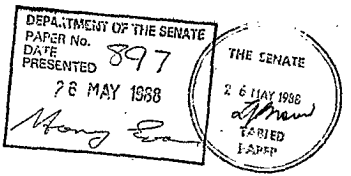

JOINT COMMITTEE OF PUBLIC ACCOUNTS

REPORT 290

A BETTER DEAL FOR OUR VETERANS

The Management of Repatriation General Hospitals
by the Department of Veterans' Affairs

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA 1988

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DUTIES OF THE COMMITTEE

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 inter-governmental 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;
>
> (c) to report to both Houses of the Parliament any alteration which the Committee thinks desirable in the form of the public accounts or in the method of keeping them, or in the mode of receipt, control, issue or payment of public moneys; and
>
> (d) to inquire into any question in connexion with the public accounts which is referred to it by either House of the Parliament, and to report to that House upon that question,
>
> and include such other duties as are assigned to the Committee by Joint Standing Orders approved by both Houses of the Parliament.

PREFACE

This Report presents the findings of the Committee's inquiry into the management of Repatriation General Hospitals by the Department of Veterans' Affairs.

The inquiry was begun in November 1987 as part of a general review of the Auditor-General's reports on audits undertaken between 1985 and 1987. The Committee found that the Auditor-General had reported adversely on aspects of the Department of Veterans' Affairs management of its Repatriation Hospitals on a number of occasions. The Committee subsequently sought three submissions from the Department and held two public hearings, in November 1987 and March 1988, into the management of the Repatriation Hospitals.

The Committee was concerned to find fundamental deficiencies in the management information systems maintained by the Department to monitor and assess the performance of the various Repatriation Hospitals. In particular, the Department lacked measures capable of comparing the performance of the Repatriation Hospitals and State public hospitals and of monitoring the performance of Visiting Medical Officers engaged by the Department.

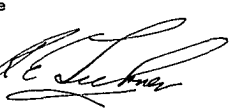
The Committee was also concerned by the lack of an effective management structure within the Department and by its apparently cavalier approach to responding to the findings of the Auditor-General. In the three year period reviewed by the Committee the Department of Veterans' Affairs either failed or lacked the capacity to ensure that deficiencies in the management of Repatriation Hospitals reported by the Auditor-General were systematically rectified at a national level.

The Committee experienced a number of delays in obtaining information from the Department and admonished the Department for failing to approach the Committee's initial investigations with a degree of seriousness appropriate to a Commonwealth Parliamentary inquiry.

The Committee confirmed the Commonwealth Government's responsibility to provide comprehensive health care services for Australian veterans. Throughout the inquiry the Committee emphasised that it was incumbent on the Department of Veterans' Affairs to maintain information systems and management structures capable of ensuring that the Commonwealth's responsibility to care for the health of veterans and their dependents is administered as efficiently as possible. The Committee did not believe that the Department had achieved this objective or that it had the capacity to provide objective information on the relative efficiency of the Repatriation Hospital system even if it were being managed efficiently.

The Committee's recommendations are aimed at promoting the development of an improved management structure in the Department and at establishing more comprehensive management information systems in the Repatriation Hospitals. It is the Committee's belief that the implementation of the recommendations of this report will not only lead to improved administrative efficiency in the Repatriation Hospital system but will also promote the development of a health care system which is more responsive to the health care needs of veterans. The Committee will monitor the Department's implementation of its recommendations with considerable interest.

For and on behalf of the Committee



R E Tickner, MP
Chairman

Karin Malmberg
Acting Secretary
Joint Parliamentary Committee of Public Accounts
Parliament House
CANBERRA
25 May 1988

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List of Recommendations

The Committee has made a number of recommendations which are listed below, cross referenced to their locations in the text. The Committee's analysis in the text should be referred to when considering these recommendations.

The Committee recommends that:

1. The Department negotiate the inclusion of provisions for monitoring and assessing services provided in all future contracts for Visiting Medical Officers and other health professionals contracted to provide regular services for the Department, including domiciliary nurses. (p.3)

2. In order to achieve cost-effective management the Department should develop and institute information systems which provide qualitative and quantitative comparisons of performance on key indicators between the different Repatriation General Hospitals (RGHs). Where possible, the Department should also develop and institute similar qualitative and quantitative comparisons between Repatriation Hospitals and State public hospitals. (p.9)

3. i. In devolving authority and responsibility for hospital administration from Central and Branch Offices to the respective RGH managements, the RGH Chief Executive Officers (CEOs) and senior executive staff should have recognised management training and expertise commensurate with the increased responsibilities and managerial skills required; and

   ii. where administrative devolution has taken place to officers who are not suitably qualified, such officers should be required to upgrade their management qualifications. (pp 9-10)

4. i. Faults and deficiencies found by Audit in the management of one RGH should be rectified in all RGHs, where such faults and deficiencies exist; and

ii. there be a formal response in the Department of Finance Minute to this report on the Department's activities in all Repatriation Hospitals to rectify possible management deficiencies similar to those reported by the Auditor-General since 1985 as existing in the management of one or other RGH. (p.11)

5. That the Department develop and implement an effective national hospital management policy aimed at ensuring that all RGHs:

i. provide similar high standards of health care; and

ii. are operated and managed as efficiently as possible. (p.12)

6. i. The Department and the Public Service Commission review the required qualifications of RGH CEOs as a matter of priority, with a view to abolishing the present requirement that medical qualifications be a pre-requisite to appointment as a CEO; and

ii. the relevant section of the Personnel Management Manual be amended to state that persons appointed as RGH CEOs in future have relevant health or hospital administration qualifications, or a demonstrated high level of health management expertise. (pp.13-14)

7. The Department consult with the Departments of Finance and Industrial Relations in order to review the large pay differences between RGH CEOs and their counterparts working in the various state health systems. (p.14)

Introduction

1. The Department of Veterans' Affairs (DVA) operates a Repatriation General Hospital (RGH) in each State to provide acute care and diagnostic and treatment services to eligible veterans and their dependents. The Department also operates Auxiliary Hospitals in some States to provide hospital treatment and short term nursing and convalescent care for patients needing less acute treatment services.

2. In September 1985 the Auditor-General reported on aspects of the management of Repatriation Hospitals in Victoria and Tasmania.[1] Hospital management in New South Wales was discussed in the Auditor-General's Report of March 1986.[2]

3. The major problems highlighted in these two Audit reports were:

- a lack of adequate controls over the provision of treatment services by Visiting Medical Officers (VMOs);
- the reluctance or inability of the Department to determine its information needs and appropriate reporting mechanisms; and
- the failure of the Department to develop a cohesive set of standardised procedures for the delivery of hospital services.

4. The Committee sought a total of three submissions on these matters from the Department and interviewed Departmental Officers at two public hearings. However, the Committee was disturbed by delays experienced in obtaining some information from the Department and the Department's failure to approach the Committee's initial investigations with a degree of seriousness appropriate to a Commonwealth Parliamentary inquiry.[3]

Monitoring of Visiting Medical Officers

5. DVA supplements its staff medical specialists at RGHs by appointing qualified medical practitioners as Visiting Medical Officers on an agreed sessional or relieving basis. Selected specialists are offered appointment to the visiting medical panels for particular specialties at a Hospital. Terms and conditions of Visiting Medical Officers' employment are set out in a formal agreement between the Department and each specialist. The term of appointment is currently 5 years.

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1. Report of the Auditor-General upon Audits, Examinations and Inspections Under the Audit and Other Acts - September 1985, AGPS, Canberra, 1985, pp. 190-193.
2. The Auditor-General Report on Audits to March 1986, AGPS, Canberra, 1986, pp 171-2.
3. Joint Parliamentary Committee of Public Accounts, Review of Reports of the Auditor-General, 1985-87, Minutes of Evidence, AGPS, Canberra, 1988, pp. 524-5.

6. The September 1985 Report of the Auditor-General referred to an audit carried out at RGH Hobart in Tasmania to determine the cost-effectiveness of the Visiting Medical Officer scheme in that State and to ascertain whether payments made met the legislative requirements.[4]

7. The following major problems were identified in the Audit report:

- the absence of certification by a suitably qualified medical officer of time spent and services provided by visiting specialists; and
- the absence of specific procedures for monitoring the extent of services provided.

8. In March 1986 the Auditor-General reported on the controls and procedures associated with the payment of fees to Visiting Medical Officers at RGH Heidelberg in Victoria.[5] Again the certification of time spent by specialists was highlighted as a problem. By agreement Visiting Medical Officers engaged by the Department can also treat their private patients in RGH facilities. To ensure that sessional fees are paid only for the time spent in treating Repatriation patients, visiting specialists are required to record the time they spend in treating private patients on attendance records. However, none of the attendance records examined by Audit had recorded the time spent with private patients.

9. In September 1986 the Auditor-General reported on controls and procedures for the administration of services provided by Visiting Medical Officers at RGH Daw Park in South Australia.[6] The audit identified that information needed by the Hospital to assist in assessing the need for specialist services was either not being received by management or was in a form which made analysis by management difficult. For example, reports on the incidence of cancelled specialist sessions and of specialists consulting for less than the agreed minimum session hours were not being reviewed and statistics on patient attendances and waiting times were inadequate. Further, and importantly,

- performance standards for specialist services had not been determined; and
- reviews to detect possible overservicing were not carried out.

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4. Auditor-General Report - September 1985, op. cit., p. 193.
5. Auditor-General Report - March 1986, op. cit., pp. 167-8.
6. The Auditor-General Report on Audits to 30 June 1986, AGPS, Canberra, September 1986, pp. 156-7.

10. The Committee was concerned by the Auditor-General's repeated finding that services provided by Visiting Medical Officers were not being certified by suitably qualified Departmental officers. In particular, the Committee was concerned that without such certification the Department had no quantitative record of VMOs' services and no independent way of detecting possible underprovision of services to Repatriation patients. In other words, there was no evidence of proper management structure or procedures in the Department.[7]

11. The Department indicated that it had responded to the reported inadequacies in monitoring and reviewing the sessional activities of VMOs by instructing staff in the outpatients areas of RGHs to report the number of patients treated by each VMO per session to the officer in charge of the outpatients department. However, the Department also noted that obtaining adequate information on VMOs' services in part depended on the inclusion of provisions for monitoring services provided in Departmental VMO contracts.

12. The Department informed the Committee in November 1987 that the inclusion of such monitoring provisions in VMO contracts was disputed by the various State branches of the Australian Medical Association (AMA) when VMOs' five yearly contracts with the Department expired in 1987 and had to be renegotiated. The AMA's refusal to agree to such monitoring had delayed the signing of new contracts in some states and led to some VMOs withdrawing their services at RGH Hobart in Tasmania.[8]

13. The Committee acknowledged the industrial sensitivity of the Department's negotiations with the AMA on the conditions of new VMO contracts. Nevertheless, the Committee also believed that the Department should have a contractual guarantee that its VMOs will provide an agreed level and quality of service by ensuring the inclusion of explicit monitoring and review procedures in VMO contracts. The Committee was pleased to receive the Department's report in March 1988 that new VMO contracts had been successfully negotiated in all states and included the provisions that specialists, 'will enter into quality assurance activities'.[9] However, the Committee was concerned that all health professionals engaged by the Department should be subject to contractually agreed monitoring procedures.

14. The Committee recommends that:

The Department negotiate the inclusion of provisions for monitoring and assessing services provided in all future contracts for Visiting Medical Officers and other health professionals contracted to provide regular services for the Department, including domiciliary nurses.

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7. Minutes of Evidence, op cit., p. 725.
8. ibid., pp. 476-8.
9. ibid., p. 714.

Repatriation Hospital Management Information Systems

15. The Department informed the Committee that, in its opinion, the fact that VMOs at Repatriation Hospitals were engaged on a sessional rather than a fee-for-service basis meant that there was little incentive for doctors to re-book patients or engage in overservicing.[10] The Department further stated that it regarded the present system of peer reviews among VMOs and monitoring of services provided by officers in charge of RGH outpatient departments as providing adequate safeguards to detect and prevent possible abuses by VMOs.

16. However, the Committee regarded the possibility of overservicing to remain whenever reporting procedures are inadequate and was concerned by the Auditor-General's finding of deficiencies in the monitoring of services provided by VMOs in various RGHs.[11] The Department argued that the establishment of more comprehensive information systems in the present economic climate of limited resources would require the transfer of personnel and funding from patient treatment areas. In particular, the Department maintained that,

> to have an improvement in the efficiency of the (Repatriation) Hospitals must in effect result in a cutting of patient care.[12]

17. While the Committee acknowledges the financial constraints placed upon the Repatriation Hospitals, it does not believe that the Department has made the most efficient use of the resources available to it or that resources have been directed towards developing the most useful management information systems.[13] In his September 1985 Report the Auditor-General noted deficiencies in the following Repatriation Hospital management information systems:

(a) Management Accounting Reports

> One of the management reports generated to assist the Department in monitoring the performance of RGHs is the Management Accounting Report (MAR), which provides costing and statistical information for management control purposes. However, the Auditor-General noted that statistics required for preparing MARs were not received on a timely basis, resulting in considerable delays in the preparation of the Reports. As a consequence Audit questioned the importance and effectiveness of the MARs.[14]

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10. ibid., p. 709.
11. **Auditor-General Report - September 1985**, op.cit., p. 193; **Auditor-General Report - March 1986**, op.cit., pp. 167-8; **Auditor-General Report - September 1986**, op.cit., pp. 156-7.
12. **Minutes of Evidence**, op.cit., p. 563.
13. ibid., p. 745.
14. **Auditor-General Report - September 1985**, op.cit., p. 191.

(b) Nursing Dependency Rate

The Nursing Dependency Rate (NDR) is one of the performance standards used to determine nursing resources. Audit found that the NDR at RGH Hobart had not been reviewed since 1974.[15] Audit argued that because of the dynamic nature of patient care associated with changes in treatment and technological advances, the NDR might not now be appropriate. In Audit's opinion this could possibly give rise to either an under or over utilisation of resources with implications for financing and patient care.

(c) Domiciliary Nursing

Domiciliary nursing of veterans at home is carried out by State registered nurses co-ordinated by the local RGH Medical Social Worker. Audit noted that there was little, if any, control exercised by the Department over the quality of domiciliary nursing provided.[16] Furthermore, there was no evidence tha the Department had taken steps to:

- ensure the adequacy of treatment;
- control the frequency of visits by domiciliary nurses, or
- determine whether the treatment provided was the most beneficial and/or cost effective.

18. In addition to the reports of the Auditor-General, the inadequacies in the information systems of Repatriation Hospitals were revealed by such comments as the following from the 1987 consultancy report by Wright, Adam and Hohnke on inpatient scheduling in RGHs,

> We have tried to obtain information from the RGH system as to the extent and incidence of hospital re-admission rates... Unfortunately this information, which would provide useful evidence as to whether a hospital was discharging its patients too quickly (or, conversely, not quickly enough) is not available. In our view this information is an essential ingredient of any inter-hospital length of stay comparisons.[17]

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15. Ibid.
16. ibid, p. 192.
17. Graham Wright, Bill Adam, Narelle Hohnke, **Report of Consultancy on Inpatient Scheduling in Repatriation General Hospitals**, September 1987, Exhibit No. 2, p. 13.

19. Furthermore, in a supplementary submission which the Committee required to be furnished the Department stated that,

> Statistics on the number of people treated by visiting medical specialists are not routinely collected at the RGHs. The unit of measurement for out-patient services is occasions of service and for in-patients the measurement is admissions or separations.[18]

20. The Committee regarded these comments by the Department as indicative of inadequate reporting information systems, as statistics on the services provided to individual patients by different medical practitioners were not routinely available to management.

21. In response the Department stated that it regarded the systems of peer review and monitoring by persons in charge of outpatients departments to provide adequate checks of services provided by VMOs.[19] However, the Committee questioned the value o adequacy of such systems given the number of deficiencies found and maintained that without a clear statistical basis the Department's claims about the effectiveness of its procedures could not be objectively determined.[20]

Wright Report on Inpatient Scheduling

22. In 1985 a group of medical researchers, C. W. Aisbett, G.R. Palmer and B. Reid, approached and received approval from the Department to undertake an academic study at the various Repatriation General Hospitals. The study, commonly referred to as the Aisbett Report,[21] sought to,

> examine the feasibility of using Diagnosis Related Groups (DRGs) to form the basis of a system of case-mix based cost management and utilisation review for Repatriation General Hospitals (RGHs).[22]

23. While the primary intention of the study was to examine the value of the diagnostic tool of DRGs to hospital management, the findings of the final report also reflected upon the general management of the RGHs and the inadequacy of management information systems. The most significant finding of the Aisbett Report was that,

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18. Correspondence, 28 April 1988.
19. **Minutes of Evidence**, op. cit., p. 715.
20. ibid., pp. 725, 757.
21. C W Aisbett, B Reid, G R Palmer, **The Analysis of the Case Mix of Repatriation General Hospitals, Using Diagnosis Related Groups**, G R Palmer, November 1986, Exhibit No. 1.
22. ibid, p.v.

> Although length of stay performance varies somewhat between RGHs, their clients tend to stay in hospital about thirty percent longer than similar clients in comparable Victorian Hospitals...[23]

24. Despite the significance of Aisbett's finding and the relevance of his report to the Inquiry, the Committee was disturbed that the Department of Veterans' Affairs did not voluntarily bring the Report to its attention and that the existence of the Aisbett Report was only discovered because of the Committee's persistent questioning of Department officers during the proceedings of the public inquiry.

25. Upon receiving the Aisbett Report, the Department engaged a consultancy led by Mr Graham Wright to investigate the adequacy of the RGHs' inpatient scheduling procedures in the light of Aisbett's adverse findings. The significant impact of Aisbett's findings upon the Department and RGH management can be gauged from the following preliminary comment in the Wright Report that the consultancy had found, 'widespread incredulity and deep disappointment with the principle finding of the Aisbett Report'.[24] Wright concluded that,

> The Aisbett DRG Report was inappropriately conceived and executed, with the clear potential to be misleading.[25]

26. Wright maintained that the data on which Aisbett et al. had based their conclusions was suspect because shortages of trained medical records administrators in preceding years had meant that the coding of morbidity or disease groups, the basis of the Aisbett analysis, had been given a low priority and was frequently rushed.[26]

27. However, the Committee was not convinced of the objectivity of the Wright Report given the condemnatory nature of the language used in the Report. For example, recommendation No 8 of the Wright Report suggested that,

> The authors of the Aisbett Report be formally requested to repudiate the unfair and damaging conclusion reached in the Report.[27]

28. Furthermore, the Wright Report stated,

> The conclusion of the Aisbett Report (based on what appears to be an inadequate understanding of the unreliability of data supplied by the Department and the non-comparability of the

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23. ibid., p. 13.,
24. Wright, op. cit., p.3.
25. ibid., p.4.
26. ibid., p. 14.
27. ibid., p. 18.

RGH system with other public hospital systems) has been so unfairly damaging to morale within the RGH system, and to external perceptions of the system, that Aisbett should be formally requested to repudiate the conclusion that was reached.[28]

29. The Committee gained the strong impression that, whether implicitly or explicitly, the Wright Report was not directed at resolving substantive issues raised by Aisbett but at discrediting the initial study and its findings.

30. The value of the Wright Report as a morale boosting exercise for the Department was indicated by the Department's apparent relief with the Report's findings, which indicated that the Repatriation Hospitals were, 'not too bad at all.'[29] The Committee also noted C W Aisbett's criticisms of the Wright Report as lacking 'quantitative ability' and misrepresenting his own research, and as appearing to provide, 'a platform for organisation politics'.[30]

31. Nevertheless, under questioning from the Committee, the Department stated that, despite misgivings about the methodological accuracy of the Aisbett Report, it did regard the findings of the Report as significant and relevant to the efficient management of the Repatriation Hospital system.[31] The Committee concluded that, methodological arguments and Departmental politics aside, both the Aisbett and Wright reports reached similar conclusions, namely, the need for a common measurement unit to gauge and compare the performance of the various Repatriation Hospitals and the need for a centrally determined management structure to ensure the efficient management of all RGHs.[32]

32. The Committee was particularly concerned that the significant disparity in average length of patient stay between Repatriation Hospitals and a sample of Victorian public hospitals had only been brought to the Department's attention as an incidental finding of the independently sponsored Aisbett Report. Furthermore, the Committee questioned the extent of actual differences between Repatriation Hospitals and community hospitals and thus the validity of the Department's argument that statistical comparisons between RGHs and community hospitals are invalid.[33]

33. The Committee was concerned that the Department had not sought to establish quantifiable performance standards for RGHs based on statistical comparisons with other hospital systems. The

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28. ibid., p. 16.
29. Minutes of Evidence, op. cit., p. 721.
30. Correspondence, 28 April 1988.
31. ibid., p. 729.
32. ibid., p. 752.
33. ibid., p. 786.

Committee recognised the limitations of such comparisons due to such factors as the varying age and health profiles of patients attending different hospitals and the disparate treatment emphases and specialisations of different hospitals. Nevertheless, the Committee rejected the Department's contention that such comparisons were of no value and believed that comparative data, even if highly qualified, are essential for the objective assessment of the performance and efficiency of the management of the Repatriation Hospital system.

34. The Committee therefore recommends that:

In order to achieve cost-effective management the Department should develop and institute information systems which provide qualitative and quantitative comparisons of performance on key indicators between the different Repatriation General Hospitals. Where possible, the Department should also develop and institute similar qualitative and quantitative comparisons between Repatriation Hospitals and State public hospitals.

Departmental Management Structure

35. On the issue of Departmental management the Department claimed that, while its Central Office Health Services Planning Division sets policy parameters and monitors Repatriation Hospitals' performance, responsibility for the financial management and routine operations of the RGHs is being devolved to the Chief Executive Officers or Medical Superintendents of the various Hospitals.[34] This policy of administrative devolution wa recommended by the Efficiency Scrutiny Review of the Repatriation Hospital System.[35]

36. While the Committee approved of the Department's policy of devolving responsibility for RGH administration from Central and Branch Offices to the respective Hospitals, the Committee was concerned that this devolution should not take place unless and until RGH Medical Superintendents had professional health management training or proven managerial expertise. The Committee was concerned that administrative devolution was taking place when some the RGH Superintendents lacked formal management qualifications and regarded it as inappropriate to devolve hospital administration to persons lacking the necessary skills.[36]

37. The Committee recommends that:

i. In devolving authority and responsibility for hospital administration from Central and Branch

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34. ibid., p. 496.
35. ibid., p. 498.
36. ibid., pp. 630-1.

Offices to the respective RGH managements, the RGH Chief Executive Officers and senior executive staff should have recognised management training and expertise commensurate with the increased responsibilities and managerial skills required; and

ii. where administrative devolution has taken place to officers who are not suitably qualified, such officers should be required to upgrade their management qualifications.

38. The Committee was also concerned that the Department lacked adequate management structures and procedures to ensure that individual Hospitals were being managed as efficiently as possible. In particular, the Committee was concerned by the Department's apparently cavalier approach to responding to the Auditor-General's findings about inadequacies in the management of its RGHs and the absence of a systematic approach to improving management practices in all the Hospitals for which the Department is responsible.

39. The Committee found that the lack of adequate national review and management control procedures meant that the Department often failed to ensure that deficiencies isolated at one RGH were also remedied in all other Hospitals. This general deficiency in the management of the Department was demonstrated by the fact that Audit had reported similar inadequacies in monitoring and information systems at different RGHs over a number of years.

40. The Committee believes that the Department should place a much greater emphasis on remedying the administrative problems noted in the reports of the Auditor-General. The Committee regards the failure to rectify similar deficiencies in different RGHs over the three year period 1985 to 1987 reviewed by its inquiry to represent an unacceptable level of managerial neglect.

41. The Committee also found that the Department lacks national co-ordination mechanisms to ensure that efficiency gains made or innovations introduced into one RGH can be promptly and effectively communicated and applied in other Departmental hospitals. From the evidence presented to the Committee, it was apparent that various State administrations of the Department had unnecessarily duplicated management review activities and continued with apparently inefficient procedures after other states had introduced innovations. This was exemplified by the lack of national co-ordination of a long series of state and national reviews of the provision of patient transport conducted by the Department in the 1980s.[37]

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37. Exhibit No. 6.

42. The historical management structure of individual RGHs reporting to a State Branch Office and then to the Department's Central Office meant that the RGHs were administratively isolated from each other. It is clear that this traditional structure, while maintaining a basic level of uniform quality between RGHs, has not encouraged the systematic improvement of the Repatriation Hospital system at a national level and has not effectively used the talents and skills of its health administrators.

43. The Committee recommends that:

i. **Faults and deficiencies found by Audit in the management of one RGH should be rectified in all RGHs, where such faults and deficiencies exist; and**

ii. **there be a formal response in the Department of Finance Minute to this report on the Department's activities in all Repatriation Hospitals to rectify possible management deficiencies similar to those reported by the Auditor-General since 1985 as existing in the management of one or other RGH.**

44. The Committee acknowledges that the different administrative operating environment in each State makes complete national standardisation of practices between RGHs difficult to obtain. Nevertheless, the Committee believed that a national management strategy for RGHs was urgently needed to ensure a uniformly high standard of health care provision and efficiency in hospital management.

45. The Committee questioned the role of the Department of Veterans' Affairs in oversighting the administration of Repatriation Hospitals if the Department does not exercise effective central management and maintain indicators and information systems which can be used to assess the administrative efficiency of the RGHs relative to each other and when compared with the State public hospital systems.

46. The Department argued that it did not wish to impose new across-the-board management structures or management information systems on its RGHs because this may lead to conflicts with the procedures of the different State health systems, with which the Repatriation Hospitals will eventually be integrated.[38] However, the Committee was concerned that the Department's policy of not seeking to actively develop and implement nation-wide standards indicated that the Department does not have measures in place to ensure that veterans in all states receive a uniformly high standard of health care treatment and that Commonwealth funds for veterans' health care are expended efficiently in all states.

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38. Minutes of Evidence, op.cit., p. 511.

47. The Committee was concerned that national management information systems and monitoring systems should be developed now so that systems will be in place to ensure that the Commonwealth will be able to continue fulfilling its responsibility to provide efficient high quality health care to veterans after the integration of the RGHs with the various State health systems. The Committee was particularly concerned that, in the lead up to integration and the eventual alignment of RGHs with the State health systems, the existence of different standards or customary practices between the various State health systems does not result in significant variations in the quality and efficiency of health care provided to veterans in the different States. As veterans' health care will remain a Commonwealth responsibility after integration, the Committee was concerned to see effective monitoring systems developed now.

48. The Committee regarded it as vital that the Department of Veterans' Affairs should put in place adequate monitoring systems which permit Parliament to assess the efficiency of its operations and which ensure that the Department operates with the maximum level of administrative effectiveness.

49. The Committee recommends that:

The Department develop and implement an effective national hospital management policy aimed at ensuring that all RGHs:

i provide similar high standards of health care; and

ii are operated and managed as efficiently as possible.

Asset Registers and Provision of Pharmaceutical Supplies

50. In his Report of September 1987 the Auditor-General deemed pharmacy inventory records at RGH Hollywood in Perth and RGH Greenslopes in Brisbane to be inadequate.[39] Drugs held been recorded on stock records and consequently it was not possible to trace the movement of drugs once they had left the pharmacy. Audit also found that the hospital pharmacy did not keep a complete record of sample signatures of all medical staff authorised to prescribe drugs. Furthermore, Audit reported that controls over ward imprest sheets were deficient, receiving staff were not signing for receipt of drugs and imprest sheets were not retained as part of pharmacy records.

51. The Committee reviewed the Department's Repatriation Hospital asset registers system and stock control procedures for

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39. **The Auditor-General Report on Audits to 30 June 1987**, AGPS, Canberra, September 1987, pp. 186-9.

monitoring the loss of equipment and materials from Repatriation Hospitals. The Department reported that, while there was no central control or monitoring of RGH assets registers, it was nevertheless complying fully with Department of Finance guidelines in these matters.[40]

52. However, officers of the Department's Central Office were unable to provide the Committee with concrete and precise answers on what action had been taken to remedy the deficiencies in asset registers control noted by the Auditor-General in his 1987 Report.[41] While the Committee believed that the hospital in question had probably implemented satisfactory monitoring procedures for the ordering and issuing of hospital equipment, the Committee also regarded the inability of the Department's officers to provide precise information as indicating that the Department lacked adequate management controls at the Central Office level to ensure that the Auditor-General's findings were acted on promptly and adequately.[42]

Medical Bar for Chief Executive Officers of Repatriation General Hospitals

53. The Department reported that the present Personnel Management Manual (PMM) issued by the former Public Service Board specifies that persons occupying positions designated as Departmental Medical Officers should:

> Possess qualifications which confer eligibility for registration as a medical practitioner under one of the States or Territories of Australia[43]

54. This condition places the Repatriation Hospitals out of line with State public hospitals, which now emphasise professional health management qualifications for their Chief Executive Officers (CEOs) more than formal medical qualifications. The Committee regarded the PMM requirement that all CEOs be qualified doctors as antiquated and as not reflecting the need for Departmental CEOs to exercise a high level of management skills. The Committee was pleased to note that the Department was investigating abolishing the requirement that RGH CEOs have a medical degree, as recommended by the Efficiency Scrutiny Review of the Department,

55. The Committee recommends that:

i. **The Department and the Public Service Commission review the required qualifications of RGH CEOs as a matter of priority, with a view to abolishing**

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40. Minutes of Evidence, op. cit., p.542.
41. ibid pp. 545-6.
42. ibid., p. 549.
43. ibid., p. 632, (Personnel Management Manual, Vol. 6, Section 37, Opinion/53, Determination of 12 December 1974.)

the present requirement that medical qualifications be a prerequisite to appointment as a CEO; and

ii. the relevant section of the Personnel Management Manual be amended to state that persons appointed as RGH CEOs in future have relevant health or hospital administration qualifications, or a demonstrated high level of health management expertise.

Chief Executive Officer Pay Scales

56. The Committee was concerned that the Department was hindered in recruiting suitably qualified CEOs to its RGHs because of the disparity in pay scales between CEOs employed in Federal and State health systems. For example, the Department noted that the Medical Superintendent of Fremantle Hospital received approximately $15,000 per annum more than the CEO of RGH Hollywood in Perth, and that the difference in the annual salaries of the CEOs of Royal North Shore and RGH Concord Hospitals in Sydney was of the order of $25 000.[44] The Committee observed that such pay differentials placed the Commonwealth health system at a disadvantage in providing high quality health care to veterans and the most efficient level of hospital administration.

57. The Committee recommends that:

The Department consult with the Departments of Finance and Industrial Relations in order to review the large pay differences between RGH CEOs and their counterparts working in the various state health systems.

58. The Committee believes that the principle of parity in wage levels between Commonwealth and State health employees should be implemented for senior managerial staff in the same way that it has already been applied for nursing staff and VMOs at Repatriation Hospitals. Such parity in CEOs' salaries will have to be considered before any proposed integration of the RGHs with the various State hospital systems. Therefore, the Committee recommends that this issue be investigated as a matter of priority.

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44. ibid., p. 480.