No

1981-82

PARLIAMENT OF NEW SOUTH WALES

SECOND REPORT

OF THE

PUBLIC ACCOUNTS COMMITTEE

OF THE

FORTY-SEVENTH PARLIAMENT

(INQUIRY INTO REFERENCE MADE BY THE MINISTER FOR HEALTH TO THE COMMITTEE UNDER THE PROVISIONS OF SECTION 16 OF THE AUDIT ACT, 1902)

ORDERED TO BE PRINTED, FEBRUARY, 1982

MEMBERS OF THE COMMITTEE

MR M.R. EGAN, B.A, M.P. (Chairman)

MR N.G. GREINER, M.P.

MR J.C. BOYD, M.P.

MR S.T. NEILLY, M.P.

MR T.S. WEBSTER, M.P.

CONTENTS

CHAIRMAN'S FOREWORD

The Public Accounts Committee has existed for eighty years, yet this is the first occasion that the Committee's powers under Section 16 (a) of the Audit Act, 1902, have been invoked.

Those powers are "to enquire into and report to the Legislative AsseMbly upon any question which may have arisen in connection with the Public Accounts, and which may have been referred to the Committee either by a Minister of the Crown or by the Auditor-General or by a resolution 'of the Legislative Assembly ...".

As the Progress Report of the Joint Committee upon Public Accounts and Financial Accounts of Statutory Authorities commented, the fact that these powers bave not previously been used "suggests either a standard of efficiency in the financial administration of Departments stretching credulity to more than reasonable]imits or alternatively - and more probably - a lack of understanding on the part of both the Legislature and the Executive of the need for vastly improved machinery for improvement in the control of public finance".

The Committee's long inaction has finally been ended by the current reference from the Minister for Health, the Honourable L.J. Brereton, and a further reference from the Auditor-General, Mr J. O'Donnell, to enquire into the extent of overtime worked by Police and Corrective Services officers.

I agree with the Auditor-General's view that it would be a "giant step forward" for the Committee to have power to initiate enquiries on its own volition and I we]come the Government's commitment to introduce legislation to reconstitute the Committee and extend its powers.

The current enquiry is being carried out as expeditiously as possible. This is essential if the Committee is to be an effective means of finding solutions to pressing problems, rather than a pigeonhole for those problems.

Expedition and thoroughness, however, are not mutually exclusive. In only three months, the Committee has taken more evidence (10 days and approximately 70 hours from 62 witnesses), made more inspections (seven), studied more submissions (almost 3,000 pages) and held more meetings and discussions than most Select or Joint Committees in recent years.

From the hearings held so far, some procedural shortcomings have become apparent. Clearly, on the "wider" questions, public hearings are essential if public accountability is to be the goal. However, they are not always conducive to unravelling complex details. In future, therefore, I intend to also make use of informal around-the-table discussions so that disputes over complex matters of fact can be more quickly resolved.

Finally, I would like to express the appreciation of all Members of the Committee for the invaluable assistance we have received from Mr Warren Hickson, Miss Robin Long, Mr Mervyn Sheather, Dr Tim Smyth and Mr John Woodget.

MICHAEL EGAN, B.A., M.P.,

CHAIRMAN

NEW SOUTH WALES PUBLIC HOSPITAL OVEREXPENDITURE (GROSS 0PERATING PAYMENTS) 1980/81 *

Hospital	Variation from Budget	
	$ 000's	%
INNER METROPOLITAN REGION		
Balmain	101	1.2
Canterbury	235	2.5
Royal Prince Alfred	1,492	1.7
St Luke's	365	9.6
St Vincent's	642	1.5
Sydney	1,055	3.1
NORTHERN METROPOLITAN REGION		
Gosford	446	1.4
Hornsby	697	3.1
Manly	191	1.5
Mater	217	1.7
Royal North Shore	850	1.2
Royal Ryde Rehabilitation	223	7.0
WESTERN METROPOLITAN REGION		
Fairfield	109	1.7
Parramatta Centre	521	4.5
St Joseph's, Auburn	64	1.3
Westmead Centre	603	1.0
HUNTER REGION		
Belmont	176	3.3
Cessnock	253	4.4
Dungog	62	8.2
Kurri Kurri	228	5.6
Maitland	482	7.4
Newcastle Mater	947	6.0
Rankin Park	130	4.6
Royal Newcastle	2,034	5.1
Singleton	59	2.0
Wallsend	542	6.3

Hospital	Variation from Budget $ 000's	
	$ 000’s	%
ILLAWARRA REGION		
Bowral	75	1.9
Port Kembla	486	5.3
Shoalhaven	361	8.1
Wollongong	1,146	5.6
MURRAY		
Balranald	65	12.2
Deniliquin	230	7.2
Finley	52	4.6
Wentworth	96	16.9

* The Committee confined its exam ination to hospitals with a minimum overexpenditure of 0.5% and $50,000

TERMS OF REFERENCE AND INTRODUCTION

The Committee's Terms of Reference are to:

* enquire into the causes of expenditure over-runs in health funding to Schedule 2 and Schedule 3 hospitals in the financial year 1980/81 and matters related thereto; and

* investigate the standard of public accountability of Schedule 2 and Schedule 3 hospitals and make such recommendations as it sees fit to ensure full accountability of these hospitals to the Parliament of New South Wales

This Interim Report addresses itself primarily to the first term of reference concerning over-expenditure in 1980/81. It also flags major areas which will be further discussed in the Final Report. The Committee believes that the question of general accountability of the public hospital system in New South Wales is of considerable long-term significance.

The Committee also recognises that since June, 1981, some improvements have already been made by both hospitals and the Health Commission on matters of detail associated with the budget over-runs being investigated.

The Committee recognises that the hospitals with which this Report deaIs are not necessarily the least efficient or effective in the system. Indeed in many cases the converse is true. However, this does not excuse their failure to live up to the responsibilities of operating within the funds allowed.

Although the budget over-runs are serious, they must been seen in the context of the overall performance of public hospitals in that year. The over-run of $15,7 million represents 0.86% of the budget for gross operating payments. Four of the Health Commission Regions had no hospitals exceed budget. Accordingly, the Committee whilst addressing itself to some specific examples has sought to draw conclusions that will be of benefit to the public hospitals system in general.

It is also appropriate to note that the escalation of hospital and health care costs is recognised as being inadequately controlled in most Western countries regardless of the systems of medical and hospital care involved.

This, of course, points up both the importance of the problem and the difficulty of finding simple all-embracing solutions.

SUMMARY OF RECOMMENDATIONS

The Committee recommends that:

(1) The Minister for Health automatically review the appoin tment of the Board of any Schedule 2 Hospital which exceeds its approved budget for gross operating payments.

(2) Consideration be given to the temporary appointment of an administrator to any Schedule 3 hospital which exceeds its approved budget for gross operating payments. The appointment be made by the Health Commission and hospital agreement to the appointment be a condition of further subsidy.

(3) A review of the processes involved in the allocation of funds to hospitals be undertaken to ensure that final budgets are received by the hospitals as soon as practicable after the State budget allocations are determined.

(4) A review be undertaken of the systems used to monitor and control hospital expenditure to ensure that they are appropriate to management needs, and in particular that they facilitate prompt corrective action being taken when necessary.

(5) In the event of future rationalisation of hospital services the following measu res be taken:

* adjustments to hospital budgets to reflect proposed service reductions be based on clearly defined and realistic plans providing for real and continuing savings;

* such adjustments be reviewed in the light of unforeseen and unavoidable circumstances affecting implementation of the plans;

* the introduction of new services dependent upon savings resulting from service reductions elsewhere be programmed in such a manner that should changed circumstances result in the savings not being fully realisable, expenditure on new services can be curtailed or eliminated as necessary;

* the provision of additional funds to adjust hospital budgets for non-realisation of savings due to lower than anticipated attrition rates not be granted unless the Health Commission has satisfied itself after a detailed review of the position that everything possible bas been done to achieve those savings;

* there be full consultat ion between the Health Commission and hospitals affected by rationalisation reductions and a clear understanding reached as to the steps necessary to ensure a reduction of services in real terms. The Health Commission advise and assist with any special problem areas identified;

* future rationalisation programmes concentrate to the maximum extent practicable on the re-direction of whole services or service units.

(6) The setting of staff establishments, other than for medical practitioners, for each hospital be discontinued.

(7) Hospitals be totally responsible for their staffing levels subject to the funds available.

(8) Where a hospital exceeds its salaries and wages budget consideration be given to the imposition by the Health Commission of controls on that hospital's staffing appointments for such time as is necessary.

(9) The basis for determination of supplementary allocations of funds to meet award costs be the actual or budgeted level of salaries and wages expenditure, whichever is the less. All hospitals be clearly informed to this effect and the existing systems of calculating the costs of award variations be reviewed to ensure that future claims accord with this principle.

(10) Prior to approving supplementary funds for award variation costs the claims made by hospitals be carefully reviewed by the Health Commission.

(11) The Health Commission take action to ensure that hospitals do not proceed with the appointment of staff for new units except in accordance with a timetable specifically approved in writing by the Heath Commission.

(12) The Health Commission not approve new units being brought into operation until the necessary funds have also been approved.

(13) The Health Commission review the processes of consultation and communication to ensure that:

* full details of interim and final budgets and all relevant factors pertaining thereto are conveyed to Regional Offices by the Central Office of the Health Commission;

* the hospitals are properly informed as to the basis upon which their initial estimates should be prepared and given full details of the variations embodied in their actual budgets;

* specific exclusions for special items such as award costs, long service leave payments and new units should be fully detailed.

(14) Hospitals implement appropriate for mal communication processes with their medical staff.

(15) Hospitals review their budgetary and financial control procedures to avoid clerical errors leading to expenditure over-runs.

(16) With the exception of funds required to be held in reserve for specific but as yet unquantified requirements such as future aware variations, new unit provisions and other special factors, funds provided to Regional Offices of the Health Commission for hospital operating costs be fully allocated to the hospi tals in their budgets. Hospitals be clearly informed that it is their responsibility to set aside reserves to meet contingencies.

(17) Hospital budgets contain a specifically identifiable adjustment for role changes.

(18) Hospital budgets be built up and monitored on a departmental basis.

(19) Resource allocation within regions be based on clearly defined and understood formulae.

(20) A separate inquiry be hetd into the administration, financing and utilisatio n of the New South Wales Ambulance Service. Amongst other matters, the inquiry examine:

* the use of ambulances for inter-hospital transfers and the desirability of alternative means of transport;

* whether the control mechanisms required to ensure that the ordering of ambulance transport by medical practitioners is appropriate to the health care need of patients.

BACKGROUND TO THE PROCESS OF DETERMINATION OF 1980/81 HOSPITAL BUDGETS

Commonwealth-State Interaction

The budget process for public hospitals during the period of operation of the Commonwealth-State hospitals cost sharing agreement up to 30 June, 1981 was a complex and protracted one. The hospital budget timetable was geared to the requirements of the Commonwealth, through bi-annual meetings of the Commonwealth-State Standing Committee, as well as the State budget itself. While States were responsible for initiating expenditure proposals, the Commonwealth had the final say in determining the agreed net budget figure which it would fund on a 50:50 basis with each State. Once agreed, this budget was finalised between the Health Commission and the New South Wales Treasury (and announced in the State Budget) and allocations were then made to the 13 Health Regions and ultimately to individual hospitals.

The rules of the game changed fundamentally in 1979/80. In 1979 the Commonwealth Government announced there would be no increase in its financial support to the New South Wales hospital system other than provision for inflation. (See Table 1).

Due to the impending opening of some 750 new beds the New South Wales Minister for Health announced that there would be a funding shortfall of $28 million. Accordingly, a hospital rationalisation programme was commenced.

Table 1

Commonwealth Hospital Cost-Sharing Payments to New South Wales, 1978 - 79 to 1980 - 81

1978/79		1979/80		1980/81	
$m	% Increase	$m	% Increase	$m	% Increase
383.8	10.8	425.3	10.8	469.1	10.3

Source: Commonwealth Budget Paper No. 7, 1981/82.

In its submission to the Committee, the Health Commission of New South Wales provided an assessment of the budgetary implications of the rationalisation exercise. The Commission stated that the full year effect of the rationalisation programme amounted to $35.6 million of which $17.6 million was scheduled to be saved in 1979/80, with the remaining $18.0 million reduction being effected in the following year.

(See Table 2) In fact, only a $15.7 million saving was achieved in 1979/80. The framing of the 1980/81 interim hospital budgets therefore carried the legacy of a non-achieved saving of approximately $1.9 million from the 1979/80 rationalisation programme.

Table 2

Cost Implications of Opening New Services and Bed Closures, May, !980

	New Services		Closures
	$		$
1979/80	12.1		17.6
1980/81	22.3(a)	2.5(b)	18.0
TOTAL	34.4(a)		35.6

(a) New units opened in 1979/80

(b) New units opened in 1980/81

Source: Health Commission of New South Wales
(Information provided to April, 1981, Commonwealth-State Standing Committee Meeting)

It is also clear from Table 2 that it was expected that by 30 June, 1981, the value of rationalisation closures would exceed the cost of the new services by $1.2 million (i.e. $35.6 - $34.4 million). This figure was later revised to $2.1 million mainly due to reductions in outlays on new services. Commonwealth approval was subsequently obtained to introduce additional new services costing $2.4 million in 1980/81.

The Budget Timetable

The hospital budget timetable proceeded over a number of stages covering 18 months:

(a) January 1980: Health Commission Regions prepared 1980/81 estimates covering outlays by recognised hospitals using the Commonwealth forms setting out 20 expenditure headings. Regions were required to account separately for incr eases to cover;

- inflation; and

- new services

The general instruction provided to Regions in preparing budget estimates was that they should allow for no net growth and that any proposed real increases in expenditure had to be offset by rationalisation savings.

(b) February, 1980: Regional budget bids were submitted to the Commonwealth.

(c) May, 1980: Estimates were considered by Health and Treasury officers at the Commonwealth-State Standing Committee meeting at which there was substantial agreement; The agreed gross operating payments budget was $1,228.6 million.

(d) Early July: 1980: The Commission notified Regions of the basis for determining interim budgets to 'each hospital. Budgets were to be "based. on 1979/80 approved budgets adjusted to annual basis after allowing for full year effect of 1979/80 reduction of services" As the State Budget had not been handed down, a reduction of 0.5 per cent was to be applied to salaries and wages. With the exception of the Hunter Region, regions generally complied with those guidelines. In evidence the Hunter Region Office stated that it "built-up on the anticipated results" in determining interim hospital budgets.

(e) September 1980: The State Budget was brought down containing an allocation broadly similar to the total of the Health Commission's interim budget.

(f) November 1980 : Following the Commonwealth's offer of an increase of 0.75 per cent in the inflation rate allowed for goods and services, the Standing Committee agreed to a corresponding adjustment in the figure notified in the State Budget.

(g) Early December, 1980: Final budgets were issued to Regions. Except for an increase for the North Coast region the allocations were similar. to those advised on 4 July, 1980. It was recognised, however, that many individual hospitals' interim and final budgets would differ. According to the Health Commission, "although it was known that some rationalisation proposals were not able to be folly implemented, it was the general view that Regions should try to achieve off setting savings elsewhere"

(h) January, 1981: Hospitals foreshadowing over-expenditure were directed to examine suggested cost-saving measures.

(I) February, 1981: The Chairman of the Health Commission wrote to all hospitals which were foreshadowing over-expenditure and proposed economy measures. Proposals for reduction of services were required be discussed with Regional Directors. Retrenchment of staff and non-payment or deferment of creditors' payments were advised as being unacceptable to the Government.

Not all hospitals responded.

(j) February, 1981: Approval was granted to a supplementation of the State's allocation to provide for an increase of $5.6 million in the hospitals' gross operating cost bu dget which had been previously agreed upon by the Commonwealth.

(k) April 1981: The Commonwealth-State Standing Committee met and the Commonwealth refused any further budget increase until New South Wales supplied more detailed information on over-runs and increases in patient activity.

(l) June, 1981: The Commission supplied further information to the Commonwealth.

(m) November, 1981: Commonwealth-State Standing Committee meeting deferred.

(n) February, 1982: The Commonwealth's final position on 1980/81 funding remains unknown.

FAILURE TO TAKE BUDGETS SERIOUSLY

"There are budgets and budgets". Evidence from Mr R.J. Lane, Chief Executive Officer, Wentworth Hospital.

As other sections of this report point out, some hospitals could genuinely claim that factors outside their control contributed to the failure to live within their budget.

Generally, however, explanations of over-expenditure received by the Committee were unsatisfactory. Most hospitals supplied lists of token cost containment measures. Some could not even do that. Very few could provide evidence of serious efforts to review admission policies or otherwise contain their level of activity.

In many cases, hospital submissions revealed a recklessness towards spending public funds. Many argued they had not over spent at all, but rather their budget allocations had failed to meet their 'expenditure. Some of the offending hospitals "explained" that although they had not lived within the budget allocated by the Health Commission, they had lived

within the budget they had set for themselves. Wallsend Hospital, for example, drew a distinction between its Health Commission approved budget of $8,577,978 and its own budget of $9,060,365. Unfortunately, it overspent both.

Notwithstanding the clear evidence that New South Wales has a relative oversupply of hospital facilities, many hospitals seem to think the public purse can and should be expanded to meet whatever level of demand can be generated. It is hard to believe that this "money-tree" attitude is held by otherwise intelligent people.

One of the most alarming and most frequent excuses put to the Committee by the hospitals was the belief that their interim budget allocations and, in some cases, their final budget allocations were not meant to be taken seriously.

Nearly every hospital expressed surprise that their final budgets (issued about January, 1981) reflected their interim budgets (allocated about July, 1980). It was a common complaint that the final budgets could not be met because the interim budgets had been considerably over-run.

Hornsby Hospital, for example, had exceeded its interim budget by $400,000 before its final budget was received. Royal Prince Alfred Hospital explained that it expected "a considerable improvement on the first interim budget" The interim budget, it seems, was ignored because the hospital disagreed with it as being based "on some historical accounting process that does not take into account activity". The result was that by mid-year the hospital was projecting an over expenditure of $4,400,000. When asked why the hospital expected an increase the reply was: "Past experience".

Wollongong Hospital similarly argued that in previous years "supplementary funding and budget adjustment have invariab]y flowed". Canterbury Hospital's Chief Executive Officer referred to Health Commission requests for financial restraint as suffering from a "credibility gap" and claimed that "previous years have been typically marked by requests for financial constraint but funds to my experience have been made available ultimately to meet any shortfall at the end of each financial year. In 1980/81 this was not the case".

In other words the hospitals were saying that they had been bailed out before and expected to be bailed out again. In 1980/81 this expectation was naive. Clearly, no hospital board, administrator, or senior Health Commission officer should have entertained any doubt about the budgetary situation facing hospitals in that year. Hospital funding had been a major political issue for considerable time, the Commonwealth Government was adamant in its no-growth hospital policy, the Jamison Inquiry into hospital costs had been established, and a major hospital rationalisation was taking place. As well the message from the central office of the Health Commission was loud and clear. The ritual warning of previous years gave way to repeated and unequivocal demands that hospitals must live within their budgets.

Unfortunately, it appears that this point was not only missed by some hospitals, but by some regional offices of the Health Commission as well.

Correspondence from the Northern Metropolitan Regional Office to Manly Hospital as late as December, 1980, was calling on the hospital to make out a convincing case to justify additional funding. In January, 1981, the hospital was advised by the region that "every effort will be made by the office to obtain additional funds". Royal Newcastle Hospital was also being advised by the Hunter Regional Office until February, 1981, that "it was hoped that more funds would be forthcoming".

Therefore, at a time when the severe budgetary situation should have been forcefully brought home to every hospital two Regional Offices were encouraging hospitals in their expectations of additional funds.

The Committee recommends that:

* the Minister for Health should automatically review the appointment of the Board of any Schedule 2 hospital which exceeds its approved budget for gross operating payments.

* consideration should be given to the tem porary appointment of an administrator to any Schedule 3 hospital which exceeds its approved budget for gross operating payments. The appointment should be made by the Health Commission and hospital agreement to the appointment should be a condition of further subsidy.

BUDGET AND REVIEW PROCESSES

Budget

A number of hospitals have attributed their failure to keep 1980/81 expenditure within the funds allocated to:

* the fact that they were given no opportunity to make any input into the budget deliberations and that the allocations accordingly did not properly reflect changed circumstances and needs.

* the fact that their final budget allocations were not advised to them until December, 1980, or January, 1981, by which time it was too late to rein back their expenditure to the extent necessary to live within the budget.

From the evidence presented to it, the Committee is not convinced that these were significant factors in the 1980/81 overexpenditure.

There is no doubt that the process of building up a budget using the previous year's budget as s base has its weaknesses. One of the most serious is that an inappropriate distribution of resources becomes built-in. The Committee proposes to examine in more detail the systems proposed by the Health Commission to provide for a more appropriate allocation Of funds between regions and between hospitals within regions. This aspect will be covered in the Committee's final report.

Nevertheless, the budget processes in operation for the year in question appear to have provided for an examination of factors which would require variations from the 1979/80 budget. The Health Commission has the responsibility for reviewing the hospitals' input, which is provided in a form based on the Commission's requirements, and for putting together the budget proposals in macro form. It appears to the Committee that most of the hospital's complaints about lack of consultation in the budget process really stem from the fact that in the end they do not get as much as they ask for.

There is no question that it is desirable for budgets to be set as early as practicable and certainly well before December or January as occurred in 1980/81. The Health Commission has advised that the Commonwealth's involvement in the budget setting process, and associated delays in coming to agreement, was the major factor in these delays. The changed funding arrangements now in operation wi11 enable that situation to be corrected.

However, the Committee is also conscious of the problems inherent in setting an annual budget for the health system prior to final decisions being made on the State budget generally and accepts that, unless the whole process is brought forward, there is little prospect of final hospital budgets being advised prior to or at the commencement of the financial year as hospitals would wish.

In 1980/81, to help overcome some of these difficulties, the Health Commission issued interim budgets in July, 1980. Hospitals were advised they had to operate within the financial constraints of those interim budgets until final. budgets were notified.

In such circumstances, and since in general the final allocations were at least equal to the interim budgets, the Committee does not accept the late notification of the final budget as a reasonable excuse for the overexpenditure which occurred. The fact that many hospitals chose not to take the interim budget seriously is abundantly clear and this issue is canvassed in more detail in another section of the report.

Review

No doubt largely influenced by attitudes to the interim budgets, the importance of monitoring expenditure performance against those budgets and taking corrective action where necessary appears to have been largely ignored by many of the hospitals.

This attitude appears to have been encouraged by the Inner Metropolitan Regional Office of the Health Commission, which advised the Royal Prince Alfred Hospital (and presumably other hospitals in the Region) that in their monthly reporting system they should not report against the interim budget but were to report, as they usually do in the early part of a financial year, against the previous year's budget. Bearing in mind that the 1980/81 interim budgets had adjustments built into them to reflect the full annual savings required from the rationalisation programme, the 1979/80 budget would appear to The Committee to have been totally irrelevant as a benchmark for 1980/81 performance.

The result of these weaknesses in monitoring and control procedures is evidenced by the slowness of the system to react to what was obviously a very serious financial situation. Hospitals appear generally not to have got the message until some time in February, 1981, notwithstanding that adverse expenditure trends were evident long before that.

The Committee recommends that:

* a review of the processes involved in the allocation of funds to hospitals be undertaken with a view to ensuring that final budgets are received by the hospitals as soon as practicable after the State budget allocations are determined.

* a review also be undertaken of the systems used to monitor and control hospitals' expenditure to ensure that they are appropriate to management needs, and in particular that they facilitate prompt corrective action being taken when necessary.

1979/80 RATIONALISATION PROGRAMME

Reference to the rationalisation programme announced by the Minister for Health in August, 1979, bas been made in the introduction to this report. This section looks specifically at the service reductions proposed for 1979/80 and their intended full-year effect in 1980/81.

The 1980/81 State wide hospital budget was formulated on the theoretical basis that the service reduction had achieved savings of $15.7 million in 1979/80 and $35.5 million on a full year basis.

The term "theoretical" has been used because, as will be seen from the following examination, for a variety of reasons a significant proportion of the savings were illusory.

Impact on 1980/81 expenditure results

The fact that the 1979/80 rationalisation plan failed in its objective to rationalise hospital services, as distinct from beds, is obvious from an analysis of patient statistics. Patient activity did not decline commensurately with the bed reductions and in fact in some instances actually increased over the previous yesr's level.

The Committee has not attempted to quantify the proportion of the hospitals' total 1980/81 over-expenditure which could be attributed specifically to the failure to achieve the planned rationalisation. This would be a subjective exercise and the results would be of questionable value. Suffice to say that this factor was a major one and the Committee's primary concern has been to attempt to indentify the various reasons for this failure.

The following is a brief outline of the explanations considered by the Committee and our views thereon.

Deferment of Rationalisation Proposals

As a result of concern expressed by certain hospitals and hospital staff concerning the implications of the 1979/80 rationalisation plans, a committee was set up under the Chairmanship of Mr John Ducker, a member of the Public Service Board, to review and make recommendations on the services in question.

Mr Ducker's Report, whicb was submitted in June, 1980, recommended the defermernt or non-implementation of rationalisation at a number of hospitals. Evidence given to the Committee indicated there was no formal communication of any decision at Government or Health Commission level as to what action should be taken on that report. However, it is clear that the recommendations were adopted. The consequence of non-implementation of. rationalisation at the hospitals concerned was that savings of $2 million in 1980/81 were not achieved.

The overexpenditure incurred under this heading resulted as a direct consequence of:

* no adjustment being made in the State wide hospitals' budget to reflect the decision that rationalisation would not proceed at the designated hospitals

* the policy adopted by the Heal th Commission that where rationalisation did not proceed the particular Region whose hospitals were involved had to make up the savings elsewhere within the Region; and

* the failure of the regions to achieve those offsetting savings.

The Committee is not convinced that alternative and perhaps more desirable financial options which may have been open to the Health Commission in dealing with this problem were properly pursued. The figures furnished by the Commission to the Commonwealth State Standing Committee, for the purposes of the 1980/81 budget deliberations, indicated that the net result of the 1979/80 rationalisation programme was that savings achieved (including "savings" referred to above) exceeded the actual costs of new services introduced in 1979/80.

On the basis of those surplus reductions, the Commission was able to negotiate approval for some additional services to be introduced in 1980/81. Given the doubts then existing about full achievement of the savings, it would have been prudent to defer the expenditure on further new services until those doubts were resolved.

In order to fund some of these new services further offsetting savings during 1980/81 were required.

The problems associated with effecting these savings elsewhere within the system were compounded by the delay in notifying specific hospitals that such savings were necessary. The Hunter Regional Office redistributed the associated budget reductions amongst the Royal Newcastle Hospital and other hospitals in their final budgets, which were not conveyed to them until 28 January, 1981.

Non-Attrition of Staff

In announcing the 1979/80 rationalisation proposals, the Minister for Health gave a clear undertaking that there would be no staff retrenchments. Surplus staff were to be absorbed as new vacancies occurred.

The attrition rate was lower than originally anticipated, resulting in reduced savings or, in other words, costs for which no budget allowance bad been made. These additional costs for the State as a whole have been identified by the Health Commission as totalling $2.6 million for 1980/81.

A number of hospitals have claimed that their budgets were not adjusted during 1980/81 to account for the savings not being realised and the Health Commission has confirmed that, with the exception of funds totalling $456,000 which were redistributed to some hospitals from existing resources, no budget adjustments were made on this account, although cash was advanced to meet unavoidable payroll commitments outlined in the budget.

The Committee is of the view that hospitals should not have been penalised for genuine inability to reduce staff numbers to the extent necessary by attrition and that budgets should have been adjusted accordingly.

However, it is appreciated that in a situation where hospitals resist change their inability to lose staff by attrition is likely to be overstated. Elements of that existed in. 1980/81. Accordingly, the provision of additional funds would need to be based on a detailed review of actual attrition rates within categories of staff and of the scope for transfers.

Lack of Co-operation by Hospitals

The Committee has concluded that one of the major factors contributing to the failure to achieve the 1979/80 rationalisation plan was the unwillingness of many hospitals to accept the changes and to adjust their activity levels accordingly.

Evidence given to the Committee indicated

that:

* the Royal Prince Alfred Hospital assumed that "the 1979/80 rationalisation was a one-time occasion, rather than an ongoing thrust to lower levels of hospital activity".

* no doubt in keeping with that line of thinking, quite a number of hospitals achieved the required level of savings in 1979/80 by "once-only" measures such as reducing stock levels, cutting down on staff relief, deferring payments to creditors and the like.

* it is the view of some hospital administrators that it is a hospital's role to accept all patients seeking admission, from whatever source, and that it is the Health Commission's responsibility to take the necessary action to either reduce the numbers of such patients or re-direct them.

The Committee rejects any contention that hospitals involved in the rationalisation programmes had grounds for believing that if they achieved the savings required in 19 79/80 they would be able to revert to their previous level of activity in 1980/81. On the evidence presented to the Committee the steps taken by the Minister for Health and the Health Commission to spell out the purpose of the rationalisation proposals and their financial implications were such that, as observed by one Regional Director of the Health Commission, the fact that hospitals would not be bailed out at the end of the year "must have been apparent to any reasonably intelligent, perceptive hospital administrator".

The Committee also rejects the contention that the Health Commission should accept responsibility for the direct control of patient flows. While the Commission has an important role to play in providing advice and assistance to hospitals, it is the hospitals which have, or should have, control over admissions.

In the Committee's view hospitals must accept responsibility for their failure to reduce activity.

It is easy to make the observation in retrospect, as many have, that the problem with the 1979/80 rationalisation programme was that it was expressed in terms of bed reductions rather than specific service reductions. However, it seems to the Committee to be a poor reflection on the hospitals for them to suggest that the Health Commission should have been expected to dictate in chapter and verse how they should line up their levels of activity with the financial resources provided.

That is not to say that the Committee thinks that effecting across-the-board bed reductions is the best approach to rationalisation. In fact it is obvious that much greater financial benefits would flow from the re-direction of whole services or service units.

The Committee recommends that:

* in the event of future rationalisation of hospital services the following measures should be taken:

  * adjustments to hospital budgets to reflect proposed service reductions should be based on clearly defined and realistic plans prov iding for real and continuing savings.

* such adjustments should be reviewed in the light of unforeseen and unavoidable circumstances affecting implementation of the plans.

* the introduction of new services dependent upon savings resulting from service reductions elsewhere should be programmed in such a manner that should changed circumstances result in the savings not being fully realisableii expenditure on new services can curtailed or eliminated as necessary.

* the provision of additional funds to adjust hospital budgets for non- realisation of savings due to lower than anticipated attrition rates should not be granted unless the Health Commission has satisfied itself after a detailed review of the position that everything possible has been done to achieve those savings.

* there should be full consultation between the Health Commission and hospitals affected by rationalisation reductions and a clear understanding reached as to the steps necessary to ensure a reduction of services in real terms. The Health Commission should advise and assist with any special problem areas identified.

*future rationalisation programmes should concentrate to the maximum extent practicable on the re-direction of whole services or service units.

STAFF ESTABLISHMENTS

The major ares. of expenditure in public hospitals is salaries and wages which accounts for approximately 70 - 75% of gross operating payments. It is apparent to the Committee that a review of staff establishment policies in public hospitals is required to bring them into line with the realities of health care financing in the 1980's.

Staff establishments are set by the Regional Offices of the Health Commission for all public hospitals. Adherence to this establishment is one of the conditions attached to the payment of subsidy to public hospitals by the Health Commission. The establishment set by the Commission is not simply a maximum number of staff that may be employed but a detailed listing of staff numbers by functional category (e.g. medical, nursing, ancillary services, catering, domestic, maintenance, etc.). These broad categories are then subdivided into specific groupings based on award classifications. The approval of the Health Commission is required to make adjustments including those that do not alter the total staff establishment

Prior to the 1978/79 financial year, hospitals compiled their budgetary estimates for salaries and wages through a detailed costing based on their approved staff establishment. in 1978/79 this procedure was altered by the Commission and estimates are now based on the previous year's budget plus award variations.

Evidence to the Committee from a number of hospitals indicates that they have failed to appreciate the effects of this change in funding of salaries and wages by the Commission. Salaries and wages budgets are no longer tied to staff establishments, but are instead.based on the funds available to the Commission.

A number of hospitals appear to regard the staff establishment as being the minimum number of staff required to operate the hospital rather than a control mechanism to set a ceiling on staff numbers employed. This attitude is fostered by departmental heads within the hospital and the employee industrial associations. Clearly, such an attitude ignores the financial reality facing hospitals and the Health Commission.

The detailed nature of current staff establishments also reduces the flexibility available to hospital management to adjust staff levels to meet changes in both the activity of the hospital and the financial climate. While the Health Commission has indicated that it will facilitate appropriate interchanges between categories within hospital establishments, the resources are not available to regularly review and adjust staff establishments for every hospital in the State.

Continued adherence to the concept of a rigid detailed staff establishment will only hinder the efficient utilisation of staff in public hospitals and provide a convenient excuse for some hospitals to avoid their financial responsibilities.

Some control mechanisms, however, are needed. As pointed out elsewhere in this report, the medical profession largely determines the activity and utilisation of public hospitals. Clearly there is a need to control the number of doctors appointed to, or employed by, hospitals to ensure that they are appropriate to the health care needs of the community.

For other categories of staff the Committee would only see a need for controls to be imposed in situations where the staffing of a particular hospital was of concern to the Commission.

The adoption of this approach would provide hospitals with greater flexibility in staffing while at the same time requiring hospitals to fully accept their financial responsibilities in this area.

The Committee recommends that:

* the setting of staff establishments, other than for medical practitioners for each hospital be discontinued.

* hospitals be totally responsible for their staffing levels subject to the funds available.

* where a hospital exceeds its salaries and wages budget consideration should be given to the imposition by the Health Commission of controls on that hospital's staffing appointments for such time as is necessary.

PROVISION FOR AWARD COSTS

Inadequate financial provision to meet increased costs arising from award variations to salaries and wages was cited by a number of hospitals as a factor in their 1980/81 expenditure over-runs. In some cases the amounts involved were quite significant.

Funding for award variation costs is normally excluded from the initial budget allocations made to hospitals but, as award variations occur, supplementary funds are provided based on the calculated actual costs involved. Returns derailing these costs are furnished by the hospitals to the Regional Offices of the Health Commission and, subject to the Commission's acceptance of those figures, the budgets are adjusted accordingly.

From the evidence submitted to the Committee it has been concluded that the main reason for the difference between the funds allocated for award variations and the costs as claimed by the hospitals was that the former were based on the approved budgets for salaries and wages whereas the latter were calculated either on staff establishments or actual staff levels.

The implications are twofold:

* to the extent that staff establishments are used as the basis for the calculation and actual staffing levels are below that level there would be an overstatement of the cost of the award variations and, if funded on that basis, the hospitals would be provided with excess funds;

* even though hospitals may have correctly calculated the real cost of award increases, based on actual staff levels, if those staff levels were in excess of the levels supported by the base budget allocation for salaries and wages then the award variation costs will correspondingly be in excess of the budgeted provisions.

If hospital expenditure is to be controlled within approved budgets, it is clear that provisions for the cost of award variations must similarly be geared to those limitations. In other words, the provision of supplementary funds for such variations should be determined on the basis of actual salaries and wages cost levels provided they do not exceed the budgeted levels, and on the hodgered levels if they do.

There is a marked lack of uniformity of procedure at Hospital and Health Commission level relating to the provision of additional funds for these variations, which in some cases has obviously compounded the problems experienced. It is noted that in a number of instances the higher provisions claimed by hospitals were wrongly supported at Regional Office level, requiring reductions to hospital allocations on this account after the close of the financial year.

Reference was also made in evidence that the use of figures furnished by the HOSPAY salaries system results in an overstatement of award cost variations, as those figures are based on staff establishments.

The Committee recommends that:

* the basis for determination of supplementary allocations of funds to meet award costs should be the actual or budgeted level of salaries and wages expenditure, whichever is **the** less.

* all hospitals should be clearly informed to this effect and the existing systems of calculating the costs of award variations should be reviewed to ensure that future claims accord with this principle.

* prior to approving supplementary funds for award variation costs the claims made by hospitals should be carefully reviewed by the Health Commission.

PROVISION FOR NEW UNITS

Approval for the introduction of all new or expanded services of any significance (termed "new units") must be obtained from the central office of the Health Commission.

A number of hospitals pointed to inadequate financial provision for the cost of approved new units as factors in their 1980/81 expenditure over-runs.

The most significant of these were Gosford and. Royal Newcastle hospitals.

Gosford Hospital claimed it required $477,250 for the cost of 1980/81 relief staff for its new unit which commenced operation on 21 March, 1980. However, the funds provided by the Commission amounted to only $152,000.

The Committee has been unable to elicit the full facts of this matter and obtain satisfactory explanations.

In evidence, the Northern Metropolitan Regional Office supported the hospital's claim, notwithstanding that the initial estimate of $152,000 was made by the Regional Office.

In a letter dated 15 February, 1982, the Regional Office explained that the problem was caused by the Hospital's "misinterpretation" of the Commission's definition of "opening date" for new units, i.e., the Hospital advised the Regional Office that the opening date was the date on which the first patient was admitted "viz: February/March, 1980", rather than the date when the first staff were engaged "which was November/December, 1979" This meant, according to the Regional Office, that the need for relief staff in 1980/81 arose much earlier than 1 February, 1981 - the date upon which the Regional Office had based its estimate of $152,000 which was submitted "for Commonwealth approval at the State Standing Committee meetings in May, 1980".

After considering all the evidence the Committee has concluded that the major factors leading to the overexpenditure by Gosford were:

* the Hospital proceeded with the appointments without the specific approval of the Health Commission and in anticipation of funding approval.

* the Regional Office of the Health Commission was not aware of the true position and based its funding request to the Central Office on incorrect assumptions.

* no action was taken to adjust the Hospital's budget when the true position was ascertained.

The Committee has made persistent attempts, without success, to elicit a satisfactory answer to the direct question as to whether there was a real need for the hospital to appoint as many relief staff as early as it did. In these circumstances, and having regard to evidence concerning the staged introduction of the new services, the Committee has concluded that the need was not real.

In respect of Royal Newcastle Hospital, Health Commission approval was given for staffing of the new CAT scanner and the Clinical Sciences Building. However, no financial provision was made either in the original budget or by way of supplementary allocation.

It appears that approval was conveyed for the appointment of staff and advice given that supplementary fonds would be available prior to the finalisation of hospital budgets. However, because of the worsening budgetary situation, these funds did not eventuate.

The Royal Newcastle Hospital was already over budget for other reasons and the invetiable outcome was that their position worsened to the extend of the cost of these new units, identified as $82,000.

The Committee believes there is a need for tighter control and direction to be exercised in respect of new unit approvals and for better co-ordination between the authority to proceed and the provision of funds.

The Committee recommends that:

* the Health Commission take action to ensure that hospitals do not proceed with the appointment of staff for new units except in accordance with a timetable .specifically approved in writing by the Health Commission.

* the Health Commission should not approve of new units being brought into operation until the necessary funds have also been approved.

COMMUNICATION PROBLEMS

The Committee was surprised at the degree of confusion among hospitals about the details of specific inclusions or adjustments in their budgets. The confusion was such that, even at the time of the Committee's hearings some six months after the close of the financial year, derails of the 1980/81 budgets as advised by the Health Commission and the hospitals could not be readily reconciled.

The Committee is of the view that a significant factor in this confusion is the inadequacy of information provided by the Regional Offices of the Health Commission in correspondence advising the hospitals of their allocations. In particular, problems were caused by the lack of specific detail about amounts included for items such as award costs, long service leave payments and new units, and of adjustments made in respect of expenditure over-runs in the previous year.

There was also considerable confusion in some evidence given to the Committee. The Hunter Regional Office, for example, initially contended that the reason for the cut back in the Royal Newcastle Hospital budget was that the Region's overall budget had been cut back. Six days later the Regional Office flalty contradicted its own contention.

The lack of specific details in the Central Office's instructions to the Regions on 1980/81 interim budgets was also a weakness.

The general level of communication between hospital administrations and their medical staff is unsatisfactory. While there are various informal communication channels which may work from time to time, it is clearly of paramount importance that at all hospitals the medical practitioners be fully aware of and involved in the resource management of the hospital. It was notable that of hundreds of internal memoranda on the subject of budgets which were provided to the Committee by way of evidence of activity by hospital administrators, the majority were not communicated to the medical staff organisations. A formal commitment by the body of medical practitioners at a hospital to cost containment is an essesntial prerequisite to any meaningful activity in this regard.

The Committee recommends that:

* the Health Commission should review the processes of consultation and communication to ensure that:

* full details of interim and final budgets and all relevant factors pertaining thereto are conveyed to Regional Offices by the Central Office of the Health Commission.

* the hospitals are properly informed as to the basis upon which their initial estimates should be prepared and given foil details of the variations embodied in their actual budgets.

* specific exclusions for special items such as sward costs, long service leave payments and new units should be fully detailed.

* hospitals implement appropriate formal communication processes with their medical staff.

CLERICAL ERRORS AND MISUNDERSTANDINGS

The Committee heard evidence of a number of instances of clerical errors or misunderstandings by hospitals. Notable among these were the explanations submitted by the Royal Prince Alfred Hospital in respect of an amount of $409,000 identified as "Clerical problems of setting the budget".

The Hospital advised that over-runs in expenditure to this total amount occurred due to two factors:

* an incorrect assumption that the interim budget excluded provision for the salaries and wages costs ($171,000) of a new regional computer service. The error was not discovered until the final budget was received.

* a double counting of the cost of the July, 1980, National Wage Case for Medical Relief Workers ($238,000).

In, the Committee's view these instances point to the need for a tightening of hospital budgeting and financial control procedures.

The Committee recommends that:

* hospitals review their budgetary and financial control procedures to avoid clerical errors leading to expenditure over-runs.

DISTORTION OF CASH FLOWS

A number of hospitals referred to the adverse effects of the Health Commission's practice, apparently until as late as 1978/79, of "dumping funds" at the end of the financial year.

Royal Prince Alfred Hospital gave evidence that it was requested in June, 1979, to exceed its "other goods and services" budget by $1,165,000. Funds to this amount were applied to the purchase of goods and payments in advance for services such as rents, lease payments and insurance premiums. As a result 1978/79 expenditure was abnormally inflated and 1979/80 deflated, seriously distorting subsequent years budgetary formulations.

Referring to a graph depicting expenditure on food, drugs and medical/surgical supplies, Wollongong Hospital stated: "It is also worthy of note that the peak in. April/June, 1979, shows how 'end of the year' Commission surplus funds were used to increase stocks. In the corresponding period, April/June, 1980, when normal 'end of the year' surpluses were not provided, stocks were partly run down, resulting in major increases in expenditure in July/September, 1980".

Sydney Hospital reported similar experiences: "The goods and services budget has been a mess for a long time ... The last time when it really got messy was in June, 1978. In the last two or three weeks of that month we were given half a million dollars to spend as quickly as we could ... The system of control was to keep the budget fairly low and an interim budget would be given during the year, after the Budget was given in Parliament ... There would be increases that would come to us suddenly towards April. The people working within the system were used to doing it this way. We did not agree with it. We did not like it".

It appears that with the objective of minimising hospital expectations, and thereby avoiding overall expenditure over-runs, it was a common practice until 1978/79 for Regional Offices of the Commission to hold back some proportion of the funds allocated to them. Predictably, when hospitals became acquainted with this system, it had the reverse effect.

The Commission's desire to keep the funds allocated for hospitals 'within the system' also resulted in the unsolicited distribution late in the financial year of what would otherwise have been genuine savings.

The Committee has no doubt that these practices contributed towards the 'credibility gap' referred to in an earlier section of this report. They also distorted the pattern of cash flows and contributed towards the problems hospitals experienced in keeping within their 1980/81 budgets.

The Committee recommends that:

* with the exception of funds required to be held in reserve for specific but as yet unquantified requirements such as future award variations, new unit provisions and other special factors, funds provided to Regional Offices of the Health Commission for hospital operating costs should be fully allocated to the hospitals in their budgets. Hospitals should be clearly informed that it is their responsibility to set aside reserves to meet contingencies.

ROLE CHANGES, HOSPITAL BUDGETS AND REGIONAL EQUITY

"Thou shalt grow and wither"

Submission from the Newcastle Mater Misericordiae Hospital, 8 December, 1981.

Hospitals voiced the same general criticisms of the incremental budgeting process to this Committee as they put to the Jamison Commission of Inquiry in 1980. In particular it was argued that an allocation based on the previous year's budget, plus an allowance for inflation and new units, largely maintains hospital services at a level and intensity which may no longer be appropriate. The allocation is therefore insensitive to the changing role of hospitals and relative levels of efficiency between hospitals.

The Jamison Inquiry had recommended that "State health authorities move towards implementation of output related methods of budgeting as a matter of urgency" and. that funding be established on a needs basis. The Committee sees a need for some allowance in hospital budgets for the impact of role changes and recognises that this will involve redistribution of resources between Regions and hospitals.

At the outset of the Committee's deliberations Royal Prince Alfred Hospital argued that the delineation of hospital roles should be an essential part of the budget process: ''If you are really talking about establishing proper budgets those proper budgets should be established against an agreed role of hospitals ... I think our budgets ought to be based on management information systems that give us knowledge of what is happening at a cost responsibility level". The Hospital indicated that hospital roles should be delineated by the Health Commission.

Sydney Hospital responded to questioning on the explanation of its goods and services over-run by pointing to the need to rationalise medical services by relocating medical staff between hospitals. The Hospital recommended that medical staff establishments should be reviewed in line with the defined role of each hospital. The Committee's view is that this is an. area requiring joint action by hospitals and the Health Commission.

One developing hospital adversely affected by the incremental budgeting procedure was Wollongong. The Hospital attributes the major increase in its other goods and services expenditure to the referral and specialist units recently established, the accompanying appointment of six staff specialists and an increase of 16 per cent in the number of visiting medical staff.

In recent years this Hospital has appointed, with the approval of the Health Commission, a number of specialists such as renal physicians, intensivists, a physician in nuclear medicine, haematologists, a staff anaesthetist and a director of emergency services.

While the necessary funding of these positions was apparently adequately catered for, no provision was made for the substantial increases in associated indirect costs, particularly in areas such as- drugs, pathology requisites, nuclear medicine requisites, and radioisotopes which inevitably accompanied this increased specialistion of services.

What happened in effect was that there was a change in the Hospital's role, the full financial implications of which were not taken into account.

Changes in roles and increasing levels of patient activity should not be confused. The latter can be accommodated by the introduction of tighter admission control policies consistent with the defined role of the hospital. The Commission has stated that "traditionally hospitals have operated with a fairly laissez-faire admission policy".

The Health Commission has pointed out that in setting Regional budgets in recent years it has taken into consideration the target regional shares determined by the Regional Resource Allocation Formula. This population-based formula incorporates a specific cost allowance for teaching/specialist hospital "beds" in each Region. While Illawarra was spared from the 1979/80 bed rationalisation programme, its actual share of hospital funding has remained below its target share.

In the case of the Hunter Region, which the Royal Newcastle Hospital claims is also a health scarcity Region, the Health Commission advised that "we have resourced the Royal Newcastle bed days and the Mater Waratah bed days at the average cost of teaching hospitals in New South Wales, which is well above the average cost generally. The net result is that the Hunter Region still comes out showing a favourable set of resources when compared to the State average ...". It has been suggested that Regional Offices of the Commission should give greater consideration to allocating resources between hospitals using an approach similar to the Resource Allocation Formula.

The Committee' views the delineation of hospital roles and the clinical privileges of medical practitioners as essential ingredients of any expenditure control and financial management strategy. When linked to the development and monitoring of hospital budgets on a departmental basis, such action will encourage restraint on the number of inappropriate and unnecessary procedures and will assist in reducing pressures on hospital budgets arising from the expansion of new services.

The development of new hospital services must be planned in an orderly way consistent with the level of resources available to the hospital. The detailed components of the role delineation process will be further dealt with in the Committee's final report.

The Committee recommends that:

* hospital budgets should contain a specifically identifiable adjustment for role changes.

* hospital budgets should be built up and monitored on a departmental basis.

* resource allocation within regions should be based on clearly defined and understood formulae.

ROLE OF THE MEDICAL PROFESSION

Submissions from hospitals and evidence taken by the Committee have highlighted the medical profession's role in generating hospital expenditure.

While patient expectations have risen with the increasing media attention given to advances in medical care and technology, once contact is made with the medical profession most aspects of the patient's treatment are dictated by the attending medical practitioner.

The admission of the patient, the ordering of pathology, x-ray and other investigations, the type of surgery performed, the drugs prescribed and the length of stay in hospital are all controlled by the medical profession.

Despite this major role in generating hospital expenditure, doctors' activities are not effectively monitored and controlled by either hospitals of the Health Commission.

The influence of the medical profession extends beyond the individual hospital to which they are appointed. In evidence to the Committee from both hospitals and the Commission it is apparent that doctor referral networks have distorted the distribution of health care services in the State.

Among the factors that prevented full implementation of the 1979/80 hospital rationalisation programme was the rigidity of doctor referral patterns. Though additional beds were opened at Westmead Hospital, many doctors in the Western Suburbs continued to refer their patients to the Royal Prince Alfred and other inner city hospitals.

While the Committee accepts the desirability of an efficient doctor referral network there is an obvious need to rationalise medical appointments at public hospitals to ensure that they are appropriate to the needs of the community.

Though the automatic right of access to a public hospital for local medical practitioners was withdrawn in July, 1978, following repeal of Regulation 48 under the Public Hospitals Act, insufficient attention has been paid to the appointment procedures for visiting medical practitioners. Despite the clear association between the number of doctors appointed to a hospital and the cost of operating the hospital, realistic establishments for visiting medical practitioners have not been set in all hospitals. In situations

where establishments have been set it is apparent that there have not been regular reviews to ensure that both the number and specialty mix of doctors remains appropriate.

In appointing visiting medical practitioners inadequate attention is given to defining the type of activities that may be undertaken by the doctor in the hospital. Many examples were given to the Committee of instances where a doctor has carried out procedures inappropriate to the role of the hospital. The appointment of a general practitioner with an interest in orthopaedics, for example, can transform a community hospital into an orthopaedic centre in a very short space of time in the absence of clearly defined conditions of appointment.

Once appointed to a hospital, visiting medical practitioners currently have a legitimate expectation of automatic re-appointment every three years. Hospitals do not appear to have adequate, comprehensive and relevant criteria for considering the desirability of re-appointing visiting medical practitioners.

Wide variations exist in the treatment of patients with similar illnesses. These variations are largely the result of the treatment preferences of medical practitioners. While the Committee accepts that no two patients will have identical problems, evidence from a number of hospitals indicates that many variations in treatment cannot be justified and generates unnecessary hospital expenditure.

Examples given to the Committee include a study of the charges over a six month period incurred by patients discharged from the Reval Prince Alfred Hospital following a heart attack. The indicated a significant difference between costs of a cardiotogist and a general physician. At a country hospital 25% of one general practitioner's obstetric patients had their babies delivered by caesarian section. A fellow GP, with a similar number of patients, had a caesarian section rate. of only 5.7.% In the,e same hospital one doctor used an anaesthetic drug that was eight times as expensive as an equally effective alternative used by other doctors.

In a large teaching hospital in. Sydney, a review of the use of diagnostic services by two groups of specialists demonstrated use by one group in some services more than 100% higher than use by the other group in treating patients with the same condition.

A study by the Health Commission of surgical procedures in New South Wales in 1979 also highlights variations between health regions in the incidence of common surgical procedures. When standardised for age/sex differences in the population the rates of tonsillectomy and adenoidectomy varied by as much as 56% from the State average in one region. The differences between individual regions were of the order of 62% in the case of appendicectomy, 42% for cholecystectomy, 31% for hysterectomy and 58% in the case of tubal ligations. Regions such as the Western Metropolitan, North Coast and Illawarra had consistently high rates of surgery after adjustments for differences in age and sex.

Unnecessary hospitalisation and prolonged lengths of stay also generate costs to the hospital. At one hospital, following a warning to the doctors by the Chief Executive Officer, 15 patients were discharged overnight. Evidence to the Committee highlighted the lack of appropriate admissions policies. At a number of hospitals problems are being experienced with doctors sending non-urgent cases to casualty departments for admission by-passing the hospital's normal admission procedures.

With the need to ensure that expenditure on health care is appropriate and cost-effective the introduction of mechanisms to monitor doctor behaviour in public hospitals is required. While some tentative steps have been taken, a comprehensive programme does not exist. The Committee endorses the views expressed by the Royal Prince Alfred Hospital as to the need to make doctors accountable for the costs they generate.

The Committee sees a need to further examine:

* the appropriateness of current visiting medical practitioner establishments.

* hospital based programmes to monitor and regularly review the provision of medical services by each doctor in public hospitals.

* the desirability of making participation in such programmes a condition of appointment for each visiting medical practitioner.

* the delineation of hospital roles.

* the delineation of clinical privileges for each medical practitioner.

These matters will be dealt with in the Committee's final report.

REUNERATION OF MEDICAL PRACTITIONERS

Payments to medical practitioners in New South Wales public hospitals in 1980/81 totalled $110.8 million. In addition, practitioners receive income from charging private patients who amount to approximately 55% of the total patients treated. Details of these earnings are not available to the Committee or the Health Commission.

Included in the figure of $110.8 million are payments made to salaried medical staff and payments made to visiting medical practitioners for their services to "hospital" (i.e. public) patients. Salaried medical staff include interns, residents and registrars as well as salaried staff specialistS. Payments made to visiting medical practitioners are essentially of two types - fee for service and sessional payment.

The table below details payments made to medical practitioners for the years 1978/79 to 1980/81.

PAYMENTS [1] TO MEDICAL PRACTITIONERS

NEW SOUTH WALES PUBLIC HOSPITALS (1978 - 1981)

Category	1978/79	1979/80	1980/81
	$	$	$
Salaried Staff	67,534,564	73,540,317	76,659,188
Sessional Payments	6,694,606	10,465,729	19,077,624
Fee for Service	13,312,270	15,175,916	12,964,026
Other	2,483,091	2,681,948	2,120,161
TOTAL	$90,024,531	$101,863,910	$110,820,999

1 Excludes income received from charging private patients

Salaried Staff Specialists

The salary range of staff specialists employed in in New South Wales public hospitals is currently $33,578 to $45,695. However, under an arrangement negotiated between the Health Commission and their industrial association, the Public Medical Officers Association, salaried staff specialists may elect to receive additional income through charging private patients treated in the hospital. The arrangement became effective on 1 October, 1976.

There are three basic schemes of election:

Scheme A: Under this arrangement the staff specialist is paid an additional allowance equal to 16% of the appropriate award salary. The cost of fares and other expenses associated with conference and study leave are met by the hospital. The payment of the allowance is conditional upon the specialist giving the hospital written authority to render accounts in his name to any private patients he may see. This revenue is retained by the hospital.

Scheme B: Under this arrangement accounts are rendered to private patients by the hospital on behalf of the salaried specialists. From the revenue collected a percentage, varying according to the nature of the specialty involved, of between 20 and 90% is retained by the hospital. From the remainder the specialist may receive an allowance not exceeding 16% of his award salary with the residue being paid into a trust fund for use at the specialist's discretion for travel, research and equipment.

Scheme C: Under this arrangement the staff specialist elects to forego a percentage, up to a ceiling of 25%, of salary in return for the right to receive from private patients an amount equivalent to four times the salary foregone. The hospital takes a percentage of the revenue as in Scheme B with the residue going to a trust fund for use at the specialist's discretion for travel, research and equipment. Under Scheme C the staff specialist may increase his base salary to between $58,761 and $79,966.

In addition to the salary from the hospital and income received through charging private patients, the overheads of operating the specialist's practice (e.g. office, secretary, superannuation, long service leave, worker's compensation) are met by the hospital.

Payments to Visiting Medical Practitioners

Visiting medical practitioners are doctors in private practice appointed to public hospitals. They charge their private patients directly retaining all revenue raised. For services to "hospital" patients they are paid directly by the hospital. There are two such methods of payment - sessional and fee for service.

Sessional Payments

This form of payment is used in all metropolitan and major country hospitals. Payment is based on an all inclusive hourly rate determined by arbitration between the Australian Medical Association and the Health Commission before a Judge of the New South Wales Industrial Commission.

The current base hourly rates range from $22 for a general practitioner to $38 for a senior specialist. Additional payments are made for being on-call and call-backs to the hospital. Base payments are limited to a maximum of $34,670 per annum (senior specialist rates).

Despite early resistance by the medical profession to the introduction of sessional payments, the majority of visiting medical practitioners have accepted sessional payment in the hospitals using this form of remuneration.

Fee for Service Payments

Fee for service payments in respect of the treatment of "hospital" patients are now confined to small country hospitals. Payment is made to the doctor for each service rendered to the patient based on 75% of the medical benefit schedule fee.

Income received is directly related to the number of services provided by the doctor. Evidence given to the Committee by a number of country hospitals indicates that fee for service payments to individual doctors often exceed $25,000. To this figure must be added the income received from charging private patients.

Areas of Concern

Apart from the obvious importance of payments to medical practitioners in pure dollar terms, the Committee's investigations have highlighted a number of areas of concern.

Principal amongst these is the inherent undesirability of fee for service remuneration of medical practitioners. Payment for each service rendered provides an incentive to provide unnecessary medical services. Unnecessary services include inappropriate admissions, prolonged length of stay in hospital, unnecessary or inappropriate investigations and in some instances unnecessary surgical procedures.

Evidence received by the Committee indicates that there is a 40% higher incidence of common surgical procedures per head of population in New South Wales when compared with Queensland. The Committee has noted with interest that fee for service medicine is largely non-existent in the Queensland public hospital system.

Evidence given to the Committee concerning fee for service payments for services to "hospital" patients in country hospitals suggest that this form of payment encourages unnecessary medical services. In a number of country hospitals the increases in total payments to visiting medical practitioners follows closely an increase in the number-of doctors appointed to the hospital. One hospital submission to the Committee noted that the reason for a sudden increase in payments to a new medical practitioner was the "need" for the doctor concerned to admit his patients to hospital in order to create an adequate medical record as the previous doctor had taken his records with him. Payments to a medical practitioner declined significantly at a country hospital following the introduction by the hospital of a requirement that the doctor concerned notate the patient's medical record each time a service was rendered. At another hospital, a discussion with the doctors in the town resulted in a fall of 18% in the hospital's activity level.

The Committee's concern is not confined to fee for service payments for services to hospital patients. Similar incentives for inappropriate and unnecessary medical services exist in the care of private patients in public hospitals. No controls exist in this area as the fees charged by medical practitioners for services to private patients are not subject to examination or regulation by the hospital.

As discussed elsewhere in this report, the medical profession is the principal determinant of the activity and workload in the public hospital system. It is apparent to the Committee that there is a need to examine the desirability of reducing or eliminating fee for service medicine in the public hospital system if the demand for public hospital resources is to be effectively controlled.

A number of options have been identified by the Committee as warranting further consideration and will be dealt with in the final report. These are:

* review of private practice arrangements for staff specialists

* introduction of charges for the use of hospital facilities by medical practitioners

* the extension of sessional payment for services to all "hospital" patients

* the introduction of sessional payment for services to all patients (both hospital and private) with no fees being raised by the attending medical practitioner.

Review of Private Practice Arrangements for Staff Specialists

Increasing public attention is being paid to private practice arrangements of this nature as they are seen to involve a "double payment" to staff specialists.

The arrangements in New South Wales are out of line with those adopted in other States. Whereas other states limit supplementation of base salaries to 25%, Scheme C in New South Wales allows a maximum supplementation of 75%. In addition, hospitals have little control over the use of trust fund monies by staff specialists. In the larger hospitals these funds are considerable. At the Royal Prince Alfred Hospital, for example, funds available to staff specialists for travel, equipment and research totalled $1.6 million in 1980/81. Private practice income in that year totalled $5.4 million.

Evidence from a major Sydney teaching hospital indicates that private practice arrangements, particularly Scheme C, have influenced the pattern of salaried medical staffing. Diagnostic areas (pathology and X-ray in particular) and other high revenue areas provide a far higher income to staff specialists than other areas with a more limited private practice -e.g. geriatrics, rehabilitation and psychiatry.

These disparities are reinforced through departmental trust funds with staff specialists in high revenue areas having liberal access to money for travel, equipment and research; It is apparent to the Committee that greater controls should be placed on the use of trust funds to ensure that they are used for the benefit of the hospital as a whole rather than individual doctors and departments.

Introduction of Charges for the Use of Hospital Facilities by Medical Practitioners

Currently public hospital facilities for the treatment of private patients are provided at no charge to visiting medical practitioners.

Many hospitals have urged the Committee to examine the desirability of introducing facility charges both as a means of raising additional revenue and to provide a disincentive to inappropriate utilisation and overservicing in public hospitals.

While this proposal has some merit, the Committee recognises the need to avoid such a charge being passed onto the patient by the medical practitioner. This may occur directly or through an increase in medical benefit schedule fees following application by the A.M.A.

Extension of Sessional Payments for Services to all "Hospital" Patients

Following the revised determination by Mr Justice Macken on sessional remuneration in October, 1981, the Health Commission believes it is now cost effective to replace fee for service payments with sessional payments in smaller country hospitals.

Extension of sessional payments will produce savings in both payments to visiting medicsl practitioners and overall hospital expenditure by removing the financial incentive to overservice "hospital" patients.

The Introduction of Sessional Payments for Services to all Patients in Public Hospitals

The Committee has yet to consider this option in detail. However, it represents an obvious alternative to the current pattern of medical practitioner remuneration. The suggested attraction is the potential to reduce the level of demand in the public hospital system, by removing the incentive inherent in fee for service payments for overservicing and inappropriate utilisation of public hospitals.

Under such a scheme, patients would not be charged medical fees by their doctor. Instead, doctors would be remunerated on a sessional basis by the hospital.

Hospitals would therefore need to set a medical service fee in addition to the daily bed charge in order to finance:

* the sessional remuneration of visiting medical practitioners

* the loss of revenue currently received by hospitals as their share of the private practice earnings of their salaried staff specialists

* any increased remuneration which may need to be paid to salaried staff specialists to compensate for their loss of fee for service payments from private patients

The medical service fee would be fully covered by basic hospital insurance.

The associated increase in hospital insurance charges would be offset by a fall in medical insurance charges.

It is important to point out that under such a scheme all patients would have the right to choose their own doctor.

The sessional rate of remuneration of doctors should, of course, be determined. by arbitration before a Judge of the Industrial Commission. This already occurs with the setting of sessional rates for the treatment of "hospital" patients.

In view of the far reaching nature of this proposal, the Committee will not make a recommendation until its final report.

In the meantime, the Committee will seek the views of the Australian Medical Association, the Public Medical Officers Association, the Doctors Reform Society, the New South Wales Health Commission, and health insurance funds. Further hearings will be held for this purpose.

AMBULANCE SERVICES

A number of hospitals in their submissions to the Committee nominated the increasing costs of inter-hospital patient transfer by ambulance as s factor in their budget over-expenditure.

Under the current charging arrangements the hospital is responsible for meeting the ambulance charges for all transport of patients from the hospital to another hospital or health care facility. The charges made by the New South Wales Ambulance Service are based on the penalty charging scale for non-contributors to the Ambulance Contribution Scheme rather than the actual cost of the transfer. As the costs of the transfer are met by the hospital the service is essentially provided "free" to the patient and his/her attending medical practitioner. In 1980/1981 the total amount paid by hospitals for inter-hospital transfers was $11,955,005.

The impact of these costs is particularly felt in country hospitals. In evidence taken from hospitals in the Murray Region of New South Wales, Ambulance Transports represented a major area of expense. At Balranald Hospital inter-hospital transfers were the highest single expense in Goods and Services (40% of total expenditure). At Deniliquin Hospital expenditure on Ambulance Transport increased from $58,500 in 1978/79 to $123,968 in 1980/81.

The use of an ambulance for inter-hospital transfer is authorised by the patient's doctor. From evidence by hospitals to the Committee it is apparent that many of these transfers could be more economically undertaken by alternative means -for example, taxis, hire cars and commercial airlines. The medical condition of many patients does not require the use of the ambulance service. Where the patient does require medical attention it can often be cheaper for the hospital to send a nurse and/or doctor with the patient by commercial airline than use the Air Ambulance. The Royal Newcastle Hospital, in evidence to the Committee described a saving of "about 90% of the cost of comparable ambulance service" through the use of hire cars for inter-hospital transfers wherever possible.

Another area of concern is the transfer of patients by ambulance to major metropolitan hospitals from country areas when appropriate facilities are available at a base or district hospital. These transfers, based essentially on historical doctor referral networks, may bypass a closer appropriate hospital thus adding to the cost of the ambulance transfer and placing an unnecessary demand on the metropolitan hospital.

While the Committee did not have available to it statistics for the New South Wales Ambulance Service as a whole, figures obtained for the Deniliquin Ambulance Service suggest that the inappropriate utilisation of ambulance services has contributed to the growth in the service.

Deniliquin Ambulance Service

		1971	198]
Staffing			
Superintendent		1	1
Senior Officers		1	3
Ambulance Officers		3	12
Other		1	1
	TOTAL	6	17
Vehicles			
Ambulance		3	7
Day Care Bus		-	1
Other		-	1
	TOTAL	3	9
Patients Transported			
Accident		145	404
Medical/Surgical		436	684
Day Treatment		720	7,319
Convalescent		144	402
Sports Attendance		9	24
	TOTAL	1,454	8,833

The Committee recommends that:

* a separate inquiry be held into the administration, financing and utilisation of the New South Wales Ambulance Service, Amongst other matters, the inquiry should examine:

  * the use of ambulances for inter-hospital transfers and the desirability of alternative means of transport.

  * whether the control mechanisms required to ensure that the ordering of ambulance transport by medical practitioners is appropriate to the health care .need of patients.