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Public Hospital Financial Performance and Sustainability

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Victorian Auditor-General's Office

Auditing in the Public Interest

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

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

Dear Presiding Officers

Under the provisions of section 16AB of the *Audit Act 1994*, I transmit my report on *Public Hospital Financial Performance and Sustainability.*

Yours faithfully

DDR PEARSON
Auditor-General

19 June 2007

Foreword

The financial viability of Victoria's public hospital system, which had an annual turnover in excess of $7 billion in 2005-06, is one of the State's key risks.

We found that since 2002-03, a period of significant financial challenge for public hospitals, the financial performance and position of public hospitals has generally improved. This improvement has been characterised by a slow down in expenditure.

Nevertheless, several significant indicators of continuing financial challenge remain. Some of the indicators have shown consistent unfavourable trends or results over the 6 years to 2006. These point to short-term solvency issues, and longer-term financial sustainability challenges.

The Department of Human Services and public hospital boards share the responsibility for financial performance and management within the sector. They have recognised the need to act on the financial challenges and have undertaken a number of initiatives to better manage the increasing demand for services and promote financial sustainability. The full impact of some initiatives already underway will not be felt until future years.

DDR PEARSON
Auditor-General

19 June 2007

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1 Executive summary

1.1 Overview

The financial viability of its public hospital system is one of the State's key risks. Victoria's public hospitals had an annual turnover in excess of $7 billion in 2005-06, and managed assets totalling some $7 billion at June 2006.

We have undertaken an assessment of Victoria's public hospitals' financial performance and sustainability, using indicators of short-term solvency and longer-term viability.

Since 2002-03, a period of significant financial challenge for public hospitals, the financial performance and position of public hospitals has generally improved. Nevertheless, several significant indicators of continuing financial challenge remain.

The Department of Human Services (DHS) and public hospital boards share the responsibility for financial performance and management within the sector. While they have recognised the need to act on the financial challenges, and have done so, there remains the need to continue to build on and expand existing initiatives to establish greater financial sustainability across the sector.

Audit conclusions

The 2003 financial year represented the financial low point for the public hospital sector in the 6-year period to 2006, partly because revenue levels (in real terms) had not kept pace with the increase in demand.

Since 2002-03, the financial performance and position of public hospitals has generally improved. This improvement was characterised by a slow down in expenditure, in real terms, relative to demand. In particular, there has been a significant reduction in the number of public hospitals with negative operating cash flows (before capital grants), down to 8 hospitals in 2006, compared with 29 in 2003.

Nevertheless, several significant indicators of continuing financial challenge remain. Key indicators across the 91 public hospitals include:

- 35 hospitals had less than 30 days of operating cash outflows as cash holdings at 30 June 2006. Of these, 14 hospitals had less than 15 days of equivalent operating cash outflows

- the number of hospitals with negative working capital positions (current liabilities greater than current assets) has been fairly constant and remained significant during the period 2003 to 2006 (ranging between 32 to 34 hospitals)
- the number of public hospitals with operating deficits (before abnormal items) peaked in 2003 (comprising 48 hospitals), and subsequently fell before again increasing in 2005-06. Of the 37 public hospitals with operating deficits in 2006, 6 had an operating deficit greater than 5 per cent of total revenue
- 26 hospitals had a higher depreciation expense than spending (investing cash outflows) on property, plant and equipment in 2006, suggesting a diminishing asset base. Of those hospitals, 24 had depreciation and amortisation expenditure exceeding spending on property, plant and equipment by greater than 10 per cent
- DHS concluded in 2006 that 23 public hospitals did not technically comply with the "going concern" test in the Australian accounting standards, including 9 major metropolitan hospitals, which account for over 60 per cent of the total turnover of all Victorian public hospitals.

Some of the above indicators have shown consistent unfavourable trends or results over the 6 years to 2006, such as working capital positions, cash holdings and operating results, pointing to some short-term solvency issues and also some longer-term financial sustainability challenges.

DHS and public hospital boards share the responsibility for financial performance and management within the sector. They have recognised the need to act on the financial challenges and have undertaken a number of initiatives to better manage the increasing demand for services and promote financial sustainability. These initiatives have included revised governance and accountability arrangements for metropolitan[1] and major regional public hospitals.

State budget funding of programs targeted at demand management and financial sustainability has contributed to this general improvement. However, this funding, a feature of State budgets both before and since the aggregate deficit position recorded by public hospitals in 2002-03, has reduced substantially since the 2004 financial year.

It is acknowledged that the full impact of some initiatives already underway will not be felt until future years. For example, the benefits of benchmarking will accumulate over time with greater refinement of data and use by the sector.

It is further acknowledged that, despite the financial condition of the sector, the Government has reported that public hospitals in aggregate have consistently met or exceeded the targets set for public hospital admitted acute patient separations included in the State budget papers over the 6-year period to 2006.

[1] Not all of these revised arrangements apply to the privately-owned denominational public hospitals.

1.2 Recommendation

That DHS 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
- build on, and expand, existing budgetary and management initiatives to establish greater financial sustainability across the sector. In particular, extend the explicit legislative responsibilities of boards and chief executive officers from certain designated public hospitals to all public hospitals[2]
- review the ongoing effectiveness of the initiatives undertaken to date.

RESPONSE provided by the Secretary, Department of Human Services

Recommendation 1

Agree.

The monitoring of hospital operating results and revenue and expenditure trends is a core activity of the department. The monitoring of these measures is subject to ongoing development and enhancement.

Recommendation 2

Agree.

The department agrees that to build on and expand budgetary and management initiatives is important. The department also agrees that rural boards and chief executives should have an explicit range of accountabilities to ensure they operate within budget, have accurate accounting systems and appropriate reporting and risk management systems are maintained. The department will continue to progress these accountabilities through board and management education programs and the enhancement of the existing Health Service Agreement processes already in place.

Recommendation 3

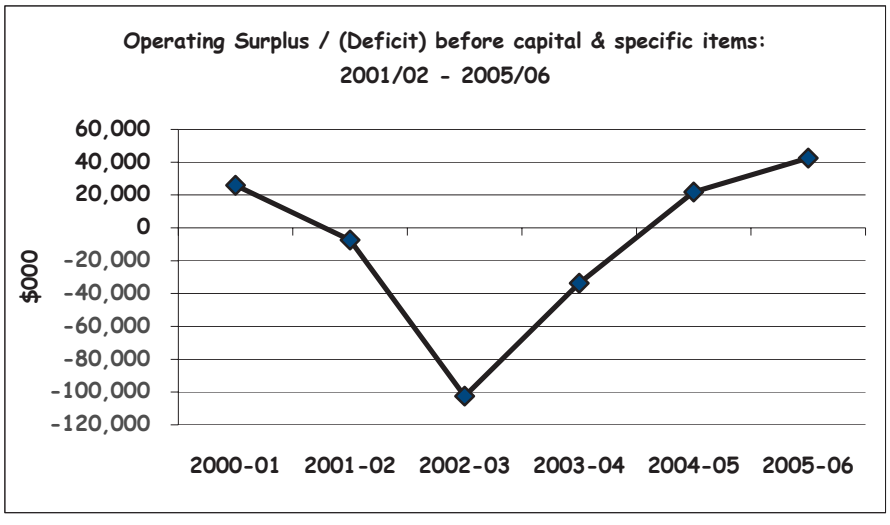
Agree.

[2] Excluding privately-owned denominational public hospitals.

RESPONSE provided by the Secretary, Department of Human Services - continued

The department concurs with the audit finding that the financial performance and position of public hospitals has generally improved, and acknowledges that there is more work to be done on health service cash positions and some individual health service operating positions.

The department believes that the key financial performance indicator is the aggregate health service operating result (before capital and specific items). On this key indicator a deficit of $102.5m in 2002/03 has been turned around to a surplus of $42.5m in 2005/06. The department does not agree that this is a "consistent unfavourable trend". The improvement since 2002/03 is also evident in the aggregated public hospital operating results and in the reduction in the number of hospitals with negative net operating cash flows.



FURTHER comment by the Auditor-General

The aggregated operating result for the sector does not provide information on the performance of individual public hospitals and is therefore not a useful indicator for that purpose. In our view a better indicator is the number of hospitals with operating deficits. Using DHS' operating result (before capital and specific items) there were 26 hospitals, or approximately ⅓ of all public hospitals with an operating deficit in 2005-06. In our view this is an unfavourable result (but a significant improvement on 2002-03). Our analysis of the frequency of public hospitals with an operating deficit (before abnormal items) is contained in Figure 3E.

2 About public hospital financial performance

2.1 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 work force supply issues.

Each of Victoria's 91 public hospitals[1] has a governing board accountable to the Minister for Health through DHS.

The *Health Services Act 1988* sets out the role of the boards, and of DHS' Secretary.

Consistent with the provisions of the *Health Services Act 1988*, public hospital boards and DHS share responsibility for financial performance and management within the sector.

DHS directly impacts on the financial performance of individual public hospitals in several ways. For example, DHS' funding and other decisions can affect hospital revenue and alter the cost structures of public hospitals[2].

Most public hospitals are also bound by the provisions of the *Financial Management Act 1994*. The Minister for Finance has issued standing directions requiring hospitals to implement and maintain appropriate financial management practices, and specifying high-level requirements for financial management (such as the requirement to appoint an audit committee to oversee and advise the hospital on matters of accountability and internal control).

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[1] This includes public hospitals, public health services (excluding Dental Health Services Victoria) and denominational hospitals as defined in the *Health Services Act 1988*.

[2] For example, during 2006 DHS, together with the Victorian Hospitals' Industrial Association, entered into a Heads of Agreement with the Australian Medical Association Victoria (AMA) in settlement of claims pursued by the parties in the 2006 Public Health Medical Workforce enterprise bargaining round. The Heads of Agreement incorporated changes to conditions and pay (including increases totalling 9.3 per cent over the first 12 months of the agreement) for the medical work force of hospitals. Consequently, when individual public hospitals entered into discussions with the AMA about the drafting of new workplace agreements, those agreements had to be consistent with the Heads of Agreement, and any proposed new workplace agreements are required by DHS to be subject to its review prior to finalisation with the AMA.

Each public hospital provides a different range of services depending on its location, size and particular community needs. Services include:

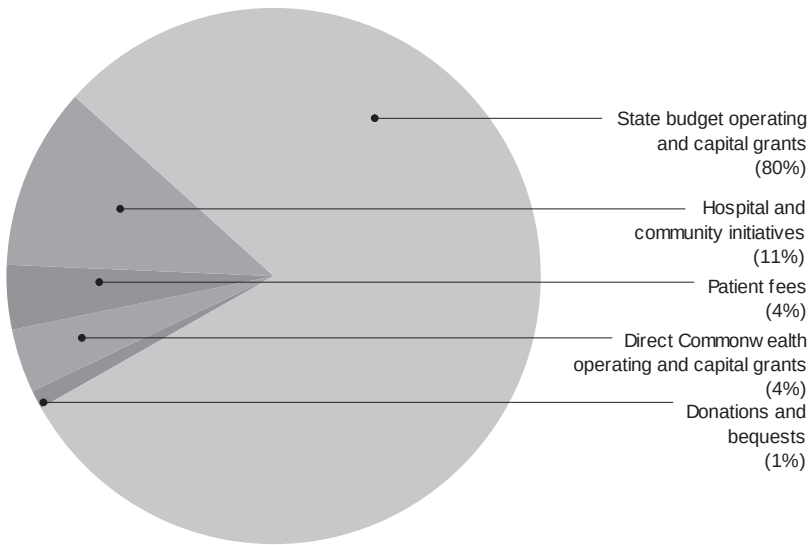
- acute services (including inpatient, ambulatory, emergency, community-based services and specialist services)
- sub-acute and non-acute services (such as rehabilitation or palliative care)
- emergency, outpatient and other services to non-admitted patients
- mental health services
- teaching and research activities.

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

Public hospital revenues

Figure 2A shows that the main source of public hospital revenue is Victorian Government funding (80 per cent), provided mainly for acute health services. The next most important revenue sources are hospital and community fundraising initiatives (11 per cent), patient fees (4 per cent) and direct Commonwealth grants (4 per cent).

Figure 2A
Key sources of Victorian public hospital revenue, 2005-06



Note: In 2005-06, around 65 per cent of grants from the government to public hospitals related to the provision of acute health services.

Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements.

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 receives. The model takes account of 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. For example, a hip replacement has a defined range of between 2 to 22 days under the casemix model[3], and the amount provided is fixed if the patient’s actual stay in hospital falls within this range. Consequently, while revenue is fixed, the costs of providing that service increases the longer the patient remains in hospital[4]. However, the model adjusts the amount provided if the patient’s stay in hospital falls outside of the nominated range.

Health services to be delivered each year are negotiated by hospitals with DHS and included in an annual health services agreement, or statement of priorities. This targeted level of service provision generally creates a funding cap[5], and public hospitals are not fully funded for any services provided that exceed the target by up to 2 per cent, and are not funded for any services provided beyond that level.

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[3] Refer to DHS’ publication *Victoria – public hospitals and mental health services Policy and funding guidelines 2006–07*.

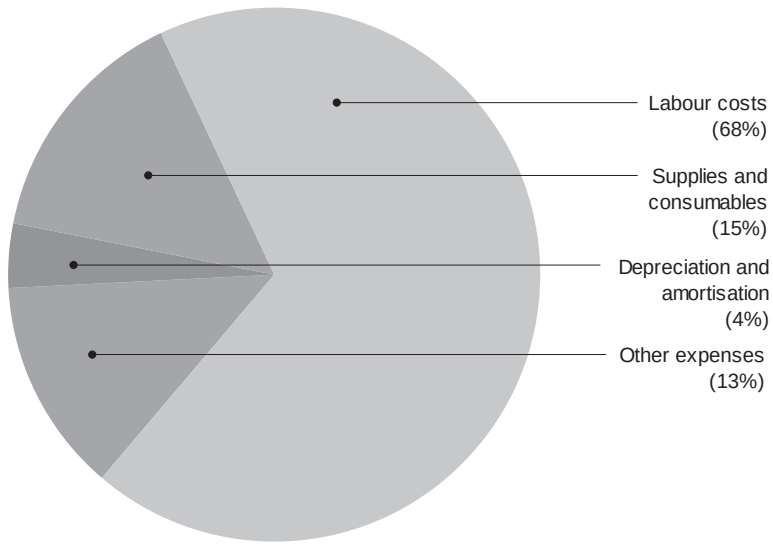
[4] The “casemix” model nominates a range of days for a patient’s stay in hospital for each acute health service, and those ranges extend from a total of 3 days for several services, up to 124 days for a heart transplant (which has a range of 15 to 139 days under the “casemix” model).

[5] Activity or funding caps are not placed on patients funded from other sources, such as those funded by the Commonwealth Department of Veterans’ Affairs and the Victorian Transport Accident Commission.

Public hospital expenditures

Figure 2B shows that the main item of public hospital expenditure is salaries and other labour costs (68 per cent). The next largest area of expenditure was supplies and consumables (15 per cent).

Figure 2B
Key items of Victorian public hospital expenditure, 2005-06



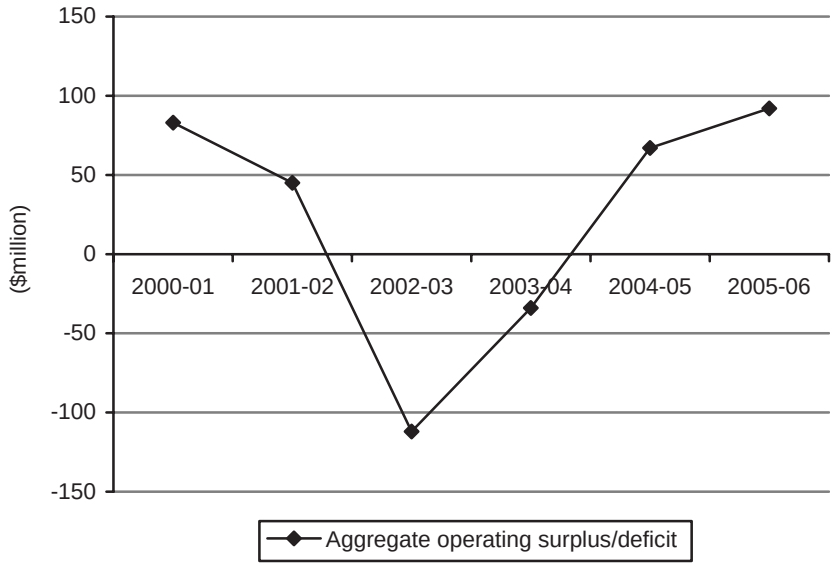
Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements.

Public hospital operating results

One key indicator of financial viability is the annual operating result[6] – the difference between annual expenses and revenues. In the Victorian context, for the 2002-03 financial year, there was a significant downturn in the combined operating result for the public hospital sector as a whole.

Figure 2C shows the aggregated operating result for public hospitals since 2000-01. By 2002-03, total expenditure for all hospitals was some $110 million more than total income – but by 2005-06, total revenue exceeded total expenditure by $92 million[7].

Figure 2C
Aggregate public hospital operating results



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (comprising operating result before abnormal items, such as non-current asset valuation adjustments).

[6] Comprising the operating result before abnormal items, such as non-current asset valuation adjustments.

[7] This does not mean that all public hospitals had operating surpluses in 2005-06, or that all public hospitals had operating deficits in 2002-03. Rather, in both years, there was a mix of operating deficits and surpluses.

Financial management and governance reform initiatives

A number of initiatives were introduced during 2003 and 2004 aimed at strengthening governance and financial management within the sector, and at improving public hospital financial performance. These included:

- State budget funding initiatives to improve public hospital demand management and financial sustainability
- formation of the Victorian Public Hospital Governance Reform Panel during 2003, with the following terms of reference*:*
  - to propose ways of strengthening the capacity of boards of governance responsible for metropolitan and major regional hospitals
  - to develop a framework for balancing governance autonomy with accountability to the minister
  - to assess the adequacy of current administrative and legislative provisions for ensuring timely and reasonable action can be taken by the minister and DHS to ensure performance of health services
  - to propose administrative, legislative or regulatory changes to give effect to the new framework.

Against this background we examined the current financial position and financial performance of public hospitals.

2.2 Audit objective and scope

The overall objective of the audit was to assess whether Victoria's public hospitals are financially sustainable.

Financial sustainability is a concept that relates both to the ability to satisfy current demand and meet near-term financial obligations, as well as the ability to respond to future demand and longer-term obligations.

In assessing whether public hospitals are financially sustainable, we:

- assessed the current position, and recent trends, in financial indicators of short-term solvency and longer-term viability
- considered progress by DHS and hospitals in implementing financial management and governance reform initiatives.

Audit approach

DHS is the lead government agency responsible for strategic planning, leadership and oversight of Victoria's public hospitals.

The audit included both DHS and 91 public hospitals, including denominational hospitals (which are privately-owned). The audit did not include ambulance services, some community health services or dental health services.

The audit was performed in accordance with Australian auditing standards.

The total cost of this audit, including the preparation and printing of this report, was $250 000.

3 Are public hospitals financially sustainable?

At a glance

Background

The financial viability of its public hospital system is one of the State's key risks. Victoria's public hospitals had an annual turnover in excess of $7 billion in 2005-06 and managed assets totalling some $7 billion at June 2006.

Key findings

Overall, we found that since 2002-03, a period of significant financial challenge for public hospitals, the financial performance and position of public hospitals has generally improved. This improvement was characterised by a slow down in expenditure, in real terms, relative to demand.

Nevertheless, several significant indicators of continuing financial challenge remain. Some of the indicators have shown consistent unfavourable trends or results over the 6 years to 2006, such as working capital positions, cash holdings and operating results. These point to short-term solvency issues, and longer-term financial sustainability challenges.

Recommendation

That DHS 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.

In assessing the financial position and performance of public hospitals, we examined both short-term (solvency) and long-term (viability) financial indicators. These indicators should be considered collectively, and are more useful when assessed over time as part of a trend analysis rather than at a point in time.

3.1 Short-term indicators

Short-term indicators relate to the ability of an entity to meet financial obligations on hand, and new obligations as they arise within 12 months. These indicators relate primarily to liquid assets (cash flows and cash reserves) as well as those assets and liabilities that will be converted into cash flows over the next business cycle (referred to as current assets and liabilities).

We used the following indicators to assess short-term solvency:

- net operating cash flows
- cash reserves
- current asset ratios.

These indicators were selected because they are generally accepted, and commonly used by financial analysts, as key relevant indicators of viability.

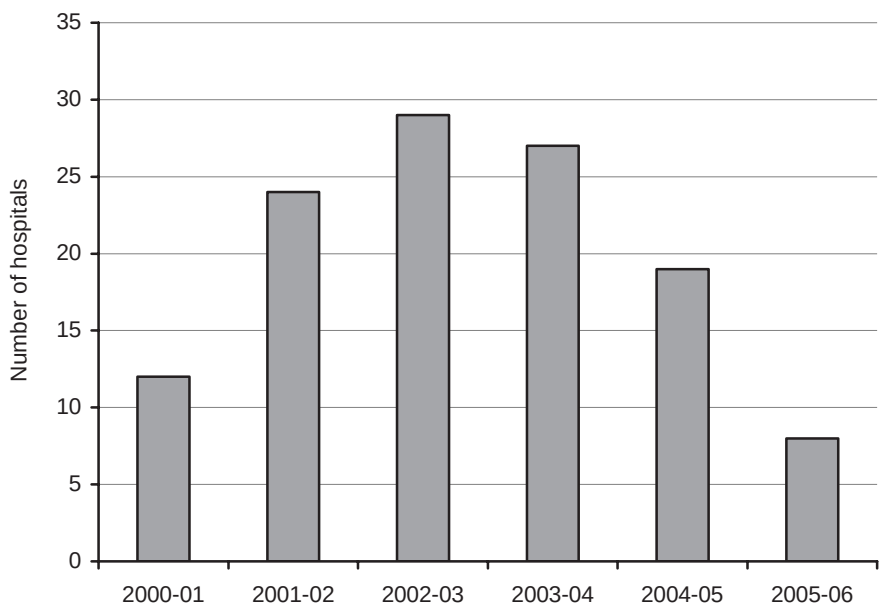
3.1.1 Do hospitals generate enough cash from their own operations?

"Net operating cash flow" is an indicator of whether public hospitals' cash inflows from operating activities are sufficient to at least cover their operating cash outflows. This indicator should always be above break even over time, otherwise an entity would not be able to meet its operating obligations.

Ordinarily, entities seek to have a reasonable excess of operating cash inflows over outflows, which they accumulate over time and can use to replace old assets and invest in new assets. Under the "casemix" funding model, separate "capital" funding (in the form of grants or capital injections) is provided by the Department of Human Services (DHS) for asset acquisition. In our analysis, we have excluded cash inflows that relate to capital grants received in order to isolate the net operating cash result (we use another long-term financial indicator to assess the adequacy of asset acquisitions by hospitals later in this report).

Figure 3A shows the number of public hospitals which had negative net operating cash flows (before capital grants). These hospitals did not receive sufficient cash from their operating activities in the year to cover their operating cash outlays for that year. They, therefore, had to use previously accumulated cash reserves (or funds from capital grants) in the short term to meet some of their outlays.

Figure 3A
Public hospitals with negative net operating cash flows



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (comprising net operating cash flows before capital grants).

The overall trend in net operating cash flows (before capital grants) has been positive over the past 3 years, both in terms of the decrease in the number of hospitals with negative operating cash flows and the amounts involved. In 2002-03, 29 hospitals (32 per cent) had combined negative operating cash flows of $115 million, compared with 8 hospitals (9 per cent) with combined negative operating cash flows of $2 million in 2005-06.

We would expect, however, that all hospitals should be able to generate positive net operating cash flows, before capital grants (or at least break even) each year.

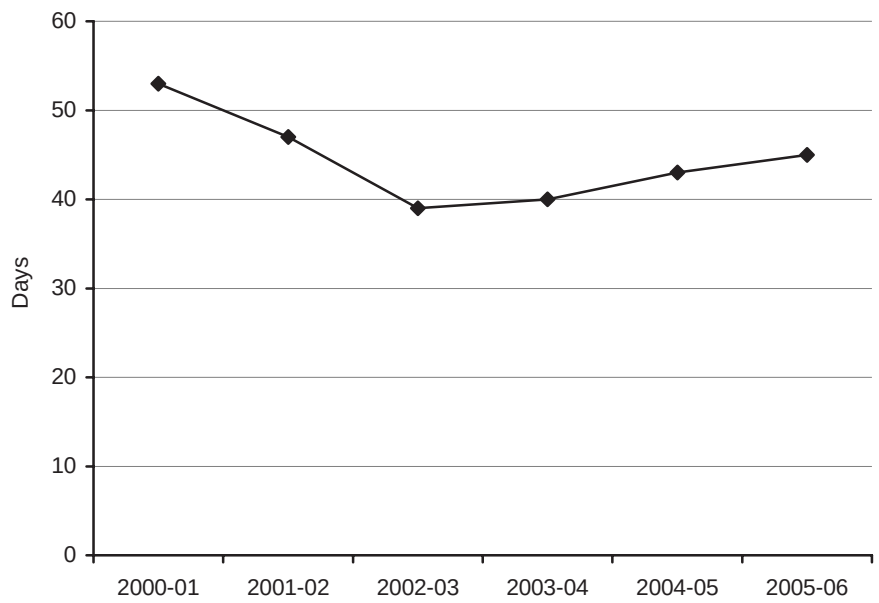
3.1.2 Do hospitals hold enough cash reserves to meet immediate operating cash requirements?

Aggregate cash holdings of public hospitals had trended downwards prior to the aggregate deficit position in 2002-03, and subsequently began to climb.

One way to put these holdings into context is to estimate the number of days of operating activities they can fund. Figure 3B shows that the average cash available at year end to cover operating cash outflows trended downwards from 2001 to 2003, but has increased since that time.

In 2005-06, hospitals had, on average, cash reserves equivalent to 45 days cash outflows; in 2000-01, they had 53 days cover.

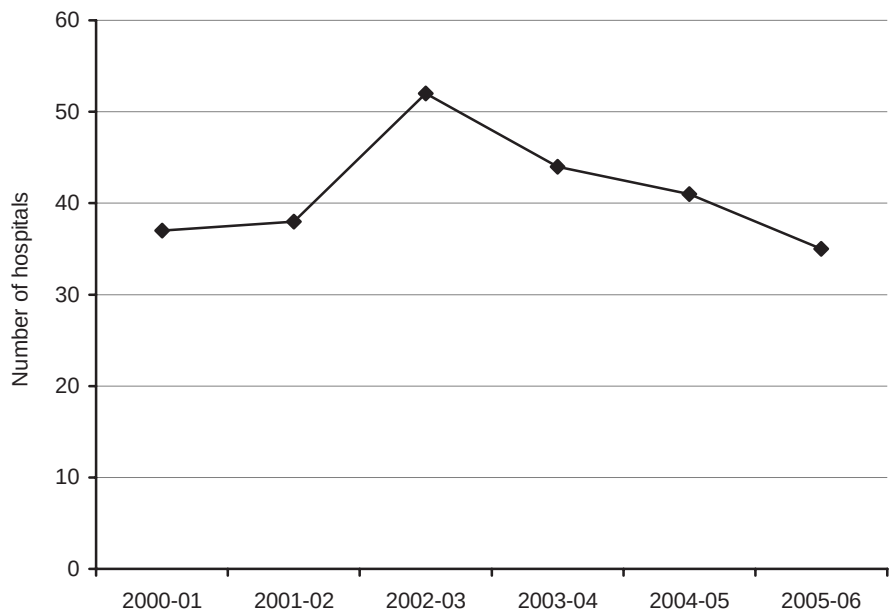
Figure 3B
Average number of days' cash available to cover operating cash outflows of public hospitals



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements.

Figure 3C shows the number of public hospitals with the equivalent of less than one month's cash holdings available at year-end. Again, after 2002-03, the negative trend has reversed but at 30 June 2006, 35 hospitals (representing around 38 per cent of the State's public hospitals) had cash holdings equivalent to less than one month's operating cash outflows, similar to the position in 2000-01. This includes 9 major metropolitan public hospitals.

Figure 3C
Public hospitals with less than 30 days cash available to cover operating cash outflows



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (comprising cash and cash equivalent current assets and gross operating cash outflows).

Some cash holdings are held for restricted or specific purposes and ideally should not be used to fund day-to-day operating activities (particularly where there are externally imposed restrictions). Of the 9 major metropolitan hospitals with low cash holdings at 30 June 2006, 4 had restricted purpose reserves that were greater than, or about equal to their cash holdings. In effect, they had no unrestricted liquid assets at balance date to meet operating cash outflows. A further 2 had other less liquid financial instruments to call upon in the event of a cash shortage.

Similarly, if a public hospital's cash holdings at balance date includes unspent capital grant funding, then the cash available for day-to-day operating activities will appear higher than would otherwise be the case. This can occur where capital grant funding is received late in the financial year.

We would normally expect that all hospitals would retain sufficient unrestricted cash holdings to meet at least one month's operating cash outflows in accordance with prudent financial management practices. There would normally be no need to temporarily or permanently "dip into" restricted cash holdings to meet operating commitments.

Of the 35 hospitals with less than one month's cash holdings, 14 (including some major metropolitan public hospitals) had less than 15 days' cash cover at 30 June 2006.

3.1.3 Do hospitals have sufficient working capital?

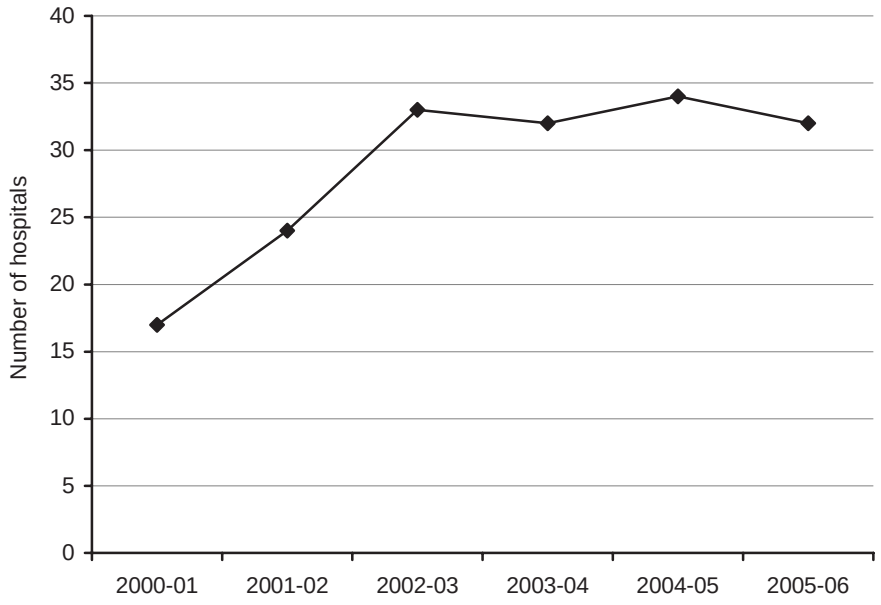
Working capital is the difference between current assets (such as cash, short-term investments and debtors) and current liabilities (such as creditors and short-term employee benefits[1]). It is a measure of an entity's ability to meet its near-term obligations (that is, those falling due within 12 months).

A working capital ratio in excess of 1:1 indicates that an entity has generated sufficient short-term assets from its operations to meet the short-term liabilities[2] it has incurred from past operations.

Figure 3D shows that the number of hospitals with negative working capital positions (current liabilities greater than current assets) increased in the period to 2003, and has been fairly constant since that time (ranging from 32 to 34 hospitals).

Prudent financial management would suggest that the current assets of all 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 commitments.

Figure 3D
Public hospitals with a negative working capital ratio



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (excluding, for example, long-term employee benefits, that is those benefits falling due beyond 12 months, which form part of current liabilities).

[1] This excludes long-term employee benefits classified as current liabilities for financial reporting purposes.

[2] That is, excluding long-term obligations, such as certain employee benefits, which form part of current liabilities under Australian equivalents to International Financial Reporting Standards.

3.1.4 Our conclusion on short-term viability indicators

Our analysis shows that while there has been a positive trend in key indicators of short-term solvency across the sector in the past 3 years, there remains a significant number of hospitals that operate on very low cash holdings. Conversely, some other public hospitals had substantially higher cash holdings, which also requires careful management. Further, over a third of hospitals had higher current liabilities[3] than current assets. Hospitals in this category must rely on new funds generated in the next year or past cash holdings to meet some of their existing short-term obligations, before they can apply them to meet new obligations.

3.1.5 What was DHS' short-term assessment at June 2006?

During 2006, DHS concluded that 23 public hospitals did not technically comply with the going concern test in the Australian accounting standards. Consequently, DHS 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 2007, should this be required. Those hospitals, including 9 major metropolitan hospitals, account for over 60 per cent of the total turnover of all Victorian public hospitals.

3.2 Longer-term indicators

The indicators we used that deal with longer-term financial viability are:

- the annual operating result (the difference between income and expenditure)
- the asset renewal gap (the difference between the amount of investment required and the actual amounts spent on replacing or renewing existing assets).

3.2.1 Are hospitals consistently making operating surpluses?

The overall operating result is a key indicator of financial health.

It is not unexpected that some public hospitals record operating deficits in some years. This is partly because the "casemix" funding model does not take account of non-cash expenditure, such as depreciation and amortisation. Conversely, funds for asset acquisition (such as for major equipment purchases and the redevelopment of buildings) are provided as annual grants, and can form part of operating revenue in the year of receipt[4].

[3] That is, excluding long-term obligations, such as certain employee benefits, which form part of current liabilities under Australian equivalents to International Financial Reporting Standards.

[4] This approach enables DHS to manage the allocation of capital funds across the sector, rather than making "casemix" payments on a full cost basis and, thereby, allowing individual hospitals to make decisions concerning their capital needs and spending priorities.

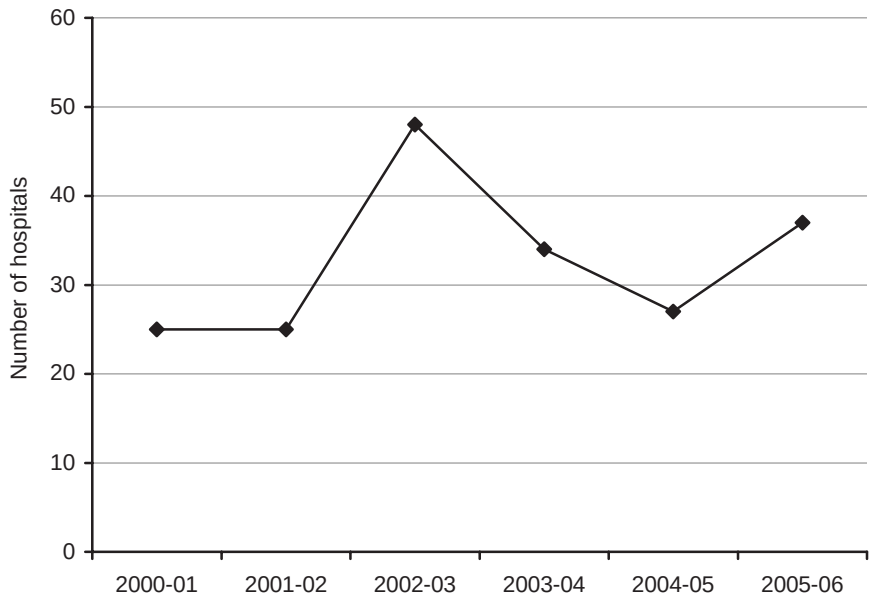
Over time, however, total revenue whatever the source must equal or exceed total expenditure, or an entity will not be able to sustain its operations.

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 maintenance, may be deferred or abandoned should deficits persist over an extended period.

Earlier in this report, Figure 2C showed the recent improvement in public hospitals' aggregate operating result since the aggregate deficit position recorded in 2002-03.

Figure 3E shows that the number of public hospitals with operating deficits (before abnormal items)[5] peaked in 2002-03 (comprising 48 hospitals). While this number initially fell after 2002-03, it has started to climb again in 2005-06 with 37 public hospitals still having operating deficits (before abnormal items). Consequently, a significant number of hospitals experienced operating deficits during the 6-year period set out in Figure 3E.

Figure 3E
Public hospitals with an operating deficit
(before abnormal items)



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (before abnormal items, such as non-current asset valuation adjustments).

[5] In our analysis we have excluded abnormal items in order to isolate the net operating result.

In absolute dollar terms, the operating results of 6 major metropolitan public hospitals (Austin Health, Bayside Health, Melbourne Health, Southern Health, Western Health, and Women's and Children's Health, now disaggregated and known as the Royal Children's Hospital and Royal Women's Hospital) have the greatest impact on the aggregated result for the sector.

However, from the viewpoint of financial viability, of more significance is the relative size of the operating deficit to each hospital's turnover. A relatively large deficit, when expressed as a proportion of total revenue, is a greater cause for concern as the hospital has less ability to continue to absorb and sustain such results.

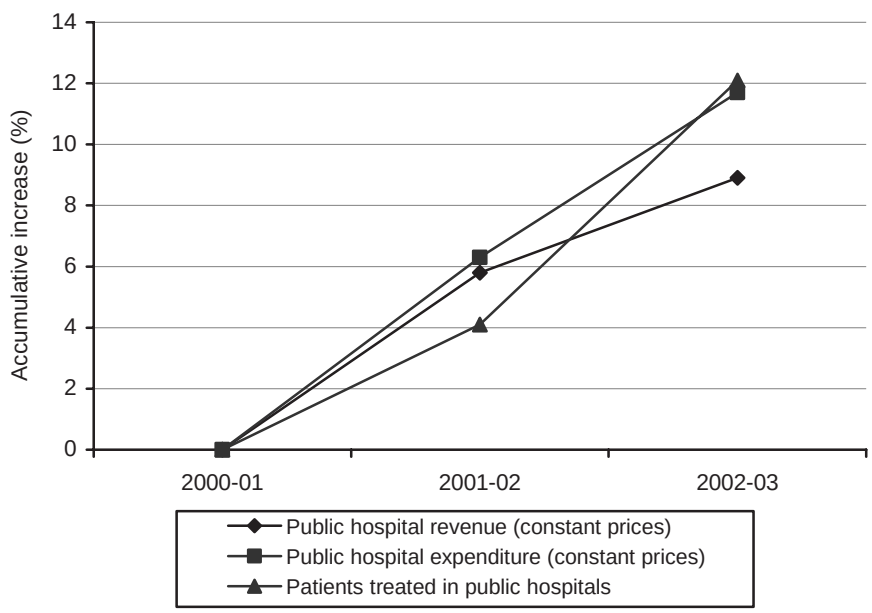
Our analysis indicates that 6 hospitals at 30 June 2006 (14 at 30 June 2003) had an operating deficit greater than 5 per cent of total revenue (before abnormal items).

To better understand the reported operating results, it is appropriate to also consider trends in the underlying operating income (excluding capital grants[6]) and expenditure of hospitals.

Figure 3F shows in the lead-up to the aggregate deficit position in 2002-03, that public hospital expenditure was increasing, in real terms, in line with the increase in the number of acute patients treated. However, the rate of increase in public hospital revenue had not kept pace, in real terms, with the rate of increase in the number of acute patients treated in public hospitals.

[6] In this part of our analysis we have excluded capital grants and will separately consider the adequacy of capital spending by hospitals later in this report, using another long-term indicator focused on asset renewal.

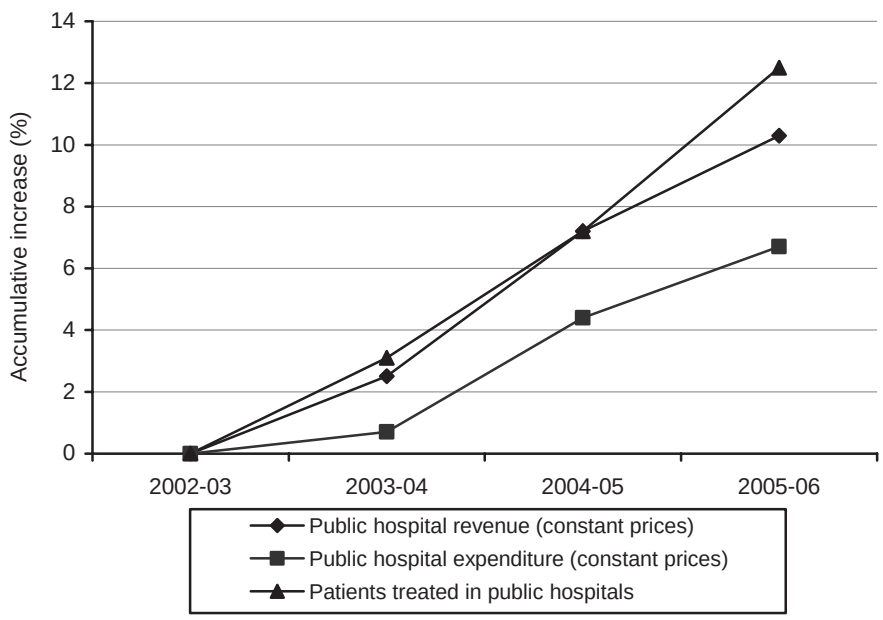
Figure 3F
Trends in public hospital revenue, expenditure and patients, 2000-01 to 2002-2003



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (comprising acute and non-acute revenue and expenditure before abnormal items, such as non-current asset valuation adjustments, and excluding capital grants), the State budget papers (public hospital admitted acute patient separation data - unaudited), the wage price index for the health and community services industry (published by the Australian Bureau of Statistics) and non-wage indexation identified in the Paxton Partners' review of hospital cost drivers and non-wage indexation (commissioned by DHS).

Figure 3G shows that since 2002-03, the increase in total public hospital revenues initially kept pace, in real terms, with the increase in the number of acute patients in 2004-05. But in 2005-06, it has again begun to fall behind. Figure 3G also shows that the rate of increase, in real terms, in public hospital expenditure had slowed when compared with the increase in the number of acute patients treated in public hospitals.

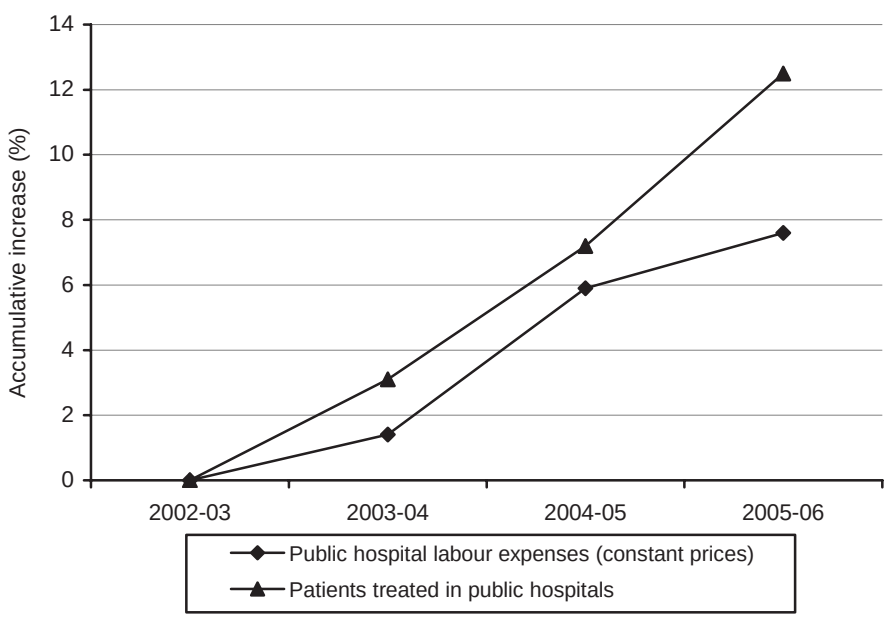
Figure 3G
Trends in public hospital revenue, expenditure and patients, 2002-03 to 2005-06



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (comprising acute and non-acute revenue and expenditure before abnormal items, such as non-current asset valuation adjustments, and excluding capital grants), the State budget papers (public hospital admitted acute patient separation data - unaudited), the wage price index for the health and community services industry (published by the Australian Bureau of Statistics) and non-wage indexation identified in the Paxton Partners' review of hospital cost drivers and non-wage indexation (commissioned by DHS).

Figure 3H, consistent with Figure 3G expenditure trends, shows that the rate of increase, in real terms, in public hospital labour expenditure had also slowed when compared with the increase in the number of acute patients treated in public hospitals.

Figure 3H
Trends in public hospital labour expenditure and patients



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements (comprising acute and non-acute labour expenditure), the State budget papers (public hospital admitted acute patient separation data - unaudited) and the wage price index for the health and community services industry (published by the Australian Bureau of Statistics).

The aggregate trends in public hospital expenditure, set out in Figures 3G and 3H, are positive when considered in real terms (constant prices) and in the light of increasing demand. However, trends in revenue show that it has not kept pace, in real terms, with increasing demand. Consequently, the recent overall improvement in the aggregate operating result recorded by public hospitals was characterised by a slowdown in the rate of growth of expenditure.

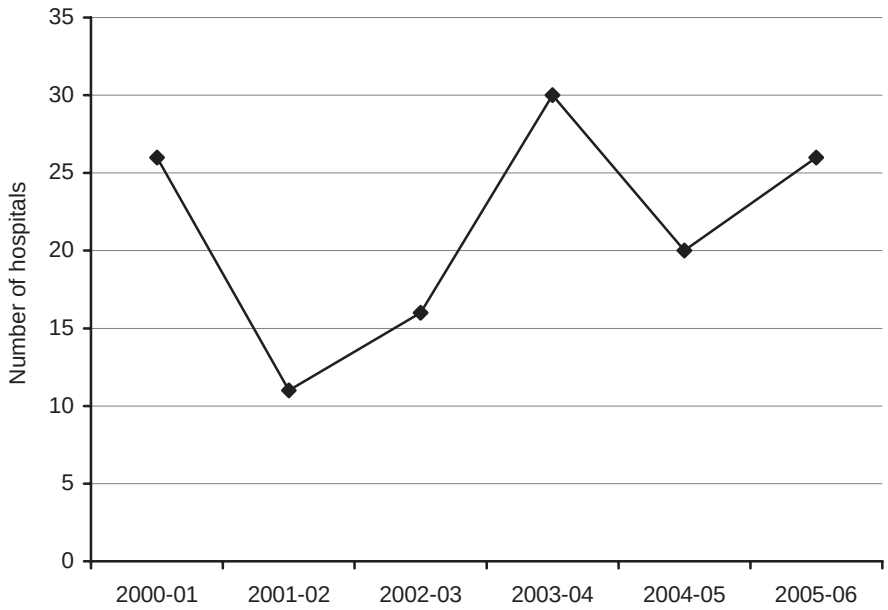
3.2.2 Are hospitals replacing their existing assets as quickly as they are being used up?

One broad indicator of the adequacy of asset renewal is whether spending on the acquisition of fixed assets (such as property, plant and equipment) is at a greater level than the rate at which existing assets are depreciating. It is a longer-term indicator, because capital spending can often be deferred if there are insufficient funds available from operations, and borrowing is not an option.

Over the period 2001 to 2006, aggregate hospital spending (comprising investing cash outflows) on property, plant and equipment has consistently and significantly exceeded aggregate depreciation and amortisation. However, this aggregate position is not representative of the position at many hospitals, and in part may be misleading, as spending on property includes new and expanded facilities which are in addition to existing facilities rather than replacing them.

Figure 3I shows the volatility in the number of public hospitals whose depreciation and amortisation expense is greater than their spending (comprising investing cash outflows) on property, plant and equipment (which includes spending on new and expanded facilities, not just asset renewal). In 2005-06, 26 hospitals had a higher depreciation expense, suggesting an underspending on asset renewal. Of those hospitals, 24 had depreciation exceeding spending on property, plant and equipment by greater than 10 per cent, and 2 of these hospitals were major metropolitan hospitals.

Figure 3I
Public hospitals with depreciation and amortisation expense exceeding spending (comprising investing cash outflows) on property, plant and equipment



Source: Victorian Auditor-General's Office, based on public hospitals' audited financial statements.

It should be noted that the asset spending data (comprising investing cash outflows) used in Figure 3I includes spending on new and expanded facilities. As a result, the true level of underspending on renewing existing assets is likely to be understated. The results, nevertheless, remain indicative and identify a key challenge for DHS and several hospitals.

3.2.3 Conclusion on longer-term indicators

As noted, it is expected that some hospitals will have operating deficits in some years, partly because the "casemix" model does not provide funding for non-cash expenditure, such as depreciation and amortisation, and partly due to the allocation of capital funding by DHS. Nevertheless, a significant number of hospitals experienced operating deficits during the 6-year period ending June 2006.

Our analysis of the operating results of hospitals indicate that while expenditure growth in real terms has been constrained relative to demand, future operating results may be at risk due to the slow down in the growth of revenue in real terms relative to demand.

Of concern, also, is the indication that the rate of asset renewal is falling behind the rate of consumption of existing assets.

Recommendation

3.1 That DHS and 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 which build on those considered in this report.

4 What has been the progress of financial management initiatives?

At a glance

Key findings

The Department of Human Services (DHS) and public hospital boards share the responsibility for financial performance and management within the sector. They have recognised the need to act on the financial challenges and have undertaken a number of initiatives to better manage the increasing demand for services and promote financial sustainability. The full impact of some initiatives already underway will not be felt until future years.

Despite the financial condition of the sector, the Government has reported that public hospitals in aggregate have consistently met or exceeded the targets set in the State budget papers for the number of acute patients treated over the 6 year period to 2006.

Recommendation

That DHS and public hospitals continue to:

- build on, and expand, existing budgetary and management initiatives to establish greater financial sustainability across the sector. In particular, extend the explicit legislative responsibilities of boards and chief executive officers from certain designated public hospitals to all public hospitals[1]
- review the ongoing effectiveness of the initiatives undertaken to date.

[1] Excluding privately-owned denominational public hospitals.

State budget funding initiatives

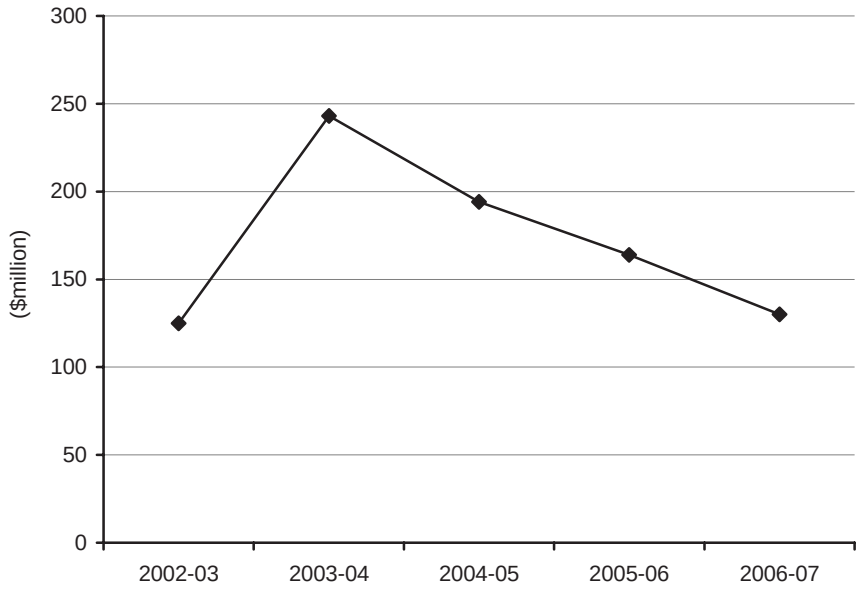
Budget funding initiatives, targeted at improved public hospital demand management and financial sustainability, have been a feature of State budgets both before and since the overall deficit position recorded by public hospitals in 2002-03.

A departmental review, conducted during 2003-04 (the "Hospital Price and Resource Allocation Review"), identified some areas of under funding of public hospitals which impacted directly on the budget funding initiatives.

Figure 4A sets out the movement in the nominal value of the additional funds provided since 2002-03.

We found that some budget funding initiatives were expended in the year/s prior to the respective budget announcement[2]. Consequently, Figure 4A does not directly reconcile to the output funding initiatives announced in the respective budget papers. It would assist readers of the budget papers if they identified any budget funding initiatives which had been expended in prior years.

Figure 4A
Public hospital demand management and financial sustainability budget funding initiatives



Source: Victorian Auditor-General's Office, based on the State budget papers (in nominal dollar terms).

[2] For example, the 2004-05 Budget identified funding initiatives for public hospital demand management and financial sustainability totalling $333 million for that year, of which $32 million had been expended in prior financial years and had also been included in the 2003-04 Budget. Of the remaining $301 million, $107 million had been expended in 2003-04, leaving a total of $194 million expended in 2004-05.

The budget initiatives also do not represent a significant percentage of total acute health funding and, as demonstrated in Figure 4A are trending downwards. Nevertheless, the additional funding has contributed positively to the "bottom line" financial performance of public hospitals.

However, as we noted previously in this report, the rate of increase in total public hospital revenue up to 2006 has not kept pace, in real terms, with the rate of increase in the number of acute patients treated in public hospitals.

Victorian Public Hospital Governance Reform Panel initiatives

In 2003, the Victorian Public Hospital Governance Reform Panel recommended several measures to improve the accountability, governance and performance of the then 15 metropolitan and 5 major regional hospitals[3].

The report of the reform panel resulted in (among other things) amendments to the *Health Services Act 1988* designed to:

- clarify financial management roles and responsibilities of some key stakeholders
- require statements of priorities, detailing financial and activity targets, to be prepared by certain hospitals.

Roles and responsibilities

Figure 4B shows an extract of the respective roles and responsibilities, related to financial management, of boards and chief executive officers for metropolitan and the 5 major regional public hospitals, and for the secretary of DHS, specified under the Act.

[3] *Victorian Public Hospital Governance Reform Panel Report* 2003, Victorian Public Hospital Government Reform Panel, DHS, Melbourne.

Figure 4B
Metropolitan and 5 regional public hospital, and DHS, financial management roles and responsibilities – Health Services Act 1988

Position	Financial management roles and responsibilities

Board	• Develop statements of priorities and strategic plans, and to monitor compliance with those statements and plans.
	• Develop financial and business plans, strategies and budgets to ensure the accountable and efficient provision of health services and the long-term financial viability of the hospital.
	• Monitor the performance of the hospital to ensure that:
	  • it operates within its budget
	  • its audit and accounting systems accurately reflect the financial position and viability of the hospital
	  • it adheres to its financial and business plans, strategic plans and statements of priorities.
	  • effective and accountable risk management systems are in place.
	• Monitor the performance of the chief executive officer, each financial year, having regard to the objectives, priorities and key performance outcomes specified in the statement of priorities.
	• Establish a finance committee and an audit committee.
	• Provide appropriate training for directors.

Chief executive officer	• Manage the hospital in accordance with:
	  • the financial and business plans, strategies and budgets developed by the board
	  • the instructions of the board.
	• Prepare material for consideration by the board, including statements of priorities, strategic plans, business plans, strategies and budgets.
	• Ensure that the board and the committees established by the board are assisted and provided with relevant information to enable them to perform their functions effectively and efficiently.
	• Ensure that the board's decisions are implemented effectively and efficiently throughout the hospital.
	• Inform the board in a timely manner of any issues of public concern or risks that affect or may affect the hospital.

Secretary, Department of Human Services	• Fund or purchase health services and monitor, evaluate and review publicly funded or purchased health services. • In consultation with health care agencies, develop criteria or measures that enable comparisons to be made between the performance of health care agencies providing similar services. • Collect and analyse data to enable the secretary to perform the secretary's functions under this or any other Act.

Source: Victorian Auditor-General's Office, based on the *Health Services Act 1988*.

We found the legislative amendments to the *Health Services Act 1988* have resulted in clarification of the legislative roles and responsibilities of the boards and chief executive officers for the metropolitan (currently 12 hospitals in all, excluding the denominational hospitals[4]) and the 5 major regional hospitals, and of DHS.

The Act sets out clear and extensive responsibilities for the boards and chief executive officers of these hospitals, with explicit reference to their responsibilities for the efficient operation of the relevant hospitals, and associated financial position and viability.

However, the Act only overviews at a very high level, the role of the boards (but not chief executive officers), of the remaining public hospitals (totalling some 70 hospitals)[5]. Consequently, the Act, while explicit with respect to the role of the metropolitan and 5 regional hospitals, does not prescribe similarly explicit or equivalent responsibilities for the boards and chief executive officers of the majority of public hospitals.

The metropolitan and 5 regional hospitals manage approximately 75 per cent of the total turnover of all public hospitals. Nevertheless, the remaining public hospitals have annual turnovers ranging up to $80 million, with the top 31 of these hospitals having annual turnovers in excess of $10 million (excluding the privately-owned denominational hospitals)[6].

DHS ran the Rural Health Boards of Management Development Program during 2006 for members of boards of all rural health agencies. The program was designed to help members of boards of rural health agencies to become more accomplished, by clarifying the roles and responsibilities of board members, strengthen the capacity of boards to operate as high performing teams and improve how boards work with management teams. A supporting website has also been established specifically for the program, providing reading and learning materials, reference notes and links to useful websites.

DHS has also put arrangements in place to provide training for the boards of all public hospitals (excluding denominational public hospitals) over a 3-year period ending September 2009.

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[4] St Vincent's Hospital (Melbourne) Limited, St George's Health Service Limited, Mercy Public Hospitals Incorporated, O'Connell Family Centre (Grey Sisters) Incorporated, Caritas Christi Hospice Limited and Calvary Health Care Bethlehem Limited.

[5] The *Health Services Act 1988* prescribes that the role of these hospital boards is to oversee and manage the hospital, and to ensure that the services provided by the hospital comply with the requirements of the Act and the objects of the hospital.

[6] Based on public hospitals' audited 2005-06 financial statements.

Statements of priorities

The legislative amendments also required (from July 2004) each metropolitan and the 5 major regional hospitals, and the denominational hospitals, to prepare an annual statement of priorities outlining its main financial and activity targets for the year. The statements must be agreed with the Minister for Health. DHS monitors the performance of those hospitals against the financial and activity targets on a monthly basis.

In addition, DHS also introduced enhanced performance monitoring frameworks for all public hospitals and financial recovery plans for public hospitals in financial difficulties, following the reform panel's report.

Rationalisation of reporting requirements

The reform panel identified a need for DHS to rationalise its reporting requirements from hospitals. In this regard, we found that DHS has established the Data Management Advisory Committee (DMAC), which includes public hospital representatives to review all data collection activities.

In the initial 12 months of DMAC's operation (ending June 2006), approximately 16 per cent of data collection reports were retired. Further reduction of the reporting burden on hospitals is also expected to arise from the implementation of the Health and Aged Care Information Management Strategy. This strategy is working to complement other initiatives to ensure that, wherever possible, data is extracted from existing business systems rather than requiring specialised collection reports within hospitals.

Other initiatives

Other initiatives that were undertaken during 2003 and 2004, and which aim to strengthen the governance and management regime within the sector, and improve public hospital financial performance, have included:

- a common chart of accounts, being progressively introduced in public hospitals from 2003, to enable more consistent and accurate financial reporting, improve the measurement of financial performance and assist benchmarking between public hospitals
- DHS convening monthly forums for public hospitals' chief executive officers and providing them with benchmarking information that enables hospitals to compare themselves with other comparable hospitals. Other forums are also convened by DHS for board chairpersons (bi-monthly meetings with the Minister for Health) and chief financial officers (monthly)
- a 6-year (2003- 2009) Health*SMART* technology program, comprising a strategy for the modernisation and replacement of information technology infrastructure within the public health care system. It aims to improve patient care, reduce the administrative burden on health care professionals and ease the costs associated with updating technological infrastructure. We are undertaking a separate audit of the progress and management of this program, the results of this audit will be included in a subsequent report to Parliament

- other independent reviews were undertaken around that time to advise DHS and public hospitals about the causes of financial difficulties and to recommend financial recovery plans.

Our review of a sample of public hospitals (including metropolitan, major and medium regional hospitals, and small rural hospitals) found:

- new board members were provided with information about their roles and responsibilities and about their particular hospital (which can include induction packages with information about good governance principles and practices), and undertook board orientation activities (such as site tours and meetings with senior managers, the chief executive officer and board chairperson)
- all had 3-year strategic plans (some of which included financial recovery and sustainability strategies)
- financial performance reporting to boards, board sub-committees and senior management was transparent and prepared in a timely manner (the sophistication of this reporting varied between the examined hospitals)
- there were clearly defined accountabilities for preparing, meeting and monitoring budgets. While most of the hospitals examined only prepared 12-month operating budgets, some did prepare 3-year budgets
- a range of cost saving and/or revenue maximisation (including fundraising) initiatives have been undertaken by individual public hospitals.

Conclusion on progress of financial management reform

DHS and hospitals have recognised the need to act on the financial challenges and, since 2003, a number programs or initiatives, consistent with the recommendations of the reform panel, have been implemented by DHS, individual hospitals and/or industry bodies.

These initiatives have enhanced or promoted better financial management within the public hospital sector.

It is acknowledged that the full impact of some initiatives already underway will not be felt until future years, for example the benefits of benchmarking will develop further over time with greater refinement of data and use by the sector.

Recommendation

4.1 That DHS and public hospitals continue to:

- build on, and expand, existing budgetary and management initiatives to establish greater financial sustainability across the sector. In particular, extend the explicit legislative responsibilities of boards and chief executive officers from certain designated public hospitals to all public hospitals[7]
- review the ongoing effectiveness of the initiatives undertaken to date.

[7] Excluding privately-owned denominational public hospitals and excluding the requirement to prepare a statement of priorities.

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2006-07

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