Public Accounts
Committee
Parliament of New South Wales


# Report on the New South Wales Ambulance Service

Report Number 44 February 1989

The New South Wales Public Accounts Committee is composed of five members of the Legislative Assembly of the New South Wales Parliament. Its functions and powers are defined in the Public Finance and Audit Act and its role generally is to serve as a Parliamentary watchdog of government expenditure to ensure that government organisations are implementing government policy as efficiently and effectively as possible.

# CHAIRMAN'S FOREWORD

It is hoped that the recommendations in this report will provide a framework to enable the New South Wales Ambulance Service to restructure for more effective and efficient management of its resources and, therefore, to be better equipped to undertake its vital role in the delivery of health services in this State.

The Committee was concerned that the Service appeared to be slow in grasping the complex and necessary requirements of modern management despite an extensive number of reviews into its operations over the last decade or so.

Burdened with a cumbersome and out dated management structure and a less than impressive financial management system, the Committee is aware that areas such as vehicle type and numbers together with Real Estate Property Management will need considerable attention to enable the general public to obtain a realistic value for money return in the provision of ambulance services throughout New South Wales.

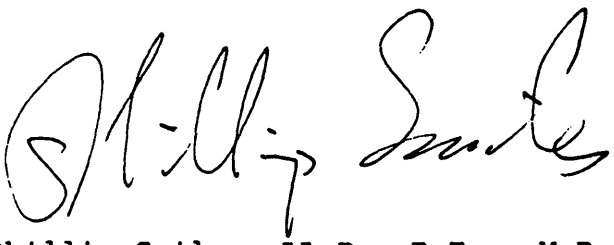
Inherent in this lack of modern management practice on the part of the New South Wales Ambulance Service are failures associated with matching officer training to need, vehicle numbers, delineation of emergency and non emergency services, a top-heavy management structure and inflexibility associated with Real Estate management.

Nevertheless, I must stress that the Committee was very impressed with the dedication of Ambulance Officers, at all levels, to their duty, particularly given the often traumatic nature of their work.

This report arises from a reference to the Public Accounts Committee of the 49th Parliament by the Minister for Health, The Hon. P. E. J. Collins, M.P., a member of the Committee between March 1983 and August 1984.

I wish to thank officers of the Ambulance Service and the New South Wales Department of Health for their willing co-operation during the Inquiry. Also, I would like to express my appreciation for the valuable assistance provided by the St John Ambulance Service (South Australia), the Queensland Ambulance Transport Brigade, HCF Careflight Limited and all other individuals and organisations that made submissions to the Inquiry.

Finally, I would like to thank the Committee's Secretariat for their work during this Inquiry. In particular, I extend my thanks to Mr Chris Thompson for his research contribution to the Inquiry and to Miss Maria Hagispiro for her highly professional secretarial assistance.



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CHAIRMAN.

# EXECUTIVE SUMMARY

The Committee found that the Service has a cumbersome management structure that does not reflect modern management practices. While this has to some degree resulted from the evolution of the Service from a large number of district Committees, the issue needs to be addressed.

A restructure of the Service management is proposed. The Committee recommends that the Ambulance Service be maintained as an autonomous body responsible directly to the Minister for Health. To provide much needed management expertise the Committee recommends that a five member board appointed by the Minister be established to manage the Service.

Throughout the Inquiry evidence was received of management inadequacies particularly in the area of personnel management, including officer morale and inefficiences in the allocation of workforce resources.

Financial issues addressed by the Committee included the accounting for fees, varying fee structures for different services and the need for cost-cutting.

The Committee has recommended a reconsideration of the use of private debt collection agencies and the introduction of credit card facilities. The Committee considers that an alternative to the health insurance levy needs to be considered to achieve more efficiency in fund raising.

The proposed introduction of a Computer Aided Despatch System by the Ambulance Service is welcomed. It will improve the existing communications system. The prompt introduction of this should be a priority.

Some problems in the management of the Service's properties were apparent. A number of recommendations have been made to ensure that the most effective use of property is achieved.

Extensive use of non-ambulance administrative vehicles as opposed to patient carrying vehicles was noted by the Committee during the Inquiry and a rationalisation of the fleet has been recommended.

The Committee was pleased to note the development of guidelines to provide for better utilization of the helicopter rescue-retrieval service by the Ambulance Service given the vital role these services play. However, the Committee has doubts about the equitable distribution of funds between the two helicopter rescue services.

A major financial problem faced by some hospitals, particularly those smaller rural ones, is the cost burden of inter-hospital transfers by the ambulance. Differential ambulance transport fee structures and a reassessment of the means by which funds are allocated to hospitals are proposed as means of addressing this problem.

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# LIST OF RECOMMENDATIONS

A full list of the Committee's recommendations follows. The recommendations are listed consecutively and should be considered in light of the discussion in the relevant chapters.

## CHAPTER 1

**Recommendation 1**

That no major reviews of the operations of the Ambulance Service be undertaken within the next three years.

## CHAPTER 2

**Recommendation 2**

That the Ambulance Service retain a separate Regional management structure from that of the Department of Health.

**Recommendation 3**

That a representative from the Ambulance Service be included on Area and Hospital Boards.

**Recommendation 4**

That the present management structure at Regional and Area levels be streamlined so as to reflect modern management practices, with leaner management and operational orientation.

**Recommendation 5**

That at ambulance stations where the four by four roster system is operating supervisors be appointed for each shift in place of a Station Officer.

**Recommendation 6**

That the Service appoint officers to Regions/Areas rather than to stations and that staff/establishment numbers be determined at Regional/Area level.

## CHAPTER 3

Recommendation 8

That seniority not be included as a criterion for promotion within the Ambulance Service.

Recommendation 9

That Ambulance Service management make all efforts to ensure that unavoidable downtime be used in a productive manner, for example, course study, skill maintenance, clerical, other station maintenance duties and community work.

Recommendation 10

That the Service ensure that shift times always reflect the demand for services.

Recommendation 11

That negotiations be undertaken to standardise award conditions for all ambulance officers throughout the State.

Recommendation 12

That the Service develop adequate performance indicators so that the level of clinical training is set at an appropriate level.

Recommendation 13

That the future staffing requirements of the Service be determined on the basis of a suitable strategic/management plan.

Recommendation 14

That, despite funding/resources constraints, resources be allocated to upgrade the level of driver training for Ambulance Officers.

Recommendation 15

That management training for Ambulance Officers be reviewed with particular emphasis on the need for outside recognition of `in house' courses and the provision of adequate assistance for Officers to undertake appropriate courses at TAFE colleges, and Colleges of Advanced Education and Universities.

Recommendation 16

That practical training/work experience in appropriate hospital areas for ambulance Officers be enhanced.

## CHAPTER 4

Recommendation 17

That areas for cost cutting within the Service be explored and that the fee structure be set to reflect costs.

Recommendation 18

That consideration be given to the introduction of a sliding scale of fees for Air Ambulance trips to recognise the decreasing unit costs for longer trips.

Recommendation 19

That the feasibility of setting non-emergency transport fees at a different scale from emergency transport fees be considered.

Recommendation 20

That consideration be given to accounting for funds paid into and expended out of Special Projects Accounts through an account in Treasury, so that transactions are included in the Public Accounts.

## CHAPTER 5

Recommendation 21

That a normal component of patient care and management by Ambulance Officers should include obtaining patient details for billing purposes where practicable.

Recommendation 22

That credit cards be accepted for the payment of ambulance transport fees.

Recommendation 23

That a further examination of the feasibility of joint accounts with hospitals be undertaken.

Recommendation 24

That the Ambulance Service consider the feasibility of using private debt collection agencies paid on a performance basis.

## CHAPTER 6

Recommendation 25

That the introduction of Computer Aided Despatch system and telephone patching be introduced into the Ambulance Service communication system as a matter of priority.

## CHAPTER 7

Recommendation 26

That where feasible, ambulance stations be located on hospital grounds.

Recommendation 27

That all avenues for the multi-use of ambulance station facilities be pursued.

Recommendation 28

That appropriate financial incentives be put in place to encourage the leasing out of any surplus Ambulance Service properties or space therein.

## CHAPTER 8

Recommendation 29

That the cost-effectiveness of a cheaper vehicle for non-emergency transport be examined.

Recommendation 30

That the feasibility of undertaking routine vehicle maintenance at night be closely examined.

Recommendation 31

That the efficiency and effectiveness of Ambulance Service repair workshops be reviewed within six months. This review should examine the Police Department's policy of using contractors to repair and maintain its F100 fleet.

Recommendation 32

That the cost effectiveness of clinical supervisors be reviewed.

Recommendation 33

That in conjunction with Recommendation 29 the feasibility of using some of the existing administrative vehicles, the station sedans, for non-emergency patient work be assessed.

## CHAPTER 9

Recommendation 34

The opportunities for the transfer of officers between the Air Ambulance and the remainder of the Ambulance Service be made available.

Recommendation 35

That the NSW Department of Health closely monitor the quality of service provided by the helicopter retrieval/rescue services and adjust its payments for services rendered to the Ambulance Service accordingly.

## CHAPTER 10

Recommendation 36

That within strict guidelines the feasibility of establishing a separate non emergency division within the Ambulance Service be considered.

Recommendation 37

That either:

i) the Regional/Area Offices of the Department of Health, rather than individual hospitals be responsible for the allocation and expenditure of funds to meet the costs of inter-hospital ambulance transport for hospitals under their jurisdiction; or

ii) hospitals be provided with an allocation specifically for inter-hospital transport which would be based on previous usage, that is not part of the hospital's global budget and is not available for any other purpose.

## CHAPTER 11

Recommendation 38

That an alternative to the Health Insurance levy be examined as a means of insurance against ambulance transport fees.

## CHAPTER 12

Recommendation 39

The PAC recommends, subject to the Gray Report, that emergency rescue services be undertaken wholly by one existing service.

## CHAPTER 13

Recommendation 40

That the level of fees charged for attendance at sporting fixtures represent the full cost to the Service including operational and capital costs.

# 1. INTRODUCTION

## REFERENCE FROM MINISTER

1.1 The Public Accounts Committee (PAC) received a reference on 4 August, 1988 from The Hon. P. E. J. Collins, B.A., LL.B., M.P., Minister for Health, to examine and report on the New South Wales Ambulance Service.

## TERMS OF REFERENCE

1.2 The Terms of Reference, set out in the Minister's letter to the Committee of 4 August, 1988 (see Appendix 1) are as follows:

i) to assess the impact of implementing recommendations of the 1982 Inquiry into the NSW Ambulance Service (Gleeson Report);

ii) to inquire into the efficiency and effectiveness of the management of ambulance services in New South Wales;

iii) to review the management and cost structure of the Ambulance Service;

iv) to examine the extent of improvements in the collection of outstanding unpaid ambulance transport fees since the PAC's inquiry into the matter in 1986; and

(v) to investigate any other matters relevant to the efficient operation of ambulance services in New South Wales.

## BACKGROUND

### THE NSW AMBULANCE SERVICE

1.3 The Ambulance Service (Service) was established under the Ambulance Services Act, 1976 and is part of the Health Administration Corporation which was constituted by the Health Administration Act 1982. Prior to 1976, when the Service was brought under the administration of the then Health Commissioner, it was a separate autonomous organisation.

1.4 The Service has two primary roles, the provision of emergency retrieval for the sick and injured and the transportation of patients in non-emergency situations to and from appropriate health services.

1.5 A fleet of 872 ambulances (including, *inter alia*, 814 general duties vehicles and 31 intensive care ambulances), 5 aircraft and 264 other road vehicles is operated from 217 ambulance stations by the Service which has over 2100 uniformed officers and 359 other personnel.

1.6 In 1987/88 total expenditure by the Service was $117.3M and an amount of $137.7M has been allocated for 1988/89 (4.1% of the State's total Health Budget of $3.350 million).

1.7 Receipts from ambulance transport fees totalled $26.9M in 1987/88.

1.8 During 1987/88 the Service transported 533,144 patients by road ambulance (13.9 million km) and 4,113 by air (1.9 million km).

1.9 All employees of the Service are employed under a special section (Section 14) of the Health Administration Act, 1982.

1.10 The level of clinical skill of the uniformed officers is constantly being upgraded following the introduction of paramedics in 1976. Currently, four levels of training are provided:

- Level 1 - probationary ambulance officers
- Level 2 - primary care ambulance officers
- Level 3 - intermediate life support ambulance officers
*
- Level 5 - advanced life support ambulance officers (paramedics)

* In 1989 the intermediate life support (level 3) is to be reclassified as level 4 with the level 2 (primary care) to be split into levels 2 and 3.

1.11 Paramedics operate in the Central District (Metropolitan), Hunter and Illawarra Regions and Level 3 officers are stationed in country areas.

1.12 The Service is headed by the State Superintendent who is responsible to the Minister for Health through the Secretary, Department of Health. Central Administration of the Service is undertaken by a Directorate. Operations are managed on a regional basis; the regional boundaries coincide with those of the Department of Health.

## METHODOLOGY

1.13 The methodology of the inquiry included inspections of Ambulance operations in NSW and interstate (Appendix 2), review of submissions, (Appendix 3), informal and formal contact with other sectors of the health care industry and public hearings (Appendix 4).

## PREVIOUS REPORTS/INQUIRIES INTO AMBULANCE SERVICE

1.14 The delivery of ambulance services in NSW has been the subject of a number of inquiries in the last decade or so. The PAC has noted that a number of correspondents in their submissions to this Inquiry expressed concern in this regard. Recent reports and studies on the Service have included:

- *"A Report on the Ambulance Transport Services of New South Wales"* - November 1965 (Slough Report)
- *"A Report on the Integration of Ambulance Services"* - January 1975 (Blackmore Committee)
- *"Report of the Working Party to Examine the Integration of the Ambulance Service into the Health Commission"* - May 1979 (Manley Report)
- *"Report of the Health Transport Services Task Force"* - April 1981 (Kille Report)
- *"Report of the Inquiry into the New South Wales Ambulance Service"* - July 1982 (Gleeson Report)

1.15 The PAC believes that adoption of the recommendations contained in this Report will provide a framework for the operation of the Service and that this should mitigate the need for any further reviews of the Service in the short to medium term, other than normal on-going internal management review. However, the Committee reserves its normal right to instigate a follow up inquiry should it appear that insufficient action and attention to the implementation of this Report occurs.

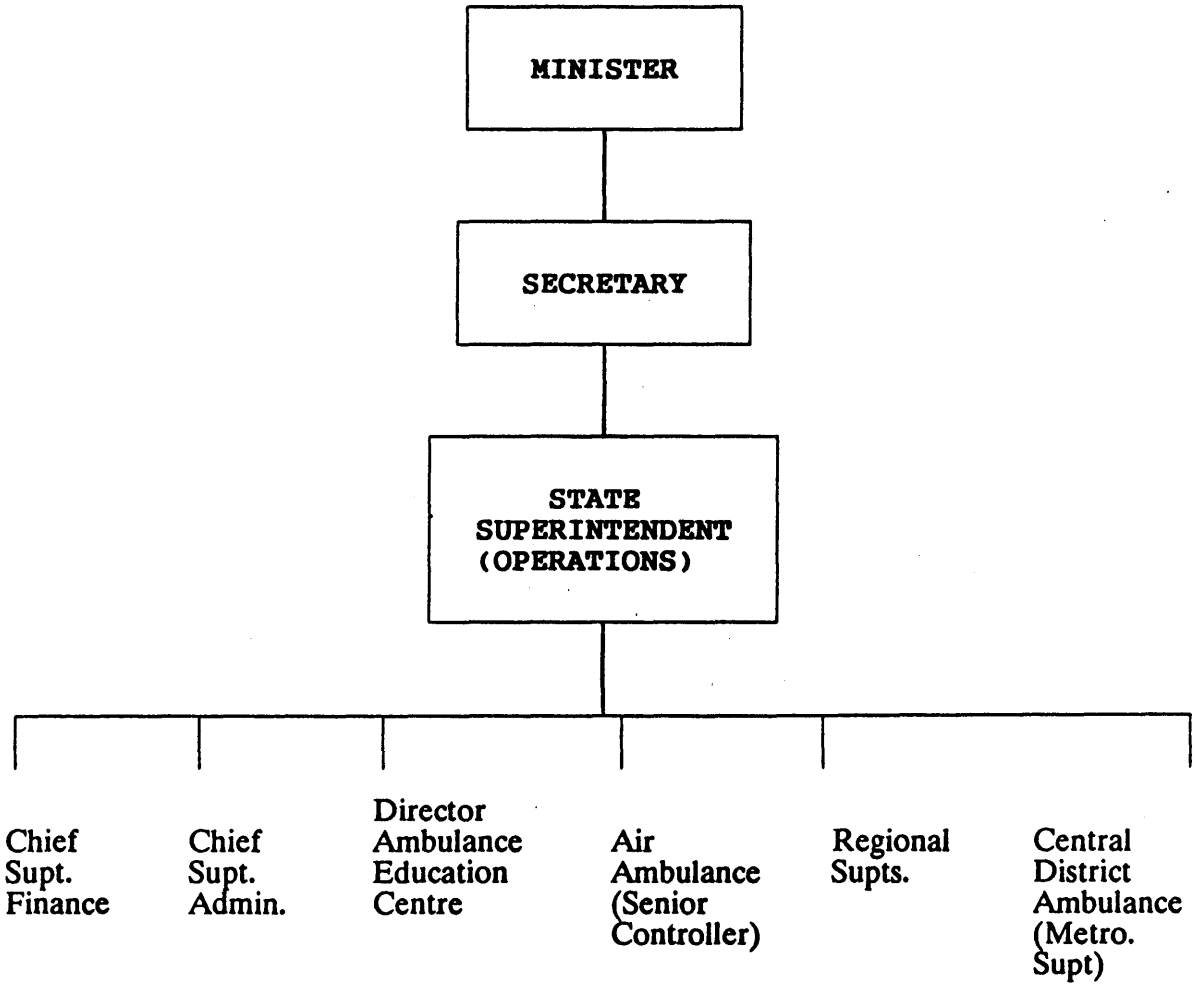
## Recommendation 1

1.16 **That no major reviews of the operations of the Ambulance Service be undertaken within the next three years.**

# 2. MANAGEMENT STRUCTURE

## EXISTING ORGANISATIONAL STRUCTURE

2.1 The NSW Ambulance Service has a regionally and functionally based organisational structure headed by a Directorate and is responsible to the Minister for Health through the Secretary, Department of Health. The following diagram outlines the structure:



2.2 The Chief Superintendent (Finance) is responsible for the overall financial management, communications and plant and equipment acquisition. The Chief Superintendent (Administration) is concerned with human resources, (but not training which is the responsibility of the Director, Ambulance Education), engineering division, counter disaster, general administration and research.

2.3 The Ambulance Education Centre, Air Ambulance, the Regions and the Central District are all separate operational units (cost centres).

2.4 A detailed chart of the structure is included in Appendix 5.

2.5 In the course of its inquiries the PAC has noted the following issues related to the organisational structure:

- some difficulties with the ambiguous relationship of the Ambulance Service with the Department of Health and with health services generally
- it is *"top heavy"*
- the difficulties associated with the complex inter-relationship of the various operational, clinical and administrative arms of the Ambulance Service.

## RELATIONSHIP WITH THE DEPARTMENT OF HEALTH

2.6 The Service has evolved from a primarily volunteer based, self-funded organisation to a sizeable Government authority. It has been amalgamated from a large number of separate districts into a Statewide service and this has had effects on the existing structure and personnel that need to be addressed.

2.7 As noted in one submission to the PAC, the evolution of the Ambulance Service:

> *"... from a public donation system to a public funded budget of $120 million (sic) p.a. required attributes unlikely to be internally generated overnight".*

2.8 This has resulted in, *inter alia*, conflicts over the years as to whether the Service should be part of the Health Department or Emergency Services.

2.9 In the course of its investigations the PAC has found evidence of a different ethos or culture in the Service from other areas of the Health delivery system. This goes some way, along with the Service's independent beginnings, to understanding the difficulties it has had in fitting in with the Department of Health structure. The Service is considered by some to have a *"blinkered"* view regarding health service delivery whereas, as one Regional Superintendent commented, the Health Department was more geared to the operation and needs of hospitals.

2.10 From the Department's point of view the Ambulance Service is a separate cost centre and for all intents and purposes is relatively autonomous. The State Superintendent concurred with this when he stated to the PAC:

*"... it should be a service separate from but forming part of the total health system."* (PAC hearing - 8th September, 1988)

2.11 During the course of the Inquiry the PAC noted that there had been conflict at the regional level between the Service and the Department. In discussions, officers from the Department indicated that savings of up to four administrative staff per region may be available to the Service if it were under the Department's Regional direction.

2.12 Senior Ambulance Officers indicated to the PAC that amalgamation of regional structures with those of the Department had not proved successful in the past. They felt the Ambulance Service did not have a clear enough path through regional to senior head office management when this had been attempted.

2.13 In some cases the PAC observed the effectiveness of the relationship between the Department and the Service at regional levels depended to a large extent *"on the personalities involved"* and that it is really up to senior management to maintain control, liaise with the Regional Health Office Executive Personnel and take appropriate measures to resolve any problems.

2.14 The PAC is of the view that a separate Ambulance Service Regional management structure should remain. Whilst part of the health delivery system the Service is in the transport sector requiring separate management skills. However, the PAC is concerned that savings and or greater efficiencies could be made from adjustments to the regional structure through close liaison with other Health Services.

2.15 The PAC considers that one means of implementing this would be for a representative from the Ambulance Service to be included on Area and Hospital Boards so that a greater appreciation of the respective roles can be gained.

2.16 A further difference between the Service and the Department is that Ambulance employees, both officers and administrative staff, are employed under Section 14 of the Health Administration Act, 1982, as are hospital employees, whereas Department employees are public servants.

## Recommendation 2

**2.17 That the Ambulance Service retain a separate Regional management structure from that of the Department of Health.**

## Recommendation 3

**2.18 That a representative from the Ambulance Service be included on Area and Hospital Boards.**

## "TOP HEAVY" STRUCTURE

2.19 It was apparent to the PAC during the course of the Inquiry that the organisational structure of the Ambulance Service is *"top heavy"* with a seemingly high number of qualified ambulance officers who are *"off the road"* doing supervisory and administration duties.

2.20 A good example, in the PAC's view, is the structure of the Regional administration and of Central District Ambulance (refer Appendix 6) where there appear to be excessive

levels of middle management (Superintendents and Station Officers), all of whom are qualified experienced ambulance officers who are not on the road doing what they are primarily trained for.

2.21 As one submission to the Inquiry stated:

> *"The Service is seriously "top heavy" with trained ambulance personnel who are performing many duplicated clerical tasks".*

2.22 While it is accepted that in some country regions factors such as distance, and population dispersion, may require larger than optimally desirable numbers of superintendents it appears to the PAC that the positions may have been created to provide promotional prospects for officers and not necessarily to enhance the effective and efficient operation of the Service.

2.23 The PAC is not convinced that the current structure is best suited to achieve that goal as there appears to be too many trained officers involved in administrative functions.

2.24 The PAC also noted on its inspections of Regional operations a case where a Superintendent (Finance), a uniformed officer, and an accountant (clerical officer), were both employed at Regional Headquarters.

2.25 The multi-tiered structure can also be seen as a consequence of a lack of strong leadership. As another commentator said on 29th September:

> *"... there is a certain feeling of goodwill, if you like, but no powerful leadership."*

2.26 The PAC considers that management structures need to be leaner at the operational (Region, Area) level to improve efficiency. A greater emphasis needs to be placed on operations and the structures should reflect this.

## Recommendation 4

2.27 **That the present management structure at Regional and Area levels be streamlined so as to reflect modern management practices, with leaner management and operational orientation.**

## STATION LEVEL MANAGEMENT

### (1) Shift Supervision

2.28 In the Central District Ambulance, *"Station Officers"* have administrative and clinical supervision roles but with the rostering system currently in use, the Station Officer is not available to supervise adequately. As the Metropolitan Superintendent, at the hearings on 27th September, said:

> *"with the four-by-four roster[1] you are really looking at three platoons - i.e., day shift, night shift, on days off."*

2.29 The Station Officer can only be on one shift at any one time and therefore is not available to provide the supervision over all shifts.

2.30 A significant number of comments were made to the PAC supporting the concept of a non-commissioned ranking structure similar to that in the armed services to provide more adequate leadership at the *"coal face"*.

[1] refer Chapter 3 for explanation.

2.31 The PAC is of the view that a system of *"shift supervisors"* should be considered as an alternative to the current structure of Station Officers, particularly in the Central District.

2.32 The shift supervisor would provide leadership in both management and clinical areas for those officers on each shift and be responsible for discipline of the shift, on the job training, reporting, stores requirements, etc.

## Recommendation 5

**2.33 That at ambulance stations where the four by four roster system is operating supervisors be appointed for each shift in place of a Station Officer.**

(2) Appointment of Officers

2.34 The PAC is concerned that the structural/management ethos has still retained some of the old *"District"* mentality. This is reflected, for example, in the existence of excessive Station Officer positions which, according to one regional officer, resulted from the old district structure.

2.35 It would seem more efficient to appoint officers to Regions/Areas rather than to stations. As the Regional Superintendent at Bathurst pointed out, if the Station at Blayney wound down he does have not the flexibility to relocate surplus officers without going through the process of altering staff numbers which are determined at the Station level.

## Recommendation 6

2.36 **That the Service appoint officers to Regions/Areas rather than to stations and that staff/establishment numbers be determined at Regional/Area level.**

## INTER-RELATIONSHIPS BETWEEN THE VARIOUS ARMS OF THE SERVICE

2.37 The PAC noted that the major issues in this regard were:

- the breakdown between non-emergency and emergency transport
- the relationship between the Directorate, Central District and the Regions
- the position of Air Ambulance
- flexibility of managers

## RELATIONSHIP BETWEEN DIRECTORATE AND OPERATIONAL ARMS

2.38 It has been brought to the PAC's attention that there have been a number of communication problems between the Directorate and Central District Ambulance, (CDA) particularly in response to Central District operational and management proposals/submissions. The PAC observed an apparent willingness by the Service to regard CDA in a manner significantly different from that of the Regions; it seems to be regarded as a separate autonomous body. However, no major problems in the relationship between the regional management and the Directorate are noted in the course of the Inquiry.

2.39 This raises the issue of how CDA should be perceived as fitting within the structure. It is the PAC's view that the CDA ought to be regarded, in terms of management and its relationship to the central administration body, as another, albeit larger and more diverse, regional structure.

2.40 The Air Ambulance is regarded as a separate and independent arm of the Service. It needs to be structured this way as it has unique operational requirements and operates across regional boundaries. However, its function is still essentially transportation. Consequently, the PAC is concerned about one aspect of this - the apparent inability for officers to transfer from the mainstream of the Service to the Air Ambulance. The operations of the Air Ambulance are considered in detail in Chapter 9.

## SUGGESTED STRUCTURE

### AMBULANCE BOARD

2.41 It is the PAC's view that the structure of the Ambulance Service should reflect its position as an autonomous body under the Minister for Health, more clearly define its position in relation to the Department and other areas of the health delivery system and provide for infusion of a higher level of management expertise.

2.42 After consideration of all the issues related to the structure of the Service, the PAC recommends the following structure as a proposal for consideration:

- There be an Ambulance Board.

- The proposed Board consist of 5 members appointed by the Minister as follows:

  - Two nominees from the private management sector;

  - One nominee from the public sector;

  - One Medical/Clinical Advisor; and

  - The senior uniformed Ambulance Officer.

2.43 Although a Board was established previously and abolished in 1976, it apparently had the express task of amalgamating the many district committees into a regionalised statewide ambulance service. It succeeded despite having in excess of 20 members;

2.44 A Board of this nature will provide much needed management expertise from outside the Ambulance Service while retaining decision-making input from within the Service and from the clinical area.

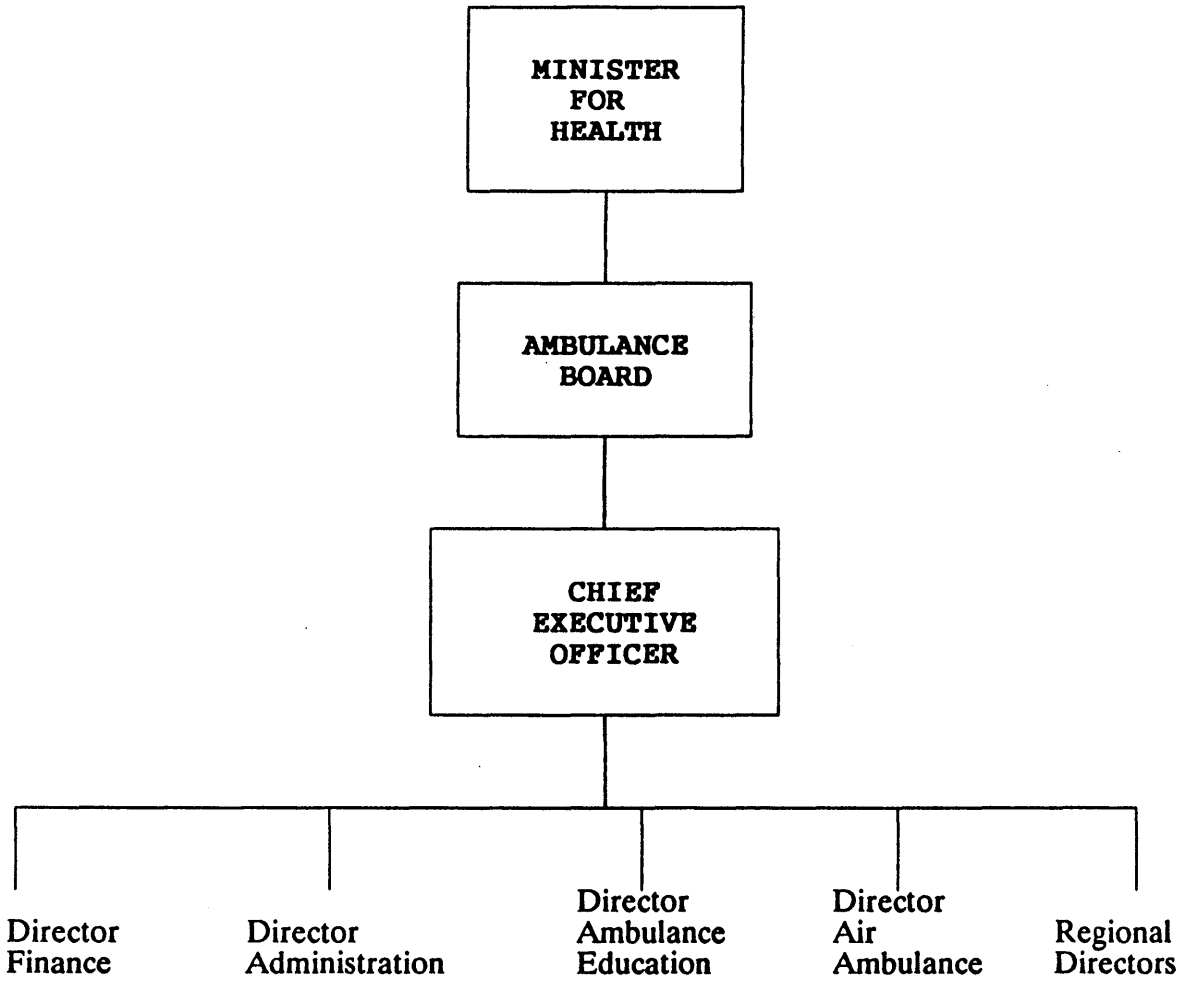
2.45 The PAC, during its inspections of Ambulance Service operations, was impressed with the quality and potential for senior management of a number of the ambulance officers with whom it had discussions. Nevertheless, it is felt that some fresh ideas from non-Service people will be of immense benefit to the Service and will compliment the skills of existing officers.

2.46 While the Service has considerable involvement in emergency situations, the major consideration is the medical result in terms of the patient and the level of care required to achieve this. Also, the non-emergency

activities of the Service utilise the same resources and contribute towards maximising their utilisation, particularly in country areas where emergency downtime is much greater.

2.47 For these reasons the PAC considers that the Ambulance Service should remain within the Health system and not become part of the emergency services administration.

2.48 The PAC recommended structure is as follows:



2.49 The above structure provides for the Service to remain within the Health system but retains the Ambulance Service as an autonomous body responsible and reporting directly to the Minister for Health.

2.50 The Chief Executive Officer, while not necessarily a member of the Board (unless nominated by the Minister as the senior uniformed Ambulance Officer), would act as Secretary to the Board.

## Recommendation 7

**2.51 That a Board be appointed by the Minister for Health to manage the Ambulance Service. The Board would have five members, being two nominees from the private sector, one nominee from the public sector, one medical/clinical advisor and the senior uniformed ambulance officer.**

# 3. PERSONNEL MANAGEMENT ISSUES

## ETHOS OF THE AMBULANCE SERVICE

3.1 It is apparent to the PAC from its investigations that a *"para-military"* ethos exists in the Ambulance Service. Investigations have indicated that this has derived from historical factors, in particular, the evolution of the Service from a self-funded, volunteer-based and fully autonomous organisation which was involved in emergency services with other para-military like organisations such as the police and fire brigade.

3.2 The PAC has found that the para-military ethos of the Service is manifested in the apparent code of discipline, military/police style uniforms and the rather insular nature of the Service. Indicative of this is the fact that all the top management - Directorate, Metropolitan and Regional have *"come up through the ranks"*. Promotion to senior and middle management positions from outside the Service seems non-existent. The then State Superintendent effectively verified this with his comment to the PAC:

> *"Remember that in my case I am coming up to 40 years service ... The other gentlemen (Chief Superintendents at hearing) are well into 30 years service ..."*
>
> (PAC Hearings 8th September, 1988)

## PROMOTION IN THE SERVICE

3.3 Senior ambulance officers have commented to the PAC that, in their view, to maintain a career service senior positions should be filled by uniformed staff. This is noted by the Secretary, Department of Health, who commented to the PAC:

> *"There is within the Ambulance Service a culture that ambulance officers are promoted from within..."*
>
> (PAC Hearings 27th September, 1988)

3.4 While the PAC concurs that a career structure in the Service is very necessary to attract people of suitable quality, there appears to be somewhat of an *"old boys network"* with seniority being the dominant criterion for promotion, particularly to senior management. The Secretary of the Department of Health has expressed concern in this regard, saying to the PAC:

> *"I do not know that there has been any other mechanism to have a promotion system that reflects probably late twentieth century management methods".*
>
> (PAC Hearings 27th September, 1988)

3.5 As Clause 27 of the Ambulance Employees (State) Award states:

> *"(i) promotions shall be by merit, seniority of service and qualifications required for each position."*

3.6 On the other hand, officers of the Service stressed to the PAC at hearings and in discussions that seniority was not the major criterion for promotion and supported this with a list of recent promotions and the criteria used to determine them. However, The PAC is not entirely

convinced, in all cases, of these assertions and further the PAC is concerned that seniority should be considered at all except as a rough indication of skill.

3.7 The PAC considers that seniority in clinical or ambulance service delivery should not be one of the criteria for promotion into management. Promotion should be based on merit as is the case for the Public Service and most other Government Authorities to maximise the likelihood of the most efficient people being promoted is maximised.

## Recommendation 8

**3.8 That seniority not be included as a criterion for promotion within the Ambulance Service.**

## MORALE

3.9 The PAC in its investigations has encountered what appears to be an undercurrent of low morale in the Ambulance Service.

3.10 The apparent morale problem in the Service concerns the PAC. In any organisation there inevitably will be a number of perennially dissatisfied employees, but in the case of the Ambulance Service it is most undesirable to have morale driven pressures placed upon and putting at risk the effectiveness of the Service. A morale problem means additional costs in terms of sick leave, resignations and inefficiency.

3.11 Information provided by the Department of Health shows that the attrition rate of ambulance officers was 8.7 officers per month (at 31/10/88) which equates to about 5% of its total workforce over 12 months.

## ISSUES AFFECTING MORALE

3.12 The issues affecting morale in the Service include application of discipline, the number of dismissals and subsequent reinstatements, the effectiveness of management, promotional opportunities, application of rosters, pressures placed on operational staff due to resources shortages and the very traumatic nature of the work at times. These issues were brought to the PAC's attention in submissions and from discussions with ambulance officers.

### (i) Discipline

3.13 A number of cases of dismissal were presented to the PAC in the course of the Inquiry. It is accepted that a strong code of discipline, while deriving from the paramilitary culture of the Service, has also developed because of the nature of the work dealing with trauma in an unstructured environment, and for this reason is necessary provided its application is consistent and fair.

3.14 However, it appears to the PAC that the application of discipline may not be consistent and be too excessive, particularly regarding dismissal. An officer of the Division of Human Resources, Department of Health told the PAC:

> *"... that the number of reinstatement cases for wrong (sic) dismissal on insufficient grounds for dismissal was quite high."*
>
> (PAC Hearings 27th September 1988)

3.15 The PAC considers this situation unsatisfactory as ambulance officers require extensive training and consequential dismissal is a significant forfeiture of talent. Also processes involved, in dismissal and reinstatement, are a use of resources better devoted to saving people's lives. The PAC also wondered whether discipline was not part of the *"status quo"* ethos and anyone breaking with tradition, even in ways not affecting their delivery of health care, was being victimised either knowingly or unknowingly.

(ii) Stress of the Job

3.16 The PAC appreciates the sometime distressing nature of the work of ambulance officers. The need for an adequate de-briefing process, (that is, after an accident, cot death, etc.) has been brought to the PAC's attention. As the Metropolitan Superintendent said:

> *"... The debriefing process is a very important one, in my view. The officers, in the course of their business, encounter many horrendous situations in any one day ..."*
>
> (PAC Hearings 27th September 1988)

3.17 However, the PAC noted that the Service has addressed this problem and a staff counselling program for ambulance officers has been in operation for over two years. The professional services of the Industrial Program Service are utilised and the program covers stress management and critical incident debriefing as well as counselling. The Industrial Program Service is a non-profit organisation which provides consulting, training and counselling services to industry. It is jointly managed by employers' and union groups.

3.18 It was suggested to the PAC that a social worker or equivalent professional be employed by the Ambulance Service to complement the above program. Such a suggestion may deserve consideration in future depending on the performance of the abovementioned program.

3.19 The services of any such program may be limited if the counselling is not entirely confidential and seen to be confidential. An officer would not be likely to seek counselling if likely to affect promotion prospects. However, it is noted that according to the Service's literature on the program, confidentiality for officers is to be preserved.

## ROSTERING

3.20 The Ambulance Service, being required to provide a 24-hour service, employs officers on rostered shifts. There are two basic systems:

i) A four-by-four roster is utilised in the Central District Ambulance and for the paramedics in the Hunter and Illawarra - it is based on officers working two day shifts of 9 hours, two night shifts of 14 hours and then four days off; and

ii) In the regions a straight eight hour shift system is used with officers on call in the smaller stations which are not manned for 24 hours. Larger stations are staffed 24 hours, medium sized stations are open from 8.00 a.m. to 10.00/11.00 p.m. and the smaller ones from 9.00 a.m. to 5.00 p.m.

3.21 There are variations in the application of rosters between regions depending on the workload and work pattern. Regional Superintendents and the Metropolitan Superintendent are responsible for the management of rosters within their area of responsibility.

## DOWNTIME

3.22 In its inspections of ambulance operations in country areas the PAC was primarily concerned with the following in relation to rostering:

i) the extent and productive use of downtime;

ii) rostered shift times versus the demand for services.

3.23 The PAC noted that due to a lower and more sparsely distributed population in the smaller country centres such as Bourke and Braidwood, the level of downtime is much higher than in, say, the Central District.

3.24 The PAC does recognise that, as an emergency service, the Ambulance Service would be ineffective if it were not available to respond within a reasonable time to an emergency and, therefore, some of the smaller stations are required for reasons of geography. Nevertheless, downtime needs to be reduced by changing shift times, reducing staff, or if it cannot be avoided, being used productively (e.g. follow up of accounts, statistics, etc).

3.25 Ambulance officers advised the PAC that downtime is to be used for study, maintenance of the station and promotional/community work. However, the PAC noted that in some cases the practice appeared different and found

considerable evidence of downtime not being productively used. Also, some industrial problems associated with demarcation were noted regarding officers undertaking maintenance duties.

## Recommendation 9

3.26 **That Ambulance Service management make all efforts to ensure that unavoidable downtime be used in a productive manner, for example, course study, skill maintenance, clerical, other station maintenance duties and community work.**

## SHIFT TIMES

3.27 The PAC observed that in some country centres, for instance, the ambulance station remained open during normal daily business hours when the workload was greatest during the evening. It was suggested by one Superintendent that this situation:

> *"... could easily derive from an historical expectation where the Service was a local community service and was visibly available from 9 to 5 ..."*
>
> (PAC Hearings 8 September 1988)

3.28 The abovementioned arrangement is inefficient and results in higher than necessary overtime costs, particularly when under their Award, officers are paid for four hours for call-outs irrespective of the length of time worked.

3.29 In respect of the four hour call-out payment a number of rorts where non-emergency transports were arranged at the end of shifts to gain overtime and/or call-out payments were brought to the PAC's attention.

## Recommendation 10

3.30 **That the Service ensure that shift times always reflect the demand for services.**

3.31 An issue that also concerns the PAC is the variation in roster conditions in the Hunter, Illawarra Regions and Broken Hill as a result of different award conditions. The maintenance of rosters in the Hunter region gave it the highest overtime cost/total salaries cost ratio in the State in 1987/88 (12.99%). The average for the State was 7.14%. Whilst the PAC is cognizant of the industrial relations climate in the Hunter Region and Illawarra and in Broken Hill it would be expected that negotiations would proceed to bring these regions with variations in awards into line with the remainder of the Service.

## Recommendation 11

3.32 **That negotiations be undertaken to standardise award conditions for all ambulance officers throughout the State.**

## TRAINING

3.33 The Ambulance Service has been consistently developing and enhancing the skills of its officers.

3.34 Training is provided in clinical and management areas. The PAC is concerned that the level of and type of training should be congruent with the mission of the Service, that it be cost effective in terms of resources applied and delivery of patient care and that it fit in

with the activities and responsibilities of other health workers.

3.35 In recent years - since 1976 when Paramedics were introduced - clinical standards in the Service have been upgraded.

(i) **Paramedics**

3.36 The PAC has noted varying opinions concerning the efficiency and effectiveness of paramedics. They are trained to perform high level resuscitative or primary patient care procedures in an unstable environment, i.e, at an accident scene. The State Superintendent told the PAC at the hearings of 8th September, 1988:

> *"... the main thrust of the paramedic is to allow better management of the emergency patient ..."*

3.37 The Medical Advisory Committee has encouraged this development. However, some medical opinion, including that of the Medical Advisor to the State Superintendent is that the Service may be trying to over extend its skills.

3.38 The PAC is concerned with cost effectiveness. The issue here is whether the extra training/cost of paramedics is more effective in terms of patient retrieval.

3.39 The PAC found that a recent Australian study[1] suggested that the use of paramedics was not necessarily leading to an improvement in patient survival. It stated:

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[1] Goldstein G., Potter D., *"A Prospective Controlled Trial of Pre-Hospital Intensive Care and Standard Ambulance Systems in Trauma Cases"* University of Sydney, March 1986

> *"Paramedic resuscitation increased the length of survival of severe trauma cases. More cases survived surgery to reach an ICU. However, there was an increased late mortality of critically injured, and overall mortality was not affected."*

3.40 The abovementioned study noted from evidence of overseas studies that the advantages of:

> *"pre hospital advanced trauma care were not as clear as those for coronary care (from which the concept of paramedics appears to have developed) because paramedic treatment of heart attacks is similar to that of a hospital. However, in other cases Paramedic treatment is only resuscitative, not definitive".*

3.41 The PAC accepts that it is not its role to judge on policy/clinical issues. However, the PAC is concerned that the Ambulance Service should not pursue expensive clinical training and the purchase of equipment to support such trained officers without a corresponding and proven improvement in patient care. For instance it costs an additional $15,000 to equip each Intensive Care (Paramedic) Ambulance vehicle.

3.42 The PAC was advised by senior officers of the Ambulance Service that the use of paramedics is not practicable in areas with a population base of less than 250,000. For this reason paramedics are only stationed in the Metropolitan, Inner Hunter and Illawarra (Wollongong) Areas.

3.43 There is an irony in this situation, as the PAC noted from its investigations, that the additional skills of the paramedic may be best utilised in the more remote rural areas where access to hospital care takes longer. It is also ironic that an officer in a remote area with much

downtime has the opportunity to study to achieve the higher paramedic levels, for example, in relatively isolated areas such as Braidwood, Walgett, Broken Hill but under current Ambulance administration is not permitted to do so.

3.44 The PAC acknowledges other approaches to patient retrieval including the St John Ambulance Brigade (South Australia) which operates the Service in that State and has adopted the *"quick scoop and run"* approach with an emphasis on quick retrieval to the nearest hospital with the minimum in resuscitative treatment on the accident/emergency scene.

3.45 Some criticism of the paramedic system has been brought to the PAC's attention in that patients in the Metropolitan area are *"over-treated"* rather than rushed to a relatively close hospital.

3.46 One medically qualified witness expressed concern to the PAC at the hearings of 29 September 1988, regarding the level of training. He stated:

> *"... There is a considerable concern with regard to training and in fact, equipment need seems to be driven by the training input rather than any measured need re potential and actual patients ..."*

3.47 One factor of the paramedic system that concerned the PAC during the course of the Inquiry was an apparent elitism. Paramedics tend to be regarded as a separate group within the Service; they are located only in specific areas/stations, use specialist vehicles and do not appear to be part of the general Service promotional structure. The PAC observed some degree of professional jealousy resulting from this.

3.48 The proposed introduction of level 4 officers in 1989 should go some way towards addressing this problem. The PAC believes that the paramedic or level 5 officer should be regarded as the top clinical rank.

3.49 Again, the PAC does not wish to be involved in clinical issues. The evidence presented to the Committee indicates that the Ambulance Service needs to develop, in line with its perceived *"mission"* so that the level of clinical training is set at an appropriate level.

## Recommendation 12

3.50 **That the Service develop adequate performance indicators so that the level of clinical training is set at an appropriate level.**

## STAFFING LEVELS

3.51 With regard to shortages of resources the Central District Ambulance submitted a document entitled "Staff Management Strategy 1987/88" outlining areas of activity cutbacks due to staff shortages. Some of these included:

- Supervision and maintenance of the in-service probationary officers' training program.
- Support and advice for ambulance officers in clinical matters.
- Lectures and demonstrations to community, corporate and medical groups (15 bookings cancelled).

- Liaison with hospital and other medical staff on paramedic or clinical matters.

3.52 The PAC is concerned that the Service employ an effective strategic/management plan to determine staffing needs. It is understood that the corporate plan prepared three years ago is being updated. Furthermore, the Service established a staffing review committee in early 1988. Its findings led to the Treasury approval to further funds in 1988/89 for the employment of an additional 125 officers.

## Recommendation 13

3.53 **That the future staffing requirements of the Service be determined on the basis of a suitable strategic/management plan.**

## DRIVER TRAINING

3.54 Evidence before the PAC suggests that the level of driver training is inadequate. Given that the Service's main business is transport and that officers are required to often drive at high speeds in all conditions in vehicles carrying patients and with up to $25,000 worth of equipment, training needs to be adequate to minimise the likelihood of accidents.

3.55 The Director, Ambulance Education, advised the PAC in discussions that currently 8 hours theory on driving techniques is provided within the level 1 training program. Insufficient funds are available to employ

instructors or train existing staff for practical training.

3.56 The PAC was also advised that the Service had negotiated with the Police Commissioner for the use of the driver training facilities at St Ives but the Service still needs to meet the cost of instructors.

3.57 In comparison, the NSW Fire Brigade, in which drivers experience similar circumstances to those in the Ambulance Service, incorporates a three-week driving course in its basic training utilizing its own certified instructors as well as Road Traffic Authority instructors. The course is conducted on the public road system and the Brigade's own obstacle course.

3.58 The PAC is greatly concerned at the apparent inadequacy of driver training, not only because patients and equipment may be placed at risk with inadequately trained drivers but also that new recruits can be required to drive at high speed in dangerous conditions.

## Recommendation 14

**3.59 That, despite funding/resources constraints, resources be allocated to upgrade the level of driver training for Ambulance Officers.**

## MANAGEMENT TRAINING

3.60 The PAC has noted that management training is provided within the Service's educational programs. Self-generated training by officers, i.e. at TAFE and Advanced Education Colleges, is also undertaken but no formal support is

given, e.g. study leave, fees assistance, as are provided by the Public Service.

3.61 Furthermore, with regard to the *'in house'* courses, they are not recognised outside the Service.

## Recommendation 15

3.62 **That management training for Ambulance Officers be reviewed with particular emphasis on the need for outside recognition of 'in house' courses and the provision of adequate assistance for Officers to undertake appropriate courses at TAFE colleges, and Colleges of Advanced Education and Universities.**

## HOSPITAL WORK

3.63 The PAC in its investigations found general support within the Service for the concept of practical training/experience in hospital casualty/intensive care areas. This is already utilized in Paramedic training.

3.64 The PAC considers that this type of training should be encouraged and expanded.

## Recommendation 16

3.65 **That practical training/work experience in appropriate hospital areas for ambulance Officers be enhanced.**

# 4. FINANCE

## FUNDING AND EXPENDITURE OF THE AMBULANCE SERVICE

### FUNDING OF AMBULANCE SERVICE

4.1 Funds are allocated to the Ambulance Service from the Consolidated Fund as part of the overall budget for the Department of Health, except for Special Projects Accounts (which will be discussed later). An amount of $130.3M has been provided in 1988/89 for recurrent expenditure and $7.36M for capital works; a total allocation of $137.7M.

4.2 The Service itself generates revenue from the collection of fees and other ambulance receipts, estimated to be $32.8M in 1988/89. Further revenue, estimated to be $42M in 1988/89, will be received from Health Insurance Levies. Under the Health Insurance Levies Act 1983 the previous Ambulance Contribution Scheme was replaced by a levy on contributors to private health insurance to cover them for the cost of ambulance services. This is discussed in detail in Chapter 11. All these receipts are paid into the Treasury (Consolidated Fund) and are not directly available for use by the Service.

4.3 Accordingly, the net Government contribution for recurrent services to the Ambulance Service for 1988/89 is estimated to be $55.5M ($130.3M less $32.8M less $42M). The actual net contribution in 1987/88 was $42.7M.

EXPENDITURE

4.4 The Schedule in Appendix 7 shows the actual recurrent expenditure and receipts by major items in recent years. The major item of expenditure is salaries and related costs which has consistently accounted for over 70% of total expenditure. This would be expected in a relatively labour intensive operation such as the Ambulance Service. However, it is one area where there may be opportunities to make savings through increased efficiency and structural change.

4.5 The Service received a significant increase of 13% over the previous year in its allocation for 1988/89, ($137.7 million). The increase was provided to enable the Service to recruit an additional 125 uniformed officers approved in 1987/88, which were not fully funded in that year.

## BUDGETING MECHANISM

4.6 The PAC is concerned at the late notification of budget allocations to the Service. Officers advised the PAC that the allocation for 1987/88 was not notified until November 1987 and the allocation for 1988/89 was not notified until September this year. The PAC is aware that the Treasury in recent years has modified the budgeting process to provide for earlier notification of allocations for inner budget sector departments to allow for more effective financial planning/management. However, there obviously has been a serious problem for the Ambulance Service in this area that needs to be addressed by the Department of Health. The Department is responsible for allocating the annual budget provision to the Service from within the total allocation provided for the Minister for Health.

4.7 The late notification of the allocation has forced the Service to operate on *"supply"* and in 1987/88 it operated on 85% of the previous year's allocation from July to November and 90% in 1988/89 until September.

4.8 Despite operating on less than the previous year's budget for this period senior officers advised the PAC at the hearings of 27th September, 1988, that services were not reduced. However, there were strategies to reduce expenditure, for example, reducing store inventories and replacing them when allocation was advised.

## EXTENT OF ALLOCATIONS

4.9 Officers of the Service expressed concern to the PAC regarding what they consider to be insufficient budget allocations in recent years. While additional funding has been provided in 1988/89 to enable the employment of additional officers, much of the concern in past years related to stores and equipment and petrol and parts allocations where price rises have been far in excess of the CPI factor allowed for by Treasury in determining allocations.

4.10 Some examples of price rises provided to the PAC include Telecom charges, vehicle parts and medical supplies. Examples were provided to the PAC at the hearings of 8th September by the Chief Superintendent (Finance):

> *"In the last year one very heavy increase was for...medical oxygen. The cylinder went from $1.12 to $1.97..."*
>
> and,
>
> *"Two years ago Telecom hit us with an increase of 27%."*

4.11 The PAC appreciates the Service's difficulties in this regard. An increasingly tight approach to budget allocation could reduce the effectiveness of the Service's operations. However, the PAC believes that, wherever possible, cost savings should be effected without reducing the quality of service to patients. Placing pressure on resources in the public sector is one means by which managers are forced to make more efficient resource allocation decisions. For example, the Service already is *"looking at Statewide deals"* (on stores/equipment) to reduce costs.

## AMBULANCE TRANSPORT FEES

4.12 Transport fees for both road and air ambulance as from 1 January 1988 are $2.79 per kilometre with a flat fee of $109.20 for the first 16 kilometres or part thereof. The maximum fee that can be charged for any one trip is currently set at $2,619 and fees are charged on a return trip basis.

4.13 The PAC is concerned with the following issues regarding Ambulance fees:

- whether fee levels accurately account for costs; and
- should there be differential fee structures between road and air ambulances and between emergency and non-emergency transport.

(i) Fee Levels and Accountability

4.14 Fee levels are adjusted annually on the basis of CPI and are proclaimed in the Government Gazette by the Minister for Health of the day. The Treasury directs the Department of Health as to the new level of fees at each review. Appendix 8 shows the levels of fees in recent years.

4.15 The PAC has been advised that the base from which the current fees have evolved (through CPI adjustments) was that level set by the previous District Committees which set fees at a high level to encourage membership of the then Ambulance Contribution Scheme.

4.16 The Auditor-General in his September 1988 Report commented:

> *"Charges for ambulance transports are clearly not based on a user-pays concept ..."*

4.17 However, the 16 kilometre *"flag fall"* seems to bear some relationship to the level of operation. It was set to reflect the average length per trip and thus be a means of covering the *"start up"* costs per trip.

4.18 The PAC, in the course of its investigation, encountered quite a deal of criticism of the high level of ambulance transport fees. However, a broadly based costing analysis based on 1987/88 operations set against the current fee structure suggests that the fee level is insufficient to cover costs or, conversely, costs are too high.

4.19 On a per kilometre basis, the average operating cost including overheads was $7.21 while the maximum potential fee collection that the Service could expect to recoup, is $4.98 per km; this assumed that all transports collected

fees, and pensioners (who are normally exempt from fee charges) were included. (Details of the analysis are included in Appendix 9).

4.20 A further costing analysis of the Service indicated an average per annum cost per employee of over $50,000, while the average salary is less than $25,000 and capital expenditure accounts for only 5.3% of total expenditure, being $2,900 per employee.

4.21 In view of the apparent high cost structure of the Ambulance Service, the PAC, while appreciating the need for an adequate level of service with appropriate support infrastructure, considers that areas for cost-cutting should be explored, e.g. leaner and/or more efficient/effective use of middle management, further pursuit of *'deals'* on equipment and that the fee structure should be set to reflect costs.

## Recommendation 17

**4.22 That areas for cost cutting within the Service be explored and that the fee structure be set to reflect costs.**

### (ii) Differential Fee Structures

4.23 Under the current arrangements, the same level of fees is charged for all types of transport. As one senior ambulance officer commented, the fees are set:

> *"On the basis that there should be a common ambulance charge to go from point A to point B".*
>
> (PAC Hearings 28 September 1988)

4.24 Air Ambulance fees are based on a road kilometre equivalent of the trip.

4.25 Information from the Ambulance Service indicates that the cost per kilometre for Air Ambulance is $3.29.

4.26 Due to the longer distance of most air ambulance trips the charges tend to be high, e.g., a trip from Dubbo to Sydney can cost a non-levy paying non-pensioner patient in the order of $2,300.

4.27 The PAC notes that in Victoria Air Ambulance charges are based on a sliding scale according to distance, as follows:

| | | |
|---|---|---|
| Up to 10 km | - | flat fee $131.45 |
| 11 to 100 km | - | + $3.04/km |
| 101 to 300 km | - | + $2.00/km |
| 301 to 900 km | - | + $1.03/km |

4.28 A sliding scale system as above recognises decreasing unit costs for longer trips. The PAC believes that a similar charging structure, depending on the extent of any additional associated administration costs, may be worthy of consideration in NSW.

4.29 The PAC believes that a fee differential between emergency and non-emergency transport is also worthy of consideration, particularly if the Ambulance Service is seen to be primarily an emergency service. The non-emergency work provides further utilisation of resources that otherwise may be idle. Therefore, it may be worth considering setting non-emergency fees at, primarily, marginal cost.

## Recommendation 18

4.30 **That consideration be given to the introduction of a sliding scale of fees for Air Ambulance trips to recognise the decreasing unit costs for longer trips.**

## Recommendation 19

4.31 **That the feasibility of setting non-emergency transport fees at a different scale from emergency transport fees be considered.**

## SPECIAL PROJECTS ACCOUNTS

4.32 Under the Ambulance Services Act, 1976 (Section 11) the Health Administration Corporation may establish Special Projects Accounts to account for revenue raised by the Ambulance Service, e.g., donations and proceeds from specific fund-raising activities such as raffles, etc., that is not required to be paid into the Consolidated Fund.

4.33 Funds held in these Accounts are invested and according to the Act, may only be used for purposes related to the improving of ambulance services as approved by the Health Administration Corporation.

4.34 The PAC was advised by officers of the Service that approval of the Ambulance Directorate (acting on behalf of the Corporation) is required to expend the funds.

4.35 The accounts are internally managed and audited by the Corporation.

4.36 The following figures show the balances of uncommitted and committed funds in the Accounts in recent years:

| Year Ended | Uncommitted | Committed | Total |
|---|---|---|---|
| 30/6/86 | $564,230.60 | $966,149.92 | $1,530,380.52 |
| 30/6/87 | $686,911.15 | $740,957.49 | $1,427,868.64 |
| 30/6/88 | $996,179.45 | $317,857.74 | $1,314,037.19 |

4.37 The figures indicate that the Accounts have an annual income of over $1 million but also that the level of uncommitted funds has remained significant, although it is understood that this was reduced to $437,508.75 as at 30/9/88.

4.38 Whilst the PAC commends the efforts of the Service in raising funds through these additional efforts and that donations are always welcome, the PAC is concerned at the apparent lack of accountability regarding these funds.

4.39 Notwithstanding their statutory establishment under the Act, issues of concern to the PAC regarding these are:

i) the relatively large amount of uncommitted funds; and

ii) the lack of adequate public disclosure of these funds. As the Accounts are not part of Special Deposits Account or the Consolidated Fund, receipts and expenditures from these accounts are not reported in the Public Accounts.

4.40 In his September 1988 Report, the Auditor-General expressed concern at the use of Special Projects Accounts for funds provided to the Service under a school's contribution scheme introduced in 1983. He considered

that these funds ($60,000 p.a.) should be paid into the Consolidated Fund.

## Recommendation 20

**4.41 That consideration be given to accounting for funds paid into and expended out of Special Projects Accounts through an account in Treasury, so that transactions are included in the Public Accounts.**

# 5. COLLECTION OF OUTSTANDING UNPAID AMBULANCE TRANSPORT FEES

## PREVIOUS INQUIRIES

5.1 The issue of outstanding unpaid ambulance transport fees and debts written off has been of concern to both the PAC and the Auditor-General in recent years.

5.2 Although the issue had been addressed in the Gleeson Report, which recommended improvements in the process of collection of bad debts and billing arrangements, it is apparent that little success in reducing the level of outstandings and bad debts was achieved.

5.3 Following adverse comment regarding this matter by the Auditor-General in his 1983/84, 1984/85 and 1985/86 Reports the PAC in December 1986 resolved to undertake an examination into the matter under Section 57 of the Public Finance and Audit Act, 1983. The PAC already had sought comments from the Department of Health on the matter in early 1985.

5.4 The PAC noted at the time that the amount of unpaid fees had steadily increased from $7.0M to $9.3M at 30 June 1986 with $1.3M being written off.

5.5 The PAC sought the comments of the then Minister for Health on the matter. The PAC correspondence of December 1986 and Minister's reply of May 1987 are included in Appendix 10. The Minister advised that *"a special fees review section"* reporting to the Directorate had been created to address the problem.

5.6 This action has led to the Directorate's appointment of fees collection officers in each of the Regions and in Central District Ambulance for accounts collection and commencement of work on the introduction of an *"improved computerised debtors system"*.

5.7 Furthermore, the outstanding unpaid transport fees were reduced to $7.8M as at 30 June, 1987 suggesting that the problem was being appropriately addressed although debts written off for the year 1986/87, were $1.6M.

## AUDITOR GENERAL'S REVIEW 1988

5.8 Despite the abovementioned improvement, the matter was again raised by the Auditor-General in his September 1988 Report as part of a Special Project Audit and Review of the Ambulance Service. The level of outstanding unpaid fees had increased to $10.1M as at 30th June 1988 and debts written off in 1987/88 had increased to $2.2M. Over the last six years $16.8M had been written off. This is equivalent to the cost of approximately 250 new ambulance vehicles which could not be purchased.

5.9 The Auditor-General was concerned at the low priority given to billing and collection of debts and the lack of a clear policy on the write-off of debts.

5.10 The Auditor-General's main recommendations following his 1988 review were:

- that strategies be introduced to ensure the prompt issuing of accounts;

- consideration be given to the development of financial initiatives to improve debt collection;
- the re-introduction of debt collection agencies be again considered with fees based on results; and
- more rigourous action be undertaken prior to debt write-off and that prompt legal action be instigated in relation to all unpaid debts.

5.11 The Service responded to the Auditor-General's comments (refer Appendix 11 for extract of response) conceding that there had been some delays in the system. The PAC noted an upgraded debtors system and computerisation was in the process of introduction but was unable to evaluate the results of the upgrading.

## PAC EVIDENCE

5.12 In the course of this Inquiry the PAC has noted concern from within the ranks of senior ambulance officers regarding the administration of debts. The following extract from PAC hearings of 28 September, 1988 indicates this:

***PAC:*** *"Are the debt levels acceptable?"*

***WITNESS:*** *"I don't believe they are" and*

***PAC:*** *"Do you think you have been acting strongly enough in chasing up this outstanding money?"*

***WITNESS:*** *"I do not think we have".*

5.13 The PAC obtained an analysis of outstanding debts at 30 June 1988 from the Ambulance Service and noted that 39% of outstandings is 90 days or older.

5.14 Advice from the Service indicates that the cost of debt collection, in terms of salaries and wages alone, is in the order of $2.4 million per annum. This amount includes $239,305 for the salaries of 11 Fees Collection Officers plus an estimated $2.1 million to account for the 35% of other clerical staff time used in fee-debt collection and follow up.

5.15 In some instances the PAC noted that senior officers were being used to collect fees. The PAC believes they could have been more productively utilised. Given the nature of their training and qualifications, the PAC notes it would be more appropriate for clerical staff to collect fees.

5.16 Actual fees collections in 1987/88 amounted to $26.9 million and are estimated to be $28.5 million in 1989/90.

5.17 The PAC considers that the proposed computerised debtor system may result in improvements to the collection of fees.

5.18 The PAC is cognizant of difficulties that the Service can have in the collection of debts. These include:

- the high proportion of relatively small debts ($200 or under);
- difficulties collecting debts in rural areas;
- the administrative problems associated with raising accounts when:
  - in doubt as to insurance or medical status of patient
  - itinerant people are involved
  - overseas visitors are involved

patients are in critically ill situation.

5.19 The PAC was disturbed that adequate patient details are not collected, particularly given that only about 1% of patients arrive at hospitals critically ill; it is not clear why patient details for billing purposes cannot be collected during, before or after transport. Also, the PAC was disappointed at finding a lack of enthusiasm by Ambulance Officers to obtain this information. It was illustrated to the PAC from internal Service 'status reports' the failure by ambulance officers to record pension numbers which leads to additional costs for the accounting section.

## Recommendation 21

5.20 **That a normal component of patient care and management by Ambulance Officers should include obtaining patient details for billing purposes where practicable.**

5.21 The option of credit cards for the payment of fees would assist in billing, given their widespread use in the community and that payment could be effected as part of the process of obtaining patient information. Already government authorities such as the Water Board (for the payment of rates) and the Forestry Commission (for sales at nurseries) provide credit card facilities.

5.22 Senior Ambulance Officers expressed concern to the PAC at hearings that there may be industrial problems if Officers were expected to collect fees via credit cards.

5.23 The PAC finds such a concern unacceptable.

## Recommendation 22

5.24 **That credit cards be accepted for the payment of ambulance transport fees.**

5.25 The PAC is also concerned at the rationale adopted by the Ambulance Service for not integrating its billing with that of the hospital. At the hearings of 28 September, 1988, the following dialogue took place:

*PAC:* *"Do you think the ambulance account could be combined with the hospital account for a patient?"*

*AMBULANCE SERVICE:* *"Before we had the debtor system introduced, we in fact had a look at Hosbill, which is the hospital billing system, and the requirements that they require on the accounts are different to what we require, and we use our accounting system to provide statistics and the new system is so designed that we would be able to take all the stats (sic) off that rather than do it manually at the moment. So we would find it difficult to include the two".*

5.26 The PAC rejects the above assertion. It suggests that the need for adequate statistics is a more important concern to the Service than a system that may improve account collection. A further examination of the feasibility of joint accounts with hospitals should be undertaken.

## Recommendation 23

5.27 **That a further examination of the feasibility of joint accounts with hospitals be undertaken.**

5.28 The PAC concurs with the Auditor-General in that the feasibility of using a private debt collection agency ought to be again considered.

5.29 The PAC is aware that debt collectors were tried previously and were not successful, mainly because they charged a flat rate and were not considered cost effective by the Ambulance Service. Any use of collection agencies in the future ought to be on the basis that payments are performance based.

5.30 The PAC anticipates that the abovementioned performance (standards/operations) would be stringently monitored.

5.31 The Secretary, Department of Health, advised the PAC that he expected an improvement in the debt collection when *"Global Budgeting"* is introduced within the Department in 1989/90. It is intended that flexibility is to cover revenue not only expenditure. As the Secretary said to the PAC:

> *"... Clearly, we are looking at a more clear basis, a more commercial and better matching basis. That is the only way to match costs and revenues. It is the only way to make people fully accountable."*
>
> (PAC Hearings 27th September, 1988)

5.32 This may provide incentive necessary to improve this alarming situation. PAC recommends that this be monitored.

## Recommendation 24

5.33 **That the Ambulance Service consider the feasibility of using private debt collection agencies paid on a performance basis.**

# 6. COMMUNICATIONS

## CURRENT SYSTEM

6.1 The communication system used by the Ambulance Service is based on Regional Co-ordination Centres through which all calls to each Region (and Central District, which has its own centre) are channelled. Under this system the workload is determined by a central allocating authority rather than at a station.

6.2 The rationale of centralising communications on a Regional basis is to provide a more efficient use of resources. Officers of the Service have advised the PAC that overtime has been reduced because of the co-ordination afforded under the system. As a senior officer commented at the PAC hearings of 8th September 1988:

> *"... we had a problem where there was a pattern of overtime being generated at the end of a shift in two stations ... We have now eliminated that because all of our calls are now centralised ... The doctor is asked whether the matter can be dealt with the next morning ... within rostered hours ... we have cut overtime substantially in at least three stations".*

6.3 Statistics provided to the PAC indicated a contrary position with regard to total service overtime costs. These have increased by 21.4% from 1986/87 to 1987/88 and by 46.7% over the four years to 1987/88. This implies that the effect on overtime of the communications centralisation may be relatively minimal.

6.3 In discussions with ambulance officers and other health operatives the PAC noted criticism of the communication system in that there was no provision for direct communication between the ambulance in the field and the hospital or doctor. This type of contact would enable the hospital to be better prepared on arrival of a patient and also to be able to provide any clinical advice to the ambulance officers. This problem was predominantly raised in country areas. The PAC has noted that this has been addressed in the policy statement released by the Minister for Health on 25th November, 1988 - two way communications systems between ambulances and trauma services are to be introduced.

## COMPUTER AIDED DESPATCH

6.4 The PAC observed that the communications co-ordination system used by the Ambulance Service is a manual system. A phone call is recorded by an operator on a card which is passed on to the co-ordination officer for the particular area who then determines which ambulances are available, from his/her normal recording system and then places the appropriate call. As the State Superintendent said to the PAC at the hearings of 8th September, 1988, regarding the Committee's visit to the CDA Co-ordination Centre:

> *"You would have noticed that the co-ordinator has considerable paperwork. To a degree the co-ordinator's efficiency depends upon his capability to organize his work, to be able to identify the location of a particular crew, and therefore which would be likely to be the closest vehicle.*

6.5 The State Superintendent expressed his concern to the PAC in this regard and said:

> *"... I believe that the system needs to change to get a better response and take some of the stress off the operator ..."*
>
> (PAC Hearings 8th September 1988)

6.6 The PAC agrees that this has created some problems, particularly in Central District where a number of operator mistakes have led to disciplinary action. These should have been avoided.

6.7 One submission to the PAC suggested that staff savings of equivalent to 29 full-time staff may be available in the co-ordination area if computers were introduced.

6.8 The PAC has noted that $946,000 has been allocated to the Service in its 1988/89 Capital Works Program for a communications upgrade, i.e. to install a Computer Aided Despatch (CAD) system. The installation of a CAD system was also included within the Minister's policy statement of 25th November, 1988.

6.9 The CAD system will provide updated information on the availability of ambulances and staff to the operators. A description was provided by the State Superintendent as follows:

***AMBULANCE SERVICE:*** *"Any ambulance cases that are received are entered into the computer with standard case detail ... In routine transports where a doctor might have a medical case to go from home to hospital the basic information is the name of the authorizing doctor and the patient's details. When that goes into the computer system the co-ordinator can obtain advice as to the nearest available ambulance to take that case. He will receive pre-*

*warning of what we term a time-critical case. This takes much stress off the co-ordinator.*

***PAC:*** *Will that system assist in communication between doctors and ambulance officers?*

***AMBULANCE SERVICE:*** *Yes, as part of the preparation the computer aided despatch there must be a review of the communication system. One facility to be built into that system is a means for communication with doctors. That will be by telephone patching ...*

***PAC:*** *What is a telephone patching?*

***AMBULANCE SERVICE:*** *A means of connecting someone on the radio network, for example, an ambulance at an accident scene, that has a particular problem and may need additional advice ... On our arrival they can more efficiently manage that patient.*

*The reason we favour patching is that we can be in touch with appropriate medical advice regardless of where that person may be ... With telephone patching the doctor may be anywhere in the hospital and may be paged to the nearest telephone.*

6.10 Patching would seem to be an essential requirement. The PAC is surprised that, while patching is used widely in commercial uses it has not been introduced into a service which deals with life and death situations daily. This is especially so since technology has been available in recent years and the need for it is established.

6.11 The PAC is disappointed at the length of time taken for the implementation of CAD as the technology has been available for some time.

6.12 The PAC supports the introduction of a CAD system and telephone patching as these will improve primary patient care leading to savings in the cost of hospital care.

## Recommendation 25

**6.13 That the introduction of Computer Aided Despatch system and telephone patching be introduced into the Ambulance Service communication system as a matter of priority.**

# 7. PROPERTY MANAGEMENT

7.1 With 217 stations throughout NSW the Ambulance Service has a significant property portfolio.

7.2 The PAC finds it extraordinary that it was not able to obtain a valuation of the portfolio. However, the PAC has been informed that an Assets Management Unit has been established in the Department of Health to set up an assets register. Unfortunately, while information is being gathered, this process is being given a low priority.

7.3 According to evidence received by the PAC, the Treasurer has recently given approval for 100% of the proceeds from the sale of assets by the Department of Health including Ambulance Service properties to be retained by the Department for asset replacement rather than being paid into the Capital Receipts of the Consolidated Fund.

7.4 Previously there was no incentive to sell and relocate properties for both the Department and the Service. The abovementioned arrangement provides the impetus for a more efficient asset management program and is a commendable step.

7.5 The PAC noted that a small proportion of Ambulance Service properties are leased, usually to provide temporary accommodation prior to relocation, e.g. Queanbeyan. However, in some cases the arrangements have been mismanaged. For example, one submission stated in respect of the Ambulance Station at Taree:

> *"For the past three years the Ambulance Service has been paying some $55,000 - $60,000 p.a. rent on a building used for the purpose of an ambulance station in Taree whilst the previous station lies unused because of the lack of renovation".*

7.6 This matter was also raised in discussions that the PAC had with Ambulance Officers in the Taree area whilst on inspection in June 1988. The PAC also noted delays in selling and relocating the station at The Entrance to a less commercially valuable site.

7.7 It is expected that the Asset Management Unit of the Department of Health will address these and other problems. The PAC will follow up progress in this area over the next 12 months.

## LOCATION OF AMBULANCE STATIONS

7.8 According to the State Superintendent the location of Ambulance Stations is determined on the basis of:

> *"... providing a reasonable response time ..."*
>
> (PAC hearings 8th September 1988)

7.9 The PAC does not object to this approach. However, the PAC is concerned that following its inspections of sites during the course of the Inquiry, sub-optimal sites were identified. Cheaper alternative sites that do not adversely affect the spacial distribution, e.g., the possibility for relocation to hospital grounds or Crown land, were noted by the PAC, particularly in some of the country centres and smaller Sydney sites visited.

7.10 The PAC has observed that already the Ambulance Service has relocated stations on the above basis. The relatively new Blacktown Ambulance Station was built on the grounds of Blacktown Hospital. The former site is now a shopping complex. It is also planned to construct a new station on the grounds of Queanbeyan Hospital. The current premises are leased by the Service. Another example is the recently completed station complex in the grounds of Armidale Hospital.

7.11 During the course of its investigations the PAC noted considerable agreement from a variety of sources, particularly in country areas, to the concept of locating ambulance stations on hospital grounds. The advantages of this include:

i) Providing the opportunity to dispose of the old site. However, it was found that in some cases this was not feasible in country towns due to insufficient return on property sale in comparison to the cost of relocating;

ii) provision for closer co-operation with the hospital staff and visiting doctors. Ambulance officers would be able to assist in casualty, and gain useful experience during downtime; as well as being conveniently located to undertake practical training in hospitals referred to in Chapter 3;

iii) combining use of administrative facilities would provide opportunities for cost savings; and

iv) in smaller centres, especially in the country, there is no apparent advantage in any location over another in terms of response times.

## Recommendation 26

7.12 **That where feasible, ambulance stations be located on hospital grounds.**

7.13 The co-location of ambulance services with other emergency services such as the police and fire brigade was also raised during the Inquiry. Already this is being considered on an experimental basis at Hurstville in Sydney and at Macquarie Fields.

7.14 The PAC sees some advantages in this approach, particularly in respect of co-ordination between the services, communications and savings to be achieved in multi use of back-up facilities such as mechanical repair shops and officers' amenities.

7.15 However, there may also be conflicts as the Ambulance Service is part of the health delivery business including transport of patients with non life threatening diagnoses. It is understood that the abovementioned experiments are currently being assessed.

7.16 As the Secretary, Department of Health, at the PAC hearing of 27th September 1988, said:

> *"... An interdepartmental committee has recently reported on the feasibility of building such a station at Hurstville ... There seemed enough negatives to offset the positives ... it appeared that each of the three services had really just co-located (sic) their individual total entities ... there could be some diseconomies in terms of one being forced to move out of a fairly new building into an entity of that nature ..."*

## USE OF PROPERTIES

7.17 As well as the abovementioned multi-use of properties by the emergency services, there is also the issue of the multi-purpose usage of a site For example, siting of office space or an ambulance residential above a station.

7.18 This approach already is taken in some country areas where the Regional Office or a residence is located above the Station.

7.19 The PAC considers that all avenues for multi-use of stations should be considered.

7.20 The PAC has noted that under existing financial arrangements there is no incentive for the Ambulance Service to lease out properties, as all the revenue is paid into the Treasury (Consolidated Fund).

7.21 To expand multi-use of properties, some form of incentive arrangement, as has been established with the sale of assets, would need to be established.

### Recommendation 27

**7.22 That all avenues for the multi-use of ambulance station facilities be pursued.**

### Recommendation 28

**7.23 That appropriate financial incentives be put in place to encourage the leasing out of any surplus Ambulance Service properties or space therein.**

7.33 During the course of its investigations it was brought to the PAC's attention that Service residences in the Sydney area were occupied by senior ambulance officers (Superintendents) as well as Station Officers. The PAC viewed with some concern that this may be a 'rort' to provide these officers with subsidised accommodation, outside current Ambulance guidelines or the most efficient allocation of ambulance real estate resources.

7.34 The Service advised the PAC that accommodation for Superintendents is provided under the Award on the basis that they are on 24 hour call. In regard to officers at lower levels the Ambulance Officers Award provides for accommodation to be provided at a rental equivalent to their on-call allowance.

7.35 Despite the application of the Award provisions, particularly in the case of Superintendents, the PAC believes that the Assets Management Unit of the Department of Health should closely examine whether alternative arrangements may be more efficient.

# 8. VEHICLES

8.1 The NSW Ambulance Service has a total fleet (at 31/8/88) of 1,134 vehicles, including 814 General Duties Ambulances, 31 Intensive Care Vehicles and 289 Administrative and other vehicles.

8.2 Since 1968 the Service has used Ford F100 and F250 models for its General Duties and Intensive Care ambulances.

8.3 According to evidence provided by senior Ambulance Officers a General Duties vehicle costs in the order of $70,000 with an Intensive Care ambulance costing $85,000. In 1987/88 an amount of $6,047,163 was expended on replacement and ambulance vehicles. No State or Federal taxes are paid by the Service for vehicle purchase.

## DESIGN EFFECTIVENESS OF AMBULANCE VEHICLES

8.4 In the course of its investigations the PAC noted differing approaches to vehicle design and use in different States. In Queensland, for example, cheaper ($30,000) Ford Fairlane Station Wagons are used for non-emergency work and in South Australia the modular *"twin life"* ambulance Ford F100 series engine, cab and chassis is used with less equipment.

8.5 In contrast, the NSW Service utilises the Ford F250 and its predecessor, the F100, for all ambulance work. As the NSW Ambulance Engineer said:

> *"... Our philosophy has been to construct one type of vehicle to meet the needs of the whole State ..."*
>
> (PAC hearings 27th September, 1988)

and in commenting on the South Australian concept of the low cost vehicle, the Chief Superintendent (Finance) stated:

> *"I have seen the low-quality cost-effective ambulance from Adelaide. I would prefer to stick with our vehicle..."*
>
> *"The vehicle fleet situation ... is always foremost in our mind to provide comfort. The Fairlane, Valiant era... they didn't have the room to allow full patient treatment and comfort and they were in some instances equally as rough as what some of the FI50's are."*
>
> (PAC hearings 28th September, 1988)

8.6 The PAC has noted that the NSW Ambulance Service is attempting to adopt what was termed by senior ambulance officers at the PAC hearings *"a compromise approach"* to equipping its ambulance fleet.

8.7 The objectives of the NSW approach according to the Ambulance Engineer (PAC hearing 27th September, 1988) appear to be to achieve economies of scale in a heavy duty multi-purpose vehicle.

8.8 A separate, more heavily equipped vehicle is used for intensive care (paramedics) and also, there is a separate rescue vehicle design. However, senior officers have expressed a lack of conviction for the need for these specialist vehicles.

8.9 In the case of rescue, the PAC was advised by the Metropolitan Superintendent at the hearings of 27th September:

> *"... the majority of rescues that are carried out involve the extrication of people from motor vehicles and some simple tools will effect that operation in the majority of cases."* (Emphasis added)

8.10 The PAC does not see its role as being involved in assessing the merits of particular vehicle types. As a medically qualified witness said to the PAC at the hearings of 29th September:

> *"It depends on how much you're prepared to spend. Ideally, you would say that every ambulance that goes anywhere must be able to deal with any situation that it encounters but that's not realistic. I mean, it's like saying to a G.P. - 'your black bag must contain every bit of equipment in it that you would need in any emergency'."*

8.11 This comment sums up the situation in the PAC's view. Any type of medically oriented service can be improved with additional resources.

8.12 It appears to the PAC that efficiency has obviously not been a key factor and the emotive nature of the product may explain the present situation more than any rational decision making. However, given that every dollar spent on upgrading ambulances could have been spent for example, on research into geriatric problems, cot deaths or AIDS, it is essential that efficiency be the criterion for allocating resources. This is particularly the case for incremental spending because, at the margin, the

additional life-saving effect is likely to be limited and may even be counter-productive.

8.13 The PAC appreciates that the compromise approach adopted by NSW may very well be the most appropriate. However, cost and patient care/retrieval effectiveness need to be considered. The PAC believes that the cost-effectiveness of a cheaper vehicle for non-emergency transport deserves to be examined, i.e. station sedan or mini bus.

## Recommendation 29

8.14 **That the cost-effectiveness of a cheaper vehicle for non-emergency transport be examined.**

8.15 Even given the expense involved with NSW ambulance vehicles, an issue brought to the PAC's attention was the safety aspect of the vehicles, particularly in relation to the stowage of equipment carried within and its propensity to *"fly about"* in the case of an accident and pose an additional danger to the patient and the ambulance officers on board. As the Metropolitan Superintendent told the PAC:

> *"... The vehicles may have been designed from a functional point of view but not necessarily from a safety point of view ..."*
>
> (PAC hearings 27th September 1988)

8.16 The PAC considers that this matter should be addressed and that design features be examined to ensure adequate safety if this is a real issue and bearing in mind cost effectiveness.

## MAINTENANCE OF VEHICLES

8.17 The Ambulance Service operates its own workshop to undertake vehicle repairs and maintenance. Major repairs are done at the workshops whilst routine servicing is handled in the main by mobile mechanical vans.

8.18 Statistics provided to the PAC indicate that, on average, just under 20% of vehicles are off the road under repair at any one time with the maximum off road percentage occurring in Central District (32%).

8.19 The PAC is cognizant of the heavy workload and nature of use of ambulance vehicles, particularly in the Central District, but on the basis of each vehicle being worth $70,000 an average of 170, or $11.9M worth of vehicles are off the road at any one time. This is a significant opportunity cost to the NSW taxpayer.

8.20 In view of the downtime being greater, on average, during the night time, it was proposed during the Inquiry that mechanical work, especially the routine maintenance, could be done at night to reduce the level of vehicles off the road during the busiest period. Two counter arguments to this were raised by officers of the Service:

i) The Crown Employees Award, under which mechanics are employed, provides for day work. There would be penalty payments and industrial problems if night work were introduced; and

ii) There would be difficulties in obtaining parts during the evening and night.

8.21 Despite these issues the PAC considers that this option should be examined closely, particularly for the Central District Ambulance.

8.22 The use of outside contractors to undertake repairs and maintenance was raised in discussions with the Service. This would reduce dependence on Crown Employees Award.

8.23 Officers advised the PAC that the Ambulance Service preferred to undertake its own repairs. This was considered advantageous due to the specialised nature of the vehicles and the greater reliability and timeliness of repair work done in house.

8.24 However, no evidence could be provided to the PAC to substantiate this claim.

8.25 Furthermore, by contrast, the NSW Police Department, which has a fleet of 150 Ford F100 vehicles, utilises private contractors for maintenance and repairs in rural centres; in the Sydney metropolitan area the Government Motor Services is the contractor. Police usage, and therefore wear and tear, on its vehicles is very similar to that of the Ambulance Service.

8.26 Officers from that Department advised that there were no particular problems associated with using contractors. This was contrary to advice provided by the Ambulance Service in respect of mechanical, not body work repairs, and maintenance.

8.27 It was brought to the PAC's attention that it may be efficient for the Ambulance Service mechanical workshops, particularly in the regions, to be used for the repair and maintenance of vehicles operated by other Government departments/authorities such as the Police, Forestry

Commission. These have regional operations and may not have their own facilities.

- Savings would be available through economies of scale in relation to infrastructure, workforce and parts acquisition.

- It would be an opportunity for the Service to gain additional income by charging out its services to other authorities.

- In cases where a number of authorities have separate facilities the feasibility of combining these should be investigated.

## Recommendation 30

8.28 **That the feasibility of undertaking routine vehicle maintenance at night be closely examined.**

## Recommendation 31

8.29 **That the efficiency and effectiveness of Ambulance Service repair workshops be reviewed within six months. This review should examine the Police Department's policy of using contractors to repair and maintain its F100 fleet.**

## USE OF ADMINISTRATIVE VEHICLES

8.30 The PAC is concerned at the relatively large numbers of administrative/non-ambulance vehicles (269) in the Service's fleet. These represent 24% of the total fleet which appears excessive given the Service's perceived

mission and public perception of what an Ambulance Service does. It is understood that there are 55 cars in Central District alone.

8.31 By way of comparison the London Ambulance Service has only 65 administration vehicles, although it serves more than seven million people and has over 2,900 employees.

8.32 The PAC believes that a certain number of these vehicles are necessary to perform management tasks in such a widely geographically dispersed organisation, particularly in country areas, but little evidence was provided on use of vehicles.

8.33 The PAC examined a sample of CDA administrative vehicle log sheets and is concerned that they do not provide sufficient detailed information on the actual purpose of a particular trip.

8.34 Evidence suggests that a number of those vehicles can be attributed to the wide use of clinical supervisors. While the PAC is not in a position to comment on the medical necessity for these positions it considers that the cost effectiveness of clinical supervisors should be reviewed.

8.35 The PAC is concerned that these positions are filled by the more experienced officers who are therefore not available for normal on the road duties. While it is accepted that clinical supervisors are necessary at major incidents and play a vital role, the number of these positions needs to be reviewed.

## Recommendation 32

8.36 **That the cost effectiveness of clinical supervisors be reviewed.**

8.37 Another issue may be to consider the use of some of these vehicles - the station sedans - for non-emergency work.

8.38 The PAC considers that the Service should re-assess its use of administrative vehicles in the light of the above issues with a view to a reduction in numbers. Any proceeds from sales of those vehicles should be available for Service purposes as in the case of asset sales.

## Recommendation 33

8.39 **That in conjunction with Recommendation 29 the feasibility of using some of the existing administrative vehicles, the station sedans, for non-emergency patient work be assessed.**

# 9. AERIAL RETRIEVAL SERVICES

## NSW AIR AMBULANCE

9.1 The Air Ambulance is a separate arm of the Ambulance Service directly responsible to the Directorate. Its operations include the transport of emergency and non-emergency patients normally from the relatively distant country centres to the better equipped hospital facilities in Sydney and other major centres. In 1987/88 total expenditure was $6.16M with a total of over 4,100 cases.

9.2 The Air Ambulance was established in 1967 and is based at Sydney (Kingsford Smith) Airport. The Air Ambulance currently has five aircraft with pilots and engineering services contracted from East-West Airlines. (Details are included in Appendix 12).

9.3 A number of issues covering the operation of the Air Ambulance have been brought to the attention of the PAC. These include:

i) cost
ii) response time
iii) position in management structure

i) Cost

9.4 As stated in Chapter 4, information provided to the PAC from the Ambulance Service indicates that the average operating cost per kilometre of the Air Ambulance was $3.29 in 1987/88 - this compares to an estimate of $4.98

per kilometre for the Service as a whole. (Refer Appendix 9).

9.5 The PAC noted that, unlike road ambulance, the major cost component for Air Ambulance is aircraft operating costs, accounting for 79%, followed by salaries and wages at 18% of total costs.

9.6 While the above costings of the delivery of air ambulance services do not include the necessary road component at each end, the PAC notes that the apparent lower operating costs are not reflected in the fees charged (refer Chapter 4).

9.7 The PAC was intrigued to note that in comparison to commercial airline operators the cost of air ambulance appears excessive. Comparisons were obtained as follows:

| | Air Ambulance | Commercial |
|---|---|---|
| Sydney/Dubbo (return) | $2,300 | $204 |
| Sydney/Bathurst (return) | $1,272 | $142 |

9.8 Although officers of the Service equated one stretcher patient to six on a commercial flight in terms of space requirements the commercial fare equivalents would be for six people:

| | |
|---|---|
| Sydney/Dubbo (return) | $1,224 |
| Sydney/Bathurst (return) | $852 |

ii) Response Time

9.9 During the course of its investigation a number of sources indicated to the PAC that excessively long response times for air ambulance, in some cases up to five hours, were being experienced in country areas.

9.10 Officers of the Air Ambulance advised the PAC that a response time of one hour was applicable in ideal circumstances if crews were readily available plus an average of one hour's flying time.

9.11 In the light of the evidence obtained the PAC accepts that relatively lengthy response times are unavoidable in the case of country retrievals due to the distances involved and the equipment available.

9.12 The State Superintendent advised in this regard:

> *"... In emergency cases doctors are asked to give two indications, should the patient be moved under three hours or in three to six hours ..."*

9.13 It was suggested to the PAC that decentralising the Air Ambulance operation to country areas may improve logistics and consequently response times. However, the PAC understands that the Air Ambulance previously had a base at Dubbo which, according to advice from Service officers, proved unsuccessful primarily because of problems in obtaining suitable staff.

9.14 Another factor that needs to be considered is that, according to statistics made available to the PAC, over 60% of Air Ambulance patients are non-emergency and that routine *"milk run"* flights are made to country areas on a regular basis.

iii) <u>Position in Management Structure</u>

9.15 The PAC has noted an apparent problem regarding the relationship of the Air Ambulance to the road ambulance.

9.16 This concern was expressed to the PAC by one senior ambulance officer:

> *"... In my view, the Air Ambulance should be part of the normal operational area ..."*
>
> (PAC hearings 27th September, 1988)

and,

> *"... staff should be able to move from the Air Ambulance to the road group and vice versa".*
>
> (PAC 27th September, 1988)

9.17 However, as one senior officer stated in a submission:

> *"... The Air Wing is only a secondary system and the key is the all-important road service ..."*

9.18 As stated in Chapter 2 the PAC considers that the Air Ambulance is properly positioned in the management structure but that opportunities for movement of staff need to be examined to broaden skills, career opportunities and improve relations, e.g. utilisation of road ambulance officers on air ambulance escort duties, clerical and co-ordination staff transfers.

## Recommendation 34

9.19 **The opportunities for the transfer of officers between the Air Ambulance and the remainder of the Ambulance Service be made available.**

## HELICOPTER SERVICES

9.20 Helicopter retrieval/rescue services are available in the Sydney, Newcastle, Wollongong and Lismore areas. These are provided by the following privately sponsored and volunteer based organisations.

- HCF Careflight - primarily covers Western Sydney/Blue Mountains
- Surf Life Saving Association - primarily covers Coastal Sydney, Newcastle and Lismore
- National Safety Council based in Wollongong

i) Relationship with Ambulance

9.21 While not part of the Ambulance Service the helicopter services work in conjunction with the Service in providing short haul, i.e. trips of less than an hour, retrieval services and assistance in rescue

9.22 The PAC has discovered some problems concerning co-operation between the helicopter services and the Ambulance Service. These include professional jealousy, co-ordination, and operating standards.

9.23 Examples of the problems brought to the attention of the PAC:

(a) One helicopter service operator cited a case where a diver with injuries was transported by ambulance from a coastal locality to Sydney rather than by helicopter and as a consequence his condition deteriorated - legal action followed. The

helicopter operator was critical of the ambulance controller - should have taken doctor's advice and used helicopter.

(b) The concern of a major Sydney-based helicopter operation about the general under-utilisation of its service (staffed by doctors) by the Ambulance Service.

(c) Problems with Ambulance Co-ordination, e.g. Ambulance, contacted two hospitals for doctor to attend a major traffic accident in northern Sydney. None was available - one hospital contacted the helicopter service which sent its doctor - Ambulance should have contacted helicopter service initially.

(d) A case where the Ambulance Service denied under-utilisation of helicopter services - Officers undertake a helicopter familiarisation program indicating support for and understanding of need for helicopter services.

(e) Rejection by Ambulance Service of a proposal from one of the helicopter services to have Ambulance Officers included in the helicopter rescue crew.

(f) Apparent differences in operating standards between Careflight and the SLSA helicopter services.

ii) <u>Operating Standards</u>

9.24 The helicopter services in the Sydney area, unlike the Ambulance Service, utilize medical practitioners in

retrieval work and a medical practitioner from one of the helicopter services, in discussions, expressed the view that helicopter retrieval involves more than playing a resuscitative role, but is more akin to that of a portable casualty ward.

9.25 The PAC noted that according to a submission from one of the helicopter rescue/retrieval services only about 8% of missions flown involve injuries/illness that can be managed by paramedics within their medical protocols. According to the submission the remainder require a fully qualified medical team as is employed by the services in the Sydney area. The PAC is concerned, however, that the Newcastle Surf Life Saving Association helicopter service uses paramedics rather than doctors and that consequently two standards of operation appear to exist, one in Sydney and the other in Newcastle.

9.26 Another issue brought to the attention of the PAC is the variation in operational times of the helicopter services. Careflight have a full 24 hour service - staff live in at its headquarters at Westmead. The SLSA and the National Safety Council operate on a 9 to 5 basis with staff on-call for after hours missions. The advantage of Careflight's arrangement is that response times after hours are less; 5 to 15 minutes compared to 45 minutes to one hour for the other operators.

9.27 As a result of the problems in co-operation and co-ordination between the Ambulance Service and the helicopter operators guidelines have been drawn up for the despatch of authorised helicopters to primary (pre hospital) patients (refer Appendix 13).

9.28 The PAC has been informed from a number of sources that guidelines,if followed, will help address the problems. Given these circumstances, the PAC has agreed to monitor the situation in 6 months' time.

9.29 As from 1 July 1988 the helicopter services have been provided with Government assistance, by way of a fee for service arrangement plus a subsidy for medical and office support, administered by the Ambulance Service.

9.30 The fee for service assistance is in the form of an hourly rate ($1850) based on an agreement that annual demand will approximate 250 hours (per operator). Funds are provided through the Ambulance Service budget allocation.

9.31 In the period July to November 1988 a total amount of $292,000 was paid to Careflight Ltd, $166,000 to the SLSA Sydney operation plus $165,000 for its operations in Newcastle and Lismore. These amounts tend to reflect workload (refer statistics hereunder).

9.32 Other sources of funding for the helicopter operators include charges made to insurance companies in cases where Workers Compensation and the like are involved and sponsorship donations.

9.33 The PAC received evidence that it has been the practice of Careflight Ltd to attempt recovery of costs from Transcover and other insurance organisations if considered applicable. However, it is understood that the SLSA by way of comparison has a policy of not seeking recoupment from these organisations for patient rescue or retrieval.

9.34 Since the introduction of this assistance the number of cases undertaken for the Ambulance Service (July to November 1988) both primary retrieval and inter-hospital transfer, for the respective helicopter operators has been as follows:

| | |
|---|---|
| Careflight Ltd | 103 |
| Sydney SLSA | 57 |
| Hunter SLSA | 118 |
| Lismore SLSA | 36 |
| National Safety Council | - |
| Wollongong | 29 |

9.35 The PAC is intrigued to note the relatively small number of cases for the Ambulance Service handled by Sydney SLSA compared to Careflight Ltd. Furthermore, given the variance in population, it is apparent that the Hunter Region Ambulance has a much higher utilisation rate of helicopter than CDA given that it has undertaken more of these missions than either Careflight or SLSA.

## Recommendation 35

9.36 **That the NSW Department of Health closely monitor the quality of service provided by the helicopter retrieval/rescue services and adjust its payments for services rendered to the Ambulance Service accordingly.**

### iii) Ambulance Service Operated Helicopters

9.37 The concept of the Ambulance Service operating its own helicopter service has been raised in the course of the Inquiry. This was ruled out by senior officers of the Service on the basis of cost. As the Chief Superintendent (Finance) said to the PAC:

> *"... to set up the equivalent of the service that is available now in Wollongong, Sydney, Newcastle and Lismore would entail more than $12M just in capital costs ..."*
>
> (PAC hearings 28th September, 1988)

9.38 The PAC considers this argument valid, particularly in the light of the recently established guidelines.

# 10. IMPLEMENTATION OF THE GLEESON REPORT (1982)

10.1 In his reference to the PAC, the Minister for Health requested the assessment of the impact of implementing recommendations of the 1982 Inquiry into the NSW Ambulance Service (Gleeson Report) by the then Minister for Health, The Hon. L. J. Brereton, M.P.

10.2 Terms of Reference covered the role of the Service, use of ambulances, management structure and finance. A committee under the chairmanship of J. N. Gleeson was established to conduct the Inquiry.

10.3 The recommendations of the report and the status of their implementation as seen by the Service are included in Appendix 14.

10.4 The Report contains wide-ranging recommendations towards improving the operations of the Ambulance Service. The PAC is mainly concerned with the recommendations affecting inter-hospital transfers of patients, attendance at sporting fixtures, the replacement of the Ambulance Contribution Scheme, and Rescue operations.

10.5 Other issues arising from the Gleeson Report, e.g. management structure, Air Ambulance, have already been considered in other chapters of this report.

## NON-EMERGENCY TRANSPORT/INTER-HOSPITAL TRANSFERS

10.6 Following from the recommendations of the Gleeson Report the Minister for Health in 1983 published *"Ambulance Transport Guidelines"* (refer Appendix 15). The issue of non-emergency transport is extensively covered in these Guidelines.

10.7 The Guidelines recommended that the Ambulance Service discontinue the provision of inter-hospital patient transport unless specifically requested by the appropriate medical practitioner. The then Health Commission was given the responsibility of ensuring the provision of alternative transport for patients not authorised to travel by ambulance. The cost of the transport was to be met by the despatching hospital.

10.8 Despite the attempt by the Gleeson Inquiry to rationalise the use of Ambulances for non-emergency transport the PAC has, during its investigations, found that problems still exist in this area, particularly with regard to use of Ambulance Service resources for non-emergency transport and the cost burden on despatching hospitals.

### Non-Emergency Transport

10.9 The PAC found that there were the following difficulties for the Ambulance Service regarding non-emergency transport:

i) the use of sophisticated emergency vehicles for transporting non-ambulatory patients;

ii) problems in co-ordinating resources for this type of transport due to the difficulty in forecasting demand; and

iii) the general tardiness of hospitals in paying accounts.

10.10 The matter of separating the non-emergency and emergency operations of the Service was raised by many in the course of the Inquiry. The issues in connection with this matter include the skill requirements of officers, vehicle type differences, response time and the overall cost effectiveness.

10.11 Although contrary to the findings in the Gleeson Report, the concerns of which the PAC appreciates, the PAC believes that there may be some merit in having a separate *"busing"* service as opposed to a non-emergency ambulance division within the Service, particularly as the type of transport can be organised on a regular timetable. It may be a good opportunity to provide a basic training for probationary officers in both driving and patient care (the London Ambulance Service already adopts this approach for its probationary staff) and provide a useful role for those officers, who, either due to age or disability, cannot perform all the duties in emergencies required of an ambulance officer. However, any move in this direction would require analysis of overall cost effectiveness for not only the Ambulance Service but also for hospitals and other organisations involved in the provision of patient transport services.

10.12 This analysis would have to include the economics of separate fleet management or the need for greater flexibility of vehicles within existing fleet and the costs of appropriate personnel, strict guidelines for the operation of the separate fleet would need to be established.

10.13 The PAC considers that co-ordination of resources will always be a problem for the Ambulance Service. Both emergency and non-emergency trips have unpredictable demand patterns . However, wherever possible, '*set*' runs for appropriate non-emergency transport should be organised. Already the PAC noted that a road "shuttle service" operates between Wollongong and Sydney. The PAC noted that this had been also successfully arranged for rural patients in the New England Region. Also, the PAC considers that past demand trends for ambulance services would provide a reasonable guideline for resources allocation.

## Recommendation 36

**10.14 That within strict guidelines the feasibility of establishing a separate non emergency division within the Ambulance Service be considered.**

## COST TO HOSPITALS

10.15 Hospital and Health Department officials interviewed by the PAC indicated that the high cost of inter-hospital ambulance transport was a major concern. A particular problem noted was that the hospitals most frequently requiring inter-hospital transport tended to be the smaller hospitals with less resources to meet the cost.

10.16 The problem has affected hospitals to the extent that the State Superintendent commented:

> *"We have seen evidence of some hospitals where people have been discharged home and subsequently transferred from home, thereby making the individual responsible for inter-hospital transport from home to the next place."*

10.17 The results of a survey by the Hospitals and Health Services Association of NSW conducted at the end of 1986 of the input of interhospital transfers on the cost structure of hospitals, particularly the smaller rural hospitals, were made available to the PAC. The general view of the respondents (over 80) was that the current funding and charging arrangements, were unsatisfactory. The Association, following the survey, likened the system to *"a leech sucking blood"*.

10.18 The costs of inter-hospital transport are met from within hospitals' *"Goods and Services"* budget allocation. Budgeting is apparently a problem for hospitals due to the relatively unpredictable demand for inter-hospital transfers and can place further strain on other scarce hospital resources.

10.19 The PAC recognises the incentive effects that *"Global Budgeting"* provides but in view of the cost burden on hospitals in this regard it seems compromised.

10.20 Despite the abovementioned problems the PAC was in general satisfied with the approach of hospitals to the management of inter hospital transfers.

10.21 It was brought to the attention of the PAC that the ageing of the population could be expected to place increased pressure on demand for inter-hospital transport.

10.22 The PAC considers that the funds allocation arrangements may be handled more efficiently by the Regional/Area Offices of the Department of Health rather than by the individual hospitals. As the Secretary of the Department of Health said:

> *"... most hospital administrators do not understand or are not skilled in medical transportation ...".*

10.23 Furthermore, the Regional Offices already play a co-ordinating role in the allocation of resources to hospitals and would be in a better position to determine, in conjunction with the Service, if unjustifiable costs are being incurred by any hospital for this type of transport.

10.24 Another means of addressing the problem of costs to hospitals would be to provide an allocation specifically for inter-hospital transport, based on previous usage trends, that is not part of the hospital's global budget and therefore is not available for any other purpose.

10.25 A further concern expressed to the PAC by hospital administrators was the expectation of patients that ambulance transports should be available which places additional pressure on resources.

## Recommendation 37

10.26 That either:

i) the Regional/Area Offices of the Department of Health, rather than individual hospitals be responsible for the allocation and expenditure of funds to meet the costs of inter-hospital ambulance transport for hospitals under their jurisdiction; or

ii) hospitals be provided with an allocation specifically for inter-hospital transport which would be based on previous usage, that is not part of the hospital's global budget and is not available for any other purpose.

# 11. PRIVATE HEALTH INSURANCE LEVY SYSTEM

11.1 The Gleeson Report recommended the replacement of the Ambulance Contribution Scheme by a levy on basic private hospital insurance. This has been implemented through the Health Insurance Levies Act, 1982.

11.2 In 1987/88 revenue from the levy amounted to $39.6M and is anticipated to be $42M in 1988/89. The levy is determined on a monthly basis by a formula under Section 4(1) of the Act. (Appendix 16).

11.3 The rationale behind the Gleeson Committee's recommendation to abolish the Contribution Scheme was based on the fact that the collection costs (14% of income) were considered excessive and that there was a poor branch network for the collection of contributions. The Ambulance Service was able to reduce clerical staff numbers by 120 as a result of the change.

11.4 The introduction of the levy was considered appropriate at the time (1982) as membership of private health funds was growing. The State Superintendent stated to the Committee:

> *"... this was all right in the sense that we had Mr Fraser in power and with the Liberal policy of encouraging people to accept private health cover ..."*
>
> (PAC hearings 8th September, 1988)

11.5 However, soon after the introduction of the levy system the Government changed (in 1983) and with it the introduction of Medicare acted as a disincentive for people to continue membership in private health funds.

11.6 The Act does include provision for membership of a State Ambulance Insurance Plan, introduced during 1983/84. This is available for non-members of private health funds, using selected funds as agents. However, it appears to the PAC that this Plan is not sufficiently promoted by either the funds or the Ambulance Service. In fact, the PAC was advised by the State Superintendent:

> *"... Recently, someone from the health funds came up with the suggestion that we could make contributions to health funds a lot more attractive if we took off the Ambulance levy ..."*
>
> (PAC hearings 8th September, 1988)

11.7 According to figures provided to the PAC the Plan accounts for only $2M out of around $40M revenue per annum indicating its low profile.

11.8 The PAC has noted that there have been concerns regarding accountability under the levy system. Senior officers of the Ambulance Service have indicated difficulties in tracking down the exact number and identity of contributors to the levy system. The Chief Superintendent (Finance) explained to the PAC:

> *"... We have got no real control or ability to check when a person tells us they are a subscriber through the health fund..."*

11.9 The Ambulance Superintendents Association in a submission to the Inquiry agreed that this was a problem and that a quantifiable list of subscribers can be more readily maintained under a contribution scheme.

11.10 The Health Funds Association in its submission to the PAC recommended that because of the declining membership of funds, the levy scheme be abolished in favour of a levy on motor vehicle licences. This scheme was favoured as a larger number of people have drivers licences, it would be less discriminating and the administration would be less complex; the Department of Motor Transport already has the infrastructure and mechanism in place for the collection of licence fees.

11.11 In view of the problems being experienced with the current private health insurance levy system, the PAC canvassed a number of options as means of contributing towards the funding of the Service. These options are:

i) That no charges be levied on users of ambulance services and all costs be met from general Government revenue;

ii) Negotiate with the Commonwealth for ambulance charges to be included under Medicare;

iii) Re-introduce a contribution scheme similar to the previous Ambulance Contribution Scheme;

iv) A levy be raised on motor vehicle licences; and

v) Retain the existing levy arrangements.

11.12 On balance the PAC believes that consideration be given to the introduction of a levy and/or contribution scheme that provides a greater coverage of the population.

11.13 The introduction in 1989 of the new motor vehicle licences with fees to be paid on a five yearly basis may render a levy on these impractical.

11.14 The first two options are not favoured as the full government funding goes against the principle of user pays and there appears to be little guarantee that any negotiations with the Commonwealth would be successful particularly as they were not in the past.

## Recommendation 38

**11.15 That an alternative to the Health Insurance levy be examined as a means of insurance against ambulance transport fees.**

# 12. AMBULANCE RESCUE

12.1 The Gleeson Report made recommendations towards improving the co-ordination of rescue activities between the Ambulance, Fire Brigade and the Police and that sufficient ambulances in NSW be equipped with basic rescue (from motor vehicle accidents) equipment.

12.2 It appears to the PAC that the Ambulance Service has attempted to comply with the recommendations. The State Superintendent, Operations, advised the PAC that a *"bat phone system"* connecting the communications networks of the Police, Fire Brigade and Ambulance had been established and that the service with the shortest response time is commissioned in a rescue situation.

12.3 Despite this action, the PAC, in the course of its investigation, has noted that co-ordination between the three services can still cause difficulties, with more than one service responding to a call. The PAC considers this to be inefficient use of scarce resources and there appears to be unwarranted competitiveness between the services.

12.4 While it is understood that the Police have the statutory responsibility for rescue, the Ambulance Service, however, plays a significant role in rescue, particularly with the large number of road accident rescues. It was brought to the PAC's attention on many occasions that ambulance officers, with their training in patient care and resuscitative skills, are vital to the success of rescue operations. As the Metropolitan Superintendent said:

> *"... Ambulance Officers are the best equipped ... there is a medical consideration ..."*

12.5 The PAC was interested to note comments during its Inquiry concerning the nature of the majority of rescue incidents. As noted before, the Metropolitan Superintendent explained to the PAC that:

> *"... the majority of rescues that are carried out involve the extrication of people from motor vehicles and some simple tools will effect that operation in the majority of cases".*

12.6 The PAC has not been able to gain access to the report by Major General Gray on Rescue Services.

12.7 The PAC looks forward to reviewing the Gray Report as it considers that the role of rescue needs to be clarified and either retained wholly by one of the services or set up and managed as a separate service.

## Recommendation 39

12.8 **The PAC recommends, subject to the Gray Report, that emergency rescue services be undertaken wholly by one existing service.**

# 13. ATTENDANCE AT SPORTING FIXTURES

13.1 The Ambulance Service provides stand-by ambulances at selected sporting fixtures, in particular, racing events. The Gleeson Report recommended that charges for this service should be monitored and reviewed regularly.

13.2 This has been implemented and the current scale of charges is as follows:

| | | |
|---|---|---|
| Ambulance with one officer | half day | $120 |
| Ambulance with one officer | full day | $200 |
| Ambulance with two officers | half day | $200 |
| Ambulance with two officers | full day | $360 |

13.3 In its investigations the PAC has noted some concern regarding the use of scarce staff and vehicles for this stand-by work. In particular, attendance at race meetings in the metropolitan area, where downtime is insignificant, appears to cause problems.

13.4 In view of the above the PAC considers that not only should charges be monitored and reviewed regularly, but that the ability to pay of the organisation running the fixture (e.g., the Australian Jockey Club, Sydney Turf Club) should be taken into consideration in setting the level of fees for a particular organisation and that fees wherever possible, should represent both operating and capital costs.

## Recommendation 40

13.5 That the level of fees charged for attendance at sporting fixtures represent the full cost to the Service including operational and capital costs.

# APPENDIX 1

Minister for Health
New South Wales

Sydney

ANG:np

4th August, 1988.

Mr. Phillip Smiles, M.P.,
Chairman,
Public Accounts Committee,
Parliament House,
SYDNEY. 2000

Dear Phillip,

As Minister for Health, I am now in a position to invite the PAC to examine the N.S.W. Ambulance Service according to the Terms of Reference attached to this letter.

I look forward to receiving your Committee's comments on this Ministerial Reference once you have had time to deliberate upon it.

There are other matters in the Health portfolio that I will refer to you once I am in a position to do so.

Yours faithfully,

PETER COLLINS, M.P.,
Minister for Health.

## TERMS OF REFERENCE
## AMBULANCE SERVICE, N.S.W.

The terms of reference for the Inquiry are:-

i) to assess the impact of implementing recommendations of the 1982 Inquiry into the N.S.W. Ambulance Service (Gleeson Report);

ii) to inquire into the efficiency and effectiveness of the management of ambulance services in New South Wales;

iii) to review the management and cost structure of the Ambulance Service;

iv) to examine the extent of improvements in the collection of outstanding unpaid ambulance transport fees since the Committee's inquiry into the matter in 1986;

v) to investigate any other matters relevant to the efficient operation of ambulance services in New South Wales.

# APPENDIX 2

## INSPECTION BY THE PAC
## FOR THE INQUIRY INTO
## THE NSW AMBULANCE SERVICE

### INTERSTATE INSPECTIONS

The PAC visited Adelaide and Brisbane in June and Melbourne in July having discussions with officials of the Ambulance Services in those respective centres.

### INTRA-STATE INSPECTIONS

To maximise coverage of the State the PAC split into sub-committees and visited the following Ambulance Stations:

| MONTH | | LOCATION |
|---|---|---|
| June | | Broken Hill, Bourke, Walgett, Taree, Port Macquarie, Coffs Harbour, Lismore, Tamworth, Armidale. |
| July | | Wagga Wagga, Albury, Wollongong, Bomaderry, Bowral, Goulburn, Braidwood, Queanbeyan. |
| September | Central District Headquarters | Various metropolitan stations, Air Ambulance (Mascot) |
| October | | Dubbo, Bathurst |
| November | | Belmont, Hamilton (Newcastle), Boolaroo |

# APPENDIX 3

## SUBMISSIONS RECEIVED

### MINISTERS

| | |
|---|---|
| The Hon. V.A. Chadwick, MLC | Minister for Family & Community Services |
| The Hon. J.R. Dowd, MP | Attorney-General |
| The Hon. T. Moore, MP | Minister for the Environment |
| The Hon. M. Singleton, MP | Minister for Administrative Services |

### MEMBERS OF PARLIAMENT

| | |
|---|---|
| Mr D.J. Berry, MP | Member for Bathurst |
| Mr R.F. Chapple, MP | Member for Northern Tablelands |
| Ms A.M. Cohen, MP | Member for Minchinbury |
| The Hon R.S.L. Jones, MLC | |

### OTHER ORGANISATIONS/INDIVIDUALS

Acol Pty Ltd
Ambulance Superintendents Association

Mr B. Brown

Careflight Ltd
Central Coast Community Transport Inter-Agency
Community Transport Organisation
Mr J. Cowper
Mr S. Croft

Mr G. M. Eastlake

Mr A. Fritsche

Mr P. Goodwin
Mr J.M. Gooley

The Health Funds Association
Health & Research Employees Association of Australia -
Brisbane Water Ambulance Sub-Branch
Hordern Hutchings Pty Ltd

Mr C. Kimmings

OTHER ORGANISATIONS/INDIVIDUALS

Marrickville-Canterbury Community Transport Inc.
Medical Benefits Fund
Medibank Private
Mr R.W. Merlin
Mr R. Morris
Mr D.J. Mott

Associate Professor M.F. O'Rourke

Rockdale Community Aid & Information Service Inc.

Mr J.J. Sillance
Mr K.W. Smith
Mr R.M. Stewart

Mr E.J. Taylor

Mr J.D. Walker
University of Wollongong School of Health Services

Dr R.V. Young

# APPENDIX 4

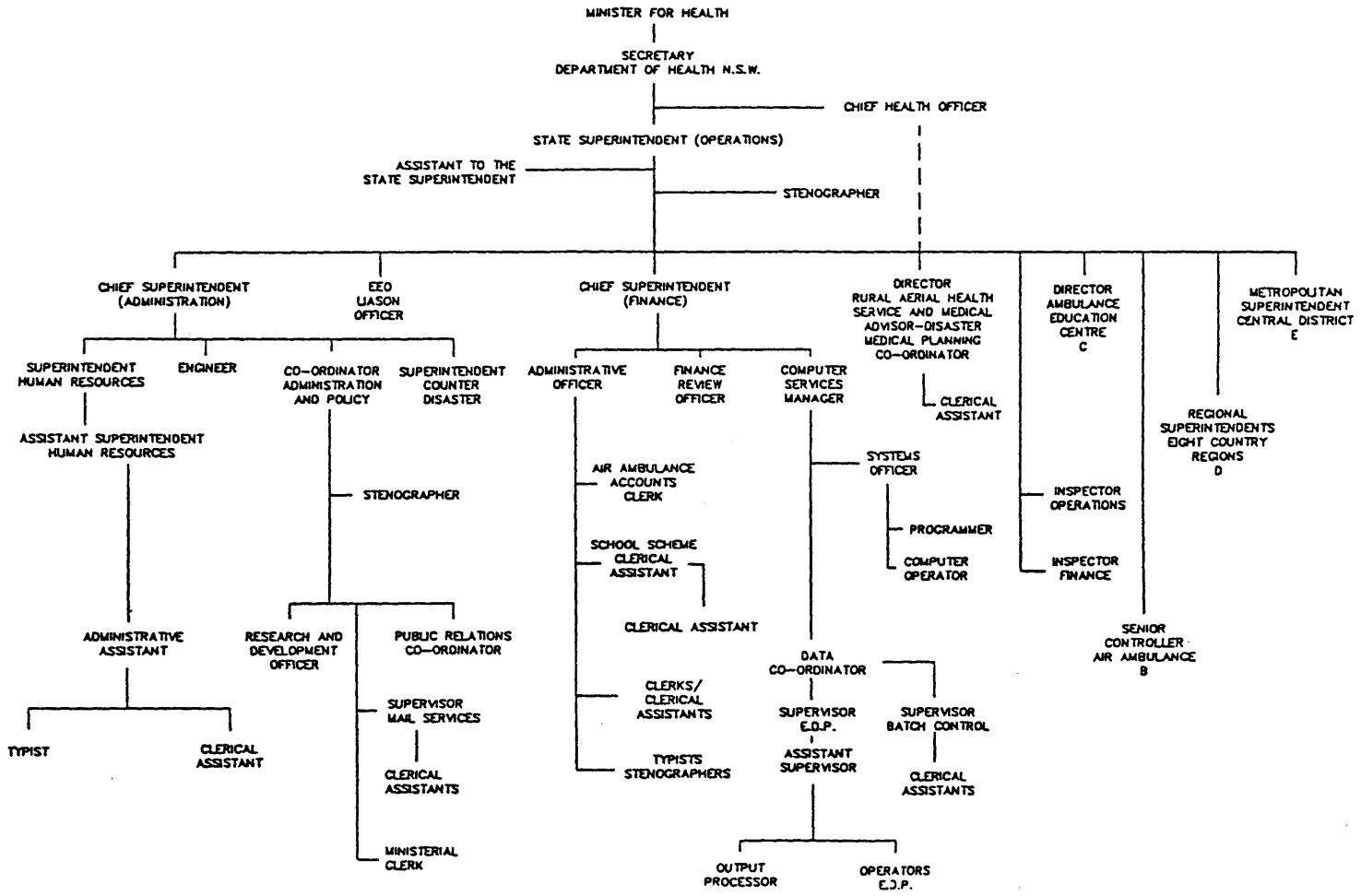
## WITNESSES AT HEARINGS

(*Transcripts of Evidence in Volume 2*)

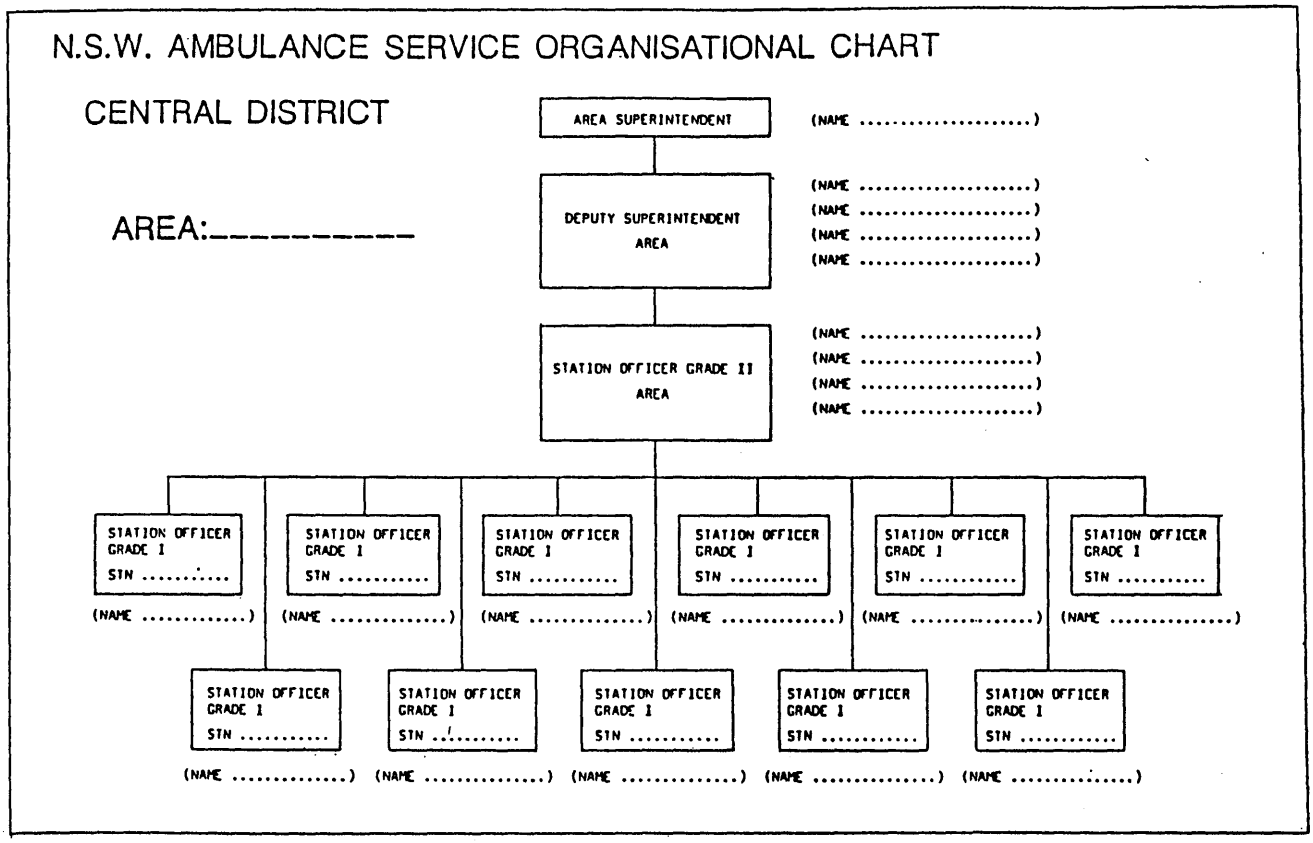
| Date of Hearing | Name of Witness |
|---|---|
| 8th September, 1988 | ***NSW AMBULANCE SERVICE***<br>Mr K.W.F. Graham<br>*State Superintendent Operations*<br><br>Mr J.K. Bradford<br>*Chief Superintendent, Finance*<br><br>Mr J.N. Ryan<br>*Chief Superintendent Administration*<br><br>Mr G.R. Webster<br>*Regional Ambulance Superintendent, Central Western Region*<br><br>Mr J.R. Noble<br>*Director of Ambulance Education*<br><br>***NSW DEPARTMENT OF HEALTH***<br>Mr T.C. Wootton<br>*Executive Director, Management Unit*<br><br>Ms A. Goodwin<br>*Policy Analyst, Service Planning Branch* |
| 27th September, 1988 | ***NSW AMBULANCE SERVICE***<br>Mr J. Hawkins<br>*Metropolitan Superintendent Central District Ambulance*<br><br>Mr P.J. Bylsma<br>*Ambulance Engineer* |

| | |
|---|---|
| 27th September, 1988 | ***NSW DEPARTMENT OF HEALTH***<br>Mr M. A. D. Rosser<br>*Secretary*<br><br>Mr J.B. Kilkeary<br>*Deputy Director (Industrial)*<br>*Division of Human Resources*<br><br>Mr A.G. St Flour<br>*Policy Adivsor (Finance)* |
| 28th September, 1988 | ***NSW AMBULANCE SERVICE***<br>Mr J.K. Bradford<br>*Chief Superintendent, Finance* |
| 29th September, 1988 | ***NSW DEPARTMENT OF HEALTH***<br>Dr G.A. Ambrose<br>*Medical Advisor to State Superintendent* |

## ORGANISATIONAL STRUCTURE N.S.W. AMBULANCE SERVICE



# APPENDIX 6


N.S.W. AMBULANCE SERVICE ORGANISATIONAL CHART
CENTRAL DISTRICT
AREA:_____
AREA SUPERINTENDENT
(NAME .....)
DEPUTY SUPERINTENDENT AREA
(NAME .....)
(NAME .....)
(NAME .....)
(NAME .....)
STATION OFFICER GRADE II AREA
(NAME .....)
(NAME .....)
(NAME .....)
(NAME .....)
STATION OFFICER GRADE I
STN .....
(NAME .....)

# APPENDIX 7

$'000

| ITEM | 1984/85# | 1985/86# | 1986/87# | 1987/88# | 1988/89* |
|---|---|---|---|---|---|
| *RECURRENT EXPENDITURE* | | | | | |
| Salaries & Related | 71,812 | 74,655 | 80,942 | 87,719 | 99,589 |
| Transport Costs | 7,510 | 8,106 | 8,371 | 10,355 | - |
| Motor Vehicles | 4,836 | 4,829 | 5,326 | 6,214 | 7,200 |
| Repairs & Maintenance | 1,880 | 1,377 | 1,441 | 1,364 | - |
| Other Expenditure | 6,416 | 6,313 | 6,852 | 8,672 | 23,529+ |
| Total | 92,455 | 95,280 | 102,932 | 114,324 | 130,318 |
| *CAPITAL WAGES EXPENDITURE* | | | | | |
| Major Works - Planning & Construction | 4,228 | 3,199 | 2,165 | 1,662 | 4,814 |
| Minor Works - Building, Communications & Equipment | 762 | 1,266 | 1,922 | 1,118 | 2,046 |
| Properties | 332 | 384 | 348 | 358 | 500 |
| Total | 5,322 | 4,849 | 4,435 | 3,138 | 7,360 |
| *RECEIPTS* | | | | | |
| Transport Fees - | | | | | |
| Road | 18,644 | 19,714 | 21,116 | 20,683} | |
| Air | 5,263 | 5,100 | 5,392 | 5,996} | 28,500 |
| Other Income | 2,923 | 3,201 | 3,938 | 4,245 | 4,300 |
| Total | 26,830 | 28,015 | 30,456 | 30,924 | 32,800 |

# Source : Ambulance Service
* Budget Estimate
+ Includes Transport & Repairs & Maintenance Costs

# APPENDIX 8

## AMBULANCE SERVICE

### SCHEDULE OF AMBULANCE FEE COMPARISON 1981/1988.

| YEAR DATE OPERATIVE | FIRST 16 KILOMETRES OR PART THEREOF | EACH ADDITIONAL KILOMETRE OR PART THEREOF | MAXIMUM FEE CHARGED |
|---|---|---|---|
| 1. 2.81 | $62.50 | $1.60 | $1,500.00 |
| 1. 1.82 | $75.00 | $1.92 | $1,800.00 |
| 1.12.83 | $82.50 | $2.11 | $1,980.00 |
| 1.12.84 | $89.10 | $2.28 | $2,138.00 |
| 1.12.85 | $95.40 | $2.44 | $2,288.00 |
| 1. 1.87 | $102.10 | $2.61 | $2,448.00 |
| 1. 1.88 | $109.20 | $2.79 | $2,619.00 |

Fees increased by Treasury Direction contained in budget advice each year.

# APPENDIX 9

# COSTING ANALYSIS 1987/88

| TOTAL TRANSPORT | CASES | KILOMETRES TRAVELLED |
|---|---|---|
| | 537,257 | 15,854,469 |

Average Kilometres per case = $\frac{15,854,469}{537,257}$ = 29.51

Total Recurrent Expenditure 1987/88 = $114.093 million

Average Cost per case = $\frac{\$114.324 \text{ million}}{537,257 \text{ cases}}$ = $212.79

Average Cost per kilometre = $\frac{\$114.324 \text{ million}}{15,854,469 \text{ km}}$ = $7.21

Average recovery per km based on current fee structure i.e., $109.20 for first 16 km + $2.79 per km thereafter

| | | |
|---|---|---|
| 16 km | - | $109.20 |
| 13.51 @ $2.79 | - | $ 37.69 |
| 29.51 km | | $146.89 |

Average recovery per km = $\frac{\$146.89}{29.51}$ = $4.98 [1]

1 The mathematical limitations of this analysis, where there is averaging of an average, are recognised but it is felt that it provides a reasonably accurate result.

# Public Accounts Committee

**APPENDIX 10**

Parliament House, Sydney 2000
Telephone 230 2631
230 2111

PARLIAMENT OF NEW SOUTH WALES
LEGISLATIVE ASSEMBLY

11th December, 1986.

The Hon. Peter T. Anderson M.P.,
Minister for Health and
Minister for the Drug Offensive,
22nd Floor, McKell Building,
Rawson Place
SYDNEY New South Wales 2000

Dear Mr Anderson,

The Committee is currently reviewing the 1985-86 Report of the Auditor-General. As you may be aware the Committee raised the issue of unpaid accounts for ambulance transport fees with your Department as part of its review of the 1983-84 Report of the Auditor-General.

The Committee notes that the amount of unpaid fees has continued to increase since 1983-84 and stood at $9.3 million at 30 June 1986. Amounts written off during the year were $1.3 million.

The Committee would appreciate your comments on the reasons for the continuing increase in fees outstanding and the high level of write-offs.

The Committee notes that a number of reforms were introduced following a Committee of Inquiry established in March 1982, which addressed among other matters, the financing of the Ambulance Service. The Committee is interested in action taken following this inquiry and the current position re review and follow-up of unpaid accounts.

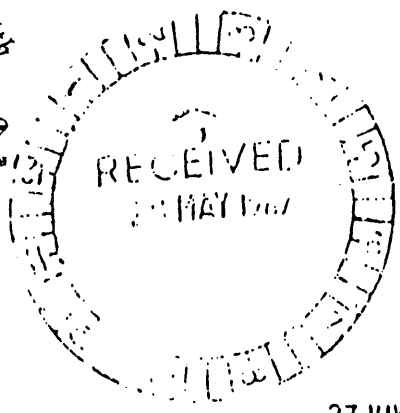
The Committee would also appreciate an aged and category analysis of unpaid transport fees.

Receipt of your comments by Friday 16 January, 1987 would be appreciated.

Yours faithfully,

John Murray, M.P.,
Chairman.

Minister for Health
New South Wales




86/8459

Sydney

Mr. J.H. Murray, B.A., M.P.,
Chairman,
Public Accounts Committee,
Parliament House,
SYDNEY. N.S.W. 2000

27 MAY 1987

Dear Mr. Murray,

I refer to your letter of 11 December, 1986 in which you raise questions relative to the level of outstanding Ambulance transport fees. The delay in replying is regretted.

I confirm that outstanding ambulance transport fees stood at $9.3 million as at 30 June, 1986 compared to $7.0 million at 30 June, 1984.

Three major factors have contributed to the increase in outstanding fees as at 30 June, 1986 compared to outstanding fees as at 30 June, 1984.

Factor one has been the increase in fees charged for ambulance transports, as directed by Treasury, viz.-

| Date | 1-12-1984 | 1-12-1985 |
|---|---|---|
| Increase | 8% | 7% |
| Minimum Fee | | |
| Rate - | $89.10 | $95.40 |
| Increase - | $6.60 | $6.30 |
| Kilometre Charge | | |
| Rate - | $2.28 | $2.44 |
| Increase - | $.17 | $.16 |
| Maximum Fee | | |
| Rate - | $2138.00 | $2288.00 |
| Increase - | $158.00 | $130.00 |

Note should also be made of further increases from 1 January, 1987 of 7% which have an effect on the 1986/87 financial year.

Factor two is that despite an overall decrease in patients transported, there has been an increase in the number of accident/emergency and medical/surgery patients transported which is the category of patients that generate accounts.

Factor three involves the charges made for inter-hospital transports, which form 48.62% of accounts issued for the year 1985/86. At 30 June, 1984, fees owed for inter-hospital transport were $3.5m, 39.66% of the total outstanding, whilst at 30 June 1986, fees owed for this service amcunted to $3.9m, 42.39% of the total outstanding. This represents an increase of $.4m or 2.73%.

Recognised Public Hospitals throughout the State have tended not to regard the payment of Ambulance fees as a high priority, as the Ambulance Service is one part of the Health Department. This is subject to constant monitoring and follow up by the Department with Hospitals.

Methods of accounting and reporting in place prior to 30 June, 1984 do not permit a comparison of accounts issued for 1983/84 with total accounts issued in 1985/86. However, actual total charges for 1985/86, when compared to charges issued for the year 1984/85, show an increase of $3,803,590.

The level of charges or accounts written off is affected also by increased fees and increase in transports that generate accounts.

As a result of difficulties experienced in obtaining accurate information at the time of some transports, due to the condition of patients, a number of accounts raised have to be written off as a bad or doubtfut debt.

Categories of patient transport accounts raised which subsequently required action to be taken to write off the accounts include Workers' Compensation cases, pensioners or other recognised Health Care card holders, subscribers to the Ambulance Schools Scheme, Interstate Ambulance Contributors, State Wards, Prisoners in Custody and Police Officers injured whilst on duty.

Accounts are now being written off progressively where there is clear evidence that collection is not appropriate.

On 1 February, 1982 the following persons became eligible for free ambulance service in New South Wales:

a) Those who are holders of one or more of the following cards issued by the Department of Social Security: Pensioner Health Benefits, Health Benefit, Health Care, Pharmaceutical Benefits Concession, Concession Card and Social Security Card.

..3/

b) Persons who are in receipt of Service Pensions under Division 5, part 3 of the Repatriation Act (1920) of the Commonwealth.

On 1 February, 1983 the N.S.W. Government legislated to abolish ambulance charges for those people covered by basic hospital insurance with a registered health fund, and to replace the Ambulance Contribution Scheme with an ambulance levy on basic hospital tables of those funds.

The Health Insurance Levies Act 1982 requires a declaration to be furnished regarding a patient's basic hospital fund membership, before any exemption from Ambulance transport charges can be applied.

On 1 February, 1984 the Federal Government's health scheme (Medicare) was introduced. With its introduction it became necessary for the N.S.W. Government to establish the State Insurance Plan for those people who required ambulance coverage and opted for Medicare cover alone, without separate basic hospital insurance with a registered health fund.

The State Ambulance Insurance Plan is available through four nominated Health Funds, acting as authorised agents for the Plan. Rates are comparable to those applied to the Ambulance levy on the Health Funds.

State Ambulance Insurance Plan members are required to complete the declaration form declaring details of their membership to be exempted from ambulance transport charges.

It is not always convenient at the time the ambulance transport is being carried out for a patient to complete a declaration form. The declaration form is normally forwarded out to the client at the time that the ambulance transport account is submitted. At times patients are reluctant to complete and return the declaration form to enable appropriate action to be taken to cancel the account.

Special arrangements were established with the Government Insurance Office of N.S.W. in regard to bulk billing of motor vehicle third party ambulance transport accounts. The G.I.O. does not pay the total cost of ambulance transport accounts raised by the Service. In fact the reimbursement received by the Ambulance Service is an amount equivalent to 90% of the claims lodged and registered with the G.I.O. Any difference between the amount received from the G.I.O. and the total amount of third party ambulance transport fees raised is required to be written off.

..4/

As previously indicated in correspondence to the Public Accounts Committee, following the establishment of a Directorate of Ambulance Services within the Central Office of the Department, a special fees review section was created which was responsible for:

i) An ongoing review of all aspects of fees raising, fees collection and follow up of outstanding accounts throughout the whole of the Ambulance Service.

ii) The establishment of standardised fees procedures which each Ambulance Regional Administration must follow.

iii) Submission of monthly reports to the Central Finances Committee within the Directorate on the performance of each Region.

iv) Regular visits by officers in charge of the review section to each Region to ensure adherence to practices and procedures.

v) Presentation each month of an age and category analysis of outstanding fees for each Region as well as total overview.

vi) Twice yearly conference of the Assistant Superintendents (Finance) are held to discuss issues pertaining to finance and fees collection.

The special section has continued to carry out these respective responsibilities, with overall control and direction being provided through a Chief Superintendent (Finance) who was appointed in April 1985. Additionally, the Ambulance Directorate has taken action to appoint a fees collection officer in each of the Regions and Central District Ambulance. These fees collection officers are now responsible for follow up procedures and instituting recovery action on all outstanding transport debtor accounts.

Standard practices have been established within each Region for accounting and handling of uncollected accounts. Where necessary, appropriate legal action is taken to recover the outstanding debt. Accounts in excess of $2000 are referred to the Crown Solicitor for recovery action.

Since the last report to the Parliamentary Accounts Committee, the Ambulance Directorate has been working to introduce an improved computerised debtors system, applicable on a Statewide basis. This is scheduled to commence on 1 September, 1987.

..5/

As requested, a copy of the aged analysis and reconciliation statement of the Ambulance Service's unpaid transport fee account as at 31 November, 1986 is attached.

Yours sincerely,

Peter Anderson

PETER ANDERSON,
Minister for Health

# APPENDIX 11

1. BILLING

1.1 It is accepted that in 1987 accounts were delayed and this was inherent in the former system. Some delay is being experienced in having case slips processed at station level at present and this issue is being addressed with the view of minimising the delays. An upgraded debtors system was implemented in December, 1987 in conjunction with the establishment of a new computer network.

Strategies implemented to overcome some of the problems are:

(i) New computer operational from 1 December 1987. This has overcome many of the problems identified in work prior to this date.

(ii) A new billing system has been developed and is now operational. Reporting is being refined, however a comprehensive reporting system does exist at present.

(iii) Issue of accounts is now generally within approximately 14 calendar days of undertaking the transport.

(iv) Account runs are presently undertaken once per week, however daily processing will be introduced when the system is able to accommodate the process.

(v) Action has been taken to appoint a programmer to Ambulance computer Services. This position was approved some time ago but not filled as a result of the Government imposed staff freeze.

Preparation is under way to bring all the State Services on line for receipts and batch processing of accounts on a daily basis. At present the system of daily receipting is being tested for Central District Accounts to verify the programme. Illawarra, Hunter and North Coast Regions will be on line for payments from Monday, 22 August, 1988. Remainder of Regions to follow by January, 1989.

In comparing the time taken with other Authorities for a client to settle an account due regard should be given to the physical ability of an Ambulance Service client and incentives other Authorities employ (e.g. cut off services) which are not available to the Ambulance Service.

1.2 (i) Random data entry eliminates the need for an additional manual sort to isolate the priority case slips. At the time of audit backlog did exist and priority was given to chargeable case slips. There is no backlog at present. Should backlogs occur priority will be given to isolating case slips which result in the generation of accounts.

1.2 (ii) As from 22 August, 1988 first reminder notices will issue at 14 days (maximum) and notice before proceeding will follow in a further 21 days.

A review will be undertaken for the purpose of identifying alternative methods to facilitate payment of accounts (e.g. Bankcard, Direct Bank Deposit).

1.2 (iii) Debt collection agencies were utilised by the New South Wales Ambulance Service for a limited period. The cash returns from the two collection agencies engaged were insufficient to meet the costs involved. The period involved was January 1984 to December 1984 when agreements were terminated.

The Ambulance Service will undertake a cost/benefit analysis on the collection of outstanding fees and make a determination on the additional methods to be employed.

1.3 As you have indicated in your report, not a great deal of money is involved in the transport of overseas visitors. There is no practical method that can be implemented to ensure payment prior to visitors returning home and it is not considered practical to seek to establish a separate system for this group. Alternative solutions of the past are now not industrially acceptable to the employee association involved.

1.4 As outlined in the opening comments on financial accountability, the adoption of a user pays principle for ambulance services would be a policy decision for Government determination.

While the desirability of providing information to the public on costs of services provided free to pensioners, etc. is not disputed, there is no existing provision for such reporting within the Treasurer's Directions under the Public Finance and Audit Act.

An implication of introducing the user pays principle would necessitate a substantial increase in fees to embrace all overhead costs.

1.5 The comments in the review relating to debt collection are noted. The review of collection procedures as mentioned in 1.2 (iii) applies.

1.6 Remitting or cancelling accounts is provided for in the Delegations of the Department of Health.

1.6 (i) Previous comments in 1.2 (iii) refer to a review of the total collection process.

1.6 (ii) The Ambulance Service will arrange for an independent review of "write off" schedules.

1.7 A strategy has been put into place in an effort to encourage the hospitals to respond to the accounts earlier than they have in the past.

(i) A schedule is now provided to the hospital in duplicate; one to use as the invoice on which to pay and the second for their own records.

(ii) If payment is not received in 30 days, the Transport Accounts Co-ordinator contacts the hospital by telephone and requests early settlement.

(iii) If payment has not been received after 60 days, the Metropolitan Superintendent contacts the Chief Executive of the Area Health Board who is requested to take action to have accounts settled.

(iv) Action will be taken to alleviate delays in the receipt of case slips from ambulance stations. Further strategies for collection will be addressed in the proposed review as mentioned earlier.

1.8 Collection procedures will be reviewed in line with earlier comments (See 1.2. (iii).

1.9 The Ambulance is investigating a suitable computer programme to establish a master list of bad debts.

1.10 At the time of audit the billing programme and reporting systems were still in the final developmental stage. Users were still unfamiliar with the operation and the capabilities of the programme.

Two members of the programme project team had recently met with an officer of the Auditor General's Department and most issues have been addressed and resolved, and additional issues raised have been addressed.

1.11 In most cases the Sydney Turf Club and Australian Jockey Club settle accounts within one month of receipt of account.

The problem which existed was an internal traditional system problem whereby case slips for attendance at sporting fixtures have been held out until all the months attendances have been accounted for. Processing was then permitted to proceed. This practice no longer exists. A random review indicates accounts are now being settled promptly.

The practice of prior payment is enforced with known delinquent operators.

# APPENDIX 12

## NEW SOUTH WALES AIR AMBULANCE SERVICE

The New South Wales Air Ambulance Service operates from Sydney (Kingsford-Smith) Airport. An Air Ambulance Base was constructed in 1985 and is located on the corner of Eleventh Street and Perimeter Road. This Base consists of a twin bay in tandem aircraft maintenance hangar, patient wing including ambulance bay, administration and amenities wing, engineering facilities and aircraft apron and taxiway.

Twelve Control Officers are employed by the Department of Health, N.S.W. on full time duty giving continuous 24 hours control. Sixteen Flight Nurses are employed by the Department of Health, N.S.W. on full time duty with the Air Ambulance Service. Pilots are Senior Commercial pilots employed by East-West Airlines for exclusive duty with the Air Ambulance Service. Engineers are also employed by East-West Airlines on full time duty with the Air Ambulance and provide a 24 hour engineering coverage.

The scope of the operations is primarily within New South Wales, but has the capacity to operate to Melbourne, Brisbane, Adelaide, Broken Hill, Lord Howe Island and other suitable airstrips within a 700 nautical mile radius from Sydney. The Service operates on a routine basis Monday to Saturday (inclusive) to provide a planned routine service to the various Health/Ambulance regions twice per week. For the transport of urgent cases the Service is available at all times.

The Air Ambulance Service operates five Air Ambulance aircraft:-

Beechcraft Queen Air B80 Series unpressurised, piston driven:

VH-AMG Year of Manuracture 1969 In service date 11.11.1969
VH-AMQ Year of Manufacture 1971 In service date 19.09.1971
VH-AMD Year of Manufacture 1975 In service date 10.08.1983

Beechcraft King Air B200C series pressurised, turbo prop aircraft:

VH-AMM Year of Manufacture 1985 In service date December 1985
VH-AMR Year of Manufacture 1985 In service date November 1985.

Helicopters are available to the Ambulance Service for both Primary and Secondary responses. Responses by helicopters for Primary reeuqests are activated and authorised by the Ambulance Service. For hospital to hospital transfers the Air Ambulance Service activates and authorises the appropriate helicopter service. The helicopters are operated by the Surf Life Saving Association of Australia, CareFlight and The National Safety Council of Australia.

The Air Ambulance Service assists in arranging medical retrievals from country hospitals to major medical facilities.

HEALTH ADMINISTRATION CORPORATION
Ambulance Service

AMBULANCE DIRECTORATE
Our Reference: V.McMahon:LM
Your Reference:
Phone: (02) 818 0209
Fax: (02) [redacted] 818 0360

METROPOLITAN SUPERINTENDENT
REGIONAL SUPERINTENDENT, HUNTER REGION
REGIONAL SUPERINTENDENT, ILLAWARRA REGION

7 November 1988.

Below are interim trauma triage guidelines for despatch of authorised helicopters to primary (pre-hospital) patients as approved for implementation by the past meeting of the Medical Advisory Committee of the N.S.W. Ambulance Service.

Aim: To provide the benefit of rapid medical care to the patient, with the rapid provision of a doctor to the patient, or rapid transport of the patient to appropriate facilities.

1. A helicopter should be called when the expected response time of the helicopter to the scene would be less than the road time to hospital with appropriate specialist facilities.

2. Head injury with Glascow Coma Scale nine or less, after initial resuscitation.

3. Head injury with localising signs (regardless of Coma Score).

4. Severe chest or abdominal injury if trapped and likely to be a significant delay in transport to hospital.

5. Trauma where, after receiving three units of Haemaccel, the systolic blood pressure remains less than 90 mm of Hg.

6. Spinal injury where there is known neurological deficit.

7. Decompression sickness or diving air embolism, with a requirement to maintain the lowest safe altitude.

Notes:

a) These guidelines do not exclude helicopter despatch for other reasons if the officer on scene deems it necessary.

b) This does not exclude the request of a medical officer for non-trauma related incidents.

c) Where the helicopter is unavailable by virtue of weather or built up area location, consideration should be given to despatching the medical officer by road ambulance.

d) It is not the intention of these guidelines to prevent transport to a nearby hospital for interim management. In these cases the officer should alert the Ambulance Co-ordination centre so that a helicopter can be put on standby or despatched to rendevouz at that hospital.

John K Bradford

J.K. BRADFORD,
for
STATE SUPERINTENDENT (OPERATIONS).

# APPENDIX 14

SUMMARY OF RECOMMENDATIONS

Role and Function of the Ambulance Service

1. The Ambulance Service should have a dual role:-
   A) to provide emergency services; and
   B) to transport patients in non-emergency situations to and from appropriate health services, where the patient's condition prohibits the use of alternative means of transport.

2. The Ambulance Service should continue to provide for all accident and emergency service requirements in N.S.W.

3. Guidelines should be circulated to medical practitioners advising them that to be eligible for non-emergency ambulance transport patients will normally require stretcher transport, active management or monitoring in transit or will be patients with conditions which would cause the patient to be either gravely embarrassed or unacceptable to other people on public transport (e.g. incontinent of bladder or bowel, gross deformity or disfigurement).

4. Where the medical condition of patients requires the use of an ambulance, Medical Superintendents or Directors of Nursing in the absence of a Medical Superintendent should be responsible for ordering such transport.

5. Medical practitioners in country areas should be encouraged to recommend the Isolated Patients Travel and Accommodation Assistance Scheme to eligible patients as an alternative to ambulance transport.

6. The compliance of medical practitioners ordering ambulance transport with these guidelines should be subject to the review mechanisms.

7. Inter-hospital transfer by ambulance should be ordered where the hospital Medical Superintendent or a medical practitioner authorised by him warrants the medical condition of the patient requires transport by ambulance. If the hospital does not have a Medical Superintendent, transport should be authorised by the Director of Nursing.

8. The Ambulance Service should not continue transporting day treatment cases except those who meet the criteria outlined above.

9. The fleet of ambulance vehicles and staff establishment should be consistent with the numbers required to meet the defined role as outlined above but should not be expanded in order to accommodate day treatment cases falling outside the defined role.

10. A review of the staff establishment and vehicle numbers should be undertaken after the implementation of recommendations concerning the role of the Ambulance Service.

11. The Health Commission should ensure the provision of alternative means of transport for day treatment patients.

12. Sufficient notice should be given to current users of day treatment transport services who will qualify under the new role of the Ambulance Service to allow them to make alternative transport arrangements.

13. In small country towns where there is some ambulance stand-by time available to transport day treatment patients this should continue but demand for day treatment transport should not be used as the basis for allocating additional resources.

14. Charges for attendance by the Ambulance Service at sporting fixtures should be monitored and adjusted regularly to avoid a repetition of the recent steep increase in stand-by charges.

15. Ambulance Officers should no longer provide first aid casualty services at ambulance stations except in the following circumstances:-
    - an emergency requiring immediate treatment
    - where an ambulance station is located at a substantial distance from a hospital casualty; such stations should be formally designated by ambulance management.

16. Transport utilisation should be referred to the review Panels established by Recommendation 18 below.

17. A comprehensive transport review mechanism should be established to ensure that unwarranted growth of ambulance transport services does not recur.

18. Ambulance Transport Review Panels should be established in each rural health region and in the Central Ambulance District. These panels to comprise a nominated Ambulance Officer, a medical practitioner, and should be chaired by the Regional Director in rural health regions or a nominee of the Health Commission in the Metropolitan area.

Paramedics

19. An evaluation of the comparative benefit of the paramedic service should be undertaken as a matter of extreme urgency.

20. There should be introduced a long term intensive, statewide programme to be conducted by the Ambulance Service in co-ordination with other interested community groups, public hospitals, and the Health Promotion Division of the Health Commission designed to improve public skills in cardio-pulmonary resuscitation techniques.

21. Such training should be part of the school curriculum.

Rescue Services

22. Sufficient ambulances in N.S.W. should be fitted with rescue equipment to extricate the majority of patients involved in motor vehicle accidents and all ambulance officers should be trained in the use of this basic equipment as part of their routine training.

23. In metropolitan areas, co-operation between the emergency services involved in rescue work namely the Ambulance, Fire Brigade and Police should be improved and better regulated in the following manner:-

1. Where an emergency requires patient extrication, the service first alerted should immediately notify the Ambulance Service if casualties are involved.

2. At the scene of the emergency no action should be taken to rescue injured persons without consultation with the senior Ambulance Officer present who shall have prime responsibility for the safety of the patient both during and after extrication.

3. Where no Ambulance Officer is present and none likely to arrive within a reasonable time, rescue workers at the scene may take action only where they form the view that the patient's safety is in danger if the rescue is not effected forthwith.

4. Efforts should be made to develop interservice relations at the local level between officers of the Ambulance Service, Fire Brigade and Police. These relations should be further cemented by regular joint exercises simulating low level disasters.

24. In rural areas where there are currently no rescue services or distances involved are such as to make response times by qualified rescue teams unacceptably long, a more advanced rescue service should be provided by the Ambulance Service. This would involve:-

1. Training on a progressive basis of country ambulance officers in more advanced rescue techniques. This more specialised rescue training of Ambulance Officers should be conducted at a statewide training centre.

2. The provision so far as is practicable of additional standard equipment in rural ambulances necessary to effect rescue consistent with the training referred to in 1 above.

25. The Ambulance Rescue Training School at Caringbah should be closed forthwith.

26. Existing Ambulance Rescue vehicles should remain in service until sufficient Ambulance Officers are trained in patient extrication skills and the equipment obtained to given an adequate level of cover. These vehicles should then be withdrawn from service or, if they still have some useful life they should be transferred to rural areas currently without specialised services. No new specialised ambulance vehicles should be purchased.

Air Ambulance Service

27. Where there are no medical contraindications some form of public transport should always be used in preference to the Air Ambulance.

28. Patients who take public transport should be encouraged to take advantage of the Isolated Patients Travel and Accommodation Assistance Scheme, and where necessary on social welfare grounds transferring/-discharging hospitals should pay the balance of transport costs not covered by the Scheme.

29. The Air Ambulance should only transport patients with acute medical and surgical complaints and only when either destination or source is an approved hospital.

30. The compliance of medical practitioners and Medical Superintendents with these requirements should be subject to the review mechanisms recommended earlier.

Management Structure

a) Central Administration

31. There should be established within the Health Commission a Division of Ambulance Services which should be headed by a Director of Ambulance Services, who is to be employed pursuant to Section 14A of the Health Commission Act. The Director should be responsible through the Director of Medical and Allied Services to the Commission for the overall management and all operational characteristics of the service.

32. The Health Commission should delegate to the Director of Ambulance Services and his senior staff appropriate authority which will allow the Division to make all necessary decisions on operational matters.

33. The Director of Ambulance Services should be assisted by:

1. Chief Superintendent Metropolitan Services
2. Chief Superintendent Administration and Planning
3. Chief Superintendent Non-Metropolitan Services (including Air Ambulance Service)

34. This executive group should be responsible for the formulation of standard operating policies and procedures, budgets, monitoring of performances, service planning and priority setting, purchase of equipment and preparation of capital works programmes.

35. The Board of Ambulance Education (the establishment of which is recommended in this Report) and the Director of the Training School should report directly to the Director of Ambulance Services.

36. Operating procedures of the Ambulance Service should be standardised at a regional level.

37. A uniform manual of procedure should be developed as a special urgent task.

39. The Brisbane Waters District Ambulance should be incorporated in Central District Ambulance.

40. The Chief Superintendent, Administration and Planning should be responsible to the Director of Ambulance Services for the operation of the central office which should be small.

41. Regional superintendents should report to the Director of Ambulance Services, but the normal channel of communication should be through the Chief Superintendent, Non-Metropolitan Services.

b) Regional Management Structure

42. The budgets for each Regional Ambulance Service as well as Central District Ambulance, should be set by the Health Commission on a needs basis following consultation with the Director of Ambulance Services.

43. The achievement of these budgets should be the responsibility of the Regional Superintendents and the Chief Superintendent Metropolitan Services.

44. Final accountability for adherence to those budgets should be with the Regional Director and in the Metropolitan Area should be with the Director of Ambulance Services.

45. It should be the responsibility of the Regional Director to determine in consultation with the Regional Superintendent the Ambulance needs unique to the region and they should not be altered for budgetary or operational reasons without the Regional Director's agreement.

46. The Regional Superintendent should be responsible to the Director of Ambulance Services for the efficient management of the Ambulance Service at regional level, consistent with the standardised procedures manual and the uniform policies when developed by the Director of Ambulance Services and approved by the Health Commission.

47. There should be established a regional organisational structure consisting of:
- a Regional Superintendent as described;
- an Assistant Superintendent for Operations and Equipment Management;
- An Assistant Superintendent, for Finance and Personnel Management;
- the division of the region into a small number of areas administered by an Area Officer;
- each station in each area to be administered by a Deputy Superintendent, or Station Officer Grade 2 or 1 depending on the size of the station.

48. In view of the change in the level of responsibility proposed for Regional Superintendents consideration should be given to the capacity of present occupants to perform duties satisfactorily. Under the guidelines set down for the efficient operation of the Service in the region, the Regional Superintendent should be required within a budget period to demonstrate his ability to manage the region. Failure to do so may result in the position being declared vacant and advertised.

c) Ambulance Advisory Council

49. The Ambulance Advisory Council is no longer needed and should be disbanded.

d) Advisory Committee.

50. All major advisory committees to the Ambulance Service should be disbanded.

51. There should be appointed by the Commission a broadly based committee of health professionals to advise the Ambulance Service.

52. The principle of fixed terms of appointment should be established for all Committees advising the Ambulance Service.

53. The Director of Ambulance Services should form ad hoc Committees to deal with specific tasks as and when required.

Personnel Policies

54. There should be concerted efforts on the part of the Ambulance Service to acquaint Ambulance Officers with the principles of Equal Employment Opportunity.

55. Promotional material relating to the N.S.W. Ambulance Service should be reviewed to ensure that the images portrayed and the language used are non-sexist and non-racist.

56. New guidelines for recruitment of Ambulance Officers should be adopted.

57. New application forms should be printed and distributed as a matter of urgency.

58. The Ambulance Service should remain a ranked structure providing for career development.

59. Career development should be linked with operational and administrative training.

60. The practice of awarding chevrons should be discontinued. Any system of differentiating Ambulance Officers below the rank of Station Officer should be based on training and merit.

61. Promotion to Station Officer and above should be based on the attainment of appropriate qualifications.

62. The career structure open to Ambulance clerical personnel should be reviewed.

63. Retirement and superannuation practices in the Ambulance Service should be reviewed.

Training

64. Level I and Level II training courses should be retained subject to some modifications.

65. An essential component of Level I training should be familiarisation with the F100 ambulance vehicles together with training in appropriate defensive driving skills.

66. The practice of recertifying Ambulance Officers every three years should be terminated.

67. There is a case for training Ambulance Officers, especially those in remote areas of the State, in selected additional clinical skills. Implementation of this should be left to the Ambulance Service on the advice of the committee of health professionals.

68. A looseleaf Manual of Training should be developed and issued to all Ambulance Officers.

69. Promotions to senior management positions should occur only after appropriate management training and experience.

70. The Board of Ambulance Education should draw up a list of approved and necessary courses to achieve the requisite managerial skill.

71. The clinical training of Ambulance Officers should be conducted primarily by the Ambulance Service, and the Ambulance Training School should be maintained as the location for training.

72. A Board of Ambulance Education should be established to administer programmes conducted at the Training School.

Financing the Ambulance Services

73. Hospitals should continue to meet the full cost of inter-hospital transport.

74. Hospitals should be allowed and in fact encouraged to arrange transport by the most efficient means available, consistent with the patient's medical condition.

75. Only one charge should be raised for the use of an ambulance for inter-hospital transfers regardless of the number of patients carried.

76. Workers Compensation and Veterans' Affairs patients should be charged the full cost of the ambulance services they use.

77. Simplified billing arrangements similar to the one between the G.I.O. and the Ambulance Service should be sought wherever possible on the basis of full cost recovery.

78. Charges for attendance by an ambulance at sporting fixtures and other special events should be altered in accordance with movements in actual costs.

79. Bad debts incurred by individuals should be pursued by the Ambulance Service in a manner similar to the recovery of bad debts by public hospitals and to this end the Ambulance Service should be exempted from the requirement that the Crown Solicitor pursue all bad debts in excess of $2,000.

80. A detailed analysis of accounts receivable should be undertaken.

81. The existing ambulance levy on drivers' licences should be retained and its level reviewed.

82. The Ambulance Contribution Scheme should be replaced by a levy on basic hospital insurance.

Implementation

83. A Ministerial Task Force should be established to implement the recommendations of this Report.

29 SEP 1988

PROGRESS REPORT

IMPLEMENTATION - GLEESON RECOMMENDATIONS.

ROLE AND FUNCTION.

1.

A) Implemented: This area of responsibility did not alter.

B) Guidelines have been prepared and widely distributed to Ambulance Officers, Doctors, Hospitals and any other health related organisation.

2. Currently in operation.

3. See Recommendation 1. B) above.

4. Implemented.
This is now causing problems in small hospitals because nursing staff frequently override V.M.O's decision to use ambulance transport for patients that fit the guidelines.

5. This recommendation has proved to be of little advantag The IPTAASS programme is very restrictive and it now appears that there is an upper limit as well as the distance limit. This system is now administered by the Department of Health, N.S.W.

6. Review panels have been established in all Regions and C.D.A. There has been limited need to use this facilit These committees were designed to function as exception committees and not as standing committees. This still applies.

7. Implemented.
This recommendation is subject to the same problems as outlined in Section 4. DIrectors of Nursing frequently override the requests of V.M.O's. and deny ambulance transport to patients with genuine need for that level of care.

8. Implemented.

9. This recommendation has been implemented. However the review was based on the old rosters.
Substantial alterations have been required since the introduction of the 4 X 4 roster systems.

10. Implemented.

11. Implemented. 83 bus vehicles were transferred to hospitals and community health centres, however in som instances these vehicles have been sold and not replac by these organisations concerned.

12. Implemented.

13. Implemented. Many small country towns are still provided with this service.

14. Implemented. These costs were last varied in December 1986.

15. Implemented.

16. See Recommendation 6. No longer necessary.

17. Implemented. Growth is monitored by the Regions and C.D.A.

18. see Recommendation 6.

19. Review has now been completed. The report has been submitted to the Minister.

20. All Regions now are involved in Community C.P.R. training.

21. No discussions have been held with the Education Department to date. It is considered more appropriate to develop the programme referred to in Recommendation 20 before any arrangements are made with the Education Department to examine the feasibility of an ongoing training programme as a routine part of the school curriculum. A number of individual schools have "interest elective" subjects and "first aid" is offered to their students. A/O's provide the service in their "off duty"

RESCUE SERVICES

22. This scheme has been costed and appropriate steps are being initiated to have this recommendation fully implemented over several financial periods.

23. The Rescue Co-ordination Committee has been reconstituted by the Minister for Police and Services. It is intended that this Committee review the entire rescue programme on a State-wide basis.

This recommendation has been conveyed to the Co-ordinator of the Committee.

Rescue services are now rationalised and in the Metropolitan area these services are co-ordinated by the Senior Operations Officer at the Police H.Q.

24. This recommendation is in the process of being implemented. Basic rescue training is an ongoing programme at the Ambulance Education Centre - Rozelle.

25. Implemented.

26. The R.E.S.C.C. has allocated primary response areas for each existing rescue unit and therefore virtually eliminated over response by any of the organisations with rescue equipment.

27. The approved guidelines for road Ambulance service are being applied to the Air Ambulance Service. Accordingly, the routine usage of this facility has been reduced.

28. See Recommendation 27.

29. See Recommendation 27.

30. See Recommendation 27.

MANAGEMENT STRUCTURE

31. The new management structure has been implemented.

The State Superintendent now reports directly to the Secretary of the Department.

32. Implemented.

33. Implemented. The The newly appointed State Superintendent in his role as a member of the Implementation Committee recommended that he be assisted by two Chief Superintendents:

1. Chief Superintendent (Administration)
2. Chief Superintendent (Finance).

This provided a structure similar to the Regional systems.

34. The Executive of the Ambulance Service meet regularly to deal with policy issues, and the formulation of policies in regard to matters pertaining to procedures, budgets, etc.

35. A Director of Ambulance Education has been appointed. However, the need to establish a board was never substantiated.

36. Implemented and are under constant review.

37. Implemented.

38. The summary of recommendations omitted this recommendation. However, it has now been implemented.

39. Implemented.

40. Implemented.

41. Implemented.

42. Implemented.

43. This recommendation is reinforced at each meeting of Regional Superintendents.

44. Implemented.

45. Implemented. however the prior approval of the State Superintendent must be obtained.

46. Implemented.

47. Implemented.

48. Implemented.

49. Implemented.

50. Implemented.

51. Implemented.

52. Implemented.

53. This recommendation is being utilised as and when the need arises.

54. An Officer has been seconded to the Directorate and Co-ordinators appointed in C.D.A. and the Regions.

These Officers have the task of implementing E.E.O. policies on a State-wide basis.

55. Implemented.

56. Implemented. Final documentaiton will be included in the manuals that are currently in draft form.

57. Implemented.

58. Implemented.

59. Implemented.

60. This had unacceptable Industrial implications and therefore has been abandoned.

61. Implemented.

62. A career structure for clerical officers has been develop for the Regions, C.D.A. and the Centr al Office.

63. The Minister for Industrial Relations has been contacted by the H.R.E.A. and at least one formal meeting has occurred. The Secretary has been advised. Not achievabl at the present time. The matter has now been resubmitted by both the H.R.E.A. and the N.S.W. Superintendents Association.

64. Implemented.

65. Partly implemented.

66. Implemented.

67. Implemented.

68. Implemented.

69. Implemented.

70. Officers can receive guidance from the DIrector of Ambulance Education.

71. Implemented.

72. It has been agreed this group should be known as the "Ambulance Education Advisory COmmittee".

FINANCING THE AMBULANCE SERVICE

73. Implemented. However this practice is in urgent need of review due to the attitude taken by many hospitals.

74. Implemented. Many hospitals are now developing their own transport systems to avoid paying the inter-hospital transfer fees.

75. Implemented.

76. Implemented.

77. Implemented. However some difficulties have developed since the introduction of Workcover/Transcover.

78. Implemented.

79. Implemented.

80. Implemented.

81. This levy can no longer be identified. The Ambulance Service now operates on an expenditure budget.

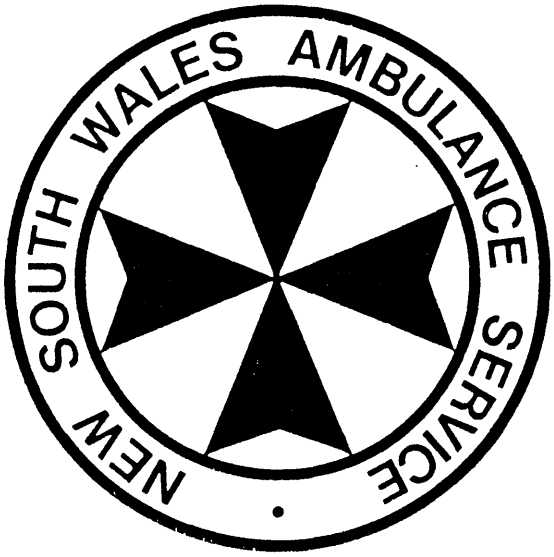
82. Implemented. Health funds should be required to provide a list of financial members. This would give this Service the ability to veryify membership claims.

83. Implemented.

APPENDIX 15

# Department of Health

# New South Wales Ambulance Service




# Ambulance Transport Guidelines

September, 1983

## PREAMBLE

In March, 1982, a committee of inquiry was commissioned by the Minister for Health, the Honorable L.J. Brereton, to examine all aspects of the New South Wales Ambulance Service.

The terms of reference to the committee of inquiry were:-

1. to assess and define the role and function of the Ambulance Service.

2. to review the use of ambulances.

3. to review the management structure and management of the Ambulance Service and define the relationship that should best exist between the Ambulance Service, the health authority and the Minister, appropriate to the defined role.

4. to assess the financing of ambulance services and make recommendations as to the continuation of the Ambulance Contribution Fund.

5. to make recommendations to the Minister on the role, use, management and financing of the ambulance services.

Submissions were sought from interested persons and organisations and due consideration was given to these by the committee during its deliberations.

The inquiry concluded in July, 1982, with the presentation of a 179 page report to the Minister for Health. The report contained 83 recommendations for the Minister's consideration.

The Minister had the report distributed and called for responses to the recommendations contained therein. These responses were then considered by the Minister in conjunction with the whole report.

In December, 1982 the Minister handed down his decision on the recommendations, adopting these with some qualification.

Attached is a copy of recommendations 1 to 18, 27 to 30 and 73 to 82 relating to ambulance transport by road and air and financing of the Ambulance Service with the Minister's response to each. These recommendations are in accordance with terms of reference 1, 2, 4 and 5 above.

Attention is particularly drawn to recommendations 1, 3, 5, 6, 8, 27, 29 and 74.

## ROLE AND FUNCTION

The New South Wales Ambulance Service has a dual role:-

A. to provide emergency services; and

B. to transport patients in non emergency situations to and from appropriate health services, where the patient's condition prohibits the use of alternative means of transport.

## ELIGIBILITY

To be eligible for non emergency ambulance transport, the patient will be medically unsuitable for public or private transport and will normally:-

1. require stretcher transport

   or

2. require active management or monitoring in transit

   or

3. be a patient whose condition would cause the patient to be either gravely embarrassed or unacceptable to other people in public transport e.g. incontinence of bladder or bowel, gross deformity or disfigurement.

## GUIDELINES FOR AUTHORISING AMBULANCE TRANSPORT

Ambulance transport is a limited and costly resource and to ensure that it is used appropriately, guidelines for authorisation have been established.

Compliance with these guidelines should ensure the availability of ambulance transport for emergency and eligible non emergency patients.

## AMBULANCE TRANSPORT REVIEW PANEL

Each ambulance region and Central District shall have an ambulance transport review panel to ensure the compliance by registered medical practitioners, hospitals and the Ambulance Service in the provision of ambulance transport consistent with the guidelines.

## INQUIRIES

Any inquiry relating to the ambulance transport of a patient should be directed to the senior ambulance control officer by telephoning the usual ambulance number.

## DEFINITIONS

EMERGENCY PATIENT:

An emergency patient means a person who is injured or has an acute medical condition requiring urgent attention.

MATERNITY PATIENT:

A maternity patient means a person who requires immediate transport to a hospital for confinement.

MEDICAL OR SURGICAL PATIENT:

A medical or surgical patient means a person certified by a registered medical practitioner as requiring admission to a hospital for treatment and whose condition indicates that the patient is unsuitable for transport other than by ambulance.

DAY TREATMENT PATIENT:

A day treatment patient means a person whose course of treatment requires him/her to be transported to a diagnostic or treatment centre and returned from there the same day and whose medical condition indicates that the patient is unsuitable for transport other than by ambulance.

CONVALESCENT PATIENT:

A convalescent patient means a person requiring transport to a private residence or a convalescent/nursing home and whose medical condition indicates that the patient is unsuitable for transport other than by ambulance.

INTER HOSPITAL TRANSFER PATIENT:

An inter hospital transfer patient means a patient who is transferred from one hospital to another and whose medical condition is such that the patient is unsuitable for transport other than by ambulance. e.g. stretcher case, cannula or catheter in situ, disoriented, convulsing, incontinent, requiring oxygen therapy or monitoring or any other condition where the general supervision of the patient is necessary in the interest of patient care.

# AUTHORISATION OF AMBULANCE TRANSPORT

## EMERGENCY:

A request will be accepted from any person for ambulance response to an emergency.

## MATERNITY PATIENT:

A request will be accepted from any person for ambulance transport of a maternity patient.

## MEDICAL OR SURGICAL PATIENT:

Authorisation for transport of a medical or surgical patient must be given by a registered medical practitioner, after having made arrangements for the reception of the patient.

Where possible, advance notice should be given for this type of transport. A booking will be accepted up to six days in advance.

## DAY TREATMENT PATIENT:

Authorisation for transport of a day treatment patient must be given by a registered medical practitioner. A booking for a day treatment patient will be accepted up to 1500 hours on the day prior to the required ambulance transport.

Where possible, advance notice should be given for this type of transport. A booking will be accepted up to six days in advance.

## CONVALESCENT PATIENT:

Authorisation for transport of a convalescent patient must be given by a registered medical practitioner. A booking for a convalescent patient will be accepted up to 1200 hours on the day required for transport within the local area.

For ambulance transport of a convalescent patient outside the local area a booking should be made by 1500 hours on the day prior to the required ambulance transport.

## INTER HOSPITAL TRANSFER PATIENT:

Authorisation for transport of a patient from one hospital to another must be given by the Medical Superintendent or his/her nominee of the dispatching hospital.

In the absence of the Medical Superintendent or his/her nominee, authorisation for transport of a patient from one hospital to another must be given by the Director of Nursing or his/her nominee.

## AIR AMBULANCE PATIENT:

Authorisation by a registered medical practitioner is required for a patient to be transported by air ambulance.

A booking for urgent transport of a patient by air ambulance will be accepted at any time.

A booking for non urgent transport of a patient by air ambulance will be accepted between 0900 hours and 1500 hours daily up to the day prior to the required transport. A booking will be accepted up to six days in advance.

## AMBULANCE TRANSPORT AUTHORISATION FORM

A registered medical practitioner authorising ambulance transport for a patient should complete and sign an ambulance transport authorisation form.

The completed form should accompany the patient and be retained by the ambulance officer for attachment to the Ambulance Service records.

Where it is not practicable for the form to accompany the patient, the requisition number should be quoted by the registered medical practitioner when ordering the ambulance transport and the completed form forwarded to the Ambulance Service as soon as possible.

### REPEAT TRANSPORTS:

Where a day treatment patient who is eligible for non-emergency ambulance transport is required to be transported on several occasions to a treatment centre the one ambulance transport authority form will suffice for the remainder of the current month.

Should the patient require ambulance transport during the following month, it will be necessary for another ambulance transport authority form to be completed by the registered medical practitioner.

## GENERAL CONDITIONS

Except where special circumstances prevail and unless prior arrangements have been made, the Ambulance Service should not be expected to routinely transport a patient to a facility where a medical service adequate to the patient's condition is available closer to the patient's present domicile.

Nothing contained in these guidelines should inhibit consideration of a reasonable request for ambulance transport and it would be expected that the senior ambulance control officer would exercise discretion to ensure that the patient's welfare is not disadvantaged.

Any request for a patient to be accompanied by a relative or close friend should receive sympathetic consideration, taking into account the capacity of the vehicle to accommodate the number of patients to be transported e.g. a young child or an elderly person may need to be accompanied for welfare reasons.

# MINISTERIAL RESPONSE TO THE RECOMMENDATIONS OF THE INQUIRY INTO THE NEW SOUTH WALES AMBULANCE SERVICE

| RECOMMENDATIONS | MINISTER'S RESPONSE | COMMENT |
|---|---|---|
| Role and Function of the Ambulance Service | | |
| 1. The Ambulance Service should have a dual role:- | Accept | |
| A) to provide emergency services; and | | |
| B) to transport patients in non-emergency situations to and from appropriate health services, where the patient's condition prohibits the use of alternative means of transport. | | |
| 2. The Ambulance Service should continue to provide for all accident and emergency service requirements in N.S.W. | Accept | |
| 3. Guidelines should be circulated to medical practitioners advising them that to be eligible for non-emergency ambulance transport patients will normally require stretcher transport, active management or monitoring in transit or will be patients with conditions which would cause the patient to be either gravely embarrassed or unacceptable to other people on public transport (e.g. incontinent of bladder or bowel, gross deformity or disfigurement). | Accept | |
| 4. Where the medical condition of patients requires the use of an ambulance, Medical Superintendents or Directors of Nursing in the absence of a Medical Superintendent should be responsible for ordering such transport | Accept | |
| 5. Medical practitioners in country areas should be encouraged to recommend the Isolated Patients Travel and Accommodation Assistance Scheme to eligible patients as an alternative to ambulance transport. | Accept | |
| 6. The compliance of medical practitioners ordering ambulance transport within these guidelines should be subject to the review mechanisms. | Accept | |

| RECOMMENDATIONS | MINISTER'S RESPONSE | COMMENT |
|---|---|---|
| 7. Inter-hospital transfer by ambulance should be ordered where the hospital Medical Superintendent or a medical practitioner authorised by him warrants the medical condition of the patient requires transport by ambulance. If the hospital does not have a Medical Superintendent, transport should be authorised by the Director of Nursing. | Accept | |
| 8. The Ambulance Service should not continue transporting day treatment cases except those who meet the criteria outlined above. | Accept in principle | Subject to alternative transport schemes being made available |
| 9. The fleet of ambulance vehicles and staff establishment should be consistent with the numbers required to meet the defined role as outlined above but should not be expanded in order to accommodate day treatment cases falling outside the defined role. | Accept | |
| 10. A review of the staff establishment and vehicle numbers should be undertaken after the implementation of recommendations concerning the role of the Ambulance Service. | Accept | |
| 11. The Health Commission should ensure the provision of alternative means of transport for day treatment patients. | Accept | |
| 12. Sufficient notice should be given to current users of day treatment transport services who will qualify under the new role of the Ambulance Service to allow them to make alternative transport arrangements. | Accept | Subject to insertion of word 'not' prior to word qualify |
| 13. In small country towns where there is some ambulance stand-by time available to transport day treatment patients this should continue but demand for day treatment transport should not be used as the basis for allocating additional resources. | Accept | |
| 14. Charges for attendance by the Ambulance Service at sporting fixtures should be monitored and adjusted regularly to avoid a repetition of the recent steep increase in stand-by charges. | Accept | There will be no increase during the current wages, salary, charges and levies pause |

| RECOMMENDATIONS | MINISTER'S RESPONSE | COMMENT |
|---|---|---|
| 15. Ambulance Officers should no longer provide first aid casualty services at ambulance stations except in the following circumstances.<br>- an emergency requiring immediate treatment<br>- where an ambulance station is located at a substantial distance from a hospital casualty; such stations should be formally designated by ambulance management. | Accept | |
| 16. Transport utilisation should be referred to the Review Panels establishment by Recommendation 18 below. | Accept | |
| 17. A comprehensive transport review mechanism should be established to ensure that unwarranted growth of ambulance transport services does not recur. | Accept | |
| 18. Ambulance Transport Review Panels should be established in each rural health region and in the Central Ambulance District. These panels to comprise a nominated Ambulance Officer, a medical practitioner, and should be chaired by the Regional Director in rural health regions or a nominee of the Health Commission in the Metropolitan area. | Accept in principle. | Composition c Review Panels to rest with Implementatic Task Force |
| Air Ambulance Service | | |
| 27. Where there are no medical contraindications some form of public transport should always be used in preference to the Air Ambulance. | Accept | |
| 28. Patients who take public transport should be encouraged to take advantage of the Isolated Patients Travel and Accommodation Assistance Scheme, and where necessary on social welfare grounds transferring/-discharging hospitals should pay the balance of transport costs not covered by the Scheme. | Accept | |
| 29. The Air Ambulance should only transport patients with acute medical and surgical complaints and only when either destination or source is an approved hospital. | Accept | To be read in conjunction with Recommendatio 27 |
| 30. The compliance of medical practitioners and Medical Superintendents with these requirements should be subject to the review mechanisms recommended earlier. | | |

| RECOMMENDATIONS | MINISTER'S RESPONSE | COMMENT |
|---|---|---|
| Financing the Ambulance Services | | |
| 73. Hospitals should continue to meet the full cost of inter-hospital transport. | Accept | |
| 74. Hospitals should be allowed and in fact encouraged to arrange transport by the most efficient means available, consistent with the patient's medical condition. | Accept | Adequate guidelines should be prepared to indicate those patients and conditions that normally require transport by ambulance. In particular, hospitals should not establish for the purpose of inter-hospital transport their own separate transport system for patients who require stretcher transport or whose medical conditions require the use of an ambulance type vehicle or ambulance attendance |
| 75. Only one charge should be raised for the use of an ambulance for inter-hospital transfers regardless of the number of patients carried. | Accept | |
| 76. Workers Compensation and Veteran's Affairs patients should be charged the full cost of the Ambulance Services they use. | Accept | |
| 77. Simplified billing arrangements similar to the one between the G.I.O. and the Ambulance Service should be sought wherever possible on the basis of full cost recovery. | Accept | |
| 78. Charges for attendance by an ambulance at sporting fixtures and other special events should be altered in accordance with movements in actual costs. | Accept | Refer Recommendation 14 |

| RECOMMENDATIONS | MINISTER'S RESPONSE | COMMENT |
|---|---|---|
| 79. Bad debts incurred by individuals should be pursued by the Ambulance Service in a manner similar to the recovery of bad debts by public hospitals and to this end the Ambulance Service should be exempted from the requirement that the Crown Solicitor pursue all bad debts in excess of $2,000. | Accept | |
| 80. A detailed analysis of accounts receivable should be undertaken. | Accept | |
| 81. The existing ambulance levy on drivers' licences should be retained and its level reviewed. | Accept | |
| 82. The Ambulance Contribution Scheme should be replaced by a levy on the basic hospital insurance. | Accept | Presently being implemented |

**Interpretation.**

4. (1) In this Act, except in so far as the context or subject-matter otherwise indicates or requires—

"ambulance service" means a service related to the work of rendering first aid to, and the transport of, sick and injured persons, but does not include a service of a class prescribed for the purposes of this definition;

"Assistant Commissioner" means the Assistant Commissioner for Health Insurance Levies referred to in section 6;

"basic hospital benefits" means those benefits payable to a contributor by an organisation in accordance with the basic hospital benefits table of the organisation;

"Commissioner" means the Commissioner for Health Insurance Levies referred to in section 6;

"contributor", in relation to a hospital benefits fund conducted by an organisation, means a person who is a contributor to that fund in accordance with the rules of the organisation, and includes a person for whom or on whose behalf contributions are made;

"hospital benefits fund" means a fund out of which an organisation makes payments to contributors for periods of accommodation and maintenance in hospitals, and for surgical, therapeutic or other medical or health treatment, service or procedure in hospitals;

"inspector" means an inspector referred to in section 7 (1);

"levy" means a monthly levy or an additional levy under this Act;

"month" means any of the 12 months of the year;

"monthly levy", in relation to a particular month specified in Column 1 of Schedule 1 in which the monthly levy is payable by an organisation, means the amount calculated in accordance with the following formula:—

$$L = \frac{AC}{B}$$



where—

L is the monthly levy to be obtained;

A is the total amount of contributions received from contributors to the organisation in the relevant month (being the month specified in Column 2 of Schedule 1 opposite that particular month) for the purpose of securing entitlement to basic hospital benefits;

B is the amount of weekly contribution, as at the 15th day of that relevant month, required to be paid to the organisation by a single person for the purpose of securing entitlement to basic hospital benefits; and

C is the prescribed rate;

"organisation" means a society, body or group of persons, whether corporate or unincorporate, which conducts a hospital benefits fund;

"out-patient service", in relation to a hospital, means a health service or procedure provided by the hospital to a person other than an in-patient in the hospital, but does not include a health service or procedure of a class prescribed for the purposes of this definition;

"prescribed rate" means—

(a) for January, 1983—40 cents; and

(b) thereafter—70 cents, as adjusted from time to time in accordance with Schedule 2;

"record" includes book, account, deed, writing and document and any other source of information compiled, recorded or stored in written form, or on microfilm, or by electronic process, or in any other manner or by any other means;

"regulations" means regulations under this Act.

(2) An organisation shall, for the purposes of this Act, be deemed to carry on the business in New South Wales of providing hospital benefits to contributors if—

(a) for the purposes of, or purposes related to, the enrolment of contributors to a hospital benefits fund conducted by it or the payment of benefits to any such contributors—

(i) it uses premises in New South Wales; or