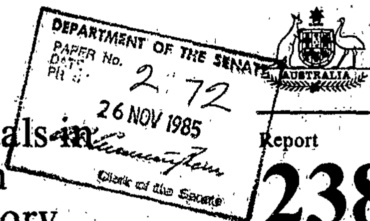

Public Hospitals in the Australian Capital Territory

Report

238

Joint Committee of Public Accounts

Parliament of the Commonwealth of Australia

1985

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

JOINT COMMITTEE OF PUBLIC ACCOUNTS

REPORT 238

REVIEW OF THE AUDITOR-GENERAL'S EFFICIENCY AUDIT REPORT:

ADMINISTRATION OF PUBLIC HOSPITALS BY THE CAPITAL TERRITORY HEALTH COMMISSION

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Section 8.(1) of the Public Accounts Committee Act 1951 reads as follows:

> Subject to sub-section (2), the duties of the Committee are:
>
> (a) to examine the accounts of the receipts and expenditure of the Commonwealth including the financial statements transmitted to the Auditor-General under sub-section (4) of section 50 of the *Audit Act 1901*;
>
> (aa) to examine the financial affairs of authorities of the Commonwealth to which this Act applies and of intergovernmental bodies to which this Act applies;
>
> (ab) to examine all reports of the Auditor-General (including reports of the results of efficiency audits) copies of which have been laid before the Houses of the Parliament;
>
> (b) to report to both Houses of the Parliament, with such comment as it thinks fit, any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Parliament should be directed;
>
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>
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>
> and including such other duties as are assigned to the Committee by Joint Standing Orders approved by both Houses of the Parliament.

PREFACE

This report outlines the findings of the Committee's Inquiry into the 'Report of the Auditor-General on an Efficiency Audit - Administration of Public Hospitals by the Capital Territory Health Commission'. The Auditor-General reported in May 1983.

The commencement of the Committee's Inquiry was delayed until March 1984 because of competing inquiries. Public hearings for the Inquiry were conducted in September 1984.

Coincident with the Committee's Inquiry, there was widespread industrial activity in the public hospital system of the Australian Capital Territory (ACT). Subsequently, the Minister for Health abolished the positions of the Chairman and Commissioners of the Capital Territory Health Commission and vested authority in a new general manager. The name of the Commission became the ACT Health Authority.

Industrial relations issues do not, however, fall within the scope of either the Audit Report or the Committee's Inquiry. The former concentrates primarily, and quite properly, on the managerial issue of how the former Commission balanced the need to contain hospital costs whilst ensuring an acceptable standard of service. The latter focusses on the Audit Report's findings and recommendations on this issue.

In its Inquiry the Committee finds that whilst the former Commission generally expressed support for the recommendations of the Audit Report and developments were in progress in some areas (eg ADP), there have been only limited substantive changes in administration pursuant to the Report. To an extent, this divergence reflects the inevitable constraints placed upon managerial approaches to hospital administration by the exigencies of the hospital environment.

The Committee has made 27 recommendations for action by the Authority. The Committee's recommendations together with those of Audit, qualified where necessary by the findings of this Committee, need to be implemented.

The Committee is grateful to the former Commission and the ACT Health Authority for the co-operation provided throughout the Committee's Inquiry. The Committee thanks its Advisor and members of its Secretariat for the support given to this reference.

For and on behalf of the Committee.

Senator G. Georges
Chairman

M.J. Talberg
Secretary
9 October 1985

TABLE OF CONTENTS

	Page
Preface	(v)
Conclusions and Recommendations	(viii)
PART I - OVERVIEW	1
1. BACKGROUND	
. Introduction	2
. Commission/Authority Role, Structure and Operation	2
. Overview of Efficiency Audit Report	5
2. EFFICIENCY AUDIT RECOMMENDATIONS	
. Planning of Hospital Services	10
. Clinical Administration	13
. Hospital Resource Management	15
3. OTHER ISSUES	
. Consultancy Study of Clinical Efficiency	17
. Organisation of Clinical Services	18
. Contracts with Doctors	19
. Accreditation	21
4. EFFICIENCY AUDIT PROCESS	
. Introduction	23
. Criticisms of the Audit	23
. Audit Methodology - Evaluation Frameworks	25
PART II - ANALYSIS OF AUDIT RECOMMENDATIONS AND AUTHORITY ACTION	28
5. PLANNING OF HOSPITAL SERVICES	
. Regional and Strategic Planning	29
. Planning for Facilities	34
6. CLINICAL ADMINISTRATION	
. Appointment Processes	44
. Hospital By-Laws	47
. Clinical Privileges	48
. Review of Clinical Performance	53
. Admission Arrangements	59
. Discharge Arrangements	62

7. HOSPITAL RESOURCE MANAGEMENT	
. Financial Controls - Budget Development	67
. Financial Controls - Expenditure	71
. Staffing Control - Ceilings, Workload Assessment and Procedures	74
. Maintenance and Minor Works	78
. Payment of Fees to Clinicians for Services to Public Patients	79
. Cleaning Arrangements	81
. Hospital Properties and Services	83
. Patient Accounts and Debt Recovery	86
APPENDIX	
A Conduct of Inquiry, Witnesses, Observers, and Submissions	92
LISTS OF TABLES AND FIGURES	
A Receipts and Payments, Royal Canberra and Woden Valley Hospitals 1984-85	4
B Staffing of the Australian Capital Territory Health Authority	4
C ACT Public Hospitals - Bed Capacity and Staffing	5
D ACT Public Hospitals - Inpatient Details	8
E ACT Public Hospitals Beds - Availability and Occupancy	9
F Patient Debts Outstanding in Royal Canberra and Woden Valley Hospitals (June 1984)	89
G Patient Debts Outstanding in Royal Canberra and Woden Valley Hospitals (June 1985)	90
FIGURE A - Authority Organisation	7

CONCLUSIONS AND RECOMMENDATIONS

Summary

The Committee found the audit to be comprehensive in design and conduct. Within this overall assessment, however, the relevance of the audit varied.

The audit was most satisfactory in its coverage of resource management issues. Such issues are readily amenable to analysis based on a managerial perspective. Conversely, the audit was least satisfactory when addressing the planning of hospital services. In the Committee's view, it is difficult to examine the planning of hospital facilities apart from the planning of health services more generally, and in isolation from factors largely excluded from the Audit analysis. Factors such as political and historical constraints and the sensitivities of the medical profession and the union movement in the ACT, can render systematic planning measures irrelevant.

In regard to resource management issues, the Committee considered that Audit findings concerning the excessive cost of staff cleaning and the magnitude of debts outstanding to the Authority were accurate and cause for concern. Further, the recommendations for upgraded management information systems and associated administrative changes were sound. On the question of the quality of medical services in the Authority hospitals, the recommendations for enhanced peer review activities were considered to be the major practical means of improving the service.

In reviewing the responsiveness of the former Commission and the Authority, the Committee found that although most of the findings and recommendations appeared to have been accepted, overall progress in implementation had been slow. The Committee was also not fully satisfied with the submissions received from the former Commission during the Committee's Inquiry. Although the former Commission responded on a timely basis to the Committee's requests, lengthy questioning was required to obtain detailed and comprehensive information.

The Committee has made a number of recommendations for action by the Authority. The recommendations are listed below, cross-referenced to their locations in the text. The Committee's detailed analysis of the Audit report and the Authority's responses should be referred to when considering the Committee's recommendations.

Recommendations

Accreditation

1. The Authority require the Royal Canberra and Woden Valley hospitals to begin immediately to prepare for assessment leading to accreditation by the Australian Council of Hospital Standards. Application to the Council for assessment should proceed at the earliest opportunity (p. 22).

Regional and Strategic Planning

2. The Authority review arrangements for liaison with the NSW Health Department to reduce unnecessary expenditure. In the Committee's view, the review should be neither protracted nor expensive (p. 31).

3. There be early public involvement in the strategic planning process once the new Health Authority structure is operating and that subsequent planning steps be expedited. Progress on strategic planning activities should be reported in the Annual Report to the Parliament of the ACT Health Authority (p. 34).

Planning for Facilities

4. The Authority undertake, and document in detail, a comprehensive examination of the possibilities for comparative review of the parameters and assumptions of the bed-planning formula (p. 37).

5. The Authority compare prescribed and actual length of stay figures for major resource consuming operations and conditions to identify potential inefficiencies. Where necessary, appropriate clinical review studies and associated discussion amongst clinicians should be encouraged subsequently (p. 39).

6. The Authority take early action to secure legislation requiring private hospitals to supply morbidity data (p. 39).

7. Audit recommendation 10 be pursued (p. 39).

Hospital By-Laws

8. Any by-laws that are introduced be processed promptly (p. 48).

Clinical Privileges

9. The Authority take early action to finalise the proposed amendments to the Health Services Ordinance 1975 concerning the granting of Visiting Medical Officer status at Authority hospitals. The proposed amendments should be submitted to the Minister for Health for approval at the earliest opportunity (p. 51).

10. That the former Commission's 'Administrative Arrangements' be updated (p. 52).

11. The Authority no longer delay taking the necessary procedural step of revising the composition of the Clinical Privileges Committee to include the Clinical Superintendants (p. 53).

Review of Clinical Performance

12. In reviewing its quality assurance and review arrangements, the Authority give specific attention to the model for systematic clinical review proposed by the Committee's consultant, Dr Ireland. Aspects of this model include:

    - the establishment of a representative committee to direct the programme. There must be clear lines of communication and accountability between this committee and clinical practitioners on one side, and the committee and the executive of the institution on the other;

    - the creation of routine statistical reporting systems to provide regular analyses of clinical performance data;

    - regular reporting of these analyses to the clinical practitioners, through their specialist departments;

    - identification of high-priority issues within each speciality or section of the service, priority being determined on the basis of resource consumption or demonstrable inconsistencies in clinical performance in a given area;

    - the introduction of a formal schedule for the review of these priority issues;

    - the implementation of clinical review projects to employ objective protocols and examine adequate samples of clinical case material; and

    - development of machinery (vested in the committee) to ensure that practitioners are aware of review findings, participate in creating policies to correct deficiencies in practice, and receive feedback through follow-up reviews as to the success of corrective policies (pp. 58-59).

13. The Authority review the clinical care issues arising from the Efficiency Audit's consultancy study (p. 59).

Admission Arrangements

14. The Authority monitor the scope for introducing the review of admission decisions in quality assurance activities as the standard of such activities and the co-operation of the profession develop (p. 61).

15. The Authority take steps to encourage the demand for day-only stays by encouraging, for example:

    - community/patient/clinician acceptance of day-only stays; and

    - morning rather than afternoon operating theatre for minor surgery (p. 62).

16. The Authority develop guidelines on elective admission priorities and ensure that these guidelines are applied at hospital level and sent to clinicians to foster consistency in priority setting (p. 62).

Financial Controls - Budget Development

17. The Authority place the highest priority on implementing proposed ADP (automatic data processing) hospital management systems. The Authority should report in detail on ADP systems implementation in its Annual Report to the Parliament and significant project delays should be explained (p. 70).

Staffing Control Procedures

18. The Authority use its ADP systems, once available, to review staff usage in relation to workload (p. 77).

19. The Authority's Establishments and Review Section develop staff to workload matching guidelines for the higher labour cost areas/functions in Authority operated hospitals (p. 77).

20. The Authority undertake, as a matter of priority, a comparison of staff use by main departments against existing indicators as suggested by Audit. Resource allocations should be reviewed if necessary (p. 78).

21. The Authority ensure that the inbuilt relief staff establishment bases applied by the two hospitals for clerical assistant and nursing employment groups are consistent (p. 78).

22. The Authority participate in information systems providing indicative data on hospital performance (p. 78).

Maintenance and Minor Works

23. The Authority ensure that the agreement with the ACT Electricity Authority concerning electrical maintenance at Authority hospitals be signed without further delay (p. 79).

Payment of Fees to Clinicians for Services to Public Patients

24. The Authority take early action to encourage the co-operation of the medical profession in the introduction of the computerised doctors' claims system (p. 80).

Cleaning Arrangements - Royal Canberra Hospital

25. The Authority set annual targets for reducing the costs incurred in the cleaning of Royal Canberra Hospital (RCH) by the identification and introduction of economies. Although the Committee is aware that cost should not be a primary constraint in the cleaning of hospitals, the scope for using contract labour at the RCH should be reviewed (p. 83).

Hospital Services

26. The Authority disband the working party examining common procurement and storage procedures (p. 86).

Patient Accounts and Debt Recovery

27. The Authority conduct a detailed review of the scope for reducing outstanding patient debts (p. 91).

PART I

OVERVIEW

CHAPTER 1

BACKGROUND

- Introduction
- Commission/Authority Role, Structure and Operation
- Overview of Efficiency Audit Report

Introduction

1.1 The Auditor-General's Report entitled 'Efficiency Audit - Administration of Public Hospitals by the Capital Territory Health Commission'[1] was tabled in the House of Representatives on 3 May 1983. It was the fifth Efficiency Audit (EA) report to be tabled and the third on which the Joint Parliamentary Committee of Public Accounts has reported.

1.2 In conducting its inquiry the Committee held public hearings in September 1984 and sought the views of two expert witnesses: Dr R B Holland, Director, Department of Anaesthetics and Resuscitation, Westmead Hospital and formerly Chairman, Australian Council on Hospital Standards; and Dr A W Ireland, formerly consultant on clinical review to the Auditor-General and the 'Jamison Inquiry'. Details of the conduct of the inquiry are set out in Appendix A.

1.3 During the inquiry, the top structure of the Commission was significantly altered as described below. The Committee reviewed these changes and considered that they were largely irrelevant to the Committee's inquiry as the focus of the efficiency audit was on managerial rather than structural issues. Coincident with the changes to its top structure, the name of the Commission was changed to the Australian Capital Territory (ACT) Health Authority. The Committee uses the term 'Commission' to refer to the former Capital Territory Health Commission throughout this Report.

Commission/Authority Role, Structure and Operation[2]

1.4 The Commission was established on 1 July 1975 by the Health Commission Ordinance 1975 to provide health services in the ACT.

1.5 Until early 1981, the Commission comprised three full-time and six part-time members all sharing executive authority.

1.6 In 1981, following the 'Inquiry into the Efficiency and Administration of Hospitals' (Jamison Inquiry), the Commission was re-structured to comprise three statutorily appointed members - a Chairman and two Commissioners.

1. Parliamentary Paper No. 3 of 1983.
2. Parts of this chapter are updated from the EA Report.

1.7 In February 1985, the Minister for Health, Dr Blewett, decided to replace the Commission with a new authority. The positions of the Chairman and the Commissioners were abolished and authority vested in a new general manager. The name of the Commission was changed to the ACT Health Authority. The Minister's decision followed industrial disputes in the ACT in which the Commission's conduct was considered unsatisfactory. In particular, the Commission had not advised the Government on a timely basis that, in negotiations with nursing staff, the Commission had committed itself to additional expenditure.

1.8 On 24 May 1985 the Minister for Health issued a proposal for restructuring the ACT Health Authority. The proposed new structure consisted of an authority responsible to the Minister, comprising a general manager and six part-time members. The Chairman of the Authority would be one of the part-time members, appointed by the Minister from community and trade-union nominees.

1.9 Under the proposal the general manager would be responsible to the Authority for the day-to-day operations of the authority. Policy direction would come from the authority and two boards, one covering institutions (hospitals and nursing homes) and another covering community health services. These boards would each comprise seven appointed part-time members.

1.10 Stating that the proposed structure was not fixed, the Minister sought suggestions and comments by 28 June 1985.

1.11 The Minister announced the new structure for the ACT Health Authority on 1 October 1985. The structure was substantially in accordance with the proposal issued in May 1985. A patient advocacy and complaints unit to increase the authority's responsiveness to the community, was the main difference. The new structure was expected to be operating early in 1986. A chart of the organisation of the Authority as at February 1985 is provided at p.7.

1.12 There are three public hospitals - Royal Canberra, Woden Valley, and Calvary - and one private hospital - John James Memorial Hospital - in the ACT. The Authority administers the Royal Canberra and Woden Valley hospitals and provides grants towards the operational and capital costs of Calvary Hospital ACT Incorporated which is administered by the Roman Catholic Order of the Little Company of Mary. The Authority exercises some administrative control over Calvary Hospital, for example, through determination of bed numbers, services provided, budgets and conditions of service for staff. The private hospital is independent of the Authority.

1.13 Parliamentary appropriations to the Authority for 1985-86 were $107.4 million for operational items and $4.0 million for capital works and services. $77 million was allocated to public hospitals.

TABLE A RECEIPTS AND PAYMENTS FOR ROYAL CANBERRA AND WODEN VALLEY HOSPITALS FOR 1984-85 (Source : ACTHA)

	RCH $ '000	WVH $ '000
Receipts	8 197	5 427
Payments		
Operating	38 691	33 102
Capital	1 490	573
Total	40 181	33 675

1.14 The grant to Calvary Hospital in 1985-86 was $9 066 000 million.

1.15 The staffing of the ACT Health Authority as at 30 June 1985 is set out in Table B.

TABLE B STAFFING OF THE ACT HEALTH AUTHORITY BY FUNCTIONAL UNIT AT 30 JUNE 1985[a] (Source : ACTHA)

	Full-time Staff	Part-time Staff
Central Office and Services	408	45
Royal Canberra Hospital[b]	1085	279
Woden Valley Hospital[c]	868	284
Community Health	499	91
Mental Health	71	20
Hostels	101	56
Nursing Homes	183	132
Rehabilitation and Geriatrics	66	16
Pathology Services	124	24
Nursing Policy and Nurse Education	363	1
Alcohol and Drug Service	16	9
Total Staffing	3784	957

a Includes both 'operative' and 'inoperative' staff but excludes 16 unattached officers. Inoperative staff are those who are on continuous leave or otherwise absent for 12 weeks or more, e.g. for maternity leave, long service leave, compensation etc.

b Includes 62 full-time medical practitioners, and 64 full-time and 12 part-time other health professionals.

c Includes 63 full-time medical practitioners and 1 part-time practitioner, and 72 full-time and 9 part-time other health professionals.

1.16 Canberra's public hospitals have excess bed capacity. The three public hospitals were designed to provide 1448 beds.[3] The numbers of beds for which ACT public hospitals were designed and the numbers of staffed beds available as at 30 June 1985 are presented in Table C.

TABLE C ACT PUBLIC HOSPITALS: BED CAPACITY AND STAFFING AT 30 JUNE 1985

	Designed	Staffed	Staffed/Designed %
Royal Canberra	509	443	87
Woden Valley	630	369	59
Calvary	309	101	33
Total	1 448	913	63

(Source : ACTHA/EA Report, p. 9)

1.17 In addition, 81 staffed beds and 10 day-stay beds were available at John James Memorial Hospital at 30 June 1985.

1.18 An overview of the operations of the public hospital system in the ACT is provided in Tables D and E at pp.8-9.

Overview of Efficiency Audit Report

1.19 Although the Commission provided a full range of health services, the efficiency audit focussed on the provision of hospital services. Management systems within Calvary Hospital were not audited. Although Calvary received public funding through the Commission, it was not operated by the Commission.

1.20 The audit examined the administration of hospitals by the Commission in three areas:

- planning of hospital services;
- use made of hospital services by clinicians; and
- management of hospital resources, in particular, finances and staffing.[4]

1.21 In the conduct of the audit, evaluative frameworks were developed for each of these areas. The frameworks set out those processes which Audit considered were required for efficient hospital management. Audit used the frameworks as standards or benchmarks against which to compare the Commission's performance. The Committee reviews these frameworks in Chapter 4.

3. EA Report, p.9.
4. Ibid, p.v.

1.22 Audit reported that:

- in terms of broad indicators of financial performance, the Royal Canberra and Woden Valley hospitals (RCH and WVH) were comparable to similar hospitals in Victoria and New South Wales; and

- the hospitals had achieved a desirable reduction in length of patient stay and compared favourably in terms of low patient length of stay with a group of Sydney metropolitan hospitals.[5]

1.23 However, Audit also identified a number of areas in which the administration of the hospitals could be improved. Particular criticisms were:

- the lack of developed processes for peer review of clinical use of hospital facilities;

- processes for planning the number of public hospital beds appeared to allow an excess supply of staffed hospital beds relative to efficient bed usage;

- despite the improvement mentioned earlier, patient length of stay at both RCH and WVH was still excessive with resultant inefficiency of bed utilisation;

- there were weaknesses in systems for identifying financial and staffing requirements and monitoring staff use within the Commission's hospitals - management information systems were inadequate;

- there was under-use of physical facilities, especially accommodation; and

- cleaning services employed at RCH were uneconomical[6].

5. Ibid.
6. Ibid., pp. v-vi.

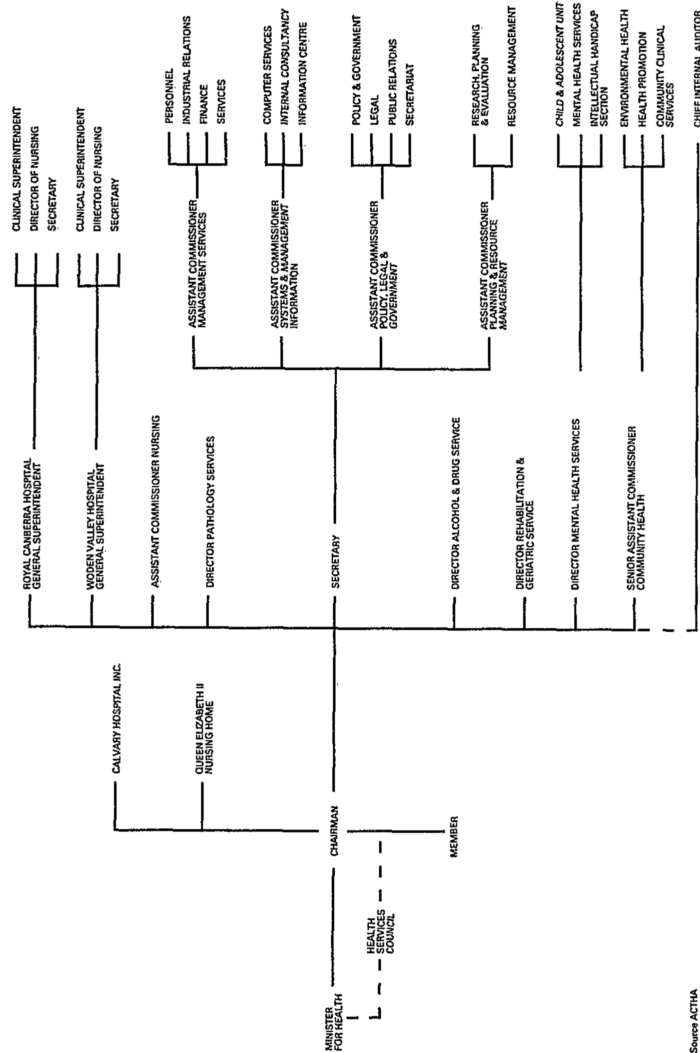

TABLE D ACT PUBLIC HOSPITALS: DETAILS OF INPATIENTS FOR YEARS ENDED 30 JUNE 1984 AND 1985

	Year ended 30 June	
	1984	1985
Beds available at 30 June	860	913
Admissions	42 657	41 964
Births (live)	4 609	4 571
Inpatients accommodated	43 393	42 665
Discharges	42 084	41 298
Deaths	611	670
Short-stay patients (a)	4 989	8 283
Occupied bed days	260 547	263 618
Average length of stay (days)	6	6
Percentage occupancy	81	82
Daily average occupied beds	712	722
Adjusted daily average (b)	869	(c)
Daily average bed costs ($)	285	(c)
Adjusted daily average bed costs ($)	233	(c)

(a) A short-stay patient is a person who was an inpatient for less than 8 hours. The figures are for day ward short stay patients at RCH and for non ward patients at WVH.

(b) Adjusted daily average converts non-inpatient services to equivalent inpatient days.

(c) Calvary financial data not available at August 1985.

Source: ACTHA

TABLE E ACT PUBLIC HOSPITAL BEDS: AVAILABILITY AT 30 JUNE 1985 AND OCCUPANCY RATE FOR YEAR ENDING 30 JUNE 1985

	RCH		WVH		CALVARY	
Ward	Beds	Occup Rate %	Beds	Occup Rate %	Beds	Occup Rate %
Coronary Care	10	38.2	7	60.2	4	49.0
Intensive Care	17	61.8	4	91.9	-	-
Isolation	16	71.7	-	-	-	-
Medical/Surgical	288	85.8	221	83.8	57	90.4
Obstetric (a)	61	67.4	48	85.4	20	92.3
Paediatric	51	65.4	- (b)	-	-	-
Psychiatric	-	-	20 (c)	76.6	20	88.6
Rehabilitation and Geriatric	-	-	56	90.0	-	-
Detoxification	-	-	13	82.3	-	-
TOTAL	443	77.3	369	84.2	101	88.7

(a) Excludes all cots.
(b) 12 bed ward with 57.4% occupancy until closure in January 1984.
(c) Reduced from 32 beds in May 1984.

Source: ACTHA

CHAPTER 2

EFFICIENCY AUDIT RECOMMENDATIONS

. Planning of Hospital Services
. Clinical Administration
. Hospital Resource Management

2.1 The main findings and recommendations of the efficiency audit, as summarised at pp. 36-42 of the EA Report, are included in Chapters 5, 6 and 7 of this report. The Committee sought the response of the Commission to each of the main findings and recommendations and subsequently requested additional information both from the Commission and the new Authority. The Committee's conclusions on the Audit recommendations and the action taken by the Commission/Authority are set out in detail in Chapters 5, 6 and 7. In this chapter the Committee provides an overview of its assessment of the Audit recommendations and the responsive action taken.

Planning of Hospital Services

2.2 Audit evaluated the planning processes of the Commission against a systematic planning framework and found deficiencies in performance.

2.3 There were 13 Audit recommendations, covering:

- the Commission's regional role in planning health services (R 1);
- strategic planning (R 2, 11);
- planning for the supply of hospital beds (R 3-10); and
- planning for medical specialities (R 11-13).[1]

2.4 Audit found the liaison arrangements between the Commission and the NSW Health Department to be unsatisfactory, and recommended definition and Government endorsement, where necessary, of the respective regional responsibilities of the two authorities (R 1). Strategic planning activities were considered not to be integrated and development of an overview planning statement was recommended (R 2).

1. The Audit recommendations are not numbered in the EA Report. To assist its analysis, the Committee numbered the recommendations - see Chapters 5, 6 and 7.

2.5 Refinement of the Commission's formula for planning hospital bed numbers was recommended to address identified weaknesses (R 3-10). The final recommendations relating to the planning of hospital services were for the review and application of guidelines for the provision of specialist services in the ACT (R 11-13). There were indications that the ACT was over-provided with some specialities and under-provided in others.

2.6 In its written responses to the Committee, the Commission objected to only one recommendation (R 5 - concerning use of prescribed rather than past achieved length of stay figures in the bed-planning formula), expressing general support for the others. The Commission placed less importance on the bed-planning formula and the specialist planning guidelines as planning mechanisms.

2.7 Notwithstanding this general support, the Committee found that there had been only few substantive changes in administration as a result of the EA recommendations.

2.8 There had been development of the liaison arrangements between the Commission and the NSW Health Department (R 1) and the new Authority had proceeded with them. The responsibilities of the two administrations had been defined and endorsed by the responsible Federal and State Ministers as recommended, and a Regional Liaison Committee had been established in 1985.

2.9 The Commission and Authority had been less responsive to the other recommendations. Although an overview planning statement had been produced addressing the requirements of the Audit recommendation, the statement had not been endorsed by the Federal Minister for Health and made available for public discussion. The Committee acknowledges that strategic planning had been constrained in 1983 by an independent inquiry, and in 1985 by the restructuring of the Commission.

2.10 Although some of the recommended measures to refine the bed-planning formula had been implemented, the formula appeared to have only limited relevance to the planning of bed-numbers. The Commission viewed the formula as only one of a number of planning measures. It had consistently endeavoured to maintain strict control over the number of staffed hospital beds in the ACT.

2.11 There had been some review and application of the specialist planning guidelines. However, the guidelines were again considered to be only one factor to be assessed when examining manpower needs. The Commission attributed the manpower imbalances that Audit found between various specialities to general surpluses or deficiencies in the supply of specialists, factors largely outside the Commission's control.

2.12 The Committee was generally satisfied by the logic of Audit's systematic planning framework. However, it became clear to the Committee during the conduct of its inquiry that there was no unanimity of opinion that the problems identified by the framework were major.

2.13 The Committee heard a diversity of views on the value of the recommendations and saw evidence of differences of opinion within the Commission.[2] It appeared to the Committee that these differences stemmed from the differing values accorded to factors falling outside the systematic planning framework (i.e. political, historical and resource allocation factors). In the course of its inquiry the Committee concluded that these and other factors were important and did modify or lessen the relevance of systematic planning approaches and techniques.

2.14 Nevertheless, for the reasons set out in Chapter 5, the Committee found merit in many of the Audit recommendations on the Planning of Hospital Services. The Committee's assessment of the recommendations, in summary, is as follows:

R 3, 4, 6-8, 10-13	: supported; the Committee accepts that there is a role for quantitative/statistical approaches in planning for hospital facilities;
R 1	: not supported; the Committee views Commonwealth/State liaison as inevitably political;
R 2	: endorsed in principle; cataloguing of existing services is not supported as unnecessary;
R 5	: intent of recommendation is supported; but the need for caution in use of prescribed rather than achieved length of stay figures is accepted; and
R 9	: access to morbidity data from the private hospital in the ACT is supported; however, the former Commission did not have the legislative power to require the submission of such information as stated by Audit.

2. Transcript of Evidence, pp. 175-178.

2.15 Against this background of substantial endorsement of the Audit recommendations, the Committee found the Commission's response to be unduly slow. The Commission had been tardy in responding (to recommendations 1, 2 and 9) and appeared not to have given serious consideration to recommendations 3, 10 and 13. The Committee acknowledges that political, historical and other factors had constrained implementation of some recommendations.

2.16 The Committee has made a number of recommendations for Authority action as detailed in Chapter 5.

Clinical Administration

2.17 Audit examined the following areas of performance:

- appointment processes and determination of clinical privileges;
- review of clinical performance; and
- admission and discharge arrangements.

2.18 Audit appointed a medical consultant, Dr A W Ireland, to assist its review of clinical services. The terms of reference required the consultant:

- to undertake an objective analysis of clinical performance in terms of patient length of stay and selected clinicial activities; and
- to assess the significance of results of the analysis in terms of improved bed utilisation and cost-effective use of resources.

2.19 The consultancy study is examined in Chapter 3 of this Report.

2.20 In its recommendations, Audit supported:

- needs-based recruitment of salaried specialists (R 14);
- formalisation and rationalisation of appointment processes for non-salaried clinicians (R 15-17);
- upgraded quality assurance and clinical review arrangements (R 18-20); and
- formalisation of admission and discharge arrangements (R 21-25).

2.21 The Committee found reviewing the audit's coverage of clinical administration to be relatively straightforward compared to reviewing the planning issues. The issues covered under the former topic were more limited in impact, and the recommendations less controversial. The Committee supports most of the recommendations as sensible, specific and feasible. The recommendations for improved quality assurance and clinical review arrangements in Authority-operated hospitals are particularly supported. The Committee considers these arrangements to be the major avenue for improving the administration of clinical services in the hospitals.

2.22 The Committee's assessment of the individual recommendations, in summary, is as follows :

- R 14 : partially supported; a policy statement on the role of salaried specialists is not supported in the short term;
- R 15 : supported, no comment;
- R 16 : substantially supported; statutory protection for the Clinical Privileges Committee is not seen as essential;
- R 17 : supported, although the reference to the need for provision for access to specialist advice is superfluous;
- R 18-20 : supported, important recommendations;
- R 21 : no comment, this recommendation is by way of a cross reference to other recommendations;
- R 22 : supported, useful recommendation; and
- R 23-25 : substantially not supported as unworkable.

2.23 The Committee's detailed comments are set out in Chapter 6.

2.24 Given the relatively wider support for the recommendations concerning clinical administration, the Committee expected to find, and did find, the Commission and the new Authority to be more responsive than they had been to the planning recommendations. The Commission opposed only part of one recommendation (R 24 - use of hospital regulations to control visiting times), and had taken specific steps in response to at least some of the recommendations (R 16, 18, 19). The Commission had, however, been slow in implementing recommendations 16 and 17, and there was much scope for improvement in respect of action taken on recommendations 18 and 19.

2.25 The Committee has made several recommendations for Authority action as detailed in Chapter 6.

Hospital Resource Management

2.26 There were 28 Audit recommendations, covering financial controls (R 26-34), staffing controls (R 35-44), and miscellaneous managerial issues (R 45-53).

2.27 The first two groups of recommendations (R 26-44) are concerned with enhancement of the Commission's hospital management information systems. Rigorous analysis of management information for budgeting, expenditure control and staff management was also required. The remaining recommendations require that:

- the Royal Canberra Hospital (RCH) assume responsibility for its own maintenance (R 45);
- controls over payments to clinicians for treatment of public patients be tightened (R 46);
- the RCH investigate use of contract rather than staff cleaning (R 47);
- management of Commission properties and other facilities be upgraded (R 48-52); and
- debtor control be improved (R 53).

2.28 The Committee found Audit to be on its firmest ground when addressing issues of resource management. It was clear that the Commission's hospital management information systems were deficient. Further, there was scope for significant additional revenue through improved debtor management and for material reductions in expenditure through alternative arrangements for cleaning at the RCH.

2.29 The Committee endorses all but two of the 28 recommendations. The recommendation for leasing excess residential accommodation to the general public (R 48) is endorsed only in principle because of the many factors precluding such use. The recommendation (R 26) that there be specification in the Commission's long term planning framework of the types and activity levels of hospital services to be provided, is not supported because the Committee is not convinced of its feasibility.

2.30 In its response to the Committee, the Commission disputed few recommendations, and stated that it had commenced major ADP developments addressing many recommendations. Five recommendations required ADP systems development (R 28, 30, 32, 35 and 44) and others were closely linked to such developments (R 33, 34, 42 and 43).

2.31 Although the Committee welcomes these developments, it notes, that the ADP systems are still at the early stages of implementation and there have already been delays. The Committee concludes therefore that it remains to be seen, firstly, whether the ADP systems will supply the information recommended as required, and secondly, whether that information will be used for identifying financial and staffing requirements and monitoring staff use within the Authority's hospitals.

2.32 The Committee was again not satisfied with the pace and diligence of the Commission in a number of areas. The Commission misinterpreted recommendations 26 and 40, was unduly slow in addressing recommendations 45 and 50 and had made little progress on recommendations 32, 37, 39 and 41. The Commission's response to the Committee concerning excessive cleaning costs at RCH (R 47) was considered superficial.

2.33 The Committee has made further recommendations as set out in Chapter 7.

CHAPTER 3

OTHER ISSUES

- Consultancy Study of Clinical Efficiency
- Organisation of Clinical Services
- Contracts with Doctors
- Accreditation

3.1 In this Chapter the Committee discusses issues reviewed by Audit without recommendation, or arising in the course of the Inquiry.

Consultancy Study of Clinical Efficiency

3.2 The study was undertaken as part of the efficiency audit by a medical consultant, Dr A W Ireland. The study examined the scope for improvement in hospital productivity at RCH and WVH in terms of reduced patient length of stay and improved clinical practice.

3.3 The major findings were that although both hospitals were relatively efficient in bed utilisation and had improved their efficiency appreciably between 1978 and 1980, scope for further improvement was indicated. Specifically, within the selected samples tested, it was found that closer adherence to achievable standards for patient lengths of stay (LOS) could lead to reductions of bed capacity at RCH of 15% and 11% at WVH. The effect of such a change in LOS performance if applied to the entire hospital population could be represented as either:

- *the closing of 26 beds at WVH and 47 beds at RCH;* or
- the increase of annual caseload by about 1350 patients at WVH and 2900 patients at RCH without increasing bed capacity.[1]

3.4 The Committee noted the indicative nature of the savings[2] and that there was likely to be an increase in daily bed costs as a result of the increased intensity of clinical services. The net cost per admission and the demands for new capital development were, however, considered likely to have been reduced.[3]

3.5 Accordingly the Committee views such potential savings as dramatic and their identification as the most significant aspect of Dr Ireland's study.

3.6 In reviewing the consultant's report (reproduced in full as Appendix 1 of the EA Report) the Committee noted its clarity and comprehensiveness. In particular, the Committee observed

1. EA Report, p. 59.
2. Ibid.
3. Ibid.

that sufficient detail was provided of the two major techniques used in the study for reviewing hospital performance (utilisation review and subject specific clinical reviews (clinical audits)) to enable the study to be duplicated.

3.7 A number of other factors caused the Committee to consider that the study had been carried out competently:

- findings were sufficiently detailed and there were measurable conclusions about areas for improvement of hospital performance;

- data collection was not overly onerous; 40 man weeks were required, of which eight were for manual extraction and summary of data, which in future could be done by ADP; and

- the relationship between the quality of clinical services and the efficiency of their delivery was discussed.

3.8 The Committee considers that there is in the EA Report a blueprint of a valuable method for examining hospitals. The method merits wider application.

Organisation of Clinical Services

3.9 In the course of its inquiry, the Committee noted that the structure of medical staff in Authority-operated hospitals was unusual. The medical staff structure was not based on hospital-based units but on 'divisions' spanning both the Royal Canberra and Woden Valley hospitals. These divisions were medicine, surgery, obstetrics and gynaecology, diagnostic and laboratory services and general practice.

3.10 The divisions were in turn sub-divided into units which again spanned both hospitals, except where a unit was located only at one hospital. At September 1984, there were 39 units with 392 full-time non-nursing staff. Four units (pathology, physiotherapy, pharmacy and radiology) accounted for 204 (52%) of the staff.

3.11 One of the Committee's consultants, Dr Holland, stated his view that effective leadership of clinicians, particularly for clinical review, required hospital-based groupings of a viable size. Structures spanning both hospitals were considered unworkable as the hospital was the administrative unit.[4] About eight or nine departments were suggested as being appropriate to the Canberra hospitals, these being, for example:

4. Evidence, pp. 193-194.

- anaesthesia, intensive care, emergency care;
- community medicine, primary care;
- internal medicine;
- obstetrics and gynaecology;
- surgery;
- psychiatry;
- paediatrics;
- organ imaging;
- pathology.[5]

3.12 Although the Committee does not draw any conclusions on this proposal because it is not close enough to the workings of the Authority hospitals it makes the following general observations:

- the non-hospital based organisation of clinicians in Authority hospitals is a model not generally used;

- accreditation is unlikely with this structure (discussion at pp. 21, 22 refers);

- it would appear that the link between each hospital's administration and its medical staff would certainly be enhanced with a hospital-based organisation of clinicians:

  - the current complex committee-based arrangements spanning both hospitals appear not to facilitate such communication; and

  - communication on divisional matters is particularly likely to be reduced when the divisional chairman is located in the other hospital;[6] and

- except for being hospital-based, the departmental proposal suggested by Dr Holland is similar to the previously outlined divisional arrangements (p. 18). The fact that three of the suggested departments (psychiatry, pathology and paediatrics) are units restricted to single hospitals, is noted.

Contracts with Doctors

3.13 An issue about which there was considerable controversy in the course of the Committee's inquiry was the proposal of the Commission to introduce sessional payment arrangements for doctors appointed under part-time contracts to treat public patients in its hospitals. As at 30 June 1985 there were 126 such appointments. Existing contracts provided for payments on a fee-for-service basis and the Commission proposed replacing these payments by payments on a sessional basis. Although the Committee

5. Evidence, p. 195
6. Ibid, p. 53

learnt in July 1985 that the issue had been resolved, it is reported to illustrate the environmental complexities of health authority management.

3.14 The matter had come to the Committee's attention in pursuing Audit's examination of the more cost-effective mode of payment of contracted specialists (fee-for-service versus sessional).[7] Audit had found that the issue had been under review for some time but had not been finally resolved. The Commission had, however, accorded a high priority to the establishment of sessional payment arrangements in lieu of the existing emphasis on fee-for-service.

3.15 The Commission advised the Committee in April 1984 that sessional contracts were to be offered to all non-salaried specialists to replace existing fee-for-service contracts most of which were due for renewal during the period January to April 1987. It was also proposed, subject to legal clearance, to offer any current or new non-salaried specialists who signed the sessional contracts preference in the allocation of patients to those who insisted on retaining fee-for-service contracts.

3.16 The Committee had serious misgivings about these proposals and sought clarification. The Commission subsequently advised that:

- existing fee-for-service contracts were binding;
- if the Commission wished to terminate existing contracts unilaterally it would do so at risk of response or damages from the doctors concerned;
- the question of whether fee-for-service contracts would be removed was very much a live issue;
- the Commission was letting contracts that had expired ride pending the outcome of the Penington Inquiry into Rights of Private Practice (the Inquiry Report was issued by the Minister for Health on 11 October 1984);
- although new contracts were being offered on a sessional basis, no doctors had signed such contracts; and
- the ACT medical profession did not support the concept of sessional payments.

3.17 The Commission stated that the question of fee-for-service versus sessional payment for services to public patients had been examined many times in Australia, with differing results depending on circumstances. As far as the Commission was concerned, an important factor in determining whether to pay doctors on a modified fee-for-service or a sessional basis had been the policy and the political emphasis of the Federal Government of the day. Until March 1983, the Commission had been under no pressure from the Government to change the existing fee-for-service arrangements.

7. EA Report, p.13 and p. 115 refer.

3.18 In July 1985 in response to Committee request concerning the status of the issue, the Authority advised that it would continue to offer the option of sessional or fee-for-service remuneration when contracting with private specialists to provide medical services to hospital patients.

3.19 The Committee noted that the Authority's policy in this area was consistent with trends in Government policies. In particular, as part of the package to resolve the 1984/85 Medicare dispute, the Federal and NSW Governments extended the option of fee-for-service payments to doctors working in major country and metropolitan district hospitals.[8]

Accreditation

3.20 Neither of the Authority-operated hospitals is accredited. Accreditation of hospitals in Australia is undertaken by an independent body, the Australian Council on Hospital Standards. It is a voluntary process. Hospitals seeking accreditation apply to the Council. Council surveyors then review the performance of the hospital in relation to the Council's standards, and report to Council which grants full (3 year), provisional (1 year) or consultative (non) accreditation status.

3.21 The WVH applied for accreditation in 1979 but was unsuccessful largely because of the hospital's unsatisfactory medical structure. It lacked hospital-based departments which were discussed above. The hospital was also judged to lack developed processes of clinical review. The medical staff structure at the WVH has not changed since 1979 and the hospital has not re-applied for accreditation status. The Royal Canberra Hospital has not applied for accreditation. Other hospitals in the ACT have been accredited for some years. Calvary Hospital was granted full accreditation status in November 1984. The John James Memorial Hospital was similarly granted such status in May of that year.

3.22 The Committee examined the accreditation process in some detail in 1984 during a separate Inquiry - its Inquiry into Medical Fraud and Overservicing.[9] The Committee learnt that the majority of public hospitals in New South Wales and Victoria and increasing numbers of private hospitals in these states had been surveyed for accreditation. During the period 1974-1983, 68% of hospital beds in New South Wales and 81% in Victoria had been surveyed. The process was less developed in the other States.

8. Age, 3 April 1985, p.1.
9. Public Accounts Committee File 1982/9/203 B(79).

3.23 The Committee formed the view that the process was valuable. The principal value to the hospitals surveyed was the process of self examination to prepare for the survey and any associated remedial action.[10]

3.24 The Committee considers it unsatisfactory that the two major public hospitals in the ACT are not accredited.

3.25 The Committee recommends that:

1. The Authority require the Royal Canberra and Woden Valley hospitals to begin immediately to prepare for assessment leading to accreditation by the Australian Council of Hospital Standards. Application to the Council for assessment should proceed at the earliest opportunity.

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10. Evidence, p. 187.

CHAPTER 4

EFFICIENCY AUDIT PROCESS

- . Introduction
- . Criticisms of the Audit
- . Audit Methodology - Evaluation Frameworks

Introduction

4.1 In this Chapter the Committee addresses the limited number of general criticisms of the efficiency audit of the administration of public hospitals in the ACT that were put to the Committee. The Committee also comments on the methodology applied in the audit.

4.2 The Committee does not comment on the value of efficiency auditing in general in this Report. The Committee has already expressed its views in a previous Report[1], and although there have been major changes in the conduct of efficiency audits since that Report[2], it is too early to comment further. The revised efficiency audit arrangements are in any case under the scrutiny of the House of Representatives Standing Committee on Expenditure in its inquiry into public service efficiency review mechanisms. In foreshadowing that inquiry, the Expenditure Committee stated the reservation that the revised arrangements for the conduct of efficiency audits seemed 'to be a dilution of the purpose for which efficiency audits were introduced'.[3]

Criticisms of the audit

4.3 Although the Commission/Authority has appeared to have accepted at least in principle the major recommendations of the EA Report, in the course of the Committee's Inquiry the Commission levelled a number of criticisms at the EA Report and the audit process. Major criticisms, and the Committee's responses are as follows:

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1. Joint Committee of Public Accounts Report 201 Efficiency Audit: Administration of Australia's Bilateral Overseas Aid Program, Canberra, AGPS, 1982, pp. 41-48.
2. Efficiency audits are now undertaken as part of the mainstream auditing work of the Australian Audit Office and not, as occurred initially, by a separate Audit division with many staff recruited from outside the Audit Office. Efficiency audits are narrower in scope and focus, and issues are closer to those traditionally covered by auditors. The elapsed time for audits is shorter. As at August 1985, a total of 21 efficiency audit reports had been tabled in the Parliament. Nine were tabled in 1984/85.
3. House of Representatives Standing Committee on Expenditure Management of the main battle tank by the Department of Defence, Who was outgunned?, Canberra, AGPS, 1984, p. 11.

The audit took too long to complete: There were delays and results were not available as quickly as expected.[4]

4.4 The Committee disagrees in part with this criticism as the audit fieldwork was undertaken and reported on a timely basis. Fieldwork commenced in March 1981 and reports on the results of the fieldwork were provided to the Commission progressively in June and October 1981 and February 1982. A draft report was made available to the Commission in April 1982. The Committee agrees, however, that the full efficiency audit process was lengthy. Over two and a half years elapsed from the commencement of the efficiency audit in September 1980 to the transmittal of the final report to the Presiding Officers in May 1983. In addition to this period, a feasibility study examining the scope for a full-scale efficiency audit, was undertaken from August 1978 to January 1979. The full audit did not follow immediately the completion of the feasibility study because of the relative priority of other audit tasks.[5]

4.5 The Committee accepts the two year gap that elapsed between the feasibility study and the audit. Such delays are inevitable if feasibility studies are to be conducted. The Committee supports testing the feasibility of an audit given the expense of a major efficiency audit.

4.6 There were, however, two delays in the audit process which should have been reduced. These were the six month delay between the letter from Audit initiating the efficiency audit and the commencement of fieldwork, and the five month delay between sending the report for printing and transmittal to the Presiding Officers and tabling. The Committee acknowledges that there was a Federal election in this latter period and that research was conducted in the earlier period.

Sections of the report relied on data which was as much as six years old. The report did not present Parliament with an accurate perspective of the administration of public hospitals in the ACT.[6]

4.7 The Committee rejects this criticism. The reference to 'six years old' data is misleading. The Commission was apparently referring to 1978 data and speaking from a calendar perspective of April 1984, the date of its first submission to the Committee. The audit was, however, undertaken primarily in 1981. The Committee accepts as accurate the perspective provided on the administration of ACT hospitals because of the Commission's general acceptance of the validity of the Audit recommendations and the evaluation frameworks applied by Audit (discussed at pp. 25-27).

4. Evidence, pp. 8, 127.
5. Ibid, p. 120.
6. Ibid, p. 8.

Too little detail was provided by the consultancy study to enable the study to be particularly useful given the age of some of the data and delays inherent in the efficiency audit process.[7]

4.8 The Committee does not accept this criticism as it found the consultancy study to be detailed. Moreover, had the Commission pursued further detail it would probably have found it in the consultant's working papers. The data used in the study (1980) was the most recent available.[8] In any case, the age of the data is irrelevant to the conclusions of the study concerning the possibility of quantifying the scope for greater efficiency in use of hospital beds.

The audit was expensive.[9]

4.9 The Committee notes that the cost of the audit to the Australian Audit Office, exclusive of general office overheads, was $163,470.[10] The audit also represented a considerable cost to the Commission/Authority, and placed significant demands on the resources of this Committee.

Many of the Audit recommendations and observations were under consideration by the Commission at the time of the audit.

4.10 In the Committee's view, this would have only represented a valid criticism if Audit had failed to acknowledge its sources, and the Committee did not find Audit negligent in this regard. The Committee would expect most findings and recommendations in any audit to derive from the agency under investigation given that body's intimate knowledge and understanding of the issues. Audit's role is to raise the priority of the issues it finds to be significant.

Audit Methodology - Evaluation Frameworks

4.11 Audit developed evaluation frameworks as standards or benchmarks against which to compare the Commission's performance. Frameworks were developed for seven processes or areas of performance[11] based on Audit's views of the 'attributes each process should have to facilitate efficient management of hospital services'.[12]

7. Evidence, p. 10.
8. Ibid, p. 124.
9. Ibid, p. 131.
10. Report of the Auditor-General upon the Financial Statements prepared by the Minister for Finance for the year ended 30 June 1983, Canberra, AGPS, 1983, p. 43.
11. EA Report, pp. 88-89, 93, 113-114, 117-118, 121, 125-126, 132 refer.
12. EA Report, p. 3.

4.12 The frameworks, which essentially encompassed Audit's view of an ideal method of administering public hospitals in the ACT, were of fundamental importance to the audit. If the frameworks were unsound, then so too was the audit.

4.13 Accordingly, the Committee sought the Commission's opinion on the value and practicality of the frameworks. In response, with only one exception, the Commission commented that the frameworks suggested by Audit were either acceptable, or desirable.[13] The exception was in respect of the framework relating to 'admission and discharge arrangements'. The Commission rejected the implicit suggestion that it set criteria for elective admissions to hospital. The frameworks judged to be desirable were those relating to financial and staffing controls.

4.14 Although the Commission's response was positive, the Commission also indicated that factors were omitted from the frameworks. The Commission's overall assessment is conveyed in the following comments made in conclusion:

> the evaluative frameworks could be useful, but for that to be brought about they would need to be developed in much more detail if they are to serve as practical frameworks. They are also, to some extent, elementary in that they fail to acknowledge the extent to which political factors affect planning and resource allocation decisions.[14]

4.15 While it does not disagree with the Commission's conclusion, the Committee considers that the frameworks are both sound and sufficiently detailed for their purpose. The efficiency audit was directed to the needs of parliamentary scrutiny and accountability and its frameworks were developed accordingly. The Committee accepts that there is inevitably tension between these needs and the requirements of auditees which are more detailed and subject to other constraints.[15]

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13. Evidence, pp. 110 - 112.
14. Ibid, p. 112.
15. The Committee notes that the Auditor-General attempted to address these different demands in the early efficiency audit reports by attaching lengthy appendices to them. The Report proper was directed to the needs of the Parliament. It was about 40 pages in length and comprised an introduction, an extended summary of the audit results, and a table setting out the main findings and recommendations of the audit. The audit results were then repeated and elaborated in appendices to the Report. The appendices were intended to meet the requirements of ministers and departments in executive government. The Committee found this format unsuitable as it was satisfied with the level of detail in the appendices and found the extended summary in the Report proper largely redundant. The 'Table of Main Findings and Recommendations' did, however, provide a valuable summary. The Committee notes that the Auditor-General has stopped using this repetitious and expensive format in recent efficiency audit reports, and has welcomes the change of practice.

4.16 The Committee endorses the Auditor-General's practice of setting out the frameworks applied for assessing performance in the conduct of efficiency audits.

4.17 The Committee makes two further observations. Firstly, the Committee recognises that some issues - eg, industrial relations matters - are not readily susceptible to Audit analysis. While accepting that there would be little merit in Audit's reviewing such issues, the Committee considers that the Audit analyses are likely to be less relevant in those areas where such issues are important. Secondly, the Committee accepts the boundaries of the audit - the administration of ACT public hospitals - as entirely appropriate for efficiency audit review. The hospitals are by far the most material of the Authority's services. $77 million was appropriated for the Authority's hospitals in 1985/86, a significant proportion of the Parliamentary appropriation for the Authority. They are a logical unit of audit. The Committee recognises that hospital services are only one of the health services provided by the ACT Health Authority and that the planning and administration of hospital services cannot be undertaken in isolation from the other services.

PART II

ANALYSIS OF AUDIT RECOMMENDATIONS AND COMMISSION/AUTHORITY ACTION

In this part, the Committee examine's the Audit recommendations appearing in the 'Table of Main Findings and Recommendations' at pp. 36-42 of the Efficiency Audit (EA) Report and the responsive action taken by the Commission and the Authority. The Commission/Authority gave evidence to the Committee in submissions of April, August and September 1984 and July and August 1985 and during the public hearings for the Inquiry in September 1984. The Audit findings and accompanying recommendations as presented in the Audit Report are included in this Part, followed by the Committee's summary of the action taken and the Committee's Conclusions and Recommendations. The transcripts of evidence taken at the public hearings and the submissions authorised for publication have been published separately. References to evidence in this Part relate to that document.

CHAPTER 5

PLANNING OF HOSPITAL SERVICES

- Regional and Strategic Planning
- Planning for Facilities

Regional Planning

5.1 Audit Findings

- The Commission lacked sufficient definition of its regional role. In 1980-81, 23% of ACT public hospital bed days were used by non-ACT residents.
- Existing forms of liaison with the Health Commission of NSW were not effectively promoting rational planning of health services in the regional area. Audit was advised in November 1981 that more formal planning arrangements were being established with the Health Commission of NSW. In October 1982, the Commission advised that a Cross-Border Working Party had been established in March 1982 to consider and report on matters associated with the provision of services in the region.

5.2 Audit Recommendation

R1. Respective regional responsibilities of the CTHC and the Health Commission of NSW should be clearly defined and, where necessary, Government endorsement sought.

Commission/Authority Action (R 1)[1]

5.3 The respective regional responsibilities of the Capital Territory Health Commission and the NSW Health Department were addressed in the Report of the Cross-Border Working Party. The major recommendation was that Canberra be regarded as the specialist referral centre of a regional health network. Other recommendations concerned the rationalisation of particular services between the two administrations and associated financial arrangements. The ACT was to service the South East Region of NSW in a number of areas.

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1. Sources for text relating to Audit recommendation 1 are:
   - Evidence, pp.13, 61-62, 75, 136-138, 162, 169, 175-176,
   - ACT Health Authority letter to Committee of 18 July 1985.

5.4 The report was accepted by the Commonwealth Minister for Health who wrote to his NSW counterpart in September 1983 suggesting that they jointly announce its implementation. The NSW Minister endorsed the principal recommendations of the report in January 1985. A Regional Liaison Committee had subsequently been established and, as at July 1985, had met twice.

5.5 The Authority, in comments to the Committee, stated that it had not been advised of the reasons for the delayed response by the NSW Minister. The Authority suggested that:

> The electorates around about the Australian Capital Territory are sensitive in terms of feeling that because of Canberra's dominant position in the relationship there may be services and jobs lost if the required concept is developed to the extent that perhaps it could be developed.[2]

Committee Conclusions and Recommendations (R 1)

5.6 The Authority acted in accordance with the Audit recommendation although jurisdictional factors delayed implementation. It is the Committee's view that such factors will inevitably constrain the systematic planning and administration of comprehensive health services for the ACT and the South East Region of NSW. However, on the basis of a review of the terms of reference and membership of the Regional Liaison Committee (RLC), the Public Accounts Committee considers that the RLC has the potential to bring the NSW Health Department and the ACT Health Authority together at appropriately senior levels for discussion. The Committee accepts the need for effective liaison between the two administrations to encourage the integration of services in the region.

5.7 Prior to the NSW Minister's ratification of the Cross-Border Working Party Report, the Public Accounts Committee asked the Commission to list the then current liaison arrangements and to advise whether they were considered satisfactory.

5.8 The Commission stated that liaison took the form of formal and informal meetings and discussion of various kinds. Arrangements were thought to 'work reasonably well ... (although they) would be enhanced at regional level with formal acceptance of cross-border proposals'.[3]

5.9 The Committee found these arrangements to be excessive *and endorsed the Audit finding that they were unsatisfactory.* Particularly following the establishment of the RLC, the *Committee considers there is likely to be scope for* significantly reducing previous forms of liaison.

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2. Evidence, p. 138.
3. Ibid., p. 75.

5.10 *The Committee recommends that:*

2. *The Authority review arrangements for liaison with the NSW Health Department to reduce unnecessary expenditure. In the Committee's view, the review should be neither protracted nor expensive.*

5.11 The *Committee also notes that due to resource* constraints and 'difficulties in obtaining up-to-date statistical *information from the* NSW Department of Health'[4] the report of the Cross-Border Working Party was delayed until *August* 1983, *eight months* beyond the December 1982 forecast by the Commission in October 1982. This was one of many delays *observed by the Committee in its Inquiry.*

Strategic Planning

5.12 Audit Finding

- Although the Commission was developing individual elements of a 'Ten Year Strategic Plan', it has not developed a planning document to link those elements. Such a document would define the Commission's regional role, its health services objectives, the range and standard of existing services, and the population to be served.

5.13 Audit Recommendation

R2. The Commission's planning processes should be better focussed and more closely integrated with Health Commission of NSW regional activity through development of an overview statement to include :

- a detailed definition of the Commission's role and responsibilities in the region;
- statements of objectives for each form of health service;
- a catalogue of the range and quantity of services currently provided;
- a catalogue of the 'needed' services not currently provided; and
- a statement of priorities for the development/adaptation of services.

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4. Evidence, p. 75.

Commission/Authority Action (R 2)[5]

5.14 The Commission stated that it addressed the recommended 'overview statement' in its strategic planning process.

5.15 In February 1983 the Commission accepted a proposal for a Ten Year Strategic Plan. A draft planning statement on the Commission's roles in health care provision and administration (36 pp, dated June 1984) was developed in accordance with the proposal, and submitted to the Minister for Health. A final statement was submitted to the Minister in October 1984 with a request that he approve its release for public discussion. On the abolition of the Commission in February 1985, the statement was returned for consideration by the Authority. The Authority anticipated that there would be public involvement in the strategic planning process following establishment of the new broad-based Health Authority structure. A proposed structure was put forward for public discussion in May 1985, and the final structure subsequently announced on 1 October 1985. The new structure was expected to be operating early in 1986.

5.16 The public consultation part of the strategic planning process ceased in July 1983 at the request of the Minister. In April 1983 the Minister announced a public inquiry into the structure to oversight the operation and administration of the Commission (the Molony Inquiry) and sought public submissions. The Minister concurrently asked the Commission not to proceed with public involvement in the strategic plan until the results of the inquiry were considered. The May 1985 proposal for restructuring the Authority was in response to the Molony Inquiry.

5.17 The Commission advised the Committee that the 'Overview Statement' envisaged by Audit was included in its draft planning statement. The statement contained sections on the Commission's aims and functions and on services and activities identified for priority development. There was reference to the Commission's regional role, and delineation of individual services was said to be 'the subject of detailed planning activities now underway'.[6]

Committee Conclusions and Recommendation (R 2)

5.18 The Committee's review of the Commission's draft planning statement indicated that the statement addressed the Audit recommendation, but only in general terms.

5. Sources for text relating to Audit recommendation 2 are:
   - Evidence, pp. 9, 10, 13-14, 76-77, 138-140, 162, 169-170,
   - Commission letter to Committee of 27 September 1984,
   - Authority letter to Committee of 18 July 1985.
6. Minutes of Evidence, p. 77.

5.19 The statement did not include specific objectives for the Commission's services nor list services currently provided. Although priorities were defined for each of the Commission's major service sectors, development targets were not set.

5.20 The Committee considers, however, that the statement represents a useful first step in the Authority's strategic planning process. The Audit requirement for objectives and service development priorities can be met subsequently. The Committee does not support the cataloguing of existing services recommended by Audit, as such documentation may unnecessarily duplicate other material.

5.21 The Committee recognises that subsequent strategic planning steps may be more complex. Reaching agreement on those services requiring priority development may involve difficult resource allocation decisions and trade-offs. Public consultation is essential. The Committee also recognises that there are differing views on the value and feasibility of strategic planning because of the political nature of the bargaining involved.

5.22 Notwithstanding these considerations, the Committee supports the aims of a strategic planning process in the health care field. Specifically, this would involve 'the production of recommendations on objectives and priorities for future resource allocation based on information regarding health care needs and service requirements and on the results of consultations involving providers, consumers, community organisations and administrations'.[7]

5.23 The Audit recommendation is endorsed in principle in that context.

5.24 However, the Committee is not satisfied with the pace of the Commission's strategic planning efforts. Although the Commission was committed to the development of a Ten Year Strategic Plan at least as early as 1980,[8] it was not until June 1984 that a short planning statement was produced in draft form. The Committee acknowledges the cessation of public involvement in the strategic planning process in mid 1983, but notes that planning activities continued. The Committee considers that far more should have been achieved in four years than the production of a short planning statement in draft form.

5.25 The Committee did not find that resource constraints had been operative, and considers that additional resources should not be allocated specifically to the strategic planning process in the future.

7. Capital Territory Health Commission Annual Report, 1982-83, p. 108.
8. EA Report, p. 7.

5.26 The Committee recommends that:

3. There be early public involvement in the strategic planning process once the new Health Authority structure is operating and that subsequent planning steps be expedited. Progress on strategic planning activities should be reported in the Annual Report to the Parliament of the ACT Health Authority.

Planning for Facilities

5.27 Audit Finding

- Although the Commission's formula for planning hospital bed numbers improves on conventional 'bed norm' techniques, it has some weaknesses:
  - the adequacy of the formula's major parameters and assumptions had not been sufficiently tested;
  - planning is effectively based on an overall average daily occupancy rate of 80%, although 85% is regarded by planners as a more realistic rate;
  - use by non-ACT residents is taken into account in a lump sum fashion;
  - length of stay information is applied to ACT residents only by broad categories, moreover it is based on past clinical performance;
  - an implication of the medical consultancy study of length of stay is that the Commission may be providing 73 beds in excess of what are required for efficient servicing of current clinical activity; and
  - to date, the Commission has not been able to obtain morbidity data for use in bed planning from the (private) John James Memorial Hospital. The bed planning formula encompasses private hospital beds.

5.28 Audit Recommendations

R3. The Commission continue to apply its bed planning formula but subjecting primary parameters and assumptions (eg, morbidity propensity) to continuing review against experience with, and standards developed for, other populations with similar demographic and socio-economic characteristics.

R4. The Commission's bed planning formula should be refined to utilise more detailed morbidity data for both ACT and non-ACT residents.

R5. Prescribed rather than past achieved length of stay figures should be used in the formula, at least for the major resource-consuming operations and conditions.

R6. Indicators of the adequacy of the formula (eg, waiting times for beds, pressure for particular types of beds) should be developed and regular reports be provided to the Hospitals and Health Services Planning Committee with a view to adjusting the formula as necessary.

R7. Individual occupancy rates used in the formula should be raised to achieve a planned occupancy target of 85% overall.

R8. The effects on bed requirements of the development of new services should be thoroughly assessed during planning for new services and included in detailed costings.

R9. The Commission should use its existing legislative authority to require the submission of morbidity data by John James Memorial Hospital for use in bed planning.

R10. The Commission should examine strategies for achieving more efficient bed utilisation, taking as the 'ideal' the number of beds indicated by the upgraded bed planning formula suggested by Audit.

Commission/Authority Action (R 3-10)[9]

5.29 The Commission stated that it had subjected its bed planning formula (R3) to continuing review but had not been able to identify urban areas either in Australia or elsewhere with

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9. Sources for text relating to Audit recommendations 3-10 are:
   - Evidence, pp. 9, 17-18, 64, 77-79, 176-177, 186,
   - Commission comment on recommendation 3 of 13 September 1984,
   - Commission letter to Committee of 27 September 1984,
   - Authority letter to Committee of 18 July 1985.

similar populations and socio-economic characteristics against which it could test its approach. The Commission believed the formula to be unique in that it projected hospital usage patterns for an urban population having rather unusual characteristics.

5.30 The Commission agreed that more detailed morbidity data would be useful in planning bed numbers (R4) and was examining the maintenance of such data in the development of its computerised hospital information system. Expansion of the data categories within the existing manual system was not considered cost-effective.

5.31 The Commission disagreed with Audit recommendation 5. It considered that:

> the use of prescribed rather than achieved lengths of stay needs careful appraisal before implementation to ensure proper standards of care are maintained. The most effective initial use of prescribed lengths of stay in the formula would be to test the effects on overall bed requirements and to determine the differences between various prescribed and actual figures.[10]...The outcome may not be relevant to use in a forward planning context. Examination of lengths of stay involves peer review and utilisation review processes rather than planning techniques.[11]

5.32 The Commission supported and had implemented Audit recommendations 6-8. The Commission was achieving occupancy levels of 80-85% although there were periods when activity fell well below such levels.

5.33 The existing legislation gave the Commission access to morbidity data at John James Memorial Hospital (R9) but did not require the hospital to submit the information to the Commission. The Commission stated that, for a number of reasons, it preferred to await the introduction of legislation requiring the data to be submitted rather than have its clerical staff access the information:

- collection by Commission staff would be intrusive and costly;
- the use of John James Memorial Hospital represented only a small proportion - just under 5% - of the public hospitals in the ACT (use of that Hospital had been reasonably stable over the last few years); and

10. Evidence, p. 17.
11. Ibid, p. 78.

- the Commission had access on a confidential basis to information from the Department of Health on the volume of patients and procedures undertaken at the Hospital.

5.34 As at July 1985, the Authority had not determined the most appropriate means of securing the legislative objective of requiring private hospitals to supply morbidity data. Ten months earlier in September 1984 the Commission had advised that there were three options requiring at a minimum one to two years to implement.

5.35 In respect of R10, the Commission submitted that since its establishment in 1975 it had endeavoured to maintain strict control over the number and type of hospital beds in the ACT. In 1981, the ACT had the second lowest number of staffed public hospital beds per thousand population and the lowest total number of hospital beds (public and private) per thousand population in Australia. No additional hospital beds had been brought into use from 1981 to 1984, despite an increase of about 15 000 in the population and an ageing of the population.

5.36 The Commission stated that it had used its bed-planning formula as one of a number of measures in assessing bed numbers.

Committee Conclusions and Recommendations (R 3-10)

5.37 The Committee is not convinced that sufficient effort has been directed to the parameters and assumptions used in bed planning (R3). Although accepting that there is no other urban population in Australia identical to the population of the ACT, the Committee believes that there is still scope and value in comparative review in bed number planning.

5.38 **The Committee recommends that:**

4. The Authority undertake, and document in detail, a comprehensive examination of the possibilities for comparative review of the parameters and assumptions of the bed-planning formula.

5.39 The Committee's assessment of Audit recommendations 4 and 6-8 and the responses of the Commission was complicated by the differing views that were put to the Committee on the practical value of systematic approaches to planning bed numbers.

The following views were expressed:

- the Committee's consultant, Dr Holland, viewed planning for bed numbers as a 'very inexact science'[12] and refinement as impractical. 'It is possible to set bed numbers anywhere within wide limits and the system will adjust to cope';[13]

- Audit and the Commission saw the bed-planning formula as one element in determining bed numbers; Audit reporting the formula as the Commission's primary mechanism for bed determination, the Commission viewing it as a check against the results of other measures; and

- the Commission considered there was little difference between its approach to planning bed numbers and the views of Dr Holland.

5.40 The Committee found that the formula had been used in a supplementary role in recent years. The formula when applied at November 1983 required 918 public hospital beds in the ACT (including Calvary Hospital) whereas actual staffed bed numbers in that year were 895. The Committee notes that this application of the formula used a bed-occupancy rate of 80%. When the rate was increased to the 85% recommended by Audit, the formula required only 872 public beds.

5.41 Despite this supplementary role for the formula, and the views of the Committee's consultant, the Committee chooses to endorse these recommendations. The Committee accepts that there is a role for quantitative approaches in planning bed numbers and value in refining the formula and its parameters.

5.42 The Committee notes that during the period 30 June 1981 to 30 June 1984, actual public hospital bed numbers fell from 903 to 864 (-4%). In respect of this decrease, the influence of the Audit finding that the Commission may have been providing a surplus of 73 beds is unknown. (This finding is discussed at p. 17). In evidence to the Committee, the Commission commented on the finding, stating that:

> even if the suggested surplus was a correct indication of how many beds should be closed, and the Commission contends that it was not, there are practical and political difficulties in so doing. Unless whole wards are closed there are very little, if any, savings in staff and no savings in overheads. There is also loss of revenue.[14]

12. Evidence, p. 170.
13. Ibid, p. 162.
14. Ibid, p. 18.

5.43 The Committee does not necessarily dispute these comments. It points out, however, that savings are ultimately achieved by ensuring that new wards are provided only when justified.

5.44 Although the Committee accepts the Commission's disagreement with Audit recommendation 5, the Committee supports the intent of the recommendation, to avoid the perpetuation of inefficiencies.

5.45 The Committee recommends that:

> 5. The Authority compare prescribed and actual length of stay figures for major resource consuming operations and conditions to identify potential inefficiencies. Where necessary, appropriate clinical review studies and associated discussion amongst clinicians should be encouraged.

5.46 The Committee considers that early legislative action to require the supply of morbidity data by private hospitals should be pursued in conjunction with the proposed maintenance of morbidity data on the Authority's computerised hospital information system (R9). The Committee notes that the John James Memorial Hospital had 9% of the staffed hospital beds in the ACT as at June 1985, and considers that the recent usage of the hospital would have been higher than the 5% figure given by the Commission.

5.47 The Committee recommends that:

> 6. The Authority take early action to secure legislation requiring private hospitals to supply morbidity data.

5.48 The Commission's response largely ignored Audit recommendation 10.

5.49 The Committee recommends that:

> 7. Audit recommendation 10 be pursued.

Planning for Facilities (cont'd)

5.50 Audit Findings

- A 'Plan for the Development of Medical Specialist Services in the ACT' developed by the Commission's Research, Planning and Evaluation (RPE) Section and partly endorsed by the Commission provides a valuable analytical framework for achieving rational development of specialist services in the ACT.

- Audit adaptation of a table in the plan showing medical specialist manpower in the ACT against developed norms, indicated that the ACT may be over-provided with some specialities, eg, general surgery, but under-provided in others, eg, geriatrics, rehabilitation medicine and gastroenterology.

5.51 Audit Recommendations

R11. The Commission should make use of the medical specialist manpower planning guidelines contained in the RPE document in development of its overview statement of Commission objectives and priorities.

R12. The Commission's medical specialist manpower planning guidelines should be updated and strengthened, where possible, by reference to authoritative service standards and related to ACT conditions.

R13. The Commission should continue to make use of its Principles of Development for Medical Specialist Facilities in the ACT and make greater use of the medical specialist manpower planning guidelines in planning for numbers of medical specialists and the types, volumes and locations of specialities.

Commission/Authority Action (R 11-13)[15]

5.52 The Commission advised that it accepted that the 'Plan for the Development of Medical Specialist Services', henceforth termed the Plan, 'provided a valuable and analytical framework and had used it as such'.[16] Since 1979, the Plan had been used in the examination of paediatric services, obstetrics and gynaecology, radiotherapy and oncology services. The Plan was, however, considered a 'research project aimed at determining the theoretical optimum number of specialists required in the ACT and indicating options for the rationalisation of hospital services'.[17] The Plan was 'only an indicator to be considered along with political, historical and resource allocation factors when examining manpower needs'.[18]

15. Sources for text on Audit recommendations 11-13 are:
    - Evidence, pp. 19-20, 79-80, 256,
    - Commission letter to Committee of 27 September 1984.
16. Evidence, p. 11.
17. Ibid.
18. Ibid.

5.53 The Plan had not been updated in total although particular elements, such as cardio-thoracic surgery and oncology services, had been examined. Data becoming available to all Health authorities through the Department of Health and the Standing Committee on Health Manpower had been used to update the Plan.

5.54 The Commission believed that the Audit finding that there was a manpower imbalance between various specialities stated the obvious. Such a situation had pertained for some time, both in the ACT and in the rest of Australia. To some extent the imbalances reflected the interests and desires of individual doctors which then manifested themselves as surpluses or deficiencies in the number of doctors practising within particular specialities. The Commission stated that it was only too aware of the difficulty in obtaining and retaining practitioners in specialities such as geriatrics and rehabilitation medicine.

Committee Conclusions (R 11-13)

5.55 The Committee supports the use of the specialist manpower planning guidelines in the Authority's strategic planning process (R 11).

5.56 The Committee's review of the Commission's draft planning statement of June 1984 (which, according to the Commission, encompassed the 'overview statement' recommended by Audit) indicated that if the Commission had used the manpower guidelines (R11) in developing the planning statement, that use was not reflected significantly in the document. Although the draft planning statement included very brief reference to existing and planned hospital specialist services, the areas listed in the statement for development in the 1980's (eg, specialist eye, ear, nose and throat surgery, joint replacement surgery, upgraded burns unit) were not specifically identified by the guidelines. Specialities indicated by the guidelines as potentially underprovided in the ACT in 1981, were not specified in the planning statement as priorities for development in Commission hospitals in the 1980's. The planning statement did, however, accord priority to a community-based geriatric and rehabilitation service. The Committee acknowledges that the 1981 data may be of limited relevance in 1984.

5.57 The Committee endorses Audit recommendations 12 and 13.

5.58 In respect of R 12, the Committee observes that the Commission had used national data to update its manpower guidelines although the need for both national and local data was acknowledged in the Plan and recommended by Audit. The Committee notes that local data should become available automatically following development of the Authority's proposed computerised hospital information system. Such data should be used as recommended by Audit.

5.59 In respect of R 13, the Committee notes with interest the *following* comments from the draft planning statement mentioned above:

- The present configuration of hospital services in the ACT is not a neat one. It has proved difficult to allocate regional specialty services between the two major hospitals (RCH and WVH) in a manner which preserves principles of continuity of care, obtains an economical and professionally viable mix of services and which at the same time, does not lead to costly duplication. Also, the reality of having three public hospitals (RCH, WVH and Calvary) that are all under-utilised, presents a significant barrier to change.

- The Commission has endeavoured to bring about rationalisation of hospital services through its medical specialty planning. These efforts will continue. It must be recognised, however, that the retention of two major referral hospitals in the ACT carries the risk of costly duplication of specialty treatment and diagnostic services. Nevertheless, it would not be realistic to pursue plans that would significantly change the fundamental character of the services currently provided by each of the three public hospitals. For this, and other reasons, the Commission considers that it would not be appropriate to attempt to move towards a more strictly hierarchical organisation of hospital roles than is currently the case. This is despite the attractiveness of such models on grounds of rational planning.[19]

5.60 The Committee observes that these comments are consistent with the Audit recommendation for more systematic planning, and the Commission's response that such planning was not always feasible.

5.61 The Committee reviewed the specialities available at the RCH and the WVH, and found that the comment - 'the present configuration of hospital services in the ACT is not a neat one' - received some support. Although some specialities were staffed at only one hospital (eg, clinical haematology and medical oncology, endocrinology, gastroenterology, paediatrics and radiotherapy) others were staffed at both hospitals (eg, cardiology, neurology, nuclear medicine and radiology). As was observed in the planning statement, such *duplications inevitably* involve significant cost.

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19. Capital Territory *Health Commission Planning Statement*, A Draft for Discussion Purposes, June 1984, pp. 26-27.

5.62 The Committee noted that in recent years the Commission had *rationalised some* clinical areas to one or other of its hospitals, sometimes in the face of public opposition (eg, closure *of* paediatrics at WVH). As a consequence the Committee questions the view put in the planning statement that 'it would not be realistic to ... change the fundamental character of the services currently provided by each of the public hospitals'.[20] The Committee considers that where changes are required on efficiency grounds they should be pursued.

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20. Capital Territory Health Commission Planning Statement, p.27.

CHAPTER 6

CLINICAL ADMINISTRATION

- Appointment Processes
- Hospital By-Laws
- Clinical Privileges
- Review of Clinical Performance
- Admission Arrangements
- Discharge Arrangements

Appointment Processes

6.1 Audit Findings

- The issue of the more cost-effective mode of payment of specialists (fee-for-service or sessional payments) had been under review for some time, but had not been finally resolved. At present, almost all non-salaried specialists are paid on a fee-for-service basis.

  The Commission has advised that it has accorded a high priority to the establishment of sessional payment arrangements in lieu of the existing emphasis on fee-for-service.

- At the time of audit the Commission had no clearly defined policy on the role of salaried specialists in Commission hospitals. The Commission advised Audit that this issue would be examined and a study has recently been completed. At present, salaried specialists, as in other public hospitals in Australia, may obtain permission to undertake private work within the hospital in addition to receiving their normal salary. Subsequent to the Audit the Commission advised that it had developed a policy of not employing further salaried specialists in a clinical capacity unless there was a demonstrated need for such clinicians.

6.2 Audit Recommendation

R14. The Commission should fulfill its stated intention to develop a policy statement on the role of salaried specialists. Workload data should be assessed to determine the amount of salaried specialist time being directed to private work and the implications for the Commission's requirement for salaried specialists.

Commission/Authority Action (R 14)[1]

6.3 The Commission objected to the first part of the Audit recommendation on the grounds that it had had a policy statement on the role of salaried specialists at the time of the audit and had informed Audit accordingly in October 1982 in response to the identical conclusions and recommendations of the draft EA Report.

6.4 The Committee sought comment from Audit on why it had persisted with the requirement for a policy statement.

6.5 Audit advised:

- in its view a policy statement in accordance with the recommendation would establish the criteria to be applied in determining which specialities were to be staffed on a salaried basis, and identify specialities falling into that category;
- the Commission had developed a document meeting these requirements; and
- it was not clear that the relevant section of the document had been adopted as a policy basis for future specialist staffing action.[2]

6.6 The Committee subsequently ascertained from the Commission that:

- in February 1982 the Commission had substantially endorsed the document's list of specialities to be provided on salaried and non-salaried bases;
- the endorsement had been on a confidential basis;
- the Commission's policy had been discussed with its Medical Committee;[3]
- many of the proposals were under contention; and
- as at September 1984, the Commission was unable to advise when the matter would be resolved.

6.7 It was not clear to the Committee whether the criteria sought by Audit had been endorsed.

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1. Sources for text relating to 'Appointment Processes' are:
   - Evidence, pp. 22-23, 80-81, 115, 147-148, 151, 206-215,
   - Commission letter to Committee of 27 September 1984,
   - Authority letter to Committee of 18 July 1985.
2. Evidence, p. 115.
3. The Medical Committee was the chief advisory Committee to the Commission on clinical matters. It comprised the Chairman of the five clinical divisions and four elected clinicians.

6.8 The Commission also provided the following background information:

- the document had been prepared at a time when there was increased privatisation of specialists and some salaried doctors were leaving the Commission to enter private practice;

- one of the document's aims was to establish how various key specialities could be maintained on a hospital campus; and

- the document reflected the health care philosophy of the previous Government; were a similar study to be conducted under the present Government the Commission's views would be different.

Committee Conclusions (R 14)

6.9 It appeared to the Committee that Audit intended by its recommendation to clarify the meaning of 'demonstrated need' in the Commission's policy on the employment of salaried specialists. Although the Committee was inclined to endorse this intent given the looseness of the Commission's policy, the Committee observed that the Commission encountered opposition when it acted in accordance with the recommendation.

6.10 The Committee heard evidence that such contention was not surprising given the importance of private medicine to the ACT public hospital system, and the historical opposition of private and salaried practitioners in the hospitals. In the early 1970's, for example, there was a dispute primarily in relation to rights and responsibilities for treatment of non-insured patients. The current working arrangements between private and salaried practitioners in Commission hospitals were said, however, to be generally effective.

6.11 In Authority-operated hospitals at 30 June 1985, there were 25 full-time salaried specialists and 91 non-salaried specialists with part-time (fee-for-service) contracts to treat public patients. The following doctors were also available to Royal Canberra and Woden Valley hospitals at that time (refer footnote 7, p. 50):

- 1 salaried non-specialist;

- 5 salaried administrative staff;

- 92 resident medical officers, junior resident medical officers and registrars;

- 63 specialists and 87 non-specialists with rights to treat private patients on a fee-for-service basis; and

- 35 non-specialists with part-time contracts to treat public patients.

6.12 Having regard to the looseness of the policy on the role of salaried specialists and the possible delicacy of the Authority's position in this area, the Committee:

- does not support in the short term the further refinement of the policy on the role of salaried specialists; and

- supports the recommended review of workload data in relation to the Authority's requirement for salaried specialists.

6.13 The Committee notes that data on the treatment of public patients will become available automatically from the proposed computerised doctors claim system (R 46 refers). Such information should be analysed in the terms recommended by Audit.

Hospital By-Laws

6.14 Audit suggested that the introduction of regulations might be considered to promote clinician adherence to hospital administrative requirements.[4]

6.15 The Commission advised that a working party on hospital by-laws, which was established on 3 November 1983 to identify those hospital activities wherein by-laws should operate, supported the introduction of such controls over clinicians. It was the view of the working party and the Commission that by-laws should be developed as a set of administrative directives, with Section 8 of the Health Commission Ordinance 1975 providing legislative support.

6.16 As at September 1984, the Commission expected that the by-laws would be promulgated in 1985, although the results of the 1984 Penington Committee Inquiry into 'Rights of Private Practice in Public Hospitals' might affect that outcome.

6.17 As at July 1985, the Authority advised that hospital by-laws had not been promulgated. Although preliminary research had been conducted for by-laws in a number of areas, no draft by-laws had been prepared to date. The issues raised by the Penington Inquiry (the Inquiry Report was issued in October 1984) and subsequent developments had been taken into account by the working party whose proposals would now have to be examined in the light of the proposed administrative changes to the Authority.

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4. EA Report, p. 13.

6.18 The Committee recommends that:

8. Any by-laws that are introduced be processed promptly.

Clinical Privileges

6.19 Audit Findings

- A detailed study of clinical privileges processes was undertaken by the Health Commission of NSW in 1980. It provides a useful reference point for consideration of processes within the Commission hospitals.
- Proposals for inclusion in legislation appear to allow the Clinical Privileges Committee executive powers in relation to the alteration or supervision of clinical privileges. Such powers should rest with the Commission, possibly delegated to the Chief Medical Administrator of each hospital.
- Amending legislation to establish the Clinical Privileges Committee statutorily has not been finalised. Consequently, assessments have been undertaken against a background of concern by some Committee members at the possibility of litigation.
- Under existing practices, the Clinical Privileges Committee assesses only applicants for Visiting Medical Officer (VMO) status. Contract applicants are considered by the full Medical Committee when advising the Commission about new appointments.
- No regular review of clinical privileges exists for contract holders or VMO's under the age of 65.
- The composition of the Clinical Privileges Committee does not appear to be ideal. At present it comprises the Heads of the five separate divisions within the Medical Committee. Consequently there may be limited knowledge of issues relevant to delineation of privileges for any particular speciality.

6.20 Audit Recommendations

R15. The Commission should examine the NSW study and, where possible, relate it to the circumstances of the ACT.

R16. Clarify and define in legislation the respective responsibilities of the Commission, Chief Medical Administrators, the Medical Committee and the Clinical Privileges Committee in relation to the delineation and approval of clinical privileges. Executive authority should rest with the Commission and its delegated officers. Functions of the Clinical Privileges Committee should include assessment of the qualifications of all applicants for contracts or VMO status in Commission hospitals and regular review of all current privileges taking into account:

- the clinician's participation in hospital quality assurance and utilisation review activity;
- education and teaching involvement;
- past use of clinical privileges; and
- clinical performance as manifested in the review processes.

R17. Review the composition of the Clinical Privileges Committee. Provision should exist for the inclusion of a hospital representation and an additional specialist from the area for which privileges are sought.

Commission/Authority Action (R 15-17)[5]

6.21 The Commission advised the Committee in 1984 that, although it was aware of the NSW study and took it into account, the relevance of the study to the ACT was reduced because the granting of clinical privileges[6] in NSW and the ACT differed. Only nominated doctors were permitted to practise in NSW hospitals, ie, they were 'closed'. ACT public hospitals on the other hand had traditionally been 'open', ie, virtually all doctors had access to them.

6.22 The open hospital policy in the ACT was said to be a product of history and the Commission stated that it recognised the advantages of limiting access. The Commission advised that in 1983, as a first step, it had obtained the support of its Medical Committee and had subsequently moved cautiously towards

5. Sources for text relating to Audit recommendations 15-17 are:
   - Evidence, pp. 25-28, 81-84, 163, 189-190, 207-208, 214-215,
   - Authority Letter to Committee of 18 July 1985.
6. 'Clinical privileges' refers to the rights of clinicians appointed to a hospital to undertake particular clinical procedures and to use particular equipment and facilities in the treatment of patients within the hospital.

implementation. Amendments to the Health Commission Ordinance 1975 in respect of the granting of visiting medical officer (VMO)[7] status at Commission hospitals were proposed.

6.23 The amendments had been submitted to the Minister for Health in draft form in June 1984. The amendments had the Minister's support, but had not been approved. As at September 1984 enactment was expected during 1985.

6.24 The Commission advised that the proposed amendments to the Ordinance were in accordance with the Audit recommendations. Specifically, executive authority for VMO appointments (as for contract appointments) was vested in the Commission rather than the Chief Medical Administrators of the hospitals; grants were for a period of three years subject to renewal on certain conditions; the Commission had the right to refuse to grant VMO status; and there was a right of appeal for applicants.

6.25 The Commission stated that under the amended provisions the Clinical Privileges Committee (CPC) would advise the Commission on the suitability of applicants for VMO appointment or re-appointment and the conditions relating thereto. On the basis of that advice the Commission would then decide whether or not to grant visiting rights and the conditions to apply.

6.26 The Commission agreed with Audit that statutory provision for the CPC was necessary but had not reached agreement on the detailed requirements.

6.27 The Authority, in July 1985, advised the Committee that the Commission had accepted in principle the concept of a closed hospital system for the ACT at its November 1984 meeting. The detailed implementation of this policy was, however, said to be awaiting the formulation of the new administrative structure for ACT hospitals. No proposed amendments to the Health Services Ordinance 1975 relevant to this issue were in existence.

6.28 As at July 1985 VMO's continued to be appointed by the Chief Medical Administrator of each hospital and contracts for the provision of medical services to 'hospital patients' continued to be entered into between the Authority and medical practitioners. The Authority stated that it would examine the scope for rationalising procedures when considering the legislative and other implications arising from the establishment later in 1985 of a Hospitals Board.

7. An appointment to provide clinical services in Commission hospitals can be one of two types:

- under a part-time contract to treat public patients or as a full-time salaried clinician; or

- as a visiting medical officer (VMO) treating private patients on a fee-for-service basis. Contract holders can obtain VMO rights and in practice all contract holders are also appointed as VMO's.

6.29 The Commission advised that it intended including hospital representation, ie, Clinical Superintendants, on the CPC (R17). There was already provision to obtain specialist advice where necessary. The CPC had the option of co-opting specialists for advice on particular issues or of discussing applications with peers in the specialities concerned.

Committee Conclusions and Recommendations (R 15-17)

6.30 The Commission accepted Audit recommendation 15. The Committee notes that Audit's endorsement of the NSW study was supported by the Committee's consultant, Dr Holland, who advised:

> Credentials committees are now working smoothly and successfully in NSW and the (former) Health Commission's document with its models is entirely applicable to the ACT.[8]

6.31 On the basis of the July 1985 advice from the Authority, it appears that the action by the Commission to amend the Ordinance in accordance with Audit recommendation 16, has come to nought. The Committee is concerned at this apparently wasted effort, particularly given the extended action of the Commission. For example, the Commission had advised Audit in October 1982 that action had been taken to amend the Ordinance in some areas in accordance with the Audit recommendations.[9]

6.32 The Committee recommends that:

> 9. The Authority take early action to finalise the proposed amendments to the Health Services Ordinance 1975 concerning the granting of Visiting Medical Officer status at Authority hospitals. The proposed amendments should be submitted to the Minister for Health for approval at the earliest opportunity.

6.33 In August 1984 the Commission supplied the Committee with documentation listing amendments the Commission proposed to the Ordinance and a copy of the actual draft amendments. The Committee reviewed this material against the requirements of the Audit recommendation and, having regard to the Committee's above recommendation, now reports its findings.

6.34 The Audit recommendation covered matters not included in the proposed amendments to the Ordinance, namely:

- legislative definition of roles;

- making the CPC responsible for review of all privileges; and

- specification of the frequency and nature of review of privileges.

8. Evidence, p. 163.
9. EA Report, p. 37.

6.35 The Committee is not concerned that there be further definition of roles. It notes that roles (occasionally outdated) are specified in the Commission's 1977 Administrative Arrangements and accepts the low priority accorded to incorporating the Arrangements into the Ordinance. Statutory protection for the CPC is not considered essential. The Committee agreed with the arguments submitted by its consultant, Dr Holland, as follows:

> The bogey of legal jeopardy has been worked to death in the matter of privileges. Many legal opinions have been given that decisions made in good faith based on factual evidence are not actionable. The existence of an appeals mechanism is an adequate safeguard for the applicant; the common law will protect the Committee which has acted fairly. Statutory protection merely fuels opposition to credentialling because it appears to deny natural practice by placing the Committee and its members in a privileged position.[10]

6.36 The Committee is not concerned that the Medical Committee rather than the CPC as recommended, assess contract appointees in relation to privileges. As at September 1984, the members of the CPC were also members of the Medical Committee. The Committee considers that the limited advantages in this case in terms of efficiency of restricting the privileges function to the CPC are probably outweighed by other factors such as possible opposition to the change. The Committee notes that the 'Administrative Arrangements' were out of date in many areas.

6.37 The Committee recommends that:

10. The former Commission's 'Administrative Arrangements' be updated.

6.38 The Committee is concerned that satisfactorily frequent and stringent review of privileges be taken, and that the Health Authority have the power to act on review findings. The Committee believes that the Authority should consider the need for more frequent review of the privileges of contract and Visiting Medical Officer appointees than the five and three year periods proposed in the Commission's draft amendments to the Ordinance for review of appointments.

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10. Evidence, p. 163.

6.39 In the Commission's documentation listing proposed amendments to the Ordinance, factors to be considered when setting conditions on VMO status and grounds for variation, suspension or cancellation of VMO status are specified. The Committee notes that some factors specified in the documentation are not listed in the draft amendments to the Ordinance. The Authority should review the Commission's draft amendments to the Health Commission Ordinance 1975 to ensure that adequate powers are specified in respect of the granting and reviewing of Visiting Medical Officer status.

6.40 The Committee sought the Commission's views on why some of the factors recommended by Audit (clinician's participation in hospital quality assurance and utilisation review activity and clinical performance as manifested in the review processes) are also not included. The Committee accepts the Commission's response that it would be premature.

6.41 The Committee notes that Audit's reference to the need for provision for specialist advice in the CPC (R17) was superfluous as the CPC was already empowered to co-opt specialists for advice on particular issues.

6.42 The Committee recommends that:

11. The Authority delay no longer taking the necessary procedural step of revising the composition of the Clinical Privileges Committee to include the Clinical Superintendants.

Review of Clinical Performance

6.43 Audit Findings

- A Quality Assurance Committee was established by the Commission in 1981 to co-ordinate quality assurance activities in Commission hospitals. However, Audit saw no evidence of the establishment of systematic review processes.
- In the opinion of hospital administrators interviewed interstate and of the medical consultant to the audit, the presentation of data to clinicians identifying their comparative length of stay performance, can result in a lowering of average lengths of stay and hence, to more efficient bed usage.

- The medical consultancy study indicated that, despite improvement in utilisation of about 10% between 1978 and 1980, scope remained for further reductions in average length of stay in the Commission's hospitals. Provision of utilisation review data to hospital management can assist monitoring of the efficiency of hospital bed usage.

- In his examination of case records the medical consultant observed differences in reported practice between the two Commission hospitals and variable rates of response to given clinical signals.

6.44 Audit Recommendations

R18. The Commission should continue to support the activities of the Quality Assurance Committee in establishing and co-ordinating quality assurance activities. Dr Ireland's study of individual medical records is illustrative of an approach the Committee could foster.

R19. The Commission and the Quality Assurance Committee should consider the introduction of systematic processes of utilisation review both in terms of length of patient stay and use of diagnostic and therapeutic services in patient care.

R20. Quality assurance activities should include a review of issues arising from the consultant's study of individual clinical cases.

Commission/Authority Action (R 18-20)[11]

6.45 The Commission advised that it no longer supported the view on the value of the medical consultancy report presented in the EA Report. The Commission was there reported as having 'serious reservations concerning several aspects of the report'.[12] Instead the Commission considered that, 'in the broad, the approach used ....could be a valid methodology which can be repeated and which would indicate possible areas for improvement'.[13]

11. Sources of text relating to Audit recommendations 18-20 are:
    - Evidence, pp. 30-32, 84-88, 198, 225-276,
    - Commission letter to Committee of 27 September 1984,
    - Authority letter to Committee of 18 July 1985.
12. EA Report, p. 38.
13. Evidence, p. 10.

6.46 The Commission provided a lengthy response on Audit recommendations 18 and 19. The documentation was reviewed for the Committee by Dr A W Ireland.[14] Four major components of clinical review activities in the ACT were identified:

Committee for Quality Assurance (CQA)

The CQA consisted of a Chairman (appointed by the Chairman of the Commission) and four members - the Clinical Superintendants of the two Commission hospitals and representatives of the Divisions of Medicine and Surgery. The CQA was advisory to the Chairman of the Commission and its role was to encourage the clinical divisions and units to develop their own quality assurance programs and to advise and assist them in their projects. The CQA did not have a role in facilitating/monitoring the review activities of the allied health professions.

Clinical Divisional Programs

Peer review and quality assurance committees had been established in three of the five clinical divisions and many units within the Divisions held regular clinical meetings. Some 'specific projects' had been undertaken, some of which (a minority) appeared to have involved systematic data collection and analysis.

Allied Health Professions

Various clinical departments, other than doctors, were engaged in clinical review programs.

Specific Projects in Clinical Review

The two major projects completed as at August 1984 were reviewed:

- Report on Clinical Efficiency (RCE), RCH and WVH, 1982

  This was a replication of the Auditor-General's Consultancy Study but using 1982 data rather than the 1980 data of the Consultancy Study. The major findings of the Consultancy Study were confirmed, namely:

  - there was considerable potential for improved efficiency (through greater conformity to peer standards by 'slow' doctors); and

  - there were wide variations in patterns of clinical practice.

14. Evidence, pp. 227-234.

The study showed that the two hospitals had made a significant improvement in efficiency. Between 1980 and 1982, bed utilisation had increased by 6%. During the period there were also shown to have been some changes in case use in the hospitals, certain clinical areas had been rationalised to one or other hospital.

- *Cholecystectomy Review, 1984*

  This was a review of 220 cholecystectomies performed in ACT hospitals during the period 1979-1982. Although some findings were very worthwhile, deficiencies in study design and in data presentation provided very few conclusions supported by evidence.

6.47 The Commission advised that it encouraged peer review activities within the various clinical divisions (R20). An appendectomy review had been conducted with the objective of inquiring into the extent to which clinical documentation in the hospital medical records was adequate for the purpose of evaluating the justification for surgical procedures and the clinical outcome of those surgical procedures.

Committee Conclusions and Recommendations

6.48 The Committee's comments on Audit recommendations 18 and 19 are based on the report of its consultant on clinical review, Dr Ireland, and other evidence taken during the inquiry.

6.49 The Committee found that the Commission had made a number of specific and positive responses to the Audit recommendations including the conduct of review programs in clinical divisions of the hospitals; the 'Review of Clinical Efficiency' (henceforth termed the RCE study); and educational seminars and workshops on clinical review. The Committee noted the conclusion of Dr Ireland that the level of review activity in clinical divisions was probably average for hospitals of the style and size of RCH and WVH.

6.50 The Committee, in strongly supporting the Audit recommendations, sees substantial scope for improving the Authority's clinical review activities. Specifically:

- there should be more quantitative, fact-based reviews of clinical records; existing activities are mostly of a general/educational nature;
- there is need to ensure that appropriate review methodologies are being applied;

- results of the systematic reviews undertaken need to be presented to the clinicians concerned, and, where necessary, corrective action taken (this had not been done with the Audit consultancy study nor with the RCE study); and
- the Committee for Quality Assurance needs revamping.

6.51 At the public hearings for the Committee's inquiry in September 1984 the role of the CQA was discussed and it became apparent that the CQA did not co-ordinate or guide clinical review activities in Authority hospitals. Following the hearings the Commission advised:

> The Commission is reviewing the circumstances of the Committee (for Quality Assurance) and overall is not satisfied with the role it has played. The Commission believes that the Committee should be reorganised to become an integral part of the Commission's functional structure and a submission making recommendations on the Commission's quality assurance requirements for all areas is being prepared for the Commission's consideration.[15]

6.52 The Health Authority advised in July 1985 that a proposal for a systematic process of quality assurance for ACT public health services had been put to the Commission in December 1984. The proposal had been circulated and comments had been received from most units and professional groups, including the Medical Committee. The Authority was now developing further proposals which would take account of these responses and would meet its obligations regarding quality assurance in public health facilities.

6.53 The Committee makes two important observations concerning the RCE study, conscious of a notable improvement of efficiency in terms of bed utilisation in Royal Canberra and Woden Valley hospitals during the period from 1980 to 1982. As previously stated, this improvement was apparent from the results of the RCE study compared to the results of the earlier Audit consultancy study.

6.54 Firstly, although the RCE study replicates the Audit consultancy study, the repeat study in no manner demonstrates the effectiveness or otherwise of such reviews as a tool for generating greater quality and/or efficiency. The RCE study examined data which had already been created before any publication of the results of the consultancy study was available. The 6% improvement in efficiency found in the RCE study reflected developments in hospital administration during the period.

15. Commission's letter to Committee of 27 September 1984.

6.55 The Committee was advised, however, that there was potential for greater efficiency following such studies. In another hospital where studies were conducted over a similar period and results were presented to clinicians with 'participatory dialogue', there was said to be an improvement in efficiency of 16%.[16] This was considerably more than the 6% found in the ACT where there was no communication of results. The Committee is impressed by the apparent importance of communicating results of studies to clinicians for achieving improvements in efficiency and effectiveness of clinical services.

6.56 Secondly, the occurrence of the repeat KCE study demonstrates that the methodologies of systematic review reported in the EA Report (Appendix 1) are transportable and reproducible.

6.57 The Committee recommends that:

12. In reviewing its quality assurance and review arrangements, the Authority give specific attention to the model for systematic clinical review proposed by the Committee's consultant, Dr Ireland. Aspects of this model include:

- the establishment of a representative committee to direct the programme. There must be clear lines of communication and accountability between this committee and clinical practitioners on one side, and the committee and the executive of the institution on the other;
- the creation of routine statistical reporting systems to provide regular analyses of clinical performance data;
- regular reporting of these analyses to the clinical practitioners, through their specialist departments;
- identification of high-priority issues within each speciality or section of the service, priority being determined on the basis of resource consumption or demonstrable inconsistencies in clinical performance in a given area;
- the introduction of a formal schedule for the review of these priority issues;
- the implementation of clinical review projects to employ objective protocols and examine adequate samples of clinical case material; and

16. Evidence, p. 270.

- development of machinery (vested in the committee) to ensure that practitioners are aware of review findings, participate in creating policies to correct deficiencies in practice, and receive feedback through follow-up reviews as to the success of corrective policies.

6.58 The Committee found the Commission lax in its response to Audit recommendation 20.

6.59 The recommendation was for a review of issues arising from the consultant's study of individual clinical areas. The consultant reported a selective list of situations in which the data from medical records raised questions concerning the suitability, *logic or effectiveness of clinical care* in that area. It appeared to the Committee that important clinical care issues were in fact raised, warranting further professional scrutiny.

6.60 The response *was, however, not to address* the issues themselves, but to question the adequacy of the medical records.

6.61 The Committee recommends that:

13. The Authority review the clinical care issues arising from the Efficiency Audit's consultancy study.

Admission Arrangements

6.62 Audit Findings

- The introduction of a control over some categories of admissions has led to a number of improvements to the admission process. However, the control does not apply to elective admissions and is not designed to significantly influence the rate of admission to hospitals or to challenge grounds of admission by specialists.
- A range of measures are available to hospital authorities to streamline admission processes and make best use of hospital facilities.

6.63 Audit Recommendations

R21. Recommendations by Audit under 'Planning for Facilities' (Section 2.1.3) and 'Review of Clinical Performance' (Section 2.2.3) have implications for the rate and appropriateness of hospital admissions.

R22. The Commission should investigate whether the number of day only beds could be increased.

Commission/Authority Action (R 21-22)[17]

6.64 The Commission acknowledged that restrictions on bed capacities and controls over the activities of doctors in hospitals impacted on the number and type of hospital admissions (R 21).

6.65 In respect of the Audit finding concerning unsatisfactory control over elective admissions, the Commission advised that subsequent to the audit it had increased its control over these admissions. Doctors who wished to admit a number of patients were asked to allocate priorities so that those patients with more urgent needs could be admitted first. The Commission stated that it was sometimes necessary to ask doctors to discharge patients before their other elective patients could be admitted.

6.66 The Commission considered it was now doing all that it could in a practical sense to control admissions.

6.67 The Commission advised that it had investigated the demand for day-only beds and had identified no extra demand (R 22).

Committee Conclusions and Recommendations (R 21-22)

6.68 Audit was not satisfied with the Commission's control over admissions and recommended three mechanisms for increased control:

- limiting the supply of staffed hospital beds;
- reviewing admission decisions in quality assurance activities; and
- greater use of day-only beds.

6.69 The Commission acknowledged the value of these mechanisms but considered it was taking all action practicable to control admissions.

6.70 The Committee endorses in principle the recommended review of admission decisions in quality assurance activities, but considers it would be premature given the level of development of techniques of review in Authority hospitals.

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17. Sources for text relating to Audit recommendations 21 and 22 are:
    - Evidence, pp. 34-35, 88, 164-165, 172-173, 181.

6.71 The Committee recommends that:

14. The Authority monitor the scope for introducing the review of admission decisions in quality assurance activities as the standard of such activities and the co-operation of the profession develop.

6.72 In respect of the recommendation for greater use of day-stay beds, the Committee comments that:

- although details of the Commission's investigation of the demand for day-stay beds were sought by the Committee, the Commission was unable to provide such details;
- during the three year period 1981-1984 the number of day-stay beds remained constant at 20 at RCH and fell from 16 to no beds specifically designated as day-stay only at WVH;
- from 1981/82 (the first year when short stay patients were reported) to 1984/85, the annual number of short stay patients rose by over 6 000, from 1968 to 8 283. During this period there were 4 683 short stay patients in 1982/83 and 4 989 such patients in 1983/84; and
- many factors other than the availability or scarcity of conventional inpatient facilities influence the demand for day-stay beds, for example:
  - community acceptance of the concept;
  - joint patient/doctor decisions;
  - operating theatre times (morning/afternoon); and
  - financial disincentives to day care enshrined in the present Medicare (and previous funding) arrangements - that is, requirement for an eight hour stay for receipt of the *Commonwealth bed-day subsidy*.

6.73 The Committee observes that the Authority's control over factors influencing the demand for day-only stays is limited. However, there are economic and other advantages from use of day-stay beds. There are nursing staff savings, and day-only stays may be more convenient to some patients and their families.

6.74 The Committee therefore recommends that:

15. The Authority take steps to encourage the demand for day-only stays by encouraging, for example:

- community/patient/clinician acceptance of day-only stays; and
- morning rather than afternoon operating theatre for minor surgery.

6.75 The Committee also expresses its concern that the Federal Government's bed-day subsidy funding arrangements may deter day-only stays.

6.76 The Committee commends to the Authority the views of its consultant, Dr Holland, in respect of controlling elective admissions through a system of specified priorities.[18] The Committee recognises the practical difficulties of categorising priorities in this area and the importance of ensuring that all persons requiring admission are not refused. Nevertheless, the Committee considers such priority setting to be important particularly given the trends for increasing pressure on beds and recent cancellations of elective surgery (because of nursing staff shortages and industrial action).

6.77 The Committee recommends that:

16. The Authority develop guidelines on elective admission priorities and ensure that these guidelines are applied at hospital level and sent to clinicians to foster consistency in priority setting.

Discharge Arrangements

6.78 Audit Findings

- In a one day ward census the medical consultant found that 10.5% of patients in Commission hospitals could be classified as not requiring acute hospital care.
- Clinicians' visits, at which decisions on patient discharge can be taken, are at irregular times. No set times exist for patient discharge.
- Systematic monitoring by hospital authorities of the frequency of clinician visits to public patients is not undertaken.

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18. Refer Evidence, p. 164.

6.79 Audit Recommendations

R23. The Chief Medical Administrator should exercise greater control over discharges from his hospital. This responsibility could be delegated. Daily reports could be provided from wards on numbers of patients ready for discharge but awaiting approval of the attending clinician. After contact with the patient's clinician, discharge could be arranged.

R24. Discussions should continue with the Medical Committee to seek means of encouraging clinicians to manage visiting times so as to enable release of hospital beds at times which facilitate prompt re-use. Use of hospital regulations might be considered.

R25. The Chief Medical Administrator of each hospital should be required to introduce procedures to monitor the frequency of clinician visits to public patients. The Commission has advised that a limited form of monitoring is under development.

Commission/Authority Action (R 23-25)[19]

6.80 The Commission advised that it supported Audit recommendation 23 and had implemented it to the practicable extent.

6.81 Clinical superintendents as delegates of Chief Medical Administrators had been given greater responsibility in the control of admissions/discharges. There was growing pressure on available beds, the concept of 'nursing home' type patients had been introduced, and increasing emphasis had been placed on post-discharge community health services.

6.82 The Commission stated that it had, with the support of its Medical Committee, made numerous approaches to medical staff to encourage them to visit at times which would facilitate prompt re-use of hospital beds (R24).

6.83 Some improvement was apparent, mainly due to the trend for specialities and therefore specialists to be located at one hospital only. This reduced the dispersal of patients and led to improved communication between doctors and hospital staff.

6.84 The Commission did not support the use of regulations controlling visiting times.

6.85 The Commission advised that the frequency of clinician visits to hospital patients (R25) was monitored by the clinical superintendants who randomly checked clinician claims for

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19. Sources for text relating to Audit recommendations 23-25 are:
- Evidence, pp. 35-36, 88-89, 116, 165, 173, 286,
- Commission letter to Committee of 27 September 1984.

payments for services. Reports on the frequency of claims would be available from a computerised system during 1985.

6.86 In response to a Committee request concerning the adequacy of existing monitoring arrangements, the Commission stated that:

- Chief Medical Administrators had held discussions with some doctors where required and these had resulted in a reduced frequency of visits; and
- discussions had also been held at meetings of the Medical Committee and hospital executive committees.

Committee Conclusions (R 23-25)

6.87 Although the Commission advised that it supported the recommendation for exercise of greater control over discharges by a hospital's Chief Medical Administrator (CMA) (R23), the Commission did not provide any details of implementation beyond saying that greater responsibility in that area had been given to the delegate of the CMA.

6.88 The Committee notes that Audit recommended that such control be exercised through the preparation of daily ward reports on patients ready for discharge but awaiting approval of the attending clinician. Discharge could be arranged after contact with the clinician. In response to a request from the Committee, Audit advised that the reports would be prepared by the nurse in charge of the ward.

6.89 The Committee has a number of difficulties with the methods of implementation recommended by Audit, notably the sensitivities of doctors and nurses to their respective professional responsibilities. Nevertheless, given the Commission's stated support of the recommendation, the Committee needs to see evidence of implementation.

6.90 The Committee accepts the findings of the Audit consultancy study's one day ward census as indicating some scope for improved discharge management in Authority hospitals. The consultancy study[20] identified some 12% of RCH patients and 30%[21] of WVH patients on a given random day (5 August 1981) as not needing acute hospital care.[22] Scope for improvement is indicated even allowing that there will always be a number of patients in any hospital who need to remain in hospital for other than acute care reasons (eg, those for whom alternative care is not available).

20. EA Report, p. 57 and p. 85 refer.
21. Including over 60% (66/99) from psychiatric and rehabilitation wards.
22. The Committee notes that Audit's summary of the consultancy results, ie, that 10.5% of patients in Commission hospitals could be classified as not requiring acute hospital care was inaccurate.

6.91 In the interests of improved discharge management, the Committee draws to the attention of the Authority:

- the view of the Committee's consultant, Dr Holland, that frequent and regular consultant attendance is the best mechanism to ensure prompt discharge of patients[23]; and
- that medical, nursing and administrative personnel of a Victorian hospital jointly produced an admission and discharge policy report. The policy was accepted by the Australian Medical Association's Victorian Branch.[24]

6.92 In view of the Commission's lack of support for regulations controlling clinician visiting times (R24), the Committee sought Audit's comments on how such regulations would be used.

6.93 Audit advised that the regulations would take the form of hospital by-laws:

> The existence and enforcement by hospital authorities, of suitably designed regulations dealing with clinician visiting and patient discharge practices could engender greater clinician awareness of and compliance with hospital requirements, leading to more efficient hospital bed use.
>
> Preferably, the regulations would encourage those visits likely to result in discharge to be made at a time early enough in the day to enable prompt re-use of the hospital bed. Such visits could be requested to be sufficiently early in the week to facilitate discharge for the weekend and to allow time for any necessary community nursing arrangements to be made for home care.[25]

6.94 Audit emphasised that the precise extent to which hospital by-laws or regulations could be applied to the issue of clinician visiting times was a matter for detailed assessment by the Authority.

6.95 The Committee considered the comments from Audit, the views of the Committee's consultant, Dr Holland, and the Commission's views, and has decided that it does not support the use of regulations to control the visiting times of clinicians. Rather, the Committee prefers the use of negotiation and discussion for a number of reasons, including the consistent trend in recent years for increasingly deregulated hospital visiting times for the relatives and friends of patients.

23. Evidence, p. 165.
24. Medical Practice, September 1984, p. 7.
25. Evidence, p. 116.

6.96 The Commission has implemented Audit recommendation 25. The Committee considers that monitoring procedures should be applied judiciously so as not to reduce the frequency of clinician visits to the point where effective management of patient discharges is compromised.

6.97 The introduction of the computerised doctors' claim system is discussed with Audit recommendation 46 (pp. 79-80).

CHAPTER 7

HOSPITAL RESOURCE MANAGEMENT

- Financial Controls - Budget Development
- Financial Controls - Expenditure
- Staffing Control - Ceilings, Workload Assessment and Procedures
- Maintenance and Minor Works
- Payment of Fees to Clinicians for Services to Public Patients
- Cleaning Arrangements
- Accommodation Use - Hospital Services
- Patient Accounts and Debt Recovery

Financial Controls - Budget Development

7.1 Audit Findings

- In the absence of statements about specific levels of service to be provided, there was an implicit assumption that existing levels were 'correct'. Consequently any imbalances which might have occurred or were developing were perpetuated.

- Input resource levels were not directly linked to outputs, nor were there other than generalised workload measures against which performance could be compared.

- The form in which estimates were presented by the hospitals did not allow for identification of resource use by activity centre or type eg, particular wards. Comparison of performance of like units in terms of staff employed and expenditure, linked to defined department outputs (eg, number of inpatient bed days) is central to systems being implemented by the Victorian and New South Wales Health Commissions. Those systems generate indicative data on hospital performance for Commission and hospital analysis and, where necessary, detailed follow-up.

- Lack of defined service levels, staff and expenditure performance measures and resulting comparisons limits the Commission's ability to analyse budget bids.

7.2 Audit Recommendations

R26. Within the Commission's long term planning framework incorporating definitions of the roles and services to be provided by each publicly funded hospital (see 2.2.2 and 2.2.3 of EA Report), the types and activity levels of hospital services to be provided should be specified.

R27. Staffing budgets should be linked to identified service needs for the year and include explicit identification of temporary relief staff hours employed to meet workload fluctuations and the relief of permanent staff.

R28. Productivity measures and quality criteria susceptible to measurement should be developed allowing hospital management and the Commission to monitor and report on the extent to which agreed services are being provided efficiently.

R29. Recent progress in establishing management information systems which report on an activity basis by cost centre in hospitals funded by the Victorian and New South Wales Health Commissions should be studied.

Commission/Authority Action (R 26-29)[1]

7.3 The Commission advised that a recent draft planning document, the 'Capital Territory Health Commission Planning Statement' of June 1984, set the framework for hospital role delineation in the ACT (R26). The considerations specified by Audit had always been a central element of the Commission's forward hospital planning.

7.4 Staffing budgets (R27) were now prepared on a position by position basis and account was taken of temporary relief staff. Identifiable levels of service were available and were used in budget preparation.

7.5 Productivity measures (R28) and quality criteria were proposed for the upgraded ADP hospital management systems under development: the Commission Administrative Hospital Information System (CAHIS) and the Human Resources Management Information System (HRMIS). The relevant data sets were:

- output statistics on, eg, patients treated, patient days from the CAHIS module termed the Admissions/Transfers/Discharges system;

1. Sources for text relating to Audit recommendations 26-29 are:
   - Evidence, pp. 37-40, 89-91, 156, 165, 173, 178-179, 219-221, 227-229, 283-284,
   - Commission letter to Committee of 27 September 1984,
   - Authority letter to Committee of 18 July 1985.

- human resources input statistics (nursing hours, non-nursing hours, overtime hours) from the HRMIS - basically a payroll system; and

- expenditure data from the general ledger module of CAHIS.

7.6 As at September 1984, the Commission had not decided how these outputs and inputs would be merged to form productivity measures. The process was not expected to be onerous, and might be performed manually. The Commission indicated that useful information on the relationships between inputs and outputs could be expected during 1985/86.

7.7 The Authority advised in July 1985 that it was examining the detailed measures that needed to be taken to derive productivity indices from its information systems. The design of CAHIS foreshadowed the need for matching input and output measures. The development of CAHIS was continuing, and while it was not expected that productivity indices would be available throughout the Authority immediately, it was planned to have available broad indicative measures by the end of 1985.

7.8 The Commission advised that in the development of CAHIS and HRMIS it had examined information systems available elsewhere (R29) and, where applicable, had made use of them. The Commission had similarly taken into account the suggestions reported by Audit.

Committee Conclusions and Recommendation (R 26-29)

7.9 The Committee reviewed the 'CTHC Planning Statement' and found that it did not include details of the types and activity levels of hospital services as recommended by Audit (R26).

7.10 The purpose of the Audit recommendation appeared to the Committee to be the provision of a planning framework for a more finely-tuned budget development process for the Commission.

7.11 Whilst the Committee supports in principle recommendations aimed at improving the Authority's budgeting systems, the Committee found R26 to be in general terms and of doubtful feasibility. However, the Committee considers that the recommendation should be pursued further than it has been to date. The Commission's reference to the 'Planning Statement' in the context of this recommendation is quite inappropriate. The statement is a broad document reviewing the total ACT health care system. Details of the hospital system to the extent recommended by Audit are unsuitable for inclusion.

7.12 The Committee found Audit recommendations 27 and 28 to be important recommendations and notes that the proposed ADP hospital management systems are in the direction recommended by Audit.

7.13 The ADP systems are, however, at the early stages of implementation and it remains to be seen firstly, whether these systems will supply the information required by Audit, and secondly, whether that information will be used in budget development and analysis.

7.14 The Committee noted recent adverse Audit comment on CAHIS development. In his March 1984 Report the Auditor-General strongly criticised the Commission's controls over the acquisition, development and implementation of the CAHIS. Also, feasibility studies, cost/benefit analyses, system proposals and management reviews and follow-up were unsatisfactory and formal procedures and standards were lacking.

7.15 However, in September 1984 when the Committee questioned the Commission on the management and status of its ADP projects, the Commission provided evidence that its project planning, management and review procedures were then adequate. The Commission stated that implementation had not been jeopardised by financial or staffing constraints. Despite these comments, the Committee found significant slippage when it reviewed planned versus achieved project milestones both at September 1984 and July 1985. In the latter case the original timetable was reported to have been subject to the impact of staff shortages. The Committee is concerned that there be no further delays given the importance of the ADP developments to improved hospital management.

7.16 The Committee recommends that:

17. The Authority place the highest priority on implementing proposed automatic data processing hospital management systems. The Authority should report in detail on automatic data processing systems implementation in its Annual Report to the Parliament and significant project delays should be explained.

7.17 While the Committee made no assessment of the results of Audit recommendation 29, it has become aware of computerised hospital management and information system development being carried out by the Department of Veterans' Affairs in conjunction with a major computing firm. This followed initial work done on systems at Royal Adelaide Hospital. The Committee believes that the Authority should consult with those organisations. The Committee's comments on hospital information systems and the role of the Authority's Systems and Management Information Branch at page 73 are pertinent.

Financial Controls - Expenditure

7.18 Audit Findings

- Reports currently prepared on hospital expenditure do not allow comparisons between the Commission's hospitals because of:
  - differing bases on which reports are prepared; and
  - inaccuracies in the allocation of costs.
- The current monthly financial reporting system is not designed to provide information on expenditure by activity or to provide measures of cost per unit of output. Its major function is to provide an overall check on expenditure against budget allocation.
- The Commission's Finance Committee, as an instrument for reviewing and reporting on budget performance, seemed limited by uncertainty concerning its information requirements, and by lack of objective analysis of reasons given for variance from budgets.
- The Commission's Central Office and each hospital separately make use of Health Commission of Victoria systems for payroll and payment of creditors. Audit was advised of difficulties associated with the use of these systems. Audit also observed a lack of expertise within the Commission for achieving co-ordinated and effective use of the Victorian system. Recently, Victoria introduced an upgraded system.
- Despite recognised limitations, new systems observed in Victoria and New South Wales significantly enhance the capacity of the State health authorities and hospital managements to plan and control hospital expenditure and resource use.

7.19 Audit Recommendations

R30. The Commission and its hospitals should move towards an activity-based system for the control and reporting of hospital financial expenditure along the lines of systems being developed in Victoria and New South Wales. If practicable, the Commission should enter the upgraded Victorian system.

R31. In line with moves towards activity-based reporting, hospital unit managers should be encouraged to participate more in budget planning and control for their units within the proposed activity-based control system.

R32. The Finance Committee should place greater emphasis upon the analysis of budget proposals through the comparison of function or activity centre performance against budget forecasts, based on objective performance as well as expenditure data.

R33. The (Finance) Committee should be required to furnish the Commission with regular reports on projected expenditure using past expenditure patterns coupled with forward commitments and expected programmed expenditure.

R34. The Commission should establish an analytical project capacity to:

- facilitate planning, development and conversion to more sophisticated management control systems;
- undertake analyses of financial and performance data;
- review cost containment and cost containment techniques; and
- promote co-ordination of hospital and Central Office activities related to the development of hospital management systems.

Commission/Authority Action (R 30-34)[2]

7.20 The Commission generally did not dispute these recommendations. It agreed that its financial management system could be improved and was developing an upgraded information systems (CAHIS).

7.21 CAHIS was to include activity based costing (R30). As part of the CAHIS development, a working party had been established to determine the requirements of financial systems for the Commission. The NSW system would be examined in that context. It had not proved practicable to use the Victorian system. The Victorian Health Authority had encountered such problems with its enhanced general ledger system that it had called tenders for a new system.

7.22 Unit managers (R31) were involved in budget planning and expenditure control through meetings with hospital General Superintendents where financial issues were discussed. Managers could also submit requests for resources.

2. Sources for text relating to Audit recommendations 30-34 are:
- Evidence, pp. 40-42, 91-95, 165, 173, 178-179,
- Commission letter to Committee of 27 September 1984.

7.23 The Finance Committee did not yet have the information to improve its analysis of budget proposals as recommended by Audit (R32).

7.24 The Finance Committee monitored interhospital costs and budget trends on a monthly basis (R33). Within the limits of existing systems steps had been taken to improve the documentation being considered by the Committee. Emphasis had been placed on improving objective analysis of budget variations. There were monthly expenditure reports to the Executive.

7.25 The Policy, Planning and Administration Division had been restructured and made more responsive to needs for an analytical project capacity (R34). A 'Systems and Management Information Branch' had been established in the Division addressing many of the functions listed by Audit.

Committee Conclusions (R 30-34)

7.26 The Committee supports these recommendations.

7.27 Although some action has been taken in response to the recommendations, it was clear that the Authority required the information from its proposed ADP systems to gain more sensitive control over resources. The Committee emphasises its previous comments (p. 70) on the need for the Authority not to delay ADP systems development.

7.28 The Committee recognises that the Audit recommendations require some significant changes in Authority administrative practices in addition to an upgraded information system. Accordingly, the Committee concludes that the extent to which the Authority would achieve enhanced expenditure control remained to be assessed.

7.29 The Committee notes that in recommending activity-based systems Audit took account of a number of factors, including the state of the art in Australia for hospital management information systems (MIS's).[3] During its inquiry the Committee heard evidence of the desirability for performance assessment and effective administration, of information systems providing details of the total costs of managing particular illnesses/operations. Activity or cost-centre based systems, representing the state of the art in Australia, could not provide such information.

7.30 The Committee observed that it appeared from the functional statement for the Authority's new Systems and Management Information Branch, that the monitoring of MIS developments would be an important responsibility of the Branch. The Committee endorses this role. The consultation referred to by the Committee at page 70 is consistent with this role.

3. Evidence, pp. 178-179.

Staffing Control - Ceilings

7.31 Audit Findings

- Staff ceilings have comprised a principal control mechanism on Commission staffing levels in hospitals in recent years.
- Present systems exhibited the following weaknesses:
  - staff ceilings do not cover all temporary short-term relief staff;
  - at the time of audit accurate data on the employment of temporary short-term relief staff could not be readily extracted; and
  - the Establishment Analysis and Retrieval system is inaccurate.

7.32 Audit Recommendations

R35. Monitoring of total staff hours used by work unit and in relation to workload should be undertaken as part of an automated wage and salary processing system (See 'Staffing Control Procedures').

R36. Within revised control and reporting arrangements the usefulness of the existing Establishment Analysis and Retrieval system should be reviewed.

Staffing Control - Workload Assessment

7.33 Audit Findings

- There was a general lack of detailed standards of service and associated work performance standards. Detailed workload indicators were not in evidence, either within the Commission or its hospitals to enable objective assessment of hospital staffing levels.
- The basis of the underlying staffing establishment of each hospital was unclear. For example, there were differences in the inbuilt relief staff establishment bases of the two hospitals in the clerical assistant and nursing employment groups.
- It would be reasonable for the Commission's hospitals to be included in systems developed interstate that enable detailed comparison of performance between like units within like hospitals.

7.34 Audit Recommendations

R37. A progressive program of staffing reviews should be undertaken to develop staff to workload matching guidelines for use in the publicly funded hospitals.

R38. The reviews should be centrally co-ordinated.

R39. Each hospital should then be required to justify its staffing requirements using the developed workload matching guidelines.

R40. Relief staff establishment bases should be consistently provided in both hospitals.

R41. In formulating its proposals for upgrading ADP systems applied to hospital management the Commission should seek means by which it might participate in interstate systems that generate detailed inter-hospital comparisions for groups of like units within similar sized hospitals.

Staffing Control Procedures

7.35 Audit Findings

- There were significant differences between the two Commission hospitals in their internal methods of staff counting, categorising and reporting for staff control purposes.
- Staffing control procedures used by the New South Wales and Victorian Health Commissions exhibit features which facilitate control by providing for an objectively determined staff base. As a result, comparisons can be made of actual staff usage of like units within and between hospitals, over time.

7.36 Audit Recommendations

R42. The Commission should rationalise the form and content of staffing reports used by its hospitals. The consistency of data definition and data entry processes should be improved and a staff reporting system common to both hospitals introduced. The Commission has advised that it is implementing this recommendation.

R43. Control reports similar to those generated within the New South Wales and Victorian hospital management information systems should be developed to enable periodic reporting of total staff usage against budgeted staffing, and to enable comparison of like units.

R44. *In planning future ADP requirements the Commission should ensure that its staffing control system is closely linked with its financial control system.*

Commission/Authority Action (R 35-44)[4]

7.37 The Commission advised that Audit recommendations on staff ceilings and staffing control procedures (R 35, 36, 42-44) were addressed by the proposed development of the Human Resources Management Information System (refer pp. 68-69). The System would identify staff usage linked in with staff funds utilisation and enable regular review of staff and use of funds against budget (R44).

7.38 The Commission stated that it recognised the limitations of the Establishment Analysis and Retrieval Systems (EARS) (R36). The quality of input data for EARS had, however, been improved.

7.39 The Commission was developing consistent staffing reports (R42) across all functional areas whereby monitoring of staff use was undertaken regularly and linked in with expenditure on salaries.

7.40 The Commission had some monitoring of staff use (R43) on a monthly basis.

7.41 The Commission commenced a program of staffing reviews for workload assessment (R 37-41) in July 1981 and a number of such reviews had been conducted. A review of nurse staffing and of the health inspection function examined staffing requirements in relation to workload indicators. All staffing reviews were centrally co-ordinated.

7.42 As part of its budgetary process the Commission required each hospital to justify staffing levels in all categories (R39) based upon workload.

7.43 Relief staff (R40) were provided as a normal working arrangement for the Commission's nursing establishment. Relief for other staff was provided on an 'at need' basis by the employment of casual staff.

7.44 The Commission agreed with the general approach of developing systems that would facilitate inter-hospital comparisons (R41) but it questioned the ability of any one approach being able to provide meaningful comparisons on an objective basis. The broad objective was, however, being pursued, and a working party would be exploring the possibilities with the other State health authorities.

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4. Sources of text relating to Audit recommendations 35-44 are:
   - Evidence, pp. 43-45, 91, 96-99,
   - Authority letter to Committee of 18 July 1985.

Committee Conclusions and Recommendations (R 35-44)

7.45 The Committee supports the recommendations on staff ceilings and staffing control procedures (R 35, 36, 42-44).

7.46 The Committee notes that the Commission's reference to the Human Resources Management Information System (HRMIS) does not fully address the requirements of R 35. The recommendation requires monitoring of staff usage in relation to workload. As previously described (pp. 68-69 refer) data on workloads (outputs) and on staff usage (inputs) will derive from separate Commission ADP systems. The HRMIS will provide only staff usage data.

7.47 The Committee recommends that:

> 18. The Authority use its ADP systems, once available, to review staff usage in relation to workload.

7.48 In respect of the second Audit finding under 'Staff Ceilings', the Authority advised in response to a Committee request that the HRMIS would identify all staffing categories (permanent, temporary, casual and relief). The Committee noted that temporary short-term relief staff represented almost 8% of effective full-time staff at the time of the audit.

7.49 The Committee considers the implementation of the recommended program of workload assessment reviews desirable (R 37-39) so that detailed guidelines may be developed to match staff to workload. The Committee is not satisfied with the Commission's/Authority's progress on this matter, despite the many practical difficulties involved. There are many areas of hospital activity where assessment of workload standards is difficult and, as acknowledged by Audit, the reviews would take 'a considerable time to complete'.[5] Nevertheless it was unsatisfactory that two years after the audit only two reviews which addressed the recommendations had been conducted. One of these (the nursing review) was current at the time of the audit (1982), and seen as 'a useful starting point'[6] for the recommended program of reviews.

7.50 The Committee notes the Audit suggestion that in the shorter term actual staff use by main departments could be compared against existing workload indicators.

7.51 The Committee recommends that:

> 19. The Authority's Establishments and Review Section develop staff to workload matching guidelines for the higher labour cost areas/functions in Authority operated hospitals.

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5. EA Report, p. 138.
6. Ibid., p. 38.

> 20. The Authority undertake, as a matter of priority, a comparison of staff use by main departments against existing indicators as suggested by Audit. Resource allocations should be reviewed if necessary.

7.52 The Committee believes that the Commission's comments misinterpret Audit recommendation 40 and the related finding.

7.53 The Committee recommends that:

> 21. The Authority ensure that the inbuilt relief staff establishment bases applied by the two hospitals for clerical assistant and nursing employment groups are consistent.

7.54 The Committee notes that the Commission supported Audit recommendation 41 in principle and was reviewing possible participation in suitable inter-state systems.

7.55 The Committee recommends that:

> 22. The Authority participate in information systems providing indicative data on hospital performance.

Maintenance and Minor Works

7.56 Audit Finding

- Lack of authority of hospital management at Royal Canberra Hospital over maintenance and minor works activities undertaken by units of other agencies has contributed to control and co-ordination difficulties.

7.57 Audit Recommendation

R45. Hospital management should assume direct responsibility for these activities. A Working Party comprising representatives of the Commission and the Department of (the then) Transport and Construction has been established to arrange transfer of the maintenance function.

Commission/Authority Action (R 45)[7]

7.58 Agreement was reached with the Department of Housing and Construction (DHC) on 5 August 1984 to the transfer of the maintenance and minor works function at RCH to the Commission.

Committee Conclusions and Recommendation (R45)

7.59 There was a significant delay in the transfer of the maintenance and minor works function. In October 1982 the transfer was forecast to take effect by 30 June 1983.

7.60 The Committee was advised that difficulties had been experienced in reaching agreement with the DHC, and negotiations with unions were protracted.

7.61 The Committee has chosen to draw attention to this delay because of the similarly slow action by the Commission/Authority in respect of a related Audit finding on which action is still in progress. Although the former Commission stated in October 1982 that agreements had been made with the ACT Electricity Authority for the execution of a formal agreement in respect of electrical maintenance at Commission hospitals,[8] the relevant document was not in fact drafted until July 1984. By September 1984 the document was expected to be signed by the end of the year. By July 1985, however, the Agreement was still only close to finalisation. The Authority advised that there were some areas of disagreement which were subject to negotiation and it was expected to be finalised shortly. The Committee notes that these delays reflect poorly on the efficiency of the Authority.

7.62 The Committee recommends that:

> 23. The Authority ensure that the agreement with the ACT Electricity Authority concerning electrical maintenance at Authority hospitals, be signed without further delay.

Payment of Fees to Clinicians for Services to Public Patients

7.63 Audit Finding

- Control by hospital authorities over accounts from clinicians for treatment of public patients is inadequate.

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7. Sources for text relating to Audit recommendation 45 are:
   - Evidence, pp. 46-47, 99-100, 166,
   - Commission letter to Committee of 27 September 1984,
   - Authority letter to Committee of 18 July 1985.
8. EA Report, p. 139.

7.64 Audit Recommendation

R46. The Commission should consider a system based on a complete check, against medical records, of accounts selected by random sample. Alternatively clinicians might be required to complete a duplicate record of treatment for checking against the account.

Commission/Authority Action (R 46)[9]

7.65 The Commission stated that it had introduced a system wherein a standardised claim form was completed by each clinician for each service. A random sample of the service claims was verified against the medical records and discrepancies were discussed with the doctors concerned. When necessary, payments for the services claimed were refused. The discrepancies had not, in total, been material.

7.66 The doctors claim system was being computerised. The new system would allow auditing of claims and provide information on the treatment patterns of doctors. As at September 1984, the system was expected to be operating by April 1985. By July 1985, the system was to become fully operational later in that year, following the completion of programming and data preparation work.

Committee Conclusion and Recommendation (R46)

7.67 The Committee notes the not insignificant delays. It also notes that use of information from the computerised claims system to modify doctors' treatment patterns would require co-operation from the doctors concerned.

7.68 The Committee recommends that:

24. The Authority take early action to encourage the co-operation of the medical profession in the introduction of the computerised doctors' claim system.

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9. Sources for text relating to Audit recommendation 46 are:
- Evidence, p. 48, 100-101, 166,
- Commission letter to Committee of 27 September 1984,
- Authority letter to Committee of 18 July 1985.

Cleaning Arrangements - Royal Canberra Hospital

7.69 Audit Findings

- Cleaning services at Royal Canberra are undertaken by hospital staff. Labour costs in the 12 months to 30 September 1981 were approximately $1 200 000. At Woden Valley Hospital, cleaning is carried out under a private contract arrangement. In comparing actual costs at Royal Canberra with costs implied by contract terms at Woden Valley Hospital, Audit concluded that actual labour costs exceeded possible costs under the conditions of the Woden Valley contract by at least $500 000.

7.70 Audit Recommendation

R47. Although the full cost differential identified by Audit may not be practically realisable, the magnitude of that differential suggests that cleaning services at Royal Canberra are uneconomical and that alternative (contract) arrangements should be investigated. Since the audit, the Commission has sought to introduce private contract arrangements. Following industrial action, working parties have been established to consider standards for cleaning services, the costs of cleaning by staff labour and ways of economising.

Commission/Authority Action (R 47)[10]

7.71 The Commission advised that this issue first arose in January 1982 when the then Acting Prime Minister requested all Ministers 'to examine the cleaning activities being undertaken by Commonwealth staff within their portfolios with a view to contracting these services out'.[11] In August 1982 the Commission issued a notice to cleaning staff at the RCH (and a Canberra nursing home) advising that the Commonwealth Government had directed that the Commission's cleaning services be contracted out to the private sector.

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10. Sources for text relating to Audit recommendation 47 are:
- Evidence, pp. 49, 101, 119, 166,
- Commission letter to Committee of 27 September 1984.
11. Letter of 8 January 1982 from the then Acting Prime Minister to all Ministers, quoted in Report by the Chairman of the Local Industrial Board, Mr P P Allsop, concerning Dispute C No. 5530 of 1982, p. 1.

7.72 The Commission stated that the following events occurred subsequently:

- the industrial action referred to by Audit arose;
- the issue was referred to the Conciliation and Arbitration Commission (C & AC);
- working parties were established to examine the issue;
- the C&AC accepted the recommendation of the working party that the present method of cleaning be continued because there 'is little evidence to suggest that substantial benefit would ensue from changing the current arrangements'[12]; and
- the dispute was resolved.

7.73 The Commission advised the Committee that not only did it agree with the assessment, but it also considered that the comparison made by Audit between RCH and WVH was not soundly based. RCH was an older hospital and its cleaning costs could be expected to be higher.

Committee Conclusions and Recommendation (R 47)

7.74 The Committee sought to examine the evidence supporting the divergent conclusions.

7.75 It found that Audit's analysis was based on applying the costs of contract cleaning at WVH to the RCH. The form of the Audit calculation is set out in the EA Report.[13] Audit advised the Committee that results were 'carefully checked with the Commission and adjusted in the light of their comments.'[14] The Committee noted that at the time of the audit the Commission accepted that the cleaning arrangements at the RCH were 'uneconomical'.[15]

7.76 The Committee had some difficulty with the evidence supporting the working party's conclusion. It appeared from an examination of the working party's report, that the conclusion rested not on evidence but on opinion.

7.77 Moreover, there was support in the working party's report for the Audit view that cleaning costs were excessive.

12. Allsop Report, p. 5.
13. EA Report, p. 141.
14. Evidence, p. 119.
15. EA Report, p. 141.

7.78 For example, the Committee noted that the working party's estimate of the annual cost of cleaning the hospital of $1.08m was significantly lower than the actual labour costs incurred ($1.32m for the 12 months ended September 1981).[16] This was despite the fact that the working party based its estimate on the existing cleaning standards, man-hours and wage rates at the RCH. The working party also concluded that some cleaning costs could be reduced through economies (rearrangement of weekend activity, introduction of part-time employment, reduction in standards, upgrading of equipment, improvement of cleaning techniques, and rationalisation of use of materials).

7.79 Given this background, the Committee is inclined to the view that the Audit estimate of the savings from the introduction of contract cleaning at the RCH of $0.5 million annually, is indeed indicative of the possible savings. The Committee notes that this estimated saving represented 40% of the labour costs for cleaning at the time of the audit (1981).

7.80 The Committee recognises the delicate industrial situation for the Authority (and hospital managements generally) in this area. Indeed one view put to the Committee was that 'the political/industrial consequences of taking on the unions in these areas appear to be an insurmountable barrier to efficient management'.[17]

7.81 Nevertheless, the Committee considers that the Authority should be able to achieve savings in cleaning costs at the RCH.

7.82 The Committee recommends that:

25. **The Authority set annual targets for reducing the costs incurred in the cleaning of Royal Canberra Hospital (RCH) by the identification and introduction of economies. Although the Committee is aware that cost should not be a primary constraint in the cleaning of hospitals, the scope for using contract labour at the RCH should be reviewed.**

Hospital Properties and Services

7.83 Audit Findings

- The present range of accommodation was established on the expectation of faster population growth and a higher rate of provision of Commission hospital services than has eventuated. In some areas accommodation was clearly under-utilised. In other areas accommodation had been put to alternative use but in such a way that long term planning problems could arise.

16. This figure includes penalty, overtime, leave and superannuation payments but excludes compensation payments. The breakdown of the working party's figure was not available to the Committee.
17. Evidence, p. 166.

7.84 Audit Recommendations

R48. Excess staff and student residential accommodation should be made available to the general public on a licence to occupy basis with charges to be applied.

R49. Conversion of excess space to other use, e.g. specialty clinics, should not preclude later reconversions; it should be undertaken within a long-term strategy for accommodation use.

R50. The Commission should develop a long term strategy for the purchase, storage and control of the various classes of hospital supplies.

R51. The Commission should assess the practicability and cost-effectiveness of greater use of the central storage facility.

R52. The continuing need for extensive pathology accommodation at Royal Canberra Hospital should be assessed with a view to releasing space for alternative uses.

Commission/Authority Action (R 48-52)[18]

7.85 The Commission supported Audit recommendations 48-49, with the proviso that excess *accommodation should only be used* for activities compatible with hospital activities. A Property Officer had been appointed, part of whose function was to develop policies and long-term strategies for accommodation use. Since his appointment, the officer had been working primarily on developing policy, and standardising contractual arrangements, for the lease of Commission premises for commercial and community use.

7.86 Two areas of under-use identified by the audit had been addressed:

- Bennett House, a 152 single nurses residential block, was partially used as office space; and
- a large warehouse facility (capacity 16300 cubic metres) at the Commission's Health Services Supply Centre in Mitchell, was used as office space.

7.87 Residential blocks at the WVH had been converted for alternative uses.

18. Sources for text relating to Audit recommendations 48-52 are:
- Evidence, pp. 50-53, 102-105, 119, 166,
- Commission letter to Committee of 27 September 1984,
- Authority letter to Committee of 18 July 1985.

7.88 An internal working party had been examining common procurement and storage procedures (R's 50-51) since (at least) 1982. On 10 June 1982 the Commission decided not to centralise storage arrangements at the Health Services Supply Centre in Mitchell.

7.89 The Commission advised that an officer had been appointed (Director, Services) to advise on procurement policies and procedures generally throughout the Commission. The Commission stated in September 1984 that it was considering introducing a decentralised procurement system using microcomputers. It expected to finalise the development of a common procurement system in 1985. Savings from such a system were expected to be only marginal (e.g. improved co-ordination of ordering could result in better prices). The Authority advised in July 1985 that the common procurement system was dependent on the development of the full potential of the Health Authority's computer network. This was not planned to occur before 1986/87.

7.90 The Commission stated that in its response of October 1982 to the draft EA Report (R52) it had advised the Auditor-General that:

> space available following transfer of the major part of the *pathology services from RCH to the Central* Laboratory adjoining WVH has been made available for other uses including maintenance of a laboratory for the Tuberculosis Division.[19]

7.91 The Auditor-General reported this advice, commenting:

> Audit has not examined this re-allocation but notes again the under-utilisation of the Central (Pathology) Laboratory.[20]

7.92 The Commission advised the Committee that it agreed that there was some under-use of the Central laboratory (designed to accommodate 250 staff, as at September 1984 staffing approximately 190). The laboratory was, however, designed to provide pathology and public health services for the ACT until approximately the year 2000. The Commission believed it was not practical to convert purpose built health laboratory facilities for alternative use.

Committee Conclusions and Recommendation (R 48-52)

7.93 The Committee was not able to undertake the on-site inspections necessary to conclude as to whether the Commission's actions in respect of the under-use of accommodation and facilities had been satisfactory (R 48-49).

19. Evidence, p. 53.
20. Evidence, p. 143.

7.94 The Committee did, however, accept that it appeared from the Commission's advice that there was less unused space in the Royal Canberra and Woden Valley hospitals than there had been at the time of the audit.

7.95 The Committee notes the difficult management task for the Authority in this area given the over-supply of properties and facilities[21] and the many factors inhibiting other use:

- unsuitability of purpose-built facilities for alternative use without modification;
- need to maintain option of later re-conversion for hospital use; and
- need to ensure compatibility of use with hospital requirements.

7.96 The Committee is concerned at the lengthy delays in the operation of the working party examining common procurement and storage procedures (R 50-51). For example, although the Commission advised Audit in October 1982 that a common procurement system was being developed, there was little evidence of any significant progress three years later. The Commission submitted in September 1984 that progress had been slow because of limited resources.

7.97 The Committee recommends that:

26. The Authority disband the working party examining common procurement and storage procedures.

7.98 The Committee made no assessment of the results of Audit recommendation 52.

Patient Accounts and Debt Recovery

7.99 Audit Finding

- Audit identified significant increases in the level of outstanding patient debts in the two Commission hospitals in the six months to 31 December 1981. The Commission advised Audit in November 1982 that outstanding patient debt in the two hospitals totalled $6,675,061 at 31 October 1982, an increase of 75.7% on the amount outstanding at 30 June 1981.

21. See EA Report, p. 141.

7.100 Audit Recommendation

R53. The Commission's Central Office has taken steps to improve the quality of revenue raising and debt collection activity. Audit endorses the steps taken by the Commission to this stage, but recommends that the adequacy of current initiatives be reviewed in the light of changes in the aggregate level of patient debt outstanding occurring in coming months.

Commission Action (R 53)[22]

7.101 The Commission advised that control measures taken had reduced the rate of increase in the value of patient debts outstanding to the Commission.

7.102 In the eight months following 31 October 1982, the value of outstanding patient debts in Commission hospitals rose by only 8% (compared with 76% in the 16 preceding months).

7.103 The Commission stated that under Medicare there was likely to be a much reduced requirement for debt recovery. As at September 1984, there was a trend towards a reduction in outstanding debts although it was still too early to make an accurate assessment.

7.104 The Authority advised in July 1985 that there had been reductions in private patients in both hospitals. Before the introduction of Medicare, on average 62% of patients at the RCH and 54% at the WVH were private patients. As at March 1985 these percentages had fallen to 51% and 41% respectively. The impact of this reduction on private patient debt recovery had, however, been checked by the following factors:

- the raising of private patient accounts had not diminished to the extent expected;
- some difficulties had arisen in the recovery of debts from uninsured patients who had elected to be private patients; and
- under Medicare patients had the option of having their 'compensable' account written off should their claim for compensation fail. The arrangements pre-Medicare meant that a proportion of unsuccessful compensable claims would have been paid by the health fund and a number of these claims were still outstanding.

22. Sources for text relating to Audit recommendation 53 are:
- Evidence, pp. 54, 105-106, 127, 166, 286-288,
- Commission letter to Committee of 27 September 1984,
- Authority letters to Committee of 18 July and 16 August 1985,
- C. Times, 23.9.84, p 2 'Who owes all that money to ACT public hospitals?',
- C. Times, 26.9.84, p 3 'Major debts not seen by insurance firms'.

7.105 The Authority stated that to the extent that the revisions to Medicare arrested the drift away from private patient status, a slight swing back to such status for insured patients might be expected with consequent effects on debt recovery.

Committee Conclusions and Recommendation (R53)

7.106 Outstanding patient debts for the two hospitals at 30 June 1984 and 1985 were $6.26 and $5.96 million respectively, representing 29% and 44% respectively of the annual receipts for patient fees in the two hospitals. In respect of the amounts outstanding at 30 June 1985, $3.70 million (62%) was for accounts which were eventual third party accident or accident at work claims settlements ($2.73 million (46%) for third party and $0.97 million (16%) for accident at work). Debts amounting to $4.05 million (68%) had been outstanding for more than 90 days. Details are provided in Tables F and G at pp. 89, 90.

7.107 The Committee sought a detailed explanation from the Authority of the reasons for the significant delays in payments.

7.108 The Authority advised in respect of third party accident and accident at work debts, referred to collectively as compensable debts, that while patients were nominally responsible for the payments, the Authority's hospitals did not pursue debtors until their right to recover from another person (third party claim) had been clearly established. A recent sample of accounts at the RCH showed that only 5% of such cases were handled by the patients and 51% were handled either by a solicitor or insurance company outside the ACT. Compensable debts involving litigation took prolonged periods to collect, commonly extending up to two years. Cases involving the stabilisation of the patient's condition took longer.

7.109 In respect of 'other' debts, the Authority stated that changes to the health care system on 1 September 1981 had had a significant impact on hospital debts. The changes introduced a category of patients who were able to carry the risk personally for hospital accommodation charges. These were patients without health insurance cover who were previously accommodated free of charge but who then became fully liable for hospital charges unless they were eligible for a health care card. Debts relating to this category of patient had proved very difficult to collect and had increased substantially the total amount outstanding. An increased debt recovery effort during 1984/85 resulted in the identification of a substantial number of uncollectable debts relating to this group. Many accounts had been written off.

7.110 Although the introduction of Medicare in February 1984 brought the arrangement to an end, the process of identifying the debts and decisions on debts to be written off continued.

TABLE F: PATIENT DEBTS OUTSTANDING AT ROYAL CANBERRA AND WODEN VALLEY HOSPITALS AT 30 JUNE 1984

Debts - 30 June 1984

	3rd Party and W/Compensation $'000	Other $'000	Total $'000	%
RCH				
Current/ 30 days	287.1	525.8	812.9	13
60/90 days	145.2	122.7	267.9	4
120 + days	2232.2	975.4	3207.6	51
Total (RCH)	2664.4	1623.9	4288.3	69
WVH				
Current/ 30 days	43.6	283.0	326.6	5
60/90 days	74.7	83.5	158.2	3
120 + days	899.1	584.4	1483.5	24
Total (WVH)	1017.4	951.0	1968.3	31
Total (both hospitals)	3681.8	2574.9	6256.7	100

Source: ACTHA

TABLE G: PATIENT DEBTS OUTSTANDING AT ROYAL CANBERRA AND WODEN VALLEY HOSPITALS AT 30 JUNE 1985

Debts - 30 June 1985

	3rd Party and W/Compensation $'000	Other $'000	Total $'000	%
RCH				
Current/ 30 days	406.7	601.7	1008.4	17
60/days	169.2	72.1	241.2	4
90 + days	2235.0	728.3	2963.2	50
Total (RCH)	2810.9	1402.0	4212.9	71
WVH				
Current/ 30 days	73.8	445.9	519.7	9
60 days	26.3	119.3	145.6	2
90 + days	793.0	290.3	1083.3	18
Total (WVH)	893.1	855.5	1748.6	29
Total (both hospitals)	3704.0	2257.6	5961.5	100

Source: ACTHA

7.111 The Committee is not satisfied by the Authority's response. Not only was insufficient information provided to assure the Committee that the substantial and long-standing overdue amounts could not be reduced, but also tardy and ineffective performance was implied. For example, it was not clear to the Committee why the process of identifying debts resulting from an arrangement that ended in February 1984, continued.

7.112 The Committee recommends that:

27. The Authority conduct a detailed review of the scope for reducing outstanding patient debts.

APPENDIX A

CONDUCT OF INQUIRY, WITNESSES, OBSERVERS AND SUBMISSIONS

The Inquiry

In accordance with standard arrangements for examining efficiency audit reports,[1] on 19 May 1983 the Chairman of the Joint Committee of Public Accounts and of the House of Representatives Standing Committee on Expenditure proposed to the Minister Assisting the Prime Minister for Public Service Matters that the efficiency audit report on Administration of Public Hospitals by the Capital Territory Health Commission (CTHC) be examined by the Public Accounts Committee and the report on Management of the Main Battle Tank be examined by the Expenditure Committee.

The Auditor-General's Report was examined by the Joint Committee of Public Accounts in full Committee.

A submission was sought on 7 March 1984 from the CTHC detailing the Commission's response to the main Audit findings and recommendations, and additional information was requested on 23 July 1984 and June 1985. Submissions were also sought from the Australian Audit Office and two expert witnesses, Dr R B Holland, Director, Department of Anaesthetics and Resuscitation, Westmead Hospital and formerly Chairman, Australian Council on Hospital Standards, and Dr A W Ireland, formerly consultant on clinical review to the Auditor-General and to the Jamison Inquiry.

Evidence was taken in public hearings on 12 and 13 September 1984. The transcripts of evidence and other evidence authorised for publication have been published separately. References to evidence in this Report relate to that document.

Witnesses

Capital Territory Health Commission, Canberra, ACT:

Mr Owen Fenwick, Acting Chairman

Mr Reginald Alan Foskett, Secretary

Dr David E Taylor, Acting General Superintendent, Royal Canberra Hospital

Dr Paul E J McCann, Acting General Superintendent, Royal Canberra Hospital

Dr Robert Wentworth Mitchell, Chairman, Quality Assurance Committee

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1. Australia, Parliament, Review of the Auditor-General's Efficiency Audit Report; Department of Administrative Services - Australian Property Function; Report from the House of Representatives Standing Committee on Expenditure, Parl. Paper No. 110/1981, Canberra 1981. p.31.

Expert Witnesses

Dr Ross Beresford Holland
21 Marguerite Crescent
Pennant Hills. NSW

Dr Anthony William Ireland
9A Bushlands Avenue
Gordon. NSW

Adviser

Ms Robyn Jessie McClelland

Observers

Australian Audit Office:	Mr B T Kimball Mr K E Gallasch
Department of Finance:	Mr C J Louttit Mr M J Kennedy
Public Service Board:	Ms A M Kendall

Formal Submissions

Capital Territory Health Commission, 3 April, 11 August, 17 and 27 September 1984

Australian Capital Territory Health Authority, 18 July and 16 August 1985

Dr R B Holland, expert witness, 4 September 1984

Dr A W Ireland, expert witness, 6 September 1984

A copy of these submissions may be found on Joint Committee of Public Accounts File 1982/7, Part B.

Other Submissions

Australian Audit Office, 14 August 1984