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PARLIAMENT OF NEW SOUTH WALES

THIRD REPORT

OF THE

PUBLIC ACCOUNTS COMMITTEE

OF THE

FORTY-SEVENTH PARLIAMENT

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

ORDERED TO BE PRINTED, 6 APRIL, 1982

MEMBERS OF THE COMMITTEE

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

MR J.C.BOYD, M.P.

MR N.F.GREINER, M.P.

MR S.T.NEILLY, M.P.

MR T.S.WEBSTER, M.P.

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CHAIRMAN' S FOREWORD

On November 11, 1981, the Public Accounts Committee received a reference from the Minister for Health, The Honourable L.J. Brereton, to:

* enquire into the causes of expenditure over-runs in health funding to Schedule 2 and Schedule hospitals in the financial year 1950/$1 and matters related thereto; and

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

The Committee's Interim Report was tabled in Parliament on 18 February, 1982, and addressed itself primarily to the first term of reference concerning over expenditure in 1980/81. It also flagged a number of major areas concerning the general accountability of the public hospital system which are now addressed in this Report.

Mr J.Co Boyd, M.P., and Mr N.F. Greiner, M.P., have asked that their disagreement with the section of the report entitled "Role of the Medical Profession" be noted.

I would like to thank all Members of the Committee for their co-operation throughout the inquiry and on behalf of the Committee again express appreciation for the invaluable assistance we received from Mr Warren Hickson, Miss Robin Long, Mr Mervyn Sheather, Dr Tim Smyth and Mr John Woodger.

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

CHAIRMAN

SUMMARY OF RECOMMENDATIONS

The Committee recommends that:

(1) The existing "modified cash" accounting arrangements be retained in the public hospital system.

(2) 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 financial reports, including the annual reports of hospitals and the Health Commission.

(3) All hospitals incl ude a table detailing the source and application of all funds,. based on a standard format, in their annual reports to the public.

(4) 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.

(5) A form of modified global budgeting be introduced with block allocations 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.

(6) 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.

(7) Expenditure reporting, both.actual and against budget, continue to be on a line item basis.

(8) 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.

(9) 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.

(10) Subject to budgetary constraints hospital managements be encourage d to provide commercial services.

(11) An incentive reimbursement scheme be introduced for public hospitals in the 1982/83 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.

(13) The retained,saving be expended in a manner approved by the Health Commission.

(14) The budget allocation for public hospitals be reduced by the full amount of savings achieved in the following financial year.

(15) Only savings deemed by the Health Commission to be "real" savings be eligible for inclusion in the incentive reimbursement scheme.

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

(17) Hospital auditors be required to report the results of their audits to the Auditor-General.

(18) The Auditor-General be given power

- 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.

(19) 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.

(20) The format of the expendi ture estimates of the Minister for Health in the State Budget Papers be varied to the extent necessary to demonstrate the major expenditure programmes provided for, Viz., hospitals, community health programme and allied services.

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

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

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

(24) Hospitals present the financial staffing and activity information in their annual reports in a standard format a pproved by the Health Commission.

(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.

(26) In determining hospital budgets, Regional Offices of the Health Commission have regard to available statistics on comparative levels of efficiency between hospitals and desirable movements in patient activity.

(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 re quirements.

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

(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.

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

(31) The Health Commission undertake a review of its present policy on the growth of private hospitals with a view to introducing needs-based criteria for the licencing of private hospital beds.

(32) Future budget allocations to.Regions be consistent with a clearly defined and understood needs-based formula.

(33) The Health Commission take immediate action to delineate the role of each hospital.

(34) Hospitals be required to develop corporate plans for their future development in accordance with the health needs of their catchment populations. Such plans should express the hospitals ' objectives, service and facility requirements, and be consistent with the Region's strategic plan.

(35) The Public Hospitals Act and the Health Commission Act be amended to facilitate the establishment of area health boards.

(36) Medical staff establishments for public hospitals be reviewed to ensure that they are relevant to both the role of the hospital and the needs of the community.

(37) The Health Commission initiate action to remove the barriers to proclamation of the amendment to the Public Hospitals Act providing for the delineation of clinical privileges for all medical practitioners appointed to public hospitals.

All major hospitals introduce appropriate forms of peer review and utilisation review where they have not already done so.

(39) Hospitals require, as a condition of appointment, that medical practitioners agree to participate in review procedures.

(40) In the event of the continuation of a right to private practice for salaried staff specialists:

* The termination of Schemes A and C.

* Modification of Scheme B to limit private practice income to say 20% of salary.

* Review of the facility charges levied on private p ractice income by hospitals to more accurately reflect the cost to the hospital of services provided to staff specialists.

* Modification of trust fund arrangements to ensure that all surplus private practice income is placed in one hospital trust fund to be used for the benefit of the whole hospital.

* Total private practice income, summary details of its disbursement and trust fund balances be published in hospital annual reports.

(41) In the event of a continuation of fee for service payments to visiting medical officers treating private patients:

* The Health Commission examine the feasibility of extending facility charges to all visiting medical practitioners.

* In concert with other State Governments, New South wales seek the agreement of the Commonwealth Government to modification of the Medical Benefits Fee Schedule to clearly identify a "non-professional" component in medical benefit fees.

* That, as a condition of appointment, all visiting medical practitioners be required to charge no more than the medical benefit schedule fee for medical services provided to private patients in public hospitals.

* 'Sessional payments for medical services provided to "hospital" patients be extended to all public hospitals.

(42) Visiting medical practitioners be remunerated for medical services to all patients in New South Wales public hospitals on a sessional rather than fee for service basis. The Public Hospitals Act be amended to prohibit charges being raised by any medical practitioner for services provided to a patient in a public hospital.

(43) The salary and conditions of salaried staff specialists be appropriately reviewed in the light of abolition of their rights to-private practice.

(44) To facilitate the extension of sessional payments for medical service to all patients in public hospitals at an appropriate time the Public Hospitals Act be amended to

appropriately redefine the positions of visiting medical practitioner and visiting medical officer to create a single category of visiting medical appointee

determine, at a specified date, all current visiting medical practitioner appointments to public hospitals with a savings provision giving preference to current appointees when appointments to the new positions are being made.

ACCOUNTING PROCEDURES

A number of hospitals and other interested bodies have argued that the introduction of accrual accounting, in lieu of the existing "cash accounting" system, would improve accountability.

The system which now applies in New South Wales is not strictly a cash accounting system. Under current arrangements accrued "salaries" expenditure, calculated on the estimated cost of salaries from the last pay day in each financial year to 30 June, are brought to account in that year, with a corresponding deduction being made against salaries expenditure in the following year. Thus an accrual system does in fact operate for "salaries" expenditure, which comprise about 70% of total payments.

Proponents of the argument for introducing an across-the-board accrual system.point out that a cash accounting system prevents both proper measurement of hospital performance against budget targets and valid comparison between hospitals. In summary, the main shortcomings seen in a cash accounting system are:

* hospitals can conceal deficits by deferring payment of creditors.

* favourable or unfavourable results can similarly be concealed by a build up or run down of stock levels.

* there is no disclosure of prepayments by hospitals.

* there is no accounting for the costs of fixed assets through depreciation provisions.

* no provisions are made for contingent or even established liabilities, e.g., long service leave payments.

* hospitals' true earnings are not revealed.

Arguments presented to the Committee in favour of retention of a "modified cash" accounting system, most of which were covered in the Health Commission's submission, are that:

* The Government's budgeting is primarily based on cash and it is desirable for the system used by hospitals to be consistent with the Health Commission and other Government departments generally.

* a cash accounting system is more easily understood and, subject to safeguards, it permits adequate controls to be exercised.

* hospitals maintain creditors records under existing arrangements and thus it is practicable (and appropriate) for information regarding outstanding balances to be extracted and incorporated in financial reports. Similarly, information on outstanding fees and bad debts is readily attainable.

* a full accrual accounting system would provide, at considerable effort and expense, a degree of refinement"of financial recording which is appropriate to the commercial world but which would be largely superfluous to hospitals and the needs of the Government. Provisions for depreciation of fixed assets and accrued leave entitlements.are specific examples cited within this category.

The Committee also noted the following observations of the New South Wales Auditor-General on statements of operations of entities funded by cash subsidies in Appendix 1 of his 1979/80 Report on the Public Accounts:

> **"Where Government subsidy finance is provided for all or most of the costs of an entity, the concept of measuring performance by matching costs against the incomes produced by those costs cannot be applied effectively. The income received is controlled by the Government's assessment of budgetary priorities (i.e., what sum of money will be granted from the public purse), not by the degree of success in selling the goods or services provided by the entity.**
>
> **Subsidies are usually provided on a basis that authorities are given in a reporting period only what. they will actually need to pay out, Accrual accounting measures expenses on the basis of the obligations incurred during that period, making provisions for depreciation, long service leave and other expenses incurred but not paid and also recognising goods and services received but not paid for. Matching. of expenses with revenues in a cash-funded entity automatically leads to the calculation of a deficit. If additional subsidies are not made available each year to cover the '"deficits" but are continued on a pay-as-you-go basis, the continued use of accrual accounting with the representation of an accumulating deficit could be confusing and suggest that the undertaking has failed to live within its means.**
>
> **Consequently, in these cases full accrual accounting is usually impracticable and uneconomic. A statement showing the sources of supply of money and the uses to which it was put (e.go, a simple receipts and payments statement (adjusted for accrued payroll costs) plus disclosure of monetary asset holdings and a quantification of forward commitments) will often provide an adequate accounting without**

the expense of more complicated procedures"

of the Jamison Commission of Inquiry that "accountability demands that hospitals, which are large enterprises, should report to the community on a meaningful basis ..." However, it supports the contention that major changes to the existing accounting system to bring it into line with commercial practices are not necessary to achieve that objective.

As previously referred to, the major proportion of hospital expenditure is accounted for by "salaries" payments, in respect of which an accrual system operates. In two other key areas requiring close oversight, viz., the levels of hospitals' outstanding creditors and debtors, the required information is available under the existing system and the action required is therefore one of ensuring that this is properly brought together in the appropriate budgeting and financial reporting mechanisms.

The position in regard to stocks is different. Since the present system excludes valuation of stocks in hand, there is no simple means of bridging this information gap.

In recommending against the introduction of a system of accounting for inventories, the Health Commission has observed that:

* the work involved in stocktaking is time consuming and confusion over which stocks should be taken into account, and at what value, inevitably arises.

* even in the event of a marked variation in the level of stocks from the end of one year to the next, the variation in values as a percentage of the total budget would be very small.

While agreeing that the introduction of full accounting for inventories, including detailed stock taking is not warranted in terms of the effort and cost involved, the Committee believes that effective monitoring of stock levels and movements is an essential management tool. It has therefore concluded that emphasis should be placed on strengthening existing controls over stock levels and the ordering, receipt and issue of stocks. Adequate stock test checking procedures should also be implemented.

The Commottee recommends that:

* the existing "modified cash" accounting arrangements be retained in the public hospital system.

* 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 financial reports, including the annual reports of hospitals and the Health Commission.

* all hospitals include a table detailing the source and application of all funds, based on a standard format, in their annual reports to the public.

* the Health Commission should ensure that hospitals have adequate systems of control over stock levels, the ordering, receipt and issue of stocks, including regular test check systems.

MANAGEMENT FLEXIBILITY

All hospitals in their submissions to the Committee saw a need for greater flexibility in the expenditure of funds allocated to them by the Health Commission.

Global budgeting encompasses a range of options. If fully implemented, it would allow a hospital to expend its budget allocation in any manner seen fit by the hospital. Funds for the operation of the hospital would be allocated by the Commission as one lump sum each year.

The Committee agrees that there is a need to minimise controls which impede worthwhile management initiative, However, unlike private sector enterprises utilising global budgeting, the public hospital system does not have a well developed cost centre accounting structure. In the private sector profit alone is a sufficient indicator of management efficiency. In the public hospital system suitable efficiency criteria are still poorly developed. At the present time, the Committee doubts that management information systems and productivity criteria are sufficiently well developed in hospitals to permit the implementation of full global budgeting.

As the public hospital system provides an essential community service, the Committee accepts the need for control measures at a Health Commission and Government level to ensure that public funds are expended in a ¢o$t effective manner consistent with government policy.

Reporting against budget by hospitals on a line item basis is a necessary ingredient of this control. This.form of reporting allows performance against budget to be monitored and identifies the specific areas where budget over-runs are occurring. Without this information, enabling some comparisons with other hospitals to be made, it is not possible to effectively evaluate hospital proposals concerning changes to the services provided by the hospital.

The Committee has noted that the procedures adopted for the purposes of setting hospital budgets and controlling expenditures within those budgets vary between Regional Offices of the Health Commission. Some Regions set line by line budgets for the hospitals and Commission approval is required to vary the budget under any expenditure heading. Others adopt a more flexible approach, making budget allocations to hospitals under a smaller number of broad headings - salaries and wages, superannuation, payments to visiting medical officers, repairs maintenance and renewals, and

other goods and services. The individual line item budget allocations within these broad headings are then set by the hospital. Moreover, provided the allocations for each of these broad headings are not exceeded the hospital has full flexibility to vary expenditure on the line item components.

Under this arrangement, the hospital's budgetary performance is still reported monthly to the Regional Office on a detailed line item basis and the Committee accepts that this is an essential element for overall control. There is also a need for the Regional Office to review the line item budgets initially proposed by the hospital to ensure that they are realistic.

The Committee endorses this approach to hospital budgeting. It corresponds with the current practice of Treasury in allocating funds to Government departments for maintenance and general working expenses, giving greater flexibility without loss of overall control of expenditure.

It should also be stated, however, that increased responsibility necessarily goes hand in hand with increased flexibility. Hospitals must accept the onus of making appropriate allowance for anticipated cost increases and contingencies within the overall sum of money provided.

* 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.

* 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 re quired for any departure from the line item budget.

* subject to budgetary constraints hospital managements be encouraged to provide commercial services.

The Committee received considerable evidence from individual hospitals of opportunities for entrepreneurial activities, such as the provision of diagnostic services where excess capacity existed, which would financially benefit the public hospital system as a whole.

The Health Commission response to such suggestions has usually been slow and unsympathetic.

The Committee recommends that:

* a form of modified global budgeting be introduced with block allocations 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.

* 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.

* expenditure reporting, both actual and against budget, continue to be on a line item basis.

INCENTIVE SYSTEMS

In submissions to the Committee, many hospitals pointed to the lack of financial incentives for cost containment. Under the current budgetary system, any economies achieved by a hospital result in a reduction in the budget allocation to the hospital.

In examining the desirability of allowing hospitals to retain all or part of budgetary savings, the Committee has been conscious of the need to ensure that any incentive system does not simply reward the inefficient hospitals at the expense of others. This is particularly so when budget .allocations to hospitals are made on an essentially historical basis - last year's budget plus an allowance for inflation.

The Committee is also aware of the need to ensure that the expenditure of public funds is financially responsible and accountable to the public. The goal of all hospital administrators should be to operate their hospital as economically and as efficiently as possible rather than ensuring that the budget allocation is fully expended.

A major practical problem is the identification of savings to be recognised under an incentive system. Any savings must be real and ongoing. Fluctuations in the level of hospital stocks and trade creditors could, for example, give a false impression of savings on goods and services. The savings should also be the product of hospital initiatives, as distinct from directives from the Health Commission. Fortuitous savings in allocations for items such as payments to visiting medical officers would also need to be excluded.

It is equally clear than an incentive system which provided for all savings achieved to be permanently retained by hospitals would be self-defeating so far as cost containment is concerned. If the introduction of financial incentives is to be justified, the savings achieved must result in a reduction in hospital costs.

The Committee sees some merit in a system which allows savings achieved in one year to be retained by a hospital in the following year on a once-only basis. Under such an arrangement the budget base would. be adjusted in the following year to reflect the savings achieved. This approach is favoured by many hospital administrators.

The manner in which retained savings are expended would need to be approved by the Health Commission to ensure that this expenditure was consistent with the role of the hospital and did not generate additional costs.

An upper monetary limit would also need to be set on the savings that can be retained by hospitals. This limit would be appropriately linked to the size of the hospital's budget.

To ensure that savings achieved under such a system can be properly taken into account in future allocations for hospital operating costs, the State Treasury would need to be kept fully informed of the savings achieved under an incentive system.

The Committee recommends that:

* an incentive reimbursement scheme be introduced for public hospitals in the 1982/83 financial year.

* 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 retained saving be expended in a manner approved by the Health Commission.

* the budget allocation for public hospitals be reduced by the full amount of savings achieved in the following financial year.

* only savings deemed by the Health Commission to be "real" savings be eligible for inclusion in the incentive reimbursement scheme.

* a review of the operation of the scheme be undertaken prior to the 1984/85 financial year.

AUDITING PROCEDURES

In exercise of its powers under Section 11 (1) (b) of the Public Hospitals Act the Health Commission has determined that it shall be a condition of subsidy from the Hospital Fund that every subsidised hospital shall comply with requirements laid down in the Commission's "Accounts and Audit Determination". This document is a detailed specification of accounting and auditing procedures required to be observed by hospitals.

Hospitals are given individual responsibility for the appointment of auditors, although the terms and conditions of such appointments are detailed in the Accounts and Audit Determination. A hospital auditor is required, in terms of that Determination, to report to both the hospital Board and the Health Commission one the results of his audit.

The Committee believes that the public accountability of hospitals would be improved if steps were taken to involve the Auditor-General of New South Wales in the hospital audit process.

This is not to say that it is necessary for the Auditor-General to be appointed as auditor to the hospitals. It is desirable, however, that he have an oversight of the audits carried out, for the purpose of:

* ensuring that the audits meet acceptable minimum standards; and

* providing a more positive assurance that unsatisfactory findings of the audit will be acted upon and, as appropriate, reported to Parliament,

A similar, if not parallel, arrangement to what the Committee has in mind is provided for in the Queensland Local Government Act. Local Authority auditors are appointed upon the recommendation of the Auditor-General and are required to report the results of their examination of the accounts to him. If the Auditor-General considers that the accounts should be disallowed as being contrary to the Act or that there has been a misapplication of funds he has the responsibility of so certifying to the Treasurer.

The Committee believes that a similar arrangement should apply for New South Wales public hospitals.

With regard to the appointment of auditors, the existing Accounts and Audit Determination provides that:

> "An appointed auditor shall be eligible for re-appointment in each succeeding year and, provided he indicates his willingness to accept re-appointment shall not be .refused by the hospital without first reporting the grounds for refusal to the Commission and obtaining its approval".

The Committee considers it desirable' that this power of approval be extended to the Auditor-General.

The Committee recommends that:

* hospital auditors be required to report the results of their audits to the Auditor- General.

* 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

* 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 a ppropriate.

MANAGEMENT INFORMATION AND REPORTING SYSTEMS

This section addresses the information and accountability requirements of Parliament, the Health Commission and public hospitals. Existing arrangements for reporting and monitoring the performance of hospitals are evaluated and a number of improvements proposed. While the Committee's recommendations are directed initially to the provision of more timely and accurate information for the purpose of strengthening controls over hospital expenditures, it is anticipated that the development of departmental or functional allocations of costs, linked to responsibility accounting, should also improve the level of accountability within hospitals.

Information Needs of Parliament

The Committee is seriously concerned at the lack of relevant, up-to-date information available to Parliament and the public on the budgetary performance and productivity of individual hospitals. Statistics published by the Health Commission often provide little basis for any critical examination of differences in the relative levels of efficiency between hospitals. In many instances unnecessary delay occurs before publication of this information. Similarly, the Annual Reports of individual hospitals vary widely in terms of the amount and quality of information provided. Greater public disclosure of comparative information would foster public scrutiny and debate.

The Committee sees an urgent need for the Health Commission to devise a method which classifies hospitals according to those factors which influence their costs. Clearly the number of beds is an inadequate criterion and needs to be supplemented by such indicators as function, patient throughput, and medical staffing. Once an appropriate classification of hospitals is made, indicators of performance (for example, nursing staff per adjusted inpatient treated or functional area) should be developed and published by the Health Commission, either as a supplement to its Annual Report to Parliament, or as a separate document.

A further problem is that the present method of presentation of the Minister for Health's expenditure estimates in the State Budget Papers fails to identify the services or programmes for which funds are allocated. In particular, the aggregation of the provisions made for "recognised " and "non-recognised" hospitals, the community health programme and allied services within one allocation in the "Other Services" section of the Budget is unsatisfactory. The costs of other health, services are distributed throughout the salaries, maintenance and working expenses provisions and are also not separately identifiable.

The existing format provides little information to Parliament and the public about the direction and purpose of the major government outlays on health. The whole question of budget presentation has, of course, been dealt with in depth in Professor Wilenski's Report, (Review of New South Wales Government Administration, Directions for Change, November, 1977) and the Committee has therefore not addressed itself to the ramifications of fundamental changes to existing practices.

However, it is. clear that some relatively minor modifications to the existing format, to enable at least the distribution of funds between the major programmes to be distinguished, would have three main benefits.

First, it would provide the Minister and the Parliament with a clearer description of the activities of the Health Commission and the resources allocated to each activity. Second, it would establish greater accountability for funds allocated. Third, it would facilitate assessments of the effectiveness (or results) of expenditure programmes.

The Committee is also concerned at the lack of availability of reliable information on how funds allocated by Parliament have been distributed to hospitals and how their expenditure performance compared with the budget allocation. The difficulties experienced by the Committee in reconciling the Health Commission's record of the 1980/81 hospital financial performance with those furnished by the hospitals referred to in the Interim Report highlight this problem.

To ensure greater accountability this deficiency should be removed. While it is appreciated that the Budget Papers would not be an appropriate medium for such information, a separate document should be prepared and furnished to Parliament for this purpose.

The Committee recommends that:

* 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 programmes provided for, viz., hospitals, community health programme and allied services.

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

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

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

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

Information Requirements of the Health Commission

The principal sources of information on hospital performance are the monthly, quarterly and annual returns to the Health Commission by public hospitals, and monthly financial progress reports from Regional Offices. The main deficiencies in this information to the Commission are:

* the inadequate financial, Staffing and patient activity data and lack of standard definitions; and

* the delays involved in processing and analysing hospital returns.

Financial Statistics : At present monthly financial progress reports are required to be lodged by each Regional Office by the 22nd of each relevant month. These reports set out estimates of aggregate expenditures and receipts for that month according to the seven common headings. The information in the.returns is compared with each Region's year-to-date approved cash flow and variances identified against the State proportion of expenditure against each item. A summary table is usually available to the Health Commission's Head Office by the second week of the following month.

The usefulness of these Reports is limited by the accuracy of the estimates prepared by Regions.

In addition, hospitals are required to furnish monthly reports to the Commission setting out actual expenditures and revenues. Although these returns provide more accurate information than the Regional progress reports, the inconsistent interpretation of definitions and instructions by hospitals detracts from their reliability. The involvement of Regions and the need to collect returns from all hospitals mean that reports are usually not available until up to eight weeks after the end of the relevant month. Clearly a delay of this magnitude diminishes the value of the information as an information and management tool.

The quarterly returns, which include debtors and creditors information and staffing statistics, suffer from the same processing delays.

The Committee is aware that a Task Force was established by the Minister for Health in January, 1982, to review the management reporting system for hospitals. The Task Force has given priority to improving the turnaround and quality of the revenue, expenditure and activity date generated by hospitals in monthly reports.

Regions have recently been instructed to forward a copy of the monthly report from each hospital direct to Head Office by the tenth working day of the following month. Where a hospital is late in submitting.its return, an estimate will be prepared based on the previous month's figure.

Hospitals have also been instructed to provide additional financial statistics, including patient fees charged and collected, payments (actual and outstanding) to creditors and cash payments for award variations not yet notified to the Region. Thus, accrual information will now be regularly reported. Information on patient activity has also been expanded to include details on casualty attendances and inpatient admissions through casualty.

There appears to be a need for Head Office to be supplied with data on actual Regional expenditures and forecasts of end of year budget results on a monthly reporting basis. Regions should clearly have primary responsibility for monitoring the expenditures of individual hospitals, although there may be cases where Head Office should become involved where a particular large hospital's budgetary performance has State-wide ramifications.

At present hospitals are required to forecast total end of year expenditures on a quarterly basis. There is a strong case for suggesting that these forecasts should be prepared each month. The capacity of hospitals to accurately foreeast whether they will live within their budgets will be enhanced by the requirement that data on accrued payments and receipts also be furnished. However, consideration should be given to the use of sanctions and budget penalties for hospitals whose forecasts prove to be consistently and seriously inaccurate.

The Committee recommends that:

* 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.

Statistics on Patient Activity : As noted earlier, there is a clear need for comparative hospital performance statistics. In particular, the Health Commission should give priority to the collection of comparable statistics on hospital activity and levels of care, especially differences in medical and nursing intensity. Unless the Health Commission is able to determine the reasons for expenditure differences between comparable hospitals, funding restraints are likely to be imposed indiscriminately on the efficient as well as the inefficient hospital. Moreover, unless agreement is reached between the .Commission and each hospital in its projected level of activity hospitals will be able to claim that they failed to meet their budget because patient activity did not decline.

The Committ ee recommends that:

* in determining hospital budgets, Regional Offices of the Health Commission have regard to available statistics on comparative levels of efficiency between hospitals and desirable movements in patient activity.

Information Requirements of Hospitals

Improved methods of management reporting at the hospital level can be based on the following:

* responsibility level (e.g., hospital department)
* function or activity level; and
* disease or episode or illness.

The Committee sees considerable benefits flowing from the development of more sophisticated measures of hospital output, in terms of patient case-mix and length of stay. However, initially the first two areas offer significant potential in the short to medium term.

According to evidence presented by the Health Commission, considerable progress is being made in developing information systems for expenditure control and accountability purposes.

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.

The system involves the collection of data on inputs (both dollars and nursing/non-nursing hours worked) used in the production of measured units of output in each functional area of the hospital. From this information, input/output ratios can be calculated and variances of current performance from some predetermined norm (e.g., budgeted performance) analysed. Management can therefore differentiate variances arising from changes in activity levels as opposed to changes in the quantity and/or price of inputs. Reports are produced monthly showing output and hours worked and quarterly in the case of departmental expenditures.

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 is 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.

Clearly computers are required to process the large volumes of information required for effective management in the larger hospitals. The fact that a number of hospitals have independently developed different approaches to computerisation should not necessarily handicap the implementation of common reporting systems.

The potential is available to use existing centralised computerised information systems to produce relevant management information. The Health Commission of Victoria, for example, employs its personnel/payroll data base to provide information to hospitals and hospital departments on payments to staff by category.

A further application of the Victorian system - "Hospower" - relates productive hours (i.e., paid working hours) to inpatient bed days adjusted for average length of stay and outpatient attendances. Comparisons of these indices can then be made between "like" hospitals. Comparative assessments of hospital productivity will be further improved when feedback from the hospital morbidity system enables a more sophisticated case-mix adjustment according to hospital size and length of stay.

The Committee recommends that:

* 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.

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

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

THE PLANNING AND MANAGEMENT OF HOSPITAL SERVICES

Until recent years, hospital services in New South Wales grew haphazardly. This growth had more to do with the demands of health providers and users, local communities and politicians than with the health needs of the State.

As a result New South Wales, with 4.92 "recognised" public hospital beds per 1000 people (June, 1981) has an excess and maldistributed supply of public hospital beds. The hospital bed ratio varies from 2.93 in Western Metropolitan Health Region to 8.89 in Orana and Far West Region.

With more than half the beds used for the fee-for-service treatment of private patients, there is a strong financial incentive to fully utilise the beds available. Thus, as the Health Commission acknowledges in evidence, the State's over-supply of hospital beds compared with overseas and interstate standards is an important contributory factor in the State's relatively high hospital utilisation (1354 occupied bed days per 1000 people in 1980/81 compared with 1043 in Victoria).

Clearly, the New South Wales hospital system needs to be re-structured to constrain the total number of hospital beds and to distribute them more equitably throughout the State.

The goal of greater regional equity can only be achieved by the contraction of hospital services in well endowed areas (e.g. (new) Southern Metropolitan Health Region) and the expansion of health services in "health-scarcity" regions (e.g., Western Metropolitan, Illawarra and North Coast Regions).

The direction and magnitude of the transfer of resources required is indicated by the Commission's proposed Regional Resource Allocation Formula. This formula identifies each Region's needs - based share of total hospital funding. Some parties have pointed to deficiencies in the methodology of the formula and the disruptive effects associated with its implementation. Although scope may exist for further refinement of the formula, the Committee believes that some needs-based formula should be progressively implemented by the Commission in determining the size of Regional budgets.

Other areas of service maldistribution and inequity need to be addressed. Currently the Health Commission is placing considerable emphasis on the development of regional guidelines on bed to population ratios. These target ratios are specified in overall terms and for particular functional bed types. (medical and surgical, paediatrics, obstetrics, etc.).

The Committee believes that efforts to constrain the overall supply of beds are a necessary but not sufficient condition for reducing hospital expenditures. As noted in the Committee's Interim Report, experience with the 1979/80 hospital rationalisation programme demonstrated that activity levels must also be reduced. Such an objective can only be accomplished if effective admission policies are implemented by hospitals and medical staff establishments are reduced. In the short-term at least, the Health Commission's expectations that "doctor referral patterns will change as you restrict the supply of beds" has not been realised.

The Committee believes that the Commission's present policy of "no growth" in private hospital bed approvals may not be appropriate for all regions in the State.

Existing private hospitals are heavily concentrated in the (new) Southern and Northern Metropolitan Regions. Although private hospitals generally appear to be relatively underutilised, there may be scope for allowing the development of some additional private hospitals and expansion of existing hospitals in health scarcity regions of the State where population is growing rapidly and where the public sector is under pressure.

Any such approvals, however, should be conditional on the proposed role of the private hospital being in conformity with the Region's strategic plan. These additional private beds should only be located in areas of need where their establishment would be expected to relieve pressure on the public hospital system. It is acknowledged that private hospital beds can only be a substitute for. public hospital beds for certain types of hospital activities patients (mainly medical, surgical and psychiatric cases). To ensure adequate access to hospital services, the public sector must remain the major provider of all hospital services, especially emergency, and outpatient services, the more sophisticated clinical specialties and paramedical services.

The Committee recommends that:

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

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

* future budget allocations to Regions be consistent with a clearly defined and understood needs-based formula.

The Delineation of Hospital Roles and Corporate Plans

It is clear from the general over-supply of hospital services and other evidence that many decisions about new hospital facilities and services have been unduly influenced by particular pressure groups and sectional interests. Considerations of need, viability, cost effectiveness and standards of patient care and medical proficiency have been relegated to secondary importance. At the same time, many hospitals have maintained existing services even though the need for those services has diminished.

The delineation of hospital roles was referred to briefly in the Committee's Interim Report and was favoured by most hospitals appearing before the Committee, as well as by the Australian Medical Association.

The Health Commission already possesses adequate statutory powers to take action in this area. Under Section 11 of the Public Hospitals Act (1929) the Commission is charged with ensuring adequate standards of patient care and services provided by hospitals. Further under Section 13 (3) (c) the Commission may determine the functions and activities of any public hospital.

In early 1981 the Health Commission established a Task Force to prepare guidelines for the delineation of hospital roles. The Task Force tackled the problem by identifying the support services necessary to maintain safe patient care each level of service.

In view of the fundamental importance of hospital role delineation, the Committee sees an urgent need for the Commission to undertake and complete this task. While some fine-tuning may be required when comprehensive strategic plans are finally developed for each Region, the Committee sees no reason why the delineation of the roles of the hospitals cannot proceed forthwith. Indeed the delineation of the role of each hospital, in terms of its core and support services, should be the catalyst for the development and review of Regional strategic plans.

As part of the process of identifying roles, each hospital should be encouraged to develop a corporate plan. .This plan should set out the specific objectives of the institution and its programmes of action to meet the health needs of its catchment population in the immediate future, consistent with the resources available. Clearly, such a plan should also be consistent with an appropriate regional strategic plan.

The Committee recommends that:

* the Health Commission take immediate action to delineate the role of each hospital.

* hospitals be required to develop corporate plans for their future development in accordance with the health needs of their catchment populations. Such plans should express the hospitals' objectives, service and facility requirements, and be consistent with the Region's strategic plan.

Area Health Boards

Much has been written on the need for decentralised management in the health industry. At present the administration of hospitals, community health, public health and ambulance transport services is fragmented with each major service area having different funding arrangements, administrative structures and conditions of employment. Present arrangements complicate the administrative work and add to the service provision responsibilities of Regional Offices of the Health Commission.

The area health board concept envisages the consolidation of the administration of various governmental health, serving a defined area, under one administration.

When referring to such a possibility, Wollongong Hospital pointed to the potential benefits in terms of securing the rationalisation and integration of hospital and health services within a Region, The Health Commission's views were more ambivalent. While foreseeing that area boards would facilitate a more rational pattern Of resource allocation and greater co-ordination of health services, it remarked that "in short-term management it will not change things".

There are several areas in New South Wales where de facto area health boards currently operate. The Committee noted that the Chief Executive Officer of the Hornsby and Ku-ring.gai Hospital, is the Area Co-ordinator responsible for the administration of all community health services in the area. In the Gosford-Wyong area an Area Health Advisory Committee has been established.

Table 1 summarises some of the essential differences between an Area Health Board and a hospital board.

Table 1

Area Health Service	Public Hospital Service
Defined geographic area.	No defined area.
Responsibility for meeting the wider health needs of the community.	Responsible for the health needs of those who present to the hospital.
Responsible for identifying health status of the population.	Responsible for caring for people with acute episodic illness.
Emphasis on -prevention and health promotion -environmental health -chronic illness and rehabilitation -integration and health and welfare services.	Emphasis on hospital based treatment and care.
Staff - have broader concept of health management	Staff - are trained in a medical model of patient care
- work in a multidisciplinary consultative system.	- work in a hierarchical, disciplinary system.
Statutory responsibilities under the Health Commission	Statutory responsibilities under the Public Hospitals

Act.

There are three main options available for establishing area health boards.

The existing Hospital Board becomes the area health board. This is the simplest arrangement administratively and politically, involving an expansion of the role of the existing hospital board. Public service staff could be seconded to the area health board which would manage staff and funds. The composition of the area health board could be altered over time by the replacement of public servants, who retire or resign, with employees of the area board. This arrangement would be resisted by some community and public health staff, who would see it as a takeover of the community oriented services by a board predominantly oriented to hospital activities. It would also only be practicable in areas in which only one hospital exists, otherwise a consolidation of hospital boards would be necessary.

An area health board is established alongside the existing hospital board. This would create an additional layer of administration.

An entirely new area health board is appointed, that is, the Hospital Board is abolished. This would require legislative changes and could attract considerable opposition from some existing board members and the community.

In evaluating the desirability of introducing area health boards, the key considerations are:

* whether they will improve standards of accountability for the services provided; and

* whether the increased flexibility to redistribute resources between services and programmes will lead to any significant net savings in health expenditures whilst maintaining the quality and client coverage of existing services.

On the one hand, it is clear that area boards may be a more effective instrument for:

* promoting rationalisation of health services by reducing the duplication of facilities;

* achieving economics of scale in purchasing and sharing of "group" services;

* enhancing career opportunities of staff, especially those presently working in non-hospital settings;

* fostering community participation in management and administration;

* improving co-operation and communication between those involved in the various health delivery services;

* removing some service delivery functions from Regional Offices, allowing them to devote more attention to planning, budgeting and monitoring.

On the other hand, area boards suffer from a number of disadvantages, including:

* doubt as to whether area health boards (especially those serving smaller populations) can adequately and effectively manage public health and other health services where State-wide administration may be more cost-effective;

* difficulty of securing .co-operation from some hospitals, especially in taking on an expanded community health role; and

* dominance of health services by powerful institutional interests.

The Committee believes that scope exists for some consolidation of hospital facilities and greater co-ordination of hospital and community health services through the establishment of area health boards. To be fully effective and accountable, however, area boards should not just involve the integration of hospital and community health services (i.e., an expanded role for the existing hospital board), but should be introduced in areas or regions where more than one hospital exists, in which case a total reconstruction of the management structure will be necessary.

Such change is unlikely to be evolutionary, as envisaged by the Jamison Commission of Inquiry, and therefore legislative action and government encouragement will be necessary.

The Committee noted that in Queensland many hospital boards administer more than one hospital. In evidence to the Committee, the Regional Director of the Illawarra Health Region advised that some of the smaller district hospitals in that Region were willing to accept an expanded role. While supporting those initiatives, the Regional Director stated that he was constrained by the absence of appropriate administrative and legislative arrangements.

The Committee recommends that:

* the Public Hospitals Act and the Health Commission Act be amended to facilitate the establishment of area health boards.

ROLE OF THE MEDICAL PROFESSION

In its Interim Report, the Committee drew attention to the major.role of the medical profession in generating hospital expenditure.

In examining this matter the Committee has taken evidence from a number of individuals and organisations representing health care administrators, health economists and the medical profession. The Committee has also examined at first hand the Queensland hospital system and held discussions with the Queensland Department of Health, hospital administrators and the State Branch of the Australian Medical Association.

There appear to be two main areas in which controls will have a significant effect on doctor generated hospital expenditure - access by the medical profession to health care facilities and the economic incentives available to the profession in the health care delivery system. While both these areas are interdependent, for convenience the Committee has considered this problem under three major headings.

* appointmen t of medical staff to public hospitals.

* monitoring of doctor activity in public hospitals.

* remuneration of medical staff in public hospitals.

Studies, both in Australia and overseas, have demonstrated a clear relationship between the utilisation of a health facility and the degree of access to that facility by the medical profession.

The utilisation of pathology services provides a simple illustration of this relationship. As the specimen, and not the patient, is transported to the laboratory the relative accessability of pathology services should have little influence on the rate of usage. However, a study of the utilisation of pathology services per head of population in statistical divisions across Australia, based on 1976 Medibank data, clearly demonstrated a decline in use proportional to the distance from the nearest pathology laboratory. In the Sydney and Wollongong areas, where pathology services are being aggressively promoted amongst medical practitioners, the utilisation in 1976 was 60 - 70% above the Australian average.

At a hospital level, studies comparing utilisation in the United Kingdom, Canada and the United States have convincingly shown a lower utilisation in hospital systems that restrict access by medical practitioners. A laissez-faire attitude to doctor access presents the hospital system with an ever-increasing doctor generated demand for its services. These demands are then translated into over-utilisation - high admission rates, high operation rates, excessive procedures and investigations.

Where a hospital system operates under a salaried, sessional or, as in the United States, a private pre-paid arrangement, control over the access to the facility by the medical profession is greatest. Under these arrangements, the hospital system is able to determine the demand it is to meet and then appoint medical staff accordingly. The nature of the demand placed on the hospital under these arrangments if no longer a demand presented to the hospital by the doctor which the hospital has no alternative but to satisfy.

The need to limit the number of doctors appointed to public hospitals has been recognised by the Health Commission of New South Wales. In July, 1978, following repeal of Regulation 48 under the Public Hospitals Act, the automatic right of access to a public hospital for local medical practitioners was withdrawn.

While establishments have been set by the Commission for medical staff at many hospitals, these establishments have tended to concentrate on the salaried staff with the numbers of visiting medical staff left largely undisturbed. The appointment of visiting medical staff, particularly in the bigger hospitals, has largely reflected previous practice. There does not appear to have been a comprehensive review of these appointments to ensure that they are relevant to the needs of the community. Such a review is desirable not only in the interests of cost containment but also to ensure the maintenance of professional standards and skills. To maintain these skills, particularly in surgery and other procedures types of medical practice, a minimum number of patients is required. In absence of an adequate number of patients, skills are lost and the temptation for over-utilisation grows.

As discussed elsewhere in this report, the delineation of an appropriate role for each hospital largely determines medical staffing requirements. Allied to role delineation is the need to ensure that the services provided by medical staff, once appointed, are apse to that role both in terms of the facilities available in the hospital and the clinical competence of the doctor concerned. There is widespread agreement that formal delineation of clinical privileges for medical practitioners appointed to public hospitals is desirable. The Committee has noted with some concern that amendments to the Public Hospitals Act providing for delineated clinical privileges, passed a number of years ago. by the New South Wales Parliament, have still not been proclaimed.

The Committee recommends that:

* medical staff establishments for public hospitals be reviewed to ensure that they are relevant to both the role of the hospital and the needs o f the community.

* the Health Commission initiate action to remove the barriers to proclamation of the amendment to the Public Hospitals Act providing for the delineation of clinical privileges for all medical practitioners appointed to public hospitals.

Peer Review

Widespread agreement also exists that on-going programmes to monitor and regularly review the provision of medical services by each doctor in public hospitals should be pursued. These programmes generally fall under the heading of "peer review". While accepting the desirability, in principle, of such review, the Committee is concerned that insufficient critical evaluation has been made of the costs and benefits of these programmes. To date the major emphasis of these programmes appears to be quality orientated while ignoring costs.

Many forms of peer review have been proposed including utilisation review, criteria auditing and quality assurance programmes. Quality assurance programmes, for example, may be counter productive in the absence of an independent determination of the standards against which the quality is to be assessed. Divorced from the role of the hospital and the resources available, these programmes may have little relevance.

Review by one's peers can have a salutory effect on behaviour in situations where the doctor's activities are significantly out of step with his/her peer group. However, being essentially voluntary, peer review panels generally cannot resort to sanctions and must rely on moral suasion to effect changes in the servicing patterns of particular doctors.

Peer review loses its effect in situations where the peer group, as a whole, practises in a manner inconsistent with the needs of the community. Self regulation alone, in a situation where the service provider controls both demand and supply, is obviously an inadequate and ineffective form of control.

In the United States, statutory Professional Standards Review Organisations (PSRO) were established in 1972 to control the cost of health services provided under the Medicare, Medicaid, and Maternal and Child Health programmes. Recent reviews of the PSRO programme have cast doubts on its cost effectiveness. The Committee sees a similar danger in Australia that the "peer review bandwagon" will divert attention from other measures with a far greater potential to contain and control health care expenditure. In view of the high regulatory costs and limited benefits associated with PSROs in the United States of America, the Committee's view is that peer review should remain a hospital based activity.

While accepting the problem of definition in this area, utilisation review, as distinct from other forms of peer review appears to be a more appropriate monitoring tool for both hospital and health administrators and the doctors appointed to hospitals. Utilisation review is a wider concept and should properly involve others outside the "peer group". By monitoring the provisions of services and procedures performed by doctors within the hospital, abnormal patterns can be identified and investigated. The data base from such programmes will assist hospital management in more effectively utilising the resources available to them and will also aid in the planning and development of health services.

The sophistication of such programmes will vary from hospital to hospital. While computer assistance will be a pre-requisite for many programmes, all hospitals are capable of implementing a utilisation review programme suited to their particular role and size.

An essential requirement for effective utilisation review is the existence of an adequate medical record for each patient in the hospital.

The Committee also sees a need for greater communication between hospital management and the medical staff, especially in the area of budgetary performance. Cost education programmes should also be established where necessary.

The Committee recommends that:

* all major hospitals introduce appropriate forms of peer review and utilisation review where they have not already done so.

* hospitals should require, as a condition of appointment, that medical practitioners agree to participate in review procedures.

Remuneration of Medical Practitioners

The measures outlined above form only part of a framework to control doctor generated hospital expenditure. While this framework is essential, by itself it cannot adequately address the problem. This is particularly so in larger hospitals.

In a small country hospital once the hospital's role has been defined and the doctor's privileges delineated, the facilities available have a self-limiting effect on the range of services provided by the doctors appointed to the hospital. In larger hospitals, particularly teaching hospitals this is not the case. The wider array of facilities and greater sophistication and specialisation dilute the effectiveness of such a framework.

To adequately control hospital expenditure, attention must also be given to the economic incentives available to the medical profession in the health care delivery system.

There is no doubt that hospital utilisation is substantially lower for patients treated by doctors paid on a time basis compared to that of patients treated by doctors paid on a fee for service basis.

The Health Commission of New South Wales in its submission to the Committee noted that:

> "The evidence that hospital utilisation is significantly higher when doctors operate on a fee for service basis is so strong that it makes the mechanism of doctor payments for medical services provided in hospitals one of the major matters, if not the major matter, in any effort to control hospital costs .... The Health Commission, in summary, sees the large role of fee for service medicine in public hospitals as a major obstacle to maximising efficient use of resources in hospitals and considers that changes are warranted and necessary".

Studies in the United States have examined hospital utilisation by members of health maintenance organisations. Most of these organisations pay their doctors on a salaried or capitation basis, with some allowing the doctors to share in any surplus. A comprehensive survey of 38 comparisons between prepaid group practice health maintenance organisations and traditional fee for service based systems revealed a 30% lower hospital utilisation in prepaid group practices.

The Jamison Inquiry concluded:

> "On balance, the figures available suggest there are incentives in fee for service payment which encourage high levels of utilisation and utilisation of costly forms of treatment, and that these levels may as a result be higher than would otherwise be the case".

A comparison between the New South Wales and Queensland hospital system confirms that a fee for service system is associated with higher hospital expenditure. In its Interim Report the Committee referred to the higher surgery rate in New South Wales when compared to Queensland. A more recent analysis, based on 1978 data, has confirmed that 'the surgery rate, per 1000 population, in New South Wales is 33% higher than in Queensland. The surplus is greatest in diagnostic and minor elective procedures but is significant even for major procedures. The procedure rates are set out in Table 2.

TABLE 2

PROCEDURE RATES: PUBLIC AND PRIVATE HOSPITALS -QUEENSLAND AND NEW SOUTH WALES - 1978

	Queensland Rate/1000 Population	N.S.W. Rate/1000 Population	% New South Wales over Queensland
Nervous System (except 028)	1.85	1.99	8%
Endocrine	0.65	0.77	18%
Eye	2.87	3.43	20%
ENT	8.65	9.94	15%
T & A (233-5)	4.35	4.93	13%
Upper Alimentary	2.33	2.97	27%
Extraction teeth (251-2)	1.17	1.59	36%
Thorax	1.50	2.12	41%
Other Heart (300-309)	0.37	1.13	205%
Breast	2.07	2.50	21%
Partial Mastectomy (381)*	0.78	1.06	36%
Mastectomy (382-5)	0.26	0.29	12%
Plastic Operation (386)	0.52	0.68	31%
Abdomen (except 431)	12.54	15.09	20%
Appendix (440-8)	2.58	3.97	54%
Cholecystectomy (522)	1.44	1.62	13%
Sigmiodoscopy (468)	0.69	1.02	48%
Haemorrhoids (492-3)	0.81	0.96	19%
Urinary and Male Genital	6.77	9.56	41%
Cystoscopy Ureter (587)	0.23	0.48	109%
Cystoscopy (608)	2.10	2.71	29%
Circumcision (661) (M)	1.18	2.06	75%
Ligation Vas Deferens (651) (M)	0.55	2.41	338%
Female Genital (F)	26.24	37.10	41%
Hysterectomy (690-4, 696) (F)	4.79	4.65	-3%
Division oviduct (684) (F)	2.95	3.82	29%
Curettage (704) (F)	8.67	13.81	59%
Obstetric (Except 749, 754-7, 760, 774-7) (F)	7.83	11.50	47%
Caesarian Section (764-9) (F)	4.10	3.51	-14%
Orthopaedic	9.08	12.17	34%
Manipulation Fracture (780)	1.23	1.80	46%
Joint Manipulation (804)	0.34	1.57	362%
Peripheral Circulation	2.01	2,45	22%
Stripping of Varicose Veins (894)	0.74	1.07	45%
Skin and Subcutaneous Tissue	6.28	10.22	63%

Other Surgical Procedures (except 950)	1.53	2.13	39%
TOTAL	75.07	99.68	33%

* Excludes 028, 431, 749, 754-7, 760, 77-7, 950

Source: Hospital Morbidity Statistics
(Numbers after procedure description refer to the International Coding of these procedures)

In the Queensland public hospital system medical practitioners are predominantly remunerated on either a sessional or salaried basis. Sessional payments were first introduced in 1938. The majority of patients in Queensland public hospitals elect to be public patients. Private and intermediate patients account for only 15% of inpatient bed days.

Queensland spends approximately 20% less per head of population than the Australian average on its hospital services and requires less doctors than the Australian average to provide these services. A comparison between New South Wales and Queensland expenditure on medical salaries and payments to visiting medical officers again demonstrates a substantial difference. Using adjusted daily average (A.D.A.), which reflects both the inpatient and outpatient workload, medical staff expenditure per A.D.A. in 1980/81 was $3,865 in Queensland and $5,090 in New South Wales.

In examining possible changes to the current methods of remunerating medical practitioners in New South Wales public hospitals, the Committee has examined a number of options. These have been outlined previously in the Committee's Interim Report.

Private Practice Arrangements for Staff Specialists

These arrangements have been reviewed on a number of occasions. Examinations by the Committee on Applications and Costs of Modern Technology in Medical Practice (1978), the Jamison Inquiry and a working party of the National Standing Committee (Hospital Agreements) have all concluded that modification of these arrangements is required. The Jamison Inquiry recommended the eventual abolition of the arrangements altogether.

The Committee has noted with interest that the Queensland Cabinet has recently rejected a proposal from the Australian Medical Association to introduce rights of private practice for salaried specialists in that State. The proposal was comprehensively evaluated by a joint working party with the Queensland Department of Health before being submitted to Cabinet.

When the current private practice arrangements were entered into in New South Wales the medical manpower situation was basically a seller's market. The supply situation has altered markedly since that time and while there is not necessarily an oversupply of doctors in all specialties there is now a such more generous supply.

In addition to the arguments expressed in the Interim Report, the Committee has been advised that amendments to the private practice arrangements may be necessary due to doubts about the taxation position of private practice trust funds and the legality of Scheme A under Section 17 of the Health Insurance Act.

In 1980/81 staff specialist private practice fees totalled $25 million. Of this amount $10 million was retained by the hospital as a facility charge, $6 million placed into the staff specialist trust funds and a further $9 million paid to staff specialists as salary supplementation.

Having heard evidence from the New South Wales Public Medical Officers Association (representing salaried staff specialists), the Australian Medical Association (New South Wales Branch) and the Health Commission of New South Wales, the Committee has concluded that the current arrangements should not continue.

The present private practice arrangements, in particular Scheme C, are out of line with those in other States. In a report prepared for Commonwealth and State Health Ministers in May 1981, a working party of the National Standing Committee (Hospital Agreements) outlined the private practice arrangements in other States.

In South Australia two arrangements exist. Scheme A (which excludes pathologists) limits salary supplementation to a maximum of 25% with an expense allowance based on 20% of total fees collected limited to a maximum of $4,000. Scheme B (principally pathologists) also has a salary supplementation limit of 25% with an additional 5% paid to a research and travel fund. Victoria limits salary supplementation to 25% also. In Tasmania the limit is 35%. The limit in Western Australia is 25% with the residual fees income being paid into a trust fund controlled by the Hospital Board. Queensland, as noted earlier, does not provide a right of private practice to salaried staff specialists.

The Committee is also concerned that there are insufficient controls on the utilisation of private practice trust funds. While the number of trust funds varies from hospital to hospital, they are generally based on individual departments or specialties with control of the fund being with the participating staff specialists and not with the hospital.

Consequently, high revenue producing areas, particularly radiology and pathology, have greater access to funds for travel, research and equipment than other departments in the hospital. The present system does not ensure that the expenditure of trust fund monies is in the areas of greatest need in the hospital. To overcome this problem a single trust fund, administered by the hospital, should be established at each hospital. Expenditure from this fund should be for the benefit of the hospital as a whole rather than individual doctors or departments.

The level of facility charges levied by hospitals to compensate for services rendered to staff specialists currently range from 20 - 90%. The services provided by hospitals include consulting rooms, nursing and clerical support staff, diagnostic and other equipment and all services related to billing, fee collection and accounting. The A.M.A., in its submission to the 1981 inquiry on medical benefit fees, stated that practice costs (excluding motor vehicle costs) consumed 43.71% of the gross income of specialists. As these costs are largely met by the hospital in the Case of salaried staff specialists, the Committee would not see as unreasonable a rise in the minimum facility charge from the current 20% to 40% of the medical benefit fee.

The Committee sees no reason why. three separate private practice arrangements should be continued. On equity grounds alone, there should be one uniform arrangement for all salaried staff specialists.

The difficulties experienced by the. Committee in compiling information on private practice income have also highlighted the need for greater accountability to the public in the expenditure of these funds.

In the event of the continuation of a right to private practice for salaried staff specialists the Committee recommends:

* the terminat ion of Schemes A and C.

* modification of Scheme B to limit private practice income to say 20% of salary.

* review of the facility charges levied on private practice income by hospitals to more accurately reflect the cost to the hospital of services provided to staff specialists.

* modification of trust fund arrangements to ensure that all surplus private practice income is placed in one hospital trust fund to be used for the benefit of the whole hospital.

* total private practice income, summary details of its disbursement and trust fund balances be published in hospital annual reports.

Charges for the Use of Hospital Facilities Medical Practitioners (Facility Charges)

Apart from salaried staff specialists, facility charges are currently levied on visiting medical practitioners only in a limited number of areas - radiology, pathology and radiotherapy.

The Health commission of New South Wales and many hospital submissions to the Committee have advocated an extension of facility charges to other visiting medical practitioners. If fee for service payments to visiting medical staff are to be retained, the extension of facility charges would appear to be appropriate.

However, there are a number of problems inherent in extending facility charges. The major concern of the Committee is the need to ensure that such a charge is not passed on to the patient either directly or indirectly through the medical benefits fee system.

With diagnostic services, it is generally accepted that there is a "non-professional" component. in the medical benefit fee established for that service. This component covers the cost of the equipment, materials and technical support staff in providing the service. The remainder of the fee is a "professional" component to cover the doctor's personal input. Facility charges should theoretically cover the "non-professional" component.

With other medical services provided in hospitals by visiting medical staff, it is not clear as to whether there is a "non-professional" component in the medical benefit fee set for each service. Unlike the Canadian medical fee schedules, there i$ no clear distinction between these components in the compilation of medical benefit fees in Australia.

If facility charges are to be introduced the existence of a "non-professional" component would need to be argued before the Medical Benefit Fees Inquiry to avoid the charge being regarded as a practice cost and increasing the medical benefit fee and thereby passing on the charge to the patient through the health insurance system.

There is, of course, also a need to ensure that the doctor does not simply bill the patient directly for the facility charge. To avoid this possibility it would be necessary to require all visiting medical practitioners to charge no more than the medical benefit fee schedule when billing the patient. This could be incorporated within their conditions of appointment to the hospital.

In summary, the Committee recognises the appropriateness of an extension of facility charges but a number of practical difficulties remain to be overcome before this extension can occur.

In the event of a continuation of fee for service payments to visiting medical officers treating private patients the Committee recommends that:

* the Health Commission examine the feasibility of extending facility charges to all visiting medical practitioners.

* in concert with other State Governments, New South Wales seek the agreement of the Commonwealth Government to modification of the Medical Benefits Fee Schedule to clearly identify a "non-professional" component in medical benefit fees.

* that, as a condition of appointment, all visiting medical practitioners be required to charge no more than the medical benefit schedule fee for medical services provided to private patients in pub lic hospitals,

Extension of Sessional Payment for all Medical Services to "Hospital" Patients

As discussed in the Interim Report, medical practitioners are currently paid by the hospital for services rendered to "hospital" patients. Private patients are billed directly by the doctor. There are two methods of payment by the hospital - sessional and modified fee for service.

Until the recent revision of the sessional payment determination by Mr, Justice Macken, it was not economic to extend sessional payment to hospitals smaller than country base hospitals. Following this determination in October 1981 which provided for an all inclusive hourly rate of remuneration and revised on-call allowance there is now no reason why time based as opposed to fee for service based, payment should not be extended to all public hospitals in New South Wales.

In a number of hospitals the appoi ntment of full-time or part-time salaried medical staff may also be a viable economic proposition.

The Committee recommends that:

* sessional payments for medical services provided to "hospital" patients should be extended to all public hospitals.

Extension of Sessional Payment for Medical Services to all Patients in Public Hospitals

As foreshadowed in the Committee's Interim Report, the abolition of fee for service payments in the public hospital system represents an obvious alternative to the current pattern of medical practitioner remuneration. As adoption of this proposal would result in a major change to the medical profession's current practice, the Committee has examined this option in great detail.

Earlier in this section of the Report, the Committee drew attention to the two major factors influencing doctor generated hospital expenditure -the number of doctors with access to the hospital and the economic incentives available to the medical profession. It is beyond question that the goal of appropriate hospital utilisation and with it, control of hospital expenditure, requires attention to both these factors.

Other measures outlined in this report address themselves to these factors. However the major advantage of sessional payments is that it combines both factors giving much greater control of doctor generated demand. In the Committee's view, measures such as delineation of hospital roles and clinical privileges are both necessary and desirable and will assist in achieving more appropriate hospital utilisation.

However, these measures can do no more than modify the framework within which medical services are provided in public hospitals. To achieve more efficient hospital utilisation at a lower cost more effective controls on doctor generated demands for hospital services are required. The experience of Queensland, New Zealand, the United States, Canada and the United Kingdom has clearly shown that salaried and sessional payment systems for medical services are the most effective means of achieving these goals.

The Committee's Interim Report outlined the basic details of a fully sessional system. Under this. system, patients would not be charged medical fees by their doctor. Instead,. doctors would be remunerated on a sessional basis by the hospital.

To offset the costs associated with sessional payment, the hospital would charge a medical service fee in addition to the daily bed charge. The medical service fee, being a hospital charge, would be fully covered by basic hospital insurance. As there would be a corresponding fall in basic medical insurance rates there would be no increased cost to the patient.

The Health Commission of New South Wales has estimated that sessional payments for all medical services in public hospitals will total approximately $60 million per annum. To cover these payments and revenue losses resulting from the abolition of rights of private practice for salaried staff specialists, a medical service fee of $22 per day would be required.

The adoption of a medical service fee of $22 per day would require a rise in basic hospital insurance premiums of under $1 per week. This rise would be offset by a fall in basic medical insurance premiums of at least the same amount. However, patients currently being charged by the doctor treating them would no longer have to meet the 15% gap between the fee charged and the medical fund rebate, resulting in an immediate saving to the patient. In the long term, additional savings would occur as the demand for hospital services fell leading to a fall in health insurance premiums.

The introduction of sessional payments would also lead to savings for both the State and Commonwealth Governments. The Commonwealth Government would immediately save the 30% of medical benefit fees it now pays for medical services to private patients in public hospitals - this saving has been estimated at $42 million per annum and is based on an estimate that medical benefit payments in New South Wales total approximately $620 million per annum. Of this sum,23% relates to medical services provided to private patients in New South Wales public hospitals. As the Commonwealth pays 30% of all medical benefits the saving to the Commonwealth is 30% of $142.6 million, approximately $42 million. In addition, as sessional payments will lead to a lowering in the demand for, and utilisation of, public hospital facilities long term savings will occur in the subsidies required to operate the New South Wales public hospital system.

Details of the Health Commission costing are shown in Table 3. The costing assumes that salaried staff specialists will be granted a 16% salary rise to compensate for loss of private practice income.

TABLE 3

COSTING OF SESSIONAL/SALARIED MEDICAL SERVICES FOR ALL PATIENTS IN NEW SOUTH WALES PUBLIC HOSPITALS (Based on 1980/81 costs and activity levels)

1.	PAYMENTS TO VISITING MEDICAL PRACTITIONERS	
	Current payments for treatment of "hospital" patients	$34.2M
	"Hospital" bed days as a proportion of total bed days	46.2%
	Estimated total payments for treating all patients ($34.2M - 0.462)	$74.0M
	.'. ADDITIONAL COST (1)	$39.8M
2.	ADDITIONAL SALARIES TO STAFF SPECIALISTS	
	16% salary rise, plus restoration of salary reduction under Scheme C (average 20%)	$10.9M
3.	LOSS OF FACILITY CHARGES	$10.0M
	TOTAL COST	$60.7M

(1) This figure would be overstated to the extent that all outpatient services are now already paid by the hospital, but is understated to the extent that sessions have not yet been taken up by some visiting medical staff.

The Committee has also obtained an independent costing from Dr J. Deeble, head of the Health Research Project at the Australian National University. Dr Deeble has estimated that medical services to inpatients of public hospitals account for approximately 23% of medical insurance costs. A 23% fall in medical insurance costs would reduce the basic medical insurance premium by $1 per week.

The costs of introducing sessional payments have been estimated by Dr Deeble as being somewhat lower than that calculated by the Health Commission. His figure was $55 million. Dr Deeble estimated the rise in basic hospital insurance premiums necessary to cover these costs as being about 85 cents per week. This rise would be more than offset by the $1 fall in medical insurance premiums.

In view of the convincing evidence available that a salaried and/or sessional system of payment for medical services results in a more efficient hospital system with resultant savings to the community, the Committee paid close attention to arguments against the introduction of sessional payments put forward by a number of witnesses.

The main antagonist was the New South Wales Branch of the Australian Medical Association. In its second submission to the Committee the Association commented on the proposal in the following terms:

" ... the proposal for total
sessions throughout the public hospitals system is a concept that would not be in any way acceptable to the practising medical profession in this State.

It is tantamount to Socialisation of Medical services ...".

The Association placed great emphasis on an apparent alteration to the doctor-patient relationship under a sessional payment scheme alleging that there would be no direct contract between the patient and doctor. In the Association's view there would be "a hardening of the attitude of the medical profession; they will not feel the same personal involvement with their patients"

The Association was unable to advance any cogent argument against sessional payments on clinical or economic grounds. In answer to a question concerning the standards of medical care for "hospital" patients treated by visiting medical practitioners currently paid on a sessional basis the Association agreed that the patients received the "same standard of clinical excellence" as that given by the same medical officers to their private patients.

In answer to a question concerning the level of remuneration under sessional payments, the Association argued that its opposition related to the method of remuneration rather than the level of remuneration itself.

However, in the absence of any other sustainable objection from the Association, the Committee can only conclude that the higher level of remuneration under fee for service payments is, in fact, the Association's real objection to sessional payments. (A survey by the Queensland Department of Health suggests the cost of fee for service payments is, on average, five times greater than sessional payments, and in some specialties, eight times greater).

In essence, the Association argued that the introduction of sessional payments for services to all patients would change the whole attitude of doctors to the treatment of patients in public hospitals solely because their method of payment changed. In the words of one Committee member the evidence from the Association suggested that "we are looking at a Dr Jekyll and Mr Hyde situation".

As the majority of patients in Queensland public hospitals are treated by doctors paid on a salaried or sessional basis, the Committee visited a number of public hospitals in Brisbane and held extensive discussions with hospital administrators, the Department of Health and the Queensland Branch of the Australian Medical Association. The Committee was unable to find any evidence that sessional payments had resulted in a poor standard of care or a detrimental effect on the doctor-patient relationship.

Apart from some minor disagreement about the level of remuneration (sessional payments in Queensland, unlike New South Wales, are not determined by an independent arbitrator), the Queensland Branch of the A.M.A. had encountered few problems with sessional payments. There had been an overwhelming acceptance by the public, health administrators and the medical profession of this form of remuneration.

Another argument advanced to the Committee against sessional payments was that it removed the patient's "right" to choose his/her doctor in hospital. In the Committee's view, the "right" to choose one's doctor will only disappear if the medical profession refuses to co-operate in meeting the patient's request.

In discussions with hospital administrators it is apparent to the Committee that the majority of private patients do not in fact choose their own doctor - the choice is made for them by their referring general practitioner. In many cases private patients admitted through Casualty have never met the doctor treating them in hospital prior to their admission.

The ability of patients (or, in reality their referring doctor) to choose a particular doctor under a sessional system of payment was examined by the Committee during its discussions in Queensland. Hospital administrators and the Queensland Branch of the Australian Medical Association both agreed that it was possible for patients to be treated by a particular doctor. This could be accomplished in a number of ways, the most common being a referral by their local doctor to a particular specialist appointed to the hospital who then arranged the patient's admission under his care. Wherever possible the hospital ensured that patients admitted through Casualty were put under the care of a particular doctor if this was requested by the patient. This arrangement, of course, depended on the co-operation of the doctor concerned.

"Hospital" patients in New South Wales are also often admitted under the care of particular doctors even though the doctors concerned are paid on a sessional basis. The only barrier to this system continuing would be lack of co-operation on the part of the medical profession.

Concern was also expressed by some witnesses from the Health Commission that the introduction of sessional payments for all public hospital patients could result in a "two-tier" system of health care. As medical practitioners will be paid for all services provided in public hospitals the Committee is unable to see the logic in such an argument. In view of the specialised facilities and sheer size of the public hospital sector, a wholesale exodus to private hospitals would appear to be most unlikely.

Evidence to the Committee suggests that there is a fairly stable group of patients and doctors who are the "natural" clientele of private hospitals. The private hospitals meet a certain specialised need. Most people distinguish quite clearly between the role of the private hospital and that of the public hospital. The private hospital is seen as being an area of convenience while major illnesses and emergencies are automatically thought of as being She public hospital's domain. In a mixed private and public hospital system the percentage of patients using the private sector tends to average 25 - 30%. This figure is supported by the experience in both Queensland and New Zealand. The Committee has noted that Queensland has more private hospital beds per head of population than New South Wales.

In its evidence to the Committee, the Health Commission expressed some concern that it would be unable to implement this proposal at the present time as "there were too many things on our plate at the moment" The principal problem seen by the Commission was the expected hostility from the medical profession. In view of the need to contain and control hospital expenditure and the acceptance by the Commission that the large role of fee for service medicine in public hospitals is "a major obstacle to maximising efficient use of resources in hospitals", the Committee is surprised that the extension of sessional payments is not seen by the Commission as a matter warranting serious consideration and a high priority.

In summary, the Committee regards the payment of visiting medical practitioners in public hospitals on a sessional basis as being the single, most effective measure available to contain and control hospital expenditure. The proposal provides an effective and flexible control over doctor generated demand for hospital services and in addition removes the economic incentive inherent in fee for service payments.

The Committee can see no reason why the quality or standard of clinical care of patients should decline. Indeed to the extent that the change leads to a reduction in inappropriate or unnecessary hospitalisation and investigation the standard of care will be improved.

In financial terms the proposal provides real savings to the public, New South Wales and Commonwealth Governments. Combined medical and hospital health insurance rates would remain unchanged in the short term and would fall in real terms due to a more efficient use of hospital resources. Patients would no longer need to meet the costs of the "gap" between the fee charged by the doctor and the medical fund rebate.

The Commonwealth Government would save a minimum of $42 million per year in medical benefit payments. When its payments under the Pensioner Health Benefit and other schemes are considered the saving is even greater.

As the costs of extended sessional payments would be covered by basic hospital insurance, adoption of this proposal would be at no cost to the Suave Government and long term savings would follow the more efficient utilisation of hospital resources.

The implementation of this scheme is likely to meet strong resistance. The Australian Medical Association, for example, has threatened industrial action. To counter such resistance and ensure that it does not adversely affect patient care, the Committee recognises that the implementation of the scheme would need to be preceded by careful groundwork.

The Committee recommends that:

* visiting medical practitioners be remunerated for medical services to all patients in New South Wales publ ic hospitals on a sessional rather than fee for service basis. The Public Hospitals Act be amended to prohibit charges being raised by any medical practitioner for services provided to a patient in a public hospital.

* the salary and conditions of salaried staff specialists be appropriately reviewed in the light of abolition of their rights to private practice.

* to facilitate the extension of sessional payments for medical service to all patients in public hospitals at an app ropriate time the Public Hospitals Act be amended to

  - appropriately redefine the positions of visiting medical practitioner and visiting medical officer to create a single category of visiting medical appointee

  - determine, at a specified date, all current visiting medical practitioner appointments to public hospitals with a savings provision giving preference to current appointees when appointments to the new positions are being made.

RECOGNISED 2ND, 3RD SCHEDULE HOSPITAL INCOME AND EXPENDITURE - NEW SOUTH WALES 1960/81

(Source Quarterly, Monthly Return Aggregates June, 1981)

EXPENDITURE .	$ MILLION	% G.O.P.
Salaries and Wages (Non Medical)	783.85	63.6
Salaries and Wages (Medical)	86.52	7.0
TOTAL SALARIES AND WAGES	870.37	70.6
Superannuation.	27.28	2 2
Payments to VMOs	34.43	2 8
Food	30.41	2 5
Drugs	36.61	3 0
Medical/Surgical Supplies	36.53	3 0
Special Service Supplies	40.58	3 3
Fuel, Light and Power	19.83	1 6
Domestic Charges	33.46	2 7
Renovations	4.00	0 3
Replacements and Equipment	18.44	i 5
Repairs and Maintenance	18.79	1 5
Administration	60.89	4.9
Other	0.05	-
GROSS OPERATING PAYMENTS (G.O.P,)	1,231.76	100.0
RECOVERIES		
Meals and Accommodation	9.78	0.8
Services to Other Hospitals	25.78	2.1
Superannuation Repayments by Employees	12.12	1.0
NET OPERATING PAYMENTS [1]	1,184.08	96. i
RECEIPTS		
Patient Fees	203.57	16.5
Nursing Home Benefits (Commonwealth)	0.03	-
Specific Grants	1.61	0.l
Other Revenue	12.93	1.0
TOTAL RECEIPTS	218.14	17.7
NET OPERATING COST [2]	965.93	78.4
COMMONWEALTH/STATE SUBSIDY	950.87	77 . 2
CASH SHORTFALL [3]	15.07	1.2

1. Net Operating Payments represent Gross Operating Payments less Recoveries.

2. Net Operating Cost represents Net Operating Payments less Receipts.

3. Cash Shortfall represents Net Operating Cost less Commonwealth/State Subsidy.

RECOGNISED 2ND, 3RD SCHEDULE HOSPITALS ' SALARIES AND WAGES ANALYSIS - NEW SOUTH WALES - 1980/81,.

Category	Number Staff S & W 30.6.81	% Total	S & W (1) $M.	% Total
General Admin/Clerical	6,038	10.4	84.30	9 7
Medical	2,579	4.5	76.66	8 8
Nursing	26,359	45.5	378.76	43 5
Radiology (Med)	97	0.2	2.65	0 3
Radiology (Non Med)	703	1.2	12.93	1 5
Radiotherapy (Med)	36	0.1	1.36	0 2
Radiotherapy (Non Med)	176	0.3	2.55	0 3
Pathology (Med)	172	0.3	5.85	0 7
Pathology (Non Med)	1,491	2.6	27.69	3 2
Pharmacy	380	0.7	7.12	0 8
Other Ancillary	4,454	7.7	63.89	7.3
Dietary & Food	5,111	8.8	70 68	8.1
Housekeeping	6,658	11.5	85.46	9.8
Laundry	1,028	1.8	12.07	1.4
Steam and General	2,610	4.5	38.36	4.4
TOTAL	57,892	100.0	870.37	100.0

(1) Salaries and Wages

SALARIES AND WAGES AS A PERCENTAGE OF GROSS OPERATING PAYMENTS

Medical Salaries	86.52	7.0
Nursing Salaries	378.76	30.7
Paramedical Salaries	114.22	9.3
Other Salaries	290.87	23.6
TOTAL SALARIES	870.37	70.6