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Financial reporting by the states and territories

…each of the state and territory governments do not necessarily work in a perfectly consistent and comparable financial framework. That is one of the complications that we are also working with.[1]

Measuring expenditure

4.1 Clauses 11 and 25(b) of the AHCAs require each state to increase their own funding for public hospital services such that the cumulative funding growth rate will at least match the cumulative rate of growth of Commonwealth funding to that state. Under Clause 33 each state agrees, that for the purpose of measuring their rate of funding increase in any grant year, the Commonwealth will consider each state's recurrent expenditure. The definition of recurrent expenditure was to be agreed between the Commonwealth and states before the AHCAs were signed.

4.2 The first challenge for Health was to determine the base level of expenditure in each state before the AHCAs were signed. Health then had to be able to confirm that the states were increasing their expenditure on public hospitals at a rate that matches any funding increase by the Commonwealth.

4.3 The states have structured their health programmes and accounts in different ways. Thus, in 2003 when the AHCAs commenced, the states were using different approaches to collecting and reporting their

1 Kalisch D, transcript, p 8.

public hospital related recurrent expenditure.[2] As a result, Health did not have a clear or consistent definition of what public hospital expenditure encompassed in the states nor how it might be compared between the states.

4.4 This problem was anticipated in the AHCAs. Clause 36 of the Agreements, committed the parties to 'develop a comprehensive, standardised system for determining recurrent health expenditure' by June 2005. In the interim, Health developed its own definitions of 'AHCA related services' to overlay state financial data and calculate each state's recurrent expenditure in a consistent manner – even though none of the states used the Health devised definitions for their own public hospital accounting and budgeting.[3]

4.5 The ANAO reported that a standardised system was developed by June 2005 and that all parties agreed to report under the new as well as the interim Health derived system for the remainder of the 2003-08 agreements.[4] Health informed the committee:

> There was significant work over the first two years of the agreement in order to set out more clearly how [the states and territories] should be reporting their financial circumstances.[5]

4.6 The new standardised system, which allows more reliable comparisons of expenditure across states and over time, will apply exclusively in the 2008-2013 Agreements. As Health commented:

> Certainly the position that we are going to be in at the start of the next health care agreements will be a superior position regarding monitoring and consistent information reporting than the one we were in at the start of 2003.[6]

Independent verification

4.7 Clause 35 of the AHCAs requires the states to provide independent verification of the financial information they are required to provide Health. Health advised the states in August 2003 that the external auditing could be done by state Auditors-General or private sector

2 For example, one state reported on a cash rather than accrual basis; some excluded depreciation in their statements and some included ambulatory services while others did not. ANAO, Audit Report, p. 53

3 ANAO, Audit Report, p 53.

4 ANAO, Audit Report, pp 53, 57.

5 Yapp G, transcript, p 7.

6 Kalisch D, transcript, p 7.

accountancy firms but not by their health department's internal auditor.[7] In this context, the ANAO advised of finding an instance of the same firm undertaking the internal auditing as well as the external audit for the AHCAs.[8]

4.8 While it gave guidance to the states on who could undertake the financial statement audits, Health had not clarified the levels of assurance to be applied by the external auditors in preparing their reports. As a result, the scope and assurances of the external audits differed between states.[9] As the ANAO noted, the benefits to be gained from having the external audits were diminished further as Health did not assess the scope of the audits nor whether the auditors had qualified their options. Health advised the ANAO that it accepted the signed verifications from the external auditors and considered that compliance was satisfied if the states provided these reports on time.[10]

4.9 The ANAO recommended that Health clarify with the states the level and nature of the assurance it requires from independent audits of state recurrent expenditure on public hospital services. The ANAO also recommended that Health review future auditors' statements on state recurrent expenditure on public hospitals to ascertain any adverse findings on its assessment of compliance with the AHCAs.[11]

4.10 Health accepted the ANAO's recommendation and advised the committee that Health and the states had agreed to a uniform financial audit methodology and guidelines and that the new protocols would give greater consistency and surety.[12] As Health conceded:

> …if the states and territories could provide [financial information] in a more consistent fashion and use more consistency in terms of their internal and external verification that would make it easier for the Commonwealth to be able to assess whether each of the states are playing ball.[13]

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7 ANAO, Audit Report, p 55.
8 ANAO, Audit Report, p 55.
9 ANAO, Audit Report, p 55.
10 ANAO, Audit Report, p 55.
11 ANAO, Audit Report, recommendation 3, p 57.
12 Yapp G, transcript, p 7. See also ANAO, Audit Report, p 57.
13 Kalisch D, transcript, p 7.

4.11 Health also committed to reviewing future auditors' statements for state public hospital expenditure and to fully investigate any limitations or adverse findings raised by the auditors.[14]

4.12 The committee was alarmed that Health was asking for auditors' statements and then not reviewing them. Possibly Health had difficulty defining what assurance it expected from the external auditors' statements. Maybe Health assumed that receipt of the audit statements, in themselves, demonstrated that states' financial records were true and accurate records of public hospital recurrent expenditure for the purposes of AHCA compliance. In any event, the committee urges Health to make it clear to the states the level of assurance it will expect from external auditors for the next round of AHCAs before they commence. The committee also expects Health to review future auditors' statements and act on any qualifications or adverse findings made by those auditors.

14 ANAO, Audit Report, p 19.