Public Accounts Committee
Parliament of New South Wales

Follow-up Report on Inquiries (1982)into the N.S.W. Public Hospital System

Report Number 21 April 1986

1985-86
Parliament of New South Wales

Public Accounts Committee of the Forty-eighth Parliament

Twenty-first Report

Follow-up inquiry pursuant to section 57 (1) of the Public Finance and Audit Act, 1983, into action taken on recommendations in the Second and Third Reports (1982) of the Committee on aspects of the N.S.W. public hospital system.

(Transcripts of Evidence included as Appendix to this Report)

April, 1986

Members of the Public Accounts Committee

The members of the Public Accounts Committee are:

Mr John Murray, M.P., Chairman*
John Murray, formerly a teacher, was elected Member for Drummoyne in April, 1982. An Alderman on Drummoyne Council for three terms, John Murray was Mayor of the Council for five years and served four years as Councillor on Sydney County Council. He is currently a member of the Prostitution Committee and the House Committee.

Dr Andrew Refshauge, M.P., Vice-Chairman** Andrew Refshauge was elected as Member for Marrickville in October, 1983. He previously practised as a Medical Practitioner with the Aboriginal Medical Service and was a past President of the Doctors' Reform Society. He is currently a fellow of the Senate of the University of Sydney.

Mr Colin Fisher, M.P.
Colin Fisher was elected Member for Upper Hunter in February, 1970. Former Minister for Local Government (1975) and Minister for Lands and Forests (1976), in opposition Colin Fisher has served as National Party Spokesman on Local Government, on Planning and Environment, and on Energy.

Mr Phillip Smiles, M.P.
Phillip Smiles was elected Member for Mosman in March, 1984. A management and marketing consultant since 1974, Phillip Smiles has been involved with entrepreneurial business activities since his teens. Since entering Parliament he has been actively interested in the areas of small business, emergency services, welfare and financial analysis.

Mr Allan Walsh, M.P.**
Allan Walsh was elected Member for Maitland in September, 1981. Following eight years as a Mirage Fighter pilot with the R.A.A.F., he was involved in business management. Allan Walsh has also taught industrial relations, management and history at technical colleges.

* Mr John Aquilina was Chairman of the Committee until he was appointed Minister for Natural Resources on 5 February, 1986. Mr John Murray was elected Chairman and Dr Andrew Refshauge, Vice-Chairman on 20 February, 1986.
** Mr Allan Walsh was appointed to the Committee on 20 February, 1986.

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Committee Members. From left: Andrew Refshauge (Vice-Chairman), Phillip Smiles, Colin Fisher, John Murray (Chairman), Allan Walsh

Committee Members. From left: Andrew Refshauge (Vice-Chairman), Phillip Smiles, Colin Fisher, John Murray (Chairman), Allan Walsh

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CHAIRMAN'S FOREWORD

In 1981 the Committee received a reference from the then Minister for Health Mr Brereton, to examine the causes of expenditure over-runs in health funding and to investigate the standard of public accountability in Schedule II and Schedule III hospitals. The Committee's second and third reports dealing with these matters were tabled in Parliament in February and April 1982 respectively.

During 1985 the Committee adopted a program of reviewing the outcome of past inquiries and action taken on past recommendations. This report dealing with the public hospital system is the first of such reviews.

In reviewing action taken on past recommendations, the Committee found a number of areas where action taken has either been ineffective or tardy. These areas, for which new recommendations have been proposed, concern the delineation of hospital roles, the budgeting process, the provision of worthwhile incentives to hospitals, hospital accountability and hospital performance measurement and comparison.

Because Health is seen as a "super" value, which cannot be challenged, i.e. it is all good, redirection of health expenditure, no matter how justifiable or necessary, will be perceived as "bad". It comes as little surprise, therefore, that the Committee has concluded that progress in reforming health administration in this State has been slow. I believe there is a crying need for clearer direction; better planning, performance measurement and management of health resources; and greater public accountability. Without progress in these areas the value obtained from our burgeoning health bill will diminish rather than increase.

It is acknowledged that this report is critical, of both the Health Department and the public hospitals. The Committee believes that there has been a lack of commitment to implementing the spirit, if not the letter, of many of its earlier recommendations.

I would like to acknowledge the cooperation given to the Committee by the Minister for Health, Mr Unsworth, the Health Department, Royal Prince Alfred Hospital, Prince of Wales Hospital, Manly Hospital, St Vincent's Private Hospital and the Hospital Corp. of Australia.

I would also like to thank Jack O'Donnell and the permanent members of staff, particularly the Director of the Secretariat, Frank Sartor, for their excellent contributions to this inquiry.

CONTENTS

1 SUMMARY OF REPORT AND RECOMMENDATIONS

1.1. The Public Accounts Committee's Second and Third Reports in 1982 recommended improvements to hospitals' budgeting and accountab ility processes. The Committee has reviewed the actions taken on the recommendations.

1.2. In examining actions taken by the Health Department and hospitals the Committee has identified a number of areas where action has either been ineffective or tardy. A resume of action taken is presented in Tables 3.1 and 3.2.

1.3. The Committee is not convinced that hospitals have taken all available steps to reduce costs so as to meet their budget obligations without the need to resort to cuts in service. Indeed, notwithstanding the various pleas of mitigating circumstances such as the doctors' dispute, there is prima facie evidence of fiscal irresponsibility on the part of many hospitals. (Refer Section 3.9)

1.4. The Committee belie ves that the Health Department has been remiss by not adequately delineating hospital roles and by not holding hospitals sufficiently accountable for their actions. (Refer Section 3.11)

1.5. In order to make hospitals more accountable, the Committee recommends that, in the short term,

(a) Health Department monitoring of individual hospital spending be improved, such monitoring to include the speedy provision of the following monthly reports in respect of each hospital:

· cash position as at the end of the month forecast cash position at year end financial operating statement for the month

financial operating statement forecast for the year · summary reports to the Minister.

(b) the Health Department more readily impose sanctions on hospitals including recommending the dismissal of,hospital Chief Executive Officers and Boards who cannot meet their fiscal responsibilities.

(c) Comparative hospital performance data be regularly tabled in Parliament. (Refer Section 3.12)

1.6. The Committee also recomme nds that the Minister consider commissioning a public inquiry into the operations of any hospital that overruns its budget. (Refer Section 3.13)

1.7. In view of the high cost of the public hospital system to the public purse the Committee foreshadows that it may in the future investigate in detail the financial affairs of individual hospitals should current budget overruns continue. (Refer Section 3.14)

1.8. In the Committee's view the goal of greater hospital staffing autonomy must still be genuinely pursued. Hospitals who fail to act responsibly in the absence of controls should have sanctions imposed on them such as the reimposition of staff ceilings for a temporary period or if necessary the dismissal options referred to in Section 3.12.(b). (Refer Section 3.16)

1.9. In the course of discussions with hospitals the Committee has become aware of the transfer of community health related staff to the establishment of some hospitals. This has caused a number of problems including a split in the reporting responsibility of community based paramedical staff and an alleged failure of the Health Department to compensate hospitals for the resulting increases in staff in subsequent years. The Committee is concerned that the issues relating to these changes be expeditiously resolved. (Refer Section 3.17)

1.10. The, Committee believes that there is a pressing need to improve the management expertise at all levels within hospitals,

including that of persons in specialised disciplines such as nurses and doctors. (Refer Section 3.18)

1.11. The Committee rejects the conclusion that the commercialisation of subsidiary hospital services is not feasible and recommends that the Health Department encourage hospitals to:

(a) charge for external services provided and more accurately cost the provision of services to other hospitals

(b) further share common subsidiary services on an area basis where economies of scale are attainable. (Refer Section 3.21)

1.12. There is little doubt that to date the Health Department's Management Information Review System M.I.R.S. and other current systems have failed to make hospitals publicly accountable for their levels of performance. New evidence given to the Committee suggests, that while M.I.R.S. may be a useful first step, the management information systems available to hospital managers need to be developed further to include patient/diagnosis based cost comparisons such as:

- costs incurred by, or on behalf of, individual patients the average cost of treating patients with particular diagnosis - an analysis of the financial performance of medical staff - an analysis of the financial performance of individual hospital units (Refer Sections 3.25 & 3.26)

1.13. The Committee recommends that the Department:

(a) urgently proceed to implement an effective performance reporting system that will allow comparison of hospital efficiency and performance across the entire N.$.W. public hospital system, in terms of such measures as are listed in paragraph 1.12.

(b) plan for the extension of the system to give appropriate output related performance measures in the longer term.

(c) ensure that hospital performance measures are regularly published. (Refer Section 3.36)

1.14. It is recommended that in order to avoid the problem of delays in budget notifications:

(a) hospital and regional budgets be prepared on a prospective basis, after proper consultation, and the time taken between final budget notification to the Health Department and the settlement of individual hospital allocations be reduced dramatically.

(b) that the Health Department seek from Treasury authority to either:

(i) regard the May budget costing advice as final and to

use it for the purposes of regional allocations

or

(ii) alter the hospital financial year to a calendar year. This would mean that hospitals would have their budget settled by December for a financial year commencing the following January. (Refer Section 3.42)

1.15. It is recommended that the present ineffective incentive budgeting system be replaced by a revised scheme which would be seen as providing real benefits for hospitals as well as the State by promoting improvement in hospital efficiency rather than short term savings. In particular, the Health Department should proceed with a feasibility study into the use of a patient/diagnosis related information system as the basis for a stable incentive budgeting system. (Refer Section 3.§1)

1.16. Evidence obtained from both the Health Department and the hospitals shows clearly that the major unresolved question

between the hospitals and the Department is how best to divide the hospitals' overall budget allocation between individual hospitals. (Refer Section 4.1)

1.17. The Committee acknowledges that the two parties have diverging goals and that this is in large measure the reason why agreement is so elusive. Nevertheless, it believes that the lines of communication must be improved. (Refer Section 4.21)

1.18. The funding process should include the following two steps:

(a) an assessment of the average cost of services at which a hospital will be financial remunerated for budgeting purposes

(b) an assessment of need, based on hospital role, and incorporating an adjustment aimed at achieving greater inter-regional equity. (Refer Section 4.24)

1.19. The Committee recommends that the Department set out to reach final agreement with each hospital on its role, and a clearer identification of the services to be delivered. (Refer Section 4.17)

1.20. In respect of the budget setting process the Commi ttee recommends the following:

(a) that the output from the performance reporting system and from the clearer identification of roles/needs be used to relate ideal service levels to total funds available both at State level and at individual hospital level.

(b) that the Health Department take steps to make the budget setting process better understood by hospitals and the public generally.

(c)that, notwithstanding the problems cited in para. 4.23, consideration be given to a split system where: **a**

calculated sum is given to pay for accident and other emergency treatment; an arbitrary sum is given for all other services - with the hospital taking responsibility for deciding what services it is to provide. (Refer Section 4.26)

1.21. As the above recommendations would take time to implement, it seems inevitable that the block or arbitrary allocation of funds will continue in the meantime. To ease the effects of this, hospitals could be given greater discretion to manage their operations within the total sum allotted to each subject to the firmer implementation of the recommendations contained in Section 3.12.

2 BACKGROUND

2.1. In abridged terms the first ever reference from a Minister to the Committee was to:

> **enquire into the causes of expenditure overruns** in health funding in Schedule 2 and Schedule 3 hospitals in 1980-81 and matters related thereto ;
>
> · investigate **the standard of public accountability** of Schedule 2 and 3 hospitals and make **recommendations... to ensure** full accountability **of these hospitals to the** Parliament.

2.2. In February, 1982, the Committee presented an interim report with twenty recommendations. (Identified as the Committee's Second Report). Broadly, they covered:

> budgeting, financial control and reporting systems;
>
> planning, control and remuneration structures for services by the medical profession;
>
> strategic planning for hospital services.

2.3. The second area (dealing with the role of the medical profession) is still the subject of Government policy decisions/planning. It has therefore, not been addressed in this Report.

2.4. In April, 1982, a further report (identified as the Committee's Third Report) made forty-four recommendations - dealing mostly with the financial accountability issue.

2.5. In November, 1982, the Minister's responses to those recommendations were tabled in Parliament.

2.6. Annual reports by the Department of Health (some under the title of Health Commission) describe action taken by it. The Department's 1983 report states (page 3) that the vast bulk of the Committee's recommendations were accepted by the Minister -including incentive budgeting intended to allow retention of real savings. It was also stated that there would be more power for hospitals to decide how the budget allocation was to be spent. At the same page was a statement that "unexplainable, over-expenditure could now lead to dismissal". At page 6 of the report was a general comment that 1982-83 saw major efforts being made to monitor and control financial performance and to enhance the level of financial accountability.

2.7. As part of its process of reviewing and following up on action taken on its recommendations, the Committee scheduled a public hearing on 16 September, 1985. Evidence was given by representatives of:

Royal Prince Alfred Hospital

Royal North Shore Hospital

Department of Health

Written submissions were made by those bodies and a separate submission was made by the Royal Newcastle Hospital.

2.8. The Committee also examined the management informati on and performance reporting systems of a number of hospitals. In this regard further discussions were held with:

· The Department of Health (on the operation of the M.I.R.S. System)
The Prince of Wales/Prince Henry Hospitals Group

- Manly Hospital

- St Vincent's Private Hospital

- Hospital Corp. of Australia

2.9. This report sets out the Committee's comments on action taken to date and makes further recommendations on unresolved issues.

3 ACTION ON RECOMMENDATIONS CONTAINED IN COMMITTEE'S SECOND AND THIRD REPORTS

3.1. In appendices to this Report are the written submissions by the Health Department setting out action taken on the recommendations of the second and third reports of the Public Accounts Committee.

Overview

3.2. The recommendations contained in the Second and Third Reports, together with the Committee's comments, are summarized in Tables 3.1 and 3.2 respectively.

3.3. The Department claims to have acted, or tried to act, on all of the recommendations. In its brief examination of Departmental and hospital actions arising from the recommendations, the Committee identified a significant number of areas where action has either been ineffective or tardy. A brief discussion of some of these areas follows.

Accounting and Auditing

3.4. In its Third Report the Committee made eight recommendations. Some of the specific recommendations on accounting were referred by the Minister to a working party but it was not until March, 1984, that a circular was issued to hospitals (reference File No. C6584, Circular No. 84/75). The circular reported the review of hospital accounting standards and set out some specific policies to be followed. Accounts and Audit Determination to formalise the accounting policy directions was not issued until September 1985, a delay of over three years.

Table 3.1, Summary of Action taken on Second Report Recommendations

Recommendation No.	Subject	Comment
1, 2	Action against Board if a hospital exceeds budget.	Not adequate
3	Early notice of budget.	Action to date has not solved the problem. See recommendation 3.42 of this Report.
4,13	Review of hospitals' expenditure monitoring systems and the budget consultation process.	Some action has been taken but needs to go further. See comments and recommendations in Sections 3 and 4,
5	Action needed in event of rationalisation of hospital services.	The Department lists action taken for the initial spate of rationalisations. The Committees recommendati ons stand for any future moves. Recommendations in Section 4 of Report could he!p to quantify and validate any future adjustments required.
6-12	Staff levels.	These matters are overshadowed by industrial and policy implications.
14	Formal communication with medica1 staff.	These matters are overshadowed by industrial and policy implications.
15	Avoidance of clerical errors.	*
16	Reserve funds,	*
17	Budget for role changes.	Not adequate. Recommendations in Section 4 of this Report could help to quantify the adjustments required.
18	Hospital budgets to be structured on a department or program basis	Not adequate
19	Allocations within regions to be on clearly defined and understood formulae.	Hospitals believe that allocations are arbitrary and not based on needs formula. See discussion and recommendations in Section 4.
20	Ambulance services.	*

* Committee accepts that action taken meets present needs.

Table 3.2 Summary of Action Taken on Third Report Recommendations

Recommendation No.	Subject	Comment
1,2,3,4,7, 17,18,19	Accounts and auditing.	*
20,21,22, 23,24	Reporting.	*
27,28,29	Management	Not adequate. See discussion Section 3.
5,6,8,9, 26	Budget process.	Not adequate. See discussion Section 4.
11,12,13, 14,15,16	Incentive budget system.	Not adequate. See Section 3. and recommendation 3.51.
10	Commercial services.	Not adequate. See 3.21.
25,33,34	Role definition.	Not adequate. See discussion Section 4 and recommen dation 4.17.
30,31,35, 40	Medical practice and policy.	Currently subject to Government policy decisions.

* Committee accepts that action taken meets present needs.

Accountability of Hospitals

3.5. The key recommendations dealing With the need for greater hospital accountability and specific action to be taken against hospitals if they exceeded their budgets are nos 1 and 2 of Third Report.

3.6, The Department's reported action on recommendation No. 1 is indicative of its failure to implement the spirit of some of the recommendations.

> Committee Recommendation:
>
> "The Minister for Health automatically review the appointment of the Board of any Schedule II hospital which exceeds its approved budget for gross operating payments."
>
> Departmental Response:
>
> "Circular 83/3 of 7 January 1983 requires Regional Directors to provide a report on over-expenditure each year with proposals regarding any action that should be taken.
>
> Should those proposals recommend against the dismissal of a board, the Regional Director is to certify that all reasonable actions have been taken by the board to come within budget."

3.7. While it is understood that the Health Department does monitor hospital spending at regional level there is no public or external result from this monitoring. Clearly recent experience shows that any internal action that is being taken is ineffective.

3.8. Figures supplied by the Health Department for five major hospitals showed that they all overspent their 1984-85 budget allocations. The total overrun for these hospitals of $9.76 million comprises:

	$M	% overrun
Royal Prince Alfred	3.66	2.8
Prince Henry/Prince of Wales	1.47	1.2
St Vincents	2.17	3.4
St George	0.98	2.2
Royal Alexandra Childrens	1.48	3.5
	9.76	

3.9. The Committee is **not convinced** that hospitals have taken all available steps to reduce costs so as to meet their budget obligations without the need to resort to cuts in service. Indeed, notwithstanding the various pleas of mitigating circumstances, such as the doctors' dispute, there is prima facie evidence of fiscal irresponsibility on the part of some hospitals. This is supported by Tables 3.3 and 3.4 which show the levels of allocation and overruns for the three years to June, 1985 for five hospitals. With one exception overruns occured in years of real increases in budget allocation. Stronger evidence of fiscal irresponsibility on the part of the hospitals is given by Table 3.5 which shows budget allocations, adjusted for rise or fall in hospital activity levels, against inflation rate. It is clear from this table that not one hospital suffered real cuts in spending and in many cases they were given significant real increases, yet overruns still occured. (See footnote associated with Table 3.5.)

3.10. A brief review of press reports suggests that many hospitals are acting increasingly like political organisations. Requests for budget increases, and the funding of spending overruns, are being supported more by public political pressure than by well argued cases based on a proper analysis of priorities and needs and due regard for their own level of efficiency. Unfortun ately, it seems that the goals of some hospitals have more to do with expanding individual empires than supplying health services at maximum efficiency.

TABLE 3.3 GROWTH IN BUDGETS OF FIVE HOSPITALS 1982/83 to 1984/85

	Year	Final Budget Allocation [1] $,000	Increase on Previous Year %	Inflation Rate [2]	Budget Overrun [3] ($,000 overspent)
Royal Prince Alfred	1982/83	12,393			
	1983/84	[4] 126,813	12.8	5.3	+ 444
	1984/85	[4] 132,517	4.5	4.2	+3658
Prince Henry/P.O.W Groups	1982/83	107,724			
	1983/84	[4] 118,140	9.7	5.3	+ 549
	1984/85	[4] 124,116	5.1	4.2	+1473
St Vincent's Hospital	1982/83	53,581			
	1983/84	[4] 58,633	9.4	5.3	+ 233
	1984/85	[4] 63,512	8.3	4.2	+2168
St George Hospital	1982/83	38,848			
	1983/84	[4] 44,161	13.7	5.3	+ 196
	1984/85	[4] 45,494	3.0	4.2	+ 983
Royal Alexandra Childrens'	1982/83	36,476			
	1983/84	[4] 39,705	8.9	5.3	+ 248
	1984/85	[4] 41,641	4.9	4.2	+1476

TABLE 3.4 CHANGES I# ACTIVITY LEVELS OF FIVE HOSPITALS 1982/83 to 1984/85

	Year	Bed Days	Admissions
Royal Prince Alfred Hospital	1982/83	339,607	48,948
	1983/84	343,501	48,363
	1984/85	332,053	44,215
Prince Henry/P.O.W. Group	1982/83	356,442	39,876
	1983/84	352,768	40,395
	1984/85	347,533	40,083
St Vincent's Hospital	1982/83	184,599	22,868
	1983/84	185,270	22,284
	1984/85	180,508	19,992
St George Hospital	1982/83	153,969	23,882
	1983/84	159,086	23,860
	1984/85	146,167	21,041
Royal Alexandra Childrens I	1982/83	77,938	14,318
	1983/84	74,880	14,725
	1984/85	75,624	14,391

(1) Final allocation including allowance for new service provisions and provision of supplementary funds for salary award increases and other specific factors.
(2) Measured by 70/30 weighted average of movements in Minimum Award Rate and Consumer Price Index.
(3) Variation between actual gross operating expenditure and final budget allocation.

(4) Includes reduction for transfer of funds to colleges of advanced education. % increase year to year adjusted to exclude impact of this reduction.

TABLE 3.5 GROWTH RATE IN HOSPITAL BUDGETS ADJUSTED FOR CHANGES IN LEVELS OF ADMISSION

Hospital	Year	Budget as % of previous year	Admissions as % of previous year	% Increase in Budget Adjusted for Admissions	Inflation % p.a.**	Real Budget Growth % p.a.
Royal Prince Alfred	1983/84	112.9	98.8	14.2	5.3	8.9
	1984/85	104.5	91.4	14.3	4.2	lO.1
Prince Henry/Prince of Wales	1983/84	109.7	lO1.3	8.3	5.3	3.0
	1984/85	105.1	99.2	5.9	4.2	1.7
St. Vincents	1983/84	109.4	97.4	12.3	5.3	7.0
	1984/85	108.3	89.7	20.7	4.2	16.5
St George	1983/84	113.7	99.9	13.8	5.3	8.5
	1984/85	103.0	88.2	16.7	4.2	12.5
Royal Alexandra Children's	1983/84	108.9	102.8	5.9	5.3	0.6
	1984/85	104.9	97.7	7.4	4.2	3.2

It is noted that this analysis is limited by the fact that hospital costs do not increase/decrease linearly with activity levels as many costs of a fixed nature. Nevertheless, the effects indicated are expected to be correct in qualitative if not quantitative terms.

Measured by 70/30 weighted average of movements in Minimum Award Rate and Consumer Price Index.

3.11. Although the budget setting process is more explicitly addressed in Section 4 it is imperative that the current tendency whereby the loudest hospital gets the most money, be halted. Either hospitals are given sufficient budgets or they are not. If funds are insufficient then the Department has a responsibility to alter the distribution of funds to ensure that individual hospitals can carry out their agreed functions. Alternatively, if budgeted funds are sufficient then individual hospitals must be made to live within them. In this regard, the Committee was disturbed to learn that the senior management of one hospital made a conscious decision to over-run its budget. The Committee believes that the Health Department has been remiss by not adequately delineating hospital roles and by not holding hospitals sufficiently accountable for their actions.

3.12. In Section 3.36 the Committee has made r ecommendations which will assist in making hospitals more accountable, but this is dependent upon the implementation of new management information systems. In the short term it is recommended that:

(a) Health Department monitoring of individual hospital spending be improved, such monitoring to include the speedy provision of the following monthly reports in respect of each hospital:

cash position as at the end of the month

. forecast cash position at year end
. financial operating statement for the month
financial operating statement forecast for the year
summary reports to the Minister.

(b) the Health Department more readily impose sanctions on hospitals including recommending the dismissal of hospital Chief Executive Officers and Boards who cannot meet their fiscal responsibilities.

(c) Comparative hospital performance data be regularly tabled i n Parliament.

3.13. The Committee also recommends that the Minister consider commissioning a public inquiry into the operations of any hospital that overruns its budget.

3.14. In view of the high cost of the public hospital system to the public purse the Committee foreshadows that it may in the future investigate in detail the financial affairs of individual hospitals should current budget overruns continue.

Hospital Staffing

3.15. Recommendations 6-12 of the Second Report deal with giving hospitals greater autonomy over their staffing. Although the Department adhered to recommendation no. 6 by abolishing staff establishment ceilings it then took away autonomy by ordering hospitals to obtain its approval for all appointments above a certain (low) grade. This did not effectively increase the autonomy of hospitals.

3.16. The Department rightly sees difficulties in removing staff ceilings because some hospitals have acted irresponsibly by overstaffing. In the Committee's view the goal of greater hospital staffing autonomy must still be genuinely pursued. Hospitals who fail to act responsibly in the absence of controls should have sanctions imposed on them such as the reimposition of staff ceilings for a temporary period or if necessary the dismissal options referred to in Section 3.12.(b).

3.17. In the course of discussions with hospitals the Committee has become aware of the transfer of community health related staff to the establishment of some hospitals. This has caused a number of problems including a split in the reporting responsibility of community based paramedical staff and an alleged failure of the Health Department to compensate hospitals

for the resulting increases in staff in subsequent years. The Committee is concerned that the issues relating to **these changes** be expeditiously resolved.

3.18. In the course of discussion with representatives of a number of private and public hospitals members of the Committee were struck by the far greater consciousness of the need for management experience/skills in the private hosptials compared to the public hospitals. The Committee believes that there is a pressing need to improve the management expertise at all levels within hospitals, including that of persons in specialised disciplines such as nurses and doctors.

Costing and Sharing of Subsidiary Hospital Services

3.19. Recommendation 10 of the Committee's Third Report stated that:

> "Subject to budgetary constraints hospital management be encouraged to provide commercial services".

In its response to the recommendation, the Department stated that, after surveying hospital opinions;

> "It was decided that the disadvantages outweighed any benefits to be obtained and no further action was taken".

3.20. In discussions with some hospitals and officers of the Health Department it become apparent that:

(a) Subsidiary Services (e.g. pathology, linen, meals) provided by some hospitals, and used by other hospitals, are not properly costed and consequently hidden cross-subsidization is likely.

(b) Whilst some sharing of services among hospitals is occurring there appears to be more scope for sharing on an area basis with significant economies of scale

3.21. The Committee rejects the conclusion that the commercialisation of subsidiary hospital services is not feasible and recommends that the Health Department encourage hospitals to:

(a) charge for external services provided and more accurately cost the provision of services to other hospitals

(b) further share common subsidiary services **on an area basis** where economies of scale are attainable.

Management Information Systems for Hospitals

3.22. In its Third Report the Committee recommended that:

> "The Commission (now Department) take steps to expedite the implementation of the Management Information Review System in all base, district and teaching/referral hospitals throughout New South Wales."

3.23. The Committee's third report (pp. 48-51) reveals the following reasoning supporting this recommendation:

> "One area where the Health Commission of New South Wales has acted to assist hospital managers to improve control over hospital expenditure is the development and application of a Management Information Review System (M.I.R.S.). The main purpose of M.I.R.S. is to provide a means for hospital administrators and department heads to measure and review their use of resources against changes in level of activity.
>
> Initially piloted in five district size hospitals in the Sydney metropolitan area, M.I.R.S. is currently being introduced in an additional 21 public hospitals throughout New South Wales·
>
> Although M.I.R.S. has been designed principally as an internal management tool, it also provides hospitals with a set of common performance indicators for peer group comparison. When introduced on a wider scale, it could serve as an aid to the Commission in monitoring and reviewing the budgets of individual hospitals.

Evidence given to the Committee from several participating hospitals and the Health Commission indicated that M.I.R.S. has been effective in assisting hospitals to identify areas of high 'controllable costs'.

Wollongong Hospital and Royal Prince Alfred Hospital strongly supported the development of responsibility budgeting based on the allocation of costs to departments or functional units. They argued that this development should be linked to the use of computer systems. Both Wollongong and Sydney Hospitals suggested that accounting and patient information systems should be developed on a regional basis."

3.24. The Department proceeded to implement the M.I.R.S. program. The system has been installed into more than fifty hospitals including four teaching hospitals. Acceptance by the hospitals has been less than wholehearted. Five of the teaching hospitals have started to develop their own system and have not adopted M.I.R.S.

3.25. In summary, the major weaknesses of M.I.R.S. appear to be:

(a) The cost centres defined in the M.I.R.S. system do not correspond to the same departments within hospitals where decisions to incur costs are taken.

(b) M.I.R.S. was originally developed as an internal hospital management tool and is therefore of limited use for inter-hospital performance comparisons.

(c) It does not provide key output performance measures such as - costs incurred by, or on behalf of, individual patients

the average cost of treating patients with particular diagnosis - an analysis of the financial performance of medical staff - an analysis of the financial performance of individual

hospital units

3.26. New evidence given to the Committee suggests that while the Health Department's Management Information Review System (M.I.R.S.) may be a useful first step, the management information systems available to hospital managers need to be developed further to include patient/diagnosis based cost comparisons.

Assessing the Cost of Services and Hospital Performance

3.27. An approach used in the U.S.A., referred to by Dr. Scarf, (for the Department), is the use of diagnosis related groups to fund hospitals on a basis of $ "X" to look after a patient with a particular health problem (P. 175):

> "It does not say how much it will cost the hospital to look after a patient with that disease, but it tells them how much they will be reimbursed for their care. That is an approach to cost control that has had a very substantial impact obviously on hospitals performance and private hospital survival in the United States".

3.28. Royal Prince Alfred Hospital gave the Committee information on its annual operating plan. The system draws its input from the HOSPAY system for labour costs, and matches this with input data on volumes of service delivery. The systems reports provide an impressive array of data on raw costs of services and on costs per unit of volume of a very extensive range of services but it still falls far short of the system referred to by Dr Scarf. Whereas the M.I.R.S. system reports past costs with prior year comparisons the A.O.P. is designed to report spending versus budget. A detailed comparison of the A.O.P. and M.I.R.S. system is presented in Appendix 3.

3.29. The Health Department has commented about the R.P.A.H. system in the following terms:

> "The Annual Operating Plan has been subject to development at the Royal Prince Alfred Hospital since about 1979. It is considered that it is more applicable to the large teaching hospitals and is

dependent upon computer support within the hospital. It is not considered that the level of detail reported by the regular reports could be of use in smaller hospitals and the resources necessary to support it could not be warranted in those smaller hospitals.

3.30. There is little doubt that to date the M.I.R.S. and other systems have failed to make hospitals publicly accountable for their levels of performance. It may be that the M.I.R.S. system is a useful first step but it does not go far enough.

3.31. The Committee believes that an essential element in making individual hospitals more accountable, and the public hospital system more efficient, is the development of a meaningful performance measures that facilitate inter-hospital efficiency comparisons. The types of measures available, together with comments, were summarized by R.P.A.H. and are included in Appendix 4. These include:

- Bed day cost
- Occupancy
- Cost per patient treated
- **C**ase-mix variation
- Disease groupings extracted from N.S.W. Hospital Morbidity Collection
- Diagnostic Related Groupings
- Disease costing
- Medical staff profiling
- Program Budgeting

3.32. It was noted that the Prince of Wales/Prince Henry Group of Hospitals is planning to adopt a program budgeting approach. This system may have merit in.assisting in role definition and in resource allocation. However, it does not address the question of inter-hospital efficiency comparisons.

3.33. The private hospital system, excluding non-profit hospitals, has moved to patient oriented costing systems in recent years. Information obtained from the Hospital Corp. Aust. Pty Ltd indicates performance reporting comprises two major components:

- monthly reports showing costs of line items by cost centres and departments within cost centres

- an additional report giving costs per patient per day on a diagnostic related basis, which is based on the International Classification of Diseases. This report gives comparisons between hospitals for the same type of treatment.

The latter system currently suffers from the lack of a weighting system for length of stay.

3.34. The Committee does not wish to prescribe a performance reporting system for the N.S.W. public hospital system. However, it is clear that a system with the kind of information given in paragraph 3.31 is long overdue. In this regard, the Committee is critical of the Department's indecision in recent years.

3.35. The Committee rejects the view that inter-hospital comparisons cannot be made. It notes that this is occurring in the private hospital system and is being developed in the Victorian public hospital system.

3.36. The Committee recommends that the Department:

(a) urgently proceed to implement an effective performance reporting system that will allow comparison of hospital efficiency and performance across the entire N.S.W. public hospital system, in terms of such measures as are listed in paragraph 3.31.

(b) plan for the extension of the system to give appropriate output related performance measures in the longer term.

(c) ensure that hospital performance measures are regularly published.

Timing of Budget Notification

3.37. The present system is that after the Health Department knows its budget allocation it can tell each Region the size of its share. Each Region must then set the amount for each hospital in its area. Until the hospitals are told by the Region the size of their shares, the hospital budget planning can't be finalised. It was confirmed by the Department in evidence (P.165) that regional budgets cannot be notified until the Department has a firm and final allocation (i.e. September). This means that hospitals are not advised of their allocation until October/November or later.

3.38. The Department seems convinced that hospitals already know enough - based on past events - to guess their probable allocation quite early in the piece. The hospitals deny this -but in terms which suggest they won't believe or act on figures which are not "firm". It seems to the Committee that there is more common ground in the views than the parties are willing to admit.

3.39. Recent budgetary reforms by the Government now provide Ministers with advice of firm ceilings for expenditure in May. (See the Treasurer's 1985-86 Budget Speech P. 9). Because of the position of the Health Department - i.e.having the hospitals waiting at the end of the information line - a change is warranted. If the Department was able to regard the May advice from Treasury as final, and to quote it, this would mean that regions could settle the allocations in May/June and advise hospitals immediately - i.e. at one stroke, the hospitals would know their individual expenditure ceilings some four months

earlier than has been past practice. Although a small and simple step to take, this action would have a tremendous impact in removing one of the great bones of contention between the Department and the hospitals.

3.40. Notwithstanding this possible improvement, the delays between official notification of budget amounts to the Health Department and the final settlement of the budget of individual hospitals is still too great. There appears to be no good reason why the budgets of individual hospitals could not be devised on a prospective basis and adjusted back automatically if the amount of money allocated to each region is less than that assumed in the budget bid. Such adjustment should take one week rather than two to three months.

3.41. An alternative approach to the budget setting timetable proposed in 3.39 would be for hospital budgets to be calendar year budgets and the budget setting timetable be maintained as is. This would fit into a natural cycle which sees a drop in activity and in doctor and nurse availability at the end of the calendar year.

3.42. It is recommended that in **order to avoid the problem** of delays in budget **notifications:**

(a) hospital and regional budgets be prepared on a prospective basis, after proper consultation, and the time **taken** between final budget notification **to the** Health Department and the settlement of individual hospital allocations be reduced dramatically.

(b) that the Health Department seek, from Treasury, authority to either:

(i) regard **the May** budget costing advice as final and **to** use it **for the** purposes of **regional allocations**

or

(ii) alter the hospital financial year to a calendar year. This would mean that hospitals would have their **budget settled** by December for a financial year commencing **the** following January.

Incentive Budgeting

3.43. Recommendations 11 to 16 of the Third Report concerned an incentive budgeting system. It was proposed that "real" savings:

be retained by hospitals, to an upper monetary limit, for use in the following year; and

· be expended as approved by the Health Commission (now Department).

3.44. In November, 1983, the Department issued a circular with details of an incentive scheme. The Department has claimed (P 143) that "In essence, the scheme incorporated the characteristics of the recommendations of the Committee". However, as emerged in evidence at the "follow up" hearing the scheme certainly strayed from the spirit of the original recommendations. It was doomed from the start and has been virtually ignored by the hospitals.

3.45. Essentially an upper limit of $50,000 in savings was set and only 60% of the saving could be used by the hospital. The remaining 40% of the saving was to be allocated to the Region's pool for capital expenditure. For a potential maximum benefit of only $30,000 p.a. it was rightly seen by hospitals as not worth the effort. Only one hospital applied to take the benefits of the scheme - and it failed to pass the guideline tests. No savings were achieved by the scheme as promulgated.

3.46. !t is obvious that if an incentive budgeting system is to work, the hospitals must see real advantages. For example the savers should not be punished by cutbacks in the next year. If a scheme is set up which a hospital finds attractive it, in turn, must make sure it is attractive within its own structure. If a unit or section saves money through hard work and greater efficiency, it must see some tangible, direct reward for its efforts. Otherwise, just as the hospitals "voted with their feet" against the Department's scheme, the lack of enthusiasm of hospital units and sections would shut off the hospital from any real benefits.

3.47. It has been stated that there is no incentiv e for the Government to run a scheme unless it gets the advantage of reduced total expenditure. It has also been stated that it is not feasible to have a scheme which provides both incentives to the hospitals and benefits to the Government. This depends, however, on whether the benefit to the taxpayer is seen as saving money or improving hospital efficiency.

3.48. If hospitals were allowed to use savings from budget to improve the quality or level of services then they would have a real incentive to spend less than their budget allocation. These savings would allow improvement/increases in services which would in turn reduce unit costs of services.

3.49. Assuming the Health Department had a budget setting process as outlined in Section 4, hospitals would be allocated funds based on, inter alia, average performance/efficiency levels. There would then be a stable system of incentives that would satisfy all parties: namely the hospitals (they are assured of a stable incentive), the Health Department (it would be satisfied that efficiency would be improving), and Treasury (it would be assured that expenditures are reasonable and predictable).

3.50. Two current problems existing which mitigate against an incentive budgeting system as described above are:

(a) lack of meaningful comparative performance data on which to base individual hospital budgets

!b) inequitable allocation of resources between hospitals.

Whilst an incentive budgeting system would work best if both of the above problems were overcome it is considered that the first problem is the most crucial to an effective incentive. budgeting system. Without hospital performance data it would be difficult, if not impossible, to know whether savings made by hospitals against budget are due to genuine improvements in efficiency or to an overgenerous budget allocation. It may therefore be that the introduction of a comprehensive incentive budgeting system has to await the introduction of a suitable performance monitoring system covering all hospitals.

3.51. It is recommended that the present ineffective incentive budgeting system be replaced by a revised scheme which would be seen as providing real benefits for hospitals as well as the State by promoting improvement in hospital efficiency rather than short term savings. In particular, the Health Department should proceed with a feasibility study into the use of a patient/diagnosis related information system as the basis for a stable incentive budgeting system.

4 ROLE DELINEATION AND BUDGET SETTING

Introduction

4.1. In Section 3 action taken on the recommendations contained in the Second and Third Reports was reviewed. From the evidence obtained from both the Health Department and the hospitals it is clear that the major unresolved issue is: how best to divide the hospitals' overall budget allocation between individual hospitals.

4.2. In essence the Committee's recommendations dealing with this area supported an approach which involved assessing regional and individual hospital needs as well as individual hospital efficiency in determining budget allocations to individual hospitals. This process can be simplified into the following steps.

Step l: Cost statistics and comparative efficiency data from all hospitals to be used to assess cost of services.

Step 2: Hospitals, in conjunction with the Health Department, to assess their roles and needs for services so as to estimate their desired level of service delivery.

Step 3: Hospitals to submit budget bids taking into account costs and desired volume of services as determined from Steps 1 and 2 above.

Step 4: The Health Department to arbitrate between claims to determine regional and individual hospital allocations. The Department would clearly start out with its overall allocation from the Government. It would then apportion funds between regions on the basis of a formula incorporating an adjustment for equity and then

distribute funds to individual hospitals according to individual need based on their agreed roles and cost and efficiency data.

4.3. The evidence given at the follow-up hearing and the supporting material supplied, shows that the above steps span the major outstanding dispute over the funding of hospital services. The Committee adopted the above approach in its earlier reports. As little progress appeared to have been made in this area, the Committee decided to explore the issue in greater depth in the follow-up inquiry.

The Health Department's View V The Hospitals' View

4.4. At the outset it must be pointed out that there will always be dispute between a funding body and the organisations receiving

funding. This tension, which arises because of differing expectations, exists in all organisations reliant upon budget allocations. It is understandable and will never be completely eliminated. However, it is useful to look more closely at the problems and views of both sides of this dispute.

The Health Department's View

4.5. The Health Department faces the reality that it is the Government's duty to manage the finances of the State. In practical terms this means that Government must decide how much of the State's resources can be used to meet the competing demands of: health; education; roads; recreation; the consequences of crime; and other priorities.

4.6. The Health Department, having been told the ceiling sum which the Government has set as a fair share for health services, then has to spread that sum fairly over the competing claims of the individual hospitals {and other health services). The Committee understands that the Department is unable to satisfactorily set priorities for competing claims because:

(a) It has very little in the way of quantitative assessment of hospital's needs;

(b) It does not have adequate data on costs of individual services and comparative hospital efficiency. (See discussion in Section 3.)

4.7. It appears that the Department adopts a pragmatic approach. The first step is to adjust "last year's" allocation for each hospital by the movement (up or down) in total funds available for the health sector. Raw block adjustments are made where major segments have been transferred from one hospital to another (or out of the health sector as happened with nurse education).

4.8. The results must still be little more than well intentioned but intuitive guesses. The trouble starts when the Department's "guess" is less than what a hospital considers it needs.

The Hospital's View

4.9. The above view of the system was supported in evidence by hospitals:

1. Dr. Child, Chief Executive Officer, R.P.A.H . stated:

   "I believe that the health budget continues to be historically based and formula based and that there is very little of building the budget from workload below up. The budget is in fact built deliberately from above down". (Page 22 of Transcript)

2. The Chairman of the Board of Directors of Royal North Shore Hospital stated:

   "....the budget that is invariably set is unrealistic and bears no relationship to the needs of the hospital. Nevertheless we attempt to comply. Cuts are arbitrarily imposed without consultation". (Page 108 of Transcript)

3. The Royal North Shore's Director of Medical Services backs this up:

> "The region finds itself in the position where it is handed an amount of money from the central administration and then has to divide it among the hospitals in the region. In an overall sense, the region does not have a great discretion to move very far from a split-up based on the previous financial year's allocation". (Page 110 of Transcript)

4.10. The essence of the problem, was expressed in the following Committee question (P. 186):

> "I inferred,from your earlier statements that you **see** the budgetary process as happening from above. That Treasury allocates **the money and** you have to dole it out. The hospitals obviously see it from a **different** perspective of having to provide services and having to put in effective submissions to get money to pay **for** those services. Those different perspectives seem very much in conflict and also not very useful in achieving the best utilisation of resources. What are you doing to try to make those two perspectives work together rather than against each other? A.
> You are quite right; there is an inherent conflict. One of the ways in which we address that is through our regional directors, who have a commitment to both service delivery and development and, at the same time, to achieving the department's objectives. If there is any conflict, ! guess quite often it is in the mind of the regional directors who have those dual charters which are quite often in conflict with each other".

The Definition of Role and Needs

4.11. In its third report the Committee had recommended that the Health Department take immediate action to define the role of each hospital. Further, in Recommendation 34, it proposed that hospitals be required to develop corporate plans in accordance with the health needs of their catchment populations and that such plans should express the hospitals' objectives and servicing facility requirements. In response to this recommendation the Health Department stated that roles for all

public hospitals had been delineated and the interim guide had

been issued in February, 1983. It also stated that a strategic planning process was implemented in 1982.

4.12. Evidence obtained from the major hospitals suggest that effective role definitions and quantification of needs have not taken place. For example, when asked what improvements he would like to see in the process of developing budgets, Dr. Child (R.P.A.H.) responded, inter alia :

> "A hospital starts with no indication of what we are expected to produce or what sort of activities we are expected to perform. If you are asking me what I would regard as being the most fundamental change that would produce the best results, I would state that it would be a clear definition of roles both in relation to the types of service and the quantum of service."

4.13. Professor Blackburn (R.P.A.H.) was then asked how long it would take, given cooperation between the Health Department and the hospital, to develop a clear and definite role for R.P.A. Hospital. He replied that it was relatively easy to develop a concept of the hospital's role. Quantification of the hospital's role however was more difficult especially defining the role of R.P.A.H. in the medical services in the region and the State. When pressed he stated that it would be possible to develop the role before the 1986-87 budget year.

4.14. Royal North Shore Hospital put a similar view in evidence. When asked whether the hospital could quantify its needs and justify its assessments, Mr. Johnson replied :

> "Based upon what we perceive to be the needs of the hospital we can certainly do that."

4.15. Mr. Johnson went on to say that it is up to the Department of Health to determine exactly what it wants of North Shore Hospital and that this should be done in consultation with the region. He went on to say that the Health Department, in his opinion, did have the capacity to determine its requirements

from North Shore Hospital. He went on to say that if needs were adequately determined a budget could very easily be constructed from that.

4.16. On role definition the Health Department has issued documents

on:

interim guide on definition of hospital roles;

strategic overviews of health service development for metropolitan region, hunter region, non-metropolitan and hunter region and country regions.

While those do not (and could not) attempt to quantify the volume of services expected they could provide useful bases for individual hospitals to work up needs related plans as a basis for the next stage of discussion.

4.17. The Committee recommends that the Department set out to reach final agreement with each hospital on its role, and a clearer identification of the services to be delivered.

Assessing the Cost of Services for Budgetary Purposes

4.18. The Committee believes that the assessment of cost of services and relative hospital efficiency is an essential element in establishing an effective budgetary process. As discussed in Section 3 a universal system which provides output related performance measures is urgently needed.

Communications

4.19. As indicated in the budgeting. steps listed in paragraph 4.2 the budgetary process is an iterative one involving negotiation between

hospitals and the regional offices of the Health Department

regional offices and head office of the Health Department

· the Health Department and State Treasury

4.20. The Department says it has consulted hospitals, considered their bids and accommodated those needs in their budget "as well as it can". However, the hospitals don't see it that way. Despite the talks (mainly at regional level) they seem to feel their complaints fall on deaf ears.

4.21. The Committee acknowledges that the two **parties have diverging** goals and that this is in large measure the reason why agreement is so elusive. Nevertheless, it believes that the lines of communication must be improved.

The Budget Setting **Process**

4.22. The answer to the two divergent views (arbitrary alloc ation versus "needs" - based calculations) might lie between them. It seems clear that there are basic, essential, unavoidable, lifesaving or emergency procedures. There are also, at the other extreme, optional procedures - almost a "wish list" if the State could spare unlimited funds for health services. The Committee's suggestion is that the Department and hospitals study whether they could:

(a) agree on the basic, emergency services and their costs - based on the levels of demand experienced to date by each hospital.

(b) agree that, given a block.allocation above the base,

hospitals would take the responsibility of what type and level of other services could reasonably be delivered in their areas.

4.23. The above split-funding approach, while laudable in principle, has a number of difficulties:

(a) it may not be possible to get agreement on what are

emergency and other services. Consequently the establishment of guidelines may not be possible.

(b) hospitals would have a financial incentive to reduce admissions of non-emergency patients because funds for emergency patients would be easier to justify and would not be subject to the same rigid limits as funds for non-emergency services.

(c) Treasury may object to any aspect of hospital funding which appears open ended

4.24. Notwithstanding the feasibility or otherwise of the above suggestion the funding process should comprise two basic components:

(a) an assessment of the average cost of services at which a hospital will be financial remunerated for budgeting purposes

(b) an assessment of need, based on hospital role, and incorporating an adjustment aimed at achieving greater inter-regional equity.

4.25. Once the above information is available the Government can more easily make the following decisions:

Whether the State can afford to continue all those services at existing volumes (or to reduce or expand them).

Whether some services of high ranking priority are under-provided and should be met by cutting back on lower ranking .services.

Whether individual hospitals are wasteful of resources and appropriate sanctions are required.

Whether part of the answer to the problem is split-level funding - as discussed at 4.22.

Conclusion

4.26. The Committee recommends the following:

(a) that the output from the performance reporting system and from the clearer identification of roles/needs be used to relate ideal service levels to total funds available both at State level and at individual hospital level.

(b) that the Health Department take steps to make the budget setting process better understood by hospitals and the public generally.

(c) that, notwithstanding the problems cited in para. 4.23, consideration be given to a split system where: **a** calculated sum is given to pay for accident and other emergency treatment; an arbitrary sum is given for all other services - with the hospital taking responsibility for deciding what services it is to provide.

4.27. As the above recommendations would take time to implement, it seems inevitable that the block or arbitrary allocation of funds will continue in the meantime. To ease the effects of this, hospitals could be given greater discretion to manage their operations within the total sum allotted to each subject to the firmer implementation of the recommendations contained in Section 3.12.

Appendix 1: Health Departments Response to recommendations contained in the Second Report of the P.A.C. concerning Over-Expenditure in Health Funding to Hospitals (February 1982).

Recommendation 1 The Minister for Health automatically review the appointment of the Board of any Schedule II hospital which exceeds its approved budget for gross operating payments.	Action Taken Circular 83/3 of 7 January 1983 requires Regional Directors to provide a report on over-expenditure each year with proposals regarding any action that should be taken. Should those proposals recommend against the dismissal of a board, the Regiona1 Director is to certify that all reasonable actions have been taken by the board to remain within budget.
Recommendation 2 Consideration to be given to the temporary appointment of an administrator to any Schedule III 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.	Action Taken As a result of this recommendation, the advice of the Crown Solicitor was sought following which action was taken to amend the Public Hospitals Act, 1929 - (a) to allow the Minister to attach any condition to the payment of subsidy to a Schedule III hospital - see amended section 17(8) of that Act; (b) to specify the duties of the governing authorities of separate institutions - see newly inserted Section 29AD of that Act, The Minister's power to attach any condition to the payment of subsidy would enable him to legally insist upon the appointment of an administrator to a Schedule III hospital as a condition of subsidy (assuming that the hospital management had the powers to so appoint an administrator).
Recommendation 3 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.	Action Taken This recommendation was dealt with in Circular 83/3 with respect to the 1983/84 and ongoing financial years and requires that final budgets be with the hospitals within Four weeks of the receipt of the allocation letter from Treasury or on the date of introduction of the State Budget to Parliament whichever is the later.

Recommendation 4	Action Taken
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 action being taken when necessary.	In May 1982 the then Health Commission approved the creation of a Task Force to examine financial and performance reporting systems operating within hospitals. As a result of that review major changes were made to thehospitals Reporting Systems. The end result of the new systems that were introduced in July 1983 was more timely and accurate data and greeter regional and central office control based upon monthly, quarterly and annual reports. These systems were subjected to review and enhancement as necessary. In fact, a major review was undertaken in early 1984 and the revised system commenced in July l984. The initial systems were documented in Circulars 83/3 (Implementation of Ministerial Responses - generally) 83/12 (Revised Mentally (sic.) Reporting System), 83/91 and 83/197 (Quarterly Reporting System) with subsequent amendments being covered in a letter to Regional Directors of 13 July 1984.
Recommendation 5	Action Taken
In the event of future rationalisation of hospital Government services the Following measures be taken:	The Program for the Redevelopment and Redistribution of Health Services, announced by the in April 1982, included the closure of Crown Street and Mater Misericordiae (Crows Nest) Hospitals, and a variation in role for War Memorial Hospital Waverley and Sydney Hospital. The purpose of this rationalisation program was to generate savings in order to Fund new units opening principally in the Western Metropolitan Region of Sydney. The approach taken by the Department in the implementation of this program was as follows:
(a) Adjustments to hospital budgets to reflect proposed service reductions be based on clearly defined and realistic plans providing For real and continuing savings.	(a) adjustments to hospital budgets to be based on clearly defined and rea1istic plans Adjusted hospital budgets, on a cash Flow basis, were prepared to advise affected hospitals of savings to be achieved. Such cash Flow projections were based on a phased reduction of services, taking into account ward and service areas to be closed and services to be re-located elsewhere, in consultation with the aFFected hospitals. New unit budgets were developed based on estimated savings to be achieved.

(b) Such adjustments be reviewed in the light of unforeseen and unavoidable circumstances affecting implementation of the plans.

(b) Review of adjustments

Projected cash flows were continually reviewed, taking into account changed circumstances e.g.

changes in dates of anticipated re-location of specialty services.

alterations to projected service closures on a ward by ward basis (e.g. one hospital achieved a Faster closure rate due to high staff attrition).

(c) The introduction of new services dependent upon saving 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.

(c) Flexible introduction of new services

The new program included new units where capital expenditure had been completed and new units where capital expenditure was still in progress and was earmarked for new unit expenditure for 3 years. Therefore maximum flexibility was built in to adjust For savings achieved, by slow-streaming of new units if necessary.

(d) 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 every-thing possible has been done to achieve those savings.

(d) Provision of Funds to adjust hospital budgets for non-realisation of savings, due to low attrition rates

Review mechanisms were introduced by the Department, including regionally-based staff placement committees, to ensure that staff attrition was achieved at anticipated rates wherever possible with supplementary funds provided where attrition targets were not achieved.

(e) There 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 advise and assist with any special problem areas identified.

(e) Full consultation between the Department and affected hospitals

There was continuous consultation between the Department and affected hospitals on the rationalisation program, together with the formal constitution of the Health Services Industrial Consultative Council to monitor the program (including employer and employee organisations).

(f) Future rationalisation programs concentrate to the maximum extent practicable on the re-direction of whole services or service units.	(f) Concentration on re-direction of Whole Services or Service Units The 1982 program concentrated on the closure of the entire hospitals or major units/service areas. Since 1982 there has been a continual review of hospital services with changes being implemented involving adjustments to bed numbers in accordance with regional strategic planning guidelines. In this context the best strategy to apply is not necessarily the closure of whole units. Focus has chiefly been on the re-direction of service units, based on the process of the role delineation of hospitals.
Recommendation 6	Action Taken
The setting of staff establishments, other than For medical practitioners, for each hospital be discontinued.	Circular 83/15 advised of the implementation of the new policy covered by Recommendations 6 and 7.
Recommendation 7	As Above
Hospitals be totally responsible for their staffing levels subject to the funds available.	
Recommendation 8	Action Taken
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.	Provision has been made to allow For controls to be imposed on a hospital's staff establishment should it exceed its salaries and wages budget. Circular 83/168 in respect of Recommendation 8 states, inter alia, "..... where a hospital exceeds its salaries and wages budget Regional Directors may impose controls on that hospital's staff establishment. The nature of the controls and the period for which those controls are imposed are matters to be determined by the Regional Director."
Recommendation g	Action Taken
The basis for determination of supplementary allocations of funds to meet award costs be the actual or budgeted level of salaries and wages	'HOSPAY', being the Public Hospitals computerised payroll procedure has been redesigned to allow for accurate assessment of the balance of financial year and full year costs of Award variations.

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.

Recommendation lO	Action Taken
Prior to approving supplementary funds For award variation costs the claims made by hospitals be carefully reviewed by the Health Commission.	Award variation cost claims made by hospitals are carefully reviewed by the Regional OFFice and then again reviewed by Central Office in its assessment of the Region's cost of award claims.

Recommendation 11	Action Taken
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.	It is Departmental policy not to approve staffing for new units until specific funds have been allocated in the normal budgetary process.

Recommendation 12	Action Taken
The Health Commission not approve new units being brought into operation until the necessary funds have also been approved.	It is Departmental policy not to permit the establishment of new units until the neceessary Funds have been approved in the normal budgetary process.

Recommendation 13	Action Taken
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.	*Circular 83/3 covered the subject of interim budgets and promulgated the practice to be adopted From the 1983/84 financial year with respect to Final budget allocation. In the light of difficulties associated with the issue of interim budgets this practice was discontinued For 1985/86. Rather, expenditure constraints based on the limitations of "supply" provisions as defined at Section 25 of Public Finance and Audit Act were instituted and Regions were Fully advised of this process by letter on 18 July 1985.

* 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.	*Full consultation has taken place with hospitals concerning estimates requirements and the variations embodied in budgets. For reasons already outlined, however, the submission of Formal estimates was not sought by hospitals for the 1985/86 financial year.
* specific exclusions for special items such as award costs, long service leave payments and new units should be fully detailed.	*Award Costs, new units and other special items are separately identified in the budgetary/estimating process.

Recommendation 14	Action Taken
Hospitals implement appropriate formal communication processes with their medical staff.	The Manual for 'Formulation of Hospital By-Laws' issued by the Health Commission in late 1980 and now adopted by the majority of hospitals provides in By-Law 74 for the establishment of a Hospital Medical Staff Council which is a formal medical staff organisational structure which has clearly defined functions and which is advisory to the Board of Directors. Although this was introduced prior to the Public Accounts Committee Reports, its impact would not have been Fully effective at the time of the Reports.

Recommendation 15	Action Taken
Hospitals review their budgetary and financial control procedures to avoid clerical errors leading to expenditure overruns.	As a consequence of the P.A.C.'s report hospitals were required to review their budgetary and finanicial control procedures to avoid cierical errors leading to expenditure overruns.

Recommendation 16	Action Taken
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 be fully allocated to the hospitals in their budgets.	This matter was addressed in Circular 83/3. Reserves retained by the Region are required to be disclosed and limited to specified provisions for award variations, long service leave, emergency repairs or other special factors.

Hospitals be clearly informed that it is their responsibility to set aside reserves to meet contingencies.

Recommendation 17 Hospital budgets contain a specifically identifiable adjustment for role changes.	Action Taken Where role changes are significant (e.g. Sydney Hospital - a major teaching hospital to a general hospital with major outpatient component) the particular hospital and Regional budgets are specifically adjusted to reflect the change.
Recommendation 18 Hospital budgets be built up and monitored on a further departmental basis.	Action Taken The Management Information Review System (M.I.R.S.) is now implemented at 50 hospitals with a 13 due for implementation in 1985/B§. This system identifies costs and other data on a departmental basis. The introduction of program budgeting for Government Departments will be followed by the implementation of program budgeting for hospitals.
Recommendation 19 Resource allocation within Regions be based on clearly defined and understood formulae.	Action Taken Circular 83/18 directed that Regions were expected to apply principles of relative health care needs in making sub-regional allocations. The Regional Resource Allocations Formula endorsed by the Department in 1981 incorporated such a needs-based methodology. Regions were also advised that mechanical approaches were not to be adopted in resource allocation.

Recommendation 20	Action Taken
Separate inquiry be held into the administration, financing and utilisation of the New South Wales Ambulance Service. Amongst other matters the inquiry examine:	The Minister for Health at the time established a Committee of Inquiry into the New South Wales Ambulance Service in March 1982.
* the use of ambulances for inter-hospital transfers and the desirabi1ity of alternative means of transport;	In December 1982 the Minister handed down his decision on the recommendation of the Committee of Inquiry and established a Committee of Implementation.
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.	Resulting from the recommendation accepted a new administrative structure for the New South Wales Ambulance Service has been developed and introduced.
	The new structure allows greater control and supervision of resources also providing a mechanism for planned future development.
	In respect of other matters that the inquiry was to examine:-
	* Recommendations in respect of the use of ambulances for interhospital transfer and the desirability of alternative means of transport were accepted by the Minister with one amendment and the Ambulance Service has introduced a11 recommendation and reinforced the decision by the preparation of a document titled "Ambulance Transport Guidelines".
	* The abovementioned document also includes guidelines to be used in the ordering of Ambulance transport by medical practitioners and has been issued to all Medical Officers, Hospitals and Ambulance Officers.

Appendix 2: Health Departments Response to Recommendations Contained in the Third Report of the P.A.C. Concerning Public Accountability in Public and Other Subsidised Hospitals (April 1982).

Recommendation	Action Taken
The existing "modified cash" accounting arrangements be retained in the public hospital system.	A working party was formed in February 1983 to review hospital accounting standards and issues such as the wording of the annual certificate given by the hospital auditors and the form of the statement of financial operations. The working party comprised representatives of the Auditor General, The Australian Society of Accountants, The Institute of Chartered Accountants in Australia, The University Teaching Hospitals Association, The Australian College of Health Administrators and the Department of Health. Because of the importance of the fore of accounting to the whole question of Financial reporting, this working party was also required to report on the respective merits of cash and accrual accounting. The working party supported the retention of the existing modified form of cash accounting in hospitals and the Department and the Minister accepted this recommendation.
Recommendation 2	Action Taken
Action be taken to ensure that details of the levels of hospital creditors and debtors, and the incidence of bad debts, be incorporated in all appropriate budgeting and finanical reports, including the annual reports of hospitals and the Health Commission.	Details of outstanding trade creditors ("total amount of invoices not paid by due date") and details of fees raised during the period are reported each month in the hospital Monthly Reporting System. A Further breakup of these, including bad debts is also incorporated in the Quarterly Financial Reports of hospitals. Details of debtors and bad debts are also incorporated in the audited annual reports of hospitals to the Department of Health.
Recommendation 3	Action Taken
All hospitals include a table detailing the application of all Funds, based on a standard format, in their annual reports to the public.	All hospitals have been advised to include a table showing the sources and application of funds in their annual reports to the public. (Circular number 84/75 refers). Point 4.5 of the Revised Accounts and Audit Determination also requires that the Statement of Financial Operations be accompanied by a Source and Application of Funds Statement.

Recommendation 4	Action Taken
The Health Commission ensure *that* hospitals have adequate systems of control over stock levels, and the ordering, receipt and issue of stocks, including regular test check systems.	In order to facilitate detailed compliance the attention of all hospitals was directed to the Purchasing and Storekeeping Procedures Manual which had been issued in the second half of 1981. This Manual contains sections that detail the stores procedures and requirements in respect to ordering, receipt, issue and control of stocks together with details of stock test requirements. The Accounts and Audit Determination also contains provisions relating to stores and controls required to be exercised. As part of the revised inspection program for Public Hospitals which was issued in 1983, checks are made to ensure that the systems of control over stocks including the acquisition of stores are adequate and operating effectively.

Recommendation 5	Action Taken
A form of modified global budgeting be introduced with block allocation being set; after consultation with the hospital, for salaries and wages, superannuation, payments to visiting medical officers, repairs, maintenance and renewals, and other goods and *services.*	This has been fully implemented and allocations are now determined for each of the seven line items.

Recommendation 6	Action Taken
On receipt of block allocations hospitals prepare a detailed line item budget and forward this to the Regional Office of the Health Commission for approval.	The then Minister advised that he did not support this recommendation as if freedom was to be given to hospitals to manage effectively, they should not be given block allocations and then be required to report detailed line item budgets to the Regional Office of the Commission. Accordingly, no action was taken in respect of this recommendation.

Recommendation 7	Action Taken
Expenditure reporting, both actual and against budget, continue to be on a line item basis.	This recommendation has been implemented for each of the seven line items.

Recommendation 8	Action Taken
Subject to the block allocations not being exceeded, hospitals be permitted to vary from individual line item allocations as required. Health Commission approval should be required For any proposed variations between the block allocations.	This recommendation has been put into practice to the extent of Treasury concurrence to approve of inter-item changes on a State-wide basis. The Department however has flexibility to vary similar line item allocations between Hospitals and Regions. Hospitals wishing to vary budgets within the total allocation must appproach their Region and, similarly, Regions who wish to vary budgets within the total allocation must approach Central Administration.

Recommendation g	Action Taken
Where the budgetary performance of a hospital is of concern to the Regional Office, or in other appropriate circumstances, the approval of the Regional Office be required for any departure From the line item budget.	The then Minister did not support this recommendation as it was seen to be in conflict with the objectives of Recommendation 5. where budgetary performance is unsatisfactory, the more appropriate courses of action were considered to be those covered by Recommendation 1 and 2 of the Second Report.

Recommendation 10	Action Taken
Subject to budgetary constraints hospital managements be encouraged to provide commercial services	A survey was undertaken which indicated differing hospital opinions of the merits of implementing this recommendation. It was decided that the disadvantages outweighed any benefits to be obtained and no further action was taken. It is mentioned that consideration was given to the following factors -

care needs to be exercised to ensure that the pursuit of commercial enterprises does not detract from the basic function of public hospitals and/or have adverse indirect financial consequences,

2) each individual proposal would require full costing and Regional Director approval prior to commencing, including approval to adjustments to the revenue and expenditure budgets of the hospital,

3) the costings would need to include all fixed and variable expenses (not simply marginal costs),

4) the accounting details for the project would need to be recorded in separate Memorandum accounts,

5) should the proposal emanate from excess capacity within a hospital then that excess capacity within a hospital then that excess capacity should be examine with a view to diverting resources elsewhere, and

6) the operation of group laundry and pathology services.

Recommendations 11, 12, 13, 14, 15 & 15.	Action Taken
(11) An incentive reimbursement scheme be introduced For public hospitals in 1982/83	An Incentive Budgeting Scheme was set up in line with the above recommendations (11 to 16) to operate from the 1983/84 financial year - circulars 83/3 and 83/334 refer. financial year.
(12) Where a "real" saving is achieved the hospital be permitted to retain the saving subject to an upper monetary limit for use by the hospital in the following year.	The Scheme was reviewed after its First year of operation and again more recently and it was found that with one exception (which did not meet the scheme's guidelines) no hospitals had put forward any savings proposals.
(13) The retained saving be expended in a manner approved by the Health Commission.	A range of reasons were indicated by Hospitals and Regions For the Schemers failure but the key element was that the Hospitals only benefited From savings on a non recurring basis for capital expenditures.
(14) The budget allocation for public hospitals be reduced by the Full amount-of savings achieved in the Following financial year.	At the hearing on 16 September 1985, the Department indicated that it considered that there was little benefit to be gained From pursuing the implementaion of structured incentive budgeting systems of this nature even ii modified to more adequately meet hospitals' stated requirements; and that the processes of influencing savings which already occur through negotiations between the Department and Hospitals in the development of budgets and otherwise, management systems review, etc, are more likely to achieve worthwhile permanent results.
(15) Only savings deemed by the Health Commission reimbursement scheme, to be "real" savings be eligible for inclusion in the incentive	

(16) A review of the operation of the scheme be undertaken prior to the 1984/85 financial year.

Recommendation 17 & 18	Action Taken
(17) Hospital auditors be required to report the results of their audits to the Auditor-General.	The then Minister in supporting the next Recommendation i.e. 19 believed that the setting of audit standards with the assistance of the Auditor-General was sufficient to ensure proper reporting and accountability of hospitals. Therefore, no Further action was taken in respect of recommendations 17 and 18.
(18) The Auditor-General be given power to:	
-approve the appointment of an auditor for the first time in *the* case of a new hospital	

-approve proposals by existing hospitals to appoint an auditor other than the retiring auditor

-veto the re-appointment of an existing auditor.

Recommendation 19	Action Taken
The Auditor-General be requested to review the provisions of the Accounts and Audit Determination applicable to public hospitals and recommend any changes he considers appropriate.	Following reference of the Accounts and Audit Determination to the Auditor-General for his consideration, a working party was Formed in February 1983 to review hospital accounting standards and to consider questions such as the wording of the annual certificate given by hospital auditors and the form of the statement of Financial operations. In addition to a representative of the Auditor General the Working Party comprised representatives of the Australian Society of Accountants, The Institute of Chartered Accountants in Australia, The University Teaching Hospitals Association, The Australian College of Health Administrators and the Department. The working party agreed the audit standards issued by the professional accounting bodies apply generally and should apply equally to audits of hospital accounts. Recommendations were made for significant changes to hospital financial reporting including provisions that hospitals should provide financial information concerning the operations each year to the public. The recommendations of the working party were adopted and circular 84/75 embodying the required changes in financial reporting requirements was issued to hospitals in March 1984. Policy changes relating to reporting have been incorporated in recent amendments to the Accounts and Audit Determination.

Recommendation 20	Action Taken
The format of the expenditure estimates of the Minister for Health in the State Budget Papers be varied to the extent necessary to demonstrate the major expenditure programs provided for, viz, hospitals, community health program and allied services.	This recommendation was implemented and First reflected in the Budget Estimates 1983/84.

Action Take.

The budget outcome For all hospitals has been included since 1983 in the Department's Annual Report. However, it is not practicable to incorporate therein hospital budget allocations for the succeeding financial year in view of the timing of the State Budget.

Action Taken

The Department's Annual Reports For 1982/83 and 1983/84 were tabled on 2 December 1983 and 2 November 1984 respect{rely, both of which included a detailed Financial summary of public hospital expenditure.

Action Taken

The Annual Report of the Department provides comparisons between the receipts and expenditure of each hospital and the relevant budget allocations. In addition, activity levels and performance indicators are also reported. These include average available bed days, daily average of non-inpatients, bed occupancy rates, average stay and the adjusted daily average. It is proposed that in the annual report For 1984/85, the range of performance indicators will be extended and will include comparisons with the previous year.

As this document is prepared prior to the availability of audited financial data From each hospital, a Further department publication - Department of Health, New South Wales Statistical and Financial Data Public Hospitals - is issued annually and in this document, hospitals are classified according to their broad role i.e. General Hospitals, Approved Nursing Homes and Other Institutions and by size within Regions.

Action Taken

The specific policies set out in Department Circular No. 84/75 related to the form of presentation of public hospitals Financial operations and Financial position together with the timeliness and manner of publishing that information. A further Circular No. 84/153 was issued to hospitals setting out the minimum requirements to be published in respect of staffing and other statistical data.

Recommendation 21

The Minister for Health each year table in Parliament the derails of the budget outcome for each public hospital for the preceding year and their budget allocation for the current financial year.

The revised policies were effective commencing with the 1983/84 results. Due to initial problems and uncertainty and delay in having requirements clarified, the Department agreed that the published information need not be audited in respect of the 1983/84 year. Although the Department did not relax the promulgated requirements in any other respects, a number of hospitals did not comply fully with provisions relating to content and some failed to publicise the availability of the financial information.

All hospitals have been directed to comply fully in respect of the 1984/85 year and Regional Directors have been asked to ensure strict compliance to this requirement.

Recommendation 22

The Health Commission ensure that its Annual Report to Parliament is tabled as soon as possible after financial
the end of the financial year, and that the Report includes a detailed financial summary of public hospital expenditure.

Action Taken

In May 1982 the then Health Commission approved the establishment of a Task Force to examine and performance reporting systems operating in hospitals and in the Commission with a view to:-

(a) determining the minimum data set and reporting timetable necessary for the effective monitoring and control of the financial position of hospitals and Regions;

(b) eliminating unnecessary information recording demands on hospitals;

(c) determining the most appropriate method of data collection and processing to facilitate the timely production of reports;

(d) determining the format, content and distribution protocols for the reports generated.

Recommendation 23

The Commission also publish each year comparisons of the budgetary performance and productivity of hospitals, appropriately classified according to size and role.

As a result of this review major changes were made to the Hospital Monthly, Quarterly, and Annual reporting Systems. The main feature of the Monthly Reporting system was the implementation of regional computer facilities to process and validate the hospital data prior to the information being forwarded to the central office. This system also incorporated a requirement that hospitals supply on a monthly basis end of year forecasts for expenditure and revenue outcomes; details of inpatient and non-inpatient activity were also provided.

Recommendation 24

Hospitals present the financial, staffing and activity information in their annual reports in a standard format approved by the Health Commission.

The end result of the new system was more timely and accurate data and greater regional and central office control. Revised Quarterly and Annual Reporting Systems have been introduced since that time with greater use being made of computer processing. Circulars 83/12 (Revised Monthly Reporting System), 83/91 and 83/197 (Quarterly Reporting System) refer.

Action Taken

This recommendation calls upon the introduction of the Management Information Review System, which is addressed in the response to Recommendation 29.

Action Taken

Under the Forward Plan for Computing, which was adopted by the Department after receiving Ministerial approval in 1983, Management reporting is being improved through the introduction of standardised systems throughout hospitals. Common Packaged Systems for accounting and patient administration have already been installed in a number of hospitals and will continue to be installed in more during the next 12 months. Since the Forward Plan has been adopted and a contract let For computer equipment, over 40 hospitals have installed their own computers and have either implemented the common accounting and patient administration systems or are in the process of doing so. The benefit of having common accounting and patient administration systems or are in the process of doing so. The benefit of having common accounting and patient administration systems is that the Department knows the basis of the reports and can gain access to the same type of information From hospitals. The Department is also in a position to specify the type and Format of the data it requires from a hospital's accounting and patient administration systems.

Recommendation 25

The Health Commission review its information needs and the accountability requirements of Regions with a view to:

- clearly defining the roles and responsibilities of Regional Offices for monitoring, reporting and controlling the expenditures of hospitals; and

- instructing hospitals to supply forecasts of total expenditure and revenue outcomes, as well as movements in activity levels, to Regional OFfices on a monthly basis.

Action Taken

The Department recognised the 1imitations of HOSPAY to provide managment information when drawing up the Forward Plan. A specification For a Payroll System incorporating Personnel and Management Information was drawn up, tenders called and a contract for HOSPAY II let in 1984. The system is in the Final stages of development and testing with the First hospital to commence in late October or early November 1985.

Action Taken

At the time of the presentation of the Report there was some 26 hospitals already on the MIRS program. In response to this recommendation the then Minister made a commitment to implement the MIRS program into the largest fifty hospitals in New South Wales by the end of the financial year 1982/84. All teaching hospitals [except for Royal Prince Alfred, the Parramatta Hospitals, (Westmead Centre), the

Recommendation 26

In determining hospital budgets, Regional OFFices oF the Health Commission have regard to available statistics on comparative levels of eFFiciency in between hospitals and desirable movements in patient activity.

Recommendation 27

The Health Commission expedite the development of computerised data systems in hospitals where this would assist accountability and management control. Such systems should be compatible with external reporting requirements.

Recommendation 28

The Health Commission investigate the possibility of adapting the existing "Hospay" payroll system to planning produce comparative data on staffing levels, staff attrition and productivity.

Recommendation 29

The Commission take steps to expedite the implementation of the Management Information Review System in all base, district and teaching/referral hospitals throughout New South Wales.

Prince of Wales/Prince Henry Group, Royal North Shore and Sydney Hospitals] and all major district and base hospitals, that make up the group of the largest FiFty hospitals in the State, are now participating in the program.

Although the major teaching hospitals have not implemented in the MIRS program, work has been done these hospitals towards the implementation of similar systems based on MIRS concepts.

Action Taken

The Department of Health has undertaken a program of determining the role of every public hospital through a process of consultation between the hospital and regional office.

In the vast majority of cases this process in now complete and hospitals have agreed levels of service in all diagnostic and therapeutic areas. Hence it is now possible to proceed to the next stage of developing Formal admission policies. This process has been deferred pending settlement of the doctors dispute, since it is a sensitive area, particularly where numbers of particular procedures to be done each week may need to be defined.

Action Taken

Private Hospitals in Hew South Wales are an integral component of the State Health Care System. When planning hospital beds the Department takes into account the number of public and private beds available in a Health Region on a health planning area.

At the present time, the controls on bed numbers for private hospitals rest with the Commonwealth Government through its responsibility For payment of bed day subsidy. The State is consulted through the Commonwealth/State co-ordinating committee on Private Hospitals. The State has developed criteria for bed supply (both public and private) on a Regional basis and all applications for additional beds are considered in the context of this criteria.

The Private Health Establishments Act, 1982, contains Further provisions to enhance the Department's role in this area. However given the Commonwealth's stated intention to deregulate its controls in this area, the State has undertaken not to proclaim the Act until the Commonwealth clarifies and legislates to achieve its intentions.

Action Taken

Allocation of operating funds for the delivery of health services is based on the services actually being provided and needed in a Region and appropriate facilities available to do so, and not on a formula. The Department however has a 'needs-based' Regional Allocation Formula for the theoretical distribution of funds for institutional care. The Formula is a planning tool and is used as a guide to longer term re-direction of resources, to assist in decision making on location of new Facilities and services as well as to protect existing services in 'deficit' Regions from budget reductions. The Formula has been updated in 1985 with the most recent hospital utilisation and cost data.

Recommendation 30

All hospitals, in conjunction with the Health Commission, develop and implement formal admission policies consistent with their role and budget allocation.

Action Taken

Roles have been delineated for all public hospitals as part of the strategic health plans. An interim guide to the delineation of hospital roles was issued in February 1983.

Regions negotiate with Hospital Boards for implementation and review of the plans and role delineation as an ongoing process.

Recommendation 31

The Health Commission undertake a review of its present policy on the growth of private hospitals with a view to introducing needs-base criteria for the licensing of private hospital beds.

Action Taken

With the implementation of the strategic planning process in 1982, it became normal practice for hospitals to develop corporate plans and functional briefs in relation to the nature and extent of future development. These plans are prepared to meet specifications which incorporate the P.A.C. recommendations and provide for consistency with Regional Strategic plans. The preparation of corporate plans and functional briefs is regarded as a key element of the planning and approval process for capital works development. Whereas some hospitals employ their own planning officers, planning work is commonly carried out by consultant planners in conjunction with hospital and Regional Office staff of the Department of Health. Additionally, staff of the Technical and Support Services Division and the Planning Division of Central Office have been actively involved in assisting hospitals and Regions in their planning role.

Action Taken

The Health Commission Act was repealed in 1982 and replaced by the Health Administration Act, 1982; its main purpose being to provide for the overall corporate objectives of the Department of Health and to prescribe the functions of the Secretary, Department of Health.

The Public hospitals Act was amended to Facilitate the establishment of Area Health Boards by the insertion oF Section 13A in 1982 which allows the closure or amalgamation of hospitals under Ministerial approval by order published in the Government Gazette.

In December 1983, four pilot Area Health Boards were proclaimed under the Public Hospitals Act and a further eleven Area Health Services which had operated until that time on an informal basis were recognised by notice in the Government Gazette.

A review of Area Management of Health Services was established in July 1985 and will include anevaluation of the pilot Area Health Boards (Circular 85/197 refers). The terms of reference also require that the legal Financial and administrative implications of an extension of any or all of the identified models for area management of health services, including area health boards be identified.

The adequacy of the Public Hospitals Act will be reviewed in this context, Review Committee will report early in 1986,

BASIC COMPARISONS BETWEEN A.O.P. AND **M.I.R.S.**

COMMENTS BY ROYAL PRINCE ALFRED HOSPITAL

ANNUAL OPERATING PLAN {A.O.P.)	MANAGEMENT INFORMATION REVIEW SYSTEM
1. Provides internal Hospital reports.	1. Provides inter - and intra-Hospital reports.
2. Compares actual figures to budgets on both monthly and year-to-date basis.	2. Compares current month to year-to-date in current reporting year, and current year-to-date to previous year-to-date. Does not incorporate any Form of budget or plan.
3. Uses a Four-level reporting structure - 1. Executive 2. Division 3. Sub-Div ision 4. Responsibility Centre	3, Uses a three level reporting structure - 1. Executive 2. Mid-Management 3. Activity Centre
HASAC Codes identify Responsibility Centres.	HASAC Codes identify Activity Centres.
Disperses labour information by taking payroll hours and costs From HOSPAY, divided into 20 basic Fields, for each employee.	4. Disperses labour information by taking pay-roll hours and costs From HOSPAY, divided into 13 basic fields, for each employee.
Groups employees by Responsibility Centre and Primary Division.	Groups employees by Industrial Position with-in Award, for each Activity Centre.
Subjects each employee's normal pay type information to accrual, and leave payment type information to prepayment breakup.	Subjects each employee's normal pay type normal pay type information to accrual.
Hours and dollars information is aggregated exactly to each higher level in the reporting structure.	Hours and dollars information is aggregated to each higher level in the reporting struc-ture, but certain specific information may be lost as a result of this ag gregation 'up-the-line'.
5. Disperses non-labour costs on a consumption basis. These type of costs for each Responsibility Centre are based on signed requisitions for goods and services provided to the Centre during reporting month.	5. Disperses non-labour costs by Hospital expenditure for the reporting month. Takes the reporting month. Takes Trial Balance by Expense Code and allocates these costs to Activity Centres using percentages gained by sampling.

6. Breakdown information to all main reports are provided automatically to each manager showing how each item of information on the main report was calculated. This breakdown information is linked directly to timesheets (for labour resources), and requisitions (For non-labour resources), all of which must have been signed b y Responsibility Centre Manager.	6. Breakdown information to main reports are not provided automatically to Activity Centre Managers. Non-labour costs cannot be broken down to individual requisition because dispersement achieved by percentages.
7. Provides computer-generated budgets (for both labour and non-labour costs) in the First instance. Allows Full involvement at Responsiblity Centre Manager level in the construction of budgets. AOP budget system enables reconciliation of micro-budgets to macro-budget. All budgets capable of updating and reconstruction at any time.	7. Does not use budgets'
8. Provides an employee count (on a Full-time equivalent basis) t o be used in the future in the calculation of standard staffing/output ratios.	8. Does not provide an employee count.
9. Reports distributed to managers by the sixth working day Following the reporting period.	9. Earliest available date for distribution of reports to managers is the 21st of the month following the reporting period.
10. Monthly processing of the AOP system requires clerical effort of 3-4 days, mainly spent on collecting output statistics and distributing reports, All major calculation and construction processes are computer based.	10. Monthly processing of the MIRS system re-quires heavy clerical effort, mainly in the construction and calculation of worksheets prior to use of computer. Schedule in MIRS manual suggests full-time clerical effort required to service the system.

COMMENTS ON OPTIONS FOR EFFICIENCY MEASURES IN HOSPITALS DISCUSSED AT P.A.C. VISIT TO ROYAL PRINCE ALFRED HOSPITAL

BED DAY COST

Efficiency measures based on "occupied bed days" fail to account for the simplest variation in hospital activity. An average hospital stay involves a concentration of services in the first few days, with a tailing off in the convalescent period. As a consequence, shortening this "low cost" element of patient stays and substituting new patients with more concentrated care leads to an increasing cost per occupied bed day.

OCCUPANCY

Longer stays and predictable admissions (i.e. no Casualty) can produce the highest hospital occupancy figures. Patients staying over a year (very likely to be of the "nursing home" type) mean a bed is 100% occupied. A patient stay of 48 hours is counted as 'l day' - using Health Department definitions which count either day of admission or day of discharge - but not both. The shorter the length of stay, the greater the percentage error introduced by this methodology. A 48 hour stay means a bed is counted as 50% occupied.

"Cost per patient treated" takes many of these factors into account, but fails to recognise differences caused by variations in patient mix.

Casemix variation can be used to account for some percentage of cost variation between hospitals, it leaves variations to be explained by "severity of patient illness", teaching/training needs, socioeconomic status of patients, community support facilities as well as variations in efficiency.

The N.S.W. Hospital Morbidity Collection is based on ICD-9 coding of hospital discharges - using the principal diagnosis to derive broad disease groupings based on the body system in which the illness falls° The collection itself is not suitable for casemix measurement, but the data held by the hospitals could be manipulated differently to produce DRGs on a similar system for casemix comparison.

DRGs or Diagnosis Related Groupings are a form of casemix comparisons developed at Harvard, originally to throw up 'exception ' data in utlisation review studies. Patient age and sex, diagnoses, surgical procedures are used to organise hospital discharges into classes that are relatively homogeneous in resource use - normalised around length of stay. These permit cost comparisons between institutions after "standardising" the patient casemix using DRGs. In the U.S.A., Government sponsored patients generate a DRG payment to the hospital -i.e. the more patients a hospital treats (particularly in a 'profitable ' DRG), the more money the hospital receives. In Australia it might be more appropriate to examine the DRG mix within each hospital and derive a "costliness index n. This index could be used as a modifier on an agreed proportion of budget subsidy.

Disease costing will permit interhospital comparisons - whether using DRGs, or "indicator illnesses" - such as Killop 1 &. 2 Myocardial Infection. In either case it will be necessary to have cost control data based around responsibility centres, in addition to disease costing, in order to have a means of measuring and controlling the efficiency within departments whose products go to make up part of the services consumed by the patients episode.

Medical Staff Profiling - allows comparisons between medical practioners within a hospital, throwing up variations in length-of-stay or diagnostic test ordering within specific illnesses. These utilisation review data may effect changes in practice patterns of individuals - but care must be taken not to swamp the clinician with information which nullifies its impact.

Program Budgeting - allows governments to determine Funding priorities For broad health programs. Casemix variability within programs will mean cost comparisons will most likely relate to volume and range of services, rather than relative efficiency. It will permit an assessment of funds absorbed by broad programmes - but considerable overlap is commonplace - e.g. do the senile elderly fall into Mental Health or Geriatrics or both? Is childbirth in an aboriginal woman to be classed as "Maternal and Child Health" or Aboriginal health? To establish exclusive program categories would oblige a level of arbitrary allocation that would make interhospital cost comparions extremely difficult.

APPENDIX 5

Transcripts of Evidence

MINUTES OF EVIDENCE

TAKEN BEFORE

THE PUBLIC ACCOUNTS COMMITTEE

At Sydney on Monday, 16th September, 1985

The Committee met at 10 a.m.

PRESENT

Mr J.J. AQUILINA (Chairman)

Mr C.M. FISHER
Mr J.H. MURRAY
Dr A.J. REFSHAUGE
Mr P.M. SMILES

Emeritus Professor CHARLES RUTHVEN BICKERTON BLACKBURN,

Chairman of the Board of Directors, Royal Prince Alfred Hospital, of

DR DONALD STEWART CHILD, General Superintendent and Chief

Executive Officer, Royal Prince Alfred Hospital,

sworn and examined:

CHAIRMAN: Have you each received a summons issued under

my hand to attend before this Committee?---A. (Professor Blackburn) Yes.

(Dr Child J Yes.

Q. Professor Blackburn, is it your wish during the proceedings to make any submissions to the Committee in written form? Do you have anything prepared with you?---A. (Professor Blackburn) No,sir.

Q. The members of the Committee wish to thank you for attending. There are a number of reasons why the Committee has decided to launch into a monitoring process of past committee recommendations, both of the second and third reports, which dealt specifically with hospitals, and the number of other reports that followed on. Our aims are many but particularly we are concerned to find out whether or not the recommendations of the Committee at that stage were practical, which were implemented in a number of ways both from the point of view of hospitals and also from the point of view of the Department of Health. Also we are concerned to see how helpful they have been in assisting the various hospitals. What the members of the Committee would like to know also is whether or not the recommendations have had any shortcomings and, from the point of view of hospitals, whether you have anything further that you

would like to see implemented by way of machinery from the Department of Health to assist you in your various operations.

Following the second and third reports of the Public Accounts Committee of former days, the Department of Health accepted the vast bulk of the Committee's recommendations, including incentive budgeting. As stated in its 1983-84 report: there would be more power for hospitals to decide how the budget allocation would be spent. The Department also stated that major efforts have been made to monitor and control financial performance and to enhance the level of financial accountability.

Today, the Committee is interested to hear from the hospitals themselves. As well as representatives from Royal Prince Alfred Hospital there will be representatives of Royal North Shore appearing later this morning concerning these and other general matters. The Committee is concerned that the best use is made of the limited health funds, as I am sure it is of concern to everyone involved in the health field. Good budgeting control and review processes, we contend, are clearly a major way of achieving this goal. The Committee is particularly interested in the instruction and guidance that hospitals receive on the budgeting process and the setting of budgets to review expenditure in this regard. What has been requested by the Department of Health you may be able to give us information about. Professor Blackburn, if I could direct my questions to you, as will other members of the Committee, you may respond and if Dr Child wishes to augment anything you have said he is free to do so.

Can you give us some information as to what information has been requested by the Department of Health on the budgeting

processes and the setting of budgets to review of expenditure?--A. Yes. I believe it would assist you and your colleagues if I briefly presented you with the background to my comments rather than just simply make a flat statement. Financially, we are getting steadily worse as we are underfunded for the job we are expected to do in the community. Mr Hawke and Mr Wran have both said publicly that university teaching hospitals are underfunded. It is my opinion, based on our funding, that the functions and needs of university teaching hospitals are not understood to be different from those of other public hospitals. We have not been and are not consulted before we receive our budget. When inner city hospitals were closed, we took a number

of units from them and our workload has obviously increased. But

we have never been funded for that purpose since that time.

In 1983-84, we were about to close beds so that we could get

within budget or near to it. We received specific instructions

not to do so. On that occasion we received a one-off grant to help us. Since your report, ou r staff's major efforts to stay in budget have achieved this in 1981-82, 1982-83, and almost in 1983-84. In 1984-85 it was impossible; for example, the devalued dollar cost us more than a million dollars in goods and services;
the change in nurses' education has cost the best part of three-quarters of a million dollars more than was allowed for. Our emergency, and I stress this, our emergency repairs and maintenance
were a half a million dollars over the budget we were allocated.
We were not consulted about our 1985-86 budget.

Our first quarter supply, that is less the 1984-85 overrun,

is as far as we can determine the 1984-88 budget. I repeat, we have not been consulted. There are no allowances in this first

quarter supply for dollar fluctuations, none for known retrospective VMO payments, none for the new units we took on last year, such as the methadone unit, the neonatal intensive care, the sex assault services and the detox unit. I cannot emphasise to you and your colleagues too strongly that a variety of factors, including the underfunding of university teaching hospitals, the doctors' dispute, the transfer of nurse education at the time when there is a nurse shortage which was known, has resulted in Royal Prince Alfred Hospital having 166 beds unavailable for use; a 92 to 96 per cent bed occupancy; patients with an average degree of nursing dependency higher than we have ever had before and a gross shortage of patients suitable for undergraduate and postgraduate education.

We cannot expect to be accredited to train our share of specialists for this State who doctors and the average person here believe it should have to carry out their specialist treatment. Further, if a hospital like Rachel Forster is closed, the effect on us and the State will be disastrous. Joint hospitals replacement in public/will cease. Now, in our institution, patient care must be jeopardised by the intense activity of everybody in an overfull hospital.

Incentive budgeting with that background is governed by instructions that we received on 14th November 1983 after our financial budget for that year. What value is this to us when every cent or half cent we can save has to be spent on trying to maintain patient care. It is our view in general that the monitoring and controlling systems have improved. We have employed planning consultants in terms of your documents who

have been working with the Department of Health and have considered all of our real estate and we are now disposing of the agreed excess in collaboration with the Department of Health. I believe it has been necessary for me to say these things to you to present you with the background of some of our discontent. I am sorry, I believe I said 14th November 1984; that should be 14th November 1983. My apologies.

Q. Did you receive an interim budget last year?---A. Yes. I do not have the date.

(Dr Child) We do not have the date here but the answer iS yes.

Q. Was it by way of a substantial supplement? What was the difference between the interim and the final budget?---A. They were substantially the same.

Q. Would you please provide the Committee with the date of the interim budget? . A. Yes.

Q. Are there any formal consultation processes in place between hospitals and the Health Department regarding budget?---A. (Professor Blackburn) Before or after?

Q. Before?---A. A. No, not of which I am aware.

Q. What about after?---A. After discussions take place, needless to say, when we are trying to get an explanation and, if I may say, protest, of course there is consultation afterwards; but not in the ordinary sense of the word "beforehand" do we make a submission. We are not consulted, and to me consulting means that we talk to one another, our officers talk with their officers, The answer is no.

Dr REFSHAUGE: Do you mean to say that you put in a submission to the regional Health Department about next year's allocation?---A. Dr Child will .answer that question,

(Dr Child) This was the case until 1984-85 when we were asked to submit our estimate of our needs to run the hospital according to our current level of activity. That sometimes varies. Sometimes we are asked to make a submission on our budget according to the formula o f the Health Department, For 1985-86 we were told not to bother.

Q. So no formal submission was requested from you for 1985-86' Did you put in a submission despite the fact that you were not requested to do so?--A. No, we were told not to bother in words as blunt as that.

CHAIRMAN: ,Inet so as to overcome some misconceptions that the Committee might have about the budgetary process and timetable, will you give us an outline of the budget timetable from the hospital's point of view?---A. For which year?

Q. We will take the latest year?---A. The latest year

is 1985-86, presumably..

Q. Yes?---A. The budgetary timetable this year consisted of no request for advance information to the Health Department. There was a notification of supply during July; that is 1985-86.

Q. So at this stage have you already received your budget allocation or not?---A. No, this year has been entirely different from- all previous years.

Q. In what way?---A. This year we have in fact received supply rather than an interim budget, and this year for the first time we are operating or attempting to operate on net operating costs rather than gross operating costs. So we are told that until 30th September the cash that will be available to us will be, in round figures, $27 million.

Q. How has this substantially changed your operations from those of previous years?---A. If we are talking about this year, we now find ourselves in an impossible situation cashwise in that, at least in my view, the definition of supply is just that, it is a cash allocation given to you to run your organization for a three months period. However, for reasons best known to itself, the Health Department deducted

from that cash allocation the cash overrun of the previous year, which leaves us in fact with supply minus to run the hospital for the first three months. So, as supply itself is not sufficient, supply minus is grossly deficient.
Q. What figures are we talking about? What was your overrun for the last financial year?---A. It was $3.6 million.

Q. So what you would actually have is somewhere in the vicinity of $23 $\cdot^4$ million?---A. That is right.

Q. How does that compare with your expenditure in the first quarter for the previous year?---A. It is based on the expenditure for the first quarter of last year.

Q. There has been no increase in real terms?---A. No increase in real terms. As Professor Blackburn explained, there has been no building into that first quarter - this is as far as we can determine because the exact method of determining supply has not been revealed to us - a number of those new activities that were funded last year.

Q. What was the date of the recent of your final budget for 1984-85?---A. 19th November.

Q. I suppose you anticipate that it would be around about the same time this year?---A. I do not know that we can anticipate that. In l980-81 it was 19th February; in 1981-82 it was 9th October; in 1982-83 it was 3rd November; in it was 25th October; in 1984-85 it was 19th November. So I suppose we can anticipate it somewhere between October and February.

Mr SMILES: I want to ask a couple of questions following those asked by the Chairman, primarily as a point of clarification. You indicated a difference between net and gross, as it were. As I heard it, the supply figure was some $27 million; is that correct?---A. Yes.

Q. Is that 227 million a net or a gross figure?---A. Net. Q. If you are estimating a gross figure, which is obviously of some preference to you, what would that figure be?---A. In round figures it would be about one-quarter of $140 million.

Q. In other words, in some sense for this first quarter your budget has suffered, in your view, two deductions, as it were: from gross to net and then on the net figure a further reduction calculated on the overrun?---A. Not quite. No, I do not think you can say that. My comment about supply was that this is the first time that hospitals have had to function with a net figure. The budgets have always been assessed against the gross operating payments,the net figure being the difference between one's gross payments and one's revenue which is mostly patients' fees. Of course, it is very difficult to determine what your patients' fees are going to be. It depends upon a number of things, such as the insurance level of the population, whether there is a doctors' dispute, whether the health insurance funds, whom we bulk bill directly, determine they are going to disgorge money this month or not. They do not always disgorge their money in a regular pattern.

Q. Given that difficulty in terms of assessment, how fair was the calculation of the figure between gross and net this year?---A. We would regard the gross figure as being underestimated. The estimate in the revenue is not too far out.

CHAIRMAN: Have you had any supplementary funding available to you in the past two years?---A. Yes, in 1983-84 there was a considerable amount of supplementary funding. Our hospitals shared in a one-off $6 million grant to the teaching hospitals in that Fear to the extent of $1.8 million.

We had additional funds of $700,000; $500,000 of that was in addition to a sum of $1.5 million received on the commissioning of our new block. I might add that that was against our estimate of running the new block of $4.5 million, so we got $2 million, The other $200,000 of that $700,000 was to account for the increased workload from Crown Street. We estimated that that increased workload was going to cost us, gross, some $2 million. The regional office of the Health Department did not disagree with that figure. We had our budget supplemented to the extent of $200,000. In addition we were promised that we would have seconded to us 100 supernumerary staff from Sydney Hospital who would be on the payroll of the Sydney Hospital on the winding down of that hospital. In the event we got six of them. There was a budget redistribution at the end of 1983-84 within the region because, although the large teaching hospitals who did most of the work in the region overspent, the smaller hospitals could not spend their budgets and out of that we got $1.05 million.

Q. Despite the supplementary funding the hospitals still overran their budget by $3.6 million?---A. I was talking about 1983-84. For all practical purposes we came in on budget in that year. We were $440,361 over in a gross operating payment of $127 million.

Q. Was there any need for supplementary funding in the last financial year, 1984-85?---A. If we were to come in on budget we would have needed a supplementary budget allocation of $3.6 million.

Q. You touched then on the connection between the hospital and the region. I shall ask Mr Murray now to ask you

some questions about the monitoring process carried out by the regions.

Mr ,MURRAY: From where I sit, it has been a bit of a tale of woe. Things are difficult, but I might say that all government departments who come before this Committee tell the same story. You would have realized that there would be difficulty in funding. What have you specifically done, other than employ consultants to advise you on the disposal of real estate? What else have you done to look at your budget overspending and what management techniques have you developed to overcome these projected problems?---A. (Professor Blackburn) I mentioned that the consultant was not emoloyed specifically to look at our property. We employed consultants to provide the board of directors with the means of planning for the future of the hospital. In that process of providing us with the means they obviously developed a number of strategies for the hospital; but the purpose was to provide the board with a framework for planning in the future for everything from our role in the community or the region to a spinoff from the real estate. So that was not the prime purpose. I have made that quite clear,

We employed those people because we did not have the capacity to do high level planning ourselves. We were not staffed for that. Secondly, we had, and still have, no plan or no statement of our formal role other than what we think it is as a teaching hospital. We had none from the department or the region as to what is our specific role in the region in which we are. We wished to prepare that for ourselves to facilitate our own planning. That is why the consultants were there.

In terms of monitoring, in a moment I shall ask Dr Child to comment. But it is extremely difficult to see how many of the recommendations of your Committee can be dealt with when they are to rely on comparative statistics of productivity, efficiency and the like, for which I am not aware of there being any tested standards. I am not aware of any. There may be some and they may be used, but we have no standards with which we are asked to deal.

Looking at a budget and how you spend it is a separate issue. You are not asking about that. You are talking about monitoring our performance. We do our best to make our institution as efficient as we possibly can. We do not have the sort of measure you might expect in some other fields.

Q. What you are telling the Committee is that there are from the region no monitoring procedures that are helpful?---A. I did not say there are no monitoring procedures from the region that are helpful. To have proper monitoring and proper comparisons of, say, Prince Alfred Hospital and Royal North Shore Hospital, or some other hospital, one must have some sort of standards by which to judge. One cannot hope that the patient mix will be the same, that the referral pattern will be the same

that
and/there will be the same doctors, because that is not so.

In my opinion, we do not have an adequate means by which to compare the sort of performance you are suggesting. For example, how does one compare the cost savings of a sexual assault clinic with a renal transplant in terms of efficiency or productivity. At the moment, there are not proper standards. They can be developed by somebody, but that would take much effort and time. But that was not the question.

In terms of monitoring and looking at our performance,

as I said initially, we believe that things have improved.

May I defer to Dr Child.

(Dr Child) I would believe one could answer the question

in two parts. Having answered the question in two parts, there would still be a dilemma. In terms of increased efficiency within the hospital, the hospital over the past four or five years has been developing an advanced computerized reporting system, so that we can in fact get a handle on exactly what we are spending, and so we can as best we are able sheet home to individual departments and units information on their activities and the costs of those activities.

Certainly, by the use of such monitoring processes in house, one can demonstrate that the organization itself is operating increasingly efficiently.

Q. Could I interrupt you there. Is that information available to the region?---A. It is certainly available to the region. The regions know of this. We do not report to the region in that form. We report to the region the way it wishes to see its reports, which is in a line-by-line basis. There have been significant improvements in that activity in that, in accord with the second or third report of the Public

Accounts Committee we do now receive our budget not line by line but in blocks. But we are then responsible for breaking up those blocks into the line by line. Once having done that, we report against it line by line. We report now in our department on variances to those line by lines. Since January 1985 explanations have been required for those variances in that, as there have been significant improvements, at least the department is seeking reasons why we have varied from our line-by-line budgeting activity. I suppose that answers your questions.

Q. I want to follow up one aspect of your answer. You have set up performance measures and computerized them. On what did you base your initial performance? What were the criteria? ---A. Here I have to allude back to our chairman's answer. Those performance standards and reporting systems relate to the consumption of goods. It is difficult to find a satisfactory performance standard in respect to actual patient care. There are very few measures. What makes it even more difficult, and what makes the whole process of financial allocation, or budgets, or whatever one likes to call them, in the hospital system difficult is that there is no indication from the department, nor are we asked to, to develop the quantum of work we are required to do or wish to do. That means that when one finds one's financial allocation is not sufficient to undertake the quantum of work presenting, the only course available is to take steps to reduce that quantum of work.

Q. So, in effect, you determine your staff levels?---
A.No. Our staff levels are determined by budget.

Q. But there is an ability within that budget to take moneys from salaries and put them into capital works, or vice versa?---

A. No. There is no ability to transfer salaries and wages, or for that matter any maintenance fund expenditure, to capital works.

Q. So you get a budget for salaries and you determine whether that is spent on medical staff or ancillary staff?-~-A.No. We have much more flexibility on where the salaries and wages budget is spent, but we cannot do what you suggest we can do. We cannot divert moneys into employment of medical staff.
That is the exception. In fact it was, I believe, regarded as a necessary exception in the Public Accounts Committee's report that medical establishments are controlled.

Q. By whom?---A. We do not vary our medical establishment without Health Department approval. I am talking about senior medical staff.

Q. Is that the region or the Health Department?---A. We deal only with the region. Whether the region seeks central office approval is a region matter.

Q. Would it be fair to say that the thr eat of dismissal for overexpenditure has been communicated adequately through to the staff of the hospital?---A. (Professor Blackburn) Do you mean to the board?

Q. Yes?---A. Yes.

Q. Has that had any effect on some of your management decisions?---A. I should not have thought it would have had any effect on any member of my board or myself. If I am doing my best and I am sacked, that is all right. What else could one do? If you go, you go. I cannot speak for the individuals, but I should think most of those on the board would be of that view.

Q. Do you think the threat of dismissal has been an incentive to look more closely at your budget and expenditure within your establishment?---A. No.

Q. What do you think has been the main incentive for this reorganization. Is it the monitoring process of the region?

---A. The incentive for me, and I think many of my board, would be to do everything we can. We are very strongly of the opinion that we are a public hospital, a teaching hospital, and that we are extremely unwilling to cut our services unless we absolutely have to do so. Every single effort has been made, not just at board level. I have said publicly that the staff of the hospital have responded extraordinarily well and put up with an enormous amount. I think this would be the motive of my board, more than any question of being dismissed. I mean, being dismissed from the board of a hospital does not really matter, surely.

Q. I would not know. I have no been dismissed?---A. Nor have I. If it was my motive, perhaps I would not admit it out loud. But it happens not to be. Efforts have been made. Complaints have been made by many on our medical staff that they do not believe that the quality of care we are providing is equal to that which has been provided in the past. That is not because they are conservative or reactionary, but largely because the means are no longer available for it. As we have said elsewhere, if the board is faced with a position - as it is now - of having only five beds available in an institution for gynaecology, and they are used for five persons with fractured femurs, we do not like that. We do not think that is good patient care. It is not being sacked that makes one worry and try to do something about the problem. To us, that is not

what it is all about. I am quite serious, apart from my comment about not admitting it aloud, when I say that I do not think anyone on our board would feel other than I do.

Q. You did overspend last year. The thought must have gone through the minds of those on the board in the light of actions taken at Sutherland?---A. Yes. But I think I and the rest of my board would have been perfectly happy to be dismissed on the basis of overspending by $3.5 million. Just over $1 million of that was due to the dollar revaluation, for which we are not recompensed. I do not think we would feel guilty at all about saying we did not cut services on that SEE NOTE 1 basis. That is not at tributable to our mismanagement, or
I do not believe it is attributable to our mismanagement if three quarters of the $3.5 million overrun was due to matters beyond our control.

In the same way, if we have emergency repairs that cost us an extra half million, I presume we could say, "Let us not do it", or say "Let us stop patient services". If that is your choice then, in my opinion, if the board says "We will provide our patient services and overrun", that is what the board is supposed to do. If I am to be dismissed for that, well, let someone else have a go. I am not worried.
Q. Dr Child, are you on the board or are you an ex officio board member?---A. (Dr Child) I am an employee of the board.

Q. You attend board meetings and so on?---A. Yes.

I think it is reasonable to state that the board of directors told the department during 1984-85 what the situation was. We also told the department that we could meet budget in 1924-25. We told the Department also that, in order to do that, services would have to be reduced. Further, we produced a schedule of services that were proposed to be reduced to meet budget.

Q Is every doctor subject to peer revue?---

A. I do not think he can avoid it. Whether every doctor's every action is peer reviewed, the answer to that has to be no, of course. But I believe our peer review works reasonably well with us. I say I believe it. I do not attend peer review meetings myself, but I believe that they are subject to it and that the board does have a subcommittee of its own - a patient care committee - the details of which are presented each month to the board for its consideration in a gross sense only

I think I know what you are talking about. In the gross sense the board itself has the opportunity to look at the practice of medicine in the hospital. That is a gross sense because the things that appear there are perhaps near-disasters or things which change the hospital's policy.

(Dr Child) The hospital being a very large institution, those peer review mechanisms are not centralized. They function department by department or division by division, and each department does not necessarily conduct its activities the same way. But certainly if you look across the whole hospital, there is quite rigorous evaluation of the activities. Professor Blackburn has referred to the patient care committee, which
reviews the overall activities of patient care and receives reports from the four clinical divisions.

That committee is rather an exception reporting activity and it tends to look at those things that might have gone not

SEE NOTE 8 ideally. It (a) discusses or has mechanisms to discuss and

sort of counsel medical officers concerned and (b) has the capacity to make recommendations to the board of directors concerning policies in relation to patient care, particularly

where changes of policy may be recommended from experience.

Mr MURRAY: How often does that committee meet and who are the members of the committee?---A. That committee meets once a month. It has a very large membership and, as I have not got the list with me, you will forgive me for leaving some of them out.

Q. Can you generalize?---A. Generally it consists of two members of medical administration, two members each from the division of medicine, the division of surgery, the division of obstetrics and gynaecology, one member of the division of community and allied services, one representative of the division of clinical services, the head of the department of anaesthetics, the head of the emergency department, the deputy director of nursing, the chief social worker, and the committee is serviced by the medical records department.

Dr REFSHAUGE: Does this committee receive reports about the peer review mechanisms and results that are occurring throughout the hospital?---A. It receives reports from each of the divisions on their activities.

Q. So, if they do not want to report about peer review, they do not?--A. Nell, the patient care committee would be asking why.

Q. The peer review presumably is not a disaster review: it is a peer review; it is just looking at the death that occurred or the major problem that occurred?---A. We moved away from the traditional death committee many years ago. Obviously the peer review committees still look at deaths and unusual events, but just as equally they look at procedures.

Q. Talking about comparisons between hospitals, I think

Professor Blackburn said that he did not know of any suitable measures for making significant comparisons between hospitals. I understand the United States Veterans Affairs Administration hospitals have an enormous computerized network to compare all their hospitals and in fact some hospitals in Australia have previously linked in with that to see if they can make significant comparisons. Have you considered using that information and, if not, is there any problem with the way in which that information is collected to be able to make comparisons between either your hospital and the veterans affairs hospitals or your hospital and other hospitals in Australia?---A. I think the Veterans Affairs Administration in the United States is in the same situation as the Veterans Affairs Department is in Australia, in that it is a single administration activity. That is not quite so in the public hospital system in Australia. The veterans affairs hospital in the United States, as is the rest of the United States, is moving to actually getting a much better handle on case mix. I am sure you are aware there has been very little work done on case mix studies in this country. Until we can do that it is going to be very difficult to establish comparative studies; in fact, it is impossible.

Q. So you see the information that they are collecting or

the methods that they use to collect it as not of significant use to your hospital?---A. I do not believe they are. I think if you are looking at case mix comparisons, the work of DRGs . in the States will be of more value, but not for financing purposes. I think for case mix purposes, yes, but for financing purposes they are potential disaster.

(Professor Blackburn) Could I just make the point that

perhaps I am not quite agreeing with Dr Child there. In my opinion, any studies done and applied will have useful information. I am confident that those studies will have things of value to us. Perhaps Dr Child meant transferring the system to us. I am confident that that material would be of great value to us. I am sure you feel the same, that there will be information available.

Q. Coming back to what I gather you accept, that doctors make the decisions which cost the money, to have peer review seems to be a useful tool, but what other tools are there? Perhaps I can suggest that when one looks at say surgery rates in Australia compared with those in other countries, we have a very high surgery rate. It may be that all obstetricians believe that the rate of caesarean section should be twice what it is in Britain, and the cost significance here is obviously enormous; so to have obstetricians peer reviewing each other may be inappropriate as the only way to determine whether the decisions being made by a particular obstetrician or firm of obstetricians in your hospital are the correct decisions. Do you have any other mechanisms for assessing doctors' decisions which particularly affect the cost to your hospital?---A.

We have experimented with this sort of area, but I do not think there is anything much operating now.

(Dr Child) I have a couple of comments I would make in relation to the teaching hospital system concerning Dr Refshauge's statements. It is undoubtedly true that decisions of doctors are a determinant in the cost of heath care, but particularly in the teaching hospitals which carry an enormous load of very acute medicine, probably a greater determinant is the patient or the motor car or the alcohol, or whatever else it is, that has brought

the patient into hospital. I think that is probably a greater determinant of teaching hospital costs than the individual doctor decisions.

Teaching hospitals tend to treat their patients in a much more protocol-ridden fashion, such that the treatment regimes tend to be the same and not so individually based as they may be elsewhere. I think the other significant fact in relation to the high surgery rates that you are alluding to, which I think is a result of the peer review mechanisms that take place in the teaching hospitals, is that the rate of elective surgery in those communities that surround the teaching hospitals is lower than anywhere else. Whether that is cause and effect, no one really knows. It is going to be hard to make that generalization, but the fact is there.

Q. Would you be happy then with the rate of elective surgery in your hospital, whether it is higher or lower than the average, is acceptable and is justifiable?---A. At the moment there is virtually no elective surgery. I think it is very difficult to look at anything regarded as being elective surgery and I think also one has to be very careful in this context in distinguishing between elective and unnecessary. I would believe that all the elective surgery that is done within our institution is necessary.

Q. That is because of the quality of the doctors you have and the mechanisms for reveiw?---(Professor Blackburn) Both. I think, in terms of peer review, that as Doctor Child indicated there are several types of review and two that I think are pertinent to what you have been referring to in the last minute or so. The first is that the peer review does take up a question

of how, say, people with diabetes are being treated in the wards of Prince Alfred Hospital. That topic will be looked at and what is the practice of doctors doing this and are they, so to speak, conforming that is not the word. In the same way the question of appendicectomyhas been reviewed in the department of surgery vis-a-vis other institutions and other places and what is happening and that type of study is done as well as, say, looking at other facets of activity, but the forms and if you like to say the standardization of practice aiming at the best is carried out by peer review in a variety of fields.

I think when it comes to interval surgery or elective surgery, out of the present time when there is none, there is tremendous pressure on people to maintain the highest standards within a teaching hospital. If one does not want to say that one gets it from one's higher or equal peers, there is an enormous amount of pressure in the university teaching hospital from below. Many students, I can assure you, are critical.

Q. Although there does seem to be a pressure to do things, the more exciting and dramatic things being done the more people come to watch and to see. I would suggest perhaps that your caesarean rate, which may be partly elective surgery, is higher than the average?---A. I will bet it is. I mean the type of patient we get If it was not

Q. Certainly. I am not making any comment that it should not be?---A. It is. Whether it is higher than it ought to be considering it is a tertiary referral institution, that is what I meant initially when I was talking about standards. We will assume our rate for caesarean sections is statistically

significantly higher than that of a number of other institutions. What one then needs to do somehow is to find out why, what is the class of patient we get and what are the indications.

This, I think, is difficult to chase up. It is, I think, comparable in a way, its difficulty and how to do it, to the fact for example that if we are 96 per cent occupied, it seems

SEE NOTE 3 quite wrong for a nurse to change a bed. She is wasting her time. She ought to be looking after somebody who needs her care. But who is going to do this sort of thing at present? I feel that it needs to be done, but it is very difficult to see how an institution like ours can take so to speak - time out to do it. I think it is very difficult indeed. We are using the methods we can. They are not ideal.

(Dr Child) In theory, the caesarean section rates in our institution and insitutions like it should be the highest in the State. If it is not, there is something wrong with something happening elsewhere.

Q, My question is whether you think the level is

Justified?---A. (Professor Blackburn) ! would think so, but if you were to ask me my grounds then I would say because of the quality of the Dec,le we have under Deer review but I have not any standards upon which to base it.

Q. Can you provide the Committee with written details of your hospital's internal financial monetary methods and Procedures at a later date? Would *that* be reasonable?---(Dr Child) Yes.

Q. Do you think your hospital will go over budget

in this year, 1985-867---A. (Professor Blackburn) Do I think so?

Q. Yes? . A. Yes, unless something happens.

Q. Do you, Dr Child? ... A. (Dr Child) Well I think - -

Q. On present predictions?---A. (Professor Blackburn)

Taking into account what we have received as one-quarter supply, I believe the answer is yes.

CHAIRMAN: Has any action been taken in relation to it?---A. (Dr Child) If we are to provide the same level of services as we are providing now, and if the budget after the State budget is based exactly on supply, we will certainly run over budget. But on the other hand, as we can meet budget it will then be someone else's decision as to whether or not they are prepared to allow us to curtail services.

Q. You will be providing schedules to the Department of Health on the ways in which you will be able to come within your budget?---A. Yes, but on at least two previous occasions we have been actively stopped.

Dr REFSHAUGE: I think you may have answered this before but has supplementary funding been available to your hospital in the past two years? I think you have PreDated a list?---A. Yes, I have spelt *that* out.

Q. Who does the auditing of your hospital's accounts?---A. Hungerfords.

Q. Did you prepare a corporate Dian for the management of your hospital?---A. We do now have a master development control Dian that indicates where we are going. We do, at the beginning of each year, prepare in detail what we think our needs are to meet our patient load. We do that as an exercise for ourselves. We do not seem to be ever funded according to those needs.

@. As far as new services go, T gather you have had new services being provided from hospitals. What is the basis by which funding is obtained? How do you actually get that funding? Do you talk about the needs for new services first or are they imposed upon you? What discussions would you have about the actual costs that these new services would have?---A. (professor Blackburn) Essentially, there are two varieties. One service comes from without in which we have an interest as has been our policy and, to take a sort of high tech. recent example - this has had publicity-the liver transplants. I took part in discussions with federal people concerning that and I took an active role and made it perfectly clear *that* there was no was that prince Alfred Hospital could do *that* unless the whole exercise was completely funded. We could do the individual patient as required. We do it if we are funded; if we are not, we do not. There have been some other activities

that have been started for which we have had an initial earmark grant but what subsequently tends to happen is that that comes into a general subsidy and into maintenance and it is no longer adequately funded because we are underfunded overall.

(Dr Child) I think the past few seasons have not really been ones for new units and additional activities. There have not been very many at all. But of the new activities that we have taken up, the larger ones have been in fact the transfer of other units as whole units from hospitals in the rationalization programme. All of those units did come with their funding and all of those units come with inadequate funding so they have in fact contributed to the ore sent sorry state.

Q. Have you ever rejected a new unit because you think

the funding is inadequate, apart from the decision concerning the liver transplants?---A. We did not believe that we were In a position to refuse the transfer of units from otherhospitals. We did at one stage say that the situation was that we could not be prepared to accept the transfer of one of those units. We were, however, told in writing that it was a condition of the additional $1.8 million that we got from the additional $6 million in 1983-84 and we took it. I suppose faced with that situation you would take it.

Mr SMILES: Dr Child, when you were informed of that condition, had you already spent some of that money?.-- A. Which money?

Q. The $1.8 million?---A. That $1.8 million was Dart of the $6 million from State Treasury, which was said to have come from the increased revenue that would be generated by Medicare

as a one-off activity to make up or alleviate what was then seen as a large projected deficit that we were facing in January **1984.**

Q. I recall you made some mention very early in our discussion this morning. The question I would like to ask you is when you heard of the condition, was some of that $1.8 million already spent by your administration?---A. Not on the new unit or what was not yet there.

Q. No, I accent that, but just in general hospital expenditure?---A. In general hospital expenditure, in January 1984, we were facing a projected overrun of very close to $6 million, so in a sense, yes, that $1.8 million had been well and truly gobbled

Dr REFSHAUGE: Just referring back to incentive.

I infer fro m your remarks at the beginning, professor Blackburn, that incentive budgeting has not been used in your hospital because there f s no room for it, is that correct?---A. (Professor Blackburn) Yes, at the present time we have no savings and the particular scheme offered I do not find attractive. I think Dr Child may like to comment a little further on that. There are incentives and incentives.

(Dr Child) Some of my more cynical col1eagues would

ca11 it a disincentive budgeting scheme. I mean, a scheme that provides that you have to first find clearly identifying savings that in fact will be ongoing and then be able to convert 60 per cent of that to a capital project, which has to be approved of by the department, the other 40 per cent being held in the Treasury in reserve, and then the full effects of those savings being a permanent reduction from the budget, ! do not think anyone would be surprised that people

are not falling over themselves to enter such a scheme, apart from the f act that the whole system is underfunded anyway.

Q. That is the only incentive budgeting that has been suggested?---A. That is the context of Circular 83/334 , and that is the department's incentive budgeting scheme.

Q. Do you have any internal incentive budgeting scheme that is different from that, in your department?---A. Yes. We are always looking at outside methods of savings. They, however, cannot be diverted to capital. Certainly we are always looking for savings in areas in order to maintain our clinical services.

CHAIRMAN: Professor Blackburn, has your hospital been inspected in recent years by officers from the Department of Health?---A. (professor Blackburn) Yes.

Q. Have there been any beneficial results arising from those inspections?---A. The answer to that always has to be yes. And I do not mean that because I am here and you are there. But if somebody outside comes and looks at your show, unless their eyes are shut, they really should find some things that can help. I think that is the case and so my answer to you would be yes A recent inspection was not particularly valuable.

Q. How many inspections have you had out there say in

the last two years?---A. One.

Q. What beneficial results came from that?---A. (Dr Child) I would certainly have to agree with my chairman. The answer is, not many. They did point out to us that one or two of our accounting procedures were not strictly in accord with the account s and audit determination. They were immediately changed so that they were strictly in accord with the accounts and audit determination. I guess that is a beneficial result

of the exercise. They made a number of other recommendations that in fact would have cost the hospital money had they been made on correct premises. But we, in consultation with the

department, pointed out that we believed their recommndations were not on correct premises and we do not want to spend that

Q. How are your property holdings used to help the finances for the operations of the hospital?---A. (professor Blackburn) In a very minor fashion. I think Dr Child can refer to those. The property holdings that are receiving attention at the present time really cannot be described as making a significant contribution. I am talking about finance only. They are quite minor, the property holdings, in that sense.

(Dr Child) Our property holdings, for all practical purnoses, none of which were funded by the Department of Health, are used to generate income, which is then used to support the purchase of capital equipment. I suppose you would be aware that the maintenance budget of teaching hospitals is fairly miserable but the capital budget of teaching hospitals is probably even worse. If it were not for outside funds genera*ed within the system our equipment stock would be very poor indeed. That income is used for that purpose.

Q. What level of funding are we talking about?---A. We are talking in the order of $200,000 a year.

Q. Is there any way in which these property holdings can be put to better financial use on behalf of the hospital than at present?---A. The answer to that question is yes and no, in that we did, as part of our master development control plan in conjunction with State Government policy, look very carefully at all of the property holdings that may be regarded as being excess to our needs. We certainly agreed with government policy that such properties in excess of public authority use ought to be turned back into the community, and that we are proceeding to do. As I said, as virtually none of these properties was government funded originally, it would be the hospital's intention, with the approval of the Health Department, that the proceeds of those properties will be turned into capital works associated with our site redevelopment.

(The witnesses withdrew)

MINUTES OF EVIDENCE

TAKEN BEFORE

THE PUBLIC ACCOUNTS COMMITTEE

At Sydney on Monday, 16th September, 1985

The Committee met at 11.45 a.m.

PRESENT

Mr J.J. AQUILINA (Chairman)

Mr C.M. FISHER
Mr J.H. MURRAY
Dr A.J. REFSHAUGE
Mr P.M. SM1LES

PATRICK JAMES JOHNSON, Chairman, Board of Directors, Royal North Shore Hospital,

STUART ROBERT SPRING, Director of Medical Services and Acting Chief Executive Officer, Royal North Shore Hospital,

JOSEPH STANLEY PHILLIPS, Chief Accountant, Royal North Shore Hospital,
NORMAN ROY FULL, Director of Administrative Services, Royal North Shore Hospital, and
MARGARET COOPER BOOTH, Director of Nursing, Royal North Shore Hospital, sworn and examined:

CHAIRMAN: Did you all receive a summons issued under my hand to attend before this Committee?---A. (All witnesses) Yes.

Q. Has the panel any written documentation to present to the Committee today?--~A. (Mr Johnson) Yes, we have prepared a detailed submission based upon the comments that were contained in the invitation to appear before this Committee.

Q. Is it your wish that this material be accepted in evidence?---A. Yes. The submission reads:

(Not Reproduced in this Report)

CHAIRMAN: As you are aware the Committee currently is reviewing action taken following its past reports. The reports of particular interest today are its second and third reports dealing with the health system. Following the presentation of these reports, the Health Department accepted the vast bulk of the Committee's recommendations, including incentive budgeting, and stated in its 1983 annual report that there would be more power for hospitals to decide how the budget allocation was to be spent. I will be particularly interested in your comments in the course of the hearing about that matter.

The department stated also that major efforts had been made to monitor and control financial performance and enhance the level of financial accountability. The Committee is interested to hear today from the hospitals themselves on these and other general matters. Earlier today we heard evidence from representatives of the Prince Alfred Hospital. The Committee is particularly interested,as I am sure each and every one of you is, that the best use is made of our limited health funds. Good budgeting control and review processes are clearly a major way of achieving this goal.

Before I start with the formal questions on behalf of the Committee, perhaps members of the panel may like to make some introductory comments and speak to the written submission that has been presented to us. I shall address my questions to Mr Johnson but, should any other members of the panel wish to augment your comments or should you wish to defer a question to a member of the panel, please feel free to do so?---

A. (Mr Johnson) The submission is set out in some detail. Unless the Committee otherwise decides, it would not be my wish to go through the submission in detail, but certainly we will

attempt to answer by reference to the submission any questions that are put by the Committee. ! shall give a summary of our position and then the panel will be open to questions.

The major difficulty we face is to predict budgets when there has not been a stable period that one could use as a comparison. This is particularly so in 1985-86, bearing in mind that the past financial year was grossly disrupted by the doctors' dispute and has changed our case mix so enormously that that objective data or even the gut feeling no longer exists and we are almost going back to try to define the normal activity of the hospital again.

Q. I take it that you have not received your notification of budget for 1985-867---A. No, only supply.

(Mr Johnson) The supply, which is based upon the original budget of last financial year, was acknowledged by the department to be an unrealistic budget, and we received supplementary funding. Therefore, we are getting supply now based upon a budget that was acknowledged as being unrealistic.

Q. Was the hospital able to operate within its budget for 1984-85?---A. Yes, the gross operating costs; simply because of the additional funding made available.

Q. Was that by way of an interim budget?---A. No. We received additional allocations during the year.

Q. What was the basis of the additional allocations?---A. They are all set out in some detail on the eleventh page of the submission, the second paragraph. There was a total of $2.4 million additional supplementation received. That was simply because the original allocation was insufficient.

(Dr Spring) The regional office varied the budgets within the hospitals of the region to take account of the different activity that was being experienced by the various hospitals.

(Mr Johnson) It should be noted that during the doctors' dispute, Royal North Shore took a heavy load in terms of the region. A number of the other hospitals were not able to function very effectively and we were able to take the load in respect of the region in respect of emergency work. Certainly elective and routine services went by the board in favour of emergency work. That in itself increased our costs.

(Dr Spring) It should be noted that two of the budget adjustments under the third item took place after the .end of the financial year and but for those two items we would obviously have been some $700,000 over even the amended budget. This financial year the supply period has been based upon the 1984 budget prior to the $2.5 million adjustment.

Mr SMILES: I am mindful of appendix 10 where you include letters from Dr Campbell, the regional director, and following his letter, Dr Vanderfield's response and particularly page two of Dr Campbell's letter. If we look at the second page of Dr Campbell's letter under the subheading, "Formulation of budget. It is agreed that the formal notification" et cetera and then I draw your attention to the next sentence, "The likely allocations for the year were forwarded in late June." I note that you have highlighted the final paragraph on that page, "In placing on record the facts as they have occurred, it is my belief that ample and adequate guidance was forthcoming as to the likely financial allocation and the levels of expenditure." Having noted that, I turn now to the second page of Dr Vanderfield's letter in which he states in the first paragraph, "It is also not correct to say that ample and adequate guidance was given as to the likely financial allocation £or 1984-85."

The Chairman has asked questions about supply and

developing your budget on an historical analysis of the previous year. I am concerned about the notification you have by way of an informal mechanism prior to the final budget figures. First, why does the regional director and your general medical superintendent appear to be in total disagreement with regard to the understanding your hospital had on likely funding as at June or/July of the year referred to and, second, in terms of any allocation for the 1984-85 year, how different was the informal indication if and when it was learnt by the hospital to the final amount supplied?---A. (Mr Johnson) On page two of appendix ten Dr Campbell referred to the meeting at Hornsby Hospital in late June, at which all area chairmen and general superintendents were in attendance. North Shore was not represented at that meeting, other than by Dr Spring. Dr Spring was there as area executive officer. Neither the chairman of the board nor the general medical superintendent were present at the meeting. I might mention in respect of

area chairmen that North Shore is what is affectionately known as a de facto area board; we have not been constituted as an area board. Though we assume some of the functions of an area board and we are invited, on occasions, by the area board chairman and chief executives to attend meetings, we are not an area board in the true sense of the word.

The comment by Dr Vanderfield simply records that fact that neither Dr Vanderfield nor I were in attendance at that meeting at Hornsby. Subsequently the indication appeared at that meeting that there was an extra $340,000 for gross operating payments allocated over and above that allocation. Again it was an

indication that was not accurate.

(Dr Spring) I do not think there is as much difference between the two gentlemen as the letters may indicate. The style of the consultative meeting was not one of handing out budgets; it was really in the framework of a general information exchange. I doubt that anyone could have construed it as being a definitive allocation of budgets it was by way of background briefing.

(Mr Johnson) May I emphasise the fact, in case the wrong impression has been indicated, that there is no real division between Royal North Shore Hospital and the regional office. We find the regional office very co-operative to the limits of its responsibilities. We have informal discussions and to the extent that we can get assistance from the regional office, we do. We do not believe any budgetary problems are as a result of any decisions by the regional office.

Q. Given your comments that the Hornsby meeting was essentially a briefing, why would the regional office be given the impression that it was a detailed briefing, alerting your hospital, amongst others in the region, to their likely budget?---(Dr Spring) You would have to ask Dr Campbell. The way the region operates is there is a monthly meeting of all their executive officers and this has recently been constituted as the regional finance committee. It was not functioning at that time; it took up that role later in the financial year. What is absent is any paperwork other khan the background documents that were handed out at the time. There was a large amount of informal verbal feedback. If one is looking for the written evidence of a formal budget notification or likely budget notification, the only one that existed was that one in June.

Q. No minutes were circulated of the background briefing held at Hornsby?---A. No.

(Mr Johnson) You would have to understand the style of these meetings. It would hardly be an appropriate place to give a hospital the size of North Shore an indication of what its budget is going to be, bearing in mind that there were representatives of Hornsby Hospital, Gosford, Warringah, Manly, all constituting area boards. It was not the sort of atmosphere in which you could have constructively gone into the question of the North Shore budget. Time would not have permitted it to be done.

(Dr Spring) It was an evening meeting with one way traffic. There was no avenue to discuss the implications. The meeting took an hour and a half and this was one small part of the whole discussion.

Q. Therefore, would it be appropriate to conclude that to assist your hospital's administration such a background briefing meeting, such as was held at Hornsby, might be better constituted now involving the new finance committee at a more detailed briefing in that June period?---A. (Mr Johnson) I should have thought, again bearing in mind the size of North Shore, that it would be appropriate to have a detailed discussion with North Shore without the other area board people. Certainly they have their problems and we have ours. To discuss our problems in depth would take considerably more than an hour and a half when other people are competing for time.

Q. How long would you like allocated for such a June meeting for your hospital?---A. I would have thought a reasonable time would have been a day.

CHAIRMAN: On the fourth page of your submission you emphasize in the fourth paragraph that there is very little feedback on the budgetary process. On the eighth page you say, "Notification of the 1984-85 budget can only be described as absurdly late" and further you say, "The services that it is' expected to provide are not even discussed." In view of those statements can the hospital quantify its needs and justify its assessments?---A. Based upon what we perceive to be the needs of the hospital we can certainly do that. The point we make is that it is quite wrong to set a budget and to live within it and then having done that start to sort out what your needs are. Our belief is to determine what the needs are and to then budget accordingly. It is comparatively easy to budget once you know exactly what your needs are. It is up to the department to determine exactly what it wants of North Shore hospital. Having determined that, in consultation with the region, we can determine the appropriate budget for it. Our concern is to determine the budget and then determine what you do about the need afterwards.

Mr MURRAY: Do you think the Health Department has the ability to determine what you should be doing?---A. That is a leading question. I think it does. Broadly it knows what it requires of North Shore; whether or not they can fund it is another question. But in terms of needs, I do not believe there is any problem.

CHAIRMAN: I wonder whether if there was a system for earlier discussions, this would resolve the problem or just lead to more arguments?---A. I do not know. It depends on which way it is approached. I would say if it is approached on the basis that we have X amount of money that we will make available to you: do the best you can with it, that may lead to further arguments. But if the department say to us, "This is what we require of North Shore this year in terms of patient needs", we will meet it. There is no argument then. We are not going to argue with what the department require of the hospital. We do not believe it is our place to determine issues of that kind.

Q. Has the hospital any specific suggestions about

how the budgetary Process can be improved?---A. Only on the basis of consultation; first of all to determine what is required of the hospital in terms of need and then to adequately fund those needs.

(Dr Spring) My personal view is that we believe one

of our problems is that we have a sluggish system - a large system. It is hard to move it quickly in any one direction, with the exception of freezing nurse vacancies and then one gets a very rapid res-nose, if the game is Just to save money. We have found previously that when required late in the financial year to take aption, whether it be one Der cent or two per cent, if it has been unheralded or other factors have come into olay, in fact the measures to save the money have had to be doubled. To achieve a two ocr cent saving across the year, it requires four Der cent in half a year.

Something that may held would be perhaps a move towards the university approach of funding on a triennium so that we can

Dian measures over a longer period. Unfortunately the budgetary process at the moment constantly makes our horizons very short and to a regrettable extent we are often worried about how do we meet this year's financial problem rather than genuinely looking ahead.

Q. As an alternative, it has been suggested to Committee members on an informal basis that perhaps the financial year for hospitals could be changed to say from November to November. Would that be of assistance to you?---A. (Mr Johnson) It is a case of whether altering the financial year makes any difference. Our Problem at the moment is that we are simply not receiving a budget that meets the needs of the hospital, as we believe they are perceived by the department. I would not think it would matter when the financial year starts and finishes. You still have to determine what the needs of the hospital are and adequate funding for those needs.

(Dr Spring) We have always taken measures *that* have brought us in within the financial allocation, even if they have been late. I think page 7 of the document shows that, with the exception of 1980-81 which I think precipitated the second and third reports every other ?ear our performance has been satisfactory. I would dust make a rider about the 1983-84 report, which purports to show that we were $500,000 unfavourable. In fact, that was due to only two areas - visiting medical officer payments and superannuation - both of which were outside our control and for both of which we were given cash by the Health Department in recognition of the need but they did not adjust our budget. So we had the cash but the budget was not adjusted.

Mr MURRAY: How does that work?---A. They give you cash

but they do not adjust your budget.

(Mr Johnson) The budget remains unaltered but you are given supplementary assistance by means of a cash payment.

Mr SMILES: That is to keep the definition within a one-off payment?---A. Yes, not necessarily to be repeated.

CHAIRMAN: One of the major recommendations of the former Public Accounts Committee reports dealing with hospitals related to incentive budgeting. How is incentive budgeting being brought into play in your hospital?---A. A comment on incentive budgeting is set out. One of the problems is that it came a few years too late so far as North Shore is concerned. Bear in mind that over the last ten years in particular and more specifically over the last 25 years to my knowledge the hospital has actively looked for ways and means of saving · We heller% having gone through it year after year, that the extent of the savings is Just not available to make incentive budgeting on the basis proposed a viable proposition.

(Dr Spring) The Health Department document is included under appendix 2 in the submission. Though it would have some merit, with the problems that we have Just trying to save money to meet the Health Department's cuts, to add to that incentive by that condition has not been really a viable way of approaching the problem.

Mr MURRAY: What schedule hospital are you?---A. Schedule 2.

(Mr Jehnson) The uDDer limit on the basis of the circular is $50, 000 or one per cent.of Gross Operating Payment Budget.

Q. Is that for Schedule 27---A. Yes.

CHAIRMAN: So in reality incentive budgeting has not been any help at all to you?---A. No. As I say, bear in mind that

had it come a few years ago, before we made some of the

savings that we have made in the last ten years or so -

(Dr Spring) There bas been internal incentive, if I could pick up a question that was asked before. As we have gone through departments there has always been the possibility of departments, if they can achieve greaser savings than we have required of them, using hart of those savings internally. We have always been reorganizing interdepartmental budget allocations for as long as I can remember.

Mr MURRAY: If you took out the constraint that the savings had to be expended on capital items - in other words, you widened the parameters - would that give you a greater incentive to make savings?---A. (Mr Johnson) The difficulty that we would have is in making saving now. As I say bear in mind that we have been making significant savings for some years now. You run out of savings eventually.

Q. I understand that, but you can always try that

little harder, can ~you not and if you had an extra incentive you may be able to do that?---A. I do not believe there is a great deal of scope, trying even a little harder to come up with significant savings, with the constraints that we have.

(Dr Spring) Bear in mind that we are already $2.5 million

behind.

Q. Could you suggest a better system than this proposal that is obviously not working?---A. (Mr Johnson.) It is hard to suggest. As I say, ten years earlier it would have been quite appropriate in our organization.

(Dr Spring) I think the only incentive would be

a greater degree of ability to make our own Internal decisions

within a total budget allocation. But there are times when we have come in favourably in goods and services and unfavourably in salaries and wages, which admittedly have been adjusted right a + the end of the financia1 year. We ourselves have not been able to see it happening and make a decision based on that interchange. It has always happened in the last month of the financial year.

CHAIRMAN: could it be fair to say that the emphasis

of Royal North Shore is that the .' Health Department should decide the hospital's role and the level of services?---A. (Mr Johnson) Yes, and provide an adequate budget then to meet those needs and levels of service.

Q. This would also imply the Department of Health carrying the responsibility for those decisions?---A. Well, yes, and to some extent may determine it now. Obviously if there is not adequate funding available for services, they have to be cut back.

(Mr Full) It seems to me that this has to be a two-way street. I think the Department of Health has, as its responsibility, control over the planning of services, but at the workface we can offer them a degree of valuable information and data which ought to be taken together conjointly in the preparation of a strategic plan within the framework of the regional strategic plan. I think that ought to be built up concurrently.

Q. Alternatively, how would the hospital view an arbitrary system of, "Here is your allocation: do the best you can with it"?---A. Quite frankly, it would be better than what is happening at the moment. And if I could just elaborate

on the the letter that we received - which is appendix 8 on page 6 - says that boards and chief executive officers should give urgent consideration as to how hospitals will meet their 1984-85 budgets. Any reduction in activity from 1983-84 levels should be avoided unless there is a clear diminution in demand or good clinical reason to contract or discontinue a service. Then they go on and talk about efficiency But the next paragraph says that if a hospital board certifies that budgets cannot be met using the measures outlined in the above paragraph, it should put forward the proposals for contraction or closures of services based on hospital priorities.

Q. Really what we are getting to is a determination

of who should set the role and the level of services. That is basically the key factor in all this, is it not?---A. (Mr Johnson) We believe that is a matter that should be the subject of consultation. We are in a good position, we believe, to advise in respect to it. At the moment, of course, there is no question of consulting with the department. Probably the most effective way would be a consultative mechanism between the hospital and the department on the question of the needs of the hospital and then, as I say, budget accordingly. It .lust seems wrong to budget first and worry about the needs later, which is what we are doing now.

Mr SMILES: Given this issue of defining the role

for your hospital and budgetary considerations, how long would it take your hospital to develop a definitive role or perhaps alternative roles for your hospital and to quantify, by implication, what those roles would be to precipitate discussion with the health regional area?---A. I would think

there could be a big time factor.

(Dr Spring) We are in the middle of such an exercise

at the moment. It has been going on for about six months.

It has been grossly disrupted by the doctor dispute. I do not think it will take more than a fear months to finalize it, but then the problem is that until the certainties of the outcome of the doctors' dispute are known and the shortage of nurses, which is perhaps s an even greater problem as we are headed into the future, to bring it back to a point of reality may take some time because there are certain unforecastable things.

Mr MURRAY: I want to go back to the matter of supply.

It is obvious that you are unhappy with the quantum, rather than the mechanism. If a more realistic allocation were forwarded, do you feel that would overcome a lot of your budgetary problems?---

(Mr Johnson)

A./I do not know whether it is just the money or the mechanism.

Bear in mind, as I say, what occurred. We were given a budget last year which we were able to demonstrate was unrealistic and it was supplemented. In terms of supply, instead of going back to a budget that was unreal in start with, why not go back to the adjusted budget?

Q. But that is quantum, is it not?---A. It is also the mechanism, I suggest. Until such time as we can sort out this year's budget, if the mechanism had been to go back to where you were at this time last year, with due regard to inflation, that mechanism I suggest would have been the more appropriate one, instead of going back to something that was not real.

Q. But obviously it has improved. Other hospitals received their budgetary figures in February in one particular year and you have said you had yours in October or November. At least you are getting 25 per cent of your budget in June under this supply system. I would think that that would allow you to budget on a more even keel than under the previous system?---A. That depends on how realistic it is. Bear in mind it is only supply and if it is unrealistic supply, it does not really help you, does it?

Q. Could I put a scenario to you : if supply were based on 25 per cent of the previous year's budget, plus inflation -

A. The previous year's actual budget?

Q. Yes. Expenditure, that is what I am putting?---A. That is what I am suggesting to you. That would be a more realistic way of looking at it than looking at a budget that did not work.

Q. You are saying that if supply were based on 25 per cent of the previous year's actual expenditure, plus a component for inflation, it would make your position more tenable?---A. It would certainly be more realistic and tenable, yes.

(Dr Spring) There is one rider within that. There is a need to come to an early agreement about a matter that is an ongoing disagreement, that is the underfunding for the nurse education transfer. Until that is resolved we have a major shortfall, which would ultimately amount to a number of millions of dollars.

(Mr Johnson) If I could illustrate the point I was making: the budget upon which our supply is based at the moment was on a gross operating payment of $103,252,OOO. The actual was $108,370,OOO. So there was $5 million difference.

Q. I noticed in one of the annexures that you have a fairly large property portfolio?---A. No, we do not have a property portfolio in terms of property. All the property that belongs to the hospital is used for hospital use.
The only property that we acquire from time to time is property that may be left to us. We have a policy of disposing of that and putting the proceeds of the property into an appropriate trust fund.

(Dr Spring) All that property is part of the hospital site.

Q. Within the complex?---A. (Mr Johnson) Yes. We hold no other property. As I say, we do hold it from time to time when it is bequeathed to us but only until such times as we can dispose of it.

(Mr Full) Just for the purposes of clarification, on that map there is an area to the northern boundary that shows cottages, but that is now a hospital parking lot. So it is not a series of cottages as shown there.

Q. In your total operating receipts, what sort of flexibility do you have there?---A. (Mr Phillips) With regard to the total operating receipts, the largest item that constitutes that amount is the patient fees income and generally in the past couple of years there have been fairly significant changes as a result of federal Government policy, mainly due to Medicare, and we have in fact had significant changes with regard to patients from charge to no charge services. We have more free patients. The result is that our patient fees income has fallen quite considerably and in fact the department did recognize this because although they set their budget at a certain figure, we obviously did not meet that by quite

a significant amount. On page 7 of the submission you will see that in particular for the years 1985-84 and 1984-8S total operating receipts in 1985-84 were $2 million and in 1984-85 they were $2.S million less than the budget set. However, that fact was recognized and we were provided with cash to meet the shortfall.

Q. So those figures are shortfalls?---Yes they are.

Q. What percentage of your total operating receipts would come from patient fees?---A. About 20 per cent. The rest is government subsidy.

Q. So you have 20 per cent, which is really set by the Commonwealth Government?---A. (Mr Johnson) Yes.

Q. And the other 80 per cent is funding?---A. That is correct.

Q. You do not have any income-generating facilities within the hospital?---A. No, we would not have any other income as such. We do have private trust funds and various other funds that are income generating for the funds themselves.

(Dr Spring) There are some. There are the cafeteria receipts from the staff cafeteria and there is also - I forget whether it is termed a facility charge associated with the staff specialists' right of private practice.

Q. What percentage of income would be derived from that? ---A. (Mr Phillips) In total those two amounts would probably make up about $4 million in total receipts of $100 million for the whole hospital expenditure.

Q. You do not have much flexibility in that area?---A. No.

(Dr Spring) Even if we do, it only offsets the subsidy. It is not something we are able to put to local use.

(Mr Full) If I may add something whilst we are referring to

patients' fees: we do in fact receive financial supplementation although not up to the full amount of the deficit. If I could refer the members of the Committee to page 12. What happened in the hospital report to the department is that the deficit is shown without the additional budget adjustment. We get the cash but they do not adjust the budget. If the *Department* of Health were to follow your recommendation No. 21 of the Third Report, and to publish our budget performance, we would have shown in this year an unfavourable variance of $2.297 million. If, however, they had adjusted the budget by the $1.6 million that they actually gave us, the unfavourable variance in the net operating costs would have been substantially lower.

Q. Why do they do that?---A. (Dr Spring) Perhaps you could ask *them.*

Q. You must have some idea?---A. I suggest it may be to demonstrate to the Commonwealth that the State's income from Medicare has been a lot less that predicted. But that is purely assumption.

(Mr Full) Our concern is that any published reports along the lines of your recommendations would show us as being less favourable than we in fact finished up.

Q. There is a question *that* I did ask the *representatives* of Royal Prince Alfred Hospital and I pose the same question to you: with those block grants there is some flexibility in staffing in terms of payments. You state at the end of the last paragraph on page 16:

> Restrictions imposed of by the Department of Health however meant *that* hospitals had the authority to change establishment of gradings on lower levels only.

Could you just elaborate on that?---A. If you would like to have a look at appendix 12, what started out to be a wonderful idea finished up being constrained somewhat rigorously by the department. We certainly do have greater flexibility now than we did quite a few years ago. In fact, if you have a look at the constraints listed in 83/15 you will find that the degree of freedom that the Public Accounts Committee was envisaging has been somewhat watered down.

Q. More particularly, what was meant by" ..... change

establishment of gradings on lower levels only"? What is the cut-off point? What are you talking about there?---A. The cut off is specified in those circulars.

(Mr Johnson) There is a schedule in appendix 12 that states that the more senior positions are not included. It is the lower level positions that are included.

Q. I do not know what is a higher level or a lower level? ---A. (Dr Spring) In nursing, for instance, any alteration, charge nurse or above, must be referred to the Department of Health. We can interchange junior medical or junior clerical staff in the direction of the nursing staff or, what is more likely at the moment, nursing positions to ward assistants or people like that, to help in the general running of the hospital. But it precludes us from making a more major shift at the supervisory level.

Q. So it is based on the salary level rather than the departments within the hospital?---A. (Mr Johnson) Yes, it is the salary level.

(Mr Full) For example, within the clerical division, we can

only have flexibility up to grade $ and

and off the top of my head

grade 4 and above are to be referred/ I think that would be

about $18,000.

(Mr Johnson) But you are correct, it is cut off at the salary level rather than the classification.

Q. What flexibility is there in relation to the medical staff?---A. (Dr Spring) There are different interpretations. We exercise that discretion at a registrar, resident intern level, but it does not exist for senior registrars, medical administrators, staff specialists or visiting medical officers. But that is helpful. We have been pleased with what we have been able to do. We perhaps have not been able to go as far as we might want to.

Q. You would look for a freeing up of those constraints or, alternatively, so that you may be allowed to work within a structure that makes your decision making easier?---A. Yes. I mean I agree with Dr Child's comments to the extent that the biggest problem is the unrestrained appointment of specialist medical staff, because they are the ones that will generate expense either by starting a new service or by just the normal practice of medicine. Other than that there is no real justification.

Q. Has it worked in that way? You have not had pressures from the senior medical staff to implement new programmes because they know that that decision is out of your hands?---A. We have had pressure but we have always been able to resolve it one way or the other with the regional office. Some we have rejected, others we have been able to use. Most of the changes in recent times have been in fact transffered from hospitals that have closed. There have been very little in the way of new initiatives.

Q. I was impressed *with your* internal audit review systems. You have obviously undertaken a number of comprehensive reports.

However, when it came to the revenue system you only have

a periodic review rather than an ongoing review. I would have thought that that would be an area, in relation to receipts and accounting for revenue, where you would need to take a closer look if you are having budgetary problems. Why would you be undertaking only periodic reviews rather than ongoing reviews in that area?---A. (Mr Phillips) If I may answer that question: in the case of the revenue systems, they, for a start, do not constitute a very large portion of hospital income and in the other sense they are in fact fully computerized now. It is basically a systems review that we need to do once in a while . audit.
rather than carry out a detailed transaction/ I think

the systems reviews that have been carried out in the past few years have shown that generally the revenue systems are working quite effectively.

(Dr Spring) The income received does not really make

a big difference to the gross operating budget, and that is

the thing that we focus on, the gross operating budget.

Q. So there is a nil return from it in terms of the costs involved?---A. Yes.

Q. What did you find in relation to the examination of taxi use carried out in the report dated 29th March, 19847 Was that a worthwhile report?---A. (Mr Full) Yes.

Q. What prompted that report?---A. There was the high cost of ambulance billing and, in fact, given some freedom to move I suspect there would have been times when hospitals would have found it more economical to order taxis rather than ambulances.

at medical board level. There is a great deal of monitoring, both of an informal and formal nature. Added to that is the recent appointment of the patient representative, which, is an initiative of the Health department with which we agreed and endorsea. The ouster side of that question is determining whether the decisions being made by the medical staff are meeting the needs of the patients.

Obviously, in a very large organization with 30 000 admissions a year, one person is uphill in that respect. But the process is there. Anyone who works at Royal North Shore knows he will be looked at at every turn.

Q. Do you have a restricted drug list?---A. Yes.

Q. What size is that?---A. I cannot answer that.

Q. Would it be similar to the 200 drugs that the World Health Organisation recommends as a restricted drug list?---A. It would be in that order. Certainly, no drug can come into the hospital without rigorous investigation by the drug committee, and many of the drugs have significant restrictions placed upon them, both as to who can prescribe them and the number of days without review.

Q. Is that a satisfactory procedure?---A. It is satisfactory in the sense that it is a control. The difficulty is that the procedure adds to the weight of administration, and it is getting harder and harder to extend the monitoring process as far as one believes it ought to go. To a large extent, this is where the medical staff and nursing staff have to pick this up.

We are currently in the process of getting a larger degree of monitoring at ward level, and have recently established a group at ward level involving nurses, consultants and registrar staff as well as other allied help, specifically to look at utilization at ward level, rather than in the macro sense.

Q. A recent article in the medical press stated that a study had been conducted of your hospital about the inappropriate ordering of routine tests on patients entering hospital. I think the report referred particularly to no change of decision being made by doing a chest x-ray or cardiograph. Has that led to any

changes in your procedures in hospitals?---A. I think that report probably dates to 1979-80. It was a report by Dr Catchlove and related to 100 elective admissions. Unfortunately, we do not do elective admissions to any great extent, so it has not had any significant effect in changing practices. At the time it raised the issue, which was certainly discussed and reviewed by medical staff. I guess that in that subtle way peer review works and

it

I have, no doubts/changed practice.

Q. Could you explain in more detail the peer review systems, not so much at the levels inside departments, but more in respect of what other departments are doing to oversee each other, or what you are doing to oversee departments?---A. The main point where it all comes together is at the medical board level. It conducts not just a medical record audit but uses the medical record as a medical case audit along the lines of the Austin hospital. All departments in that hospital can be subject to that.

There is a meeting monthly at which a number of cases are

j~st~ standar d

selected at random. A reviewer is chosen to review

of the medical record but the standard of treatment. Many

people attend. Certainly, those whose cases are nominated for review make sure they are present. As I say, with 30 000 admissions, we do not get through more than $00 cases in a year. But the practice is there, and anyone's case can be reviewed, and everyone knows that.

(The witnesses withdrew)

(Luncheon adjournment)

MINUTES OF EVIDENCE

TAKEN BEFORE

THE PUBLIC ACCOUNTS COMMITTEE

At Sydney on Monday, 16th September, 1985

The Committee met at 2.40 p.m.

PRESENT

Mr J.J. AQUILINA (Chairman)

Mr C.M. FISHER
Mr O.H. MURRAY
Dr A.J. REFSHAUGE
Mr P.M. SMILES

ROBERT DONALD McGREGOR, Acting Secretary, Department of Health~

KENNETH REGINALD BARKS, Manager, Finance and Accounts Branch, Department of Health,
JOHN DAVID WOODGER, Assistant Secretary, Finance, Department

of Health, and

CHRISTOPHER GEORGE SCARF, Regional Director, Western Metropolitan Health Region, Department of Healthy sworn and examined:

CHAIRMAN: Have each of you received a summons issued

under my hand to attend before this Committee?---A. (All witnesses) Yes.

Q. Gentlemen, as you will be aware from my letter of

29th August this year, the public Accounts Committee is reviewing action taken following its past reports. The subject of this hearing is follow-up of the Committee's second and third reports. The majority of questS. ohs that the Committee will be ask%rig you today were included in my letter, so no doubt you will have had an apportunity to consider those matters.

Financial accountability was the focus of the Committee's third report. This was acknowledged in the department's 1983 report. Some particular questions arose from that. Those questions were on page 3, where I stated that the vast bulk of the Public Accounts Committee's recommendations were accepted by the Minister, including incentive budgeting, intended to allow retention and real savings. It was also stated that there would be more Dower for hospitals to decide how the budget allocation was to be spent. The Committee now asks: how is the incentive budgeting aspect being implemented?---A. (Mr McGregor) Perhaps I could deal with that initially.

Subsequent to the recommendation of the Public Accounts Committee, the Minister for Health established a committee which comprised representatives of the Treasury, of the department and hospital representatives to determine appropriate guidelines for the operation of an incentive budgeting scheme. Details of the scheme and the guidelines for *that* were notified in a circular from the department of 14th November, 1983. This was issued to all hospitals. This outlined the full details of the scheme, which was to operate from the 1983-84 financial

In essence, the scheme incorporated the characteristics

of the recommendations of the Public Accounts *Committee~* that is, *that* any real savings *that* were achieved were to be used in the short term, with the department retaining a proportion of the savings, with longer term total reductions in the budgets. As I indicated, the specific deta ils of the scheme are included in *that* circular, a COpy of which we will be tendering to the Committee in due course.

Q. What ins%ructions have been issued to hospitals

or other concerned parties to attain objectives?---A. As indicated, the details of the scheme were included in that circular issued to all hospitals. In addition *to that,* regions had discussions with hospitals about the intent and meaning of the incentive budgeting scheme and clarified details of the conditions under which the scheme was to operate.

Q. What monitoring procedures have been set up?---A. The scheme itself was reviewed after the first year of operation . The department sought information from hospitals as to their participation in the scheme through the regions. It revealed *that* in the first year of operation, with one exception,

hospitals had not *submitted* any details for proposals for inclusion in the scheme. A further review was carried out recently by the department. It revealed the same results; *that* is, *that* there had been in the second period of review no hospital that had indicated willingness to participate in the scheme.

Q. Have savings been achieved?---A. No, not through the scheme.

Q. Have any hospitals benefited from incentive budgeting?---A. Not in terms of the scheme *that* has been promlgated.

Mr MURRAY: Why have the scheme then?---A. ! think it was an *attempt to* introduce incentives other than by coercion, to participate in a scheme. The difficulties with the scheme as developed and proposed WaS *that* the savings to the hospital through real efficiencies were to be very short term only and in fact to a large extent were to be committed solely in the first year of the savings to capital expenditure, and thereafter the savings were to be withdrawn.

CHAIRMAN: The hospitals have commented that they received the circular on incentive budgeting after they received their final budgets. Would you care to comment on that?---A. That may well have been true. The incentive budgeting scheme was developed outside any specific budgetary context for a given year and entailed detailed discussions with representatives of the hospitals through I think the United Teaching Hospitals Association and other groups. So I think in the preparation of the scheme hospitals were well aware of what was being developed and it had no particular relationship or did not intend to have any particular relationship to any particular budget allocation for a particular year.

Q. Have hospitals commented.to you on incentive budgeting? ---A. Yes, they have.

Q. What has been the general run of their comment?---A. I think for the most part the comments have been negative, that they saw that having savings available for capital expenditure only was a limitation; that the withdrawal o£ savings after a specific period was no incentive in the long term to develop alternative services from the hospitals, be they agreed with the region; and I think that the measure o£ the success o£ the scheme is to be found in the fact that very few indicated any interest and only one, as I understand it, put forward a proposal £or inclusion in the scheme.

Q. Your comment that their replies have been negative as opposed to perhaps unfavourable would imply on your part that you are making a value assessment there o£ what their attitude is. Would you care to comment on that?---A. I think the detail of the responses was negative. I do not think it calls for a conclusion on my part.

Q. Do you plan to continue incentive budgeting?---A. I do not believe there is any particular value in continuing with the scheme as it has been outlined.

Q. Are any amendments being contemplated?---A. I think instead of the department detailing very rigid criteria for the operation of an incentive budgeting scheme, it is best left to the representatives of the department through its regional directors to liaise and negotiate with hospitals in the event of real savings being achieved, for the purposes of those being put to the development of the services that would be consistent with regional strategic plans.

Q. The 1983 annual report makes the general comment that 1982-83 saw major efforts being made to monitor and control financial performance and to enhance the level of financial accountability. The Committee would like amplification of what the department had in mind there and described as these major efforts?---A. The department did move towards the expansion of the management information review system that was operating I think at the time of the Public Accounts Committee recommendations in some twenty hospitals. That system is now operational in fifty of the largest hospitals in the State and plans are in hand to bring another thirteen hospitals on stream in that programme in 1985-86. It has not yet been extended into some of our major teaching hospitals because of the complexity of the systems that they operate, although they are developing systems for management information and review that will parallel the basic system that the department operates.

(Mr Woodger) There are a few other measures. That is one of a number of measures, some of which are touched upon

in other questions that you have asked, and they would be the public statements issued, the correspondence issued about the threat of dismissal of hospital boards in the event of over-expenditure. That was during the financial year in question - the 1982 copies of the 1982-83 annual report were issued to all hospitals and a circular 83/3 was issued which emphasized the importance of the significance of recommendation 1 of the Public Accounts Committee second report dealing with the over-expenditure by hospitals. Those three or four measures were in fact undertaken during that year.

Q. Going back to your annual report, which contained the statement that unexplainable overexpenditure could now lead to dismissal, what public statements on this policy have been issued?---A. (Mr McGregor) As has been indicated, the 1982-83 annual report was issued to all hospitals, which included a comment about that issue. The Public Hospitals Act was amended to impose upon the board of each hospital a duty to ensure the efficiency and economic operation of the hospital. The Department of Health in January 1983 issued circulars which dealt with that issue. Regions were directed each year subsequent to that that they were to obtain information concerning expenditure levels in hospitals and report to the department on overexpenditure. The department imposed a requirement on the regional director to ensure that if he proposed that action be taken against a particular board, he had to certify that all reasonable actions had been taken by him and that the board should be held to account for the over-expenditure.

There has been of recent time a publication issued by the department entitled "Information for Applicants for Appointment

as Directors of Public Hospitals", which includes particular comment about the duties of a director of the board of a hospital. The Minister issued letters to particular hospitals during the course of certainly 1952-83 and in respect of 1981-82 results, which made it abundantly clear that if they continued along the courses which they had outlined in their projections of expenditure, they would face dismissal.

In addition to that, I think in allocating budgets, certainly the year before last, regional directors - not all of them, but some of them as I am informed - did indicate in the allocation of budgets to hospitals that the Minister had accepted the proposals of the Public Accounts Committee and drew attention to the provisions in the department's circular on that issue, that boards that did not achieve their budgets and resulted in excessive overexpenditures would be called to account.

Q.What specific notices of possibility of dismissal were sent to hospitals?---A. As I mentioned, the Minister personally wrote to a number of hospitals who, during the course of the 1982-83 financial year in particular, were at that time projecting in their financial information forwarded to regional directors that they may overexpend and the details of those hospitals were brought to the notice of the Minister and he wrote personally to the chairman of the board of each of the hospitals concerned.

Q. Could the Committee be provided with copies of these letters?---A. Certainly.

Q. The Royal Prince Alfred Hospital told us this morning that their budget last year was overspent by $3.6 million. Did you consider sacking them?---A. In respect of the recently completed financial year the department, through its regional directors, is at present assessing the position in respect of

every hospital that had overexpenditure of any significant amount. It is the intention to report to the Minister by the end of September on all of those hospitals and any action that may be recommended. So far as the Royal Prince Alfred Hospital is concerned, it has to be remembered and it is just not a situation unique to them as a teaching hospital, that the last financial year was a particularly difficult one for them in the context of the disputation with the medical profession in terms of the teaching hospitals being the mainstay of the public hospitals system during that particularly long period of dispute and they were placed under particular stresses when they became the trauma hospital for almost the whole of the metropolitan area of Sydney.

Q.How many hospitals were over budget in 1984-857---A. ! do not have the details at this stage on a hospital-by-hospital basis. As ! said, that information is at present with the regional directors; they are assessing the situation with a view to a detailed report being put to the Minister.

Q. Can we have *that* information also for 1983-847---

A. Certainly.

Q. How many dismissals have there been because of over-expenditure?---A. One, I believe.

Mr MURRAY: That is Sutherland, is it?---A. Correct. CHAIRMAN: Has the threat of dismissal enabled closer probing of overexpenditures and with what results?---A. I believe it has had a particularly salutary effect upon the managements of public hospitals, that they are aware of the fairly dramatic consequences of their actions. ! think *that* the evidence of our expenditure over the last three to four years would indicate that it has had a very good effect.

Mr SMILES: The 1983 annual report of the department makes the general comment at page 6 that 1982-83 was a year that saw major efforts being made to monitor and control financial performance and to enhance the level of financial accountability? ---A. Yes.

Q. The Committee would like amplification of what the department had in mind or could describe as these major efforts? ---A. I think perhaps it would be appropriate for us to give you some details of the changes in the monitoring system that have been developed by the department. Perhaps Mr Barker might give you some details of that.

(Mr Barker) That relates back to previously where we addressed that the MIRS computer system has now been expanded to cover the fifty largest hospitals still in operation except for four of our larger teaching hospitals which are going to implement similar types of systems; also our circular 85/3 was a major effort to control expenditure whereby we addressed tp regional directors '. the importance of recommendation 1 of the Public Accounts Committee second report.

There were the various letters that were sent out threatening dismissal following the 1982-83 financial year, then our 1982-83 annual report, where the department was quite clear on the fact that the hospitals had to be much more accountable for their operations.

Q. Some of the specific recommendations on accounting were referred by the Minister to a working party. In March 1984 a circular was issued, which you have already mentioned. It is the reference file C6584 and circular number 84/75. The circular reported the view of hospital accounting standards and set out some specific policies to be followed. Where and how

have the expressed policies been effected in hospitals' accounting systems and financial statements?---A. We did issue that circular on 30th March, 1984, and it was to implement changes from the 1983-84 financial year. The main two thrusts of that were that the financial information on public hospitals' accountability was to be made available by 30th September each year and that the information was to be in two parts; one part addressing the general fund and the other part addressing their special purpose and trust fund.

In view of the lateness of that instruction, it was agreed that not all those statements would have to be audited during 1985-84, but that they all have to be audited for the 1984-85 financial year, although some did audit them for the previous financial year. Where are we up to now with the flow-on effect is that the department's accounts, as it was issued by circular it became departmental policy but the accounts and audit determination review committee met on 28th June this year and the recommendations including those various policy changes were approved by the secretary on 23rd August, 1985. The revised accounts and audit determination is now at the Government Printer being printed and it is hoped it will be available to be distributed during September or later on this month with copies of the proposed amendments were sent to the Treasury and the Auditor-General.

Q. Would it be appropriate to expect that those policy initiatives would be implemented in the 1985-86 financial year?---A. They should be implemented in the 1984-85 financial year because they have all had to have their accounts audited for 1984-85 and they should all be issued by 30th September.

constantly being sought about service delivery, about roles, about financial services. As I indicated, there are in at least one region active participations by the area health service administration in a formal way and in other regions in a more informal way.

I do not believe that the department takes an inflexible

view towards financing of the particular hospitals. We recognize that from time to time for reasons beyond their control problems are generated out of, say, particular disputes, such as that with the medical profession. As Dr Scarf said, the major teaching hospitals had a significant impact because of the demands for their high technology services and the very fact that they became the emergency services for their regions. At the same time, there are other hospitals - district hospitals, smaller hospitals - in the region that made budgetary savings. It was possible for the department, in negotiating with all of those hospitals concerned, to transfer as much as it could of the resources into those teaching hospitals to sustain them during the period of the dispute.

Q. I say that because the overwhelming impression conveyed

to us so far from the hospitals is that they feel that they have no input into the budgetary process, but you would not agree with that point of view?---A. I do not agree with that entirely. In the last financial year, because of these difficulties that related to the changes that had taken place with the medical profession, they may have felt somehow powerless because many of the decisions that were taken about the role of the medical profession in hospitals were taken at government level, both State and federal. Views were expressed about the allocation of resources at a federal level in a decision conveyed by the Prime Minister to allocate some $50 million to the major teaching hospitals in New South Wales, and the federal Government will have the final decision on how that money is disbursed. By the same token, once that decision is taken it is the result of a process of very close consultations with the hospitals in terms of their

priorities for the spending of that money. In essence they have had the major say as a group represented through the united teaching hospitals association in how that money will be spent. In those discussions the department is more of a conductor than a decision maker.

Q. Would it be fair to say that whatever input there has been to date it has been on a fairly ad hoc basis and that there is really the need for the establishment of a formal strategy in relation to input?---A. In past years there has been a formal strategy in terms of the submission of budget estimates, in submissions for what we call new units; that is, additional services. Hospitals have had the capacity to put in bids or claims for new services that they might wish to develop. There have been discussions through the process of the development of regional strategic plans, through the process of the delineation of the roles of hospitals in which hospitals were consulted about the range and level of services that they would provide, recognizing that in the ultimate the department and the Minister have to make the decisions about those services.

Mr MURRAY: Why the change?---A. Why the change in what?

Q. From the system that operated up to last year to a system where there is no liaison?---A. I think that is an extreme statement. I do not believe that there is no liaison; I believe there is continuing liaison. However, it has been difficult for both hospitals and the department in the crises that have confronted the health care system over the past twelve months.

Q. Prior to this year the hospitals could submit a budget to your department; this year they were not offered that opportunity?---A. (Mr Woodger) There was a major change in the

development of forward estimates with the Treasury this year. That was one factor - I do not feel it was the only factor - in changing the previous approach in getting detailed estimates from the hospitals. If I recall correctly, the Treasury wrote in about December, about the time the department would normally be writing out to get the estimates of those hospitals, seeking submission of estimates within a short time frame, within a ceiling allocation. Obviously that did not give the department, had it so desired, time to get in detailed estimates from the hospitals and get them reviewed within the regions and then in turn submit them to central office within the short time frame involved. However, I do not believe that is the only reason that that process of getting detailed estimates should have been discontinued in any event. Dr Scarf's comments earlier about the change in the process really highlights what the budgetting process is about. It is not about getting detailed bids from every hospital in the State, adding them up and seeing how they come out, because in many cases you will get an answer that is ridiculous in the budget making process.

The process is one of starting with a base budget, looking at the areas of change, all the various factors that would impact upon the need for the number of dollars to change from one year to the next; and that is the process which the regions are really asked to address and in relation to which in turn they are expected to consult they do consult - with the hospitals. For those two reasons I think the previous practice of getting from hospitals detailed estimates was bound to be changed.

Q. The impression that I gained from the hospitals was they felt that they had been jilted. They had a nice cosy relationship

with the region up to this year and all of a sudden it has changed and they do not know why?---A. I have also heard the other criticism, that they were frustrated over all these years because nobody took any notice of all these estimates they put in, meaning that the number of dollars they received was nowhere near what was in their estimates. It may be a reflection of that.

Q. Did you attempt to explain to the various hospital administrations the rationale behind *the* change?---A. I cannot answer that question. It would be a regional matter.

(Dr Scarf) I cannot give you a directly accurate answer.

The finance officers in the western metropolitan region are in regular contact with the hospitals. I am sure that every hospital's finance officer would be speaking with the regional officer, in some cases once a day and in other cases at least once a week. The way things are going is usually very well explained. I have been away from the region for a short while, so I have not been involved with *them* directly. I have been on a short period of secondment to the city.

Q. But there was no official communication?---A. I cannot

give you an assurance *that* there was or was not. The central department issued a letter which was then transmitted to hospitals. That letter related to the way in which the supply provisions would provide for this financial year. So, there has been a detailed explanation of the way in which spending patterns could continue until the budget is set, after the bringing down of *the* State Budget.

There was a change in that build up this financial year.

That change involved following the Government's supply provisions exactly rather than adopting the process of presenting an interim

budget which had occurred in previous years. I think that that change over has presented some interpretive difficulties for hospitals because the language is slightly different. It has presented them with some concerns. Perhaps that is a source of anxiety for them this financial year. I think that represents the major change. I agree with Mr Woodger that the estimates of the past created a large amount of work for the hospitals, a large amount of work for the regions. The issues on which there was to be change were usually matters that had been negotiated through the previous financial year - issues about staffing problems or staffing levels, either upwards or downwards. We would usually come to agreement with the hospital well before the budget time.

CHAIRMAN: Do you feel that the contention of one hospital that stated to us that it was told that it need not bother sending in budget estimates for 1985-86 would accurately sum up the feelings of most hospitals?---A. (Mr McGregor) When you say that they were told not to bother to send in detailed estimates, it has to be seen in the context of that opposition that existed for many years from the hospitals to fill in detailed estimates. No inhibition has been placed on the hospitals to put forward proposals that may have expenditure implications in the budgetary context. Certainly the very formal process of submitting budget estimates in the sort of detail that we have sought in the past has been abolished. It was abolished in respect of this year.

Q. I shall deal now with regional-head office relationships. What input does the region have to your budget?---A. (Dr Scarf) The head office finance administration is conducted in such a way that the secretary i-, the person who has the final say. The central office finance committee has regional representation on it;

two regional directors are members of that committee. Also the regional directors meet with the department as a group every second month, at which time the financial situation of the department and the regions generally are discussed and usually occupy an inordinately large proportion of the time available. We have direct contact with Mr Woodger and Mr Barker. Both the people working within my office and I have direct contact with the secretary and deputy secretary and the assistant secretary of finance on matters that are of specific concern to us.

We are usually very well informed of what is going to happen

to us. When it comes, there are very few surprises. We, somewhat like hospitals, will argue about the fine detail and whether we feel we have been justly or unjustly treated in the final carve-up, but in general there are very few real surprises for us. I believe that we have more than an adequate opportunity to contribute in relation to policy decisions which stem from changes in financing of regions.

Q. When do the regions receive their budgets?--A. The regions will receive their budgets at the time of the bringing down of the State Budget, the final budget for the year. We expect that will be available to us at the end of this month.

Q. How long does it then take to allocate the budget to the hospitals?---A. It usually takes the regions somewhere between ten to fifteen working days to work through all the fine detail.

Mr MURRAY: I wish to follow up on the supply aspect. It seems to me that the system of supply that has applied to the various hospitals has been inadequate this year because it has been based, not on the expenditures that the hospitals have incurred in the previous twelve months but on their previous .budgets.

The representatives of the two hospitals that appeared before the Committee this morning gave evidence that because they overexpended in the previous twelve months they have been disadvantaged. Added to that there has been no account taken of inflation. As I see it, if I were a hospital administrator and I were asked to budget for 25 per cent of the year based on the supply provisions laid down by you, I would find it extremely difficult. Is that scenario correct or incorrect?---A. (Mr McGregor) In part. It has to be seen against the backdrop of the other large number of hospitals that achieved expenditure in the last financial year below their budget allocation; that is, their actual expenditure was less than the allocation made to them. I have not received a complaint from any of those hospitals about the supply provisions being based on last year's budgets. Those who for various reasons have exceeded their budget allocation would much prefer to have the allocation made on the basis of actual expenditure. Some rational decision needs to be taken about how it is to be done.

Q. So it is a uniform formula that is applied throughout the State?---A. At this stage, yes. As I said, in respect of some of those that have overexpended I am sure you are referring to the two hospitals that appeared before you this morning - a detailed assessment of their expenditure is being undertaken. There may well be a reasonable explanation for that overexpenditure which could be taken into account; for example, the cost of devaluation on the goods and services budget. Those factors will be taken into account in the light of the final budget allocation from the Treasurer.

Q. I refer back to the monitoring procedures that we were discussing earlier, that is in terms of new accounts. The point of view has been out to this Committee that there has been value in the changes. However, some of the Interpretations from regions and head office have been rather inflexible, and there has been a lot of pinpricking. Evidence we have had this morning would suggest there is not enough adaptability in the new procedures. Could you comment?---A. I am not sure of the specifics of what you are putting. But if you translate adaptability into meeting the needs of hospitals as they perceive them, then I guess from time to time we are inflexible. But the transfer from the interim budget allocation arrangement that we have had in previous years, to the supply provision, was seen at least to respond to some of +he criticisms about inflexibility of interim budget allocations. Certainly, in building up the supply provisions an attempt was made to take into account fluctuations in respect of which one could expect some budgetary provisions through the State budget.

Q. It was not so much the supply provision½ it was more the on-line criteria required. If hospitals went over budget in one year, they could not take that through to another line. They felt that the procedures themselves were developed on a pattern throughout the whole of the State but that they did not take into account the special needs of each individual hospital. Possibly the procedures were developed for non-teaching hospitals. I do not know. Could you explain the rationale?---A. (Mr Woodger) The ultimate constraint stems from the requirement of Treasury in the first

place. Those constraints are based on some line item detail, a necessary control at State level as well as departmental level There is control of certain line items; in line with the Public Accounts Committee recommendations, they were broken down considerably from what they were at one point of time to six or seven main expenditure headings.

The department does not have flexibility with Treasury to depart from these controls without putting forward a case as to why it is necessary to depart from them. In turn, a department, for its own expenditure control reasons, needs to maintain that same sort of control on hospitals and therefore requires adequate cases to be out forward for variation between those line items. A simple example could be given of not enough expenditure being incurred on repairs and maintenance of hospitals if flexibility is allowed. The necessary provision for those purposes might well have been neglected. Other fortuitous savings would be spent inappropriately, and so on. So there are control constraints at State level and departmental level within those headings. They are not finely tuned constraints. They are major expenditure headings, and it remains open to the department to out a case to the Treasury, and in turn for the hospitals to out their cases and have them appropriately considered and the expenditure provision varied if there is a good case to do so.

Q. That is at variance with evidence you gave recently, where you indicated that under the new provisions there is much more flexibility and you could take out of B items funds that could be put into C items and that there was not this stringent line for line system. You have just told the Committee the reverse?---A. My evidence is not at variance.

The evidence given recently was in relation to departmental expenditure transfers between maintenance and working expenses. The Treasurer has allowed that flexibility for the department £or example to transfer/between stores and travelling.

Q. But you have not allowed hospitals that flexibility?---A. Yes we have, because the major items that are inflexible are salaries and wages, which is an inflexible matter under the Treasury arrangements½ provision of payments to visiting medical officers, which is not an item applicable to the public service, but if it were it would certainly be nominated as an inflexible item for good reasons; repairs and maintenance, which I have already touched upon, because there are all sorts of good reasons for that matter other goods and services, which would pick up just about all the normal departmental maintenance and operating expenditures; and superannuation payments. So there is no inconsistency.

(Mr McGregor) In the past few years we have gone from a situation where, in expenditure, in hospitals we have gone from 23 or 25 line items down to those five broad headings to which Mr Woodger has referred. So that is certainly an improvement. Indeed, within the total health budget, if we have a situation where a hospital wishes to make some changes between those inflexible headings and can offset them with some changes in another hospital, in other words, reverse them, then that flexibility is available.

By the same token, if the region can accommodate it, it is within the department's domain, provided we stay within those particular headings nominated by the Treasurer.

Q. Could you explain the budgetary process in more detail. As I understand it, there is a budget and each hospital receives its budget. But if hospitals overrun their budgets, they can then go to the hip pocket somewhere and get an extra couple of million. Where does that money come from?---A. Let us look at salaries and wages, for example. There are reserves held for award provisions, for example, where there is a change in an award and an increase is granted, hospitals are expected to be able to indicate specifically what is the amount involved and advise the department, and then the department, on instructions from the Treasurer, holds a bucket of money for award changes. It is available only for that purpose. Then that money is allocated to the hospital.

It is the same with long service leave provisions. For example, it would not be very wise to allocate a total or proportion of the long service leave bucket to all hospitals, because some of them may not have a call on it in one particular year. So it is held in reserve and as actual expenditure is incurred on that the hospital notifies the department, and that can be paid.

In addition to that, in the other area we mentioned, RMR, it is valid for the regions to retain a small amount of the total allocation for RMR to meet any unusual emergency that may arise if that could not be accommodated within a particular hospital field, for example, if the whole X-ray department blew up. These reserves can be held for such emergencies and then allocated on that basis. There are also specific grants given for specific maintenance and repairs on application from hospitals~ *but that* is in the normal budgetary process. So, if they are the buckets of money you refer to, they are the

particular sources.

Q. Actually, I referred to hip Dockets, not bucket s?---A. It is the same thing.

Q. There has been a difficulty with the change in

exchange rates. That would have caused additional expenditures?---A. Yes.

Q. What sums of money are we looking at on a statewide basis?---A. In terms of devaluation, we did an estimate on an across-the-board basis of the order of $8 million to $10 million as being the impact on the goods and services basket, particularly within hospitals. Some estimates have been put forward through the Treasurer to take account of that in the budget context.

Q. Where would that have been funded from? You would

not have a devaluation reserve?---A. No, we have not had. It has been a matter for hospitals to be able to accommodate that within their total budgets.

Q. But Royal North Shore Hospital had a supplement

from the region of in excess of $1 million to cover that?---A. Royal North Shore did have a supplementation from the region, largely related to stresses and activity levels imposed on that hospital during the currency of the doctors' dispute. I can assure you that $1. 3 million would not be due to devaluation.

There were other hospitals like Manly and Mona Vale that would tell you how they yielded up $1 million to transfer to Royal North Shore because their activity levels in some instances dropped to 30 to 35 Der cent. So they did have within their budget allocations some reserves that could be transferred. In that whole process there was consultation with all hospitals about how much each could keep to assist those hospitals to maintain their services.

Q. And that was on the advice of the region?---A. Yes.

O. The hospitals state that they have been given no additional funds for new units in the first quarter of the 1985-86 supply period. Could you comment?---A. The new units are representative of claims for additional services which this department receives from hospitals and from regions and then allocates priorities to those in accordance with the strategic plans that have been developed, and they are put forward to the Treasurer. It would not be competent of us to allocate those moneys without the approval of government. They are all additional services.

Q. So you have to wait till the Budget comes down?---Yes, and that is always a difficulty with the establishment of new services when one is preparing estimates. However, we always try to anticipate some delay in the bringing down of the State Budget and availability of those fUnds, so that in the first year of a new initiative obviously less than twelve months' expenditure is anticipated.

We have had some difficulties with a number of programmes that have been retarded, not just because of the budget process but just in terms of planning to commission those services.

Q. Do you have a performance measure to compare hospitals throughout the State with each other?---A. I think there are a number of indicators. But it is always difficult to take specific performance measures and to say in terms of hospital A and hospital B that hospital A performs at a certain level and why cannot hospital B do the same. Hospital administrators seem to have an endless capacity to be able to demonstrate why they are unique in terms of their expenditure pattern, and in many instances their explanations are quite valid.

For example, if one looks at cleaning service costs,

let us take Westmead Centre and Royal Prince Alfred Hospital. On the one hand we have a new major hospital, with different floor surfaces, co,roared with a very old hospital with completely different physical layout and a different method of managing its cleaning services. Therefore it is difficult to find detailed performance measures. Certainly we have measures in terms of total cost per adjusted daily average of a hospital, and in those there are some remarkable differences hospital by hospital.

Q. Doctor Scarf, how many hospitals do you administer in your region?---A. (Doctor Scarf) Approximately 22 or 23.

Q. Do you fly by the seat of your pants in measuring each of those?---A. We do make regular comparisons. We try to group hospitals in light groupings. Obviously, we do not compare many hospitals with Westmead We tend to compare hospitals of equal bed number size. There are differences between those hospitals, as Mr McGregor said. Certainly, the hospitals also look at those fairly crude measures. Anyone at the bottom of the league will continuously tell us about those at the top and how they warrant better *treatment.*

Q. So you do not really have criteria. You really look at the performance of each of those 23 hospitals in terms of cleaning, and the one at the bottom obviously must be the least efficient, and you tell it so?---A. It is in Dart that. But there are a large number of indicators one takes into consideration. Some hospitals are relatively cheap to run, but their patient turnover may be quite low compared with other hospitals. The length of stay of their patients may be longer. One could choose another method of measuring those hospitals, say, cost Der patient treated. They may turn out to be more expensive or appear to be more expensive on another measure.

I guess one has to make a series of judgments using the data available . One just make an assessment of the competence of the service provided, the breadth of the service provided, and community acceptance.

Q. From your reading or experience, how do overseas regions compare hospitals and look at their efficiency?---A. There is no universally accepted measure of hospital efficiency. It is a problem of trying to measure performance of highly complex systems and there is neither interstate nor overseas any easily accepted measure of how hospitals perform.

Q. Are you sure?---A. I am confident. I know that I do not know of one. Of that I am sure.

Q. Do any other members of the panel know?---A.(Mr McGregor) I am not aware of any definitive system for measuring performance and efficiency in hospitals accurately. A whole range of attempts has been made in terms of allocating budgets and performance measurement on diagnostic related groupings and allocating budgets on performance against just a daily average or levels of service, and all of them have some faults with them.

(Dr Scarf) Could I add that the diagnosis-related groups - DRG's which is an American system of funding hospitals tells a hospital that it will get $X to look after a patient with this disease. It does not say how much it will cost the hospital to look after a patient with that disease but it tells them how much they will be reimbursed for their care. That is an approach to cost control that has had a very substantial impact obviously on hospital performance and private hospital survival in the United States.

Q. You would not be looking at using that system here?

---A. (Mr McGregor) I understand the federal Government, because of its national implications, is undertaking some form of review of diagnostic-related groupings and we are participating in that review.

Mr SMILES: Dr Scarf, do you believe that the hospitals within your region internally generated have a clear idea of their

role?---A. (Dr Scarf) I believe that the vast majority, what their role is is quite clear to them. There are some areas that are subject to debate between the department and those hospitals. Some of the hospitals' ambitions are at times seen by them frustrated by the conservatism o£ the department. However, I would say in the main hospitals quite clearly understand what their role is. It is a role I would agree with.

Q. Mr McGregor, earlier you made some mention of the fact that the department was some way towards delineating a role for the hospitals. How far away are we from your role definition or your department's role definitions being completed and how long has the process taken to date?

Some of the teaching hospitals employ a battalion of staff working in the finance area. Those people should be aware of what their commitments are and should be able to accommodate them without the need to have a final budget allocated as early as perhaps they would like. For example, they would like it in July. We all know that, given the budgetary processes of Government, that isnot possible. In past years the department has addressed that in terms of the allocation of an interim budget. That flowed from a recommendation of the Public Accounts Committee. We have had difficulties with that. Then we have moved across to the supply provision. I do not accept as an explanation the statement by hospitals that the late allocation of a budget causes them budgetary difficulties.

Q. What were the difficulties with the interim budgets?---

A. I think the hospitals tended to treat them just as that for the most part and take the attitude that they need not worry until they got their final budget. It seems to me that the department was better off before in not allocating finances until the budget had come down and simply telling the hospitals that they were on supply. That is what we have now done. They follow the general pattern that all government departments follow. There is a supply period and it is outlined to them in broad terms what they can spend during that period. As I said, the interim allocation was perceived by them as the minimum they were ever going to get in that year, and they did not believe it in any event.

Q. I understand that the supply provisions are worked out on the allocated budget at the time the budget was presented in the previous year, not on what was actually spent and not taking

into account any supplementary allocation that might have been seen as an error or miscalculation by the head office in working out a budget?---A. Certainly this year it was allocated under a set of principles that I think would have taken into account any adjustments in the way of supplementary allocations at the end of the year. This is the first year we have moved in this way. I am aware that there has been some interpretive problems, both at the regional and hospital level, as to what is counted and what is not. We have certainly worked through that with them. I am not aware of any situation where that should have been a problem. If it were, it is open to the hospital to discuss it with the region and, in turn, us. As I said, as it is the first year, we are open to some suggestions about some of the small matters that may or may not have been included in the supply provision, recognizing that you cannot include everything in it.

(Mr Woodger) I point out that the percentage that has been used as a base is the same as that provided for in the Public Finance and Audit Act. Therefore the department has the same constraint imposed upon it; it cannot get any more dollars from Treasury in the supply period without the specific approval of the Treasurer to increase it. So, if we need any more funds, we have to put up a case. We looked at all the plusses and minuses that we were aware of in terms of impact on hospitals the doctors' dispute, fee shortfalls and all those ranges of things and came to the conclusion that for the general range of hospitals that should be quite adequate. Again the advis given that if there is a problem they should write and tell us about it so that we can look at it.

Mr MURRAY: The Royal Prince Alfred Hospital told usthat it should have received $27 million and received $25 million. Has that hospital been in contact with you?---A. I cannot answer that. It would have contacted the southern metropolitan region. I have had no referrals to me, other than general inquiries that indicated that for the most part if they had perceived a problem it was because they did not quite understand or had ignored some of the minuses in the system.

Dr REFSHAUGE: It seemed to us that the minus was the amount by which that hospital had overspent its budget in the previous year. Whether or not it is justified, to penalize the hospital in the first quarter, or to withdraw that amount in the first quarter, seems to me to be a little heavy handed?---A. Certainly it would be difficult to have a supply provision that allowed for an overexpenditure in the previous year that had not been analysed in terms of whether it was justifiable or not.

CHAIRMAN: Section 25C of the Public Finance and Audit Act indicates that in relation to supply there should be an inbuilt factor of two-thirds of the consumer price index increase. Is that taken into account?---A. Yes, that is allowed for in the calculation.

Mr MURRAY: I think you missed the point. The overrun of $3 million was not funded by the department; it was funded out of the $27 million supply of the hospital?---A. Do you mean that thehospital had enough in its supply ceiling to cover the over-expenditure, plus its budgetary requirements?

Q. No, it had enough in supply to cover its normal operating expenses in that three month period, but then the department took out $3 million to cover the overrun in the previous year.

CHAIRMAN: In fact, it was $5.6 million?---A. I am not aware of that particular case.

Q. Dr Scarf, has that happened inyour region?---A. (Dr Scarf) Since the last financial year, the western metropolitan region has come in substantially under budget. Because of the doctors' dispute there is no such problem, although a couple of hospitals came in marginally over budget. I guess because of the flexibility available to the region we can cash out their problems during this period. I can understand that in the southern metropolitan region there would be some cash problems.

Dr REFSHAUGE: But it was not a principle that whatever it overspent the previous year would be deducted from their supply for the first quarter?---A. It did not happen because we did not have the overrun. The regions supply provision, because it is based on budget, is in excess of that which was spent last year.

Q. Individual hospitals may have overspent?---A. Individual hospitals, yes.

Q. Was their supply provision reduced by what they had originally overexpended?---A. In essence, yes, their budget would have been based on the budget at the beginning of the year. Consequently they may well have been not disadvantaged because of the fact that whole hospital budgets got adjusted through the year because of the doctors' dispute. We went back to the budget at the beginning of the financial year and based the build up from there. I do not believe that any hospital would be in major cash difficulties at this stage; that is, any hospital in the western metropolitan area.

CHAIRMAN: Going back to my former question,we had evidence from representatives of the Royal Prince Alfred. Hospital that in relation to its supply, there is definitely no inflation factor taken into account?---A. . By way of explanation, the

supply provision arrangements as issued by the central office to the regions were never intended to be an absolute right in relation to quarter of an allocation which each hospital was entitled to. It was clearly identified as a maximum level of cash flow that the department through its regional offices could pay to hospitals. The circumstances of the payments to particular hospitals would necessarily be a matter for the individual regions to determine in the light of the circumstances of those hospitals but within that ceiling arrangement. So, we would certainly hope that each region would not automatically pay out cash to hospitals according to that formula because in many cases I believe it would be too much rather than too little.

Q. So it would not necessarily have been based on an historical analysis of 25 *per* cent of expenditure for the previous year?---A. The ceiling was determined on the basis of 25.7 per cent. of the allocation for the previous year. That determination had built into it an inflation factor, in the same way that the inflation factor in the Public Finance and Audit Act is calculated. I cannot answer exactly what each region did for each hospital because they could well have provided different funds to meet the circumstances of particular hospitals in their region, as they should do.

Mr MURRAY: I wish to follow that matter through. I understand there was an embargo that prevented hospitals from taking out an

overdraft to fund any shortfall. Is that correct? ... A. I do not

know. I think that is a restatement of a general constraint that applies to hospitals, and that constraint is put there because hospitals are expected not to overspend their budgets.

(Mr McGregor) It is part of the condition of a subsidy allocated to hospitals for a long period that they should not go into overdraft without approval of the department. There have been one or two exceptions, from memory, where that has been permitted.

Dr REFSHAUGE: I inferred from your earlier statements that you see the budgetary process as happening from above, that Treasury allocates the money and you have to dole it out. The hospitals obviously see it from a different perspective of having to provide services and having to put in effective submissions to get money to pay for those services. Those different perspectives seem very much in conflict and also not very useful in achieving the best utilization of resources. What are you doing to try to make those two perspectives work together rather than against each other?-o-A. You are quite right; there is an inherent conflict. One of the ways in which we address that is through our regional directors, who have a commitment to both service delivery and development and, at the same time, to achieving the department's objectives. If there is any conflict, I guess quite often it is in the mind of the regional directors who have those dual charters which are quite often in conflict with each other.

In my view, that is no different from the role that many managers in the health care system have to fulfil. The chief executive officer of a hospital is placed in the same position. The board itself is placed in the same position. In fact, the

amendments that were effected to the Public Hospitals Act stipulated that the role of the board was to maintain services, et cetera, but at the same time came the conflict in terms of maintaining efficiency and economy. So one could argue that there is an inherent conflict in that. There are times when that conflict can be destructive, but on many occasions it has proved to be a useful tension within the system.

Q. When a hospital board sees that it is running over budget, what options does it have? What things can it do inside and what does it need to get regional approval for, particularly in relation to the provision of services?---A. The first thing it has to do is analyse why it is heading towards budget overexpenditure. In my view there are occasions when boards are not fully informed by their executive staff about the reasons why they are heading in that direction, recognizing that boards of hospitals are made up of people who quite often have full-time commitments in other places, that their understanding of the financing of the health care system is perhaps not as complete as that of those who work for them. There are some difficulties with that. The first role of the board is to have a complete understanding of why it is heading in that direction.

Q. If it can be substantiated that events have occurred that justify an approach being made to the department, clearly it will do that; that is the process. Hospitals are interacting with regions all the time in terms of budget allocations and expenditure levels. It is not unusual for hospitals to continue a flurry of letter writing and activity and exchange of correspondence with regions throughout the financial year, endeavouring to sustain their own point of view about the budget allocation. That process is putting their submissions to the regional director and the department.

Being corporate entities or separate entities and not being part of the public service exercise, they also have a right to whatever avenues they see fit, quite often to the embarrassment of the department. That is a tension in the system that we have to accommodate.

CHAIRMAN: Following on from Dr Refshauge's question, the hospitals that the Committee has heard evidence from stated that when they became aware that they were heading for exceeding their budget they sent into the department schedules itemizing what services could be cut. The department refused to allow these cuts to take place. Do you feel that the suggestions of the hospitals that they cut services are unrealistic?---A. Within the totality of the health care system, quite often the simplest solution to a budget problem is to propose the closure of the casualty department.

Q. The two teaching hospitals that gave evidence to the Committee today have had great difficulty in keeping to their budgets, saying that the doctors' dispute bad out extra pressure upon them. I understand that Westmead was one of the few hospitals in the region that was fully operational during the doctors' dispute. How was Westmead able to maintain its budget while other teaching hospitals were unable to do so?---A. I cannot speak for the other hospitals, but I will try to soeak about Westmead. now recall that Westmead did make a minor adjustment to its budget during the year. It was in the order of $300,000 supplementation of budget.

Westmead predicted at the beginning of the financial year,

as it had predicted in all previous financial years, that it would have great problems living within its budget, but it found methods through management of resources during the year to provide services and meet its budget.

There are many contradictions in what I tell.Fun now,

because I do not quite understand it myself. One contradiction was that Westmead through last year was harder hit than other hospitals are this year with a shortage of nurses though, unlike other hospitals, Westmead treated more patients. In Dart, it is .management will, and in Dart it is good luck. These are vast organizations with budgets larger than the vast majority of New South Wales governmental departments. As Mr McGregor has said, they have quite sophisticated finance advisers and finance staff, large enough to make Mr Woodger's number look quite small.

These hospitals differ from other forms of corporations outside government in that they are dependent upon a State

budgetary programme external to their control. I guess, therefore, that not all hospitals accent as full a responsibility as perhaps some corporations accent for themselves.

Q. Mr McGregor, would you like to give the Committee an insight as to why Royal North Shore Hospital or Royal Prince Alfred Hospital might not have been able to do what the Westmead Centre did?---A. (Mr McGregor) I do not have available to me the detail of the events that occurred in both those hospitals which led to the problems that they have. Clearly, though, they did have a problem. To some extent the regions were able to assist them although, from the evidence the Committee apparently has had this morning, not able to assist them sufficiently to be able to cope. I do not have any further detail on that.

Q. I put to the hospitals earlier today that one major factor in costs of hospitals is the decisions that doctors make. Although patients .may present with illnesses, it is what the doctors decide needs to be done that incurs a significant amount of cost for the hospitals. Those hospitals had some monitoring of doctors' decisions. Do you have any overall policy about how to entre doctors' decisions are made most effectively?--A. For the most hart, the most effective weapon we have is the budgetary control or budgeting process. The large teaching hospitals have within them other processes that monitor what doctors are doing, for instance,, patterns of services, etcetera It is difficult for the department to become too involved in that process because we are at least at arms length from that, and it would involve departmental officers with limited or no expertise in those areas becoming involved in clinical decisions
and clinical processes. I think there are many difficulties

with that.

Q. There are other things the department could do,

such as supporting Deer review mechanisms in all hospitals to ensure they occure. Do you do things like that?---A. We have had discussions with the Australian Medical Association on and with the Deer review resource centre about development of that. But it is the situation in which we would have great difficulty in imposing a condition of subsidy. Largely, it must be a voluntary arrangement, achieved by education of the profession and their participation in peer review. I think we are slowly moving towards that.

(Dr Scarf) Support for it is idiosyncratic. We have been working in a hospital in which it is possible to' retain resources from the department to assist in such undertakings; and subsequently, working in the region, it has been possible to support hospitals that have wanted to set up such mechanisms to find a few dollars to help underwrite those undertakings.

I agree with Mr McGregor that it has not been a requirement. We have done much to encourage hospitals to be interested in that, but really one needs a zealot to be leading. I have formed the view that peer review is not a natural human practice, and requires someone to promote it heavily and enforce it in order for it to be successful. Consequently, other than outside teaching hospitals, it is a rather rare occurrence.

Q. As it is such a rare occurrence other than outside teaching hospitals, and as I understand the Medicare provisions to allow a greater amount of fee for service in peripheral hospitals and non-teaching hospitals, and also taking into consideration that surgery rates seem to be much higher

in fee for service systems compared with salary systems, I should imagine that peripheral hospitals will have a much greater problem with doctors doing a lot more in them and therefore not being able to meet their objectives. Would you expect that as well?---A. I should expect that if that is to occur, it will occur in the longer term. In the interim the department has the agreement of the AMA to work with it in developing systems of utilization review by medical staffs for their hospitals. The developing of that process is to begin. It is an intention of the department to work to achieve that over the next twelve months. The dotting of the is and the crossing of the t's would be quite a difficult task, as will promulgation of information on how to do it. But it is our intention that with the introduction of fee for service, certain hospitals have been advised and doctors have been advised that the introduction of fee for service will be coupled with a requirement to analyse data by doctors within the hospitals. That principle has been accented and endorsed by the AMA.

Q. Is that for your region only?---A. No. That is

for the State.

(Mr McGregor) We had to deal with that fairly sensitively given it was a federal Government decision to expand fee for service in peripheral hospitals. Then we as a State sought to impose some sort of external review. We have done that, net by decree, but in the process of transmitting the federal Government's decision to the S, ate AMA we have had discussions with them about that. Obviously, they also are concerned with the perception that there might be that payment of a fee for service arrangement may lead to some abuse.

They say that in their interests and in the interests of their members they will work with us over the next twelve months to develop appropriate monitoring systems, recognizing there is still the overall budgetary control.

Q. The Committee has had evidence today that one

reason for incentive budgeting not working is that most of the savings have already been made and there is little that can be cut away to make further savings. Do you think there have been significant savings in the cast five years in hospital expenditure by individual hospitals?---

A. Given the budgetary constraints and the increasing costs in the health care system, there obviously have to be some savings, and obviously of some magnitude. We have not specifically Undertaken any overall costings or what the order of magnitude of that may be. Our management service consultants have assisted hospitals specifically in undertaking specific reviews, and have identified potential savings in those hospitals that have sought their assistance. They are of some magnitude.

Q. Do you think/there are further savings to be made?---A. Given the constraints on the health care system, yes, there will have to be further savings made in order to achieve the budgets allocated by government.

Q. The Committee had evidence today from one of the teaching hospitals that patient care is suffering because of these savings. Do you think patient care will suffer further?---A. There is no doubt that during the process of the dispute with the medical profession, patient care suffered. I am not so convinced that, nutting aside that major aberration, patient care has suffered in terms of budget constraints that have been imposed on hospitals in the past few years. There may be

specific exceptions *to that* which some may point to. But, over all, the quality of service *that* is being provided is probably as high as it ever was.

Q. Dr Scarf, you said that the variation from the expected to the actual budget is only a small percentage - maybe 2 per cent. If the final budget arrives just before Christmas, there certainly is not a full year to be effecting those savings in expenditure and so what one has to do perhaps in six months is save 4 per cent, not 2 per cent, which gets perhaps a little bit further from around the margins. Do you think that is creating a problem for hospitals?---

A. (Dr Scarf) Yes, I do. And I think that the last financial year was abnormal because the budgets were late, for reasons that have already been explained to the Committee, but also certainly the majority of hospitals in Sydney at least were advantaged in meeting their budget by the doctors' dispute. Obviously for those teaching hospitals that had troubles, they found that an extra problem.

Q. So you would have expected for the hospitals that had extra problems from having a greater load with the doctors' disputes that their budget overrun should have taken into account what was happening?---A. I do not know what the attitude of the department and the Government to that will be. I understand that has yet to be decided.

Q. But in the supply provisions one would have thought it should have been taken into account then?---A. I understand that the department has available a certain amount of resources for the supply provision. It is illegal for the department to allocate what it does not have available to it. It has allocated its resources along the formula that the Government sets and those resources have been allocated to the hospitals.

Q. The Government also withholds a certain amount in case of disasters or whatever, as was explained earlier. It is not totally and absolutely linked to what was given at the time of

the previous budget, because obviously the department spent more than was allocated at the original budget time?---A. I am afraid I cannot give you any further detail than the answer I have given.

Woodger

(Mr) Perhaps I can answer *that.* I think the

reference earlier was to standard reserves which Treasury requires in some cases to be held back for award increases.
You do not hand them out until the award has actually taken place and *they* are measured in dollar terms. That certainly takes place with the budget setting process. In terms of the supply provisions though, the percentage there is simply based on last year's total appropriation, admittedly excluding award provisions because they have to be separately accounted for.

Q. The award provisions that were made in the previous year are not taken into consideration in the supply provisions for this year?---A. There is an *adjustment* made specifically *to* cover the problem of the award provisions, yes.

CHAIRMAN: Going back to before the supply period, if supplementation can be made to hospitals for things such as dollar devaluations, could supplementation not be made also for those hospitals that are carrying a greater share of the burden due to doctors' disputes?---A. Yes. There were two parts to the question. First, the devaluation: there was no general provision made last year on a statewide basis because there was no provision in the budget. Apparently from the evidence we have heard, certain regions did provide some *supplementation* on a particular case basis. I guess other hospitals would have handled it without needing supplementation because of savings due to doctors' disputes. What was the second part of the question?

Q. It is just that where some hospitals ran into problems because of the devaluation, supplementation was found. The Committee has heard evidence from both Royal North Shore and Royal Prince Alfred that they had tremendous problems because of their particular teaching hospital nature during the doctors' disputes, yet apparently they have been asked to overcome their overexpenditure through the supply process?-'--A. In the case of the stresses put on certain hospitals during last year the department's position certainly was for regions to look at those problems and to make
appropriate adjustments.

Now, the adjustments made, or what was appropriate, may

not have necessarily agreed with the particular hospital's perspective of what was appropriate. I would suggest that may be a reason for a difference, but certainly I think as was mentioned earlier it was part of the department's review during last year to look at particular needs because of particular circumstances and to do transfers between hospitals to meet those circumstances, where justified.

Q. So you are saying that some supplementation will have taken place in relation to that matter?---A. Certainly.

Dr REFSHAUGE: could you see any advantage in changing the financial year from July to June to perhaps November to November? .. A. The only experience I have of it - I take it

you are talking about hospital budgets w ithin the normal State financial framework?

Q. Yes --A.· The only experience I have had of that is where we had the tertiary education grants when the State had responsibility there, where they were on a calendar year basis and, frankly, it created more confusion than the problems it solved.

Q. Would you see any advantage in going to triennial funding or a variation of that?---A. There could well be advantages, but again I cannot see it happening unless the whole State budget process is changed to accommodate it.

Q. Are you basically happy that the hospitals are getting their budgets allocated early enough to be able to make decisions to stick within those budgets?~--A. I believe that, as with the State departments generally, an earlier budget setting would be desirable if it was practicable. It does not seem to be practicable at this point in time. I also share the view expressed earlier by Mr McGregor that with the possible exception of last year, which was an exceptionally late allocation, the normal time frame, though it may pose some difficulties, does not present a genuine reason for over-expenditure, as some hospitals would have us believe.

In general terms the variations that are allowed for would have regard to that time lag in any event.

CHAIRMAN: The third report of the Public Accounts Committee was brought down in April 1982. The head office circular that went out to the various hospitals was in March 1984. We are now a further eighteen months down the line. When do you feel *the* new standards based on the specific recommendations of the 1984 circular will be in operation? ---A. (Mr McGregor) So far as the accounts and audit determination is concerned, that is in the process of printing now and should be out' in, I hope, a matter of weeks.

Q. What about in relation to other recommendations?---

A. I think for the most part the other recommendations have as far as possible been implemented.

CHAIRMAN: There are some further questions contained in my letter to you which, for a number of reasons, we will not pursue this afternoon but we will ask that you provide the Committee with documentation of those matters. They deal specifically with the computer-based registry of property and the Hospay contracts. Thank you for your submission.

(The witnesses withdrew)

(The Committee adjourned at 5 p.m.)