13. Financial governance

A high performing health service is one that not only provides high quality, safe clinical care, but is also financially viable and sustainable. Directors must actively monitor the health service's financial performance in the context of health service funding mechanisms in order to effectively fulfil their directorial and Minister appointed responsibilities.

Questions that directors of health services should ask

- Am I fully aware of my responsibilities with respect to governance of the financial performance of the health service?
- Do the board understand activity based (i.e. funding based on ouputs) versus non-activity based (i.e. block funding/program funding) funding?
- Does the board understand the health service's demographic and its relative casemix?
- How is the board getting assurance that its financial risks are being managed effectively?
- Is the information being reported by management aligned to our strategic objectives?
- What are the major financial risk areas that our health service is, and will be, exposed to?
- Does the board have an understanding of financial risk thresholds and tolerances, to enable identification and escalation of risk mitigation actions?
- Does the board have a clear view of how the health service performs against other services?
- Does the board regularly engage with external advisors to detect and understand issues?
- What checks and balances are in place to monitor the effectiveness of financial risk management strategies? What are our integrity controls (e.g. separation of approver and purchaser)?
- What are our cash flow patterns? Is our expenditure reasonable in the circumstances?
- Are we being provided financial forecasts by management that helps ensure future risks are known?
- Do I have the required financial literacy to make informed decisions in relation to the governing of the health service as required under the FMA?

Red flags

- Financial reports from management are approved by the board without question.
- There are no directors with financial or accounting skills on the board.
- Variance and trends in financial performance data are not discussed or questioned by directors.
- Directors do not understand deficit funding and how revenue is recognised.
- Performance reports are provided in an ad hoc manner and/or inconsistent format.
- Directors leave questioning of financial performance data to the 1-2 specialists on the board.
- Financial surprises occur when rectification takes place at the end of financial year.
- Directors are unable to articulate the top financial risks faced by their health service.
- No benchmarking of financial performance is undertaken.
- Funding issues emerge 'without warning' and the board spends too much time dealing with emergency financial risk situations.
- The board does not regularly consider how it could be reducing costs, such as input costs and matters that can be outsourced or provided in partnership to reduce net costs.

- The board is not aware of HPV and its role in the Victorian health system.

Introduction to the chapter

This chapter goes through how health services are funded, specific funding models and provides information for directors with respect to their individual and collective responsibilities in relation to financial governance as well as applicable legislation and Victorian Government policies.

Financial governance underpins the monitoring of a health service's ability to provide ongoing, safe and quality health care to the community and is therefore closely aligned with clinical governance – both with respect to the importance of the issues and the governance processes applied.

How health service budgets are set and relevant funding models

The DHHS initially negotiates its fixed health budget with DTF. Once this figure has been agreed the DHHS then determines the funds to be allocated to health services.

The DHHS then negotiates with each health service with respect to the provision of nominal budgets for the following (where applicable to the health service):

Variable funding i.e. activity based funding (ABF)

- Calculated as the agreed volume of activity at the agreed prices.
- Activity targets are set to manage performance and demand.
- Funding is output based.
- Different prices for different types of activity are set to manage financial risk.
- Typically represents about 60% of a health service's budget (SRHS are not funded through ABF).

Fixed or block funding (specified grants)

- Funding is input based – For example, funds are provided to keep an emergency department running regardless of whether patients attend.
- Funding is indexed by population growth and the Consumer Price Index.
- Currently, this is the primary funding model for SRHS.

Please note, not all health services will be funded by both models, some may only be funded with block funding.

> Activity based (WIES/NWAU) funding recognises the costs as a result of the patient's complexity, needs and length of stay.

In 2017-18, Victoria uses a combined approach, which utilises both ABF and block funding approaches. A health service may receive funding under all of the following (this is not an exhaustive list):

Activity	Funding description	ABF or block funding
Emergency	Non-admitted emergency services grant Group C accident and emergency grant – this is the regional equivalent of an emergency department (as some emergency presentations are seen)	Block
Admitted acute (this includes those admitted from the emergency department)	Weighted Inlier Equivalent Separations (WIES)	ABF
Admitted subacute	Subacute Weighted Inlier Equivalent Separations (subacute WIES)	ABF
Non-admitted acute	Weighted Ambulatory Service Events	ABF
Non-admitted subacute	Available bed days	ABF
Admitted mental health	Health Independence Program	Block
Non-admitted mental health	Various ambulatory contact hour grants	Block
Some training (e.g. pre-vocational medical training)	Specific grants	Block
Other	Various block grants to subsidise existing funding models to support programs that are not equitably funded e.g. high cost, low volume	Block

Table 4 - Health service funding (Source: Victorian Government)

As you can see from the table, not everything is ABF. For example, SRHS are funded through block funding. However, as ABF forms a significant part of health service funding, the following section discusses what ABF consists of (with WIES being the main example of ABF), some limitations of the ABF model (and why it is not used in all circumstances) and some case studies to help explain how ABF works in practice.

Activity based funding - ABF

ABF uses classifications, called diagnosis related groups (DRGs), which bundle patient care episodes into clinically coherent groups that require similar resources. Simply put, health services are funded based on activity. In Victoria, the ABF model is used to monitor, manage and administer the funding of healthcare provided by a number of health services.[142]

The ABF model is continuously refined in order to:

- promote funding policy objectives
- better moderate financial risk
- maintain funding equality
- align funding with clinical practice changes and new technologies.

How ABF allocation works

The ABF model allocates funds based on:

- the **types** of patients treated - Patient types are determined by using information from patient medical records to group patients into DRGs. This is discussed in detail below under WIES.
- the **number** of patients treated; and
- **length of stay** (LoS).

Weighted Inlier Equivalent Separation (WIES): An ABF unit for admitted acute patients

The Victorian WIES model (used for admitted acute patients) is the main ABF model that allocates funds in recognition of the relative costs and complexity of different patients.

As such, each patient episode of care is grouped to a specific DRG, which reflects the costs incurred by health services in treating the patient.

Patients admitted in accordance with the funding model will generate differing amounts of WIES as a result of their care needs, with the health service being paid by DHHS at a

Case study – How external factors and a change in patient profile influence ABF

Better Care Service (BCS) is a specialist hospital, with a large portion of their services catering for maternity services. Additionally, they operate a 24 hour emergency department and undertake elective surgery procedures (acute admitted patients).

BCS' service mix has been established to cater for the demand of a relatively young and growing population on the fringes of Melbourne, and is located in a high growth corridor. In recent years however, BCS has experienced slow revenue growth and has moved from generating small but healthy operating surpluses, to a small deficit in the most recent financial year.

In the current year, revenue is tracking behind the health service's forecasts. The CFO and CEO have reviewed patient numbers, which continue to show strong growth experienced over the last few years. However, within this they have identified a shift in the complexity of births over the last 2 years. This shift attracts lower revenue based on the lower complexity associated with it in the funding model. Further, overall births have remained relatively stable, whilst other areas of their hospital, such as their emergency department have grown significantly.

Given the hospital had established its cost base on the traditional patient mix, they have identified that this shift in birth complexity and the increase in demand for other services, has now started to impact on their traditional revenue streams while simultaneously experiencing additional costs in their ED.

The health service is now looking at ways to restructure its staff profile and cost structures to cater for these changes. Funding will now be modified based on the changing demographic and demand as a result. This is an example of how ABF adjusts and changes over time as health services adapt to cater for their population and demographic changes and health service demands.

Health services cannot control these ever changing demands however must be aware that these changes can drastically impact health service funding.

[142] For more detailed information, please visit: <https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability>.

standard rate for each WIES recognised.

The DRG takes into account a range of factors in order to arrive at the relevant cost e.g. how many hours of surgery, how much electricity required, length of stay, staff (including specialities) required and various other factors.

For example, a sleep disorder has a relatively low DRG weight of 0.2. A liver transplant has a relatively high DRG weight of 25. This recognises the differing needs and complexity of each patient and the WIES generated by the health service will vary accordingly.

A single WIES has been calculated as approximately $5,000[143] (being the average cost of treatment for one episode of care in Victoria). Therefore, the DRG for a sleeping disorder will impact the total WIES amount. So, for that episode of care, the funds allocated to the service will be calculated as follows:

0.2 (W) x $5,000 (IES) = $1,000

Five (5) separate episodes of care for sleep disorders will equate to 1 WIES:

(i.e. $1,000 x 5 = $5,000)

How are DRGs assigned to patients?

When a patient enters a health service, displaying or stating various symptoms, health practitioners assess the patient and collect a medical history. This information is then used by coders to group the patient to a specific DRG and can include (but is not limited to):

- the patient's diagnosis
- any particular complications
- previous procedures a patient has had
- age
- co-morbidities.

The information that health services report about their patients is then used to work out the ABF (e.g. WIES) health services receive.

DRGs are based upon the reported costs of treating patients as provided by the health service to DHHS.[144]

Case study – WIES

At Better Care Service (**BCS**), 2 newborn babies are transferred to the neonatal ward. Both babies were born prematurely, one weighing 1,499 grams (**Child 1**) and the other weighing 1,550 grams (**Child 2**). **Each child in this case has the same length of stay and is provided the same care needs**.

While the weight difference is only 60 grams, this places each child into a different DRG, which impacts the average cost associated with each child:

- **Child 1:** 19 WIES
- **Child 2:** 10 WIES

As compared to their associated DRG cohorts, the calculated, average length of stay for a child similar to:

- Child 1, is approximately 32 weeks
- Child 2, is approximately 21 weeks.

While there is a small weight difference and each child is given the same care needs in this case, given the structure of the funding model, and how each child is identified by it, Child 1 is allocated a greater amount of WIES on the basis of the different DRG.

The reason for this is that Child 1 has been recognised by the funding model as, on average, although not in this case, a more complex patient, due to the weight difference requiring more care (which includes specialist equipment and staff), and have an increased length of stay in the health service.

This has potential implications for BCS as factors in the surrounding population can change, such as diet and physical activity, which impacts average birth weight. The resulting affect is an increase in cost due to more babies born under 1,500 grams.

[143] The actual value varies year on year with funding model changes. As such, $5,000 has been used as a simple, round-number approximation for the purpose of this toolkit. Refer to the PFG each year for the actual value.

[144] For more information on the ABF model, please refer to the DHHS' ABF webpage available from: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding/casemix-funding.

NWAU – what is the difference?

An NWAU is the national version of a WIES; in other words, it is an ABF unit.[145] It is much like comparing metres and yards – both measure the same thing in the same way, but are just a slightly different size.

Limitations of ABF

Each and every patient in a DRG is funded at the same amount (a flat rate of funding). However, not every patient in a DRG needs exactly the same level of care.

A flat rate of funding may not adequately track cost variation across time and levels of severity within a DRG. For example, some:

- groups of patients require additional care, even within the same DRG, therefore the costs to treat them exceed the DRG.
- health services treat more complex patients due to their speciality.

This approach can create financial risk to providers and purchasers of healthcare.

[145] Refer to the Independent Hospital Pricing Authority at https://www.ihpa.gov.au/

WIES – Questions for board directors to ask if your health service is not meeting its targets

This information is included to give you a better understanding of how health services are funded and to arm you with the knowledge to ask the right questions of your executive team, assuring yourself that the health service remains financially viable.

If your health service is:

- not meeting its ABF targets (e.g. admitted acute patients - WIES); or
- exceeding projected ABF targets and spending more than anticipated (e.g. admitted acute patients - WIES).

Questions	Considerations
Has our patient cohort changed? *i.e. has the population demographic changed?* *See the 'how external factors and a change in patient profile can influence ABF' case study*	Has the number of patients you normally treat changed? Have the types of patient you normally treat changed? Are they patients staying longer/shorter (length of stay) in hospital?
Has the patient information changed?	Has the way that you *collect* information about your patients changed? Are we coding the information properly? When was our last coding audit? Has the way that you *report* information about your patients to the DHHS changed?
If the patients and patient information haven't changed, where are we going wrong?	Are we coding the information properly? When was our last coding audit? What can we do to get back to our ABF target? Can we manage this or should we speak to the DHHS? Is there a problem with the DRGs or funding model? Does the revenue we can recognise make sense?
Specific questions to ask Health service is not meeting ABF targets	Are we treating enough patients? If not, why not? Have we had a lot of staff absences that is impacting service delivery? Could we partner with another hospital who have patients waiting for treatment?
Health service is exceeding projected ABF targets and spending more than anticipated	Are we seeing more patients than expected? Why is that? (E.g. has there been a seasonal flu epidemic or major emergency department event). Are there safe ways to treat patients without needing to have them stay in hospital?

Table 5 - Questions to ask to tease out issues relating to unmet WIES targets (Source: Victorian Government)

Block funding

ABF is not practical in all health provision circumstances, as discussed above. Additionally, it is not appropriate for all health services and some are better funded through block grants, for example some services in rural and regional communities.

Block funding example - Acute specialist services: Emergency departments

In Victoria, 39 hospitals are funded to provide 24-hour emergency services. Patients who attend these emergency departments can either be admitted to hospital or may be discharged after they receive care in the emergency department. The funding approach for emergency department activity mirrors this patient flow through two streams of funding.

- NAESG: Funding for patients who are not admitted, but who receive care in the emergency department only, is provided via the Non-Admitted Emergency Services Grant (NAESG). The NAESG comprises two parts: an availability component and an activity component.
- Funding for activity that occurs in the emergency department for patients who are subsequently then admitted as inpatients is provided through the inpatient price, which is WIES.

In 2015–16 the department commenced reforms to better align the non-admitted and admitted acute funding pools to reflect the activity being reported. This shift saw some funds being transferred from the NAESG into the admitted funding mechanism.

In 2017–18, DHHS will continue with this funding reform and maintain this split funding approach for the different patient pathways (admitted or non-admitted). Improving the specificity of the two funding streams will provide a clearer signal to health services about the efficient level of resources required for admitted and non-admitted emergency care.

In addition to improving the alignment between cost and funding for non-admitted emergency care, DHHS has used different measures to allocate the availability and activity component of the funding. The funding model design will retain the two components.

Another block funding example - SRHS funding model

The block funding model applies to SRHS that meet the IHPA criteria for block funding.

The IHPA criteria is used to determine which public hospital services are eligible for block funding. Block funding can apply when:

- it is not technically possible to use ABF
- there is an absence of economies of scale that means some services would not be financially viable under ABF.

Case study – SRHS funding

An elderly gentleman with a chronic medical condition attends the urgent care centre where he assessed by the general practitioner on call, who assesses and treats the patient before sending him home.

The GP costs for this episode are funded through the **Medical Benefits Scheme**. The other costs involved in running the urgent care centre are funded through the small rural flexible funding model.

To support this patient in his home, the urgent care centre provides a number of non-admitted services, for example, district nursing and allied health assessment and support.

These services are funded through the **small rural flexible funding model**.

Despite this, the patient's condition deteriorates and he is admitted as an acute inpatient.

This episode is also funded through the small rural flexible funding model.

After an extended admission it is decided that the patient's underlying health status has deteriorated and he is no longer able to live at home. He is assessed as eligible for residential aged care and moves into the nursing home wing of the hospital.

Funding for his care is now through the aged care funding system.

Eligible facilities in scope for block funding are Local Hospital Networks that meet the block funding criteria.

The Victorian Government is required to provide advice to the IHPA on which hospitals meet the block funding criteria on an annual basis. For SRHS, this advice can be provided once every six years, or more frequently at the discretion of the government.

The Victorian SRHS funding model allows the hospital to use funding flexibly according to the needs of the community. Funds can be used to provide the optimum mix of admitted and community based care.[146]

Other funding types

Some types of funding are block funded rather than ABF for other reasons, such as the complexity of developing a DRG type system for those services. Examples of this include mental health treatment and aged care.

Mental Health Funding

The IHPA has priced admitted mental health services using DRGs as the classification system, however, the pricing authority has determined that non-admitted mental healthcare will be block funded until such time as the new mental healthcare classification is available.

IHPA is currently developing a new classification system for mental health services. Overall mental health budgets for each health service across both admitted and community settings will be maintained during this transition period to the ABF model.

Dental Health

The Dental Health Program provides public dental care to eligible Victorians.

The Department of Health & Human Services funds Dental Health Services Victoria (DHSV) to deliver both routine and urgent dental care. Services are delivered through the Royal Dental Hospital Melbourne and 79 clinics across Victoria, operated by community health and rural public health services.

Providers of public dental care are guided by Department of Health & Human Services policies and guidelines on eligibility, priority of access, public dental fees, the dental waiting list, and data reporting.

Aged Care Services

For some health services, the provision of aged care services will be the primary form of service provided. The SRHS case study also touches on this.

The aged care system caters for Australians aged 65 and over (and Indigenous Australians aged 50 and over) who can no longer live without support in their own home. Care is provided in people's homes, in the community and in residential aged care facilities (nursing homes) by a wide variety of providers.

The Commonwealth is the primary funder and regulator of the aged care system. Total government expenditure on aged care services was around $15.8 billion in 2014–15,[147] with the Commonwealth providing approximately 95 per cent of this funding.

The *Aged Care Act 1997* (Cth) and associated Aged Care Principles set out the legislative framework for the funding and regulation of aged care, although services are also provided through contractual arrangements outside of this Act. The Department of Health is responsible for the operation of this Act.

The Victorian Government also contributes funding and support for public sector residential aged care services (PSRACS).

There are over 180 PSRACS throughout Victoria, making the Victorian Government the largest public provider of

[146] For more information, please visit: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability/activity-based-funding/abf-services-streams/small-rural-services

[147] Australia Government, Productivity Commission, *Report on Government Services 2016*. Available from: https://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services

residential aged care in Australia. Most services are operated by public health services, in rural and regional Victoria. This helps older people to access residential aged care within their local community.

PSRACS have an important role in providing care to older people with more complex, specialised care needs. Victoria is the only provider of aged persons' mental health services that specialise in caring for older people with a mental illness and/or persistent cognitive, emotional or behavioural issues.

DHHS contributes funding for PSRACS to support:

- the viability of SRHS
- residents with specialised care needs
- a skilled and qualified nursing workforce.

The Victorian PFG explains DHHS' process and unit-priced funding approach for PSRACS.

A service planning and development framework has also been developed to help PSRACS to develop services that meet the needs and expectations of their local communities.

Accrual accounting – How health services are funded for service provision

Accrual accounting refers to the approach of accounting where financial transactions are recognised in their relevant accounting period, (i.e. the point in time when the services are delivered), whereas the associated cash flows can occur at different times (i.e. the point in time when the services need to be paid for).

Consideration for the timing differences of cash flow need to be understood.

Directors and the board should seek information from their executive on any financial implications arising from accrual accounting.

Cash Flow Forecasts & Financial Sustainability Issues

Boards should receive regular cash flow reports from their management group that also forecast the cash position of the health service to the end of the financial year. This encourages active consideration of financial sustainability and helps to identify cash issues as soon as possible.

In the event a health service is anticipating or experiencing financial difficulties, the health service should contact DHHS as soon as they become aware of this. While DHHS will typically work to facilitate health services in managing their own cash and other financial issues independently, DHHS will also help to provide direct financial support in exceptional circumstances (see the case study 'financial sustainability').

Case study – Accrual accounting

From 01 March 2015 to 30 June 2015, Better Care Service recognised expenditure for electricity of $10,000 each month, a total of $30,000. They did not receive an actual invoice until 30 June 2015.

Even though expenditure of $30,000 was recognised, no cash had been paid against the invoice. The terms of payment on the invoice give the health service 14 days to pay the full value, which means Better Care Service will actually pay for the electricity in July, however, expenses have been recognised for each of the 3 months from 01 March to 30 June.

The health service has a mismatch between the expenditure they see in their accounting system and the cash they have paid as at 30 June.

There are instances when events occur that cannot be anticipated, for example malfunctioning equipment that cannot be easily predicted and can have significant cash implications. DHHS may consider these types of events however, there is an expectation the health service is adequately maintaining equipment and infrastructure, and creating cash provisions for eventual replacement.

Case study: Financial sustainability

The board of Better Care Service (BCS) holds its board meeting in the first week of each month. In anticipation of the February meeting, the CFO finalises the January accounts and prepares updated financial reports for the board to review.

In the February meeting, the board asked the CFO to present the health services current financial position. The CFO reported that a financial risk had been identified - BCS was experiencing higher salary and wage costs than budgeted for. The reason for this was due to the recent departure of several long standing nursing staff, for which BCS was struggling to find full time replacements. As such, they were relying on agency staff, which cost more than full time staff equivalents.

The implication of this in the short term was costs were higher than the revenue they were receiving, with cash reserves continuing to reduce until the vacant positions could be filled. Given the current skills shortage in the region, it was unlikely BCS would be able to recruit new staff against these positions for at least another 2 months.

This was placing stress on BCS's financial operating outcomes and available cash with the CFO forecasting BCS would deplete its current cash reserves within 3 months. After this point, BCS will be forced to delay payments to some creditors; prioritising financial obligations to pay current hospital staff and critical medical supplies.

Following the presentation, the CFO recommends BCS seek additional funding support from DHHS. The board votes and unanimously agrees with the CFO's recommendations. The board directs the CFO to formally correspond with DHHS highlighting the financial risk identified.

The CFO writes to DHHS outlining BCS's current financial situation, the CFO's analysis of the factors affecting BCS's cost overrun and a request for financial support should they not be able to recruit new full time staff within the next 2 months. In order to expedite the matter, the CFO calls the relevant executive at DHHS.

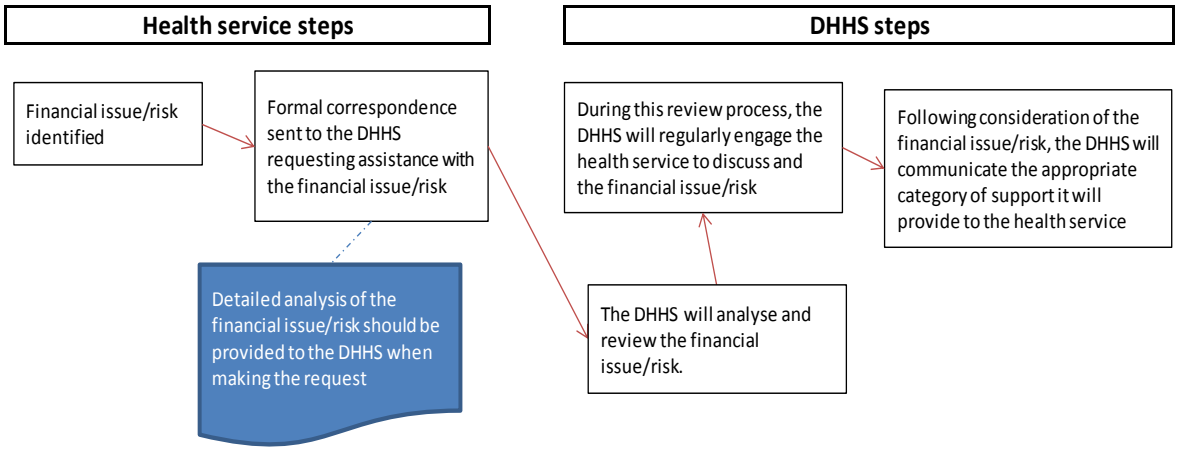

Figure 13-1 Funds request flow chart (Source: Victorian Government)

As you can see from the case study 'financial sustainability', accrual accounting can impact many transactions, such as payment of salary and wages. In practice, this can create problems where a health service may **appear** to have more cash available than anticipated.

The funds request flow chart above (Figure 13.1) highlights the latter points raised in the case study 'financial sustainability' and what a health service should do when it has identified a financial issue/risk.

Financial governance framework

Each health service is accountable to the Minister for its own financial management and reporting on the resources it uses. Financial governance is an important responsibility for all directors of a health service board. All health services have accountabilities under various legislation including the FMA and the Audit Act.

The FMA sets the financial management accountability, reporting and financial administration obligations of the Government and the Victorian public sector. The diagram below sets out the financial management framework hierarchy.[148]

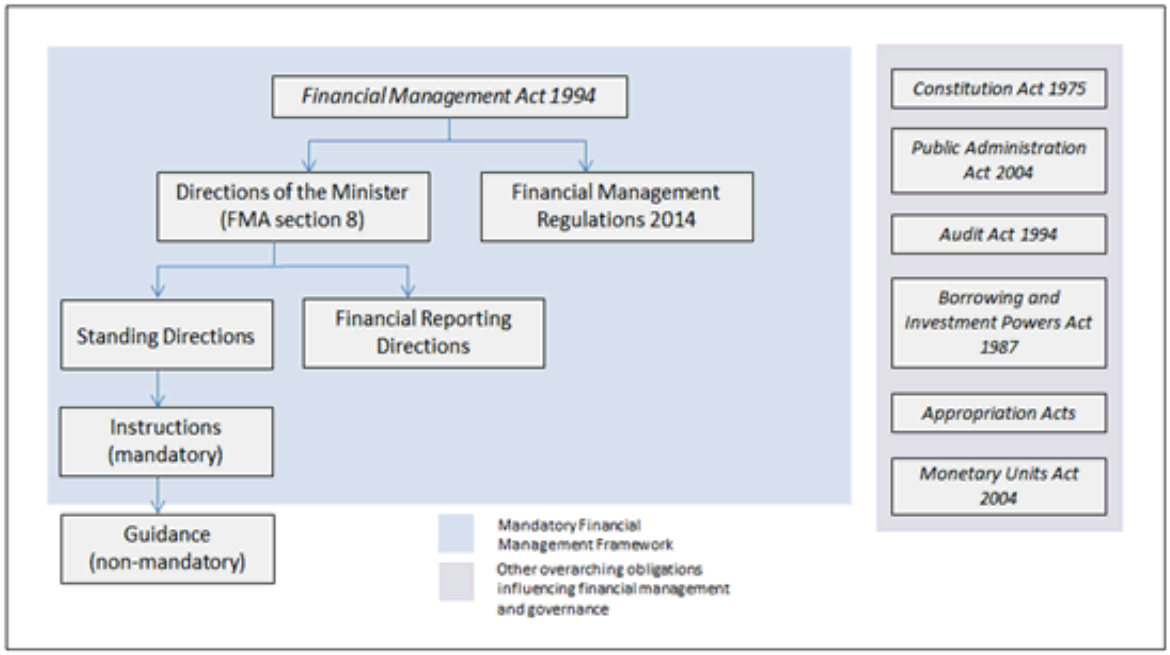

Figure 13-2 Breakdown of the relevant accountable provisions and directions

The financial governance framework is essentially a number of elements that assist a health service board in ensuring its health service is financially viable. The elements are discussed below.

The role of the board is to steer the health service on behalf of the Minister in accordance with Victorian Government policy and consequently the board is accountable to the Minister for achieving the financial targets agreed in its annual SoP (or other service agreement established with the Government), in line with the requirements of the Enabling Acts and other statutes.

Financial governance underpins the viability of a health service and directors' responsibilities in this regard are outlined not only in the Enabling Acts but also by broader obligations established by the Victorian Government for the management of public monies.

There are four main elements to financial governance:

[148] Available from: http://www.dtf.vic.gov.au/Publications/Government-Financial-Management-publications/Standing-Directions-of-the-Minister-for-Finance-2016/Standing-Directions-2016-publications. Please note, new standing directions are published every year. When reviewing this guide please refer to the latest standing directions.

- **Specific obligations under the relevant Enabling Act** - outlines that health services are accountable to the Minister for achieving the financial targets agreed in its annual SoP or service agreement established with the Government
- **Obligations outlined in the FMA** - Accounting and reporting policy and processes applicable to all public sector entities
- **Standing Directions from the Minister for Finance** – additional high-level procedures applicable to health services to enable agencies to tailor arrangements to suit their circumstances[149]
- **Audits by the Auditor General** – independent review of financial reports and processes to provide Parliament and the public with assurance that the financial information contained in the financial statements of public sector entities is presented fairly and in accordance with the relevant accounting standards.

In the Victorian health system, directors are also required to understand their accountabilities and obligations set out in the SoP (or equivalent service agreement with DHHS) and the PFG. We discuss the four main elements in detail below.

Enabling Acts (including the FMA)

Health services are required to meet specific financial obligations under the Enabling Acts. The key responsibilities of the board under the Enabling Act and other relevant legislation (e.g. the FMA) include:

- achieving financial targets agreed in the SoP (or other service agreement)
- monitoring financial performance
- ensuring the health service is financially viable
- establishing an audit and finance committee
- preparing an annual report of operations and financial statements.

Financial Management Act – specific requirements

The FMA provides the basis of preparation of financial reports for health services. It details the accounting standards that must be applied to internal management accounts and reflected in the health service's annual report (public) and key content that must be disclosed. DTF administers the FMA and provides guidance to board directors regarding the format and content of financial reports.

Specific requirements of the FMA that health service boards and management must be aware of, include:

- maintaining a register of assets
- keeping proper accounts and records of financial transactions
- provide the Minister for Finance with any information as requested
- preparing an annual report of operations and financial statements.

Standing Directions of the Minister for Finance

The Minister for Finance issues standing directions to health services to enable tailoring of the broader public sector financial policies and processes to suit individual health service circumstances. The Standing Directions and other related material, are available from the DTF website.[150] The Standing Directions are updated each year and include directions such as:

- financial management governance and oversight, including requirements to implement and maintain a financial code of practice and establish an audit committee

[149] Available from: www.dtf.vic.gov.au. Please note, new standing directions are published every year. When reviewing this guide please refer to the latest standing directions.

[150] Available from: www.dtf.vic.gov.au

- financial management structure, systems, policies and procedures
- financial management reporting, including information to be included in the annual report required under the FMA.

Audits by the Victorian Auditor-General's Office (VAGO)

Under the Audit Act, the Victorian Auditor-General's Office (VAGO) conducts financial statement audits of public sector entities every year. The purpose of the audits is to provide assurance that the reported financial information is accurate and prepared in accordance with the relevant accounting standard and policies applicable to Victorian public sector entities.

Boards should also be aware that health services are required to prepare and account their financial data in accordance with the Australian Accounting Standards (AAS). The AAS set the framework for which transactions, financial elements and processes should be recognised, recorded and reported. This is particularly pertinent to the annual financial report that is required to be prepared following the end of each financial year and is subject to auditing by VAGO.

Audits of health services accounting, record keeping, processes and reporting are undertaken directly by VAGO or a VAGO representative. Health services are required to ensure that these are done in accordance with the AAS framework. The annual report must be prepared to meet the minimum requirements of the AAS and auditors will issue a statement as to whether or not the health services accounts have met these standards.[151]

Compliance with the Audit Act requires the health service to allow these audits to take place, i.e. that all the information is provided and that relevant staff are available to answer questions and provide any necessary documentation. Other elements of compliance with the Audit Act include:

- the board's audit and risk management committee and the health service's internal auditors maintain a constructive relationship with VAGO
- the health service administers a well-targeted program of internal financial and compliance audits so there are no surprises when VAGO conducts an audit.

The role of the board in financial governance

As discussed briefly above, the board has ultimate responsibility for the monitoring and oversight of financial performance of a health service. The Enabling Act outlines the key responsibilities of boards with respect to financial governance and these include:

- the development of financial and business plans, strategies and budgets to ensure the accountable and efficient provision of healthcare services and the long-term financial viability of the health service
- monitoring the performance of the health service to ensure it operates within budget, and its audit and accounting systems accurately reflect the financial position and viability of the health service.

Together, boards and management are responsible and accountable for ensuring the systems and processes are in place to comply with the financial governance framework (the four categories listed above), with the board responsible for setting the financial parameters, accounting policies, KPIs, targets and objectives through the development of the SoP.

Management are responsible for implementing these policies and preparing the relevant financial information and reports for board review.

- In practice, the board's role in financial governance requires directors to:
- have a good working knowledge of the financial governance framework and its requirements
- understand the funding mechanisms that support the health service (both clinical and operational)
- have a basic level of financial literacy and understanding of key financial performance metrics for a health service

[151] Available from: http://www.aasb.gov.au/Pronouncements/Current-standards.aspx

- understand the links between financial performance and the provision of clinical care services, risk management and strategy development.

Financial performance reporting

There is a range of financial reports that boards of health services should regularly monitor. The board should ensure they, or the audit committee, receive regular financial management and performance reports. Table 6 below provides an example of standing items that could be reported directly to boards or through board committees.

Activity	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
External												
Review Annual Report (draft)												
Sign off Annual Report												
Vic Health Incident Management Report												
Patient Satisfaction Monitor Report												
Internal												
CEO/CFO Report (balanced score card)												
Financial Operating Results												
Sustainability Report												
Finance Committee reports												

Table 6 Annual reporting activities throughout the year: the blue highlighted boxes show when the activity is relevant during the year. Rows highlighted in blue show the activity will be relevant in all months of the year

Directors' duties

There are many ways that financial information can be presented, and sometimes this information can be complex. Boards must be comfortable with the reports it receives in order to effectively fulfil its duty to ensure the financial viability of the health service. Each director has a duty to ensure the financial management of the health service meets the required standards, therefore, a lack of financial literacy or understanding does not justify or absolve any director of their responsibilities.

In practice this involves actively understanding the clinical environment in which the health service operates; the services it provides; how they are provided; the quality and safety standards that must be adhered to and the compliance and administrative frameworks (within the health service and within DHHS) to which the organisation must align.

Reading and interpreting financial reports

Boards must review and interpret financial and clinical data on a regular basis. A range of reports will need to be tabled at board meetings at regular intervals throughout the year. The board's annual agenda (refer to **Appendix 6**) should outline what is to be reviewed and when, so that nothing is missed.

Refer to ***Chapter 14*** – *Understanding data* for more information about reading and interpreting financial reports.

Useful references

- DHHS: *Funding, performance and accountability*: https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability
- DHHS: *Policy and funding guidelines*: https://www2.health.vic.gov.au/about/policy-and-funding-guidelines
- DTF: *Government financial management*: http://www.dtf.vic.gov.au/Government-Financial-Management
- DTF: *Standing Directions of the Minister for Finance* 2016: http://www.dtf.vic.gov.au/Government-Financial-Management/Standing-Directions-of-the-Minister-for-Finance/Standing-Directions-of-the-Minister-for-Finance-2016
- VPSC: Gifts, benefits and hospitality: http://vpsc.vic.gov.au/ethics-behaviours-culture/gifts-benefits-hospitality/
- Australian Accounting Standards Board: Standards: http://www.aasb.gov.au/Pronouncements/Current-standards.aspx
- IHPA, *Pricing Framework for Australian Public Hospital Services 2018-19*. Available here: https://www.ihpa.gov.au/publications/pricing-framework-australian-public-hospital-services-2018-19
- IHPA, National Weighted Activity Unit (NWAU) calculators website: https://www.ihpa.gov.au/what-we-do/national-weighted-activity-unit-nwau-calculators
- Health Purchasing Victoria: https://www.hpv.org.au/
- ASIC *Corporate Governance – Risk oversight*, http://www.asic.gov.au/regulatory-resources/corporate-governance/risk-oversight/
- Davidson, Robert , Dey, Aiyesha and Smith, Abbie J., *Executives' 'Off-the-Job' Behavior, Corporate Culture, and Financial Reporting Risk* (February 27, 2013). Chicago Booth Research Paper No. 12-24; Fama-Miller Working Paper . Available at SSRN: https://ssrn.com/abstract=2096226 or http://dx.doi.org/10.2139/ssrn.2096226
- Australian Government Aged Care Financing Authority (ACFA), *Factors Influencing the financial performance of residential aged care providers*, (May 2015), ACFA, Canberra.
- Kayser-Bril, Nicolas, *Become Data Literate in 3 Simple Steps*, from Jounalism++, published online in the Data Journalism Handbook (1.0 beta): http://datajournalismhandbook.org/1.0/en/understanding_data_0.html
- Doig, Steven, *Basic steps in working with data*, from xx, published online in the Data Journalism Handbook (1.0 beta): http://datajournalismhandbook.org/1.0/en/understanding_data_2.html
- Davenport, Thomas H, *5 Essential Principles for Understanding Analytics*, (October 2015), Harvard Business Review. Available here [paywall]: https://hbr.org/2015/10/5-essential-principles-for-understanding-analytics
- Davenport, Thomas H, *Keep Up with Your Quants* (2013), Harvard Business Review (July-August 2013), Available here [paywall]: https://hbr.org/2013/07/keep-up-with-your-quants