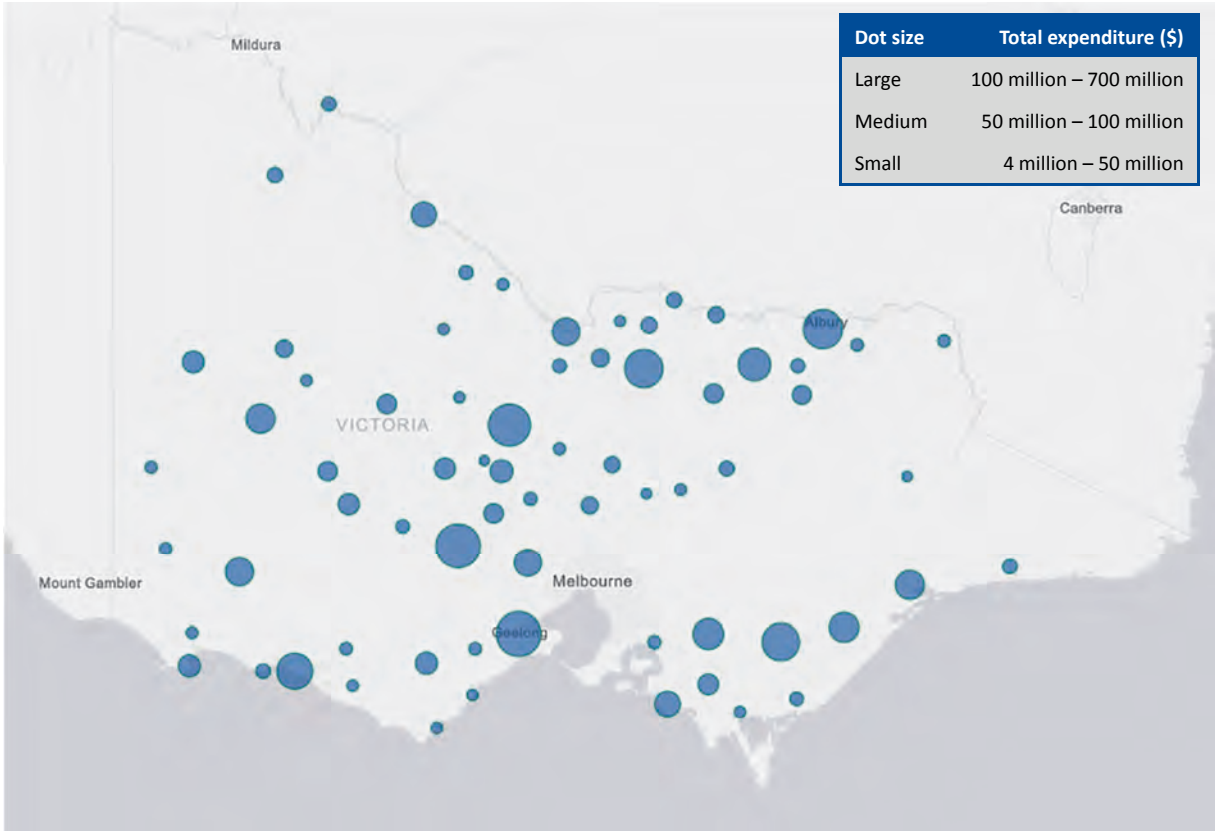
The Royal Children's Hospital Foundation Trust Funds provides information on the outcome of an independent audit of their financial report for the year ending 30 June 2017.

1 Audit context

Victoria has 86 public hospitals, some of which control a further 23 entities. These are listed in Appendix B.

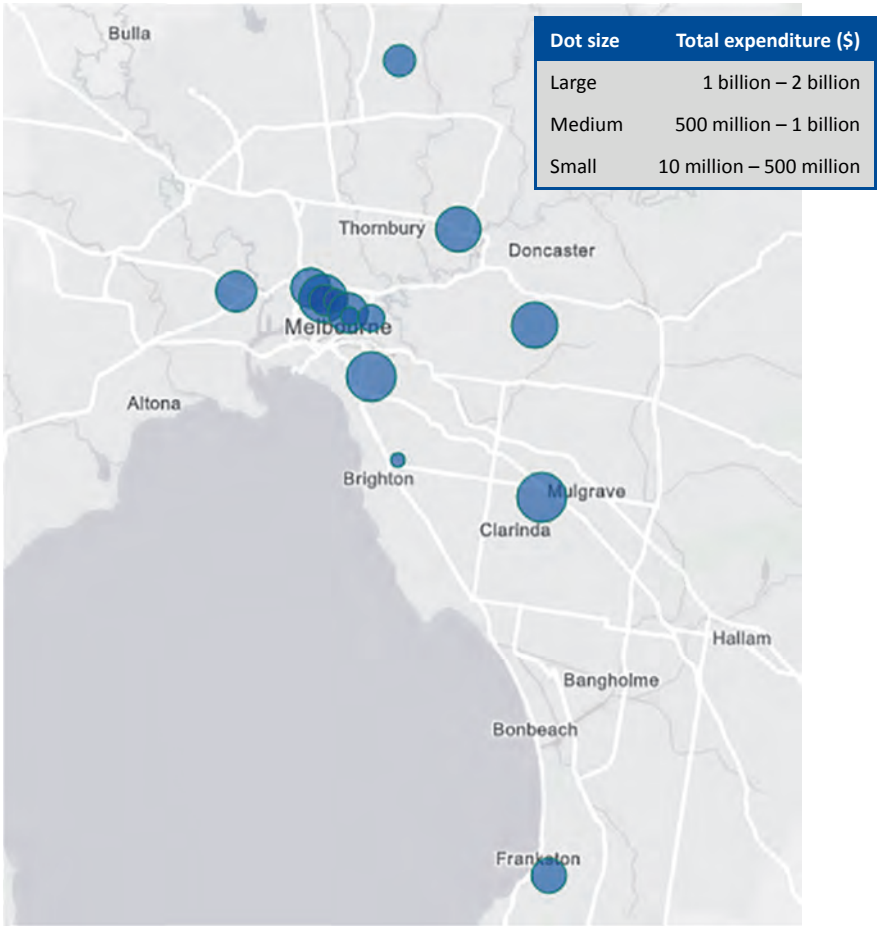
Figures 1A and 1B show the locations and level of expenditure by each of the public hospitals operating in Victoria during the 2016–17 financial year.

Figure 1A
Location and expenditure of Victoria's regional and rural public hospitals, 2016–17



Source: VAGO.

Figure 1B
Location and expenditure of Victoria's metropolitan public hospitals, 2016–17



Note: Where hospitals have multiple locations, only the main hospital site is shown.

Source: VAGO.

1.1 Legislative framework

Public hospitals are established under the *Health Services Act 1988* and governed by a board, which is directly accountable to the Minister for Health. DHHS oversees these hospitals on behalf of the minister, including monitoring the quality of the services they provide.

The board sets the strategic direction for the hospital within the government's policy framework, ensuring it:

- is managed effectively and efficiently
- provides high-quality care and service delivery
- meets the needs of the community
- meets its financial and non-financial targets.

Designated as 'public bodies', public hospitals must comply with Part 7 of the *Financial Management Act 1994* (FMA), as well as with any general or specific direction given by the Minister for Finance.

They are also subject to the *Public Administration Act 2004*, which provides a framework for governance in the public sector.

1.2 Public hospitals funding model

Health services, including public hospitals, are funded under the National Health Reform Agreement between the Commonwealth and the state government.

Public hospitals are funded through activity-based funding (ABF) and block funding models.

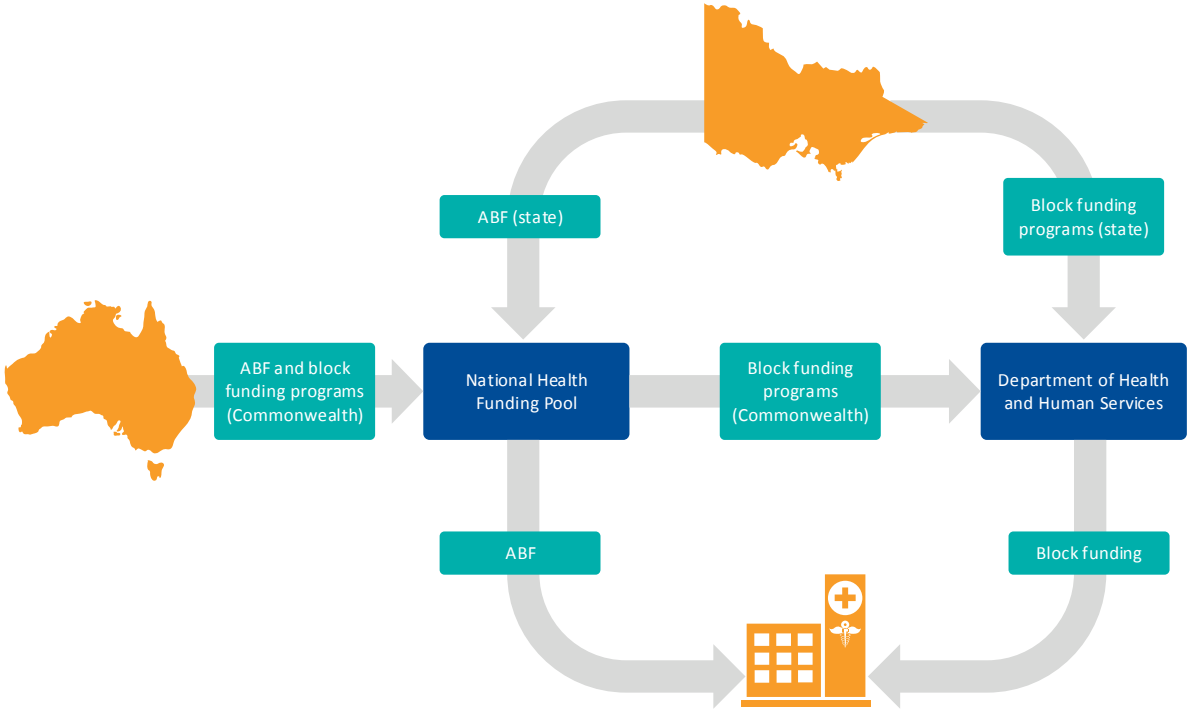
A key element of the ABF model is that funding is allocated according to the number and types of activities that the hospital performs in treating patients. Hospitals receive funding for specific activities—for example, treating acute admitted patients, providing emergency services, operating specialist clinics and providing post-operative care.

Where it is not practical to fund activities through the ABF model, hospitals receive block funding. This model is used for services such as small rural hospitals and non-admitted mental health services, as well as to fund teaching, training and research.

Typically, metropolitan hospitals—which treat a greater number of acute patients and perform more complex procedures than rural hospitals—receive most of their funding through the ABF model. Conversely, small rural hospitals —which treat more patients requiring aged and community care—receive mostly block funding.

Figure 1C provides an overview of these funding models.

Figure 1C
The flow of activity-based and block funding to Victoria's 86 public hospitals



Source: VAGO.

1.3 Report structure

In this report, we discuss the outcomes of our financial audits of the 86 public hospitals and their 23 controlled entities, for the year ending 30 June 2017. Appendix B lists all 109 entities included in the sector.

We also identify key financial reporting and internal control issues, and analyse the financial performance and position of Victoria's public hospitals.

Figure 1D outlines the structure of the report.

Figure 1D
Report structure

Part	Description
Part 2—Results of audits	Comments on the outcomes and results of the financial report audits of the 86 public hospitals for the 2016–17 financial year. Discusses the key audit themes for the sector.
Part 3—Internal controls	Summarises the internal control issues observed during our audits. Discusses the implementation of the HPP framework by the sector.
Part 4—Financial sustainability	Provides an insight into the public hospital sector's financial sustainability risks and financial challenges.

Source: VAGO.

We undertake our financial audits according to section 8 of the *Audit Act 1994* and the Australian Auditing Standards. These audits are paid for by each entity.

We used the results of these audits in preparing this report. The cost of preparing this report was $377 400, which is funded by Parliament.

2 Results of audits

Independent auditor's reports add credibility to management's financial reports by providing reasonable assurance that the information reported is reliable and accurate.

A clear audit opinion—included at the front of the independent auditor's report—confirms that the financial report presents fairly the transactions and balances for the reporting period, in accordance with the requirements of relevant accounting standards and applicable legislation.

All entities in the public hospital sector are required to follow Australian Accounting Standards and the financial reporting requirements of Part 7 of the FMA in preparing their financial reports. This consistency in how public hospitals account for and report on their financial results and enables comparison between entities in the health sector.

2.1 Financial report audit opinions

We issued 108 clear audit opinions to 86 public hospitals and 22 of their controlled entities for the financial year ended 30 June 2017. This positive outcome means the financial reports of the sector are materially correct and reliable.

The audit opinion for the Royal Children's Hospital Foundation Trust Funds remains outstanding. This is because we are conducting an ongoing review of the trust funds' audit reporting requirements.

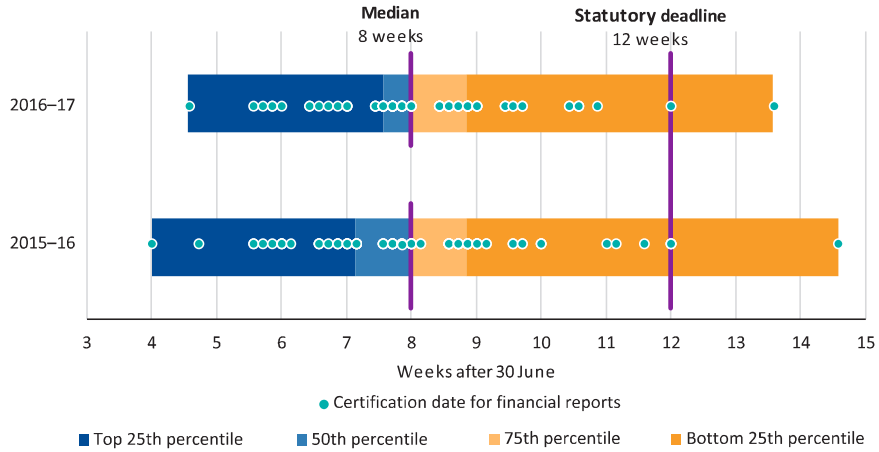
Appendix B lists the public hospital sector entities we audited, and the dates on which our audit opinions were issued.

Timeliness

Timely financial reporting enables informed decision-making and facilitates the accountability process between management and stakeholders. The later financial reports are produced after the end of the financial year, the less useful they become.

Public hospitals are required to finalise their financial reports and have them audited within 12 weeks from the end of the financial year. Figure 2A shows that public hospitals took a median time of eight weeks to certify their 2016–17 financial reports. This is consistent with the previous financial year.

Figure 2A
Number of weeks taken after 30 June for hospitals to certify their financial reports for financial years 2015–16 and 2016–17



Source: VAGO.

While almost all public hospitals certified their financial reports within the legislated 12-week time frame, one hospital in each of the last two financial years did not meet the statutory deadline. For the financial year ending 30 June 2017, Bendigo Health Care Group missed the deadline. For the previous financial year, it was the Peter MacCallum Cancer Centre.

In both cases, significant building projects—undertaken through public private partnerships (PPP)—were in progress. PPPs are complicated arrangements, involving multiple stakeholders. As well as the hospital, this can include the state government, departments, private consortiums and third-party experts.

In each case, the financial reporting delay was due to consultation with the PPP stakeholders to finalise the complex accounting treatments for these arrangements.

2.2 Key audit themes

Each financial year, as we plan our financial audit work across the sector, we seek to identify key audit risks. These risks, if not addressed, may lead to potential material misstatements in financial reporting. We communicate these risks in our audit strategy documents, which are presented to those charged with governance at each public hospital prior to the end of the financial year.

The homogeneous nature of hospitals means that there are often common risk themes across the sector. This year, the most common key audit risks we identified were:

- the implementation of Australian Accounting Standard AASB 124 *Related Party Disclosures*
- the valuation of non-current physical assets
- employee expenses and the valuation of employee leave entitlements.

Implementation of AASB 124

In their financial statements for the year ended 30 June 2017, not-for-profit entities were required to apply AASB 124 *Related Party Disclosures* for the first time. This meant that all government entities needed to disclose information about material related-party relationships and transactions that may have affected their financial performance or position. The application of AASB 124 created challenges for both those preparing financial reports and auditors, in making sure that the new accounting standard was met and that the information disclosed was complete and accurate.

Across the public sector, material related-party relationships that required disclosure included:

- key management personnel (KMPs) and their close family members
- Cabinet ministers and their close family members
- other entities controlled by either Cabinet ministers or KMPs
- all other state-controlled entities.

KMPs are people who make strategic decisions for the entity.

DHHS provided comprehensive guidance to hospitals on how to approach and adopt AASB 124.

While all public hospitals met the standard and made adequate related-party disclosures in their financial reports, we found that many had not prepared for this new standard in a timely manner.

This was partly due to a poor understanding of the new disclosure requirements of AASB 124, resulting in additional unforeseen work being required by those preparing the financial reports and auditors.

The poor understanding resulted in a low level of identification of the related parties that might be included in this disclosure. All hospitals identified DHHS as a significant party that they transacted with, but very few named anyone else—including other public hospitals. While the disclosures that hospital made were materially accurate, they could have been significantly improved through a more thorough identification process.

Physical asset fair value assessments and revaluations

At 30 June 2017, the 86 public hospitals held $14.2 billion worth of physical assets (compared with $13.5 billion in 2015–16). The change in the value of the assets held reflects:

- an increase of $1.5 billion worth of new assets ($1.9 billion in 2015–16)
- an increase of $111 million in the value of existing assets ($235 million in 2015−16)
- a decrease of $858 million due to depreciation ($795 million in 2015–16).

To comply with Australian Accounting Standards, each Victorian public sector entity must annually determine and disclose the fair value of its infrastructure, property, plant and equipment assets in its financial report. The fair value is the price the entity would expect to receive for the asset if it were to sell the asset in an orderly transaction between market participants.

There are two common valuation methods used across the public hospital sector to calculate fair value:

- Market approach—reflects market sales of similar land assets.
- Current replacement cost—reflects the expected cost in today's dollars of replacing assets to a similar standard and at a similar age. This method tends to be used to value items such as buildings and medical equipment.

To ensure consistency of approach, hospitals must comply with Financial Reporting Direction 103F *Non-Financial Physical Assets*, issued by the Minister for Finance.

As the total value of the infrastructure, property, plant and equipment usually represents a significant percentage of a public hospital's total assets, we allocate a significant amount of time and effort to checking these fair values. Since they are only estimates and may involve significant management judgement, there is a high risk of material financial report errors.

Overall, we found that all public hospitals had appropriately valued their physical assets at 30 June 2017.

Employee expenses and employee leave entitlements

Employee expenses and employee leave entitlements make up a significant portion of public hospitals' expenses and liabilities respectively. Employee expenses made up $9.7 billion (63 per cent) of the public hospital sector's expenditure for the year ending 30 June 2017 ($9.0 billion in 2015–16). Hospitals also held $2.7 billion in liabilities for leave entitlements ($2.5 billion in 2015–16).

Public hospitals are subject to complex contracts, awards and enterprise agreements. In any given year, a number of these agreements expire and are renegotiated, often with changes to existing working conditions. The use of contractors and temporary, casual and agency employees is common practice to accommodate fluctuations in the demand for services. The calculation of employees' leave entitlements involves a number of variables, including assumptions about wage growth, movements in the Consumer Price Index and estimates of the likelihood that employees will remain with a hospital long enough to be entitled to long service leave. These factors increase the audit risk for these items.

Through our audit work, we are satisfied that items relating to employee expenses and employee leave entitlements at all 86 public hospitals have not been materially misstated.

3 Internal controls

Effective internal controls help entities to reliably and cost-effectively meet their objectives. Strong internal controls are a prerequisite for delivering sound, accurate and timely external financial reports.

In our annual financial audits, we consider the internal controls relevant to financial reporting and assess whether entities have managed the risk that their financial reports will not be complete and accurate. Poor internal controls make it more difficult for entity management to comply with relevant legislation and increase the risk of fraud and error.

3.1 Internal control observations

We found that the public hospitals' internal controls that we identified and tested were adequate for ensuring reliable financial reporting. However, we also found instances where important internal controls were weak and needed improvement.

As required by Australian Auditing Standards, we communicate significant internal control issues to the board of the relevant public hospital, often through its audit committee. We assign each issue a risk rating for possible impact and likelihood—Appendix C describes these ratings.

Across all our 2016–17 public hospital audits, we identified 136 internal control issues (90 in 2015–16), which we assessed as extreme, high or medium risks. Figure 3A provides a breakdown of these issues.

Figure 3A
Internal controls issues at public hospitals, by area and risk rating, 2016–17

	Risk rating			
Issue area	Extreme	High	Medium	Total
IT systems	1	21	21	**43**
Governance	–	4	26	**30**
Expenditure and accounts payable	–	3	16	**19**
Payroll	–	4	15	**19**
Reconciliations	–	1	9	**10**
Fixed assets	–	–	6	**6**
Revenue, cash and accounts receivable	–	–	4	**4**
Other	–	–	5	**5**
Total	**1**	**33**	**102**	**136**

Source: VAGO.

Of these internal control issues, 32 per cent related to the IT systems environment, including inappropriate user access, a lack of system support and weaknesses in disaster recovery plans. These issues increase the risk that data held in public hospitals' information technology systems may be compromised or lost.

A further 28 per cent related to weaknesses in payroll, expenditure and accounts payable systems, including inadequate checks of master-file changes, poor separation of duties across staff roles, and incomplete time sheet approval processes. These issues increase the risk of fraudulent payments and may make them harder to detect. At 10 of the hospitals, this risk was increased by poor processes for reviewing journal entries.

The 34 issues we rated as extreme and high risk in 2016–17 (compared to no extreme- and 20 high-risk issues identified in 2015–16) occurred across 11 hospitals—see Figure 3B. In line with the risk rating descriptions in Appendix C, we urge management of these entities to address these issues promptly, in order to reduce their exposure to fraud and error. All of the relevant hospitals are actively working to resolve these issues.

Figure 3B
Public hospitals with extreme- and high-risk rated issues identified in 2016–17 audits, by category

Public hospital	IT systems	Expenditure and accounts payable	Payroll	Reconciliations	Governance	Total
Ballarat Health Services	3					**3**
Barwon Health	4					**4**
East Wimmera Health Service		1				**1**
Eastern Health	10[(a)]		1			**11**
Goulburn Valley Health Services					1	**1**
Lorne Community Hospital		1				**1**
Monash Health	2					**2**
Otway Health		1			1	**2**
Peter MacCallum Cancer Centre	2					**2**
The Royal Children's Hospital			3	1	2	**6**
The Royal Women's Hospital	1					**1**
Total	**22**	**3**	**4**	**1**	**4**	**34**

(a) Includes one extreme-risk rated issue.

Source: VAGO.

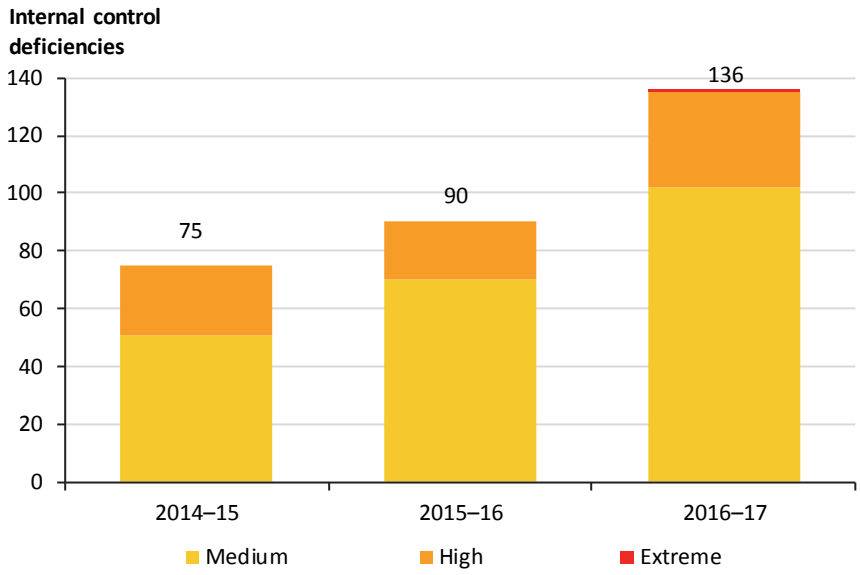
3.2 Status of internal control matters raised in prior-year audits

As part of our audit process, we track the resolution of internal control matters that we have reported in our management letters. We expect all these matters to be resolved according to the timetable shown in Appendix C. Where issues remain outstanding, we factor this into our risk assessment for the following year's audit.

This section of the report provides an update and commentary on internal control issues raised in prior years.

Figure 3C shows the number of extreme-, high- and medium-risk internal control issues that we identified in our audits for the past three financial years.

Figure 3C
Internal control deficiencies at the 86 public hospitals, 2014–15 to 2016–17



Source: VAGO.

The total number of issues reported across the sector is consistently low—averaging 1.6 per hospital in 2016–17, increasing from 0.9 in 2014–15.

The increasing number of issues identified is attributable, in part, to our audit approach—we target the areas or systems with the highest audit risk, which means we are more likely to identify and examine areas of weakness. The types of audit risks we identify and test can change each year, which affects the number of issues identified annually.

Status of matters raised in previous audits

At the start of the 2016–17 financial year, there were 151 unresolved extreme-, high- and medium-risk audit issues that we had raised with management in previous years. During the financial year, hospitals resolved 69 per cent of these matters—see Figure 3D.

Figure 3D
Prior years' internal control deficiencies, by status and risk rating

Status of prior period issue	Risk rating			
	Extreme	High	Medium	Total
Unresolved	–	7	40	**47**
Resolved	1	26	77	**104**
Total	**1**	**33**	**117**	**151**

Source: VAGO.

Forty-seven high- and medium-risk issues remain unresolved more than 12 months after they were identified. Some of these issues have been outstanding for a number of years, with the oldest arising from our 2009–10 financial audits.

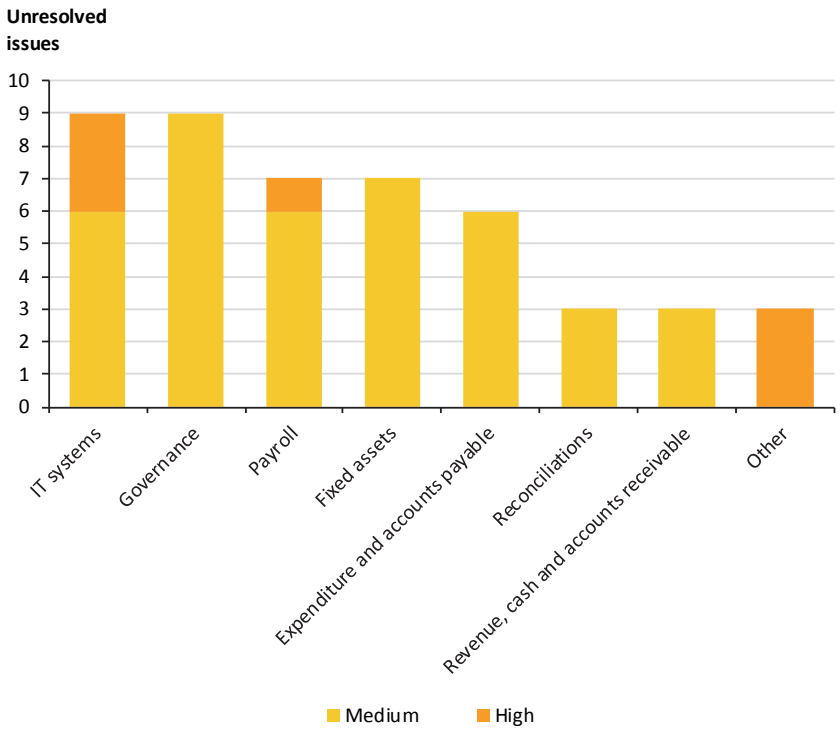
The six public hospitals responsible for the seven unresolved high-risk issues are Austin Health, Castlemaine Health, Goulburn Valley Health, Timboon and District Healthcare Service, The Royal Victorian Eye and Ear Hospital and The Royal Women's Hospital.

As shown in Appendix C, these issues should have been resolved within six months of our management letter, to reduce the ongoing significant risk of fraud and errors.

Management at the relevant hospitals is proactively managing the risks arising from these control weaknesses while they work to address the original issue.

Figure 3E illustrates the types of previously raised issues that remain unresolved.

Figure 3E
Unresolved prior years' internal control issues by issue area and risk level



Source: VAGO.

By not resolving long-standing IT systems control issues, public hospitals are at continual significant risk of their systems and data becoming unreliable. They also increase the risk of disgruntled employees or hackers circumventing security processes and stealing or altering hospital financial or patient data. Well-designed and effective IT system controls can help maintain the integrity of systems and the security of the data.

Common unresolved IT systems issues included in Figure 3E include:

- unsupported or outdated systems, including general ledger and operating systems
- poor user access management, including password management
- incomplete policies for managing IT systems, such as disaster recovery and business continuity plans.

Combined, these risks increase the likelihood of unauthorised access to hospitals' IT systems, which may result in a successful cyber attack. To reduce the risk, it is imperative that hospitals address IT systems control deficiencies in a timely manner.

A **cyber attack** is a deliberate act by a third party to gain unauthorised access to an entity's data, with the objective of damaging, denying, manipulating or stealing information.

3.3 Compliance with the Health Purchasing Policy framework

A **collective purchasing arrangement** is a contract to source a product or service from a particular supplier recognising that savings can be made through bulk purchasing.

In 2016–17, the public hospital sector spent $2.3 billion ($2.0 billion in 2015–16) on supplies and consumables, including medical goods.

Each hospital is responsible for procuring its own supplies. However, due to the large volume of similar items purchased by the sector, hospitals can save money through collective purchasing arrangements.

Health Purchasing Victoria

To help achieve this goal, the state government set up HPV in 2001. HPV works with public hospitals and health services to:

- strengthen their procurement policies and frameworks
- provide training to improve procurement functions
- negotiate with suppliers to deliver goods and services to public hospitals through collective purchasing arrangements.

In 2014, HPV set up the HPP framework to help achieve these aims.

Health Purchasing Policy framework

Seventy-six[1] of the 86 public hospitals are required to comply with the HPP framework. Compliance with HPP means that the hospital needs to:

- ensure their purchasing policies and procedures are up to date to reflect the key elements of the HPP
- have appropriate staff and systems in place to undertake the contract assessment and monitoring required by HPP
- ensure all relevant staff are trained in HPP requirements and know when to use HPV suppliers
- where applicable, use HPV-contracted suppliers to purchase goods and services rather than their own suppliers.

By implementing the HPP framework, public hospitals can improve their procurement governance, processes and management. This will help them get the best value when purchasing supplies and consumables.

Figure 3F shows the five policies that make up the HPP framework, and details the key elements for each.

[1] HPP does not apply to 10 denominational and multipurpose health services, as listed in the *Health Services Act 1988*.

Figure 3F
Key elements of the HPP framework

Policy	Key elements
Procurement governance	

HPP 1
Procurement Governance
	• A procurement framework that includes a:
	  • contract management strategy
	  • capability development plan
	  • supplier engagement plan
	  • procurement activity plan.
	• An appropriately qualified chief procurement officer.

Procurement operations	

HPP 2
Procurement Strategic Analysis
	• Health services must perform:
	  • a complexity assessment of procurement activity
	  • a capability assessment
	  • market analysis for procurement activities.

HPP 3
Market Approach
	• Mandatory requirements relating to:
	  • market approach and invitation to supply
	  • management of submissions received
	  • evaluation, negotiation and supplier selection
	  • streamlined processes in response to critical incidents.

HPP 4
Contract Management and Asset Disposal
	• Health services must ensure a contract management strategy is in place.
	• Contracts need to be:
	  • monitored effectively
	  • centrally managed.

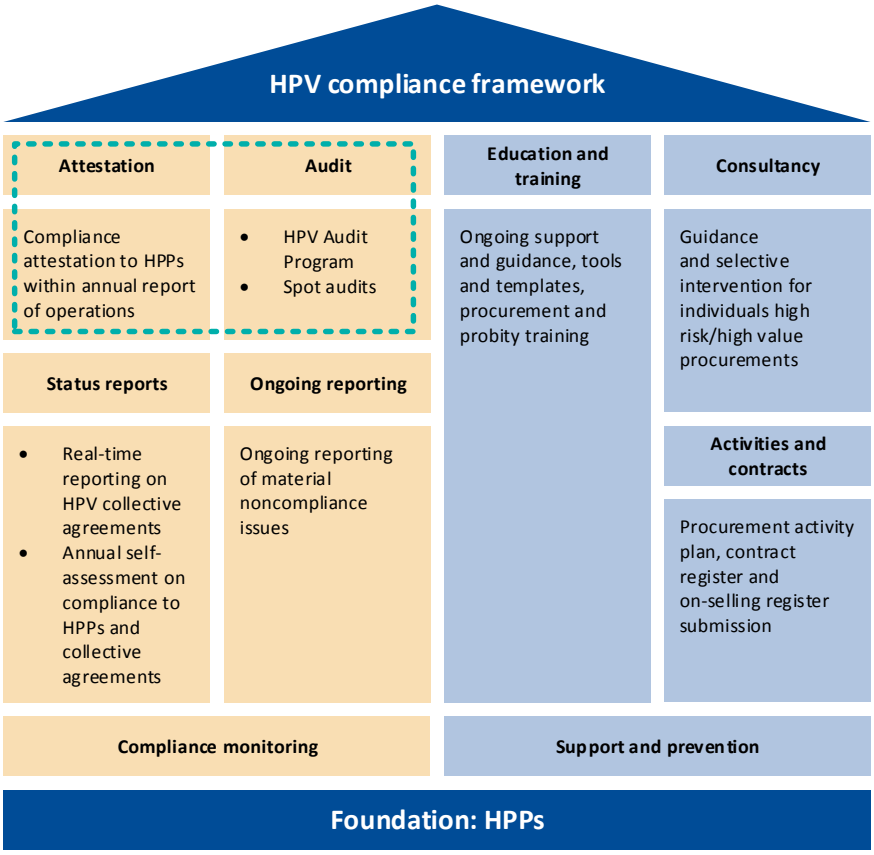
Purchasing benefits	
HPP 5 *Collective Purchasing*	• Where an HPV collective purchasing arrangement is in place, it must be used unless an exemption is obtained from HPV.

Source: VAGO based on *Health Purchasing Policies*, HPV, May 2017.

Monitoring compliance with HPP

HPV is required to monitor the compliance of public hospitals with its mandatory requirements and HPP. Figure 3G details the compliance framework set up by HPV in 2016–17 to achieve this. The circled area of the framework indicates the scope of the compliance work we reviewed.

Figure 3G
HPV compliance framework



Source: VAGO based on *HPV Health Service Compliance Strategy 2016–2019*, HPV, 2016.

HPV's compliance framework includes a rolling three-year audit program to cover all 76 hospitals in the HPP remit. Public hospitals must engage independent auditors to assess their compliance with the HPP framework. In 2016–17, compliance reviews of 26 public hospitals were completed.

Annual HPP attestation

In 2016–17, the 76 participating public hospitals were required to make an annual self-attestation of their compliance or noncompliance with HPP. These were published in each hospital's annual report of operations.

Seven hospitals attested that they had materially departed from the HPP framework during the 2016–17 financial year. This was mainly due to noncompliance with HPP 5 *Collective Purchasing*. These hospitals were:

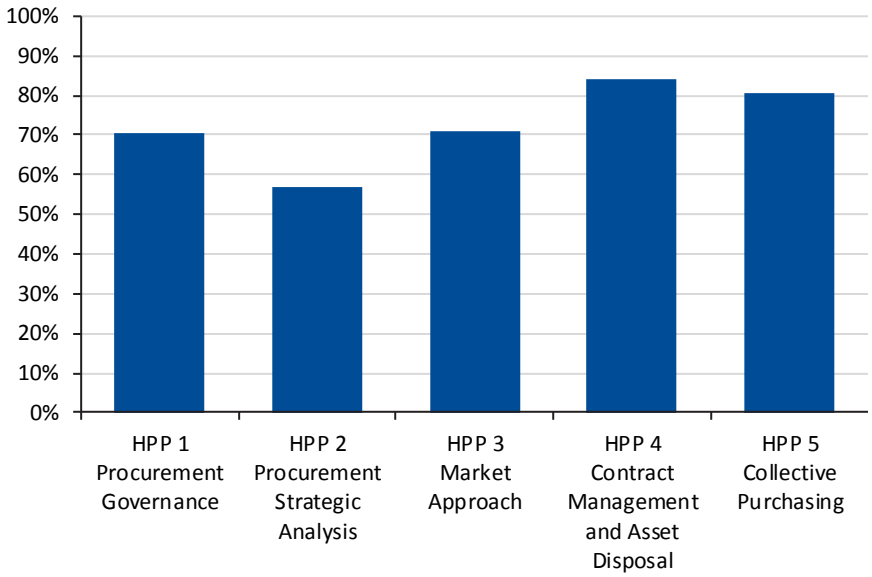
- Austin Health
- Beaufort and Skipton Health Service
- Casterton Memorial Hospital
- East Wimmera Health Service
- Goulburn Valley Health
- Monash Health
- Northern Health.

HPP compliance across the public hospital sector

As part of our 2016–17 financial audit review, we assessed relevant hospitals' compliance with key elements of each policy of the HPP framework.

Overall, the sector complies with most elements of each policy of the HPP framework. However, compliance was stronger for some policies than others, as shown in Figure 3H.

Figure 3H
Public hospitals' average compliance with each policy of the HPP framework



Source: VAGO.

In assessing the sector's compliance with the HPP framework, we reviewed the work being undertaken by hospitals. As a result, we were able to identify areas of common weakness which need to be resolved for the sector to achieve full compliance.

Setting up the governance framework

Compliance with HPP 1 *Procurement Governance* helps public hospitals to set up better practice frameworks for their procurement functions.

Without these policies and procedures in place, a hospital is at higher risk of making inappropriate purchases, or not achieving best-value contracts for the goods and services they need.

We identified 10 hospitals that did not have a finalised governance framework in place. Of these:

- five only had a draft framework
- four did not have an overarching procurement strategy, but did have policies and procedures covering key components.

Understanding procurement needs

By complying with HPP 2 *Procurement Strategic Analysis*, a public hospital is in a good position to fully understand its procurement needs.

Across the sector, this was the weakest area of HPP compliance. We identified 11 hospitals that did not have major elements of HPP 2 in place, including a complexity and capability assessment. Without these, it may be difficult for these hospitals to make informed decisions on the most efficient and effective way to purchase goods and services.

Better practice tendering

HPP 3 *Market Approach* encourages hospitals to implement a better practice tendering process. Overall, hospitals complied with the main elements of this policy. However, we found that they could improve communications with suppliers.

Managing contracts

Hospitals should hold a central register of all contracts they have with suppliers. This enables them to manage their contracts efficiently and monitor supplier performance. Compliance with HPP 4 *Contract Management and Asset Disposal* assists a hospital to achieve this objective.

There was a high level of compliance with HPP 4. Of the 76 hospitals, 75 had a central contract register, although six of these held multiple registers. Stawell Regional Health is currently developing its central contract register.

The use of multiple or decentralised registers reduces a hospital's ability to oversee and efficiently manage its contracts.

Collective purchasing arrangements

HPV has negotiated and set up more than 60 collective purchasing arrangements for the public hospital sector. These cover a wide range of goods and services.

In HPV's *Annual Report 2016–17*, it reported that the public health sector purchased $915 million of goods, services and equipment through these collective purchasing arrangements ($777 million in 2015–16). Figure 3I illustrates the benefits of collective purchasing arrangements negotiated by HPV.

Figure 3I
Benefits of collective purchasing arrangements in 2016–17, reported by HPV

Source: Annual Report 2016–17, HPV, October 2017.

HPP 5 *Collective Purchasing* requires the 76 public hospitals to use these collective purchasing arrangements. In 2016–17, HPV identified that there were 73 instances of hospitals purchasing items from suppliers who were not part of these arrangements. Common purchases that were made outside these arrangements included catering supplies, non-emergency patient transport and workplace supplies.

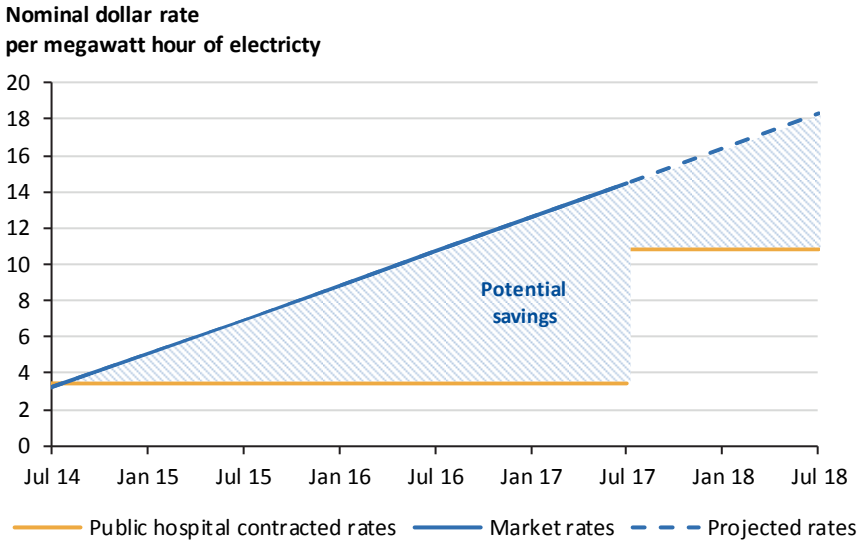
Aside from complying with the HPP framework, it is important that hospitals use the collective purchasing arrangements where required—otherwise they may not be achieving the best value for money on their purchases.

Case study: Collective purchasing arrangement for electricity costs

To illustrate the benefits to public hospitals of accessing suppliers through the HPV collective purchasing arrangement, we have reviewed the impact of this process on electricity costs for the public hospital sector.

Electricity is provided to public hospitals through HPV agreed contracts. Figure 3J illustrates the change in electricity rates for agreed contracts, the electricity market rates, and the savings achieved over the period 2014–15 to 2017–18.

Figure 3J
Public hospital HPV contracted electricity rates compared to actual and projected market rates for the period 2014–15 to 2017–18



Note: A new collective purchasing arrangement commenced in July 2017.

Source: VAGO, based on information from public hospitals and the Australian Energy Regulator.

4 Financial sustainability

A financially sustainable entity is one that can maintain operations over the long-term using existing revenue and expenditure policies. The entity should be able to absorb short-term fluctuations in income and expenditure due to reasonably foreseeable internal and external factors. We can assess an entity's financial sustainability by examining past and projected trends in financial data and key indicators.

In this part of the report, we analyse the financial sustainability of the public hospital sector using data for the past five financial years. We assess this data against two key indicators:

- net result—measures the surplus or deficit achieved by an entity as a percentage of the total revenue generated in the financial year
- physical asset replacement—compares new assets in the financial year to depreciation expenditure for the same period, showing whether physical assets are being replaced at the rate they are being used.

More information on these two indicators—including how they are calculated and benchmarked—is included in Appendix D. Appendix D also provides the results for the 86 public hospitals against these two key indicators over the five financial years to 30 June 2013 to 2017.

4.1 Financial performance

Funding model

In Victoria, the funding model for public hospitals is set up so that the costs of providing services is constrained to the amount of funding provided to the sector.

Net result of the sector

In 2016–17, the public hospital sector generated a surplus net result of $493.9 million, which was 3.1 per cent of total revenue of $15.8 billion. In 2015−16, the net result was a $114.8 million deficit from $14.1 billion total revenue (0.8 per cent).

Figure 4A shows the net result for the sector as a proportion of revenue over the last five financial years, together with the five-year average.

Figure 4A
Net result indicator for the public hospital sector, 2012–13 to 2016–17

Hospitals	2012–13	2013–14	2014–15	2015–16	2016–17	Average
Metropolitan average	-0.36%	2.21%	-0.66%	-0.42%	-0.02%	0.15%
Regional average	0.69%	1.10%	-1.83%	-1.35%	13.54%	2.43%
Rural average	-0.64%	-2.70%	-3.08%	-2.13%	0.01%	-1.71%
Small rural average	-0.70%	0.08%	-1.51%	-3.91%	-3.69%	-1.95%
Financial year average	-0.16%	1.73%	-1.02%	-0.81%	3.12%	0.57%

Key: ● High risk; ● medium risk; ● low risk.

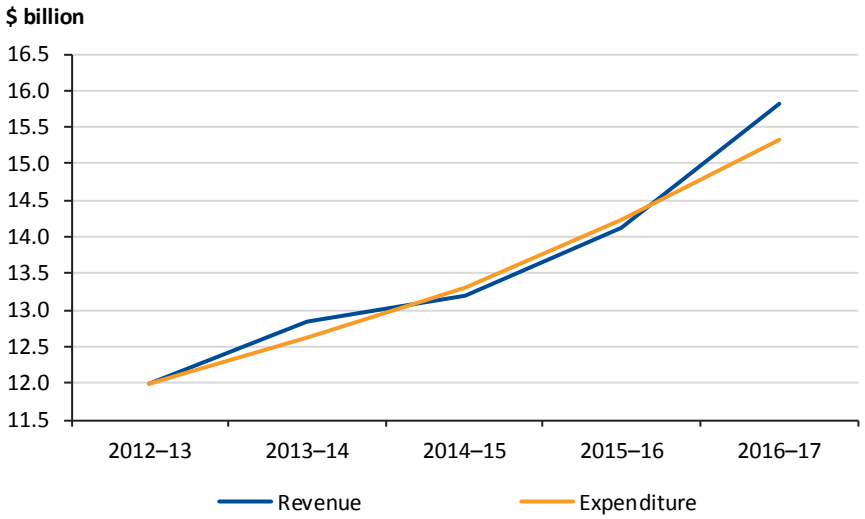
Note: The regional average for 2016–17 is attributable to the capital funding provided to Bendigo Health Care Group for the new Bendigo Hospital.

Source: VAGO.

Figure 4A shows that, over the last five years, hospital expenditure has largely matched the funds provided, with an average net result for the sector of 0.57 per cent.

Figure 4B shows a significant upward growth trend in hospital revenue and expenditure, increasing by more than $3 billion over the five-year period.

Figure 4B
Public hospitals' revenue and expenditure, 2012–13 to 2016–17



Source: VAGO.

Impact of capital grants on net result

DHHS sometimes uses private-sector consortiums to design, construct, co-finance and maintain new hospitals. The sector currently has five hospitals that have been procured this way.

Two hospitals have received significant capital grant revenue through such arrangements:

- Bendigo Health Care Group—$565.2 million in 2016–17
- Peter MacCallum Cancer Centre—$276 million between 2012–13 and 2016–17.

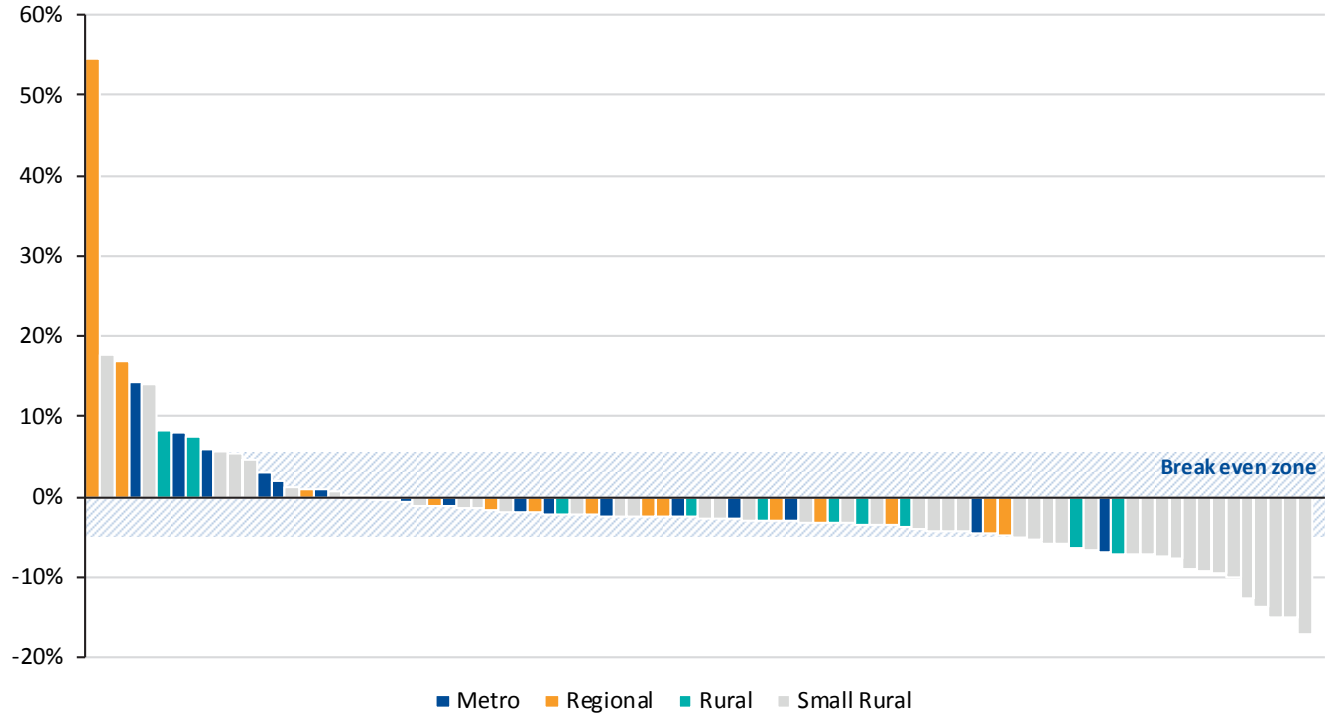
In 2016–17, the capital grants received by Bendigo Health Care Group resulted in an overall surplus of $493.9 million for the sector. Without this funding, the sector would have generated a net deficit of $71.3 million and a net result indicator of −0.45 percent.

Financial performance of individual public hospitals

While overall funding for the public hospital sector is designed to break even annually, not all of the 86 individual hospitals are expected to achieve this position each year. The hospitals generating a surplus or deficit vary from year to year, and individual results are influenced by factors such as capital funding.

Figure 4C shows the range of net result indicators generated by public hospitals at 30 June 2017.

Figure 4C
Net result indicator for each of the 86 public hospitals, 2016–17



Source: VAGO.

For the financial year ended 30 June 2017, 55 of the 86 public hospitals (64 per cent) achieved close to a break-even position. Eleven hospitals (13 per cent) generated a surplus of more than 5 per cent of their revenue. This includes Bendigo Health Care Group, due to capital grants for the new Bendigo Hospital. Twenty hospitals (23 per cent) generated a deficit of more than 5 per cent of the revenue they received for the financial year.

Managing the cost of service delivery

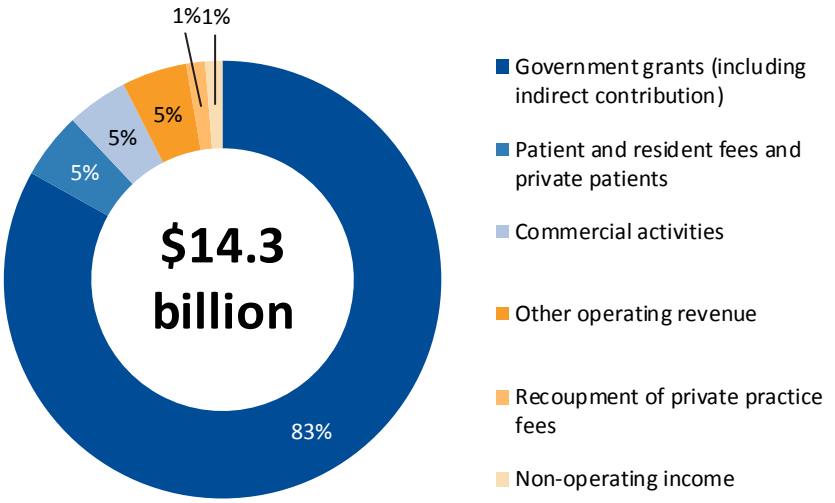
Operating result represents the net result before capital and specific items such as capital grants, depreciation and finance costs are taken into consideration.

Public hospitals' financial reports disclose both a net result and a subtotal described as their 'operating result', which excludes capital grants and depreciation. In 2016–17, the sector generated a surplus operating result of $54.7 million, 0.4 per cent of operating revenue of $14.3 billion. In 2015–16, this operating result was a $33.3 million surplus from revenue of $13.3 billion (0.3 per cent).

Operating revenue

Figure 4D shows the main types of revenue received by the public hospital sector in 2016–17.

Figure 4D
Operating revenue for the public hospital sector, 2016–17



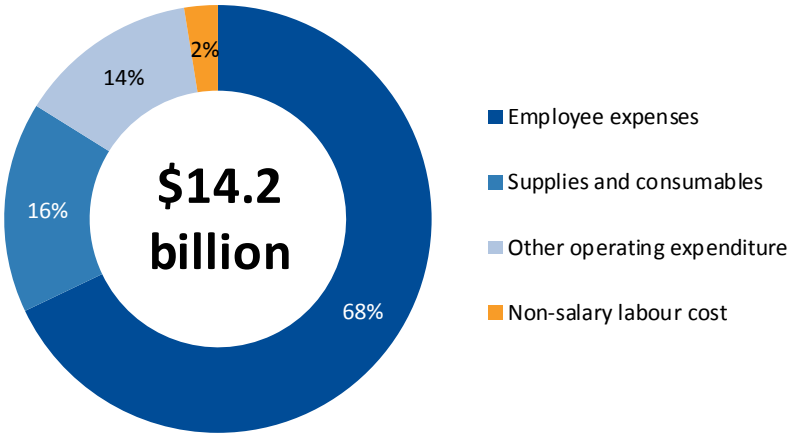
Source: VAGO.

Hospitals self-generate less than 5 per cent of their revenue through research activities, donations and commercial activities such as car parking.

Controlling expenditure

In 2016–17, the public hospital sector spent $14.2 billion providing services (compared to $13.2 billion in 2015–16). The majority of this spending falls into three main types, as shown in Figure 4E.

Figure 4E
Public hospitals' operating expenditure, 2016–17



Source: VAGO.

Employee expenses

Employee expenses were $9.7 billion in 2016–17 ($9.0 billion in 2015–16). This equates to 68 per cent of operational expenditure by the sector, which was the same in 2015–16.

Although hospitals should aim to staff its health care facilities as efficiently as possible, they have limited capacity to control employee expenditure. Staffing is managed in accordance with more than 10 enterprise agreements, which set the remuneration and working conditions of nurses, doctors and other staff. For example, public hospitals are required to meet any agreed increases in employee benefits.

An additional constraint on managing employee expenses is the legislated ratio of nurses and midwifes to patients. The Victorian *Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015* requires the operators of particular publicly funded health facilities to staff certain wards with a prescribed minimum number of staff—and a particular skill mix—based on the number of patients.

Supplies and consumables

The second highest expenditure was for supplies and consumables. This includes items such as surgical products and instruments, pharmacy supplies and utilities.

In 2016–17, the public hospital sector spent $2.3 billion on supplies and consumables (compared to $2.0 billion in 2015–16), to enable the provision of patient services. This was 16 per cent of expenditure (15 per cent in 2015–16).

The sector is actively looking to improve its efficiency in this area through full sector-wide implementation of HPV's mandated HPP framework—see Part 3.

4.2 Financial position

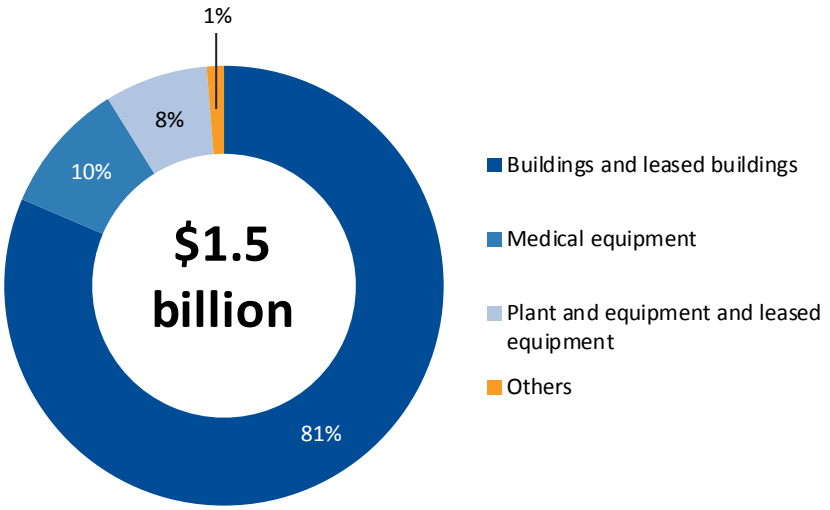
Non-current physical assets

At 30 June 2017, public hospitals held $14.2 billion of non-current physical assets ($13.5 billion at 30 June 2016). This includes land, buildings, medical equipment and other assets.

Like other public sector agencies, public hospitals need to purchase, renew or replace physical assets at the end of their lives, when their service potential has been fully consumed or as service demand increases. DHHS is responsible for allocating capital funding to individual hospitals to ensure they are able to continue providing services today and into the future

In 2016–17, the sector acquired $1.5 billion of new or replacement assets (compared to $1.9 billion in 2015–16). Updating building facilities at Monash Children's Hospital and Bendigo Health Care Group accounted for 63 per cent of the total spend. Figure 4F shows the type of assets bought in 2016–17.

Figure 4F
Physical asset purchases by the public hospital sector by type, 2016–17



Note: Leased buildings are those owned by third parties occupied by public hospitals.

Source: VAGO.

The requirements of the Asset Management Accountability Framework, imposed under Standing Direction 4.2.3 *Asset Management Accountability*—applicable from the 2017–18 financial year—raises the importance of quality information about assets.

As part of our assessment of the sector's financial sustainability, we reviewed whether hospitals' spending on new and replacement assets is greater than the rate at which they use their existing assets, as measured through depreciation. Converting these two items into a ratio (asset additions divided by depreciation) allows us to compare entities using a physical asset replacement indicator.

For this indicator, a ratio below 1.00 means a cohort spent less on acquiring assets than depreciation over the period. Conversely, a ratio above 1.00 indicates capital spending was higher than depreciation.

Figure 4G
Physical asset replacement indicator for the public hospital sector, 2012–13 to 2016–17

Hospitals	2012–13	2013–14	2014–15	2015–16	2016–17	Average
Metropolitan average	1.05	1.35	1.51	2.95	0.82	1.54
Regional average	1.25	1.35	1.42	1.16	5.10	2.06
Rural average	1.46	1.21	1.03	0.63	0.81	1.03
Small rural average	0.76	1.00	1.57	0.78	0.66	0.95
Financial year average	1.09	1.32	1.48	2.33	1.74	1.59

Note: ● High risk; ● medium risk; ● low risk.

Source: VAGO.

Figure 4G shows the five-year sector average is 1.59, which means that spending on new assets outpaced depreciation over this period. The regional average of 2.06 is distorted by the capital funding received by Bendigo Health Care Group.

The financial year averages for the sector are consistently above 1.0 for each of the last five financial years. This has been achieved while generating a positive net result indicator of 0.57 per cent for the same period.

Appendix A
Audit Act 1994 section 16—submissions and comments

We have consulted with DHHS, HPV and the public hospitals named in this report, and we considered their views when reaching our audit conclusions. As required by section 16(3) of the *Audit Act 1994*, we gave a draft copy of this report, or relevant extracts, to those agencies and asked for their submissions and comments. We also provided a copy of the report to the Department of Premier and Cabinet.

Responsibility for the accuracy, fairness and balance of those comments rests solely with the agency head.

Responses were received as follows:

RESPONSE provided by the Acting Secretary, DHHS

Secretary

Department of Health and Human Services

50 Lonsdale Street
Melbourne Victoria 3000
Telephone: 1300 650 172
GPO Box 4057
Melbourne Victoria 3001
www.dhhs.vic.gov.au
DX 210081

e4677016

Mr Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31
35 Collins Street
MELBOURNE VIC 3000

Dear Mr Greaves

Thank you for your letter of 1 November 2017 inviting comment to the forthcoming report titled *Results of 2016-17 Audits: Public Hospitals*.

I am satisfied that the report provides a reasonable overview of the public hospital results, internal controls, financial sustainability and audit outcomes given the financial indicators chosen.

I would like to thank your staff for the co-operative manner in which the audits were conducted and again thank you for the opportunity to respond to the findings.

Yours sincerely

Nick Foa
Acting Secretary

10 / 11 / 2017

VICTORIA State Government

RESPONSE provided by the Chief Executive Officer, Austin Health

Austin Health

Austin Hospital

145 Studley Road
PO Box 5555 Heidelberg
Victoria Australia 3084
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www.austin.org.au

Mr Andrew Greaves
Auditor General
Victorian Auditor General's Office
Level 31 / 35 Collins Street
Melbourne Victoria 3000

09 Nov 2017

Dear Mr Greaves,

RE: Proposed Report on the Results of 2016-17 Audits: Public Hospitals

I writing in response to your letter dated 01 November 2017 that has invited Austin Health to provide submissions or comments to be included in relation to the above mentioned the report.

My response is specific to the two areas in the extract of the report that you have provided me, in which Austin Health is specifically mentioned.

First Item:

Figure 3D: looks at Prior years risk rated internal control, deficiencies, and the report highlights that Austin Health has a high risk related unresolved issue.

On this finding I can confirm from our final VAGO Management Letter for the period ending 30 June 2017 that the single unresolved high risk item identified by your agents and which we concurred with is in relation to Austin Health still having Unsupported Information Technology Operating Systems.

To address this high risk issue I can confirm that the in the last financial year Austin Health internally funded around $1M worth of systems and IT equipment upgrades. Subsequent to that the Department of Health's Digital Health Division in the 17/18 financial year is funding Austin Health with a further $682,459 to upgrade and replace Cyber Security Technology.

At this stage it is anticipated that this work will be complete by April 2018.

Second Item:
In the Annual Report of Operations attestations, it was noted that Austin Health was one of seven (7) hospitals that had materially departed from the HPV framework during the 2016-17 financial year. This was mainly due to non-compliance with HPV5 – Collective Purchasing.

Austin Health identified one item of non-compliance with HPV5 – Collective Purchasing.

This was in relation to Cardiac Pacemakers whereby HPV had gone to single source provider - St Judes - for certain pacemaker categories.
Additionally that contract had a 10% non-compliance allowance.

Due to clinical requirements – for example if a patient has had a different make of pacemaker implanted previously, then they cannot have a St. Judes as a replacement. As a consequence Austin Health was unable to meet the compliance requirements.

Austin Health self-reported itself to HPV and recommended a rectification solution.

HPV has since gone back out to market and will be rectifying the issue.

Yours sincerely

Ms Sue Shilbury
Chief Executive Officer
Austin Health

2

RESPONSE provided by the Chief Executive Officer, Beaufort and Skipton Health Service

Beaufort Skipton Health Service

Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
Melbourne VIC 3000

3 November 2017

Re: Results of 2016-17 Audits: Public Hospitals

Dear Mr Greaves

I was appointed in March 2017 as Chief Executive Officer of Beaufort and Skipton Health Service. On appointment I commenced a review of compliance in relation to Health Purchasing Victoria.

My review noted that it was clear that the health service had a misunderstanding of HPV requirements. The main reason the health service did not meet all compliance as noted by the external auditors was because most goods and services were being purchased from Ballarat Health Service.

In April 2017, we commenced the journey to build compliance with HPV criteria. We have now rectified all outstanding concerns.

Yours sincerely

Vicki Poxon

CEO

RESPONSE provided by the Chief Executive, Eastern Health

easternhealth

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3 November2017

Mr Andrew Greaves
Victorian Auditor-General's Office
Level 31/ 35 Collins St
Melbourne VIC 3000

Dear Andrew,

Response to the Victorian Auditor General's Report – Results of 2016-17 audits: public hospitals

The independent review of the Auditor General to assist in improving the internal control environment to support the functioning of the Health Service is welcomed.

The internal control issues raised are noted and accepted, now forming a comprehensive action plan for resolution and monitoring of the associated risks through the Risk and Audit Committee and Board.

In relation to Information Technology, the finding was investigated and identified as a "false positive" by the vendor of Eastern Health's antimalware tool. With guidance from the vendor, Eastern Health has since updated the tool and is no longer reporting this vulnerability.

Yours Sincerely

David Plunkett
Chief Executive

RESPONSE provided by the Chief Executive, HPV

HEALTH PURCHASING VICTORIA

Mr Andrew Greaves
Auditor General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
Melbourne VIC 3000

10 November 2017

Re: Proposed report on the Results of 2016-17 Audits: Public Hospitals - Health Purchasing Victoria

Dear Mr Greaves,

Thank you for the opportunity to formally respond to the draft Victorian Auditor-General's Office (VAGO) report Results of the 2016-17 Audits: Public Hospitals.

We are pleased to note that the audit has found that HPV delivers significant sector benefits in undertaking collective purchasing. HPV is also pleased to note that VAGO acknowledges the benefits of the Health Purchasing Policy (HPP) Framework, and improved procurement governance and processes in achieving achieve best-value procurement outcomes.

HPV acknowledges the summary of findings in figure 3H of your report on sector compliance, noting that we have used a different methodology for reporting on sector compliance in our 2016-17 Annual Report.

We thank you for the opportunity to provide feedback and look forward to reviewing VAGO's final report on the results of the 2016-17 audit of Victoria's public health sector.

Yours sincerely

Elaine Ko

Elaine Ko
HPV Chief Executive

Health Purchasing Victoria ABN 28 087 208 309
Level 34, Casselden Place, 2 Lonsdale Street, Melbourne VIC 3000
03 9947 3700 03 9947 3701 hpv.org.au

RESPONSE provided by the Chief Executive, Northern Health

Northern Health

Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
MELBOURNE VIC 3000

9 November 2017

By email: hospitalPSA17@audit.vic.gov.au

Dear Mr. Greaves,

Re: Proposed Report on the Results of 2016-17 Audits: Public Hospitals – Northern Health

Northern Health wishes to thank you for the opportunity to provide further comments and feedback in regards to the proposed report on the results of 2016-17 Audits.

Northern Health has previously self-reported that they have not been fully compliant with one Collective Purchasing Agreement out of the fifty-six agreements in place by Health Purchasing Victoria (HPV). This was in relation to compliance with Biopharmaceutical – Infliximab contract (HPVC2016-108).

Since the original attestation, Northern Health has taken all the appropriate steps to transition to meet the requirements set out by HPV and has successfully been fully compliant since 28th July 2017.

Siva Sivarajah
Chief Executive
Northern Health

The Northern Hospital
Panch Health Service
Craigieburn Health Service
Broadmeadows Health Service
Bundoora Extended Care Centre

The Northern Hospital
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RESPONSE provided by the Chief Executive Officer, The Royal Children's Hospital Foundation

The Royal Children's Hospital Foundation
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The Royal Children's Hospital Foundation

13 November 2017

Mr Andrew Greaves,
Audit General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
Melbourne VIC 3000

Dear Mr Greaves,

Re: Proposed report on the Results of 2016-17 Audits: Public Hospitals – The Royal Children's Hospital (RCH) Foundation Trust Funds.

I am writing in response to where The Royal Children's Hospital (RCH) Foundation Trust Funds is mentioned in the above report on the Results of 2016-17 Audits: Public Hospitals.

In accordance with the reporting timetable, The RCH Foundation Trust Funds were issued an unqualified Audit Report from KPMG on the 10th August 2017 for the Financial Year 2016/17. The report has been lodged with the Australian Charities and Not-for-profits Commission. The RCH Foundation Trust Funds were reported in the Audited consolidated financial report for the Royal Children's Hospital.

Kind regards,

Sue Hunt,
Chief Executive Officer

RESPONSE provided by the Acting Chief Executive Officer, The Royal Women's Hospital

the women's
the royal women's hospital

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www.thewomens.org.au

10 November 2017

Mr Andrew Greaves
Auditor-General
Victorian Auditor-General's Office
Level 31, 35 Collins Street
Melbourne VIC 3000

Dear Mr Greaves,

Thank you for the opportunity to provide comment on the forthcoming report on the Results of 2016–17 Audits: Public Hospitals. The Royal Women's Hospital has been named in the report in relation to matters that were raised in the interim management letter year ending 30 June 2017. As such we would like to make the following comments in that respect.

Section 3.1 Internal control observations

RWH has recently completed the review with respect to the matter raised and is currently implementing the appropriate controls to mitigate the risk in this area by the end of November 2017.

Section 3.2 Status of internal control matters raised in prior year audits

RWH is working towards the replacement of its financial management system within the agreed timeframe. To mitigate the risk in the interim, we have in place an ongoing support agreement with an Oracle Financials specialist support vendor and as such believe the risk rating has been reduced to a medium risk.

We appreciate your due consideration of these comments.

Yours sincerely

Dunlop

Lisa Dunlop
Acting Chief Executive Officer

Page 1 of 1

RESPONSE provided by the Chief Executive Officer, Timboon and District Healthcare Service

Mr Andrew Greaves
Auditor General
VAGO offices
Level 31/35 Collins St
Melbourne 3000

November 9, 2017

Dear Mr Greaves

Proposed Report on the results of 2016-17 Audits: Public Hospitals

Thank you for affording me the opportunity to respond to your letter dated 1 November 2017 and the advice regarding the unresolved high risk item at years end 2016.

As advised the high risk item was an unsigned commercial lease agreement.

I am pleased to advise that that the issue has been fully resolved as at August 2017.

Thank you for your assistance with this matter and we are pleased the issue is now finalised.

Yours sincerely

Gerard Sheehan
CEO

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Appendix B
Audit opinions

Figures B1 to B4 list the entities included in this report. They detail the date we issued an audit opinion to each entity for its 2016–17 financial reports and the nature of the opinion.

Figure B1
Audit opinions issued for metropolitan hospitals and controlled entities

Entity	Clear audit opinion issued	Auditor-General's report signed date
Alfred Health	✓	25 Aug 2017
• Alfred Hospital Whole Time Medical Specialists' Private Practice Trust	✓	04 Oct 2017
Austin Health	✓	22 Aug 2017
Calvary Health Care Bethlehem Ltd	✓	28 Aug 2017
Dental Health Services Victoria	✓	16 Aug 2017
Eastern Health	✓	21 Aug 2017
Melbourne Health	✓	23 Aug 2017
Mercy Hospitals Victoria Ltd.	✓	21 Aug 2017
Monash Health	✓	21 Aug 2017
• Kitaya Holdings Proprietary Limited	✓	21 Aug 2017
Northern Health	✓	25 Aug 2017
• Northern Health Research, Training and Equipment Foundation Limited	✓	24 Aug 2017
• Northern Health Research, Training and Equipment Trust	✓	24 Aug 2017
Peninsula Health	✓	01 Sep 2017
Peter MacCallum Cancer Centre	✓	12 Sep 2017
• Cell Therapies Pty Ltd	✓	16 Aug 2017
• Cellularity Pty Ltd	✓	16 Aug 2017
• Peter MacCallum Cancer Foundation Ltd	✓	23 Aug 2017
• Peter MacCallum Cancer Foundation	✓	23 Aug 2017
The Queen Elizabeth Centre	✓	22 Aug 2017

Figure B1
Audit opinions issued for metropolitan hospitals and controlled entities—*continued*

Entity	Clear audit opinion issued	Auditor-General's report signed date
The Royal Children's Hospital	✓	29 Aug 2017
• Royal Children's Hospital Education Institute Limited[(a)]	✓	26 Sep 2017
• Royal Children's Hospital Foundation Trust Funds	✗	NA[(b)]
The Royal Victorian Eye and Ear Hospital	✓	01 Sep 2017
The Royal Women's Hospital	✓	22 Aug 2017
• Royal Women's Hospital Foundation Limited	✓	04 Sep 2017
• Royal Women's Hospital Foundation Trust Fund	✓	04 Sep 2017
St Vincent's Hospital (Melbourne) Limited	✓	07 Sep 2017
Tweddle Child and Family Health Service	✓	14 Sep 2017
Western Health	✓	21 Aug 2017
• Western Health Foundation Limited	✓	13 Nov 2017

(a) Deregistered on 16 February 2017 with Australian Securities and Investment Commission (ASIC).

(b) Not yet signed at the date this report was issued.

Source: VAGO.

Figure B2
Audit opinions issued for regional hospitals and controlled entities

Entity	Clear audit opinion issued	Auditor-General's report signed date
Albury Wodonga Health	✓	25 Aug 2017
Bairnsdale Regional Health Service	✓	24 Aug 2017
Ballarat Health Services	✓	22 Aug 2017
Barwon Health	✓	21 Aug 2017
• Barwon Health Foundation Future Fund	✓	23 Aug 2017
• Barwon Health Foundation Future Fund Limited	✓	23 Aug 2017
Bendigo Health Care Group	✓	06 Oct 2017
Central Gippsland Health Service	✓	21 Aug 2017
Echuca Regional Health	✓	24 Aug 2017
Goulburn Valley Health	✓	31 Aug 2017
Latrobe Regional Hospital	✓	28 Aug 2017
Northeast Health Wangaratta	✓	25 Aug 2017
South West Healthcare	✓	23 Aug 2017
Swan Hill District Health	✓	05 Sep 2017
West Gippsland Healthcare Group	✓	05 Sep 2017
Western District Health Service	✓	05 Sep 2017
Wimmera Health Care Group	✓	28 Aug 2017

Source: VAGO.

Figure B3
Audit opinions issued for rural hospitals and controlled entities

Entity	Clear audit opinion issued	Auditor-General's report signed date
Bass Coast Health	✓	28 Aug 2017
Benalla Health	✓	24 Aug 2017
Castlemaine Health	✓	04 Sep 2017
Colac Area Health	✓	22 Sep 2017
Djerriwarrh Health Services	✓	21 Aug 2017
East Grampians Health Service	✓	25 Aug 2017
• East Grampians Health Building For The Future Foundation	✓	25 Aug 2017
Gippsland Southern Health Service	✓	07 Sep 2017
Kyabram and District Health Service	✓	29 Aug 2017
Maryborough District Health Service	✓	25 Aug 2017
Portland District Health	✓	23 Aug 2017
• Active Health Portland Ltd	✓	17 Aug 2017
Stawell Regional Health	✓	26 Aug 2017
• Stawell Regional Health Foundation	✓	26 Aug 2017

Source: VAGO.

Figure B4
Audit opinions issued for small rural hospitals and controlled entities

Entity	Clear audit opinion issued	Auditor-General's report signed date
Alexandra District Hospital	✓	04 Sep 2017
Alpine Health	✓	31 Aug 2017
Beaufort and Skipton Health Service	✓	01 Sep 2017
• Beaufort & Skipton Health Service Foundation Ltd.	✓	01 Sep 2017
Beechworth Health Service	✓	01 Sep 2017
Boort District Health	✓	07 Sep 2017
Casterton Memorial Hospital	✓	25 Aug 2017
Cobram District Health	✓	01 Sep 2017
Cohuna District Hospital	✓	31 Aug 2017
• Cohuna Community Nursing Home Inc.	✓	31 Aug 2017
East Wimmera Health Service	✓	21 Aug 2017
Edenhope and District Memorial Hospital	✓	01 Sep 2017
Heathcote Health	✓	01 Sep 2017
Hepburn Health Service	✓	30 Aug 2017
Hesse Rural Health Service	✓	01 Sep 2017
• Winchelsea Hostel and Nursing Home Inc.	✓	01 Sep 2017
Heywood Rural Health	✓	23 Aug 2017
Inglewood and Districts Health Service	✓	18 Sep 2017
Kerang District Health	✓	15 Sep 2017
Kilmore and District Hospital	✓	25 Aug 2017
Kooweerup Regional Health Service	✓	14 Sep 2017
Kyneton District Health Service	✓	31 Aug 2017
Lorne Community Hospital	✓	29 Aug 2017
• The Lorne Figtree Community House Inc.	✓	31 Aug 2017
Maldon Hospital	✓	01 Sep 2017
Mallee Track Health and Community Service	✓	04 Sep 2017
Mansfield District Hospital	✓	25 Aug 2017
Moyne Health Services	✓	25 Aug 2017
• Woody's Murray 2 Moyne Cycle Relay Inc[(a)]	✓	25 Aug 2017

Figure B4
Audit opinions issued for small rural hospitals and controlled entities—*continued*

Entity	Clear audit opinion issued	Auditor-General's report signed date
Nathalia District Hospital	✓	31 Aug 2017
Numurkah District Health Service	✓	06 Sep 2017
Omeo District Health	✓	13 Sep 2017
Orbost Regional Health	✓	31 Aug 2017
Otway Health	✓	29 Aug 2017
Robinvale District Health Services	✓	31 Aug 2017
Rochester and Elmore District Health Service	✓	31 Aug 2017
Rural Northwest Health	✓	28 Aug 2017
Seymour Health	✓	05 Sep 2017
South Gippsland Hospital	✓	31 Aug 2017
Tallangatta Health Service	✓	04 Sep 2017
Terang and Mortlake Health Service	✓	23 Aug 2017
Timboon and District Healthcare Service	✓	21 Aug 2017
Upper Murray Health and Community Services	✓	11 Sep 2017
West Wimmera Health Service[(b)]	✓	29 Aug 2017
Yarram and District Health Service	✓	23 Aug 2017
Yarrawonga Health	✓	23 Aug 2017
Yea and District Memorial Hospital	✓	08 Sep 2017

(a) New controlled entity incorporated on 2 November 2016.

(b) New entity incorporated after merger with Dunmunkle Health Services from 1 July 2016.

Source: VAGO.

Appendix C
Control issues risk ratings

Figure C1 shows the risk ratings applied to issues raised in management letters. It also details what they represent and the expected timeline for the issue to be resolved.

Figure C1
Risk definitions applied to issues reported in audit management letters

Rating	Definition	Management action required
Extreme	The issue represents: • a control weakness which could cause or is causing **severe** disruption of the process or severe adverse effect on the ability to achieve process objectives and comply with relevant legislation, or • a **material** misstatement in the financial report has occurred.	Requires immediate management intervention with a detailed action plan to be implemented within one month. Requires executive management to correct the material misstatement in the financial report as a matter of urgency to avoid a modified audit opinion.
High	The issue represents: • a control weakness which could have or is having a **major** adverse effect on the ability to achieve process objectives and comply with relevant legislation, or • a **material** misstatement in the financial report that is likely to occur.	Requires prompt management intervention with a detailed action plan implemented within two months. Requires executive management to correct the material misstatement in the financial report to avoid a modified audit opinion.
Medium	The issue represents: • a control weakness which could have or is having a **moderate** adverse effect on the ability to achieve process objectives and comply with relevant legislation, or • a misstatement in the financial report that is not material and has occurred.	Requires management intervention with a detailed action plan implemented within three to six months.
Low	The issue represents: • a **minor** control weakness with minimal but reportable impact on the ability to achieve process objectives and comply with relevant legislation, or • a misstatement in the financial report that is likely to occur but is not expected to be material, or • an opportunity to improve an existing process or internal control.	Requires management intervention with a detailed action plan implemented within six to 12 months.

Source: VAGO.

Appendix D
Financial sustainability results

Figure D1 shows the indicators used in assessing the financial sustainability risks of public hospitals. These indicators should be considered collectively and are more useful when assessed over time as part of a trend analysis.

Figure D1
Financial sustainability risk indicators

Indicator	Formula	Description
Net result (percentage)	Net result / Total revenue	A positive result indicates a surplus, and the larger the percentage, the stronger the result. A negative result indicates a deficit. Operating deficits cannot be sustained in the long term. Net result and total revenue are obtained from the comprehensive operating statement.
Physical asset replacement (ratio)	Asset additions / Depreciation and amortisation	Comparison of the rate of spending on infrastructure with its depreciation and amortisation. Ratios higher than 1:1 indicate that spending is faster than the depreciating rate. This is a long-term indicator, as replacing assets can be deferred in the short term if there are insufficient funds available from operations, and borrowing is not an option. Asset additions are taken from the financial statement notes. Depreciation and amortisation are taken from the comprehensive operating statement.

Source: VAGO.

Financial sustainability risk assessment criteria

The financial sustainability risk of each public hospital has been assessed using the criteria outlined in Figure D2.

Figure D2
Financial sustainability risk indicators—risk assessment criteria

Risk	Net result	Physical asset replacement
High	Less than negative 10% Insufficient revenue is being generated to fund operations and asset renewal.	Less than 1.0 Spending on capital works has not kept pace with consumption of assets.
Medium	Negative 10%–0% A risk of long-term run down to cash reserves and inability to fund asset renewals.	1.0–1.5 May indicate spending on asset renewal is insufficient.
Low	More than 0% Generating surpluses consistently.	More than 1.5 Low risk of insufficient spending on asset renewal.

Source: VAGO.

Figures D3 to D10 provide the indicator results for each of the 86 public hospitals, for the five financial years 2013–14 to 2016–17.

The results are listed by public hospital cohort. The four cohorts are:

- metropolitan—18 large public hospitals which offer multi- and specialised services within the greater metropolitan Melbourne area
- regional—15 large public hospitals in regional cities or centres of Victoria that offer multi-services
- rural—11 medium sized public hospitals in rural centres or areas of Victoria that offer less services than metropolitan and regional public hospitals
- small rural—42 small public hospitals located in rural areas of Victoria, offering limited services that focus on community care.

Metropolitan public hospitals

Figure D3
Net result indicator at 30 June 2013 to 2017

	Net result (%)					
Metropolitan hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Alfred Health	-2.75%	-2.70%	-3.01%	-2.19%	-2.34%	-2.60%
Austin Health	-0.07%	-6.16%	-7.14%	-4.97%	-4.49%	-4.57%
Calvary Health Care Bethlehem Ltd	-1.27%	-0.24%	0.42%	-3.87%	-2.10%	-1.41%
Dental Health Services Victoria	-4.39%	-2.86%	-0.64%	1.50%	-2.52%	-1.78%
Eastern Health	9.15%	16.69%	-0.22%	-2.43%	-2.83%	4.07%
Melbourne Health	-3.43%	0.41%	-2.85%	-2.50%	-1.14%	-1.90%
Mercy Hospitals Victoria Ltd.	6.54%	4.18%	0.71%	3.45%	8.08%	4.59%
Monash Health	-0.20%	1.47%	-1.05%	5.93%	5.81%	2.39%
Northern Health	2.22%	1.98%	-4.71%	0.95%	2.12%	0.51%
Peninsula Health	-0.40%	8.08%	0.81%	-2.19%	-1.97%	0.87%
Peter MacCallum Cancer Centre	9.37%	23.57%	20.53%	-6.81%	-6.94%	7.94%
The Queen Elizabeth Centre	9.43%	3.32%	0.62%	11.37%	2.93%	5.53%
The Royal Children's Hospital	-13.02%	-11.03%	-0.93%	1.51%	0.84%	-4.53%
The Royal Victorian Eye and Ear Hospital	-6.07%	7.07%	18.17%	13.29%	14.15%	9.32%
The Royal Women's Hospital	-4.06%	-3.56%	-2.43%	-2.14%	-3.06%	-3.05%
St Vincent's Hospital (Melbourne) Limited	-0.14%	0.42%	-0.29%	-0.56%	-0.16%	-0.15%
Tweddle Child and Family Health Service	1.30%	-2.25%	-3.04%	-9.14%	-0.67%	-2.76%
Western Health	-3.58%	-3.15%	-2.05%	-3.76%	0.02%	-2.50%

Source: VAGO.

Figure D4
Physical asset replacement indicator at 30 June 2013 to 2017

	Physical asset replacement					
Metropolitan hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Alfred Health	0.69	1.04	0.59	0.54	0.38	0.65
Austin Health	1.09	0.43	0.24	0.46	0.44	0.53
Calvary Health Care Bethlehem Ltd	0.25	0.74	1.35	0.50	0.24	0.62
Dental Health Services Victoria	0.42	0.33	0.18	1.59	0.38	0.58
Eastern Health	2.79	4.17	1.57	0.75	0.71	2.00
Melbourne Health	0.55	1.07	1.60	1.12	0.56	0.98
Mercy Hospitals Victoria Ltd.	3.18	2.85	1.06	3.01	4.55	2.93
Monash Health	0.96	1.19	1.80	2.36	1.99	1.66
Northern Health	0.84	1.83	0.95	1.00	0.95	1.11
Peninsula Health	1.65	1.94	1.35	0.80	1.02	1.35
Peter MacCallum Cancer Centre	2.26	4.08	8.30	43.84	0.33	11.76
The Queen Elizabeth Centre	0.53	0.95	1.65	0.99	1.36	1.10
The Royal Children's Hospital	0.08	0.08	2.86	0.30	0.20	0.70
The Royal Victorian Eye and Ear Hospital	0.22	1.00	5.67	3.14	2.49	2.50
The Royal Women's Hospital	0.09	0.15	0.11	0.14	0.13	0.12
St Vincent's Hospital (Melbourne) Limited	1.65	1.33	0.91	1.23	0.85	1.19
Tweddle Child and Family Health Service	0.95	0.53	1.23	0.32	0.24	0.65
Western Health	0.56	0.65	0.81	0.44	1.14	0.72

Source: VAGO.

Regional public hospitals

Figure D5
Net result indicator at 30 June 2013 to 2017

	Net result (%)					
Regional hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Albury Wodonga Health	2.81%	3.60%	-2.90%	-3.82%	-1.98%	-0.46%
Bairnsdale Regional Health Service	-3.51%	-0.23%	-2.71%	-3.57%	0.01%	-2.00%
Ballarat Health Services	0.12%	-2.55%	-2.83%	-1.60%	-2.28%	-1.83%
Barwon Health	0.48%	2.71%	1.39%	-3.34%	-3.03%	-0.36%
Bendigo Health Care Group	-2.02%	-1.53%	-2.89%	-0.17%	54.67%	9.61%
Central Gippsland Health Service	-3.51%	-6.61%	-2.55%	-4.56%	-3.61%	-4.17%
Echuca Regional Health	11.44%	32.73%	-2.33%	-7.26%	-4.78%	5.96%
Goulburn Valley Health	-1.93%	-0.97%	-3.68%	-3.55%	-1.08%	-2.24%
Latrobe Regional Hospital	6.12%	5.31%	0.70%	8.08%	16.89%	7.42%
Northeast Health Wangaratta	-3.72%	-3.39%	-3.57%	-3.71%	-2.46%	-3.37%
South West Healthcare	0.32%	-3.35%	-6.24%	1.77%	-2.43%	-1.99%
Swan Hill District Health	-0.46%	-2.04%	4.79%	14.29%	-4.56%	2.40%
West Gippsland Healthcare Group	-2.78%	-4.00%	-5.94%	-4.32%	1.02%	-3.20%
Western District Health Service	14.45%	1.61%	-6.27%	-3.70%	-3.31%	0.56%
Wimmera Health Care Group	-0.25%	5.79%	0.16%	-1.20%	-1.64%	0.57%

Source: VAGO.

Figure D6
Physical asset replacement indicator at 30 June 2013 to 2017

	Physical asset replacement					
Regional hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Albury Wodonga Health	1.88	3.42	4.75	1.72	0.53	2.46
Bairnsdale Regional Health Service	0.57	0.72	1.22	1.33	0.82	0.93
Ballarat Health Services	1.38	0.78	1.32	1.15	0.83	1.09
Barwon Health	1.11	1.45	1.88	0.82	0.61	1.17
Bendigo Health Care Group	0.84	0.71	0.71	0.96	26.46	5.94
Central Gippsland Health Service	0.48	0.38	0.22	0.37	0.42	0.37
Echuca Regional Health	2.26	8.46	4.14	1.62	0.18	3.33
Goulburn Valley Health	0.47	0.60	0.69	0.86	0.67	0.66
Latrobe Regional Hospital	2.38	1.95	1.31	2.61	5.60	2.77
Northeast Health Wangaratta	0.95	0.82	0.51	0.47	0.46	0.64
South West Healthcare	0.95	0.63	0.88	1.75	0.82	1.01
Swan Hill District Health	1.19	2.29	1.64	3.23	0.86	1.84
West Gippsland Healthcare Group	0.90	0.52	0.64	1.22	0.54	0.76
Western District Health Service	4.98	1.63	0.40	0.23	0.18	1.48
Wimmera Health Care Group	0.93	2.84	0.96	0.47	0.48	1.14

Source: VAGO.

Rural public hospitals

Figure D7
Net result indicator at 30 June 2013 to 2017

	Net result (%)					
Rural hospitals	2013	2014	2015	2016	2017	Average
Bass Coast Health	-6.05%	-3.49%	2.22%	-3.49%	7.59%	-0.64%
Benalla Health	2.84%	-5.31%	-3.47%	0.60%	-2.11%	-1.49%
Castlemaine Health	-6.56%	2.08%	-4.34%	3.40%	-0.09%	-1.10%
Colac Area Health	-0.90%	-3.05%	-3.50%	-3.84%	-6.45%	-3.55%
Djerriwarrh Health Services	-3.79%	-3.04%	-1.27%	2.41%	8.23%	0.51%
East Grampians Health Service	-3.23%	-4.89%	-5.24%	-3.57%	-2.56%	-3.90%
Gippsland Southern Health Service	32.00%	-2.21%	-11.04%	-5.70%	-3.40%	1.93%
Kyabram and District Health Service	-3.48%	-0.20%	1.03%	-3.66%	-3.00%	-1.86%
Maryborough District Health Service	-9.07%	-8.11%	-5.17%	-5.64%	-3.36%	-6.27%
Portland District Health	-18.53%	-9.14%	-3.83%	-7.02%	-3.64%	-8.43%
Stawell Regional Health	5.30%	8.60%	-3.95%	-1.74%	-7.11%	0.22%

Source: VAGO.

Figure D8
Physical asset replacement indicator at 30 June 2013 to 2017

	Physical asset replacement					
Rural hospitals	2013	2014	2015	2016	2017	Average
Bass Coast Health	1.32	3.04	3.16	0.89	0.95	1.87
Benalla Health	0.35	0.64	0.73	0.65	0.45	0.56
Castlemaine Health	0.86	1.97	0.38	0.60	1.37	1.04
Colac Area Health	1.45	0.85	0.74	0.40	0.31	0.75
Djerriwarrh Health Services	0.77	0.42	0.81	1.52	2.39	1.18
East Grampians Health Service	0.76	0.60	0.43	0.72	0.56	0.61
Gippsland Southern Health Service	8.14	2.73	0.52	0.12	1.13	2.53
Kyabram and District Health Service	1.39	1.01	2.51	1.16	0.56	1.33
Maryborough District Health Service	0.09	0.20	0.25	0.24	0.45	0.25
Portland District Health	0.39	0.38	2.46	0.44	0.31	0.80
Stawell Regional Health	0.91	2.28	0.29	0.74	0.65	0.97

Source: VAGO.

Small rural public hospitals

Figure D9
Net result indicator at 30 June 2013 to 2017

	Net result (%)					
Small rural hospitals	2013	2014	2015	2016	2017	Average
Alexandra District Hospital	-28.41%	-17.82%	-21.75%	-11.28%	-13.58%	-18.57%
Alpine Health	-8.09%	-4.32%	-7.95%	-4.25%	-2.65%	-5.45%
Beaufort and Skipton Health Service	0.06%	0.99%	-5.29%	-5.83%	-15.07%	-5.03%
Beechworth Health Service	-2.78%	-9.44%	-0.83%	-0.63%	-4.11%	-3.56%
Boort District Health	1.79%	5.29%	11.52%	46.41%	17.72%	16.55%
Casterton Memorial Hospital	-7.12%	-5.21%	-5.93%	-8.33%	-4.25%	-6.17%
Cobram District Health	0.40%	5.07%	-7.35%	-11.95%	-7.21%	-4.21%
Cohuna District Hospital	1.53%	-7.52%	-9.02%	-6.11%	-1.41%	-4.51%
Dunmunkle Health Services	-3.49%	-6.24%	-11.90%	-4.44%	-	-6.52%
East Wimmera Health Service	21.74%	30.17%	-16.35%	-7.74%	-9.99%	3.57%
Edenhope and District Memorial Hospital	2.99%	-8.55%	-11.34%	15.08%	-1.91%	-0.75%
Heathcote Health	-13.32%	-3.45%	-9.43%	-4.56%	-4.23%	-7.00%
Hepburn Health Service	-2.14%	-6.68%	-8.73%	-14.72%	-5.93%	-7.64%
Hesse Rural Health Service	-2.78%	-3.41%	-0.60%	-5.87%	-5.35%	-3.60%
Heywood Rural Health	-7.34%	-7.86%	-5.22%	-2.98%	-5.93%	-5.87%
Inglewood and Districts Health Service	-8.49%	-10.28%	-7.90%	-18.60%	-9.22%	-10.90%
Kerang District Health	30.73%	28.82%	9.39%	-4.64%	-14.98%	9.86%
Kilmore and District Hospital	6.70%	21.61%	7.55%	-12.51%	-12.73%	2.12%
Kooweerup Regional Health Service	-4.41%	-11.27%	-4.09%	-7.57%	-4.26%	-6.32%
Kyneton District Health Service	-10.05%	-6.55%	-4.12%	-8.98%	0.57%	-5.83%
Lorne Community Hospital	11.73%	3.61%	5.75%	4.11%	-7.25%	3.59%
Maldon Hospital	-14.59%	2.06%	-6.44%	-0.44%	1.10%	-3.66%
Mallee Track Health and Community Service	-9.87%	-5.56%	-14.64%	-10.68%	5.43%	-7.06%
Mansfield District Hospital	-7.22%	-3.00%	-4.57%	-3.38%	14.12%	-0.81%
Moyne Health Services	6.37%	-6.73%	-6.41%	9.51%	5.71%	1.69%
Nathalia District Hospital	-6.86%	-7.46%	-12.14%	-6.26%	-17.04%	-9.95%
Numurkah District Health Service	-2.12%	16.92%	51.63%	-4.58%	-2.88%	11.79%
Omeo District Health	-6.78%	1.34%	-6.71%	-5.54%	-9.41%	-5.42%
Orbost Regional Health	-4.79%	-4.71%	-6.09%	-1.19%	-1.35%	-3.63%
Otway Health	3.78%	-8.77%	-4.37%	-7.08%	4.50%	-2.39%

Figure D9
Net result indicator at 30 June 2013 to 2017—*continued*

	Net result (%)					
Small rural hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Robinvale District Health Services	-2.75%	-0.46%	10.06%	-2.69%	-2.14%	0.40%
Rochester and Elmore District Health Service	-4.70%	-8.59%	-9.19%	-6.10%	-3.27%	-6.37%
Rural Northwest Health	-3.76%	-6.93%	-8.36%	-8.76%	-5.00%	-6.56%
Seymour Health	0.72%	-2.72%	4.86%	-3.14%	-2.82%	-0.62%
South Gippsland Hospital	-0.94%	-2.52%	-8.54%	-2.89%	-2.40%	-3.46%
Tallangatta Health Service	-14.09%	-7.61%	-2.43%	-3.68%	-6.66%	-6.89%
Terang and Mortlake Health Service	-0.71%	1.06%	0.72%	-1.98%	-3.36%	-0.85%
Timboon and District Healthcare Service	10.31%	-8.17%	-5.60%	-9.15%	-3.42%	-3.21%
Upper Murray Health and Community Services	-3.73%	-6.70%	-5.42%	0.72%	-1.04%	-3.23%
West Wimmera Health Service	-5.73%	-11.10%	-5.63%	-2.80%	-2.41%	-5.53%
Yarram and District Health Service	-7.16%	-8.19%	-9.55%	-10.82%	-9.00%	-8.94%
Yarrawonga Health	-4.98%	-3.12%	-5.35%	-6.28%	-7.34%	-5.41%
Yea and District Memorial Hospital	-2.84%	-3.41%	-5.57%	-6.22%	-7.74%	-5.16%

Source: VAGO.

Figure D10
Physical asset replacement indicator at 30 June 2013 to 2017

	Physical asset replacement					
Small rural hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Alexandra District Hospital	0.31	0.52	0.21	0.30	0.13	0.29
Alpine Health	0.39	0.38	0.44	0.35	0.31	0.37
Beaufort and Skipton Health Service	0.46	1.05	0.24	0.22	0.82	0.56
Beechworth Health Service	0.19	0.07	0.24	0.34	0.28	0.22
Boort District Health	0.48	0.39	1.62	12.03	3.02	3.51
Casterton Memorial Hospital	0.12	0.15	0.46	0.15	0.25	0.23
Cobram District Health	1.11	1.48	0.36	0.26	0.40	0.72
Cohuna District Hospital	1.19	1.17	0.35	0.15	0.36	0.64
Dunmunkle Health Services	0.90	0.22	0.07	0.11	-	0.33
East Wimmera Health Service	1.05	6.93	1.59	0.29	0.15	2.00
Edenhope and District Memorial Hospital	0.64	0.46	0.94	2.32	0.51	0.97
Heathcote Health	0.23	0.87	2.88	0.70	0.84	1.10
Hepburn Health Service	0.57	0.41	0.60	0.29	0.18	0.41
Hesse Rural Health Service	0.33	0.45	1.06	0.40	0.37	0.52
Heywood Rural Health	0.33	0.30	0.53	0.24	0.33	0.35
Inglewood and Districts Health Service	0.45	0.48	0.29	0.52	0.14	0.38

Figure D10
Physical asset replacement indicator at 30 June 2013 to 2017—*continued*

	Physical asset replacement					
Small rural hospitals	**2013**	**2014**	**2015**	**2016**	**2017**	**Average**
Kerang District Health	7.10	5.18	9.24	2.90	1.09	5.10
Kilmore and District Hospital	1.62	4.29	4.78	0.38	0.22	2.26
Kooweerup Regional Health Service	1.31	0.37	0.30	0.38	0.17	0.51
Kyneton District Health Service	0.26	0.63	5.91	0.29	0.14	1.45
Lorne Community Hospital	0.29	0.42	1.51	0.97	3.05	1.25
Maldon Hospital	0.29	0.66	0.33	0.55	0.43	0.45
Mallee Track Health and Community Service	0.40	0.26	0.11	0.25	2.16	0.64
Mansfield District Hospital	0.23	0.69	1.18	0.39	0.42	0.58
Moyne Health Services	2.19	0.55	1.12	1.08	2.03	1.39
Nathalia District Hospital	0.24	0.41	0.13	0.37	0.09	0.25
Numurkah District Health Service	0.51	2.88	13.99	1.51	0.40	3.86
Omeo District Health	0.14	0.48	0.32	0.42	0.11	0.29
Orbost Regional Health	0.36	0.39	0.39	0.32	0.28	0.35
Otway Health	2.95	1.07	0.98	0.52	0.30	1.16
Robinvale District Health Services	0.26	0.29	2.48	0.63	0.40	0.81
Rochester and Elmore District Health Service	0.27	0.61	0.24	0.36	0.20	0.34
Rural Northwest Health	0.32	0.26	2.60	2.03	0.66	1.17
Seymour Health	0.44	0.33	1.81	0.34	0.36	0.66
South Gippsland Hospital	3.17	0.60	0.34	0.56	0.76	1.09
Tallangatta Health Service	0.53	0.19	0.87	0.18	0.45	0.44
Terang and Mortlake Health Service	0.35	0.63	0.83	1.41	1.44	0.93
Timboon and District Healthcare Service	1.09	0.39	1.45	0.45	0.30	0.74
Upper Murray Health and Community Services	0.21	0.24	0.63	1.37	0.61	0.61
West Wimmera Health Service	0.87	0.60	0.45	0.41	1.74	0.81
Yarram and District Health Service	0.18	0.07	0.05	0.06	0.06	0.08
Yarrawonga Health	0.38	0.25	0.34	1.01	0.27	0.45
Yea and District Memorial Hospital	0.21	0.20	0.17	0.17	0.21	0.19

Source: VAGO.

Appendix E
Glossary

Activity-based funding

Method of allocating funding based on unit prices for each activity undertaken and the volume of that activity an entity is to perform.

Asset

An item or resource controlled by an entity that will be used to generate future economic benefits.

Asset valuation

The fair value of a non-current asset on a specified date.

Audit Act 1994

Victorian legislation establishing the Auditor-General's operating powers and responsibilities and detailing the nature and scope of audits that the Auditor-General may carry out.

Audit committee

Helps a governing board to fulfil its governance and oversight responsibilities and strengthen accountability of senior management.

Audit opinion

A written expression, within a specified framework, indicating the auditor's overall conclusion about a financial (or performance) report based on audit evidence.

Block funding

A system of funding public hospital functions and services based on population and previous funding.

Cabinet minister

A member of the principal decision making body of the state government.

Capital expenditure

Money an entity spends on:

- new physical assets, including buildings, infrastructure, plant and equipment
- renewing existing physical assets to extend the service potential or life of the asset.

Capital grant/capital purpose income

Government funding for an agency to acquire or build capital assets such as buildings, land or equipment.

Clear audit opinion

A positive written expression provided when the financial report has been prepared and presents fairly the transactions and balances for the reporting period in keeping with the requirements of the relevant legislation and Australian Accounting Standards—also referred to as an unqualified audit opinion.

Collective purchasing arrangement

A contract for the purchase of goods or services for the benefit of two or more entities.

Contract management

The process of ensuring that contractual obligations of successful suppliers is met during the life of a contract.

Control environment

Processes within an entity's governance and management structure that provide reasonable assurance about the achievement of an entity's objectives in reliability of financial reporting, effectiveness and efficiency of operations, and compliance with applicable laws and regulations.

Current asset

An asset that will be sold or realised within 12 months of the end of the financial year being reported on, such as term deposits maturing in three months or stock items available for sale.

Current liability

A liability that will be settled within 12 months of the end of the financial year being reported on, such as payment of a creditor for services provided to the entity.

Deficit

When total expenditure is more than total revenue.

Depreciated replacement cost

Current replacement cost less accumulated depreciation to reflect the economic benefits of the assets that have been consumed.

Depreciation

Systematic allocation of the value of an asset over its expected useful life, recorded as an expense.

Entity

A corporate or unincorporated body 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.

Expense

The outflow of assets or the depletion of assets an entity controls during the financial year, including expenditure and the depreciation of physical assets. An expense can also be the incurrence of liabilities during the financial year, such as increases to a provision.

Fair value

The price that would be received if an asset was sold or the price paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Financial Management Act 1994

Victorian legislation governing public sector entities, as determined by the Minister for Finance, including their financial reporting framework.

Financial report

A document reporting the financial outcome and position of an entity for a financial year, which contains an entity's financial statements, including a comprehensive income statement, a balance sheet, a cash flow statement, a comprehensive statement of equity and notes.

Financial Reporting Directions

Issued by the Minister for Finance for entities reporting under the *Financial Management Act 1994*, with the aim of:

- achieving consistency and improved disclosure in financial reporting for Victorian public entities by eliminating or reducing divergence in accounting practices
- prescribing the accounting treatment and disclosure of financial transactions in circumstances where there are choices in accounting treatment, or where existing accounting procurements have no guidance or requirements.

Financial sustainability

An entity's ability to manage financial resources so it can meet its current and future spending commitments, while maintaining assets in the condition required to provide services.

Financial year

A period of 12 months for which a financial report is prepared, which may be a different period to the calendar year.

Governance

The control arrangements used to govern and monitor an entity's activities to achieve its strategic and operational goals.

Internal audit

A function of an entity's governance framework that examines and reports to management on the effectiveness of the entity's risk management, internal controls and governance processes.

Internal control

A method of directing, monitoring and measuring an entity's resources and processes to prevent and detect error and fraud.

Issues

Weaknesses or other concerns in the governance structure of an entity identified during a financial audit, which are reported to the entity in a management letter.

Liability

A present obligation of the entity arising from past events, the settlement of which is expected to result in an outflow of assets from the entity.

Management letter

A letter the auditor writes to the governing body, the audit committee and the management of an entity outlining issues identified during the financial audit.

Material error or adjustment

An error that may result in the omission or misstatement of information, which could influence the economic decision of users taken on the basis of the financial statements.

Material related party transaction

A transfer of resources, services or obligations between an entity and a relate party regardless of whether a price is charged.

Materiality

Information is material if its omission, misstatement or non-disclosure has the potential to affect the economic decisions of users of the financial report, or the discharge of accountability by management or those charged with governance. The size, value and nature of the information and the circumstances of its omission or misstatement help in deciding how material it is.

Mental health services (mental health)

All specialised mental health services providing a range of inpatient, community-based residential, rehabilitation and ambulatory services that treat and support people with a mental illness and their families and carers.

Net result

The value that an entity has earned or lost over the stated period—usually a financial year—calculated by subtracting an entity's total expenses from the total revenue for that period.

Non-admitted care

Medical procedures, such as day surgery, on a patient who is not admitted to hospital.

Non-current asset

An asset that will be sold or realised later than 12 months after the end of the financial year being reported on, such as investments with a maturity date of two years or physical assets the entity holds for long-term use.

Non-current liability

A liability that will be settled later than 12 months after the end of the financial year being reported on, such as repayments on a five-year loan that are not due in the next 12 months.

Physical asset

A non-financial asset that is a tangible item an entity controls, and that will be used by the entity for more than 12 months to generate profit or provide services, such as building, equipment or land.

Procurement

The end-to-end process of sourcing a supplier, contracting, purchasing the good or service, managing the contract (including supplier performance), and contract expiry or review. This can be by a department, individual role or process, and is wider than just purchasing the goods or services.

Procurement activity plan

A list of all procurement activities that the entity anticipates taking to market over a period of time (ideally 12 to 18 months).

Procurement strategy

A document that outlines the contribution that effective procurement will make to fulfil an entity's aims and objectives.

Revaluation

The restatement of a value of non-current assets at a particular point in time.

Revenue

Inflows of funds or other assets or savings in outflows of service potential, or future economic benefits in the form of increases in assets or reductions in liabilities of an entity, other than those relating to contributions by owners, that result in an increase in equity during the reporting period.

Risk

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

Auditor-General's reports tabled during 2017–18

Report title	Date tabled
V/Line Passenger Services (2017–18:1)	August 2017
Internal Audit Performance (2017–18:2)	August 2017
Effectively Planning for Population Growth (2017–18:3)	August 2017
Victorian Public Hospital Operating Theatre Efficiency (2017–18:4)	October 2017
Auditor-General's Report on the Annual Financial Report of the State of Victoria: 2016–17 (2017–18:5)	November 2017
Results of 2016–17 Audits: Water Entities (2017–18:6)	November 2017

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