Public Hospitals: Results of the 2008–09 Audits

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VAGO

Victorian Auditor-General's Office

Auditing in the Public Interest

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

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

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report on *Public Hospitals: Results of the 2008–09 Audits.*

Yours faithfully

D D R PEARSON
Auditor-General

11 November 2009

Contents

Audit summary

This report covers 114 entities, comprising public hospitals, the entities they control and rural health information technology alliances. It is the second of six reports to be presented to Parliament covering the results of our audits of 2008–09 financial reports.

The purpose of this report is to inform Parliament about significant issues arising from the financial audits within the public hospital sector, augmenting the assurance provided through audit opinions issued on financial statements that are included in the respective annual reports. The report also comments on financial management and reporting within the sector and better practice initiatives. It provides recommendations for improving public hospital investment management practices and it assesses the financial sustainability of public hospitals.

The Department of Health (DOH) and public hospital boards share responsibility for financial performance and management within the sector. While they have recognised the need to act on financial challenges, and have done so, there remains the need to expand their current initiatives to establish greater financial sustainability across the sector.

Results of audits

Reporting framework

All public hospitals and associated entities prepare their financial reports in accordance with Australian Accounting Standards, including the Australian Accounting Interpretations. Further, 91 of the 114 public hospitals and associated entities prepare their financial reports in accordance with the *Financial Management Act 1994* and 17 entities prepare their financial reports in accordance with the *Corporations Act 2001* or the *Associations Incorporation Act 1981*. The remaining six do not report under a legislative framework.

Audit opinions issued

At 31 October 2009, clear audit opinions had been issued on all 114 public hospital and associated entities' financial reports for the financial year ended 30 June 2009.

No modified audit opinions have been issued. This continues the positive result from 2007–08, when no modified audit opinions were issued.

Quality of reporting

The timeliness and accuracy of the preparation and finalisation of the financial report is a measure of the quality of financial reporting.

There has been a significant improvement in the quality of financial reporting in 2009, particularly relating to overall timeliness, compared with 2008. This is, in part, a result of DOH requiring earlier preparation of financial statements by public hospital sector entities for the 2008–09 financial year. Specifically:

- 87 per cent (99 of 114) of financial statements were finalised well within 12 weeks, compared with 54 per cent (85 of 156) for 2008
- 91 per cent (104 of 114) of public hospitals and associated entities submitted supporting work-papers and schedules for their financial statements to audit within the agreed time lines
- there was improvement in the level of compliance of draft financial statements, as submitted to audit, with legislative requirements and Accounting Standards compared with 2008.

Despite these significant improvements:

- 69 per cent (79 of 114) of public hospitals did not provide a complete and accounting standard compliant draft of their 2008–09 financial statements for audit within the agreed time line
- 46 material adjustments to the net result or the net asset position reported in the draft financial statements were required in 2009. In addition there were 17 significant classification errors in the draft financial statements.

Improvements notwithstanding, public hospitals and associated entities need to keep planning for and allocating sufficient and appropriate resources to financial report preparation so they can produce a compliant financial report within the legislative time line.

Effectiveness of internal control

Internal control encompasses the systems, policies and behaviours established by public hospitals to reliably and cost effectively meet their objectives.

In undertaking financial audits we assess the effectiveness of internal controls, established by management, over the reliability of financial reporting. While it is not our responsibility to form an opinion on internal controls, we nevertheless raise with management any control weaknesses or breakdowns we identify.

To the extent we examined those controls, the strength of public hospital internal control systems and processes was generally satisfactory, though variable between public hospitals. Specifically a significant number of important internal control mechanisms required strengthening in the following areas:

- information system controls
- preparation and review of key account reconciliations
- compliance with financial delegations
- review of masterfile standing data changes
- revaluations of plant and equipment
- existence of core policies and procedures
- calculation of long-service leave provisions
- management of annual leave entitlements.

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

Management of investments in public hospitals

This year as part of our cyclical approach to reviewing significant aspects of corporate governance and financial management, we conducted a review of the investment management practices and outcomes for the public hospital sector.

Public hospital investments and cash holdings respectively totalled $1.2 billion at June 2009, $1.1 billion at June 2008. Public hospitals have broad discretion under the *Health Services Act 1988* to make investment decisions.

During 2008–09, 21 out of 88 public hospitals experienced investment losses totalling $35.3 million ($10.3 million in 2008). This is, in part, a consequence of the global financial crisis.

Our review of public hospital investment management practices found that:

- 80 per cent (70 of 88) had not undertaken benchmarking analysis of their investment performance
- 31 per cent (27 of 88) did not provide regular and sufficiently comprehensive investment reports to their boards
- 83 per cent (73 of 88) had not commissioned internal audits of their investment management practices
- 26 per cent (23 of 88) did not have an approved investment policy
- one-third (21 of 65) had not reviewed their existing investment policy for at least 18 months
- 85 per cent (75 of 88) had not established investment committees.

Financial sustainability

Public hospitals had an annual turnover in excess of $9.3 billion in 2008–09, and managed assets totalling $10.5 billion at June 2009.

Maintaining financially viable public hospitals is a continual challenge for government. Individual public hospital boards and DOH share responsibility for financial performance and management within the sector.

Insight into the financial sustainability of the public hospital sector is obtained from an analysis of financial sustainability indicators over a trend period. These indicators should be considered collectively, and are more useful when assessed over time as part of a trend analysis.

To be financially sustainable, public hospitals need to have the capacity to meet current and future expenditure as it falls due. They should also be able to absorb foreseeable changes and financial risks that materialise.

An analysis of five financial sustainability indicators over a five-year trend period found that the public hospital sector, on average, has an overall medium-risk financial sustainability assessment.

Other key findings from the trend analysis of the financial sustainability indicators include:

- the incidence of individual public hospitals having a high-risk financial sustainability assessment has been relatively constant over the five-year trend period. In 2009, 32 per cent (28 of 88) had a high-risk assessment
- 28 per cent (25 of 88) of the state's public hospitals, including 12 major metropolitan and regional hospitals, had cash holdings at 30 June 2009 equivalent to less than 15 days operating cash outflows
- 81 per cent (71 of 88) of public hospitals had a high-risk self-financing indicator assessment at 30 June 2009
- a worsening trend over the past five years for the capital replacement indicator, with 41 per cent (36 of 88) of public hospitals having a high-risk assessment at 30 June 2009. This outcome is consistent with that for the self-financing indicator, and largely a consequence of the departmental capital funding model
- during 2009, DOH concluded that 31 of 88 public hospitals (35 in 2008) did not technically comply with the going concern test in the Australian Accounting Standards, including 11 of the 21 major metropolitan and regional hospitals, which account for 67 per cent of the total turnover of all Victorian public hospitals.

The financial sustainability indicators highlight trends that need to be monitored arising from the adoption of accrual accounting principles across the public hospital sector. Notwithstanding the application of sector neutral Australian Accounting Standards and accrual accounting by public hospitals, it should be noted that the departmental funding model does not fully provide for depreciation until DOH has determined the capital requirements of individual hospitals.

The departmental funding model, therefore, allocates capital grant funding strategically across the sector rather than progressively to each hospital. However, public hospitals are governed by boards that are accountable for financial management and performance. This situation blurs accountability for the financial performance of the individual hospitals.

Recommendations

Number	Recommendation	Page
1.	Public hospitals, with the assistance and guidance of the Department of Health (DOH), should improve their end-of-year financial reporting processes, including the operation of effective quality assurance processes over draft financial statements.	15
2.	DOH should finalise, promulgate and monitor the application of its investment policy guidelines by public hospitals	26
3.	Public hospital boards should establish a comprehensive investment management policy.	29
4.	Public hospital boards should establish appropriate policies for the appointment, monitoring and management of external fund managers, where applicable.	29
5.	Public hospital boards should have comprehensive investment management practices, including benchmarking investment performance and conducting internal audit reviews of investment practices.	30
6.	Public hospital boards should require comprehensive investment reports.	32
7.	Public hospital boards should review their investment policies at least annually, or more frequently when volatile investment markets are encountered.	32
8.	Given the existing conditions in the financial markets and the economy more generally, public hospital boards that have significant funds available for investment should establish an investment committee to provide a specialised focus on maintaining a robust investment management framework, maximising investment performance and managing risk.	32
9.	DOH and public hospital boards should enhance the monitoring of hospital operating results, and revenue and expenditure trends, in real terms and relative to demand. This process would be assisted by all public hospitals adopting a suite of core financial sustainability indicators.	37
10.	DOH and public hospitals should expand existing budgetary and management initiatives to improve financial sustainability across the sector, while better delineating respective accountabilities. In particular, the department's 2007 decision to extend the explicit legislative responsibilities of boards and chief executive officers applicable to the major metropolitan and regional public hospitals to all other public hospitals should be implemented.	38

General

The total cost of preparing and printing this report was $202 000.

Audit Act 1994 section 16 – submissions and comments

Introduction

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

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

Submissions and comments received

RESPONSE provided by the Secretary Department of Health

I believe that the report generally provides a balanced analysis of the issues of health service financial sustainability.

Health services are treating growing numbers of patients each year with amongst the world's best clinical outcomes. Health service Board's continually try to maximise the services that they provide to their local communities in a financially responsible way.

It is not surprising that given the priority placed on patient outcomes, and the fact that the State stands behind health services, that financial outcomes are lean by commercial standards.

The Department is pleased that the financial sustainability of the sector is assessed as a low risk in four of the five categories examined and that the report acknowledges that a generally stable position has been maintained over the last 5 years.

It is acknowledged in the report that the higher risk rating of the fifth area of self financing is directly related to the way in which State capital funding operates. Whilst historically high levels of capital funding have been provided in recent years, a project rather than depreciation funding system affects this indicator.

The audit report makes a number of observations and recommendations in regard to investment management. The Department did some further work to strengthen investment guidelines earlier this year but was conscious that the State was looking more broadly at these issues. The State has now concluded its review and the Department is now in a position to proceed to release updated guidelines.

RESPONSE provided by the Secretary Department of Health – continued

The Department agrees with the Audit recommendations apart from partially agreeing to:

Recommendation 8

Whilst accepting that separate investment committees may be appropriate for health services with larger investments, DH believes that this obligation may also be able to be discharged through Finance & Audit committees.

Recommendation 10

We are committed to examining legislative changes to Board responsibilities, but implementation will depend on the review outcome.

1 Results of audits

At a glance

Background

This report sets out the results of the audit of the 2008–09 financial reports of 114 public hospitals and associated entities.

Findings

- At 31 October 2009, clear audit opinions had been issued on all 114 public hospital and associated entities' financial reports for the financial year ended 30 June 2009.
- Compared with 2008, there has been a significant improvement in the overall quality of financial reporting in 2009. This is partly because DOH required earlier preparation of financial statements by public hospital sector entities for the 2008-09 financial year. Specifically:
  - 87 per cent (99 of 114) of financial statements were finalised within 12 weeks, compared with 54 per cent (85 of 156) for 2008.
  - 91 per cent (104 of 114) of public hospitals and associated entities submitted supporting work-papers and schedules for their financial statements to audit within the agreed timelines
  - there was improvement in the level of compliance of draft financial statements with legislative requirements and accounting standards compared with 2008
  - despite the overall improvement in timeliness, 69 per cent (79 of 114) of entities did not provide a complete and accounting standard compliant draft of their 2008–09 financial statements for audit within the agreed time line.

1.1 Introduction

This report is the second of six reports to be presented to Parliament covering the results of our audits of public sector financial reports. The reports in this series are outlined in Figure 1A.

The purpose of this report is to inform Parliament about the significant issues arising from the financial audits within the public hospital sector, augmenting the assurance provided through audit opinions issued on financial statements that are included in individual annual reports. The report also comments on financial management and reporting within the sector and better practice initiatives, provides recommendations for improving public hospital investment management practices and assesses the financial sustainability of public hospitals.

Figure 1A
VAGO reports on the results of audits

Report	Description
Local Government: Results of the 2008–09 Audits	The **first** report, tabled in Parliament on 11 November 2009, contains the results of the annual audit of 79 councils, 12 entities they control and 12 regional library corporations.
Public Hospitals: Results of the 2008–09 Audits	The **second** report, tabled in Parliament on 11 November 2009, contains the results of the annual audit of 88 public hospitals, 22 entities they control and four associated entities.
Auditor-General's Report on the Annual Financial Report of the State of Victoria, 2008–09	The **third** report, to be tabled contains the results of the audit of the State's Annual Financial Report.
Water Entities: Results of the 2008–09 Audits	The **fourth** report, to be tabled contains the results of the annual audit of 19 entities, comprising 16 water corporations and three retail distribution companies.
Portfolio Departments and Associated Entities: Results of the 2008–09 Audits	The **fifth** report, to be tabled provides a summary of the results of the annual audit of financial reports of the 10 portfolio departments and 198 associated entities with 30 June 2009 balance dates.
Results of Audits for Entities with other than 30 June 2009 Balance Dates	The **sixth** of these reports, to be tabled by mid 2010 provides the results of the annual audit of financial reports of 120 entities in Victoria's public sector which has a financial year other than 30 June 2009. These entities principally comprise 76 higher education entities, 34 vocational training entities and Victoria's five alpine resorts.

Source: Victorian Auditor-General's Office.

1.1.1 Financial audit framework

The financial audit framework applied in the conduct of the 2008–09 audits of public hospitals and associated entities is set out in Figure 1B.

Figure 1B
Financial audit framework

Planning

Planning is not a discrete phase of a financial audit, rather it continues throughout the engagement. However, initial audit planning is conducted at two levels:

- At a high or entity level, planning involves obtaining an understanding of the entity and its environment, including its internal controls. The auditor identifies and assesses: the key risks facing the entity; the entity's risk mitigation strategies; any significant recent developments; and the entity's governance and management control framework.
- At a low or financial statements line item level, planning involves the identification, documentation and initial assessment of processes and controls over management, accounting and information technology systems.

The output from the initial audit planning process is a detailed audit plan and a client strategy document, which outlines the proposed approach to the audit. This strategy document is issued to the client after initial audit planning and includes an estimate of the audit fee.

Conduct

The conduct phase involves the performance of audit procedures aimed at testing whether or not financial statement balances and transactions are free of material error. There are two types of tests undertaken during this phase:

- Tests of controls, which determine whether controls identified during planning were effective throughout the period of the audit and can be relied upon to reduce the risk of material error.
- Substantive tests, which involve: detailed examination of balances and underlying transactions; assessment of the reasonableness of balances using analytical procedures; and a review of the presentation and disclosure in the financial statements, for compliance with the applicable reporting framework.

The output from this phase is a final (and possibly an interim) management letter which details significant findings along with value-adding recommendations on improving controls and processes. These documents are issued to the client after any interim audit work and during the reporting phase.

Reporting

The reporting phase involves the formal presentation and discussion of audit findings with the client management, and / or the audit committee. The key outputs from this process are:

- A signed audit opinion, which is presented in the client's annual report alongside the certified financial statements.
- A report to the minister responsible for the entity of significant findings identified during the audit
- A report to Parliament on significant issues arising from audits either for the individual entity or for the sector as a whole.

Source: Victorian Auditor-General's Office.

1.2 Scope

This report sets out the results of the 2008–09 audit of 114 public hospitals and associated entities, as set out in Figure 1C below.

Figure 1C
Public hospitals and associated entities

Hospital category	2008	2009
Metropolitan:		
Public hospitals	20	18
Entities controlled by public hospitals	15	14
Other associated entities	20	0
Regional:		
Public hospitals	15	15
Entities controlled by public hospitals	2	2
Rural:		
Public hospitals	55	55
Entities controlled by public hospitals	6	6
Other associated entities	23	4
Total	**156**	**114**

Note: Entities controlled by public hospitals generally comprise foundations and trusts, while associated entities are rural health information technology alliances and community health centres. Appendix B provides a list of all public hospitals and associated entities.

Source: Victorian Auditor-General's Office.

Figure 1C shows that fewer entities were subject to our audit in 2009. The major change relates to the 39 community health centres that are no longer subject to public sector audit. Other entities that are no longer subject to our audit are the O'Connell Family Centre (Grey Sisters) Inc., which ceased to exist in April 2008. As well as St George's Health Service Limited and Caritas Christi Hospice Limited, which both ceased operations on 1 January 2008 with all assets and liabilities being transferred to St Vincent's Hospital (Melbourne) Ltd.

Public hospital services encompass prevention, early intervention and primary care, highly complex acute care, aged care and mental health services. The total cost of operating these services amounted to $9.4 billion in 2008–09 ($8.5 billion in 2008).

The analysis of the results of the 2008–09 audits in this report is based on the outcomes of individual hospital audits and the public hospital sector as a whole and also on the basis of three categories of hospitals being metropolitan, regional and rural.

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

1.2.1 Audit arrangements for stand-alone community health centres

There are approximately 100 community health centres, some 60 of which are part of a public hospital. The remainder are stand-alone entities.

Previous reports to the Parliament have highlighted that many of the stand-alone centres had received legal advice, indicating that they were not public statutory authorities and therefore not subject to audit by the Auditor-General.

The Victorian Government Solicitor, after reviewing the centres' status under the *Health Services Act 1988*, was of the opinion that the centres were public statutory authorities under the *Financial Management Act 1994* (FMA) and the *Audit Act 1994*.

On 20 March 2008, the Minister for Health announced a review of the governance and accountability arrangements for the centres.

During May 2008 the Public Accounts and Estimates Committee of the Parliament of Victoria issued a report on the 2006–07 financial and performance outcomes. That report included commentary on the accountability of the centres and concluded:

> *The Committee supports the need for the public accountability responsibilities of community health centres to be strengthened, an issue that was first raised by the Auditor-General in a 1999 report to Parliament. In that report, the Auditor-General identified a need for the reporting framework of stand-alone community health centres to be enhanced to ensure appropriate accountability to Parliament. The Committee will view with interest the outcome of the government's review of governance and accountability arrangements for Victoria's standalone community health centres.*

Following the ministerial review new legislative provisions for community health centres under the *Health Services Act 1988* were proclaimed at the end of March 2009.

One consequence of these new legislative arrangements is that registered community health centres under the *Health Services Act 1988* no longer meet the definition of a public statutory authority under the *Audit Act 1994* and the FMA. Accordingly, the Auditor-General will no longer undertake the financial audit of registered community health centres.

1.2.2 Rural health information technology alliances

The former Department of Human Services established a framework for the delivery of information technology services to rural and regional hospitals. This framework involved the establishment of five rural health information technology alliances with around 20 public hospitals and other entities as members of each alliance.

The alliances have been strategically and operationally important for the delivery of rural and regional health services as they assist these hospitals' access to core information and communications technology, including key government initiatives such as Health*SMART*.

In June 2008, the department issued the Rural Public Health Care Agencies' Alliances Policy and a new template joint venture agreement for the alliances. This policy required regional and rural public hospitals, and community health centres, to enter into an alliance for the region in which they operate using the new template joint venture agreement. Certain other health sector entities were given the choice of joining an alliance.

The new alliance agreements are structured as unincorporated joint ventures and as such are not declared as entities that are subject to the requirements of the FMA or the *Audit Act 1994*. Accordingly, the new alliances will not prepare and table annual reports. The department does however require each member organisation to disclose their share of the alliances' activities in their own audited financial reports.

The previous financial reporting and audit arrangements have continued for the 2008-09 financial year, with the new regime operational from 1 July 2009.

1.3 Reporting framework

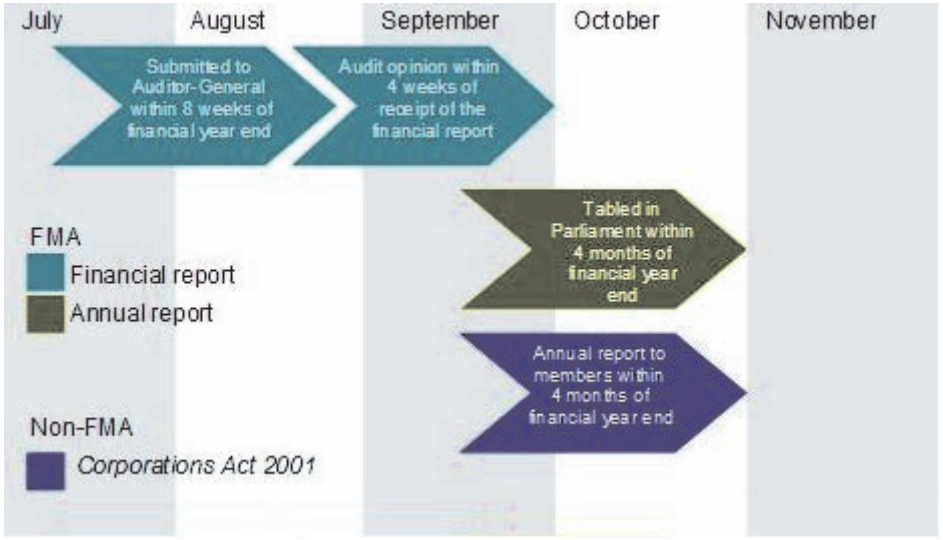
Ninety-one of the 114 public hospitals and associated entities prepare their financial reports in accordance with the FMA. Seventeen entities prepare their financial reports in accordance with the *Corporations Act 2001* or the *Associations Incorporation Act 1981*. The remaining six do not report under a legislative framework.

The FMA requires hospitals to submit annual reports to the relevant minister. These reports should be tabled in Parliament within four months of the end of the financial year, and include financial statements for the public hospital and any controlled entities which must be prepared and audited within 12 weeks. The remaining four stand-alone entities, reporting under the *Corporations Act 2001,* are required to report to their members within four months of the end of the financial year.

Under the FMA, the Minister for Finance has the authority to issue directions in relation to financial administration and reporting issues.

Figure 1D outlines the legislated reporting time frames.

Figure 1D
Legislative financial reporting time frames



Source: Victorian Auditor-General's Office.

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

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

If the report has not been prepared in accordance with the relevant reporting framework it is issued with a qualified audit opinion. A qualified opinion means that the financial report is materially different to the requirements of the reporting framework and therefore is less reliable and useful as an accountability document.

Definitions of qualified and unqualified audit opinions are included in the glossary at Appendix A.

1.4 Audit opinions issued

At 31 October 2009, clear audit opinions had been issued on all 114 public hospital and associated entities' financial reports for the financial year ended 30 June 2009.

No modified audit opinions have been issued. This continues the positive results from 2007–08, when no modified audit opinions were issued.

1.5 Quality of reporting

The timeliness and accuracy of the preparation and finalisation of the financial report is a measure of the quality of financial reporting. Public hospitals and associated entities need to plan for, and allocate sufficient and appropriate resources, to financial report preparation so they can produce a complete and accounting standard compliant financial report within the overriding FMA legislative time frame.

The factors outlined in Figure 1E contribute to the successful preparation of financial statements.

Figure 1E
Important factors in financial statement preparation

Demonstrating ownership and commitment
Maintaining robust risk management practices and internal controls
Adopting good financial reporting practices throughout the year
Establishing open and constructive relationships between key stakeholders
Managing staff and other resources effectively
Meeting whole-of-government responsibilities

Source: Australian National Audit Office, Better Practice Guide Preparation of Financial Statements June 2009.

This year we reviewed the quality of financial reporting. Our overall finding, as shown in Figure 1F, is that there was a significant improvement in the overall quality of financial reporting in 2008–09 when compared with 2007–08.

Figure 1F
Overall quality of financial reporting in 2008–09

Quality of financial reporting	Entities (%)	Entities (number)
Improved from previous year	25	29
Same as previous year	72	82
Worse than previous year	3	3
Total	**100**	**114**

Source: Victorian Auditor-General's Office.

Specific indicators of the timeliness and accuracy of financial reporting include:

- performance against the legislative reporting time frame
- timeliness of submission of draft financial reports for audit review
- timely availability of sufficient and appropriate supporting documentation
- preparation of shell financial statements
- the extent of errors in draft financial statements
- the level of compliance with legislative and accounting standard requirements.

Comment on each of these specific indicators follows.

1.5.1 Timeliness

Performance against legislative reporting time frames

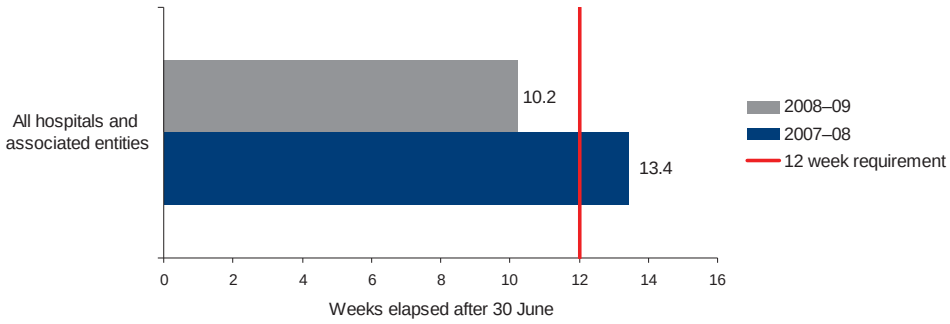
Recognising the stewardship role in relation to the use of public monies that financial statements serve, it is important that all public hospital sector entities prepare and publish timely financial information. The later the reports are produced and published after year end, the less useful they become.

The legislated time frame for entities that report in accordance with the FMA is to finalise their audited financial reports within 12 weeks of the end of the financial year. These requirements also apply to entities controlled by public hospitals reporting under the FMA, as FMA entities are required to finalise their financial statements, including the consolidation of their controlled subsidiaries, within 12 weeks.

For 2008–09, 87 per cent (99 of 114) of public hospital sector entities completed their financial statements within 12 weeks: a significant improvement on 2008, where 54 per cent (85 of 156) satisfied the 12 week requirement. This is, in part, a result of DOH requiring earlier preparation of financial statements by public hospital sector entities for the 2008–09 financial year.

Figure 1G sets out the average time taken by public hospital sector entities to finalise their financial statements.

Figure 1G
Average time to finalise financial reports of public hospital sector entities

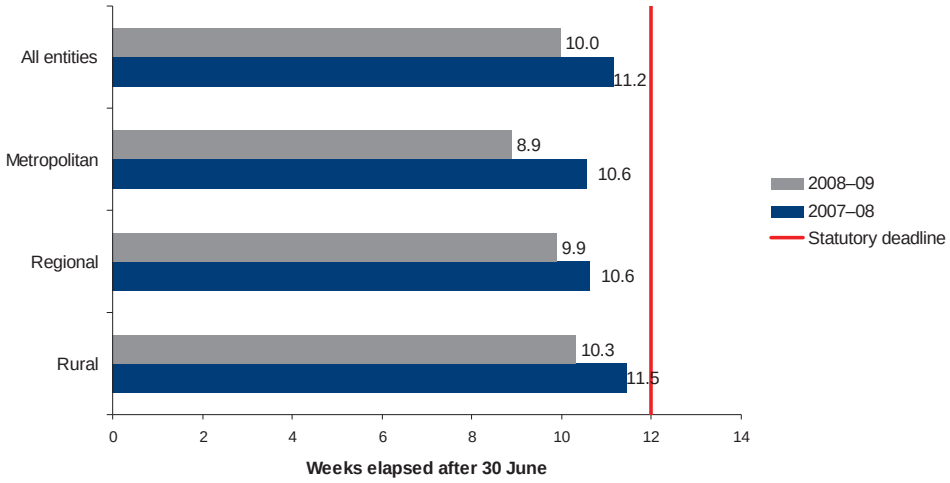


Source: Victorian Auditor-General's Office.

For those entities that report under the FMA, 95 per cent (86 out of 91) completed their financial statements within the statutory 12 week time line. This is a significant improvement from 2008 when 82 per cent (75 out of 91) met the requirement.

Figure 1H sets out the average time taken by entities reporting under the FMA to finalise their financial statements in total and by hospital category.

Figure 1H
Average time to finalise FMA financial reports, for all entities and by public hospital category



Source: Victorian Auditor-General's Office.

Timeliness of submission of draft financial reports for audit review

Hospitals provide draft financial reports for audit review and clearance before they are certified. The timeliness in providing the draft financial report for audit review is a lead indicator of the likelihood that a hospital will meet its reporting time frame.

FMA entities are required to provide draft financial reports to audit within eight weeks of the financial year end. This generally assures that the financial report can be finalised within the 12 week time frame.

Figure 1I compares the overall timeliness of the financial reporting process in 2008–09 to the previous year. Some 24 per cent (27 of 114) of entities had improved the timeliness of providing their draft financial statements for audit.

Figure 1I
Timeliness in submitting draft financial reports in 2008–09

Timeliness of financial reporting	Entities (%)	Entities (number)
Improved from previous year	24	27
Same as previous year	67	76
Worse than previous year	9	11
Total	**100**	**114**

Source: Victorian Auditor-General's Office.

This overall improvement in timeliness corresponds with the increased number of public hospitals finalising their financial report within the 12 week time frame, compared with 2007–08.

Notwithstanding the overall improvement in timeliness this year, our analysis showed that 69 per cent (79 of 114) of public hospital sector entities did not provide a complete and accounting standard compliant draft set of their 2008–09 financial statements for audit by the planned date that had been agreed between management and audit. These results indicate that there is still further scope to improve on the timeliness in financial reporting.

Availability of sufficient and appropriate supporting documentation

Work-papers and schedules form part of the documentation supporting the amounts and disclosures in the financial report. Financial reports need to be supported by sufficient and appropriate documentation, which should be available to management and audit on a timely basis so financial reports can be reliably substantiated.

Our analysis disclosed that 91 per cent (104 of 114) of public hospital sector entities submitted supporting work-papers and schedules to audit by the agreed date. This is a very positive outcome and is consistent with the significant increase in the number of audited financial reports being finalised within the 12-week time frame, compared with 2007–08.

1.5.2 Accuracy

Preparation of shell financial statements

Shell financial statements comprise the main statements and supporting notes, excluding current year figures. Preparation of shell financial statements prior to 30 June enables the early identification and clearance of key presentation and disclosure matters, and assists in the timely finalisation of the financial report.

Ideally, shell statements are provided before the financial year-end, as they provide an opportunity for management to resolve key presentation and disclosure issues at an early stage, and receive feedback from audit. Our analysis indicated that 94 per cent (107 of 114) of public hospitals and associated entities did not prepare shell financial statements for audit review in 2008–09. Hospitals that prepare shell statements are in a better position to produce a quality first draft financial report; and therefore, achieve earlier finalisation of their financial statements.

Of the seven hospitals that did prepare shell statements for audit review, six were complete and accounting standard compliant.

Errors in draft financial statements

Another measure of the quality of draft financial reports is the number and size of adjustments required to be made to those statements after submission to audit. Ideally, there should be no errors or adjustments.

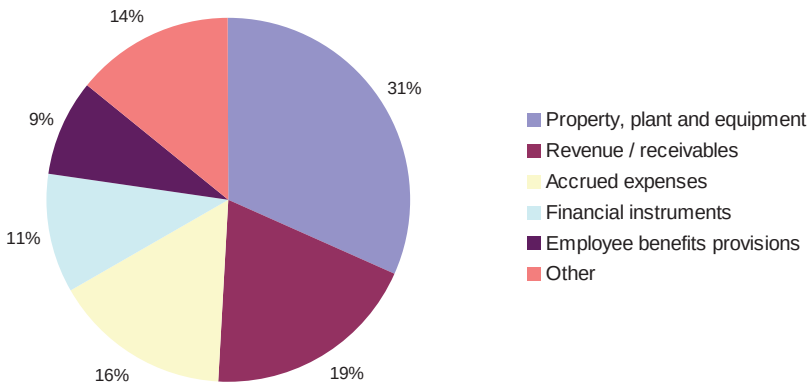
When the auditor detects errors in the draft financial statements they are raised with management. Material errors need to be corrected before a clear audit opinion can be issued.

There were a total of 46 material adjustments to the net result or the net asset position reported in the draft financial statements across the 114 public hospitals and associated entities in 2009. This means that on average there was about one material adjustment for every two entities. In addition, there were 17 significant classification errors that required adjustment in the draft financial statements. There was no discernable trend in the incidence of material adjustments and significant classification errors across the public hospital sector.

The total value of the adjustments on the net result or the net asset position was $39 million, comprising a total increase of $42 million: a decrease of $3 million. In addition a number of classification errors were identified, which do not affect the net result or net asset position, amounting to $53 million.

Figure 1J sets out which balances in the draft financial statements were impacted by the material adjustments and classification errors.

Figure 1J
2008–09 material adjustments and classification errors



Source: Victorian Auditor-General's Office.

Further comment on the nature of the material adjustments and classification errors follows:

- **Property, plant and equipment**—A substantial number of adjustments were required to correct the disclosure of property, plant and equipment, particularly in regard to land and building revaluation amounts and classifications, and the calculation of depreciation.
- **Revenue/receivables**—Adjustments were required to the amount of grant revenue recognised where entities had incorrectly brought certain revenue to account or had brought revenue to account in the wrong year, contrary to the applicable accounting standard.
- **Accrued expenses**—A number of adjustments were required to accrued expenses as certain accounts payable expenses had been incorrectly recorded in the wrong accounting period and some accrued expenses for salaries and other periodic payments had not been correctly calculated, or had been overlooked.
- **Financial instrument disclosures**—Adjustments were required to be made to financial instrument disclosures due to errors in the amounts being reported and other incomplete/incorrect disclosures.
- **Employee benefits provisions**—Adjustments were required to correct errors in the calculation of long-service leave provisions, generally caused by the incorrect application of on-costs, bond rates, wage inflation and probability factors.

Compliance with legislative requirements and accounting standards requirements

The level of compliance with legislative reporting requirements and accounting standards is a key criterion in determining the quality and accuracy of draft financial reports.

Ninety-one of the 114 public hospitals and associated entities prepare their financial reports in accordance with the FMA. While 17 entities prepare their financial reports in accordance with the *Corporations Act 2001* or the *Associations Incorporation Act 1981*. The remaining six do not report under a legislative framework.

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

Figure 1K sets out the results of our overall review of the level of compliance of draft financial statements with legislative requirements and accounting standards for public hospitals and associated entities. Overall, there was an improvement in the level of compliance compared with 2008.

Figure 1K
Compliance with legislative requirements and accounting standards

Compliance with legislative requirements and accounting standards	Entities (%)	Entities (number)
Improved from previous year	11	13
Same as previous year	85	97
Worse than previous year	4	4
Total	**100**	**114**

Source: Victorian Auditor-General's Office.

1.5.3 Better practice financial reporting initiatives

There are better practice initiatives that hospitals can implement to improve the quality of reporting. These initiatives can be done both before and after the end of the financial year.

Initiatives before year end include:

- preparation of a project plan that includes details of the required staffing and financial resources, assignment of responsibilities, and sets time lines for financial reporting
- reviewing actual and proposed changes to accounting standards, financial reporting directions issued under the FMA and other pronouncements, to identify significant accounting and reporting issues, and obtain audit agreement about any significant changes in accounting policy or reporting practice
- preparation of shell financial statements, that can be reviewed by management and audit, before the final audit visit
- undertaking a hard close, resulting in the preparation of a full set of financial statements with notes for management and audit review, a month or two ahead of the end of the financial year
- considering the extent to which current financial reporting systems have performance gaps, such as the ability to generate full accrual information with minimal manual intervention.

Initiatives after year end include:

- analysing significant variances between actual and the previous period results and budgeted outcomes to identify any potential omissions or errors
- establishing a system of documented sign-offs by executive managers with responsibility for components of the financial report
- undertaking a quality assurance review of the draft financial report before submission for audit
- submitting the draft financial report to the audit committee for review and endorsement before finalisation.

These better practice initiatives are actively promoted by audit as part of our engagement with public hospitals.

We also recommended that the Department of Human Services (which was formerly responsible for the health portfolio) adopt a number of initiatives to facilitate the timely preparation of financial statements by public hospitals. Those initiatives included:

- writing to each hospital chief executive officer and/or chair of the board and/or chair of the audit committee, reinforcing the annual reporting requirements under the FMA
- reviewing actual and proposed changes to Australian Accounting Standards, financial reporting directions issued under the FMA and other pronouncements to identify significant accounting and reporting issues, and providing guidance to hospitals thereon
- proactively identifying, monitoring and resolving key sector-wide accounting issues before 30 June each year
- undertaking early finalisation, and where possible streamlining, of the department's guidelines for hospital financial statements
- hosting forum/s to identify and resolve key challenges faced by portfolio agencies in meeting the reporting deadlines and provide guidance as appropriate
- undertaking an assessment of the capability and preparedness of each hospital to finalise their financial statements within the agreed timetable
- providing greater support, both financial and otherwise, to those hospitals, particularly small rural hospitals, which may lack sufficient resources to prepare timely and comprehensive financial statements
- encouraging all hospitals at industry or departmental forums to do an interim 'hard close', resulting in the preparation of full financial statements with notes, for audit review as at 30 April or 31 May
- undertaking early identification of those hospitals that may have a going concern issue, and arrange the timely issue of relevant letters of comfort
- preparing and issuing documentation relating to contributed capital contributions to hospitals in a timely manner
- pursuing early agreement on year end 'wrap-up' funding amounts.

We will continue to reinforce the need for these better practice initiatives to be adopted by DOH and public hospitals.

Recommendation

1. Public hospitals, with the assistance and guidance of the Department of Health, should improve their end-of-year financial reporting processes, including the operation of effective quality assurance processes over draft financial statements.

2 Effectiveness of internal control

At a glance

Background

When conducting our financial audit we assess the effectiveness of internal controls, established by the management of public hospital sector entities, which impact on the reliability of financial reporting.

Findings

- The strength of internal control systems and processes was generally satisfactory though variable between public hospitals. We identified a significant number of instances where important internal control mechanisms needed to be strengthened.
- Our review of public hospital investment management practices found that:
  - public hospital investments and cash holdings totalled $1.2 billion at June 2009 ($1.1 billion at 30 June 2008)
  - 24 per cent (21 out of 88), experienced investment losses totalling $35.3 million during 2008–09 ($10.3 million in 2008). This is in part a consequence of the global financial crisis
  - 80 per cent (70 of 88) had not done benchmarking analysis of their investment performance
  - 31 per cent (27 of 88) did not provide regular and sufficiently comprehensive investment reports to their boards
  - 83 per cent (73 of 88) had not commissioned internal audits of their investment practices
  - 26 per cent (23 of 88) did not have an approved investment policy
  - 85 per cent (75 of 88) had not established investment committees.

Recommendation

- The Department of Health should finalise, promulgate and monitor the application of its investment policy guidelines by public hospitals.

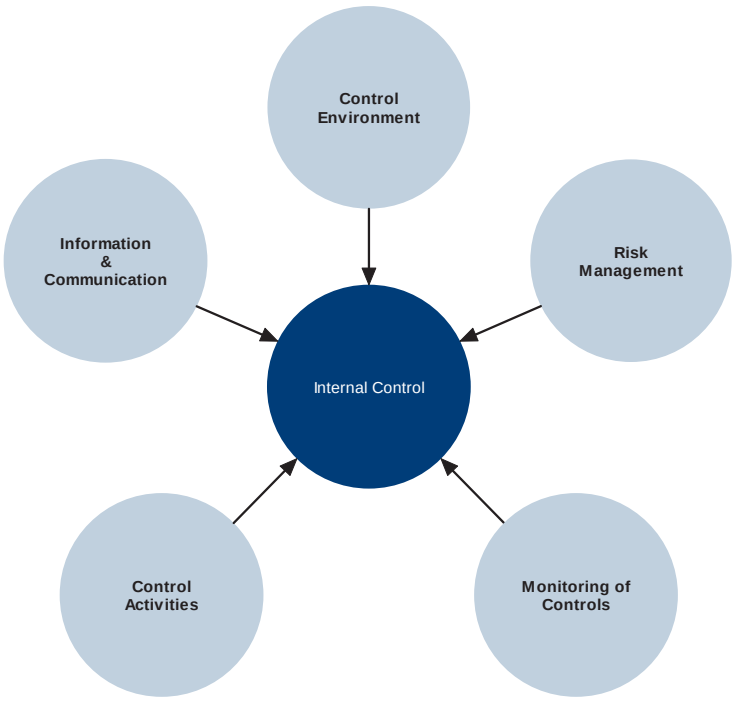
2.1 Introduction

Public hospital boards are responsible for the development and maintenance of adequate systems of internal control to enable:

- preparation of accurate financial records and other information
- timely and reliable external and internal financial reporting
- appropriate safeguarding of assets
- prevention or detection of errors and other irregularities.

Figure 2A identifies the major components of an effective internal control framework.

Figure 2A
Internal control framework



Source: Victorian Auditor-General's Office.

The annual financial audit results in the formation of an opinion on a hospital's financial report. An integral part of this process is to assess the adequacy of a hospital's internal control framework and governance processes as they relate to the accuracy and reliability of financial reporting.

Weaknesses in internal controls identified during an audit will usually not result in a qualified audit opinion. A qualification is warranted only when they give rise to significant uncertainty about the financial information being reported. Often, there are other compensating control procedures and audit processes that are used to mitigate the risk of material error. In any event, weaknesses noted during an audit are brought to management's attention.

Though it varied between public hospitals, an overall assessment of internal control at public hospitals and associated entities found that the strength of internal control systems and processes for financial reporting purposes was generally satisfactory.

2.2 Common internal control weaknesses

We identified a significant number of instances where important internal control mechanisms needed to be strengthened. These and other matters were reported to the relevant hospital boards and their management team.

The significant and commonly identified areas requiring improvement were:

- information system controls
- preparation and review of key account reconciliations
- compliance with financial delegations
- review of masterfile standing data changes
- revaluations of plant and equipment
- existence of core policies and procedures
- calculation of long-service leave provisions
- management of annual leave entitlements.

Information system controls

Controls over financial information systems (IS) are critical to the accuracy, confidentiality and integrity of transaction processing and financial reporting, and to reduce the potential for errors and the possibility of fraudulent behaviour. These controls include access controls, password controls and security over electronic funds transfer (EFT) files, which are used to make electronic payments.

Our detailed audit review of IS controls at five hospitals identified common control weaknesses, namely:

- **Access controls:**
  - untimely review of user IS access profiles
  - users with incompatible IS access rights
  - lack of ongoing monitoring of user access levels
  - unapproved granting of access rights to users.
- **Password controls:**
  - passwords had an unlimited lifetime and were not required to be changed
  - passwords were not required to contain both alpha and numeric characters
  - passwords did not have a sufficient minimum number of characters
  - the number of failed log-on attempts was not restricted.
- **Security over EFT files:**
  - before uploading onto the banking software, EFT payment files were stored in a shared computer directory folder enabling access by other users
  - it was possible for payment details on EFT payment files to be manually altered before uploading onto the banking software
  - lack of an audit trail or review over changes to EFT payment files.

Preparation and review of key account reconciliations

The majority of hospitals maintain subsidiary accounting systems, such as the payroll, fixed assets and accounts payable systems, that are periodically reconciled to the general ledger so they balance.

Timely preparation and independent review of reconciliations decreases the risk that errors may go undetected or may not be resolved in a timely manner; both of which can adversely impact on the accuracy of periodic financial reporting.

Nineteen per cent (17 of 88) of public hospitals had deficiencies in the preparation and/or review of reconciliations. Key reconciliations were either not being prepared and/or independently reviewed, or this was not occurring on a timely basis.

Compliance with financial delegations

Hospital boards should establish and approve a financial delegations listing to facilitate the approval of transactions commensurate with the efficient operation of the hospital and prudent financial governance. A financial delegations listing should result in:

- financial, administrative and business decisions being made at the appropriate level of responsibility
- hospital staff having clear guidelines in relation to their respective levels of authority and their responsibilities when exercising those delegations.

Non-compliance with approved financial delegations increases the risk of unapproved payments and misappropriation of assets.

This year we found that 13 per cent (11 of 88) of hospitals had made a significant number of payments during 2008–09, which were not authorised in accordance with the relevant financial delegations listing.

Review of masterfile standing data changes

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

It is important that all changes made to standing data on masterfiles are checked so that they are complete, accurate and legitimate. Otherwise subsequent processing errors can be repeated many times over. Further, an independent review of masterfile standing data changes is important for the detection and timely correction of unintentional or fraudulent changes, and to reduce the risk of payments to unauthorised suppliers or unauthorised adjustments to pay rates.

This year we found that 34 per cent (30 of 88) of hospitals were not independently reviewing the periodic changes that were being made to standing data on their masterfiles.

Revaluations of plant and equipment

Public hospitals were required by Financial Reporting Direction 103D *Non-Current Physical Assets* to report their plant and equipment assets at fair value in their 2008-09 financial report. Previously plant and equipment assets were reported at written down historical cost.

We noted during the 2008–09 financial audit that 31 per cent (27 of 88) of hospitals had not adequately performed a fair value assessment of their plant and equipment assets, particularly in respect of their specialised medical equipment. In a number of cases the reviews did not assess assets on a sufficiently detailed or individual basis to form an accurate assessment of their fair value.

Existence of core policies and procedures

Hospitals should have approved and up-to-date policies on all the core areas of administration and governance.

We found that 11 per cent (10 of 88) of hospitals had instances where policies and procedures, such as those governing cash receipting, accounts payable, accounts receivable processes, or fixed asset acquisitions and disposals did not exist. It was also noted that some hospitals did not regularly review or update their policies and procedures.

Calculation of long-service leave provisions

The provision for employee entitlements includes the estimated long-service leave liability of each hospital to its employees. The estimation of the long-service leave liability is partly based on a number of key assumptions, including assumed wage inflation rates, an appropriate discount rate, assumed on-costs, which include workcover and payroll tax, and the expected probability of staff attaining the minimum service requirements for eligibility to long-service leave.

In 2008–09, 13 per cent (11 of 88) of public hospitals had deficiencies in the estimation of their long-service leave liability, which resulted in the provision for employee entitlements being either under or over stated in hospital financial reports as follows:

- incorrect wage inflation rates and discount rates were applied
- incorrect wage on-costs were included in the calculations
- staff service probability factors were not being reviewed on an annual basis.

Management of annual leave entitlements

Hospital staff are generally entitled to four weeks of annual leave. The regular use of annual leave promotes a healthy and productive workforce, and avoids work disruptions caused by staff taking large blocks of outstanding leave.

In 2008–09, 16 per cent (14 of 88) of hospitals had on average 39 employees with annual leave entitlements in excess of eight weeks.

Audit management letters

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

2.3 Management of investments in public hospitals

This year as part of our cyclical approach to reviewing significant aspects of corporate governance and financial management, we undertook a review of the investment management practices and outcomes for the public hospital sector.

At 30 June 2009 public hospitals held $1.2 billion in investments and cash holdings ($1.1 billion at June 2008).

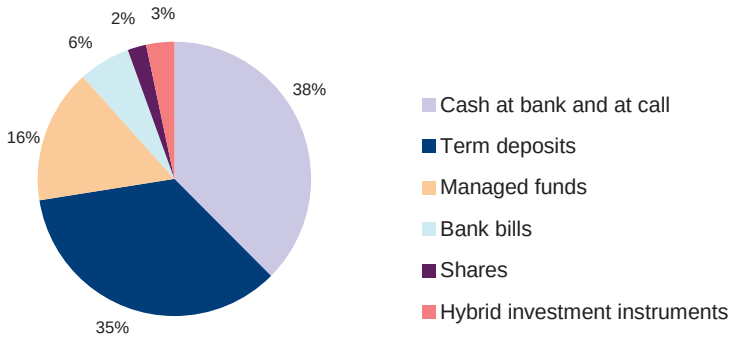
Effectively managing investment funds is one of several critical factors for the ongoing financial viability of public hospitals. Under the *Health Services Act 1988*, responsibility for the management of these investments rests with the individual public hospital boards, while the related functions of the Secretary of the Department of Health under the Act include the evaluation and review of publicly funded health services and the development of criteria or measures to compare the performance of public hospitals.

Figure 2B shows that the major portion of public hospital funds available for investment at June 2009 are held in term deposits and cash holdings. The majority of the funds held as cash, term deposits or bank bills were held with triple A rated financial institutions.

The allocation of funds available for investment to the differing investment options requires an appropriate balance of risk and return with due recognition of the hospital's cash flow needs.

Managed funds, shares and other financial instruments accounted for 21 per cent, or $250 million of the total funds available for investment. These investments have a higher-risk profile, which needs to be more intensively managed, when compared with term deposits and cash holdings.

Figure 2B
2009 public hospital investments, including cash holdings



Source: Victorian Auditor-General's Office.

2.4 Investment losses of public hospitals

Over the past two years, there has been substantial volatility in the financial markets leading to significant variations in the value of financial instruments held by public hospitals, particularly with regard to collateralised debt obligations (CDOs). Although this volatility has somewhat reduced in recent months it still has had an impact on the operating results of certain public hospitals for the 2008–09 year, and continues to be a factor beyond the end of the financial year.

Figure 2C sets out the public hospitals that have brought to account investment losses, that is financial instrument impairment losses, in their 2007–08 and 2008–09 operating statements.

Figure 2C
Public hospital investment losses for 2008 and 2009

	2007–08	2008–09		
Entity	**Impairment loss $'000s**	**Impairment loss $'000s**	**Total other financial assets (including those impaired) $'000s**	**Ratio of impairment loss to other financial assets %**
Metropolitan				
Dental Health Services Victoria	2 270	2 730	4 448	61
Melbourne Health	0	603	6 249	10
Northern Health	2 643	1 417	2 857	50
Peninsula Health	0	1 630	18 244	9
Peter MacCallum Cancer Centre	0	1 667	14 507	11
Royal Children's Hospital	0	7 676	83 835	9
Royal Victorian Eye and Ear Hospital	3 512	5 548	62 321	9
Royal Women's Hospital	0	2 460	16 627	15
Tweddle Child and Family Health Service	0	71	2 866	2
Western Health	0	15	502	3
Regional				
Ballarat Health Services	0	7 488	30 665	24
Barwon Health	27	189	1 997	9
Goulburn Valley Health	0	1 168	11 376	10
Latrobe Regional Hospital	1 120	1 201	6 879	17
Western District Health Service	0	142	1 029	14
Rural				
Benalla and District Memorial Hospital	741	760	5 481	14
Gippsland Southern Health Service	0	152	15 151	1
Inglewood and District Health Service	0	39	1 581	2
Mallee Track Health and Community Service	0	176	3 494	5
Mansfield District Hospital	0	33	2 713	1
McIvor Health & Community Services	4	0	3 608	0
Yarram and District Health Service	0	183	2 436	8
Total	**10 317**	**35 348**	**298 866**	**12**

Source: Victorian Auditor-General's Office.

Figure 2C shows that 21 out of 88 public hospitals experienced investment losses totalling $35.3 million during 2008–09 ($10.3 million in 2008). This is in part a consequence of the global financial crisis.

These substantial investment losses reinforce the need for a strong investment management framework.

2.5 Legislative framework for managing investments

In respect of investments by public hospitals, which are registered funded agencies, the *Health Services Act 1988* provides that:

> *A registered funded agency may invest money in any manner authorised by law for the time being for the investment of trust funds.*

The *Trustees Act 1958*, which establishes the legislative requirements for the investment of trust funds, provides that:

- trustees, and therefore public hospital boards, can invest funds in any form of investment and at any time vary such investments
- an onus of care is required of persons investing money in a trustee capacity
- trustees must have regard to a number of matters when exercising their powers of investment, including the purpose of investments, diversity, risk of capital and income loss, potential for capital appreciation, liquidity, inflation affecting the value of investments and the cost of investing.

The *Trustees Act 1958*, and therefore the *Health Services Act 1988*, does not restrict the type of investments that can be made by public hospitals, including higher risk investments, such as CDOs.

The former Department of Human Services previously advised that draft investment policy guidelines for public hospitals had been developed some time ago, but have not been promulgated to the sector.

The Standing Directions of the Minister for Finance under the *Financial Management Act 1994* were amended in July 2009. The directions now require most public sector agencies to undertake all borrowings, investments and financial arrangements with a financial institution that has a credit rating equivalent to the State of Victoria. Under these directions, applicable agencies were required to centralise their investment holdings with a financial institution nominated by the Department of Treasury and Finance.

Public hospitals are exempt from this direction because they are granted specific borrowing and investment powers under their constituting legislation, the *Health Services Act 1988*. As noted above, public hospitals have broad discretion under that Act to make investment decisions.

The public hospital sector has substantial funds available for investment and has experienced multimillion dollar investment losses over the past two years. Under the *Health Services Act 1988,* the primary responsibility for the management and oversight of these investment funds rests with public hospital boards, with the Secretary of the Department of Health having related legislative functions. Public hospital boards should establish and maintain an effective investment management framework, and the department should finalise and promulgate its investment policy guidelines for use by public hospitals.

Recommendation

2. The Department of Health should finalise, promulgate and monitor the application of its investment policy guidelines by public hospitals.

2.6 Public hospital investment management framework

The primary responsibility for managing public hospital investments resides with their governing boards. Prudent financial management requires that these boards should establish and monitor controls to achieve an appropriate balance between investment risk and return.

An effective means of establishing such controls is for public hospitals to adopt an investment management framework that:

- has comprehensive investment policies
- prescribes appropriate investment management practices
- establishes appropriate governance and oversight arrangements.

The key elements of an effective investment management framework are outlined in Figure 2D. This figure draws on best practice guidelines on the establishment of investment policies that have been published in Queensland[1] and Western Australia[2].

[1] Queensland Treasury 2007, *Investment Policy Guidelines*, Queensland Government.

[2] Department of Local Government and Regional Development 2008, Investment *Policy – Local Government Operational Guidelines*, No. 19, Government of Western Australia.

Figure 2D
Key elements of an effective investment management framework

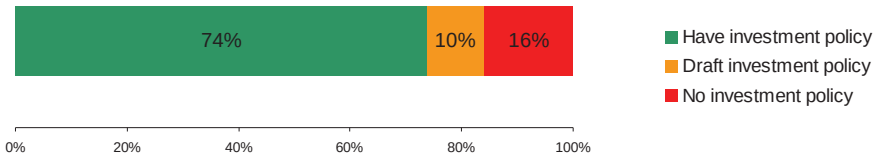
Framework components	Key elements
Policy	Investment objectives
	Level of risk aversion
	Legislative requirements
	List of permitted investments and limits on speculative investing
	Minimum credit ratings for investments and financial institutions
	Valuation requirements and methodology
	Criteria for triggering liquidation of investments
	Reporting frequency and accountabilities
	Governing body responsibilities, monitoring and oversight arrangements
	Criteria for determining the need for external funds management and process for selecting external funds management, as applicable.
Management practices	Ensuring adherence to investment policy and legislation
	Development of investment program
	Establish monitoring arrangements, including the use of internal audit
	Management of investments and operating cash flows requirements
	Management analysis of investment performance
	Benchmarking investment performance
	Periodic valuation reviews
	Maximising returns through timely investment changes
	Comprehensive reporting to executive and board
	Managing and monitoring external funds manager, as applicable.
Governance and oversight	Establishment of investment committee
	Monitoring compliance with policy and legislative requirements
	Annual review and approval of investment program
	Regular oversight of investment management practices and performance
	Intervention and direction in times of market volatility
	Review the quality and frequency of reporting on investments
	Engagement of internal audit assessment for compliance
	Periodic review of investment policy and strategy.

Source: Victorian Auditor-General's Office.

2.6.1 Investment policy

Figure 2E sets out the proportion of hospitals with investment policies.

Figure 2E
Public hospitals with investment policies at 30 June 2009



Source: Victorian Auditor-General's Office.

During 2008–09, 74 per cent (65 of 88) of public hospitals had established investment policies and collectively controlled investments, including cash holdings, valued at $1.1 billion or 89 per cent of total investments held by the public hospital sector.

A further 10 per cent or 9 public hospitals were in the process of drafting investment policies and the remaining, 16 per cent or 14 hospitals, did not have investment policies. These hospitals collectively controlled investments, including cash holdings, valued at $139 million, or 11 per cent of total investments.

While the results outlined above were largely similar across all public hospital types, it was noted that 17 of the 18, or 94 per cent of the metropolitan hospitals had an investment policy. The one exception was in the process of being drafted at the time of preparing this report.

Similarly, all the 15 regional hospitals had an investment policy or were in the process of drafting an investment policy.

Of the 55 rural hospitals that held investments, 13 did not have an investment policy to help guide their investment management practices, while four were in the process of preparing a draft policy.

While no hospital's investment policy contained all the desired elements identified in Figure 2D, the majority of the policies reviewed did incorporate the following critical elements:

- outline of investment objectives in 95 per cent (62 of 65) of hospitals
- level of risk aversion in 72 per cent (47 of 65) of hospitals
- list of permitted investments in 80 per cent (52 of 65) of hospitals
- requirement to report investment performance to the board in 65 per cent (42 of 65) of hospitals.

Conversely, the following key elements were not included in the majority of the hospitals with investment policies reviewed, whereby:

- minimum credit rating for investments and financial institutions were not specified in 78 per cent (51 of 65)
- investment valuation requirements and methodology were not specified in 65 per cent (42 of 65)
- restrictions on the use of the investment portfolio for speculative purposes were not specified in 78 per cent (51 of 65)
- criteria for determining the need for external funds management were not specified in 88 per cent (57 of 65)
- criteria that may trigger liquidation of the investment were not specified in 78 per cent (51 of 65).

External funds management

External fund managers can be used where management does not possess the relevant skills or expertise commensurate with the level of funds held. Public hospitals can use external fund managers for the following purposes:

- management of investment funds
- to provide investment products
- as investment advisors
- to value investments.

The engagement of an external investment manager does not diminish the hospital board's responsibilities for the management or performance of investments.

In 2008–09, 17 per cent (15 of 88) of public hospitals used external funds managers for various investment advisory and management processes. Of the hospitals using an external investment manager, the majority of their investment policies did not cover:

- process for selecting an external funds manager
- management and monitoring regime for external fund managers
- the required level of reporting from fund managers
- an outline of the circumstances that would require the external funds manager to be removed or replaced.

Recommendation

3. Public hospital boards should establish a comprehensive investment management policy.
4. Public hospital boards should establish appropriate policies for the appointment, monitoring and management of external fund managers, where applicable.

2.6.2 Investment management practices

This section summarises the major findings from the review of key elements of investment management practices in operation at public hospitals.

Internal audit review of investment practices

Internal audit reviews can provide hospitals with assurance that their internal controls and processes are appropriate, and that they have an effective governance and risk management framework to enable them to achieve their desired investment outcomes and appropriately manage risk.

Over the past three years 83 per cent (73 of 88) of all public hospitals did not commission any internal audit projects in relation to their investment management practices. Specifically 72 per cent (13 of 18) of metropolitan hospitals, as well as 86 per cent (60 of 70) of both rural and regional hospitals, had not commissioned an internal audit review of their investment management practices.

Benchmarking investment returns

Benchmarking of investment returns facilitates informed decisions by using comparisons of different institutions and products. Benchmarking should be used to assess the adequacy of investment returns against other investment types to confirm that returns are as expected, and that the hospital is obtaining the maximum returns on their investments, given their desired level of risk.

Our review disclosed that 80 per cent (70 of 88) of public hospitals did not conduct some form of benchmarking of their investment returns, with just 13 per cent (9 of 70) of rural and regional public hospitals undertaking such a benchmarking exercise.

Management analysis of investment performance

To assess the appropriateness of the hospital's risk and return targets, and to determine if the current expectations are reasonable, regular analysis by management of the investment performance should be undertaken and reported to the board.

Our review revealed that 50 per cent (9 of 18) of the metropolitan hospitals, and just over a third (25 of 70) of both rural and regional public hospitals assess the performance of their investments on maturity.

Furthermore, although two thirds of all public hospitals reported on their investments to the board, around half of these reports did not include a detailed explanation of the performance of investments.

Recommendation

5. Public hospital boards should have comprehensive investment management practices, including benchmarking investment performance and conducting internal audit reviews of investment practices.

2.6.3 Governance and oversight of investments

Monitoring of policy compliance and investment performance

Consistent with the *Health Services Act 1988* it is the responsibility of the hospital's board for its investments to comply with relevant internal policies, governing legislation and that investment performance is adequate. Accordingly, the board needs appropriate, clear and regular investment reports.

Regular investment reports enable the board to:

- derive comfort that all investments comply with its policy and relevant legislation
- review the portfolio composition
- monitor investment performance against established benchmarks
- assess the need for any changes to the portfolio.

We found that 31 per cent (27 of 88) of public hospitals did not provide their boards with any reports on the performance of their investment holdings.

Of those hospitals that did have regular board reports, the quality of that reporting varied markedly. Two key elements lacking in the majority of board investment reports were a trend analysis of the performance of their investments over the year, and benchmarking of investment performance.

Periodic review of investment policy and strategy

It is important that investment policies are regularly reviewed so that they accurately reflect the current policy and strategic position of the board. This is particularly important in volatile investment markets and economic conditions.

Approximately one-third, or 21 of 65 public hospital boards had not reviewed their investment policy for at least 18 months. This result was consistent across each of the three public hospital types; metropolitan, regional and rural.

Establishment of investment committees

Establishment of an investment committee as a board committee is one mechanism that strongly indicates there is adequate and specialised focus on the oversight of the effectiveness of the investment management framework. Such a committee would assist the board in meeting its responsibilities, but not absolve the board of its responsibilities. Investment committees can provide oversight of the development, monitoring and review of the investment strategy and policy.

Some 85 per cent (75 of 88) of public hospital boards had not established investment committees. Where investment committees had been established, the average number of investment committee members was four and generally three of these members were independent of management.

We were advised that in the absence of an investment committee a large number of public hospital boards rely on either the finance or audit committees to take responsibility for the oversight of their investments.

Reliance on finance or audit committees may be appropriate for some hospitals with limited funds to invest. However, for those hospitals with significant funds available for investment the increased focus provided by a specialised and appropriately skilled investment committee can greatly assist the board to maximise investment performance, minimise risks and to help maintain a robust investment management framework.

Hospitals without an investment committee held 69% of public hospital investments and cash holdings, amounting to $839 million.

Recommendations

6. Public hospital boards should require comprehensive investment reports.
7. Public hospital boards should review their investment policies at least annually, or more frequently when volatile investment markets are encountered.
8. Given the existing conditions in the financial markets and the economy more generally, public hospital boards that have significant funds available for investment should establish an investment committee to provide a specialised focus on maintaining a robust investment management framework, maximising investment performance and managing risk.

3 Financial sustainability

At a glance

Background

Maintaining financially viable public hospitals is a continuing challenge for government.

Individual public hospital boards and the Department of Health share responsibility for financial performance and management within the sector.

Findings

- An analysis of five financial sustainability indicators over a five-year trend period found that the public hospital sector, on average, has an overall medium-risk financial sustainability assessment.
- The incidence of individual public hospitals with a high-risk financial sustainability assessment has been relatively constant over the five-year trend period. In 2009, 32 per cent (28 of 88) of hospitals had a high-risk assessment.
- At 30 June 2009, 28 per cent (25 of 88) of hospitals, including 12 major metropolitan and regional hospitals, had cash holdings equivalent to less than 15 days operating cash outflows.
- At 30 June 2009, 81 per cent (71 of 88) of hospitals had a high-risk self-financing indicator assessment.
- The accountability for the financial performance of individual hospitals is blurred by the capital funding model. The funding model used by the Department of Health allocates capital grant funding strategically across the sector rather than progressively to each hospital. However, public hospitals are governed by boards which are accountable for financial management and performance.

Recommendations

- The Department of Health and public hospital boards should adopt a suite of core financial sustainability indicators.
- The department's 2007 decision to extend the explicit legislative responsibilities of boards and chief executive officers applicable to the major metropolitan and regional public hospitals to all other public hospitals should be implemented.

3.1 Introduction

Maintaining financially viable public hospitals is a continual challenge for government in the face of advances in technology and medical treatments, changing community needs, such as increasing treatment options, increasing community expectations and an ageing population. Compounding this is an increasing focus on specialist services, and workforce supply issues.

Each of Victoria's 88 public hospitals has a governing board accountable to the Minister for Health through the Department of Health. The *Health Services Act 1988* sets out the role of the boards, and of the Secretary of DOH.

Consistent with the provisions of the *Health Services Act 1988*, public hospital boards and DOH share responsibility for financial performance and management within the sector. DOH directly impacts on the financial performance of individual public hospitals in several ways. For example, the department's funding and other decisions can affect hospital revenues and cost structures significantly.

The 21 major metropolitan and regional public hospitals set out in Figure 3A, prepare statements of priorities pursuant to the *Health Services Act 1988*, which are agreed between the Minister for Health and chairperson of the hospital board. These annual statements include:

- an overview of the objectives, priorities and outcomes the hospital will achieve in the year ahead
- the key financial, service and access performance priorities and agreed outcome measures
- activity targets and the funding to be provided by DOH.

Figure 3A
Hospitals preparing an annual statement of priorities for 2008–09

Metropolitan	*Metropolitan continued*
• Alfred Health	• Royal Victorian Eye and Ear Hospital
• Austin Health	• Royal Women's Hospital
• Calvary Health Care Bethlehem Limited	• Southern Health
• Dental Health Services Victoria	• St Vincent's Hospital (Melbourne) Limited
• Eastern Health	• Western Health
• Melbourne Health	*Regional*
• Mercy Public Hospitals Incorporated	• Ballarat Health Services
• Northern Health	• Barwon Health
• Peninsula Health	• Bendigo Health Care Group
• Peter MacCallum Cancer Institute	• Goulburn Valley Health
• Royal Children's Hospital	• Latrobe Regional Hospital

Source: Victorian Auditor General's Office.

The remaining hospitals prepare health services agreements pursuant to the *Health Services Act 1988*, which are agreed between the Secretary of DOH and the chief executive officer of the respective hospital. These annual agreements include:

- the volume, scope and quality of services to be delivered by the hospital
- infrastructure works to be undertaken
- the organisation and management of the hospital
- the grants, subsidies or other assistance to be provided by DOH.

DOH monitors the financial performance of public hospitals, by reviewing:

- performance against key related performance targets, set out in the statement of priorities for the major metropolitan and regional public hospitals
- performance of the remaining hospitals against performance targets set out in their health services agreement
- the major metropolitan and regional hospitals use of a three-tiered performance management framework. 'Standard' monitoring is applied to those hospitals achieving their key performance targets. 'Performance watch' monitoring is applied to those hospitals with an emerging deterioration in performance and comprises either monthly or bi-monthly meetings with hospitals. 'Intensive monitoring' is applied where there is consistent under achievement against key performance targets and includes departmental review of more detailed information
- the remaining regional and rural hospitals that use a two-tiered arrangement that involves the closer scrutiny of public hospitals deemed to be at risk under a 'close watch process' leading to the development of financial management improvement plans.

3.1.1 Status of previous audit recommendations

Our previous report, *Public Hospital Financial Performance and Sustainability*, made three recommendations to improve the financial performance and sustainability of public hospitals in June 2007.

Recommendation 1 – Monitoring of public hospital performance

It was recommended that the department and public hospitals continue to enhance the monitoring of hospital operating results, and revenue and expenditure trends, in real terms and relative to demand. This process would be assisted by all public hospitals adopting a common core suite of financial sustainability indicators.

The former Department of Human Services responded that the recommendation was agreed, and that the monitoring of hospital operating results and revenue and expenditure trends is a core activity of the department, and that the monitoring of these measures is subject to ongoing development and enhancement.

During September 2009 DOH provided further advice in respect of this recommendation:

> *The department sets out 4 core financial indicators for public health services in the Statement of Priorities. These indicators are monitored monthly with performance compared across these health services. Comprehensive budget and activity information is submitted monthly by health services and this provides the basis of monthly, quarterly and year to date trend analysis to provide the department with a robust understanding of health services financial performance. Health services are followed up to explain unexpected variances. Where financial or budget deterioration is identified, more intensive monitoring processes are put in place, such as reviews of performance and more frequent meetings.*

These four core financial indicators solely apply to the 21 major metropolitan and regional public hospitals. The indicators include a version of the operating result and three others that collectively do not provide a comprehensive view of each hospital's financial sustainability, as recommended by audit in 2007, or include indicators relating to self-financing and capital replacement.

Recommendation 2 – Budgetary and management initiatives

It was recommended that the department and public hospitals continue to build on, and expand, existing budgetary and management initiatives to establish greater financial sustainability across the sector. In particular, to extend the explicit legislative responsibilities of boards and chief executive officers of certain designated public hospitals to all public hospitals.

The Department of Human Services (previously responsible for public hospitals) responded that the recommendation was agreed and the department agreed that to build on and expand budgetary and management initiatives was important. The department also agreed that rural boards and chief executives should have an explicit range of accountabilities to make sure they operate within budget, have accurate accounting systems and that appropriate reporting and risk-management systems are maintained. Lastly, the department would continue to progress these accountabilities through board and management education programs and enhance existing health service agreement processes.

During September 2009 DOH provided further advice in respect of this recommendation:

> *The department continues to negotiate a Statement of Priorities with Health Services and Health Service Agreements with all other public hospitals. For those rural hospitals that do not participate in the Statement of Priorities process (64 of 70), financial performance and activity is monitored by regional offices and central offices, with more intensive 'close-watch' monitoring for agencies deemed to be financially at risk.*
>
> *The department also funds a comprehensive hospital board development program, the Victorian Health Boards Governance Program (VHBGP), to develop the governance capacity of new and existing metropolitan and rural health service board members. The VHBGP focuses on governance and legal frameworks, stakeholder engagement, strategy setting, clinical and financial governance, risk, group dynamics and current health policy issues.*

Despite DOH's advice, and its acceptance of our recommendation, the explicit legislative responsibilities of the boards and chief executive officers of the 21 major metropolitan and regional public hospitals have not been extended to all other public hospitals.

Recommendation 3 – Review of effectiveness of initiatives

It was recommended that the department and public hospitals continue to review the ongoing effectiveness of the initiatives to date.

The former Department of Human Services responded that the recommendation was agreed.

During September 2009 DOH provided further advice in respect of this recommendation:

> *The department has implemented a range of initiatives to assist in the management of patient demand, these include chronic disease management programs, patient flow initiatives, emergency demand management and the construction of ambulatory care and elective surgery centres, these initiatives are reviewed on an on-going basis to maximise benefits across the health system.*

Recommendations

9. DOH and public hospital boards should enhance the monitoring of hospital operating results, and revenue and expenditure trends, in real terms and relative to demand. This process would be assisted by all public hospitals adopting a common core suite of financial sustainability indicators.

10. DOH and public hospitals should expand existing budgetary and management initiatives to improve financial sustainability across the sector, while better delineating respective accountabilities. In particular, the department's 2007 decision to extend the explicit legislative responsibilities of boards and chief executive officers applicable to the major metropolitan and regional public hospitals to all other public hospitals should be implemented.

3.2 Financial performance of public hospitals

Financial performance is measured by the operating result — the difference between revenue inflows and expenditure outflows. The objective for public hospitals should be to generate a sufficient surplus from operations to be able to meet financial obligations, fund asset replacement and new asset acquisition.

The ability of public hospitals to achieve this objective depends largely on the funding policies established by DOH and on each hospitals' expenditure management and revenue maximisation practices. This is reflected in the composition and rate of change in their operating revenues and expenses.

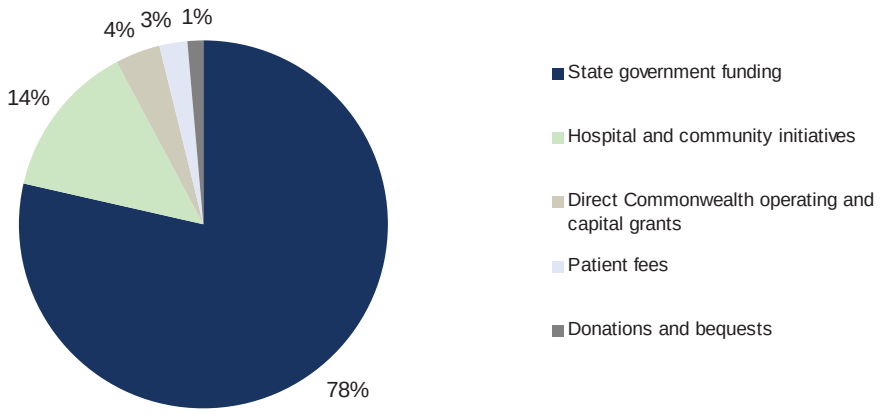
3.2.1 Public hospital revenue

Public hospitals had a combined annual turnover in excess of $9.3 billion in 2008–09. Figure 3B shows that the main source of public hospital revenue is state government funding or 78 per cent of total revenue, provided mainly for acute health services. A significant proportion of this amount is provided by the Commonwealth Government, through the Australian Health Care Agreement.

The next largest revenue source is hospital and community initiatives, providing 14 per cent of revenue.

While the proportion of revenue provided from each of the sources shown in Figure 3B has largely remained constant over the past five years, there has been a larger increase in revenue from patient fees over that period. Patient fees have increased at more than double the rate of other revenue sources, but this is still a minor proportion of total hospital revenue.

Figure 3B
Revenue by source – 2008–09



Source: Victorian Auditor General's Office.

Over the five year period total public hospital revenue has grown by a nominal 47 per cent, whereas the rate of increase for health and community services wages[1] and the number of patients treated in public hospitals[2] was 22 and16 per cent respectively.

State government funding for acute health services is based on the 'casemix' model, which uses the average cost of care for each acute health service to determine how much a hospital gets paid for performing that service. The model accounts for several factors, including the length of the patient's stay at the hospital and the category of the hospital providing each service. Key assumptions used in the model are reviewed annually.

One key variable under the 'casemix' model that can directly affect the financial performance of a hospital is the actual length of a patient's stay. The model provides a predetermined amount for each service where the actual length of a patient's stay in hospital falls within a defined range, regardless of the patient's actual time spent in hospital. Consequently, while revenue is fixed, the costs of providing that service increases the longer the patient remains in hospital.

The level of health services to be delivered each year is negotiated by each hospital with DOH, and is included in an annual health services agreement, or statement of priorities. This targeted level of service provision generally creates a funding cap, and public hospitals are only partially funded for any services provided that exceed the target by up to 2 per cent. No funding is provided for any services provided beyond that level.

[1] Australian Bureau of Statistics – Labour Price index, Australia June 2009.

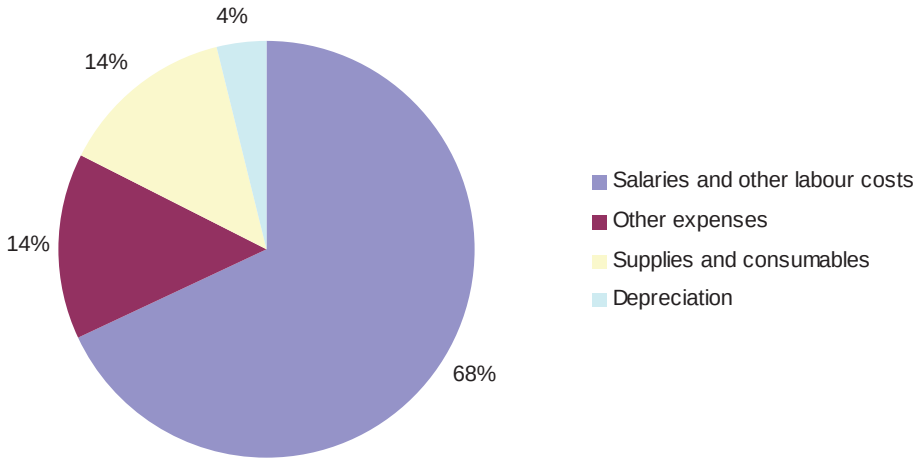
[2] *Your hospitals – A report on Victoria's public hospitals* – July 2008 to June 2009 issued by the Department of Health.

3.2.2 Public hospital expenditure

Figure 3C shows that the main item of public hospital expenditure is salaries and other labour costs, representing 68 per cent of total expenditure. The next largest area of expenditure was supplies and consumables at 14 per cent.

The relative proportion of each category of expenditure has remained fairly constant over the five-year period, although depreciation costs have increased at a faster rate than other costs.

Figure 3C
Dissection of expenditure – 2008–09



Source: Victorian Auditor General's Office.

Over the five-year period total public hospital expenditure has grown by a nominal 46 per cent, whereas the rate of increase for health and community services wages[3] and the number of patients treated in public hospitals[4] was 22 and 16 per cent, respectively.

[3] Australian Bureau of Statistics – Labour Price index, Australia June 2009.

[4] *Your hospitals – A report on Victoria's public hospitals* – July 2008 to June 2009 issued by the Department of Health.

3.3 Financial position of public hospitals

Financial position is generally measured by reference to net assets — the difference between total assets and total liabilities.

However, this measure is less relevant in the public hospital sector context, as most public sector entities are not-for-profit, and generally do not hold assets from which they generate revenue. Instead, they tend to hold infrastructure and property assets, which require funding for operating costs, repairs, maintenance, renewal and replacement.

As the revenue base for public hospitals is not tied to the value of their asset base and they cannot sell most of their assets to obtain funds, their objective should be to maintain their infrastructure and property assets, while managing commitments and liabilities so they can be paid from future operations.

The ability of public hospitals to maintain property assets depends on asset and liability management policies, and is reflected in the composition and rate of change in the value of assets and liabilities.

3.3.1 Public hospital assets

In 2008–09, the total assets of public hospital entities increased by 26 per cent, or $2.2 billion, to $10.5 billion. This increase in property, plant and equipment assets is partly a result of a revaluation undertaken during 2008–09, and reflects the large asset base that all public hospitals manage.

The challenge for hospitals is to make strategic decisions, understanding their full cost implications, about the operation and service levels of these assets. If operating costs grow faster than revenue, then hospitals will find it increasingly difficult to generate the funds necessary for asset maintenance and renewal.

However, the operating and capital funding policies of DOH also have a major impact on public hospital asset bases and the ability of hospital boards to manage their assets.

3.3.2 Public hospital liabilities

Liabilities primarily comprise employee leave provisions. Current liabilities grew by 11 per cent or $215 million since 2007–08 to $2.1 billion in 2008–09. Total non-current liabilities for the sector remained largely unchanged from 2007–08 levels at some $775 million.

3.4 Indicators of financial sustainability

3.4.1 Financial sustainability indicators

To be financially sustainable, public hospitals need the capacity to meet current and future expenditure as it falls due. They must also be able to absorb foreseeable changes and financial risks as they materialise.

Insight into the financial sustainability of the public hospital sector is obtained from analysis of five financial sustainability indicators over a five-year trend period. These indicators reflect each hospital's revenue raising performance and expenditure control, and indicate whether current revenue and expenditure trends and policies are sustainable.

Figure 3D describes the sustainability indicators used in this report. These indicators should be considered collectively, and are more useful when assessed over time as part of a trend analysis. These indicators have been applied to the public hospitals published financial information for a five-year period from 2005 to 2009.

The indicators comprise four core indicators, being underlying result, liquidity, self-financing and capital replacement. The additional indicator, average number of days cash available, was applied to the public hospital sector in our previous report, *Public Hospital Financial Performance and Sustainability*, and provides insight to public hospital cash holdings that are not apparent from the liquidity indicator. This additional indicator reflects on the ability of public hospitals to meet short-term operating cash requirements using unrestricted cash holdings.

Financial sustainability should also be viewed from both a short and long-term perspective. The shorter-term indicators involve the hospital's ability to maintain a positive operating cash flow and adequate cash holdings, and to generate an operating surplus over time. Whereas the longer-term indicators signify whether there is adequate funding available for spending on asset replacement to enable the hospital to maintain the quality of service delivery and to help meet the ever increasing community expectations and the demand for these services. These are the self-financing and capital replacement indicators.

Figure 3D
Financial sustainability indicators

Indicator	Formula	Description
Underlying result (%)	Adjusted net surplus/total underlying 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 is obtained from the operating statement and is adjusted to take into account large one off (non-recurring) transactions. Main non-recurring items are expected to be revaluation impacts on the operating statement
Liquidity	Current assets/ current liabilities	This measures the entity's ability to pay existing liabilities in the next 12 months. A ratio of one or more means that there are more cash and liquid assts than short-term liabilities. Current liabilities have been adjusted to exclude long-term employee provisions and on costs disclosed as current liabilities in their financial statements.
Average number of days cash available	Cash balance at year end/ (operating cash outflow/365)	Measures how many days of operating cash outflows can be funded by the cash balance at year end. Cash and cash equivalents balance is obtained from the balance sheet and excludes monies held in trust and restricted funds. Operating cash outflows are obtained from the cash flow statement.
Self-financing (%)	Net operating cash flows/ underlying revenue	Measures the ability to replace assets using cash generated by their operations. The higher the percentage the more effectively this can be done. Net operating cash flows are obtained from the cash flow statement.
Capital replacement	Cash outflows for capital replacement/ depreciation	Comparison of the rate of spending on infrastructure, property, plant and equipment and intangibles with its depreciation. This is a long-term indicator, as capital expenditure can be deferred in the short-term if there are insufficient funds available from operations, and borrowing is not an option. Cash outflows for property, plant, equipment, infrastructure and intangibles are taken from the cash flow statement. Depreciation and amortisation is taken from the operating statement.

Source: Victorian Auditor-General's Office.

The financial sustainability indicators used in this report highlight trends that need to be monitored arising from the adoption of accrual accounting principles across the public hospital sector. Notwithstanding the application of sector neutral Australian Accounting Standards and accrual accounting by public hospitals, it should be noted that the departmental funding model does not fully provide for depreciation until DOH has determined the capital requirements of individual hospitals.

The departmental funding model therefore allocates capital grant funding strategically across the sector rather than progressively to each hospital. However, public hospitals are governed by boards which are accountable for financial management and performance. This situation blurs accountability for the financial performance of the individual hospitals. Successfully resolving this will be a significant step towards realising the benefits of implementing accrual accounting in the public hospital sector.

We have consulted with representatives of DOH, and the Department of Treasury and Finance, in connection with the application of the financial sustainability indicators. We also contributed to a working party convened by the Department of Treasury and Finance to consider the financial sustainability indicators.

As a result of these consultations, this report acknowledges the monitoring regime, including some key financial benchmarks, applied by DOH in discharging its legislative responsibilities for evaluating and reviewing publicly funded health services.

The analysis of financial sustainability in this report reflects on the position of individual hospitals and for the public hospital sector as a whole, and also on the basis of the three categories of hospitals being metropolitan, regional and rural.

The financial sustainability indicators used in this report are consistent with those used in previous reports to Parliament, and are indicative of the financial sustainability of public hospitals.

3.4.2 Financial sustainability risk assessment criteria

The financial sustainability of public hospitals has been assessed using the risk assessment criteria outlined in Figure 3E.

Figure 3E
Financial sustainability indicators—risk assessment criteria

Risk	Underlying result	Liquidity	Average number of days cash available	Self-financing	Capital replacement
High	**Negative 10% or less** Insufficient revenue is being generated to fund operations and asset renewal.	**Equal to or less than 0.7** Insufficient current assets to cover liabilities.	**Equal to or less than 15 days** Insufficient cash is being generated to fund operations.	**Less than 10%** Insufficient cash from operations to fund new assets and asset renewal.	**Less than 1.0** Spending on capital works has not kept pace with consumption of assets.
Medium	**Negative 10% to 0** A risk of long-term run down to cash reserves and inability to fund asset renewals.	**0.7–1.0** Need for caution with cash flow, as issues could arise with meeting obligations as they fall due.	**15–30 days** May indicate insufficient cash is available to fund operations.	**10–20 %** May not be generating sufficient cash from operations to fund new assets.	**1.0–1.5** May indicate spending on asset renewal is insufficient.
Low	**More than 0** Generating surpluses consistently.	**More than 1.0** No immediate issues with repaying short-term liabilities as they fall due.	**More than 30 days** Low-risk of insufficient cash available to fund operations.	**20% or more** Generating enough cash from operations to fund assets.	**More than 1.5** Low-risk of insufficient spending on asset renewal.

Source: Victorian Auditor-General's Office.

The overall financial sustainability risk assessment is calculated using the ratings determined for each indicator as outlined in Figure 3F. This assessment is performed at the sector level, at the metropolitan, regional and rural category level, and at the individual hospital level.

Figure 3F
Overall financial sustainability risk assessment

●	High-risk of shorter-term and immediate sustainability concerns indicated either by: • red underlying result indicator, or • red liquidity indicator, or • red average number of day's cash available indicator.
●	Medium-risk of longer-term sustainability concerns indicated either by: • red self-financing indicator • red capital replacement indicator.
●	Low-risk of financial sustainability concerns – there are no high risk indictors.

Note: Red financial sustainability indicator outcomes represent a high-risk assessment based on the criteria in Figure 3E.
Source: Victorian Auditor-General's Office.

To be financially sustainable, hospitals must be able to meet their short-term financial obligations, and maintain some excess capacity to finance future capital and infrastructure development. As detailed in Figure 3F, shorter-term and immediate sustainability concerns are assessed as high-risk, and longer-term sustainability concerns are assessed as medium-risk.

3.5 Financial sustainability risk assessment

3.5.1 Overall risk assessment

Figure 3G shows the five-year average results for the financial sustainability indicators. Each financial sustainability indicator for all public hospitals combined recorded a low-risk assessment, other than in respect of the self-financing indicator, which has a consistent high-risk assessment across all categories of hospitals. This leads to an overall financial sustainability assessment of medium-risk for all categories of public hospitals and at the public hospital sector level as a whole.

Figure 3G also shows metropolitan and regional hospital categories both have a medium-risk assessment for the average number of days of cash available indicator, and regional hospitals have a medium-risk assessment for the liquidity indicator. Other indicators have a low-risk assessment.

Figure 3G
Five-year average financial sustainability risk assessment 2005–2009

Category	Underlying result (%)	Liquidity	Average number of days cash available	Self-financing (%)	Capital replacement	Overall assessment
Metropolitan hospitals	0.1	1.0	19.8	5.5	1.8	●
Regional hospitals	0.2	1.0	23.6	5.3	1.7	●
Rural hospitals	3.2	1.9	51.4	9.3	2.4	●
All public hospitals	**2.1**	**1.6**	**40.6**	**7.9**	**2.1**	●

Note: The colour of the financial sustainability indicator results represents the risk assessment based on the criteria in Figure 3E. The results in the above table have been rounded to one decimal place, however the risk assessment is based on the actual result to two decimal places. The overall assessment is based on the overall financial sustainability risk assessment criteria as defined in Figure 3F.

Source: Victorian Auditor-General's Office.

3.5.2 Hospital-level risk assessment

Figure 3H shows the financial sustainability risk assessment for individual public hospitals during the period 2005 to 2009. We found that the incidence of hospitals with a high-risk financial sustainability assessment has been relatively constant over the five-year period. In 2009, 28 hospitals or 32 per cent had a high-risk assessment. This outcome was often a result of a high-risk assessment for the average number of days cash available indicator.

Figure 3H
Public hospital financial sustainability risk assessment

Source: Victorian Auditor-General's Office.

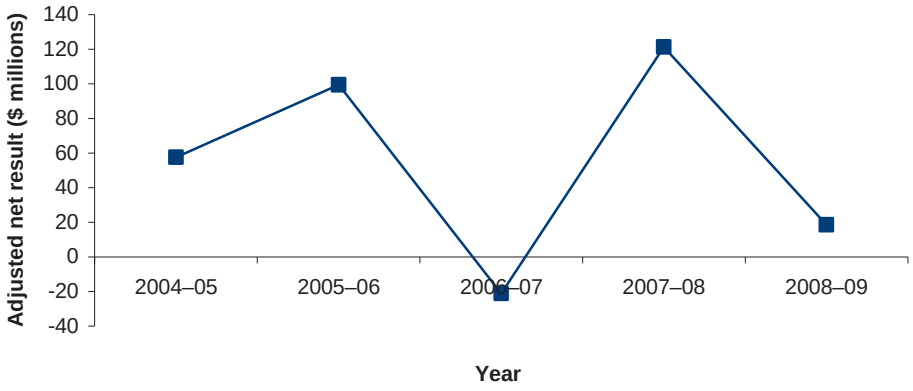
The percentage of hospitals with a medium-risk financial sustainability assessment has increased notably to 2009, comprising 50 hospitals, or 57 per cent. Deterioration in the self-financing indicator has been the main cause of this trend.

Underlying result

To be financially sustainable over the long-term, it is important that hospitals are able to generate revenue in excess of their expenses. Operating deficits are of concern but may be manageable in the short-term. However, over the longer-term they will not be sustainable. Consequently the underlying result indicates whether a hospital can also sustain their operations over the longer-term.

Figure 3I shows the aggregated underlying result for all public hospitals since 2004-05, adjusted to take into account large one-off transactions, such as asset revaluation impacts on the operating statement. The aggregate underlying result has fluctuated over the past five years. The significant aggregated deficit in 2007 was caused by five of the 18 metropolitan hospitals generating a combined loss in excess of $47 million for that year.

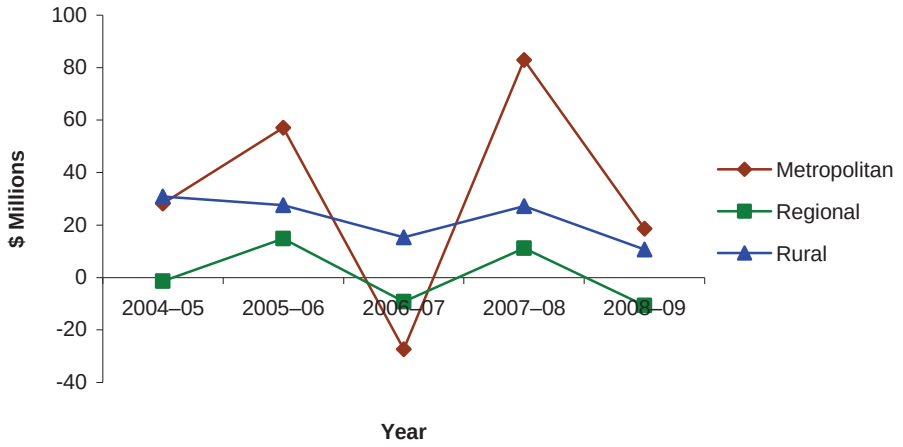
Figure 3I
Aggregate public hospital underlying result



Source: Victorian Auditor-General's Office.

For the 2008–09 financial year, there was a downturn in the aggregated underlying result for public hospitals, which was again driven by the metropolitan hospitals, as indicated in Figure 3J.

Figure 3J
Aggregate underlying result by public hospital category



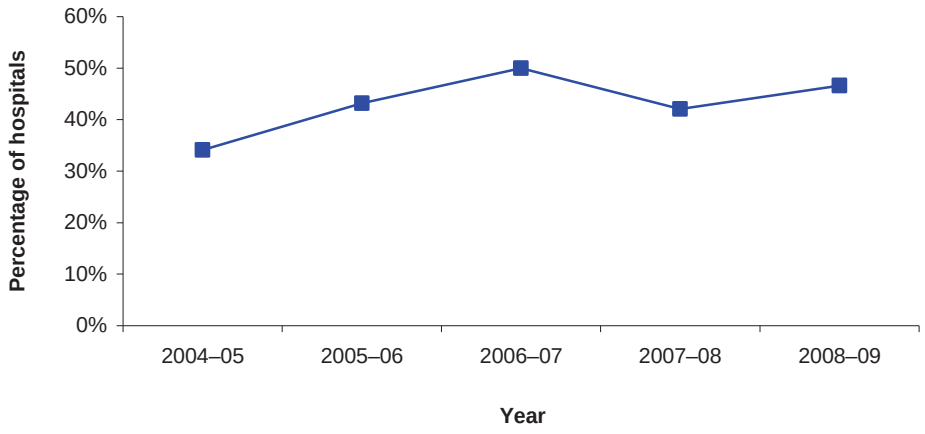
Source: Victorian Auditor-General's Office.

It is not unexpected that some public hospitals record operating deficits in some years. This is partly because the departmental, or 'casemix' funding model does not take account of non-cash expenditure, such as depreciation. Conversely, funds for most asset acquisitions are provided as annual grants, and usually form part of operating revenue in the year of receipt, but may not match the timing of depreciation as incurred.

Over time, however, total revenue from whatever source must equal or exceed total expenditure, or an entity will not be able to sustain its operations. If operating deficits persist there is a real risk that cash reserves become depleted and that expenditure and capital programs may need to be curtailed. In particular, expenditure that is perceived to be discretionary, especially for maintenance, may be deferred or abandoned should deficits persist over an extended period.

Figure 3K shows that there is a significant and slightly increasing proportion of public hospitals recording underlying deficits over the five-year period. Our analysis revealed that it is generally the same hospitals that record operating deficits as shown in Appendix C.

Figure 3K
Number of public hospitals with an underlying deficit



Source: Victorian Auditor-General's Office.

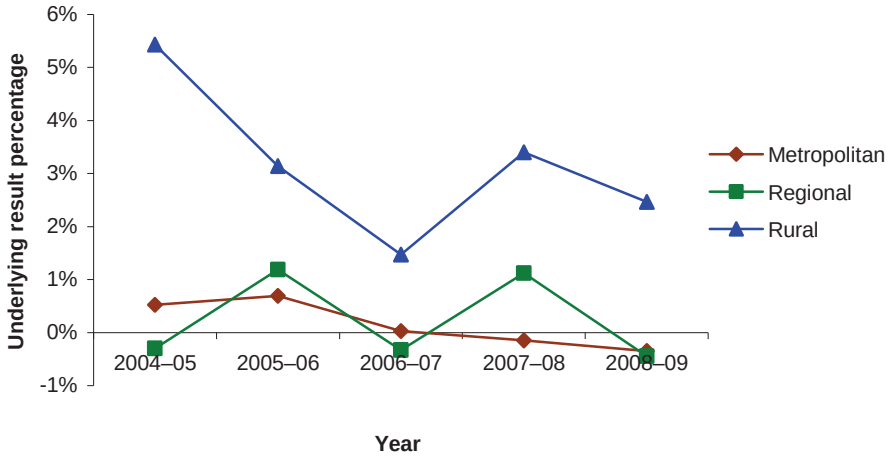
DOH monitors the net result before capital and specific items of public hospitals, rather than the underlying result. The net result before capital and specific items excludes some 16 differing revenue and expenditure types, such as:

- capital grants and related expenditure
- depreciation and amortisation
- voluntary departure package expenses
- write-downs of inventories
- non-current asset revaluation increments/decrements
- reductions in the value of investments
- reversals of provisions
- the effects of voluntary changes in accounting policies
- impairments of financial and non-financial assets.

Under this measure 23 per cent (20 of 88) of public hospitals had recorded a net deficit before capital and specific items at June 2009, with 30 per cent (26 of 88) at June 2005. Whereas Figure 3K shows that 45 per cent (40 of 88) of hospitals had recorded an underlying deficit at June 2009, compared with 34 per cent (30 of 88) at June 2005.

Figure 3L shows that the average underlying result indicator outcome has deteriorated to some extent across all categories of public hospitals, particularly in regard to the metropolitan public hospitals.

Figure 3L
Average underlying result indicator outcome by hospital category



Source: Victorian Auditor-General's Office.

Figure 3M shows that no public hospital had a high-risk underlying result assessment of less than negative 10 per cent for 2008–09. The proportion of medium and low underlying result assessments has been relatively consistent over the trend period, with 47 per cent of hospitals assessed as medium-risk at June 2009.

Figure 3M
Public hospital underlying result risk assessment

Note: Individual hospital results are detailed in Appendix C.
Source: Victorian Auditor-General's Office.

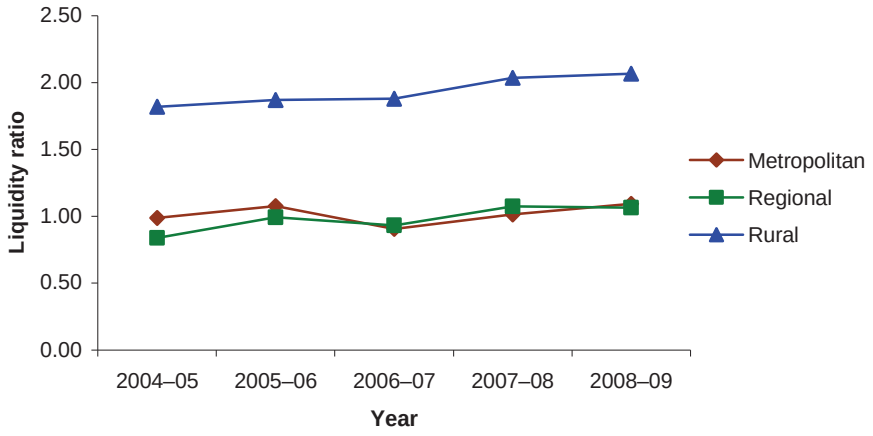
Liquidity

Prudent financial management requires that the current assets of all public hospitals should equal or exceed their current liabilities. This would mean that they do not have to rely on generating future assets to meet their past short-term liabilities. The liquidity indicator measures the hospital's ability to pay its existing short-term liabilities within the next 12 months.

Public hospital liquidity is monitored by the Department of Health, particularly for the larger metropolitan and regional hospitals. The department considers that a liquidity ratio of less than 0.7 suggests there may be insufficient funds to meet expenditure commitments. The department's benchmark of 0.7 takes into account the capital funding arrangements it applies to public hospitals.

Figure 3N shows that rural hospitals have the highest average liquidity ratio averaging 2.1 in 2008–09, while metropolitan and regional hospitals have the lowest, averaging 1.1.

Figure 3N
Average liquidity indicator outcome from 2005–2009 by hospital category

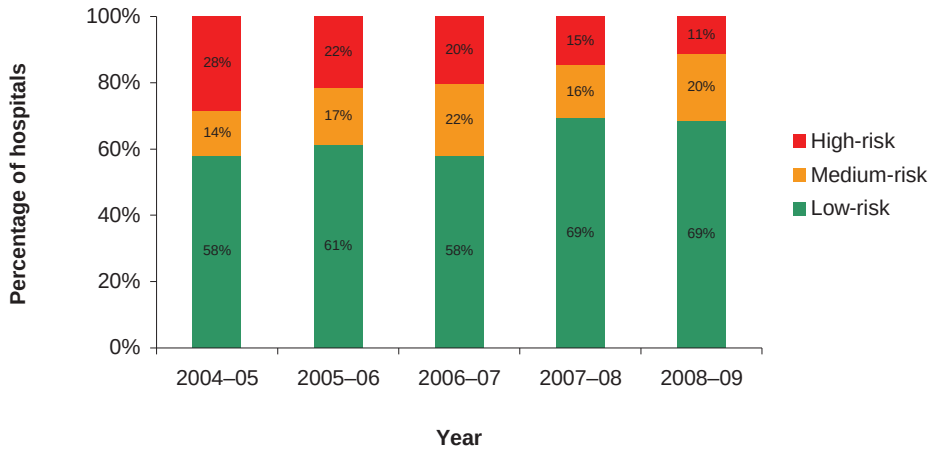


Source: Victorian Auditor-General's Office.

Our analysis shows that there has been a stable positive trend in this indicator of short-term solvency across all categories of public hospitals over the past five years. Nevertheless, a third of all hospitals had higher current liabilities than current assets in 2009, that is a negative liquidity position. Hospitals in this category must rely on new funds generated in the next year to meet some of their existing short-term obligations.

Figure 3O shows that the proportion of public hospitals with a high-risk liquidity assessment has reduced significantly over the five-year period, with a corresponding increase in the proportion of low-risk assessments. This signifies that overall the ability of public hospital's to repay their short-term financial obligations has improved.

Figure 3O
Public hospital liquidity risk assessment



Note: Individual hospital results are detailed in Appendix C.
Source: Victorian Auditor-General's Office.

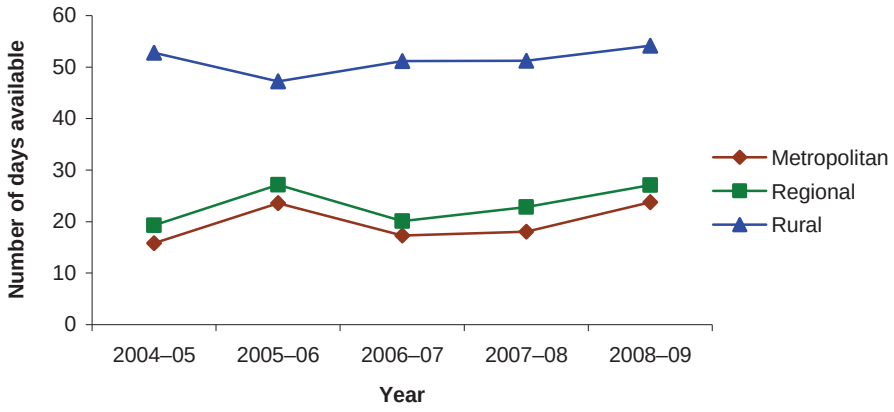
Nevertheless, there is still a significant proportion of public hospitals with a high or medium liquidity risk assessment. At June 2009, 11 per cent (10 of 88) of public hospitals have a high-liquidity risk assessment and a further 20 per cent (18 of 88) have a medium-risk assessment. Therefore around one-third of public hospitals have a medium or higher liquidity risk assessment.

Average number of days cash available

Public hospitals need sufficient unrestricted cash holdings to meet ongoing operating cash outflows. Prudent financial management practice would require the equivalent of at least one month's operating cash outflows to be available as unrestricted cash holdings, consistent with the fortnightly departmental funding model.

Figure 3P shows that the average number of days of unrestricted cash available at year end to cover operating cash outflows has remained fairly steady for each hospital category. Restricted cash, which has been excluded from this analysis, comprises funds held in trust, unspent capital grants, as well as other restricted special purpose funds. The figure shows that on average the metropolitan and regional hospitals were not able to fund their operations for more than 25 days at June 2009.

Figure 3P
Average number of days cash available by hospital category

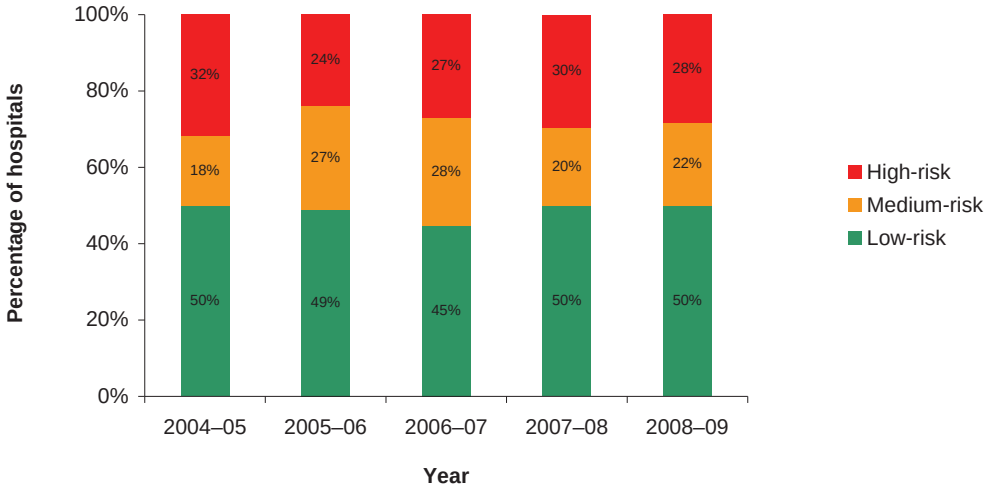


Source: Victorian Auditor-General's Office.

Figure 3Q shows that at 30 June 2009, 50 per cent (44 of 88) of public hospitals had a high or medium-risk assessment for cash holdings that were equivalent to less than one month's operating cash outflows. This includes 21 major metropolitan and regional public hospitals. While some 28 per cent (25 of 88) of public hospitals had a high-risk assessment for cash holdings, which is equivalent to less than 15 days operating cash outflows. This includes 57 per cent (12 of 21) of the major metropolitan and regional public hospitals.

Of the metropolitan and regional hospitals with low cash holdings at 30 June 2009, most had other less liquid financial instruments to call upon in the event of a cash shortage.

Figure 3Q
Public hospital average number of days cash available assessment



Note: Individual hospital results are detailed in Appendix C.
Source: Victorian Auditor-General's Office.

Departmental assessment

During 2009, DOH concluded that 31 public hospitals (35 in 2008) did not technically comply with the going concern test in the Australian Accounting Standards. This is consistent with the number of hospitals identified in our analysis as having either a high or medium liquidity risk assessment. Consequently, DOH provided the boards of those hospitals with a written commitment that it would provide adequate cash flows to enable them to meet their current and future obligations as and when they fall due up to September 2010, should this be required. Those hospitals, including 11 out of the 21 major metropolitan and regional hospitals, account for 67 per cent of the total turnover of all Victorian public hospitals. Figure 3R provides a listing of hospitals receiving a written commitment, that is a letter of comfort, from DOH in 2009.

Figure 3R
Public hospitals receiving a letter of comfort from DOH for 2008–09

Metropolitan	*Rural*
• Alfred Health	• Bass Coast Regional Health
• Austin Health	• Beechworth Health Service
• Eastern Health	• Colac Area Health
• Melbourne Health	• Djerriwarrh Health Services
• Northern Health	• Dunmunkle Health Services
• Royal Children's Hospital	• East Wimmera Health Service
• Royal Victorian Eye and Ear Hospital	• Kooweerup Regional Health Service
• Royal Women's Hospital	• Kyneton District Health Service
• Southern Health	• Lorne Community Hospital
• Western Health	• Mansfield District Hospital
Regional	• McIvor Health and Community Services
• Barwon Health	• Omeo District Health
• Echuca Regional Health	• Portland District Health
• Northeast Health Wangaratta	• Robinvale District Health Services
• South West Healthcare	• Seymour District Memorial Hospital
• Wimmera Health Care Group	
• Wodonga Regional Health Service	

Source: Victorian Auditor-General's Office.

Self-financing

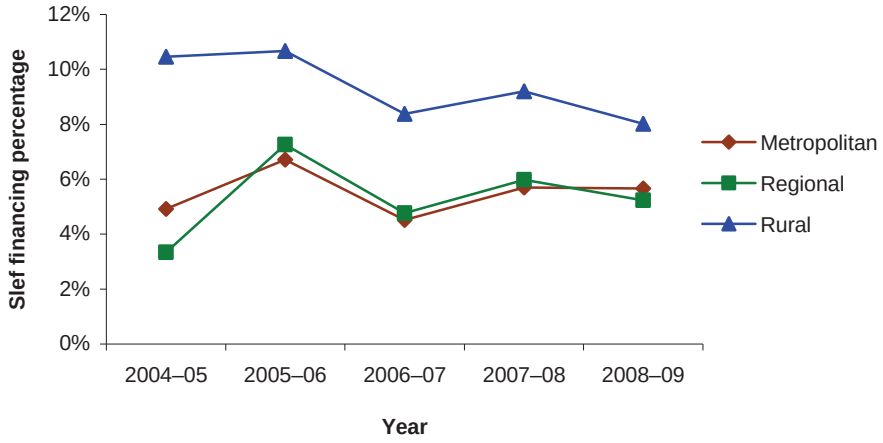
The self-financing indicator measures each hospital's ability to replace assets using cash generated from their operations, which is an effective indicator for assessing a hospital's longer-term financial sustainability.

The indicator is calculated as the percentage of net operating cash flows to total revenue. It shows if hospitals are generating sufficient cash from operations to fund new assets and asset renewals.

As shown in Figure 3S, the movements in the average self-financing ratio has been consistent for each of the three hospital classifications since 2007. Rural hospitals have achieved a notably higher average self-financing ratio than both metropolitan hospitals and regional hospitals.

The 2009 average ratio was less than the minimum 10 per cent benchmark for all three categories. Therefore, hospitals cannot effectively replace their assets using income generated by their operations over the long-term and therefore have a high-risk assessment relating to their long-term financial sustainability. Under these circumstances there is a greater reliance on the provision of additional government funding for asset renewals and replacement.

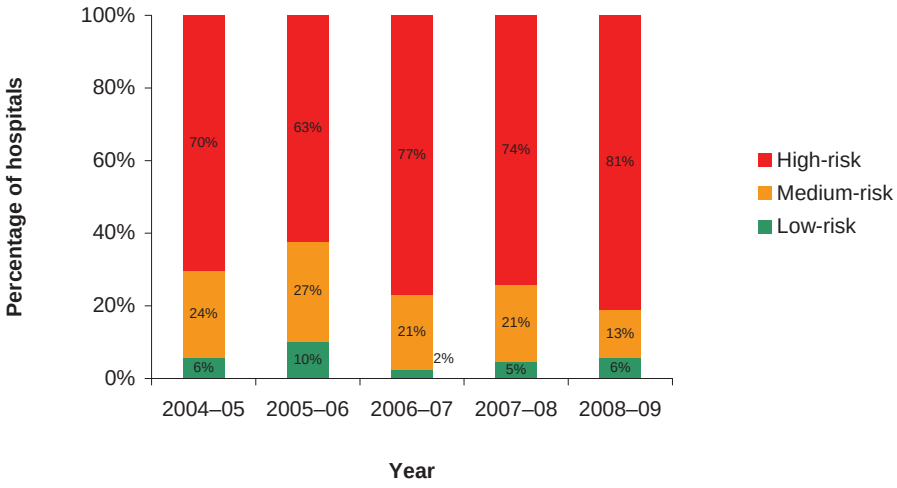
Figure 3S
Average self-financing indicator by hospital category



Source: Victorian Auditor-General's Office.

Figure 3T further illustrates that 81 per cent (71 of 88) of public hospitals have a high-risk self-financing assessment. This outcome is largely a consequence of the departmental capital funding model.

Figure 3T
Public hospital self-financing risk assessment



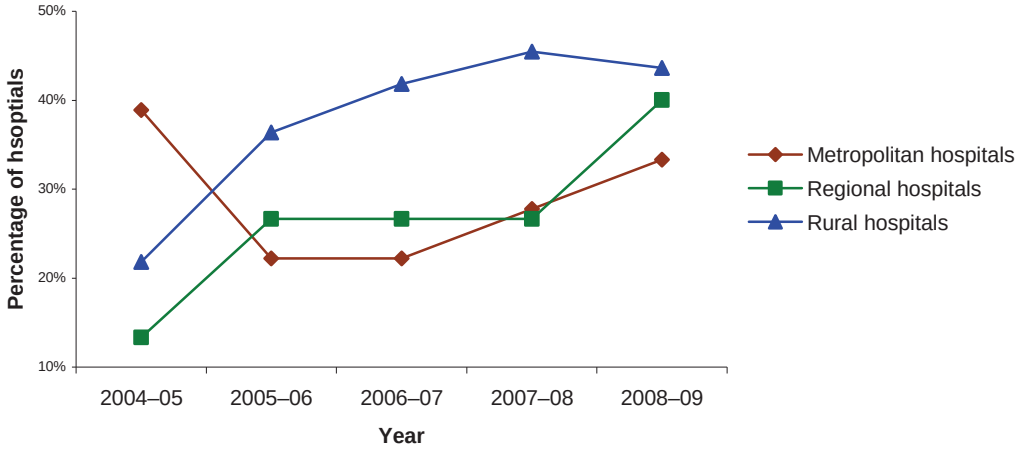
Note: Individual hospital results are detailed in Appendix C.
Source: Victorian Auditor-General's Office.

Capital replacement

The capital replacement indicator is a long-term indicator that compares the rate of spending on hospital infrastructure, plant and equipment to the annual depreciation and amortisation expense. It is a long-term indicator, because capital spending can often be deferred in the short-term if there are insufficient funds available from operations, and borrowing is not an option.

As shown in Figure 3U, the number of hospitals with a high-risk capital replacement assessment has steadily increased since 2005. This has been most prominent with regional hospitals, whereby those regional hospitals with a high-risk capital replacement assessment has tripled over the past five years from 13 per cent in 2005 to 39 per cent in 2009.

Figure 3U
Proportion of hospitals with high-risk capital replacement assessment by category



Source: Victorian Auditor-General's Office

Figure 3V sets out the capital replacement risk assessment for public hospitals. Overall this shows a worsening trend over the past five years, which is consistent for all categories of public hospitals. This outcome is consistent with that for the self-financing indicator, and partly a consequence of the departmental capital funding model.

Notwithstanding the worsening trend to 2009, aggregate hospital spending on property, plant and equipment has consistently and significantly exceeded aggregate depreciation and amortisation. This highlights a concentration in the allocation of capital funding to some hospitals.

Figure 3V
Public hospital capital replacement risk assessment

Note: Individual hospital results are detailed in Appendix C.
Source: Victorian Auditor-General's Office.

It should be noted that the asset spending data used in Figure 3V includes spending on both new and expanded facilities, in addition to existing facilities. As a result, the true level of underspending on renewing existing assets is understated. The results, nevertheless, remain indicative and identify challenges for DOH and a large portion of public hospitals.

Appendix A.
Acronyms and glossary

Acronyms

ANAO	Australian National Audit Office
CDOs	Collaterised debt obligations
DHS	Department of Human Services
DOH	Department of Health
DTF	Department of Treasury and Finance
EFT	Electronic funds transfer
FMA	*Financial Management Act 1994*
FRD	Financial Reporting Direction
IS	Information system
PAEC	Public Accounts and Estimates Committee of the Parliament of Victoria
VAGO	Victorian Auditor-General's Office.

Definitions

Accountability

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

Amortisation

The systematic allocation of the cost of intangible assets over the periods benefiting from their use.

Asset

A resource controlled by an entity as a result of past events, and from which future economic benefits are expected to flow to the entity.

Asset useful life

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

Auditor's opinion

Positive written expression within a specified framework indicating the auditor's overall conclusion on the financial report based on audit evidence obtained.

Depreciation

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

Emphasis of matter

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

Employee benefits provision

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

Entity

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

Equity or net assets

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

Expense

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

Fair value

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

Financial delegation

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

Financial instrument

A contract that represents a financial asset of one party and a financial liability or equity instrument of another party.

Financial report

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

Financial sustainability

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

Financial year

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

Going concern

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

Hard close audit

An audit visit undertaken towards the end of the financial year with the intention of substantiating figures to be provided in the financial statements that are available at a date prior to financial year end.

Impairment loss

An impairment loss occurs where there is a write down of the investment's value to reflect its reduced market value. When impairment occurs, the loss is expensed in the operating result, and is measured as the difference between the acquisition cost and current market value. Impairment losses are non-cash and only impact on cash flows on disposal of the investment.

Independent auditor's report

Issued after an audit and contains a clear expression of the auditor's opinion on the entity's financial report.

Internal control

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

Joint venture

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

Letter of comfort

Entities that do not satisfy the going concern test under the Australian Accounting Standards may receive a written commitment from another entity that it will provide adequate cash flows to enable the first entity to meet its current and future financial obligations as and when they fall due, for a period of at least 12 months from the date the annual financial report is signed.

Liability

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

Masterfile

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

Materiality

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

Material entity

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

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

Modified audit report

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

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

Net result

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

Public sector entity

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

Revenue

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

Risk

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

Unqualified audit opinion

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

Wage on-costs

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

Appendix B.
Completed audit listing

Audit status

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
COMPLETED AUDITS WITH 30 JUNE 2009 BALANCE DATES						
Metropolitan hospitals and associated entities						
Alfred Health	●		✓	11 Sep 2009	●	
Austin Health	●		✓	19 Aug 2009	●	
Calvary Health Care Bethlehem Ltd		C	✓	18 Sep 2009	●	
Dental Health Services Victoria	●		✓	2 Sep 2009	●	
Eastern Health	●		✓	12 Aug 2009	●	
Melbourne Health	●		✓	12 Aug 2009	●	
Evivar Medical Pty Ltd		C	✓	12 Aug 2009	●	
Royal Melbourne Hospital Foundation Ltd		C	✓	12 Aug 2009	●	
Mercy Public Hospitals Inc.	●		✓	18 Sep 2009	●	
Northern Health	●		✓	16 Sep 2009	●	
Northern After Hours Clinic Limited		C	✓	28 Sep 2009		●
Northern Health Research, Training and Equipment Foundation Limited		C	✓	28 Sep 2009		●
Northern Health Research, Training and Equipment Foundation Trust		O	✓	28 Sep 2009		●
Peninsula Health	●		✓	28 Aug 2009	●	

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
Metropolitan hospitals and associated entities – *continued*						
Peter MacCallum Cancer Centre	●		✓	8 Sep 2009	●	
Cell Therapies Pty Ltd		C	✓	9 Sep 2009	●	
Peter MacCallum Cancer Foundation	●		✓	9 Sep 2009	●	
Peter MacCallum Cancer Foundation Ltd		C	✓	9 Sep 2009	●	
Queen Elizabeth Centre	●		✓	3 Sep 2009	●	
Royal Children's Hospital	●		✓	23 Aug 2009	●	
Communities That Care Limited		C	✓	25 Aug 2009	●	
Royal Children's Hospital Education Institute Ltd		C	✓	25 Aug 2009	●	
Royal Children's Hospital Foundation Trust Funds		O	✓	8 Sep 2009	●	
Royal Victorian Eye and Ear Hospital	●		✓	3 Sep 2009	●	
Royal Women's Hospital	●		✓	14 Sep 2009	●	
Royal Women's Hospital Foundation Limited		C	✓	1 Oct 2009		●
Royal Women's Hospital Trust Funds		O	✓	1 Oct 2009		●
Southern Health	●		✓	12 Aug 2009	●	
Kitaya Holdings Pty Ltd		C	✓	12 Aug 2009	●	
St. Vincent's Hospital (Melbourne) Limited		C	✓	25 Sep 2009		●
Tweddle Child and Family Health Service	●		✓	23 Sep 2009		●
Western Health	●		✓	7 Aug 2009	●	
Regional hospitals and associated entities						
Bairnsdale Regional Health Service	●		✓	16 Sep 2009	●	
Ballarat Health Services	●		✓	25 Aug 2009	●	

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
Regional hospitals and associated entities – *continued*						
Barwon Health	●		✓	24 Aug 2009	●	
Bendigo Health Care Group	●		✓	28 Aug 2009	●	
Central Gippsland Health Service	●		✓	14 Sep 2009	●	
Echuca Regional Health	●		✓	22 Sep 2009	●	
Echuca Regional Health Foundation		O	✓	22 Sep 2009	●	
Echuca Regional Health Foundation Limited		C	✓	22 Sep 2009	●	
Goulburn Valley Health	●		✓	8 Sep 2009	●	
Latrobe Regional Hospital	●		✓	15 Sep 2009	●	
Northeast Health Wangaratta	●		✓	22 Sep 2009	●	
South West Healthcare	●		✓	27 Aug 2009	●	
Swan Hill District Hospital	●		✓	31 Aug 2009	●	
West Gippsland Healthcare Group	●		✓	18 Sep 2009	●	
Western District Health Service	●		✓	25 Aug 2009	●	
Wimmera Health Care Group	●		✓	3 Sep 2009	●	
Wodonga Regional Health Service	●		✓	17 Sep 2009	●	
Rural hospitals and associated entities						
Alexandra District Hospital	●		✓	22 Sep 2009	●	
Alpine Health	●		✓	9 Oct 2009		●
Bass Coast Regional Health	●		✓	14 Sep 2009	●	
Beaufort and Skipton Health Service	●		✓	22 Sep 2009	●	
Beaufort and Skipton Health Services Foundation Ltd		C	✓	23 Sep 2009		●

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
Rural hospitals and associated entities – *continued*						
Beechworth Health Service	●		✓	18 Sep 2009	●	
Benalla and District Memorial Hospital	●		✓	8 Sep 2009	●	
Boort District Hospital	●		✓	8 Sep 2009	●	
Casterton Memorial Hospital	●		✓	9 Sep 2009	●	
Cobram District Hospital	●		✓	23 Sep 2009		●
Cobram District Health Services Foundation		O	✓	30 Oct 2009		●
Cohuna District Hospital	●		✓	21 Sep 2009	●	
Cohuna Community Nursing Home Inc.	●		✓	21 Sep 2009	●	
Colac Area Health	●		✓	24 Aug 2009	●	
Djerriwarrh Health Services	●		✓	15 Sep 2009	●	
Dunmunkle Health Services	●		✓	20 Aug 2009	●	
East Grampians Health Service	●		✓	2 Sep 2009	●	
East Wimmera Health Service	●		✓	2 Sep 2009	●	
Edenhope and District Memorial Hospital	●		✓	23 Sep 2009		●
Gippsland Health Alliance	●		✓	15 Sep 2009	●	
Gippsland Southern Health Service	●		✓	14 Sep 2009	●	
Hepburn Health Service	●		✓	9 Sep 2009	●	
Hesse Rural Health Service	●		✓	17 Sep 2009	●	
Winchelsea Hostel and Nursing Home Society		O	✓	17 Sep 2009	●	
Heywood Rural Health	●		✓	1 Sep 2009	●	
HumeNet Limited		C	✓	22 Oct 2009		●

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
Rural hospitals and associated entities – *continued*						
Inglewood and Districts Health Service	●		✓	10 Sep 2009	●	
Kerang District Health	●		✓	14 Sep 2009	●	
Kilmore and District Hospital	●		✓	15 Sep 2009	●	
Kooweerup Regional Health Service	●		✓	7 Sep 2009	●	
Kyabram and District Health Service	●		✓	17 Sep 2009	●	
Kyneton District Health Service	●		✓	10 Sep 2009	●	
LMHA Network Limited		C	✓	7 Oct 2009		●
Lorne Community Hospital	●		✓	9 Sep 2009	●	
Maldon Hospital	●		✓	3 Sep 2009	●	
Mallee Track Health and Community Service	●		✓	21 Sep 2009	●	
Manangatang and District Hospital	●		✓	11 Sep 2009	●	
Mansfield District Hospital	●		✓	14 Sep 2009	●	
Maryborough District Health Service	●		✓	4 Sep 2009	●	
McIvor Health and Community Services	●		✓	31 Aug 2009	●	
Moyne Health Services	●		✓	2 Sep 2009	●	
Moyne Health Services Inc.		A	✓	2 Sep 2009	●	
Mt. Alexander Hospital	●		✓	3 Sep 2009	●	
Nathalia District Hospital	●		✓	27 Aug 2009	●	
Numurkah District Health Service	●		✓	2 Sep 2009	●	
Omeo District Hospital	●		✓	17 Sep 2009	●	
Orbost Regional Health	●		✓	18 Sep 2009	●	

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
Rural hospitals and associated entities – *continued*						
Otway Health and Community Services	●		✓	14 Sep 2009	●	
Portland District Health	●		✓	27 Aug 2009	●	
Robinvale District Health Services	●		✓	11 Sep 2009	●	
Rochester and Elmore District Health Service	●		✓	17 Sep 2009	●	
Rural Northwest Health	●		✓	24 Aug 2009	●	
Seymour District Memorial Hospital	●		✓	21 Sep 2009	●	
South Gippsland Hospital	●		✓	7 Sep 2009	●	
South West Alliance of Rural Health (SWARH) Joint venture	●		✓	25 Sep 2009		●
Stawell Regional Health	●		✓	24 Aug 2009	●	
Stawell District Hospital Foundation	●		✓	24 Aug 2009	●	
Tallangatta Health Service	●		✓	17 Sep 2009	●	
Terang and Mortlake Health Service	●		✓	14 Sep 2009	●	
Timboon and District Healthcare Service	●		✓	27 Aug 2009	●	
Upper Murray Health and Community Services	●		✓	22 Sep 2009	●	
West Wimmera Health Service	●		✓	24 Aug 2009	●	
Yarram and District Health Service	●		✓	18 Sep 2009	●	
Yarrawonga District Health Service	●		✓	18 Sep 2009	●	
Yea and District Memorial Hospital	●		✓	25 Aug 2009	●	

Entity	Audit types		Financial statements		Timeliness of audited financial statement completion	
	FMA	Non-FMA	Clear opinion issued	Auditor-General's report signed	Within 12 weeks	More than 12 weeks
2008–09 Total number of entities = 114	91	23			99	15
			Per cent (cumulative)		87	13
2007–08 Total number of entities = 156	91	65			85	71
			Per cent (cumulative)		54	46

Note: Non FMA audit types: A – *Associations Incorporation Act 1981*, C – *Corporations Act 2001* and O – other reporting framework.

Source: Victorian Auditor-General's Office.

Appendix C.
Financial sustainability tables

Underlying result indicator

Underlying result (%) – Metropolitan hospitals

	Underlying result %						
Metropolitan hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Alfred Health (formerly Bayside Health)	-0.02%	2.45%	-0.10%	2.59%	0.12%	1.01%	●
Austin Health	-3.25%	-0.79%	-2.26%	-1.71%	2.49%	-1.11%	▲
Calvary Health Care Bethlehem	-4.60%	-6.86%	0.99%	4.95%	1.34%	-0.84%	▲
Dental Health Services Victoria	0.66%	2.09%	-0.23%	-7.28%	0.10%	-0.93%	▼
Eastern Health	-0.22%	1.53%	1.64%	8.18%	-0.10%	2.21%	●
Melbourne Health	3.28%	1.29%	-1.60%	2.50%	2.88%	1.67%	●
Mercy Public Hospitals Inc.	0.36%	-1.01%	-1.39%	0.66%	0.44%	-0.19%	●
Northern Health	-3.71%	-1.01%	1.66%	-5.46%	-5.71%	-2.85%	▼
Peninsula Health	-1.63%	-1.11%	-1.39%	-2.27%	1.04%	-1.07%	▲
Peter MacCallum Cancer Centre	4.32%	3.01%	1.21%	-0.56%	-1.76%	1.24%	▼
Queen Elizabeth Centre	0.20%	-1.53%	-4.61%	-12.43%	-4.94%	-4.66%	▼
Royal Children's Hospital	10.96%	6.04%	2.72%	2.41%	-2.25%	3.98%	▼
Royal Victorian Eye and Ear Hospital	7.33%	7.76%	3.93%	0.75%	-6.55%	2.65%	▼
Royal Women's Hospital	-2.95%	-2.03%	-4.66%	-0.49%	-9.22%	-3.87%	▼
Southern Health	-1.31%	0.29%	-0.76%	0.40%	-0.40%	-0.36%	▲
St. Vincent's Hospital (Melbourne) Limited	-0.94%	0.50%	0.00%	1.04%	2.02%	0.52%	▲
Tweddle Child & Family Health Service	-0.42%	0.37%	8.33%	-1.07%	9.70%	3.38%	▲
Western Health	1.36%	1.43%	-2.95%	5.11%	4.54%	1.90%	▲
Metropolitan hospital average	0.52%	0.69%	0.03%	-0.15%	-0.35%	0.15%	▼

Note: Legend for trends:
▲ = an improving trend
▼ = a deteriorating trend
● = no substantial trend

Source: Victorian Auditor-General's Office

Underlying result (%) – Regional hospitals

	Underlying result %						
Regional hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Bairnsdale Regional Health Service	-2.01%	3.17%	7.57%	5.07%	2.60%	3.28%	●
Ballarat Health Services	0.30%	-0.57%	-0.39%	-0.19%	-3.86%	-0.94%	▼
Barwon Health	0.85%	2.57%	-0.24%	1.00%	1.93%	1.22%	●
Bendigo Health Care Group	-1.82%	-2.65%	-1.90%	-1.10%	-0.71%	-1.64%	▲
Central Gippsland Health Service	-3.32%	2.57%	1.58%	-2.02%	-0.68%	-0.37%	▼
Echuca Regional Health	0.91%	7.74%	0.79%	12.83%	-0.10%	4.43%	▼
Goulburn Valley Health	0.20%	-0.25%	1.13%	6.13%	-2.01%	1.04%	●
Latrobe Regional Hospital	3.14%	7.86%	-3.62%	-3.31%	-1.54%	0.51%	▼
Northeast Health Wangaratta	-0.01%	-2.38%	-2.28%	-2.29%	-1.89%	-1.77%	●
South West Healthcare	-2.72%	-2.65%	-0.98%	-1.77%	-2.62%	-2.15%	●
Swan Hill District Hospital	1.41%	0.91%	-4.44%	-0.71%	1.89%	-0.19%	●
West Gippsland Healthcare Group	3.67%	0.56%	1.19%	4.05%	0.37%	1.97%	▼
Western District Health Service	1.55%	4.37%	0.71%	1.16%	0.64%	1.69%	▼
Wimmera Health Care Group	-1.49%	-2.79%	-2.61%	-1.14%	-2.32%	-2.07%	●
Wodonga Regional Health Service	-5.17%	-0.68%	-1.46%	-0.92%	1.60%	-1.33%	▲
Regional hospital average	-0.30%	1.19%	-0.33%	1.12%	-0.45%	0.25%	▼

Underlying result (%) – Rural hospitals

Rural hospitals	Underlying result %						
	2005	2006	2007	2008	2009	Mean	Trend
Alexandra District Hospital	0.23%	7.62%	6.24%	7.96%	8.37%	6.09%	▲
Alpine Health	-3.94%	-3.55%	-1.57%	-2.19%	-4.97%	-3.24%	●
Bass Coast Regional Health	1.10%	-1.27%	0.76%	-2.45%	-4.96%	-1.36%	▼
Beaufort & Skipton Health Services	-2.90%	0.01%	-3.67%	-4.95%	-5.50%	-3.40%	▼
Beechworth Health Service	-27.01%	-2.78%	-1.31%	-6.12%	-6.62%	-8.77%	▼
Benalla and District Memorial Hospital	0.61%	4.35%	0.49%	0.93%	1.43%	1.56%	●
Boort District Hospital	1.50%	1.40%	-5.38%	-2.82%	13.45%	1.63%	▲
Casterton Memorial Hospital	1.72%	-2.52%	2.88%	1.10%	2.95%	1.23%	▲
Cobram District Hospital	-1.13%	-2.47%	-0.53%	1.37%	0.94%	-0.36%	▲
Cohuna District Hospital	0.60%	-1.31%	-6.46%	-2.69%	2.52%	-1.47%	●
Colac Area Health	0.35%	19.19%	2.17%	1.42%	-0.65%	4.50%	▼
Djerriwarrh Health Services	-0.28%	11.60%	27.58%	-4.30%	-0.88%	6.75%	●
Dunmunkle Health Services	3.43%	-3.65%	-0.39%	7.93%	26.76%	6.82%	▲
East Grampians Health Service	0.79%	-5.97%	1.17%	0.52%	0.41%	-0.62%	●
East Wimmera Health Service	2.45%	-2.02%	-0.98%	-4.61%	-3.97%	-1.83%	▼
Edenhope and District Hospital	3.41%	0.21%	2.61%	9.76%	2.43%	3.68%	●
Gippsland Southern Health Service	5.01%	2.98%	6.14%	4.44%	-1.28%	3.46%	▼
Hepburn Health Service	3.47%	0.43%	1.29%	-0.37%	-2.23%	0.52%	▼
Hesse Rural Health Service	7.62%	12.27%	3.43%	15.49%	13.54%	10.47%	●
Heywood Rural Health	0.17%	2.33%	-0.75%	-2.57%	-0.36%	-0.23%	●
Inglewood and District Health Service	-1.67%	-0.98%	-3.42%	0.61%	-4.39%	-1.97%	▼
Kerang District Health	-6.97%	-2.14%	-4.31%	2.35%	-0.63%	-2.34%	▲
Kilmore and District Hospital	-0.18%	-3.24%	-3.76%	1.09%	-3.66%	-1.95%	●
Kooweerup Regional Health Service	8.88%	16.93%	6.33%	11.87%	17.29%	12.26%	●
Kyabram and District Health Services	4.55%	3.99%	2.16%	0.91%	4.81%	3.28%	●
Kyneton District Health Service	-0.87%	-1.68%	-3.31%	0.51%	0.48%	-0.98%	▲
Lorne Community Hospital	64.46%	26.72%	-0.68%	-6.66%	-5.15%	15.74%	▼
Maldon Hospital	0.94%	3.23%	5.28%	3.74%	4.63%	3.57%	●
Mallee Track Health and Community Services	3.94%	9.57%	4.84%	-2.77%	5.30%	4.18%	●
Manangatang & District Hospital	-1.70%	-4.79%	10.00%	1.97%	-0.78%	0.94%	●

Underlying result (%) – Rural hospitals – *continued*

	Underlying result %						
Rural hospitals – *continued*	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Mansfield District Hospital	-3.93%	-1.71%	-3.09%	0.17%	-5.54%	-2.82%	●
Maryborough District Health Service	15.00%	20.24%	5.83%	3.99%	0.10%	9.03%	▼
McIvor Health & Community Services	0.52%	-4.02%	-5.60%	-0.87%	-6.40%	-3.27%	▼
Moyne Health Services	5.30%	6.51%	0.95%	5.88%	1.21%	3.97%	●
Mt. Alexander Hospital	4.31%	-1.43%	-1.49%	-1.33%	0.26%	0.06%	●
Nathalia District Hospital	19.86%	-2.39%	-0.92%	1.78%	-8.21%	2.02%	▼
Numurkah District Health Service	23.73%	4.02%	4.44%	12.05%	6.55%	10.16%	●
Omeo District Health	46.71%	-7.16%	-0.24%	-6.29%	-3.42%	5.92%	▼
Orbost Regional Health	6.37%	0.84%	-1.31%	2.37%	4.27%	2.51%	●
Otway Health & Community Services	0.46%	4.23%	12.11%	4.35%	7.15%	5.66%	●
Portland District Health	-5.99%	-5.95%	-1.92%	-2.81%	-1.05%	-3.55%	▲
Robinvale District Health Services	8.33%	2.09%	5.16%	2.93%	2.75%	4.25%	▼
Rochester and Elmore District Health Service	-9.95%	2.65%	-7.48%	42.82%	39.67%	13.54%	▲
Rural Northwest Health	17.42%	15.48%	5.30%	44.57%	6.03%	17.76%	●
Seymour District Memorial Hospital	5.87%	33.90%	-0.96%	-0.09%	-8.27%	6.09%	▼
South Gippsland Hospital	6.64%	-7.45%	2.75%	5.18%	8.47%	3.12%	●
Stawell Regional Health	7.31%	-3.76%	-0.87%	2.50%	-0.32%	0.97%	●
Tallangatta Health Service	6.38%	4.17%	0.90%	-4.97%	-3.81%	0.54%	▼
Terang and Mortlake Health Service	6.63%	4.67%	1.35%	1.73%	3.73%	3.62%	●
Timboon and District Healthcare Service	17.00%	18.85%	20.58%	21.26%	20.57%	19.65%	▲
Upper Murray Health & Community Services	2.41%	5.76%	1.78%	14.28%	6.34%	6.11%	●
West Wimmera Health Service	11.96%	8.78%	2.05%	5.23%	1.53%	5.91%	▼
Yarram & District Health Service	8.18%	6.18%	4.57%	4.11%	-3.20%	3.97%	▼
Yarrawonga District Health Service	3.49%	-15.94%	0.50%	-1.30%	0.06%	-2.64%	▼
Yea & District Memorial Hospital	26.29%	-0.21%	-10.20%	-1.88%	7.73%	4.35%	●
Rural hospital average	5.43%	3.14%	1.47%	3.40%	2.46%	3.18%	▼

Liquidity indicator

Liquidity – Metropolitan hospitals

	Liquidity						
Metropolitan hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Alfred Health (formerly Bayside Health)	0.55	0.88	0.64	0.64	0.39	0.62	●
Austin Health	0.40	0.71	0.78	1.03	1.07	0.80	▲
Calvary Health Care Bethlehem	0.90	0.47	0.23	0.33	0.15	0.42	▼
Dental Health Services Victoria	1.51	1.99	0.79	0.56	1.75	1.32	●
Eastern Health	0.33	0.50	0.53	0.69	0.57	0.52	▲
Melbourne Health	0.62	0.78	0.60	0.78	0.83	0.72	▲
Mercy Public Hospitals Inc.	0.63	0.64	0.57	0.61	0.59	0.61	●
Northern Health	0.52	0.59	0.50	0.35	0.32	0.45	▼
Peninsula Health	0.66	1.08	1.03	1.15	1.22	1.03	▲
Peter MacCallum Cancer Centre	1.37	1.93	1.65	1.74	1.49	1.64	●
Queen Elizabeth Centre	1.86	2.14	0.94	2.20	1.65	1.76	●
Royal Children's Hospital	1.71	1.82	1.40	1.57	1.68	1.64	●
Royal Victorian Eye and Ear Hospital	0.87	0.79	0.69	0.95	0.87	0.83	●
Royal Women's Hospital	0.52	0.45	0.30	0.46	0.32	0.41	▼
Southern Health	0.61	0.79	0.73	0.76	0.59	0.70	●
St. Vincent's Hospital (Melbourne) Limited	1.38	1.08	1.02	1.35	1.14	1.20	●
Tweddle Child & Family Health Service	2.90	2.20	3.49	2.25	4.16	3.00	▲
Western Health	0.44	0.55	0.40	0.84	0.91	0.63	▲
Metropolitan hospital average	0.99	1.08	0.91	1.01	1.09	1.02	●

Liquidity – Regional hospitals

	Liquidity						
Regional hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Bairnsdale Regional Health Service	0.95	1.16	1.30	1.44	1.55	1.28	▲
Ballarat Health Services	0.57	0.50	0.50	0.51	0.36	0.49	▼
Barwon Health	1.21	0.98	0.91	0.85	0.90	0.97	▼
Bendigo Health Care Group	0.58	0.59	0.75	0.87	0.81	0.72	▲
Central Gippsland Health Service	0.30	0.58	0.72	0.83	0.88	0.66	▲
Echuca Regional Health	0.49	0.67	0.54	1.28	1.18	0.83	▲
Goulburn Valley Health	0.48	0.68	0.66	0.88	0.83	0.71	▲
Latrobe Regional Hospital	0.87	1.18	0.48	0.57	0.86	0.79	●
Northeast Health Wangaratta	0.50	0.74	0.91	0.93	0.92	0.80	▲
South West Healthcare	1.27	1.14	0.98	1.25	1.03	1.13	●
Swan Hill District Hospital	1.56	1.94	1.85	1.68	1.82	1.77	●
West Gippsland Healthcare Group	1.44	1.40	1.03	1.00	1.04	1.18	●
Western District Health Service	1.51	2.31	2.06	2.50	2.23	2.12	▲
Wimmera Health Care Group	0.50	0.52	0.72	0.86	0.80	0.68	▲
Wodonga Regional Health Service	0.35	0.50	0.58	0.64	0.76	0.57	▲
Regional hospital average	0.84	0.99	0.93	1.07	1.06	0.98	▲

Liquidity – Rural hospitals

	Liquidity						
Rural hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Alexandra District Hospital	3.45	4.04	5.18	5.10	6.98	4.95	▲
Alpine Health	0.38	0.48	0.55	0.64	0.60	0.53	▲
Bass Coast Regional Health	0.96	0.93	0.96	1.05	0.76	0.93	●
Beaufort & Skipton Health Services	1.72	1.57	2.46	2.03	2.04	1.96	●
Beechworth Health Service	1.32	1.58	1.68	1.67	1.01	1.45	●
Benalla and District Memorial Hospital	3.53	3.09	2.47	3.11	3.37	3.11	●
Boort District Hospital	1.29	1.40	1.50	1.64	2.00	1.57	▲
Casterton Memorial Hospital	0.52	0.69	0.90	1.08	1.31	0.90	▲
Cobram District Hospital	2.24	2.33	2.00	2.09	2.08	2.15	●
Cohuna District Hospital	2.34	1.74	1.77	1.60	1.82	1.86	●
Colac Area Health	0.47	0.56	0.73	0.68	0.72	0.63	●
Djerriwarrh Health Services	0.81	0.77	0.67	0.74	0.99	0.80	●
Dunmunkle Health Services	0.61	0.91	1.39	1.05	0.80	0.95	●
East Grampians Health Service	1.98	1.47	1.20	1.23	1.34	1.44	▼
East Wimmera Health Service	2.22	2.44	2.34	1.37	1.10	1.89	▼
Edenhope and District Hospital	2.01	1.42	1.59	2.01	2.24	1.85	▲
Gippsland Southern Health Service	3.77	3.44	3.31	2.81	3.38	3.34	●
Hepburn Health Service	1.72	1.59	2.29	2.38	1.83	1.96	●
Hesse Rural Health Service	0.84	0.93	0.95	0.99	0.25	0.79	●
Heywood Rural Health	0.99	1.01	1.17	1.13	1.09	1.08	●
Inglewood and District Health Service	2.01	1.40	1.33	1.38	1.41	1.50	●
Kerang District Health	0.75	0.85	1.17	1.80	1.75	1.26	▲
Kilmore and District Hospital	1.26	2.43	1.29	1.29	1.20	1.49	●
Kooweerup Regional Health Service	2.78	1.13	1.21	1.57	1.34	1.61	●
Kyabram and District Health Services	3.07	4.85	1.69	2.03	2.46	2.82	●
Kyneton District Health Service	1.47	1.21	0.79	1.01	0.81	1.06	▼
Lorne Community Hospital	1.95	1.65	2.08	2.53	2.21	2.08	▲
Maldon Hospital	1.88	1.91	2.13	2.29	2.70	2.18	▲
Mallee Track Health and Community Services	3.61	4.98	4.77	4.32	4.89	4.51	▲
Manangatang & District Hospital	1.16	1.09	1.65	1.46	1.49	1.37	●

Liquidity – Rural hospitals – *continued*

	Liquidity						
Rural hospitals – *continued*	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Mansfield District Hospital	0.61	0.62	0.69	0.77	0.73	0.68	▲
Maryborough District Health Service	1.81	2.15	2.14	2.39	1.79	2.06	●
McIvor Health & Community Services	5.46	4.15	4.00	5.70	3.17	4.49	▼
Moyne Health Services	1.02	0.94	0.90	1.09	1.09	1.01	●
Mt. Alexander Hospital	1.11	1.12	1.11	1.01	1.12	1.09	●
Nathalia District Hospital	2.24	2.19	2.14	2.58	3.25	2.48	▲
Numurkah District Health Service	1.15	1.18	1.28	1.63	1.72	1.39	▲
Omeo District Health	2.06	1.08	1.49	1.61	1.66	1.58	●
Orbost Regional Health	1.18	1.48	1.52	1.67	2.08	1.59	▲
Otway Health & Community Services	1.04	1.29	1.45	1.35	1.47	1.32	▲
Portland District Health	0.28	0.63	0.78	1.07	0.94	0.74	▲
Robinvale District Health Services	3.56	4.19	2.25	1.69	2.01	2.74	▼
Rochester and Elmore District Health Service	0.70	0.76	0.96	1.29	1.31	1.01	▲
Rural Northwest Health	1.84	1.25	1.35	1.84	1.88	1.63	●
Seymour District Memorial Hospital	2.47	2.51	4.46	5.87	2.62	3.59	●
South Gippsland Hospital	2.49	2.96	3.40	3.74	4.33	3.38	▲
Stawell Regional Health	1.72	1.17	1.12	1.49	1.50	1.40	●
Tallangatta Health Service	1.31	1.41	1.58	1.35	1.19	1.37	●
Terang and Mortlake Health Service	2.23	2.55	2.55	2.71	2.21	2.45	●
Timboon and District Healthcare Service	4.87	7.52	7.37	10.38	12.98	8.62	▲
Upper Murray Health & Community Services	0.94	1.16	0.90	1.24	1.21	1.09	▲
West Wimmera Health Service	0.67	0.61	0.68	1.11	1.24	0.86	▲
Yarram & District Health Service	3.07	2.39	2.74	0.61	2.13	2.19	▼
Yarrawonga District Health Service	0.80	0.88	1.04	1.14	1.14	1.00	▲
Yea & District Memorial Hospital	2.28	2.71	2.25	2.55	2.92	2.54	●
Rural hospital average	1.82	1.87	1.88	2.04	2.07	1.93	▲

Average number of days cash available indicator

Average number of days cash available – Metropolitan hospitals

Metropolitan hospitals	Average number of days cash available						
	2005	2006	2007	2008	2009	Mean	Trend
Alfred Health (formerly Bayside Health)	12.15	12.17	5.66	1.44	1.78	6.64	▼
Austin Health	1.31	2.33	7.56	10.36	8.84	6.08	▲
Calvary Health Care Bethlehem	24.05	6.14	4.59	4.66	0.00	7.89	▼
Dental Health Services Victoria	54.59	53.72	15.32	5.76	21.05	30.09	▼
Eastern Health	0.00	1.51	13.48	20.29	12.05	9.47	▲
Melbourne Health	10.70	7.61	3.06	0.64	4.68	5.34	▼
Mercy Public Hospitals Inc.	11.02	25.26	20.52	15.25	17.45	17.90	●
Northern Health	11.46	15.68	0.00	0.35	0.00	5.50	●
Peninsula Health	15.95	22.53	19.59	19.71	34.74	22.51	▲
Peter MacCallum Cancer Centre	45.63	51.58	31.06	40.17	26.22	38.93	▼
Queen Elizabeth Centre	12.92	104.77	42.51	9.43	136.71	61.27	▲
Royal Children's Hospital	1.46	5.43	16.63	16.59	9.74	9.97	●
Royal Victorian Eye and Ear Hospital	15.69	9.78	7.40	30.14	35.59	19.72	▲
Royal Women's Hospital	13.33	3.34	2.03	1.73	1.72	4.43	▼
Southern Health	16.27	28.89	19.72	21.20	12.71	19.76	●
St. Vincent's Hospital (Melbourne) Limited	10.40	17.31	7.57	13.98	19.23	13.70	●
Tweddle Child & Family Health Service	17.27	38.55	88.96	76.69	58.34	55.96	●
Western Health	12.26	17.77	6.59	36.55	34.03	21.44	▲
Metropolitan hospital average	15.91	23.58	17.35	18.05	24.16	19.81	▲

Average number of days cash available – Regional hospitals

	Average number of days cash available						
Regional hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Bairnsdale Regional Health Service	9.82	39.63	23.57	37.32	61.79	34.43	▲
Ballarat Health Services	1.27	6.26	4.98	1.25	5.56	3.86	▲
Barwon Health	21.76	21.20	16.63	11.25	5.21	15.21	▼
Bendigo Health Care Group	10.65	10.33	14.18	21.70	16.34	14.64	▲
Central Gippsland Health Service	3.37	13.96	19.29	17.45	14.18	13.65	●
Echuca Regional Health	11.91	34.14	0.00	0.23	7.20	10.69	●
Goulburn Valley Health	4.22	15.30	18.97	9.35	12.67	12.10	●
Latrobe Regional Hospital	34.62	48.29	3.69	4.16	11.28	20.41	▼
Northeast Health Wangaratta	1.46	4.45	5.40	1.58	0.75	2.73	▼
South West Healthcare	36.69	32.60	20.56	28.92	22.22	28.20	▼
Swan Hill District Hospital	64.43	95.21	71.03	87.08	94.95	82.54	▲
West Gippsland Healthcare Group	59.25	49.04	50.96	56.79	58.87	54.98	●
Western District Health Service	34.00	27.50	38.33	42.85	49.22	38.38	▲
Wimmera Health Care Group	7.31	6.68	12.79	9.18	13.28	9.85	▲
Wodonga Regional Health Service	0.00	2.87	10.24	13.09	32.56	11.75	▲
Regional hospital average	20.05	27.16	20.71	22.81	27.07	23.56	▲

Average number of days cash available – Rural hospitals

Rural hospitals	Average number of days cash available						
	2005	2006	2007	2008	2009	Mean	Trend
Alexandra District Hospital	81.49	47.79	61.57	53.49	26.20	54.11	▼
Alpine Health	12.22	13.56	34.20	37.17	32.85	26.00	▲
Bass Coast Regional Health	40.07	29.27	49.30	20.03	5.81	28.90	▼
Beaufort & Skipton Health Services	38.36	66.75	28.55	26.93	100.42	52.20	●
Beechworth Health Service	34.85	31.55	43.64	50.72	36.68	39.49	●
Benalla and District Memorial Hospital	16.73	17.34	27.65	37.95	78.72	35.68	▲
Boort District Hospital	57.55	72.61	45.64	29.10	65.72	54.12	●
Casterton Memorial Hospital	0.00	18.26	76.86	98.05	95.92	57.82	▲
Cobram District Hospital	38.31	46.59	26.89	28.00	23.36	32.63	▼
Cohuna District Hospital	51.71	53.45	32.97	44.93	51.41	46.89	●
Colac Area Health	6.23	15.81	21.88	11.71	16.52	14.43	●
Djerriwarrh Health Services	32.75	5.50	3.05	0.00	20.97	12.45	●
Dunmunkle Health Services	17.30	9.93	20.92	15.43	21.96	17.11	▲
East Grampians Health Service	50.63	46.26	36.19	44.99	50.69	45.75	●
East Wimmera Health Service	50.84	31.54	36.58	27.47	17.86	32.86	▼
Edenhope and District Hospital	90.92	83.33	136.03	185.77	139.48	127.11	▲
Gippsland Southern Health Service	9.96	7.30	3.37	9.09	0.52	6.05	▼
Hepburn Health Service	38.50	25.61	49.06	50.14	59.30	44.52	▲
Hesse Rural Health Service	25.78	84.02	23.24	53.91	50.76	47.54	●
Heywood Rural Health	29.23	15.22	50.14	52.64	51.05	39.65	▲
Inglewood and District Health Service	35.08	25.60	26.49	26.56	12.24	25.19	▼
Kerang District Health	23.89	39.45	41.17	48.99	40.67	38.84	●
Kilmore and District Hospital	29.14	32.18	21.60	8.92	29.04	24.18	●
Kooweerup Regional Health Service	24.49	21.75	2.50	2.31	13.13	12.83	▼
Kyabram and District Health Services	52.99	29.32	22.74	5.40	26.99	27.49	▼
Kyneton District Health Service	26.08	15.00	7.43	21.85	10.76	16.22	●
Lorne Community Hospital	160.56	32.12	93.31	138.74	104.91	105.93	●
Maldon Hospital	75.64	105.52	123.26	31.51	14.21	70.03	▼
Mallee Track Health and Community Services	11.78	50.53	39.52	37.67	48.99	37.70	▲
Manangatang & District Hospital	81.02	63.32	103.31	92.21	78.04	83.58	●

Average number of days cash available – Rural hospitals – *continued*

Rural hospitals – *continued*	Average number of days cash available						
	2005	2006	2007	2008	2009	Mean	Trend
Mansfield District Hospital	16.48	6.88	9.95	1.94	7.52	8.55	▼
Maryborough District Health Service	1.82	77.04	34.36	60.15	15.46	37.76	●
McIvor Health & Community Services	84.92	70.50	20.64	30.54	7.35	42.79	▼
Moyne Health Services	85.95	85.63	93.36	89.57	39.63	78.83	●
Mt. Alexander Hospital	52.46	55.76	49.72	32.32	41.82	46.41	▼
Nathalia District Hospital	42.01	20.46	21.86	85.25	87.07	51.33	▲
Numurkah District Health Service	87.70	50.05	67.57	117.10	126.48	89.78	▲
Omeo District Health	122.42	50.65	58.83	75.56	87.32	78.96	▲
Orbost Regional Health	56.15	82.73	51.02	79.47	128.65	79.60	▲
Otway Health & Community Services	10.85	48.48	13.23	7.12	15.78	19.09	▲
Portland District Health	0.00	13.04	11.71	15.69	41.06	16.30	▲
Robinvale District Health Services	131.00	113.81	120.17	79.98	90.07	107.01	▼
Rochester and Elmore District Health Service	59.55	31.16	72.40	115.65	104.85	76.72	▲
Rural Northwest Health	35.03	29.71	83.71	56.66	141.12	69.25	▲
Seymour District Memorial Hospital	92.98	59.35	18.93	26.28	16.31	42.77	▼
South Gippsland Hospital	170.62	171.51	207.49	54.49	31.12	127.05	▼
Stawell Regional Health	35.78	3.70	23.96	40.90	28.06	26.48	●
Tallangatta Health Service	147.64	98.72	87.70	111.20	103.23	109.70	●
Terang and Mortlake Health Service	38.97	26.28	29.05	32.73	31.05	31.62	●
Timboon and District Healthcare Service	105.82	67.89	87.50	66.27	122.89	90.07	●
Upper Murray Health & Community Services	46.15	68.97	45.97	65.26	61.71	57.61	▲
West Wimmera Health Service	39.93	17.17	25.41	73.86	68.25	44.92	▲
Yarram & District Health Service	116.21	125.71	164.40	157.61	143.61	141.51	●
Yarrawonga District Health Service	19.62	16.46	30.65	1.27	27.15	19.03	●
Yea & District Memorial Hospital	65.13	68.63	96.77	52.18	86.42	73.83	●
Rural hospital average	52.90	47.21	51.19	51.29	54.17	51.35	●

Self-financing indicator

Self-financing (%) – Metropolitan hospitals

	Self financing %						
Metropolitan hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Alfred Health (formerly Bayside Health)	5.44%	8.77%	3.18%	10.33%	7.94%	7.13%	●
Austin Health	1.80%	7.11%	3.17%	5.62%	7.73%	5.09%	▲
Calvary Health Care Bethlehem	-0.74%	1.00%	2.56%	10.96%	2.66%	3.29%	▲
Dental Health Services Victoria	6.71%	5.06%	3.91%	-2.34%	0.79%	2.82%	▼
Eastern Health	4.91%	5.71%	7.10%	11.93%	4.66%	6.86%	●
Melbourne Health	8.61%	4.22%	4.66%	3.88%	9.18%	6.11%	●
Mercy Public Hospitals Inc.	3.41%	10.55%	1.80%	1.18%	4.38%	4.27%	●
Northern Health	-1.12%	4.42%	2.99%	3.14%	1.83%	2.25%	▼
Peninsula Health	2.95%	5.51%	4.06%	2.56%	8.63%	4.74%	▲
Peter MacCallum Cancer Centre	9.42%	10.26%	7.91%	5.82%	5.05%	7.69%	▼
Queen Elizabeth Centre	5.65%	5.83%	2.49%	-10.22%	9.76%	2.70%	●
Royal Children's Hospital	11.41%	7.68%	11.91%	8.45%	9.56%	9.80%	●
Royal Victorian Eye and Ear Hospital	11.44%	11.23%	11.00%	12.16%	9.04%	10.98%	▼
Royal Women's Hospital	5.83%	1.32%	2.00%	2.78%	1.42%	2.67%	▼
Southern Health	1.24%	6.50%	2.27%	4.61%	3.87%	3.70%	▲
St. Vincent's Hospital (Melbourne) Limited	1.34%	9.94%	1.84%	7.70%	4.12%	4.99%	▲
Tweddle Child & Family Health Service	4.86%	9.71%	5.37%	14.71%	4.18%	7.77%	●
Western Health	5.21%	6.07%	3.08%	9.24%	7.18%	6.16%	▲
Metropolitan hospital average	4.91%	6.72%	4.52%	5.69%	5.67%	5.50%	●

Self-financing (%) – Regional hospitals

	Self financing %						
Regional hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Bairnsdale Regional Health Service	2.35%	10.78%	8.98%	7.62%	9.29%	7.80%	▲
Ballarat Health Services	4.24%	6.17%	6.51%	6.07%	4.37%	5.47%	●
Barwon Health	5.02%	10.70%	5.07%	6.81%	4.71%	6.46%	▼
Bendigo Health Care Group	0.67%	4.06%	4.82%	7.83%	4.78%	4.43%	●
Central Gippsland Health Service	1.99%	6.32%	8.27%	3.07%	4.09%	4.75%	●
Echuca Regional Health	1.69%	21.21%	1.98%	10.74%	7.84%	8.69%	▲
Goulburn Valley Health	1.46%	5.28%	4.66%	11.49%	6.38%	5.85%	▲
Latrobe Regional Hospital	6.15%	11.54%	0.58%	2.90%	2.79%	4.79%	▼
Northeast Health Wangaratta	2.92%	2.26%	1.86%	1.69%	1.66%	2.08%	▼
South West Healthcare	1.51%	3.85%	2.93%	3.76%	0.70%	2.55%	●
Swan Hill District Hospital	5.99%	10.72%	0.23%	5.37%	6.04%	5.67%	●
West Gippsland Healthcare Group	9.41%	6.47%	9.21%	11.34%	5.06%	8.30%	▼
Western District Health Service	6.90%	5.40%	8.47%	5.17%	7.94%	6.78%	●
Wimmera Health Care Group	3.69%	0.63%	4.49%	3.29%	4.62%	3.34%	▲
Wodonga Regional Health Service	-3.91%	3.44%	3.42%	2.50%	8.22%	2.74%	▲
Regional hospital average	3.34%	7.26%	4.77%	5.98%	5.23%	5.31%	●

Self-financing (%) – Rural hospitals

	Self financing %						
Rural hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Alexandra District Hospital	10.56%	15.10%	9.14%	17.90%	18.80%	14.30%	▲
Alpine Health	0.19%	4.16%	6.75%	3.88%	3.06%	3.61%	●
Bass Coast Regional Health	3.44%	4.92%	6.32%	2.87%	0.12%	3.53%	▼
Beaufort & Skipton Health Services	5.68%	7.51%	0.95%	10.50%	6.57%	6.24%	●
Beechworth Health Service	-9.12%	-0.27%	7.74%	0.51%	7.00%	1.17%	▲
Benalla and District Memorial Hospital	8.74%	9.34%	7.67%	7.74%	11.98%	9.09%	●
Boort District Hospital	12.60%	8.95%	3.43%	-3.64%	15.77%	7.42%	●
Casterton Memorial Hospital	0.74%	8.73%	10.35%	7.01%	4.84%	6.33%	●
Cobram District Hospital	5.05%	4.23%	5.07%	7.94%	2.81%	5.02%	●
Cohuna District Hospital	7.58%	6.72%	-1.39%	4.41%	4.83%	4.43%	●
Colac Area Health	2.19%	26.70%	9.88%	5.23%	1.70%	9.14%	▼
Djerriwarrh Health Services	5.10%	2.51%	14.86%	4.83%	9.46%	7.35%	●
Dunmunkle Health Services	3.82%	0.18%	6.88%	12.39%	29.87%	10.63%	▲
East Grampians Health Service	3.34%	1.44%	8.56%	6.86%	5.90%	5.22%	▲
East Wimmera Health Service	5.70%	-0.08%	8.13%	0.62%	4.01%	3.68%	●
Edenhope and District Hospital	11.20%	3.32%	15.06%	17.09%	1.18%	9.57%	●
Gippsland Southern Health Service	11.05%	14.72%	10.60%	9.77%	4.71%	10.17%	▼
Hepburn Health Service	7.63%	4.11%	8.91%	6.11%	4.53%	6.26%	●
Hesse Rural Health Service	14.89%	13.18%	10.92%	20.43%	20.61%	16.00%	▲
Heywood Rural Health	7.66%	9.94%	1.08%	4.74%	4.84%	5.65%	●
Inglewood and District Health Service	11.78%	2.64%	8.64%	9.06%	5.50%	7.52%	▼
Kerang District Health	-0.24%	6.52%	5.97%	7.00%	3.52%	4.55%	●
Kilmore and District Hospital	3.86%	4.35%	1.51%	3.69%	7.98%	4.28%	●
Kooweerup Regional Health Service	10.13%	20.38%	13.43%	16.82%	20.45%	16.24%	▲
Kyabram and District Health Services	16.47%	6.20%	8.01%	2.22%	10.20%	8.62%	●
Kyneton District Health Service	5.05%	10.13%	-0.47%	9.45%	6.95%	6.22%	●
Lorne Community Hospital	69.95%	33.62%	18.16%	7.48%	2.57%	26.36%	▼
Maldon Hospital	8.39%	10.16%	10.04%	10.08%	0.63%	7.86%	●
Mallee Track Health and Community Services	9.00%	16.18%	11.77%	7.87%	12.56%	11.48%	▲
Manangatang & District Hospital	10.72%	1.73%	16.64%	6.00%	-2.38%	6.54%	▼

Self-financing (%) – Rural hospitals (continued)

	Self financing %						
Rural hospitals – *continued*	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Mansfield District Hospital	-1.25%	6.03%	5.53%	3.21%	3.83%	3.47%	●
Maryborough District Health Service	15.35%	27.63%	12.44%	8.92%	6.27%	14.12%	▼
McIvor Health & Community Services	8.45%	3.66%	3.55%	0.71%	-1.85%	2.90%	▼
Moyne Health Services	6.74%	26.68%	5.33%	12.89%	7.40%	11.81%	●
Mt. Alexander Hospital	10.13%	13.45%	2.91%	4.15%	0.00%	6.13%	▼
Nathalia District Hospital	2.00%	3.42%	5.11%	8.59%	-1.74%	3.47%	●
Numurkah District Health Service	32.89%	12.76%	8.30%	17.33%	11.60%	16.58%	▼
Omeo District Health	50.71%	13.77%	5.49%	5.29%	6.08%	16.27%	▼
Orbost Regional Health	14.55%	9.77%	5.12%	7.60%	14.53%	10.31%	●
Otway Health & Community Services	9.38%	10.47%	17.06%	7.57%	10.04%	10.90%	●
Portland District Health	1.06%	1.70%	10.84%	0.40%	5.11%	3.82%	●
Robinvale District Health Services	12.50%	10.19%	13.83%	6.59%	2.74%	9.17%	▼
Rochester and Elmore District Health Service	3.66%	6.83%	2.31%	43.83%	42.54%	19.83%	▲
Rural Northwest Health	21.04%	11.84%	21.53%	42.23%	12.97%	21.92%	●
Seymour District Memorial Hospital	8.15%	41.77%	3.41%	4.82%	0.36%	11.70%	▼
South Gippsland Hospital	12.85%	10.06%	5.74%	8.02%	16.75%	10.69%	●
Stawell Regional Health	12.60%	3.36%	10.57%	5.18%	3.76%	7.09%	▼
Tallangatta Health Service	6.26%	17.30%	1.89%	10.79%	0.01%	7.25%	▼
Terang and Mortlake Health Service	12.75%	10.14%	5.86%	5.72%	4.36%	7.76%	▼
Timboon and District Healthcare Service	20.70%	25.64%	28.32%	26.04%	27.01%	25.54%	▲
Upper Murray Health & Community Services	10.18%	9.35%	7.82%	17.21%	10.08%	10.93%	●
West Wimmera Health Service	17.08%	16.78%	8.87%	13.47%	4.24%	12.09%	▼
Yarram & District Health Service	10.98%	22.53%	11.08%	8.56%	4.96%	11.62%	▼
Yarrawonga District Health Service	6.48%	1.39%	4.85%	7.89%	8.06%	5.73%	▲
Yea & District Memorial Hospital	6.80%	12.69%	8.57%	1.96%	11.65%	8.33%	●
Rural hospital average	10.46%	10.66%	8.38%	9.20%	8.02%	9.34%	▼

Capital replacement indicator

Capital replacement – Metropolitan hospitals

	Capital replacement						
Metropolitan hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Alfred Health (formerly Bayside Health)	1.73	3.33	3.62	3.06	3.15	2.98	●
Austin Health	1.30	0.67	0.65	1.13	1.22	0.99	●
Calvary Health Care Bethlehem	0.71	6.88	1.10	3.11	3.37	3.03	▲
Dental Health Services Victoria	0.33	0.92	1.22	0.43	0.96	0.77	●
Eastern Health	1.97	2.18	5.15	4.64	2.30	3.25	●
Melbourne Health	3.43	1.92	2.71	1.89	2.21	2.43	▼
Mercy Public Hospitals Inc.	3.98	3.40	0.51	1.77	2.04	2.34	▼
Northern Health	0.73	3.01	3.99	0.66	1.70	2.02	●
Peninsula Health	1.07	1.03	2.22	1.48	2.61	1.68	▲
Peter MacCallum Cancer Centre	1.27	1.58	1.96	0.75	1.71	1.46	●
Queen Elizabeth Centre	1.07	1.55	2.98	1.15	0.33	1.42	▼
Royal Children's Hospital	2.51	4.01	2.10	1.07	0.27	1.99	▼
Royal Victorian Eye and Ear Hospital	0.92	1.39	1.34	0.79	0.92	1.07	●
Royal Women's Hospital	0.38	0.44	0.84	0.59	0.21	0.49	●
Southern Health	0.61	1.50	1.55	1.68	1.90	1.45	▲
St. Vincent's Hospital (Melbourne) Limited	1.73	2.44	2.00	3.73	1.95	2.37	●
Tweddle Child & Family Health Service	0.09	0.23	0.21	3.94	0.86	1.07	▲
Western Health	1.76	1.86	1.51	1.56	2.72	1.88	▲
Metropolitan hospital average	1.42	2.13	1.98	1.86	1.69	1.82	▼

Capital replacement – Regional hospitals

	Capital replacement						
Regional hospitals	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Bairnsdale Regional Health Service	1.28	1.25	2.95	1.35	0.78	1.52	▼
Ballarat Health Services	2.78	2.62	2.19	2.35	1.59	2.31	▼
Barwon Health	1.85	4.31	3.13	3.32	1.54	2.83	●
Bendigo Health Care Group	1.17	1.03	0.76	1.25	1.79	1.20	▲
Central Gippsland Health Service	0.49	0.52	1.26	0.63	0.96	0.77	▲
Echuca Regional Health	1.03	2.88	1.24	2.77	1.55	1.90	▲
Goulburn Valley Health	1.07	2.86	1.36	2.87	1.74	1.98	▲
Latrobe Regional Hospital	2.56	9.34	1.04	0.95	0.52	2.88	▼
Northeast Health Wangaratta	1.18	0.86	2.66	2.26	0.82	1.56	●
South West Healthcare	1.37	1.37	1.29	1.61	4.20	1.97	▲
Swan Hill District Hospital	1.48	1.18	0.83	0.86	0.88	1.05	▼
West Gippsland Healthcare Group	2.49	2.20	2.69	2.07	0.98	2.09	▼
Western District Health Service	1.14	1.14	1.17	1.03	1.47	1.19	●
Wimmera Health Care Group	1.33	0.89	0.82	0.64	1.25	0.98	●
Wodonga Regional Health Service	0.81	0.49	0.57	1.21	1.41	0.90	▲
Regional hospital average	1.47	2.20	1.60	1.68	1.43	1.67	▼

Capital replacement – Rural hospitals

Rural hospitals	Capital replacement						
	2005	2006	2007	2008	2009	Mean	Trend
Alexandra District Hospital	2.78	1.11	0.89	1.03	1.75	1.51	●
Alpine Health	1.43	0.33	0.44	0.87	0.63	0.74	●
Bass Coast Regional Health	1.52	1.07	1.18	0.88	1.22	1.17	●
Beaufort & Skipton Health Services	0.97	4.19	11.23	1.37	0.09	3.57	●
Beechworth Health Service	5.27	0.85	0.67	0.37	0.50	1.53	▼
Benalla and District Memorial Hospital	1.98	3.61	0.92	1.17	0.87	1.71	▼
Boort District Hospital	1.03	1.10	2.10	0.83	1.30	1.27	●
Casterton Memorial Hospital	0.54	0.24	0.83	0.24	0.71	0.51	●
Cobram District Hospital	1.14	0.60	1.36	1.54	1.26	1.18	●
Cohuna District Hospital	1.55	1.31	0.44	0.49	0.62	0.88	▼
Colac Area Health	2.22	7.11	2.24	1.78	0.49	2.76	▼
Djerriwarrh Health Services	1.40	1.58	3.56	0.80	0.73	1.61	▼
Dunmunkle Health Services	2.10	0.78	0.98	2.47	10.11	3.29	▲
East Grampians Health Service	1.22	4.71	5.61	0.95	0.77	2.65	●
East Wimmera Health Service	1.18	0.92	0.86	1.22	1.21	1.08	●
Edenhope and District Hospital	2.23	1.52	0.66	0.91	2.02	1.47	●
Gippsland Southern Health Service	0.69	1.77	1.48	3.57	5.85	2.67	▲
Hepburn Health Service	1.66	1.09	0.83	0.55	2.23	1.27	●
Hesse Rural Health Service	1.53	1.69	1.62	4.49	12.53	4.37	▲
Heywood Rural Health	0.31	0.81	0.59	0.94	0.71	0.67	▲
Inglewood and District Health Service	1.88	0.76	1.94	1.12	1.42	1.42	●
Kerang District Health	1.39	0.49	0.84	0.53	0.70	0.79	▼
Kilmore and District Hospital	0.40	0.95	0.61	1.76	0.68	0.88	●
Kooweerup Regional Health Service	1.78	1.70	1.04	1.13	6.48	2.43	●
Kyabram and District Health Services	2.02	1.61	2.30	3.66	0.98	2.11	●
Kyneton District Health Service	0.60	0.89	2.20	1.07	2.04	1.36	▲
Lorne Community Hospital	8.68	5.46	0.66	0.29	0.39	3.10	▼
Maldon Hospital	0.57	0.02	0.92	0.39	1.07	0.60	▲
Mallee Track Health and Community Services	1.45	1.17	1.72	1.45	1.16	1.39	▼
Manangatang & District Hospital	1.05	1.34	1.88	2.74	0.54	1.51	●

Capital replacement – Rural hospitals – *continued*

	Capital replacement						
Rural hospitals – *continued*	**2005**	**2006**	**2007**	**2008**	**2009**	**Mean**	**Trend**
Mansfield District Hospital	0.75	1.11	0.97	1.52	0.72	1.02	●
Maryborough District Health Service	2.80	4.58	2.44	0.86	3.73	2.88	●
McIvor Health & Community Services	1.52	0.53	1.71	0.77	1.73	1.25	●
Moyne Health Services	2.81	6.18	0.54	0.29	0.89	2.14	▼
Mt. Alexander Hospital	0.83	2.28	5.96	1.64	0.47	2.23	▼
Nathalia District Hospital	1.17	1.17	1.78	15.58	58.23	15.59	▲
Numurkah District Health Service	4.91	1.80	0.74	0.54	1.00	1.80	●
Omeo District Health	20.39	4.94	0.54	0.05	0.47	5.28	▼
Orbost Regional Health	3.47	1.46	1.12	1.05	0.79	1.58	▼
Otway Health & Community Services	3.07	1.00	1.61	2.80	0.53	1.81	▼
Portland District Health	0.54	0.89	4.88	1.05	0.81	1.63	●
Robinvale District Health Services	2.67	3.75	3.64	4.93	1.17	3.23	●
Rochester and Elmore District Health Service	0.75	1.62	3.41	14.97	10.77	6.30	▲
Rural Northwest Health	5.52	3.88	16.03	16.82	1.63	8.77	●
Seymour District Memorial Hospital	2.71	12.88	4.46	0.66	1.69	4.48	●
South Gippsland Hospital	1.78	0.73	1.04	1.41	3.36	1.67	●
Stawell Regional Health	3.62	2.13	1.84	0.59	1.38	1.91	▼
Tallangatta Health Service	1.40	0.60	0.59	1.02	0.79	0.88	●
Terang and Mortlake Health Service	1.29	2.19	1.91	1.70	1.49	1.72	●
Timboon and District Healthcare Service	3.66	1.05	1.93	0.31	1.09	1.61	▼
Upper Murray Health & Community Services	1.46	0.95	3.39	4.45	2.88	2.63	▲
West Wimmera Health Service	5.16	0.54	0.48	0.49	1.10	1.55	●
Yarram & District Health Service	1.36	0.45	0.92	1.89	1.36	1.20	●
Yarrawonga District Health Service	5.40	14.64	3.81	0.75	1.16	5.15	▼
Yea & District Memorial Hospital	0.76	0.80	0.40	0.24	0.56	0.55	●
Rural hospital average	2.41	2.23	2.16	2.13	2.92	2.37	●

Auditor-General's reports

Reports tabled during 2009–10

Report title	Date tabled
Local Government: Results of the 2008–09 Audits (2009–10:1)	November 2009

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