1930.

QUEENSLAND.

ROYAL COMMISSION ON PUBLIC HOSPITALS.

REPORT AND APPENDICES

OF

THE ROYAL COMMISSION

APPOINTED TO

INQUIRE INTO AND REPORT UPON CERTAIN MATTERS RELATING TO

PUBLIC HOSPITALS.

COMMISSIONERS:

W. HARRIS, P.M., CHAIRMAN; E. SANDFORD JACKSON, M.B., CH.B.;
S. A. GLASSEY, F.F.I.A., DEPUTY AUDITOR-GENERAL.

SECRETARY: W. MORTON, F.I.C.A.

PRESENTED TO PARLIAMENT BY COMMAND.

BRISBANE:
JOSEPH HEENEY STANLEY, ACTING GOVERNMENT PRINTER.

A. 51—1930.

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COMMISSION.

GEORGE THE FIFTH, by the Grace of God, of Great Britain, Ireland, and the British Dominions beyond the Seas, King, Defender of the Faith, Emperor of India :—

To WILLIAM HARRIS, Esquire, Police Magistrate for the State of Queensland, and Chairman of the Railway Appeal Board, ERNEST SANDFORD JACKSON, Esquire, M.B., Bac. Surg. Univ. Melbourne, and SAMUEL ALEXANDER GLASSEY, Esquire, F.F.I.A., Deputy Auditor-General and Chief Inspector, Audit Office.

Greeting :

WHEREAS it is expedient in the public interest that full and careful inquiry should be made into :—

(1) The best and most equitable method of providing for the financing of public hospitals with particular reference to that portion of the cost at present found by the component Local Authorities in the case of hospitals to which "*The Hospitals Acts*, 1923 *to* 1929" apply.

(2) The general administration and control of public hospitals.

(3) The advisability of framing a common set of rules for all hospitals in receipt of Government subsidy.

(4) The admission of patients to public hospitals ; the payment of fees (if any) and the possibility of arranging for intermediate wards.

(5) Whether group subscriptions entitling members thereof to free treatment in a public hospital should be permitted, and, if so, what income or other limitations or restrictions (if any) should be imposed in respect of membership of such groups.

(6) The method of appointment of the honorary medical staff of public hospitals ; the advisability or otherwise of the honorary medical staff being represented upon the governing body of the hospital ; and whether doctors other than members of the honorary medical staff should be permitted to attend patients in the hospital or intermediate wards.

(7) Whether under present conditions the facilities for the training of nurses in public hospitals are satisfactory.

(8) The administration of the Brisbane and South Coast Hospitals, the constitution of the Board, and whether there should be medical representation thereon.

(9) The duties of the Medical Superintendent of the Brisbane General Hospital and the control he should have over the general management of the hospital and over the honorary medical staff.

(10) The advisability of placing the Ambulance Transport Brigade under the control of the hospitals.

(11) The equity or otherwise of the present system under which Local Authorities bear the whole cost of the treatment of cases of infectious diseases and of the detention of carriers, suspects, etc.

Now, therefore, know Ye that We, reposing especial trust in your zeal, knowledge, learning, industry, discretion, and ability, do by these presents, by and with the advice of Our Executive Council of Our State of Queensland, constitute and appoint you, the said WILLIAM HARRIS, ERNEST SANDFORD JACKSON, and SAMUEL ALEXANDER GLASSEY, to be our Commissioners for the purpose of inquiring into the matters hereinbefore mentioned and any other matter pertaining thereto as to you should seem meet : And We do hereby require and enjoin you to make diligent inquiry (but without permitting any counsel, solicitor, or agent as representing any person, corporation, or association to appear before you or to examine or cross-examine any witness) into the matters aforesaid, and for the purpose to exercise all the powers conferred upon a Commission by "*The Official Inquiries Evidence Acts*, 1910 *to* 1929" : And We do furthermore command and enjoin you to summon before you and to examine all such persons as may appear to you able to inform you concerning the premises, and to cause to be taken down in shorthand and reduced into writing the evidence of the several witnesses that may appear before you, and such evidence, together with a full and faithful report touching the matters aforesaid, to transmit to the Honourable the Premier and Chief Secretary of Our said State : And We do hereby appoint you, the said WILLIAM HARRIS, to be Chairman of this Our said Commission.

In testimony whereof, We have caused the Public Seal of Our said State to be hereunto affixed.

Witness Our Trusty and Well-beloved His Excellency Sir THOMAS HERBERT JOHN CHAPMAN GOODWIN, Lieutenant-General on the Retired List and in the Reserve of Officers of Our Army, Knight Commander of Our Most Honourable Order of the Bath, Companion of Our Most Distinguished Order of St. Michael and St. George, Companion of our Distinguished Service Order, Governor of Our State of Queensland and its Dependencies, in the Commonwealth of Australia, at Government House, Brisbane, this twenty-ninth day of May, in the year of Our Lord One thousand nine hundred and thirty, and in the twenty-first year of Our Reign.

(Signed) JOHN GOODWIN.

By His Excellency's Command.

(Signed) A. E. MOORE.

Entered on Record by me in the Register of Patents, No. 17, page 125, this twenty-ninth day of April, A.D. one thousand nine hundred and thirty.

(Signed) G. W. WATSON,
Under Secretary, Chief Secretary's Department.

Chief Secretary's Office,
Brisbane, 29th May, 1930.

HIS Excellency the Governor, with the advice of the Executive Council, has been pleased to Appoint

WILLIAM MORTON, F.I.C.A., Reporter, Division II., State Reporting Bureau,

to be Secretary to the Royal Commission on Hospitals.

A. E. MOORE.

1930.

QUEENSLAND.

ROYAL COMMISSION TO INQUIRE INTO CERTAIN MATTERS RELATING TO PUBLIC HOSPITALS.

REPORT.

To His Excellency Sir THOMAS HERBERT JOHN CHAPMAN GOODWIN, Lieutenant-General on the Retired List and in the Reserve of Officers of His Majesty's Army, Knight Commander of the Most Honourable Order of the Bath, Companion of the Most Distinguished Order of St. Michael and St. George, Companion of the Distinguished Service Order, Governor of the State of Queensland and its Dependencies, in the Commonwealth of Australia,

MAY IT PLEASE YOUR EXCELLENCY,—

We, your Commissioners, having been appointed a Royal Commission to make full and careful inquiry into:—

(1) The best and most equitable method of providing for the financing of public hospitals with particular reference to that portion of the cost at present found by the component Local Authorities in the case of hospitals to which "*The Hospitals Acts*, 1923 *to* 1929" apply.

(2) The general administration and control of public hospitals.

(3) The advisability of framing a common set of rules for all hospitals in receipt of Government subsidy.

(4) The admission of patients to public hospitals; the payment of fees (if any) and the possibility of arranging for intermediate wards.

(5) Whether group subscriptions entitling members thereof to free treatment in a public hospital should be permitted, and, if so, what income or other limitations or restrictions (if any) should be imposed in respect of membership of such groups.

(6) The method of appointment of the honorary medical staff of public hospitals; the advisability or otherwise of the honorary medical staff being represented upon the governing body of the hospital; and whether doctors other than members of the honorary medical staff should be permitted to attend patients in the hospital or intermediate wards.

(7) Whether under present conditions the facilities for the training of nurses in public hospitals are satisfactory.

(8) The administration of the Brisbane and South Coast Hospitals, the constitution of the Board, and whether there should be medical representation thereon.

(9) The duties of the Medical Superintendent of the Brisbane General Hospital and the control he should have over the general management of the hospital and over the honorary medical staff.

(10) The advisability of placing the Ambulance Transport Brigade under the control of the hospitals.

(11) The equity or otherwise of the present system under which Local Authorities bear the whole cost of the treatment of cases of infectious diseases and of the detention of carriers, suspects, &c.,—

now have the honour to submit to your Excellency the following report and recommendations:—

Accompanying this Report are seven volumes of evidence which, with a view to economy, have not been printed.

Documents, plans, correspondence, &c., material to the matter remitted to us have not been forwarded owing to their bulk, but are available should your Excellency desire same.

GENERAL.

Evidence was obtained from members and officials of Hospital Boards and Committees, Local Authorities, Queensland Ambulance Transport Brigade organisations, representatives of other bodies affected, Departmental and Hospital Officials, Medical Practitioners, and other persons.

By advertisement in the public press an invitation was extended to any person desiring to give evidence. Witnesses were examined in public. No expense was incurred by the Commission in connection with witnesses appearing before it.

Sittings of the Commission were held as follows:—Brisbane, 11th, 12th, 13th, 16th, 17th, 18th, 19th, 23rd, and 25th June; Ipswich, 30th June; Toowoomba, 2nd and 3rd July; Warwick, 4th and 5th July; Brisbane, 7th, 8th, 9th, and 10th July; Roma, 15th July; Charleville, 16th July; Blackall, 18th July; Barcaldine, 18th July; Longreach, 19th and 21st July; Rockhampton, 22nd and 23rd July; Mackay, 25th July; Townsville, 28th and 29th July; Atherton, 1st August; Cairns, 4th and 5th August; Maryborough, 8th and 9th August; Brisbane, 15th, 19th, 20th, 21st, 27th, 28th August, and 4th September.

Though tedious repetition of evidence was discountenanced, the number of witnesses was not limited. Evidence was taken from 196 witnesses, and is contained in volumes Nos. 1 to 6.

Arrangements were made for those bodies which could not send delegates to centres, where sittings of the Commission were held, to forward evidence in the form of a statement, conditional on the person making same attending before your Commissioners for further examination if required. Evidence submitted in this form is contained in volume No. 7.

During the course of the inquiry certain evidence was submitted on matters outside the scope of the Commission, and on which no recommendations have been made.

Every facility was afforded to, and opportunity availed of, by your Commissioners to inspect the institutions at the various centres at which sittings were held.

Many of the matters raised by the terms of reference have been, and are, the subjects of much controversy among hospital and other authorities, also the medical profession, in at least many parts of the Empire and America. This necessitated much research on the part of the Members of the Commission and then conferences at irregular intervals. The diverse conditions existing in this State added to the difficulties.

Your Commissioners now proceed to deal specifically with the questions submitted to them :—

REFERENCE No. 1.—The best and most equitable method of providing for the financing of public hospitals, with particular reference to that portion of the cost at present found by the component Local Authorities in the case of hospitals to which "The Hospitals Acts, 1923 to 1929," apply.

NUMBER OF PUBLIC HOSPITALS.

The number of public hospitals in Queensland is as follows :— 118

Under "*The Hospitals Acts*, 1874 *to* 1891"	74	
,, "*The Hospitals Acts*, 1923 *to* 1929"	44	
	—	118

The number of "Ambulances under" the Acts mentioned is 62 and 3 respectively.

METHOD OF FINANCING HOSPITALS—"THE HOSPITALS ACT AMENDMENT ACT OF 1928."

Section 9 of "*The Hospitals Act Amendment Act of* 1928" prescribes the method by which the revenue for the upkeep of the hospitals, to which "*The Hospitals Acts*, 1923 *to* 1929" apply, is to be raised :—

> "Subject as herein provided, as soon as may be after the first constitution of the Board, and thereafter in every year before the fourteenth day of July, the Board shall estimate as accurately as possible—
>
> (*a*) The total amount of the expenditure required for the current year ending on the thirtieth day of June following; and
>
> (*b*) The total amount of the probable income of the Board during the same period other than contributions from the Treasurer and the component Local Authorities and without taking into account income which may be received from contributors' payments.
>
> The difference between the estimated expenditure and estimated income as aforesaid of the Board shall be paid—
>
> (*a*) By the Treasurer, who shall, out of moneys to be appropriated from time to time by Parliament for the purpose, pay to the Board an amount equal to sixty per centum of such difference; and a receipt signed by the Chairman or Secretary shall be a sufficient discharge to the Treasurer for any such payment;

(*b*) By the component Local Authorities, who shall contribute an amount equal to forty per centum of such difference.

If in any year the amount received by the Board from all sources falls short of the expenditure based upon the estimate for the year, then the deficit shall be added to the estimated expenditure for the ensuing year.

If the amount received by the Board in any year from all sources exceeds the expenditure based upon the estimate for the year, then the excess shall be deducted from the estimated expenditure for the ensuing year."

SUMMARY OF RECEIPTS AND EXPENDITURE, HOSPITALS AND AMBULANCES, 1928-29.

HOSPITALS.

	Districted Hospitals.		Voluntary Hospitals.		Total.	
RECEIPTS.	£	£	£	£	£	£
Subscriptions and donations	24,378		67,932		92,310	
Pay patients	69,596		47,894		117,490	
Local Authorities (infectious diseases)	17,546		7,422		24,968	
Other receipts (including base grants, £8,000)	11,651		12,213		23,864	
Golden Casket	50,402		11,675		62,077	
Government contributions (60 per cent.)	136,201		..		136,201	
Government endowment (£2 to £1)	..		132,921		132,921	
Local Authorities' contributions (40 per cent.)	89,313		..		89,313	
		399,087		280,057		679,144
EXPENDITURE.						
Maintenance	349,034		258,105		607,139	
Administration	15,491		12,899		28,390	
Extraordinary expenditure—Interest and redemption, &c.	18,448		14,619		33,067	
		382,973		285,623		668,596
	Surplus £16,114		Deficit £5,566		Net surplus £10,548	

SUMMARY.

Total expenditure as above			£668,596
Receipts—			
Subscriptions and donations	£92,310		
Pay patients	117,490		
Pay patients, Local Authorities, infectious diseases	24,968		
Other Receipts (including base grants, £8,000)	23,864		
		258,632	
Deficit (all hospitals) to be provided by taxation, &c.			£409,964
Provided from—			
Golden Casket direct payments	£62,077		
Government on account Boards' precepts	136,201		
Government on account endowment	132,921		
	269,122*		
Local Authorities' precepts	80,313		
	420,512		
Less Net surplus	10,548		
As above			£409,964

* Over 50 per cent. provided from Golden Casket Funds.

AMBULANCES.

RECEIPTS.	£	EXPENDITURE.	£
Subscriptions and donations	66,098	Ordinary	112,296
Other receipts	5,325	Buildings and repairs	5,688
Government endowment	48,216	Surplus	1,655
	£119,639		£119,639

GOVERNMENT SUBSIDY—HOSPITALS.

Prior to the passing of "*The Hospitals Acts, 1923 to 1929*," funds for the hospitals were raised by local efforts, and consisted chiefly of voluntary subscriptions and donations, &c., supplemented by Government subsidy of £2 to £1. During October 1930 the rate of subsidy was temporarily reduced from £2 to £1 15s. for every £ subscribed.

GOVERNMENT SUBSIDY—AMBULANCES.

Voluntary ambulances are endowed for maintenance purposes at the rate of 15s. (reduced temporarily to 10s.) to the £1, and for buildings at the rate of £ (reduced to 10s.) for £ up to a maximum of £750 for each centre. Any cost in excess of £1,500 has to be borne solely by local subscriptions.

HOSPITAL PRECEPTS.

From the point of view of the Hospital Boards the present system is an ideal one. Under it the revenue is easily collected at practically no expense, and entails very little labour on the part of the Board. It provides an assured and steady income, and casts the responsibility upon the Treasurer and the Local Authorities of finding the difference between the estimated expenditure and estimated income in the ratio of 60 per cent. and 40 per cent. respectively. Once the budget of the Hospital Board for the financial year has been prepared and the extent of the estimated deficit—for there is always a deficit—has been ascertained, the Board issues its precepts to the component Local Authorities and thereupon its anxiety ceases. The ease with which the Hospitals Board obtains its finance may not be conducive to economy.

BASIS OF TAXATION ON UNIMPROVED CAPITAL VALUE OF LAND.

The basis of the taxation levied by the Local Authorities to provide their share of the Hospitals Boards' precepts is the unimproved capital value of the land.

Evidence with regard to this method of taxation was given at every centre visited, and the Commissioners were impressed by the opposition shown thereto by all classes of witnesses. With very few exceptions it was condemned as "inequitable."

PRESENT SYSTEM INEQUITABLE.

Your Commissioners are satisfied that the present method of raising the component Local Authorities' quota towards the upkeep of hospitals is not the most equitable, for the following reasons:—

(*a*) The unimproved capital value of land is not always a sure index to a ratepayer's ability to pay;

(*b*) A considerable number of people escape direct payment;

(*c*) Ratepayers contribute indirectly as well as directly.

In support of this contention the following instances are given. The cases quoted are persons employed in the one service:—

	Unimproved Value of Land on which Rates are Paid.
(1) Salary £1,500 per annum	Nil*
(2) Salary £1,100 per annum	£400
(3) Salary £950 per annum	£290
(4) Salary £800 per annum	£600

It will be noted that (1), who enjoys the largest income, contributes nothing *direct* to hospital maintenance through the Local Authority, whereas (4), who has the smallest salary, is called upon to pay the most.

The present system also makes no provision for any contribution from a large section of the community which benefits to the greatest extent by the services provided by the institutions.

*This person rents the premises, the unimproved value of the land being £160.

PROPOSALS FOR SECURING EQUITY.

The suggestions made by witnesses before the Commission as a solution of the difficulties of financing public hospitals were many and varied, ranging from nationalisation of hospitals to a tax on a commodity in daily use.

It is admitted that experience discloses some anomalies in most systems of taxation. This is unavoidable. No system of taxation which could satisfy every section of the community has yet been devised. Those who earnestly propose remedies should be certain that such remedies do not contain elements of greater inequity and hardship than the system they propose to amend.

It was frequently made manifest to your Commissioners that Local Authorities had no desire to evade a share of the responsibility of the burden, but stressed the inequity of a system which allowed a large proportion of the population to escape its obligations.

The problem of securing an equitable basis of taxation without disturbing one or other of the two systems obtaining at present, although not insuperable, is beset with many difficulties and anomalies.

For your Excellency's information a letter received from the Commissioner of Taxes is quoted hereunder:—

"Brisbane, 23rd October, 1930.

Dear Sir,

In reply to your letter of the 22nd instant, wherein you ask that, in the event of taxation being imposed on wages, salaries, and income, such taxation to have effect only within certain isolated Local Authority areas in various portions of this State, would it be practicable to use the Income Tax machinery for the collection thereof. I have to state that this Department does not classify taxpayers in districts of any sort, and to do so would entail considerable expense to both the public and the Department.

The Income Tax Statute, as such, could hardly be used for the purposes indicated herein, but, no doubt, this organisation as a machine could be adapted within measures as a collecting machine under another Statute.

Yours faithfully,

(Sgd.) H. MAGEE,
Commissioner of Taxes."

BEST METHOD OF FINANCING PUBLIC HOSPITALS.

Viewing the hospital service in the light of a service to the individual, your Commissioners are of opinion that the most equitable method of providing the necessary hospital finance is by a direct tax on wages and income. This opinion is fortified by the almost unanimous views of the witnesses examined.

At the same time it appears to your Commissioners that the advantages of civilisation, including the availability of efficient hospital service, enhances the value of property in the neighbourhood. In the absence of such advantages the value of the property would be prejudicially affected. It is, therefore, only right and proper that a fair proportion of the burden of maintaining public hospitals should be borne by Local Authorities, and that they should have a fair proportion of representation on the management as would enable them to exercise vigilance in efficient and economic administration.

VOLUNTARY HOSPITALS—EFFECT THEREON OF DIRECT TAXATION.

Your Commissioners, of course, recognise that with the introduction of a compulsory tax, as suggested, voluntary hospitals would be brought under "*The Hospitals Acts*, 1923 *to* 1929."

The evidence before the Commission is to the effect that in those districts which have been brought under the said Acts voluntary subscriptions and donations have practically ceased.

Attention must also be directed to the fact that some of the voluntary hospitals, which are at present carrying on successfully with the assistance of the Government subsidy of £2 to £1, strenuously opposed any interference with their present system. Nevertheless, the fact remains that voluntary donations and contributions to such hospitals are generally shrinking. The representatives of many of these institutions frankly admitted that each year it is becoming more difficult to stimulate public support.

It is with diffidence and reluctance that your Commissioners have to recommend any interference with philanthropy or with that public spirit which is evidenced by the support and honorary administration of voluntary hospitals. On the other hand the question arises, should an injustice be allowed to continue when it is clearly demonstrated that benevolence, so far as hospitals are concerned, is dwindling towards the minimum ?

During the year 1928-29 the total amount required for the upkeep of voluntary hospitals amounted to £285,623, towards which sum only £67,932, or 23·78 per cent., was contributed "voluntarily." The figures for "districted" hospitals are £382,973 and £24,378, or 6·37 per cent. Included in the "subscriptions and donations" figures are amounts received from "group subscriptions," which cannot strictly be regarded in the light of "voluntary subscriptions."

The representative of the Council of Agriculture submitted the following evidence :—

> "It has been proved that, consequent upon hospitals being districted, benefits and voluntary subscriptions in their areas decreased to such extent that during the second year of Board control the subscribers' representatives have been eliminated from the composition of the said Board. Although there are quite a number of hospitals in the State which are not yet districted, the regulations and scale of patients' fees now insisted upon by the Home Department, together with the general trend of public opinion towards the desirability of ensuring stability of hospital finance, will, ere long, result in the great majority being brought under the provisions of available legislation.
>
> Although straight-out nationalisation of hospitals would undoubtedly be fairer than the present system of taxation, there is a grave danger that if such were instituted the consequent elimination of all specific local financial responsibility might result in laxity in administration—perhaps the installing of unnecessary costly equipment or other economically unsound procedure. Therefore, it would appear that a percentage of deficiency should continue to be met by Local Authorities, but that all persons who, though not ratepayers, are in receipt of reasonable incomes should also be specifically taxed, and a decrease in the percentage required of Local Authorities be thus effected. In the case of employers the ordinary income tax channels could be utilised, whilst for wage earners the machinery of the Workers' Unemployment Insurance or some kindred system would suffice for collection of a small levy."

Substantially this statement contains the views expressed by a great number of witnesses who appeared before the Commission.

RECOMMENDATION.

After full consideration your Commissioners *recommend* as the "best and most equitable" method of financing public hospitals, that—

(1) A Hospital Fund be created by the collection of a special Hospital Tax on wages, salaries, and income, with an exemption to persons in receipt of not more than £52 per annum from such sources.

(2) The difference between the estimated expenditure and estimated income of the Board shall be paid—

(*a*) By the Treasurer, who shall, out of moneys to be appropriated from time to time for the purpose, pay to the Board, out of the Hospital Fund, an amount equal to eighty per centum of such difference;

(*b*) By the component Local Authorities, which shall contribute an amount equal to twenty per centum of such difference.

To collect a special tax for hospital purposes on present income tax payers would be comparatively easy, by taking advantage afforded by the present income tax machinery; and the collection of the contributions from wages would also be rendered comparatively easy, by using the present machinery for collecting the funds under the Unemployment Relief scheme.

On the basis of figures supplied by the Department of Labour in connection with the Unemployment Relief Fund, a tax of 1d. in the £ is estimated to realise approximately £260,000 per annum. Fear was expressed that those who paid a compulsory tax for hospital purposes would expect the right to free treatment. Your Commissioners are of opinion that there need be no reasonable ground for this apprehension, as the degree of taxation should be such as only to ensure that hospital facilities are available to those entitled thereto.

Your Commissioners recognise that, owing to the present economic position and the nation-wide depression, your Excellency's advisers may deem this a most inopportune time to consider the advisableness of levying any additional direct taxation either on the individual or on industry. In the meantime, in order to mitigate in some measure the present inequity existing in many of the rural areas, your Commissioners *recommend* the basis of computing the quota to be contributed by the component Local Authorities should be altered forthwith as hereinafter suggested.

SUGGESTED VARIATION IN METHOD OF ASSESSMENT OF HOSPITAL PRECEPT.

In districts which are now, or may hereafter be, brought under "*The Hospitals Acts, 1923 to 1929*," a greater measure of equity would be secured by altering the present basis of computing the quota to be contributed by the component Local Authorities under the precepts issued by the respective Hospital Boards from the "value of the rateable land" to that shown in column 9—Appendix A—which is based on the average of the levy calculated on—

(*a*) Unimproved value (the present method);

(*b*) Number of ratepayers; and

(*c*) Rates levied.

The examples given in Appendix A show the effect of the "present" and "suggested" methods of taxation. It was necessary to use the number of "rateable properties" instead of number of "ratepayers," as the latter was not ascertainable. Under the new Local Authority franchise "occupiers" will appear on the voters' roll and should be deemed to be ratepayers, as directly or indirectly they pay the rates.

The reason for taking into consideration the rates levied instead of the "unimproved value" only is that the practice of valuing land is not uniform throughout the State. Some Local Authorities value "low" and rate "high"; others value "high" and rate "low." In the latter, therefore, on a purely valuation basis, ratepayers in one Local Authority would have to contribute more than those in a neighbouring Local Authority which values "low." By adopting the "rates levied" basis as a factor in determining the amount of the hospital contribution, the objection to the varying method of valuation is, to a certain extent, overcome.

In New South Wales there is one "Valuing Authority"—the Valuer-General's Department—for the whole State and for all purposes, Government and Municipal. Had a similar authority been established in Queensland the "capital value basis" would have been acceptable.

To further equalise the assessment, the number of ratepayers has been taken as an additional factor in calculating the amount payable by Local Authorities.

Before the recommendation of your Commissioners could be acted upon, however, section 25 of "*The Hospitals Acts, 1923 to 1929.*" would have to be amended.

Calculating the amounts payable by the several Local Authorities on the basis above mentioned, the contributions by cities and towns (where the larger populations reside) generally would be increased and those by the rural areas correspondingly reduced. (*See* Appendix A.)

GROUP SUBSCRIPTIONS.

To further assist in relieving the Local Authorities your Commissioners *recommend* that Hospital Boards and Committees should encourage, in every way, the formation of groups of voluntary subscribers. This matter is dealt with specifically under Reference No. 5.

FRIENDLY SOCIETIES.

With respect to members of Friendly Societies, evidence was given on their behalf by Mr. Wm. Atkinson, President of the Friendly Societies' Medical and Hospital Council of Brisbane.

He stated that in the event of a wage tax being imposed members of Friendly Societies would have to bear a double burden. The result might be that most of them would drop out of the societies and depend on the hospital for medical attention. This, he contended, would increase the strain on the hospitals by about 25 per cent. The witness submitted that the objection to a wage tax by the Friendly Societies would be removed if they were given intermediate ward provision, with their own doctors, at a charge not exceeding 8s. per day.

Admittedly public hospitals are considerably relieved by members of Friendly Societies receiving, through their various lodges, domiciliary medical service. In consideration thereof your Commissioners consider the suggestion made by the representative closely approximates what is reasonable, and therefore *recommend* that all *bona fide* financial members of Friendly Societies be provided with intermediate ward accommodation at the rate of 9s. per day, i.e., the maximum charge for public wards.

This proposal, if adopted, should be reviewed two years after coming into operation.

INDUSTRIAL ACCIDENT CASES.

The principal witness on behalf of the British Medical Association (Dr. Meyers) suggested that the State Government Insurance Office should, by legislation, be liable to pay from the Insurance Fund the general hospital expenses, including medical and nursing attention, in addition to the insured person's compensation, in all industrial accident cases. He recommended that an Act on the lines of the New South Wales Act be introduced, providing for the payment of medical and nursing attention up to £50 in most of the cases requiring treatment. He also recommended that this class of case should be treated as "intermediate"—the patient selecting his own medical practitioner.

Dr. MacEachern, of Chicago, in his report to the Victorian Government on the public hospitals of that State, made a similar suggestion, but, as far as your Commissioners can learn, it was not acted upon.

The State Insurance Commissioner, in his evidence before the Commission, estimated that, if the public hospital beds in such cases were to be paid for by his office at the rate of £3 3s. per week, the additional cost to employers would be £36,000 per annum. If out-patients were paid for by his office at 5s. per week, these would total £4,500; making in all £40,500 per annum, or 12·1 per cent. of the claims paid—which aggregated £337,086 for the year ended 30th June, 1930.

If these charges were added to the State Insurance Commissioner's liability, it is fairly obvious that employers' premiums would necessarily be increased by about 12 per cent. If Dr. Meyers' recommendation for the treatment of such cases in intermediate wards were given effect to it is equally obvious that still larger premiums would require to be paid by the employer.

At our request, the Manager of the hospitals controlled by the Brisbane and South Coast Hospitals Board furnished a list of State Insurance cases under the Workers' Compensation Act where the hospital fees were not wholly paid by the patient or on his behalf during the year 1929-30. The total sum of fees remaining unpaid was £253, portion of which is being paid by instalments.

As the population served by the Brisbane General Hospital is roughly about one-third of that of the whole State, the loss to the public hospitals throughout the State from this cause would probably be about £750.

In view of the opinion of the State Insurance Commissioner quoted above, and having regard to the present condition of industry, it does not seem an opportune time to place an additional burden of £40,000 on employers, in order to save the public hospitals such a comparatively small loss.

Your Commissioners, therefore, are unable to recommend that the suggestion made be given effect to.

The Insurance Commissioner and the Admission Officer of the Brisbane Hospital have an arrangement whereby the hospital is notified of the intention to pay over moneys under the Workers' Compensation Act to persons who have received the benefits of that institution. Such an arrangement is to be commended, and your Commissioners suggest an extension of this practice be applied to other hospitals.

THIRD-PARTY RISK INSURANCE—MOTOR VEHICLES.

The desirability of compulsory third-party risk insurance in respect of motor vehicles was brought under the notice of the Commission by several witnesses in different parts of the State.

The Manager of the Brisbane General Hospital, at our request, furnished the following information regarding patients admitted to that hospital as the result of motor vehicle accidents during the year 1929-30 :—

Number of cases	269
Aggregate number of days in hospital	5,716
Cost—at rate of 9s. per day	£2,572
Fees paid	£595
Net cost to Hospital Board	£1,977

He also stated that a large percentage of these cases were quite unable to pay any fees whatever, they being either unemployed, in receipt of pensions, &c. The average period in hospital was approximately 21 days.

There is nothing to indicate how many of these cases were due to the fault of the motor vehicle drivers in such a way as to render the insurers legally liable for all damage, or what proportion of the injured would have been unable to recover damages by reason of contributory negligence, inevitable accident, or of the fault or negligence of the person injured.

There is undoubtedly a considerable number of innocent victims in connection with accidents caused by motor vehicles, who, in consequence, become patients in public hospitals at the public expense, and in respect of whom the hospital fees are not recovered, by reason of the lack of resources on the part of the patient and of the person liable for the injury.

The burden thus entailed on the hospitals from this cause is not exactly ascertainable, but, in view of the large percentage of motor vehicles which already carry a comprehensive policy, is probably not so large as might be anticipated.

Legislation rendering compulsory third-party risk insurance by owners of motor vehicles on the lines of the New Zealand Act, No. 52 of 1928, would—apart from its desirability as a protection of the public generally—tend to minimise the burden on public hospitals arising from this cause.

VISITORS' FEES.

There is one source of income which appears to have been overlooked in the public hospitals of the State, i.e., visitors' fees.

It appears from the evidence of Dr. K. C. Ross, formerly Medical Superintendent of the Melbourne Hospital, that in that institution, which has a capacity of 590 beds (including the convalescent hospital), each patient is allowed two free passes for his friends on each visiting day. Other visitors are required to pay a fee of sixpence. According to the Annual Reports the amounts collected in this way were—

Year 1925-26	£4,619
,, 1926-27	4,657
,, 1927-28	4,879

These fees were collected, apparently, for revenue purposes, and also with a view to lessening the number of visitors.

A charge of this nature might well be considered by the authorities of the public hospitals of this State as an unobjectionable method of increasing the revenue of the hospitals.

Such a scheme would serve to relieve the congestion in the wards which, on visiting days, sometimes leads to serious vitiation of the atmosphere.

CONCLUSION.

In addition to the suggested alteration in the basis of arriving at the quota to be contributed by a Local Authority, and pending the carrying into effect of the recommendation of your Commissioners respecting the levying of a Hospital Tax, some relief would be afforded Local Authorities by Hospital Boards increasing their activities in—

(*a*) Economy in administration;

(*b*) Collection of fees from patients;

(*c*) Organisation of groups of subscribers.

REFERENCE No. 2.—The general administration and control of public hospitals.

During the investigations the following matters came under observation:—

CONSTITUTION OF HOSPITAL BOARDS.

It has been suggested that women should be included in the composition of Hospital Boards.

There is nothing in the Act governing the constitution of a Board to prevent women being appointed by the Governor in Council or elected by the Local Authorities or by the contributors (when entitled to representation). At the present time a woman is one of the Government nominees on the Townsville Hospital Board.

Evidence was given at one centre on behalf of the District Branch of the Returned Soldiers' League suggesting that a representative of the League be appointed to the Hospital Board.

At another centre it was suggested that one member of Hospital Boards should be a business man nominated by an approved organisation of business men, i.e., a Chamber of Commerce.

Another suggestion was that Government nominees should be men of wide and varied interest.

Subject to what has been stated by your Commissioners with respect to medical representation on Hospital Boards (*see* References Nos. 6 and 8), it does not seem wise to limit the choice of the Governor in Council, the Local Authorities, or the contributors (if any) in any manner whatsoever.

It is the community as a whole and not any particular section of it that is represented upon the Boards, in whom is vested the responsibility of the administration of hospitals.

ESTABLISHMENT AND EXTENSION OF HOSPITALS.

A hospital was recently established at Gordonvale, which is about 16 miles distant from Cairns. There is a good level macadamised road, partly bitumen, between the two places, and an efficient ambulance service at both centres. The hospital staff consists of a matron, three nurses, two domestics, and a yardman. The daily average number of patients is six. In the opinion of your Commissioners this institution was never necessary.

The Maternity Ward erected at the Maryborough Hospital, at a cost of £11,000, has, up to the present time, been little used. So far it has not justified itself. The same remarks apply to similar wards erected at other hospitals.

The Nurses' Quarters at the Toowoomba Hospital appear to be on a somewhat extravagant scale.

The Charleston District Hospital (Forsayth) has an average of two patients. It seems to be more suitable for a Bush Nursing centre. There is a hospital at Georgetown, 25 miles distant.

A cottage hospital, erected at Morven at a cost of £1,544, is now the residence of a nurse connected with the Bush Nursing organisation.

There are a number of similar instances, not necessary to mention more particularly, which lead your Commissioners to the conclusion that before approval is given to the establishment of a new hospital in any district, or to making considerable additions to an existing one, a careful survey of the requirements of the district and of the facilities available in neighbouring areas should be made by a competent authority. As a rule the smaller the number of patients in a hospital the greater the difficulty in securing efficient and economic management. The suggested survey would take cognisance of such matters as—Hospital available and the equipment at a larger centre, the facility of transport, the condition of the roads, &c. Upon the results of such a survey a decision would be made as to whether a Bush Nursing unit or a cottage hospital would meet requirements.

PROVISION FOR CHRONIC CASES, &c.

The following evidence was given by the medical superintendent of a country hospital:—

> "The most pressing need in public hospitals in Queensland is the provision of additional homes for the following classes of patients:—
>
> (1) Tuberculous cases—early and late;
>
> (2) The aged and infirm;
>
> (3) Chronic invalids.
>
> Public hospitals cannot keep the above cases for long, and, on discharge, they have nowhere to go, and so seek readmission in the public hospital of a neighbouring town. I find they are our greatest problem, and a heavy tax on the hospital. A young fellow off the road comes in as a tuberculous case. When he comes into the hospital what are you going to do with him? You cannot turn him out on to the street. We are not supposed to take him in, but you must find him accommodation. I find when we make application for the Diamantina it may be five or six months before we can get a patient there."

Evidence on similar lines was given in other centres. Your Commissioners noted that in many of the country hospitals there were often a number of unoccupied beds. In such hospitals the necessity of transferring their chronic cases to the Diamantina Hospital or to Dunwich should not be very pressing. Moreover, on humanitarian grounds, it is questionable whether it is right to move such patients such a distance as would preclude the possibility of being visited by their relatives and friends.

REPLACED PLANT AND EQUIPMENT.

Hospitals sometimes find it advantageous to replace portion of their plant and equipment, i.e., electric lighting system, X-ray plant, sterilisers, operating tables, bedsteads, &c., with more powerful or more modern units. The replaced plant and equipment may be quite efficient to meet the requirements of a smaller or perhaps less financial institution. The establishment of a central agency would enable the latter institutions to purchase at least part of their requisite plant at a price much below initial cost. It would only be necessary to supply the agency with full particulars of the discarded units. It is suggested that the State Stores Board should act as the agency.

Your Commissioners *recommend* that consideration be given to this suggestion.

RECEIVING SUPPLIES.

Inquiries elicited the fact that in a number of hospitals deliveries of meat, bread, and milk into the institution were accepted without question; some of the hospitals being even without a set of suitable scales. This elementary check on the expenditure of the institution was too frequently absent.

The Commission was only able to make the most cursory examination on such matters, but your Commissioners cannot too strongly enjoin on hospital authorities that in receiving stores the utmost vigilance is required both in regard to quantities and quality.

PURCHASE OF DRUGS AND INSTRUMENTS.

Evidence was given indicating that greater care should be exercised in ordering drugs. Two instances were cited which came under the observation of the Deputy Superintendent of the Diamantina Hospital during his examination of public hospitals in country districts. One was the ordering of 1 lb. of heroin hydrochlor:, the price of which was £25 12s., when 1 oz. would have been sufficient for years. This was said to have been ordered by a nurse who had no knowledge of the price. The other was the purchase of 1 lb. of santonin, the price of which was 8s. per dram, or £52 4s. per lb.: less than half a dram of this drug had been used at date of inspection.

Although these were not recent happenings, they serve to show the necessity for greater care on the part of those responsible, and the desirability of periodical inspections of all public hospitals by an independent official, who would report the result of his inspection to the hospital authority and to the Minister.

Most emphatically these happenings point to the necessity of a routine examination of all orders for drugs not urgently required, by someone with a knowledge of how to order drugs or to prepare the necessary requisitions.

In urgent cases or for ordinary requirements in country districts some special arrangement in each district will probably be necessary, i.e., the signing of the requisition by the medical superintendent or matron and the secretary.

It is suggested by your Commissioners that for the Brisbane and South Coast Hospitals there should be a sub-committee to which all matters relating to the purchase of drugs or instruments should be referred. This sub-committee might consist of the Chairman or representative of the Hospital Board, the Chairman or representative of the Advisory Board, the General Medical Superintendent, and the Dispenser.

This principle could well be adopted by other large hospitals.

STANDARDISATION OF SUPPLIES AND EQUIPMENT.

The simplification and standardisation of hospital equipment and supplies should be aimed at by all Hospital Boards, and support given to the Standards Association of Australia as far as practicable.

Your Commissioners are of the opinion that considerable economies could be effected if uniform standards could be fixed for lines of hospital supplies and equipment commonly required, such as beds and bedding, linen, textiles, hardware, furniture, crockery, and glassware.

The Brisbane and South Coast Hospitals Board has already taken some steps in this direction.

COMBINED BUYING.

Your Commissioners would suggest that Hospital Boards at Brisbane and the principal seaports be encouraged to combine with other Boards and Committees in the neighbouring districts in the purchase of the more important lines of hospital equipment and supplies (other than food and groceries) through the State Stores Board. This is especially recommended in the case of crockery, which should be of uniform size and branded "Q.H." or some other symbol indicating it is hospital property. The symbol could be coloured red for the use of the patients and blue for the use of the staff. To this end the respective hospital authorities once in six months should state to the State Stores Board their prospective requirements of the various supplies for the ensuing six months. This would tend to economy in buying and freights.

APPOINTMENT TO STAFF.

Evidence was given by the representative of a Hospital Board, which had several hospitals under its jurisdiction, that in a peak period at one of its hospitals the Board had to bear the additional expense of transporting a temporary nurse from Brisbane, while at the same time the nursing staff at its other institutions was more than adequate for immediate requirements.

Your Commissioners *recommend* that—

(*a*) In all future nursing appointments Hospital Boards reserve the right to transfer, either temporarily or permanently, the appointee to any of the Board's hospitals; this should be a condition of appointment;

(*b*) That applications be invited by advertisement in the press for the filling of vacancies in the executive positions of hospital.

QUALIFIED DISPENSERS.

The matter of the employment of qualified dispensers was brought before your Commissioners by the representative of the Pharmaceutical Society of Queensland. It was stated the utilisation of the services of pharmaceutical chemists had been overlooked in many instances in the present system of hospital administration.

It was found that in some of the larger hospitals qualified chemists were employed. In many instances the preparation of medicines is done by the matron or a responsible nurse under the supervision of the medical superintendent. No instance has, however, come under notice of any unsatisfactory results having arisen in consequence.

Your Commissioners are of the opinion there is not sufficient evidence to justify them in recommending any departure from the present practice of leaving this matter at the discretion of the various hospital authorities.

HOSPITAL ACCOUNTS.

During the investigations of the Commission throughout the State the lack of uniformity in the method of keeping accounts at the several hospitals was clearly demonstrated.

With a view to standardising the system and securing uniformity in the method of keeping hospital accounts, your Commissioners have drafted and append hereto specimen copies (with instructions) of the principal books for recording the required information. A uniform system is necessary for comparative purposes. (*See* Appendix J.)

Should any Hospital Board consider it advantageous to adopt a machine system of accounting, it may do so, provided the basic principles herein laid down are adhered to.

It is suggested that these books should be printed at the Government Printing Office and made available to all hospitals at the lowest possible cost.

All receipt books, patients' fees account books, and other money forms should be obtained from the Government Printer, who should submit for the approval of the Auditor-General all requisitions for such money forms before supplying the same. This is necessary for audit requirements.

> [NOTE.—Should the necessity arise, the Auditor-General may grant permission to supplement the books and forms as specified herein, or to vary the form of such books and forms, in accordance with the needs of the Hospital Board.]

CENTRAL HOSPITAL COMMISSION.

With respect to the administration of hospitals and the Hospitals Acts generally, and to certain matters which came under the notice of the Commission, to which attention has been directed specifically in other parts of this Report, your Commissioners have given consideration to the question of general control of public hospitals. After reviewing the position as it exists to-day they are of opinion that the most effective management would be attained by the creation of a Central Hospital Commission. The Commission should be endowed with adequate authority to carry out its policy with as little interference as possible from political, official, or other sources.

Inter alia it should—

(1) Co-ordinate as closely as practicable the activities of the Health Department and the public hospitals;

(2) Make a hospital survey of the State;

(3) Co-ordinate hospital system of the State;

(4) Inspect and classify all existing hospitals—
  (*a*) Buildings;
  (*b*) Equipment;
  (*c*) Location, having regard to population and surrounding district;
  (*d*) Means of transport;

(5) Exercise control over expenditure in the erection of hospital buildings, to prevent erection of same for reasons other than actual hospital needs;

(6) Decide whether hospitals should be built, amalgamated, or closed;

(7) Prescribe conditions for payment of subsidies;

(8) Deal with the framing of rules for all public hospitals, having regard to local conditions;

(9) Standardise, as far as practicable, hospital expenditure;

(10) Possess the power to inquire into management of any public hospital, also into character of local medical practitioners and local committees or boards;

(11) Report to Parliament as to the financial operations of the hospitals.

Your Commissioners *recommend* the creation of such a Commission, consisting of three members, i.e., a permanent full-time chairman and two other members. The latter would meet periodically with the chairman, and decide upon, and carry out, the general policy.

The term of service and salary to be paid to the chairman should be decided by the Governor in Council, but it is suggested that the other two members be paid an allowance not exceeding £100 per annum.

(*See* rider by Mr. Commissioner Jackson, M.B., page 56.)

The Chairman dissents (*see* page 51).

REFERENCE No. 3.—The advisability of framing a common set of rules for all hospitals in receipt of Government subsidy.

In this State, where the local conditions vary so much, your Commissioners consider it would be unwise to frame a common set of rules for all hospitals in receipt of Government subsidy.

A set of model rules, drafted by the Home Secretary's Department, was forwarded to all public hospitals for their assistance and adoption, with or without such amendments as might be found necessary having regard to local conditions. These draft rules have been largely adopted with such amendments, and are very generally considered to be satisfactory to the hospital authorities.

One provision of the abovementioned draft rules to which serious exception has been taken is that portion of Rule (8) of the rules relating to in-patients, which prescribes in relation to private patients that—

> "In case of default by any patient or person legally responsible for such patient, the medical practitioner upon whose application such patient was admitted to the private ward, or otherwise accommodated as a private patient, shall be responsible to the Committee for the payment of the account, and the Committee shall be empowered to recover the amount of such account from the medical practitioner."

Your Commissioners consider that Section (4) of the draft rules relating to in-patients, which reads—

> "Every medical practitioner, including the medical officer, shall be entitled to have his patients admitted to private wards, or otherwise accommodated as private patients, provided accommodation is available"—

might well be amended by the addition of the words "and also provided that the admission officer is satisfied that such patient is possessed of sufficient means to pay the prescribed charges for such accommodation and hospital service as set out in these Rules."

If these words were so added, the provision making the medical practitioner personally responsible should be omitted. Your Commissioners *recommend* that such an amendment be adopted by Hospital Boards and Committees.

REFERENCE No. 4.—Admission of patients to public hospitals, the payment of fees (if any), and the possibility of arranging for intermediate wards.

Your Commissioners make the following recommendations and comments :—

(*a*) ADMISSION OF PATIENTS TO PUBLIC HOSPITALS.

Hospital authorities should be required to accept and exercise the responsibility of determining whether any person is entitled to the public hospital services provided by the community.

The controlling body should have the power to delegate, subject to its direction, this very important duty to the medical officer or the matron.

The importance of the position of admission officer to a hospital cannot be too forcibly stressed, as upon that official is cast the burden of determining the eligibility for admission to the hospital, and of assessing the payment to be made by a patient for hospital services.

(*b*) THE PAYMENT OF FEES (IF ANY).

Patients should, as far as possible, reimburse the hospital for the cost of their treatment.

No person should be refused the benefits of the public ward of a public hospital by reason of inability to pay the prescribed charges or any part thereof.

The fees charged should approximate, as far as possible, the average daily cost to the institution.

A charge of 9s. per day for the public ward and £7 7s. per fortnight for the maternity ward, covering all charges (including operations and anæsthetics) has been generally adopted by Hospital Boards and Committees. These charges, although invariably less than the cost to the hospital, are conceded to be reasonable, taking into consideration the individual's general ability to pay and the probability of collection.

Hospital Boards or Committees should take the power to demand the full cost of maintenance, regardless of any fixed charge, where circumstances warrant such increased demand.

Every patient admitted to the public ward of the hospital should be requested to make a declaration as to his ability to pay the prescribed charges. (*See* Appendix J10.)

Should a patient declare that he is unable to pay in full the prescribed charge, he should be requested to sign an undertaking to pay the amount which the Board or Committee determine such patient shall pay. (*See* Appendix J10.)

In the case of those who certify their inability to pay anything, every care should be taken to verify their declarations. (*See* Appendix J11.)

COLLECTION OF FEES.

In the opinion of your Commissioners there is considerable laxity by Boards and Committees in the collection of fees from patients, and many well able to pay all, or part, of the fees incurred have been allowed to escape their liabilities.

"Fear of alienating public support" was the reason advanced by some of the representatives of voluntary hospitals for not insisting on the payment of fees; but such reasoning cannot be accepted by your Commissioners.

The percentage of fees collected to expenditure on hospital maintenance is—

	1926–27.	1927–28.	1928–29.
Districted hospitals ..	16·3	18·7	18·2
Voluntary hospitals ..	15·3	15·7	16·8
All hospitals ..	15·9	17·4	17·6

It will be noted there has been a slight improvement, but, nevertheless, it cannot be too strongly urged upon Hospital Boards and Committees that they should exercise the utmost vigilance in this matter. Patients who can pay in full, or part only, should be made to meet their obligations as far as possible.

Every patient should be personally interviewed as to his ability to pay, and every patient upon discharge should be accompanied to the office, the account presented to him, and a thorough understanding arrived at as regards the amount to be paid. If the undertaking arrived at is not kept, such account should be followed up, and a clear and sufficient reason should be obtained for default in payment of the account or the instalment decided upon. The forwarding of an account is of little value in such cases unless accompanied by a personal letter. The personal touch is necessary throughout all dealings with patients' accounts, both from the humanitarian point of view and that of the desirability of collecting whatever can be reasonably expected to be paid.

The Secretary should bring before the Board or Committee at brief and regular intervals a schedule of all accounts outstanding, with full particulars of the debtors' circumstances.

(*c*) THE POSSIBILITY OF ARRANGING FOR INTERMEDIATE WARDS.

Regarding this portion of the Reference it was found that various interpretations have been placed on the word "intermediate." The Home Department has classified wards in a public hospital as follows:—

(*a*) Public;

(*b*) Private or intermediate.

Such a classification, which incorporates "intermediate" or "private" under the one heading, has, no doubt, been responsible for some confusion.

The Members of your Commission define an "intermediate ward" as the provision made in a public hospital for persons able to pay the full charges for their hospital accommodation and nursing attention, together with the prescribed fees for extras, and who would be attended by their own medical practitioner, to whom they would be responsible for medical and surgical fees.

The establishment of intermediate wards in public hospitals is a matter which your Commissioners found was also, at present, seriously exercising the minds of hospital authorities elsewhere.

The evidence submitted shows that some such provision already exists in some of the country hospitals in the State, but, as previously pointed out, such wards were frequently designated "private." The rules of the institutions where such wards were available prescribed a fee of £4 4s. per week for medical cases, and £5 5s. per week for surgical cases.

For the indigent person or for the individual on minimum wages, the public hospital, together with the medical service provided thereat, is available without question. For the man well able to pay its charges, together with the medical and surgical fees, the private hospital with all its privileges is available. To the man receiving a wage which renders him ineligible for admission to the public ward at public ward rates—the intermediate section—there might be no alternative but the private hospital, with its fees generally beyond his capacity to pay. Such a person may have no desire whatever to take advantage of the honorary services of the medical practitioners given in public hospitals. The establishment of intermediate wards in public hospitals would meet the requirements of this intermediate class.

It is important that every care should be taken by hospital authorities in fixing the scale of fees for intermediate wards to ensure that patients making use of the facilities are in no respect a burden on the institution. Every safeguard should be exercised in the collection of such fees, even to the extent of demanding payment of same in advance, if considered necessary.

Although in accord with the establishment of intermediate wards in public hospitals wherever the conditions are favourable, your Commissioners consider that hospital authorities should concentrate on the efficiency and adequacy of their public ward accommodation before contemplating the introduction of intermediate wards. When such are established they should be under the general control of the medical superintendent of the hospital.

Representatives of some of the country hospitals gave evidence before the Commission that in their institutions it was unnecessary to make any special provisions for intermediate wards; patients otherwise ineligible for admission to the public wards but who elected to be treated therein were admitted subject to the condition that they paid the full cost of accommodation and nursing. Such patients could be attended by their own medical practitioner.

REFERENCE No. 5.—Whether group subscriptions entitling members thereof to free treatment in a public hospital should be permitted; and, if so, what income or other limitations or restrictions (if any) should be imposed in respect of membership of such groups.

(*a*) CONTRIBUTORY SCHEMES.

Group subscriptions or contributory schemes are in operation at many of the hospitals throughout the State, more especially in connection with the financing of voluntary hospitals.

Evidence has been submitted that it was with the revenue obtained from a form of "group system" that some of the voluntary hospitals, which formerly were in a languishing condition, were able to successfully carry on.

Some schemes fix the payment at 6d. or 1s. per week, and some are based upon the amount of wages earned.

The majority of the schemes which were brought to the notice of the Commission did not take into account the amount of income earned by the person seeking the benefits of the scheme, though, generally speaking, it was confined to industrial workers.

Your Commissioners *recommend* that group or contributory schemes with limitations should be encouraged. Revenue to the hospitals can be considerably augmented in this manner. Most workers are willing and anxious to make provision for their future hospital accommodation. Group subscriptions or contributory schemes provide the machinery to enable them to make such provision.

(*b*) INCOME LIMIT.

This is one of the most perplexing conditions of admission of patients that hospitals have to contend with. For the purposes of a contributory scheme the only satisfactory basis to work upon is the fixation of a defined income limit for those entitled to enjoy the full benefits of the scheme, i.e., free hospital treatment.

This limit, owing to the varying conditions in the State, should be left to the discretion of the respective Hospital Boards or Committees with the suggestion that it be—

Single man or woman—Wages, salary, or income not in excess of £260 per annum;

Married man—Wages, salary, or income not in excess of £340 per annum.

Persons in receipt of income above the defined limit might be permitted to join a contributory scheme, but only on the strict understanding that they would be entitled to intermediate ward accommodation on payment of the difference between the public ward daily charge and the intermediate ward daily charge. This would mean that such contributors would have to arrange for their own medical attendant and hospital extras.

DEPENDENTS.

As there is normally only one breadwinner in the family upon whom the burden of hospital expenses invariably falls, contributory schemes should cover husband, wife, and children up to the age of 16 years. Another point is the dependence of an aged mother, father, or

other relative dependent on the contributor. Whether such contributor be married or single, the dependent should be admitted to hospital on the single contribution of the wage-earning contributor.

It should be unreservedly accepted by the contributors that application for admission to the hospital must be subject to accommodation being available at the time.

GENERAL.

It is the opinion of your Commissioners that much can be done in the direction of the establishment of group subscriptions, and they *recommend* that Hospital Boards and Hospital Committees be urged to give the matter immediate attention and to co-operate with employers and employees for their mutual benefit.

REFERENCE No. 6.—The method of appointment of the honorary medical staff of public hospitals; the advisability or otherwise of the honorary medical staff being represented upon the governing body of the hospital; and whether doctors, other than members of the honorary medical staff, should be permitted to attend patients in the hospitals or intermediate wards.

(*a*) THE METHOD OF APPOINTMENT OF THE HONORARY MEDICAL STAFF AT PUBLIC HOSPITALS.

In the public hospitals administered by the Brisbane and South Coast Hospitals Board, the Advisory Board assists the former in matters relating to the honorary medical staff, and, under By-law No. 22 of the Advisory Board, also notifies the Hospitals Board of any further appointments to, or reduction in, the honorary medical staff which, in its opinion, are necessary.

At the present time the honorary staff consists of about ninety members, being approximately one-third of the qualified medical practitioners in the district.

The tenure of office of members of the honorary staff is limited to five years on either in-patients' or out-patients' staff, with provision for an extension of five years on the in-patients' staff. This arrangement has the disadvantage of retiring men at an age when their capabilities are at their best. Some of the present honorary staff, under the present by-laws, will have to retire at little over forty years of age. This does not appear to be to the advantage of either the patients or the community. The position will become accentuated on the inauguration of a medical school.

Your Commissioners *recommend* that, after consultation with the honorary medical staff, the Hospitals Board take steps to remedy this defect in the present system.

The usual custom outside the district of the Brisbane and South Coast Hospitals Board is that almost all duly qualified medical practitioners residing in the locality are, on application, appointed to the honorary medical staff of the public hospital by the Hospital Board or Committee. Some country hospitals have no honorary system.

Hospital Boards and Committees should have the discretionary power of rejecting an application for, or cancellation of, appointment to the honorary medical staff.

No evidence has been submitted which would suggest a need for a change in the method of appointment to the honorary staff, and your Commissioners, therefore, do not recommend any departure from the present system.

(*b*) THE ADVISABILITY OR OTHERWISE OF THE HONORARY MEDICAL STAFF BEING REPRESENTED UPON THE GOVERNING BODY OF THE HOSPITALS.

This matter is dealt with by your Commissioners under Reference No. 8—page 32.

The Chairman dissents (*see* page 52).

(*c*) WHETHER DOCTORS OTHER THAN MEMBERS OF THE HONORARY MEDICAL STAFF SHOULD BE PERMITTED TO ATTEND PATIENTS IN THE HOSPITALS OR INTERMEDIATE WARDS.

Public Wards.—Your Commissioners *recommend* that only members of the honorary medical staff be permitted to attend patients in the public wards of hospitals, with the undermentioned exception :—

Intermediate Wards.—It is a condition that patients who are admitted to intermediate wards be allowed the attendance of their own medical practitioner. In the opinion of your Commissioners this permission should not be denied if such a patient be accommodated in the public ward of the hospital owing to the lack of intermediate ward accommodation.

REFERENCE No. 7.—Whether under present conditions the facilities for the training of nurses in public hospitals is satisfactory.

In addition to the general invitation by public advertisement, your Commissioners caused notices to be posted in the hospitals visited by them inviting the nurses to give evidence if they so desired.

The evidence submitted tends to show that the limitation of duty to 44 hours per week is detrimental to the training of nurses, and is not in the interests of the patients.

Your Commissioners were much impressed by the evidence of Miss Florence Chatfield, the Lady Superintendent of the Diamantina Hospital, Brisbane, whose general experience on this subject is unsurpassed, and whose evidence is substantially supported by all the evidence submitted, with one or two minor exceptions. For these reasons we quote the following portion of her evidence :—

> "My experience in the nursing profession, which includes thirty years of administrative work, has given me ample opportunities for observing the trend of events and their results as affecting the nurse and her work.
>
> While realising very fully that, for many years, the working hours of nurses were unduly long, I am definitely of the opinion that the pendulum has now swung too far in the opposite direction, and present working hours are too short for both the efficient training of the nurse and the welfare of the patient.
>
> In considering this matter it is necessary to bear in mind that nursing is a task that continues for twenty-four hours in each day. Further, it is the experience of all who have administered institutions under the present Award that compliance with the 44-hour week inevitably involves frequent broken periods of duty. The result of this must be considered from two distinct angles :—
>
> (*a*) That of the patient for whom the nursing service primarily exists ;
> (*b*) That of the nursing staff, and, in particular, the nurses in training.

(*a*) From the point of view of the patients, many of whom, owing to prolonged illness, are in an exhausted condition, the frequent changing of nurses necessitated by the 44-hour week is definitely a nervous strain. Further, it is only by regular repetition of a duty or treatment that both patient and nurse can learn how the necessary work can be accomplished with a minimum of pain, discomfort, or fatigue to the former. In the case of the sick and suffering that is, I consider, a matter of great importance.

Under the existing Award the frequent staff changes do not permit of the nurse acquiring this familiarity with her duties, and thus the suffering of the patients, both mental and physical, is increased.

(*b*) From the point of view of the nurse the position is equally harmful. The lack of continuity in her work not only prevents her obtaining the necessary knowledge of the technique of her duties (as mentioned in above paragraph), but prevents her acquiring the keen interest in her work which is so essential if the best ideals of the nursing profession are to be reached and maintained. This lack of interest, which I am not alone in observing, is not the fault of the nurse as much as of the conditions under which she labours.

Under the present system the theoretical side of the nurses' training is disproportionate to that of the practical.

While technical knowledge is very necessary, it is of secondary importance to the practical work, and in the nurse's training it is important that theory and practice should be well balanced.

Complaints such as are sometimes made by patients concerning their treatment while in hospital are based not only on any lack of theoretical knowledge, but invariably in the application of the practical work.

At the triennial meeting of the Australian Federation, held in Hobart in March this year, the question of working hours of nurses was discussed, and it was the opinion of the Council that the lack of continuity was prejudicial to training and not in the best interests of the patients. The following resolution was passed :—

> 'That it is the opinion of this meeting that, in the interests of nurses and patients, the minimum working hours of nurses should be ninety-six per fortnight, exclusive of meal time and recreation.' "

On the evidence submitted, your Commissioners are of opinion that the present limitation of hours fixed by the Board of Conciliation and Arbitration should be altered to 96 hours per fortnight, exclusive of meal time and recreation.

Whether this alteration should be obtained by application to the Board of Conciliation and Arbitration or by other appropriate action is, perhaps, beyond our function to recommend.

In all other respects your Commissioners are of opinion that under present conditions the facilities for the training of nurses in public hospitals are satisfactory.

The suggestion was made by one of the honorary medical staff of the Hospital for Sick Children, Brisbane, that the first three years of a girl's training should be at the hospital of her choice; the fourth year to be doing special work. This would, in the opinion of your Commissioners, have a tendency to prevent the acquirement of that all-round knowledge, training, and experience which is implied by the nurse's certificate of registration.

Your Commissioners suggest that earnest consideration be given by the responsible authorities to the following submitted by a medical practitioner in a country centre :—

(*a*) A return to the former order of conducting yearly examinations, with a final examination by the Queensland Nurses' Registration Board;

(*b*) The practical and oral examinations of the final examination to be conducted by two medical men and a matron;

(*c*) If the present sectional examinations are adhered to, the General Nursing Paper to be deleted from the first sectional examination, and to be held at the completion of the nurse's training;

(*d*) Copies of lectures in the various sections, as delivered in Brisbane, to be supplied to all training schools;

(*e*) Reports of the practical skill and ability of each nurse in the various sections to be forwarded by the matron and the superintendent for the guidance of the examiners of the Queensland Nurses' Registration;

(*f*) Direct representation of the Country Training Schools on the Queensland Nurses' Registration Board.

REFERENCE No. 8.—The administration of the Brisbane and South Coast Hospitals Board, the constitution of the Board, and whether there should be medical representation thereon.

GENERAL.

The Brisbane and South Coast Hospitals Board was constituted on the 9th May, 1924, under section 3 (1) of "*The Hospitals Act of* 1923."

The following Local Authorities are comprised within the area of the Board:—

City.—Brisbane.

Towns.—Coolangatta, Redcliffe, and Southport.

Shires.—Beenleigh, Caboolture, Cleveland, Coomera, Nerang, Pine, Tambourine, Tingalpa, and Waterford.

Such areas include approximately about one-third of the population of the State.

The Board is charged with the maintenance, management, and regulation of the Brisbane Hospital; Hospital for Sick Children, Brisbane; Lady Bowen Hospital, Brisbane; Lady Lamington Hospital, Brisbane; and of any other hospital established within the district which, with the consent of the Board, the Governor in Council declares to be a hospital under and subject to this Act. It also manages the Wattlebrae Infectious Diseases Hospital, under agreement with the Brisbane City Council.

The first Board consisted of—

Three members elected by the contributors to the hospital;
Three members appointed by the Governor in Council; and
Three members elected by the component Local Authorities.

The Board is empowered to elect its own chairman.

Section 9 of the Act provides, in effect, that if at the end of any triennial period (from May 1924) the contributions from contributors fall below one-third of the total amount received by the Board from the Treasurer, the component Local Authorities, and contributors, during the same period, the Governor in Council may reduce the number of members who may be elected by the contributors and assign an additional member or members to be elected by the Local Authorities or to be appointed by the Governor in Council.

The voluntary contributions during the past few years have decreased to such an extent that the contributors' representatives have been removed. One additional member has been allotted to the Local Authorities and two appointed by the Governor in Council. The representatives, therefore, on the Board at present are five representing the Government and four representing the Local Authorities.

Under section 6 of "*The Hospitals Act Amendment Act of* 1928" the contributors' representatives may be restored should the amount received by the Board from the contributors reach the proportion prescribed by the Act.

From the "maintenance" point of view the Brisbane Hospitals under the Board's control appear to have been administered in a careful manner. Statistical information submitted by the Board shows that the cost of maintenance compares very favourably with that of the larger hospitals in the Southern States. The figures relating to the Southern hospitals, which were also submitted by the Board, have, for comparative purposes, been accepted as correct.

Comparative average cost per patient or per occupied bed, however, cannot always be accepted as an infallible test of good management. Very rarely are two hospitals alike; conditions, prices, and consumption per head vary in different districts, and more particularly in different States.

WHETHER THERE SHOULD BE MEDICAL REPRESENTATION ON HOSPITALS BOARD.

In connection with the question of medical representation on the Board, a considerable amount of evidence was taken in Brisbane and at the various places visited by the Commission throughout the State. The majority of the witnesses examined on this question favoured the proposal of medical representation. The evidence given by representatives of country hospitals was generally adverse to such representation, whilst that submitted by the medical practitioners—supported by a few lay witnesses, some of whom represented Local Authorities and Hospitals—was naturally in favour. It must be understood that the position in the country districts in regard to this matter differs materially from that in the cities.

Notwithstanding the adverse evidence, we lean towards the medical profession being given one of the Government seats on the Brisbane and South Coast Hospitals Board and other large Boards, i.e., Boards controlling hospitals each having 100 beds or over; such medical representative to be nominated by the members of the medical profession in the Board's area.

A hospital of 100 beds has been suggested, because a city which has a hospital of that capacity would probably have a number of medical practitioners sufficiently large to afford a wide selection. In country places there may be only one or two practising medical men.

The services rendered by the honorary staff, if measured in cash, are worth a very considerable sum annually to the Board. Undeniably they receive some benefit from their association with the hospital, but that does not lessen the value of the work they perform without monetary recognition.

With the limited representation suggested, no possible harm could result. On the other hand, very valuable practical advice on hospital management and equipment could be given, which should be extremely helpful to members of the Board.

A fear has been expressed in certain quarters that the medical representatives, if appointed, would dominate the Board, but as they will seldom, if ever, have more than one member out of nine, such a fear must be baseless. If one member should succeed in dominating eight others he should be commended. Those who entertain ideas of that nature pay the doctors an unwarranted tribute, and, conversely, place the other members of the Board on an exceedingly low mental plane. However, if such an unlikely situation did arise, the Government and/or Local Authority could easily rectify the position by selecting men of stronger intellectual calibre to represent them.

It was suggested by certain witnesses that the presence of the medical superintendent at Board Meetings should be sufficient. But it is not. The medical superintendent, being a paid official of the Board, could not speak with that freedom and independence which should characterise a member of the Board. It is not difficult to imagine unpleasant feelings being aroused between a medical superintendent and a chairman or members of the Board if the former had the temerity to discuss the action of the Board. He would be placed in a very invidious position. A medical representative should be free, independent, and unfettered. An honorary, should one be elected, although looked upon to some extent as an employee of the Board, is in quite a different position from that of the medical superintendent. He could exercise, quite freely, the responsibility of full membership without fear of any consequences, if his views clashed with those of the other members. The medical superintendent, in certain circumstances, could not. Therefore, to be of any value, the medical representative appointed should be free and untrammelled.

Your Commissioners, therefore, *recommend* that when future appointments are being made to the Brisbane and South Coast, and other Hospitals Boards indicated, one of the Government nominees should be a member of the medical profession dissociated from the Public Service.

The Chairman dissents (*see* page 52).

GOVERNMENT REPRESENTATION ON BRISBANE AND SOUTH COAST HOSPITALS BOARD.

At the initial appearance of Mr. C. E. Chuter before the Commission he stated that he appeared in a dual capacity—firstly, as Assistant Under Secretary, Home Secretary's Department, and, therefore, the administrative officer responsible to the Minister for the administration of the Hospitals Acts in Queensland; and, secondly, as Chairman of the Brisbane and South Coast Hospitals Board.

Your Commissioners direct attention to the fact that, in their opinion, for many reasons it is neither politic, desirable, nor conducive to sound administration that the person holding the position of Under Secretary or Assistant Under Secretary of the Home Secretary's Department should be a Government nominee to any Hospital Board. *Inter alia*—

(*a*) It is anomalous for him as Under Secretary or Assistant Under Secretary to scrutinize his own work as a member of a Hospital Board, and this is accentuated should he be elected Chairman of the Board;

(*b*) The position is somewhat akin to that of an auditor of a company writing up the books of account of the company and then auditing and reporting to the shareholders on his own work.

Your Commissioners, therefore, *recommend* that the Assistant Under Secretary, Home Secretary's Department, cease to be one of the Government nominees to the Board of the Brisbane and South Coast Hospitals.

BY-LAWS.

Under section 28 of "*The Hospitals Act of* 1923" the Hospitals Board had by-laws gazetted prescribing the duties of the medical and other officers, matron, nurses, attendants, and servants of the hospitals. According to these by-laws the staff was arranged into sections and definitely placed under the supervision of the General Medical Superintendent and Matron respectively. Subsequently, without having the by-laws amended, the Board withdrew certain employees from the control of the officials named, and placed them under the direction of an officer (the Manager) whose office is not provided for in the by-laws, nor have his duties been defined therein.

From the evidence given by the Chairman (Mr. Chuter) it appears that the Board frequently ignored and overrode its own by-laws, which had been approved by the Governor in Council.

The Board's action might perhaps be excused in times of emergency, but during normal periods it cannot be justified.

Your Commissioners regret that a responsible Board should so flagrantly contravene the by-laws which have been duly approved by the Governor in Council. To set aside by-laws expressly framed for the guidance of officers and the proper working of the hospitals under the Board's control by the mere passing of a resolution is not only openly flouting the law, but establishes a very dangerous precedent and opens the door to administrative abuses. It also tends to weaken discipline throughout the whole institution.

HOUSEKEEPER.

As the duties of this officer are so closely allied to and interwoven with those of the nursing services, this official should, in the opinion of your Commissioners, be under the control of the Matron.

DIETARY SCALE OF NURSING STAFF.

The attention of the Commission has been directed to this matter. Inquiries elicited the fact that a uniform treatment was not accorded certain members of the nursing staff. The Sisters, conjointly with the Resident Medical Staff, are allowed a more liberal scale than that allotted to the other grades. While offering no objection to the menu granted to the doctors, the Commission considers it unwise to differentiate between the several grades of nurses. Such a course tends to create dissatisfaction.

Your Commissioners, therefore, *recommend* that the nursing staff of all grades—apart from the Matron—be granted the same dietary allowance. This scale should be as liberal as possible without unduly burdening the finances of the institution. The present dietary scale for the nurses could be slightly improved. The Board should take this matter into consideration at the earliest convenient date.

PURCHASE OF SURGICAL INSTRUMENTS.

The policy of the Brisbane and South Coast Hospitals Board to purchase all instruments through the State Stores Board was unfavourably commented on by the representative of the Honorary Medical Staff (Dr. Meyers), who stated that this sort of thing makes for delay in the routine work of the hospital.

The Advisory Board passed a resolution that "In cases of emergency the Medical Superintendent be allowed to expend an amount up to £10 for the purchase of surgical instruments." This request was refused by the Hospitals Board, and the practice of procuring supplies through the State Stores Board was continued.

In cases of grave emergency to avoid delays dangerous to the patient, your Commissioners suggest that the Medical Superintendent should be empowered to purchase instruments to the value of £10, reporting the matter to the Board at the earliest opportunity.

POWERS OF ADVISORY BOARD.

The members of the honorary staff, as represented by their witness (Dr. Meyers), commented adversely on the fact that the powers of the Advisory Board had not been enlarged in accordance with their wishes, or as promised.

The position of the Advisory Board is at present as defined by By-laws Nos. 21 and 22. Its duties are defined by By-law No. 22 and, as an Advisory Board, are confined to matters relating to making recommendations concerning the members of the honorary staff. It does not possess any defined authority to give advice to, or right to be consulted by, the Hospitals Board on any other matter. It has no defined status in so far as giving advice on administration is concerned, nor to serve as the mouthpiece of the honorary staff.

In the by-laws this Board is designated as the "Advisory Board," but it has been frequently referred to by witnesses as the "Medical Advisory Board." This duality of names must be borne in mind in order to avoid confusion.

In September 1927, at the request of the British Medical Association, a conference was convened by the Hospitals Board of representatives of a number of public bodies, hospitals, &c. The following resolution was carried :—

> "The Home Secretary be asked to appoint a technical Advisory Board, consisting of one representative chosen by the City Planner's Department of the City Council, one chosen by members of the medical profession, and one architect chosen by the Institute of Architects. This body shall act as a direct Advisory Board to the Home Secretary on all matters relating to the needs of the community so far as hospital facilities are concerned for the present and future, and should select qualified architects to develop plans for such institutions, as well as to advise on other matters appertaining to the sick."

In December 1927 an answer was given by the Home Secretary's Department to the effect that it had been decided to take no action at present in the direction of adopting the suggestion contained in the resolution.

In the meantime the Chairman of the Hospitals Board (Mr. C. E. Chuter) asked Dr. Eustace Russell, the then Chairman of the Advisory Board, to attend the next meeting of the Hospitals Board, which was held on 13th October, 1927. The Chairman then stated to the Board that "at a recent deputation of the British Medical Association which waited on the Home Secretary, members of the deputation had stated that the Advisory Board should be something more than an Advisory Board on medical matters; also that Mr. Stopford had expressly asked him (the Chairman) to explain that he (the Minister) had no intention of instructing the Board in the matter." Dr. Russell then addressed the Board. The Board resolved:—

> "That a sub-committee be appointed to meet representatives of the Advisory Board to bring up proposals to extend the functions of the Advisory Board, and that the Chairman, Deputy Chairman, and the Chairman of the Finance Committee be the sub-committee with the General Medical Superintendent."

The Advisory Board was informed of the resolution. In December following, a conference took place at which a memorandum of proposed alterations to the by-laws for the medical organisation, prepared by the Board, was submitted, as set out in the evidence. This memorandum was, in substance, a re-statement of the by-laws as they stood, with amendments.

The Advisory Board also submitted proposals for the alteration of the by-laws. These proposals appear in the evidence.

These suggested amendments by the Advisory Board were practically agreed to. They were not put into precise form as by-laws, neither were the proposals of the Hospitals Board, which were put before that conference in December 1927. It was proposed to extend the functions of the Advisory Board to the extent of authorising it to make recommendations upon any matter relating to the hospital service which it might deem desirable to promote efficiency. It was also suggested that, as a matter of procedure, a conference between the Board, the General Medical Superintendent, and the Advisory Board should take place regularly. The by-laws would lay down the procedure.

At the conference, in December 1927, it was stated:—

> "The Board is prepared to extend the functions of consultation in matters connected with the hospital service and its development, and the by-laws could establish the procedure. For instance, the by-laws might provide that certain specified matters, such as plans of building, proposals for new departments, medical equipment, new appointments, staff alterations, &c., should be matters for consultation, and thus be automatically referred to the Advisory Board, but the by-laws, as with all similar enactments, would say that the Board be not bound by any recommendation of the Advisory Board. It may be desirable to alter the name of the Advisory Board to Medical Advisory Council."

It was also suggested "that the Advisory Board should be heard in an officer's favour before the Hospital Board came to a final decision in the matter of the suspension of any officer."

It was further stated at that conference "that an alteration of the law would be required to give effect to the Board's proposals in their entirety, but that the Board had decided to ask for an alteration of the law, and the Board proposed to proceed with the drafting of the proposed new by-laws as if the powers existed."

The Hospitals Board approved of these proposed by-laws, and subsequently some matters were referred to the Advisory Board as if the proposed by-laws existed; one important exception being the plans of Block No. 2 hereinafter referred to.

This arrangement continued until after the laying of the foundation stone of No. 2 Block on 3rd August, 1928. Then, in consequence of matter appearing in the public press, the Hospitals Board rescinded its resolution which approved the by-laws creating a Medical Advisory Council and enlarging its function. It also recorded on the minutes of proceedings as follows :—

> "In view of what had occurred it will be necessary for the Board to be careful that the matters referred to the Medical Advisory Council shall be entirely within its discretion, and that the by-laws should declare that the Board will not bind itself to accept the advice of the Medical Advisory Council or to adopt any recommendation in any matter."

It seems to your Commissioners this action on the part of the Hospitals Board, to a very large extent, justified the assertion of the medical witnesses that the Hospitals Board failed to honour the understanding arrived at in the previous December.

On 26th February, 1929, a conference of members of the Hospitals Board and members representing the Advisory Board was held. Dr. McLean, the General Medical Superintendent, was present. The business of the conference arose out of a letter addressed to the Brisbane and South Coast Hospitals Board requesting that a conference be held to discuss the question of holding a public inquiry into the working of the hospitals. The conference was adjourned to 13th June, 1929. In the course of that conference amendments to the by-laws were discussed and substantially agreed upon, but their being put into definite legal form was held over until the Hospitals Acts were amended.

In December 1929 the Act was amended as suggested. Since then the formal amendments of the by-laws have been held over pending the appointment and report of this Commission.

Those amendments to the by-laws, having been substantially approved by the Hospitals Board and by the Advisory Board, should, in the opinion of your Commissioners, be made effective.

PLANS OF LAY-OUT OF NEW HOSPITAL.

On 31st July, 1928, a letter was sent from the British Medical Association to the Home Secretary's Department concerning the new hospital block, and the letter was forwarded to the Hospitals Board. It suggested, amongst other things, that it was a mistake to proceed with the building of the second block without first giving the medical men, who are responsible for the treatment of patients in the hospital, the opportunity of discussing with Mr. Conrad (architect) the latest phases of hospital building and equipment.

This was followed by a deputation from the British Medical Association which waited on the Home Secretary on 31st August, 1928, relative to the proposed five new blocks of the Brisbane Hospital, and particularly affecting the building of the second block. The Minister at that deputation said that when Mr. Conrad returned from abroad the

Board could ask the medical profession to come in and thrash the whole matter out. He made this suggestion not as an instruction to the Board, which had to bear the responsibility. Mr. Chuter said the Board had agreed to extend the functions of the Medical Advisory Council, and had no other intention than to refer the lay-out to the Advisory Board.

With respect to the Advisory Board's request that the complete plans of the new hospital be made available for its inspection, the matter was referred to the architects, who wrote to the effect that while they had a block plan of the complete hospital they were not satisfied that it was entirely suitable, and that it would certainly be altered. They did not think any good purpose would be served by even discussing its arrangement. The architects also wrote—"Mr. Conrad's plans for the third block are absolutely different from those of the first two. Upon the return of Mr. Conrad and Mr. Atkinson we propose to prepare a new block plan, but it will be grouped about the first five blocks in which there can be no alteration."

The plans of the whole scheme do not appear to have been shown to the Advisory Board until May 1930, when, at the conclusion of a conference between the Hospitals Board and the Advisory Board regarding the shortage of resident medical officers, members of the Advisory Board were shown for the first time, sketch plans (which were on a small scale) of the whole scheme. At Mr. Chuter's request, Mr. Conrad explained the scheme for about fifteen minutes—too short a time to form anything but a general idea of it.

The plans had not then been fully considered by the Hospitals Board, but it appears to have been the intention that, after the Hospitals Board had studied the scheme together with the sketch plans of No. 3 Block, the Advisory Board would be invited to study them and meet the architects in conference for a general discussion thereon. Thus the matter remains for the time being.

Your Commissioners *recommend* that before the plans for any building schemes are finally adopted they should be submitted to all parties interested, with an invitation to offer written suggestions. The views so obtained should be referred to a Building Sub-committee consisting of (*a*) a representative of the Hospitals Board, (*b*) a representative of the Advisory Board, (*c*) Medical Superintendent, (*d*) Matron, and (*e*) Architect.

PLANS OF BLOCK No. 2.

Although the by-laws to extend functions of the Advisory Board had not been amended, on two occasions, i.e., January and April 1928, certain matters, viz., provision for deep X-ray therapy and the radium clinic, were referred to this Board.

Early in May 1928, the Chairman of the Advisory Board (Dr. Eustace Russell) asked the Chairman of the Hospitals Board if the plans of the second block could be submitted to the former. In explanation before the Commission, the Chairman of the Board stated, "those plans had been prepared so long previously that it was not thought of as a matter which should have been referred to that Board."

The plans were forwarded to the Advisory Board on 16th May and returned on 19th May, 1928, with some minor suggestions, and a recommendation that Block No. 2 be not proceeded with until Mr. Conrad's

return, when the Advisory Board would like to consult him. This was followed on 5th June, 1928, by another letter conveying a resolution passed by the Advisory Board, as follows :—

> "That this Board requests that the complete plans of the new hospital be made available for inspection by the Advisory Board.
>
> Inasmuch as it is of the utmost importance that the second block should be considered in relation to the complete plan of the new hospital, the Advisory Board strongly recommends that the Brisbane and South Coast Hospitals Board should wait for Mr. Conrad's return before proceeding with the second block.
>
> The Advisory Board also requests that as soon as possible after Mr. Conrad's return members of the Advisory Board be given the opportunity of discussing the complete plans of the new hospitals with the architect of the Brisbane and South Coast Hospitals Board."

These were not unreasonable requests from the point of view of the Advisory Board, but the Brisbane and South Coast Hospitals Board decided to proceed with the erection of the second block and to call tenders, for the following reasons :—

> "The block was intended for ward accommodation; the Board had been strongly urged by the General Medical Superintendent to construct them, in order to relieve the overcrowding; the necessary financial provision had been made, and delay would have jeopardised the financial arrangements."

Under these circumstances your Commissioners are of the opinion that the Board was justified in going on with the erection of the second block at once, but consider it displayed a lamentable lack of courtesy in not advising the medical staff of its reasons for proceeding.

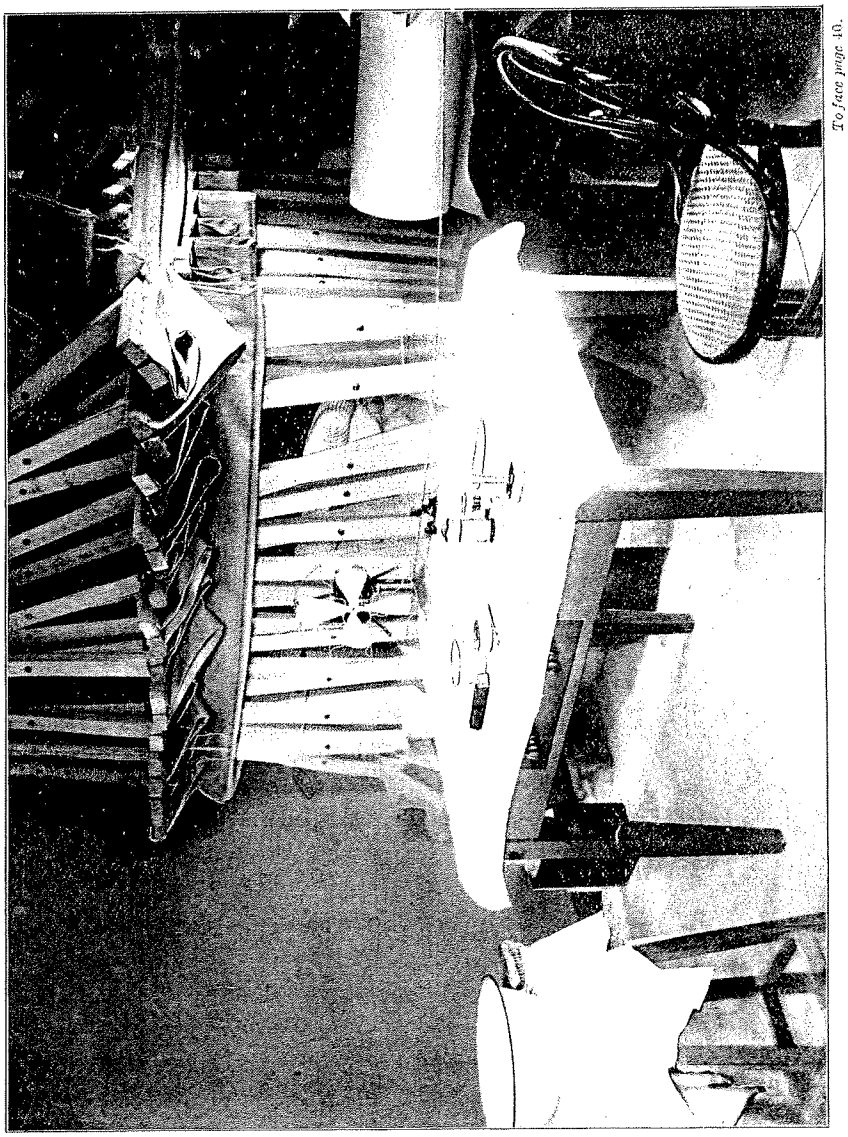
BUILDINGS.

Whilst your Commissioners agree with the statement that no reasonable administration could have postponed attempting to solve the lack of bed accommodation until the new hospital was built, they nevertheless draw attention to the fact that certain essential equipment in the Brisbane Hospital is not up to modern hospital standard.

The Senior Radiologist in the Brisbane Hospital and the staff of the X-ray department complain of want of accommodation, and that the work of the department is hampered by want of space and of further equipment.

The Melbourne department does approximately three times as much work as the one at Brisbane (30,000 as to 10,000). The Melbourne staff includes eleven individuals, and the Brisbane staff as many as eight for approximately one-third of the work. The reasons given for the disproportion expressed by these figures are "more space, better accommodation, and more machinery at Melbourne." According to the evidence, the Brisbane X-ray department is now working at its maximum capacity, and it is stated by the Senior Radiologist it is doing so "with considerable risk to staff and patients." He further states that the work is continually increasing.

Your Commissioners feel that an error was made in establishing maternity homes at large expense in many districts where they were both unasked and unnecessary, while the Medical Superintendent of the metropolitan hospital was so loudly calling for additional bed accommodation, and the honorary medical staff of that hospital was complaining of deficient equipment in their departments. Obviously the Brisbane and South Coast Hospitals Board cannot be held responsible for this.



To face page 40.

FIG. 3.

APPENDIX 4.

AIR CONTAMINATION EXPERIMENTS CARRIED OUT AT BUNDABERG.

These experiments were performed in the Engineer's Room at the Council Chamber using rubber-capped bottles of batch 78A.

Into each of these bottles air in varying amounts was injected, using syringes and needles which had been sterilized by boiling in water for 25 minutes. The sterilization was performed at the Hospital, and the syringes were transported in a closed aluminium saucepan in which they had been boiled. The syringes were fitted together in the saucepan with forceps sterilized by flaming. Two injections were made into each bottle through the liquid, the needle being plunged to the bottom of the container through the top of the rubber cap which had been sterilized either by pouring methylated spirits into the cavity and burning it out with the flame of a spirit lamp or by the use of Dr. Thomson's iodine "pencil."

After bubbling the air through the toxin-antitoxin mixture, the needle was withdrawn out of the liquid and the excess of air in the bottle removed by withdrawing the piston. The needle was now withdrawn from the bottle, the air emptied out of the syringe, and a fresh sample taken into it. The rubber cap was once again punctured and the procedure described above was repeated.

After inoculating the bottles with air in this manner, they were kept at room temperature packed in cotton wool in a closed box, which was placed inside a suit case. They were examined at Brisbane on the 16th February for turbidity, and again at Sydney on the 19th February. A guinea pig was inoculated on this latter date with 1 c.cm. from each of those bottles which showed any trace of turbidity.

On the 22nd February, 1928, at Melbourne, guinea pigs were injected with 1 c.cm. from all the bottles used in the experiment, and subcultures on blood agar were made at the same time.

In carrying out the experiments at Bundaberg, the north window and the door of the room were kept open. In some experiments the fan was "on" and in others, when the fan was "off" the air in the room was not perfectly still owing to a slight breeze.

The bottles were inoculated at varying times on the 13th and 14th February. Altogether six bottles were inoculated with the fan "off" and the air in the room perfectly still; seven at times when there was a slight wind blowing in from the north through the open window and door, and eleven when the fan was working, placed in a similar position in regard to the bottles which were being inoculated as that which it occupied during Dr. Thomson's inoculations.

No toxicity was developed in any of the bottles as judged by the results of inoculations in guinea pigs, none of which showed any infiltration at the site of inoculation or any serious loss of weight except F5, inoculated on the 19th February, which died on the fifteenth day. No definite lesions were found at autopsy and the heart blood was sterile.

The results of these experiments are set out in tabular form together with a summary of results.

—	Time Injected.	Sterilization of Cap.	Vol. Air Injected.	Fan.	Clear or Turbid.	Cultures, 22nd February, 1928.
F1	10 a.m., 14th February, 1928	Iodine	6·0 c.cm.	On ..	Turbid, 16th February, 1928	Staphylococcus albus.
F2	10 a.m., 14th February, 1928	Iodine	6·0 c.cm.	On ..	Turbid, 16th February, 1928	Slender Gram negative bacillus.
F3	10 a.m., 14th February, 1928	Iodine	6·0 c.cm.	On ..	Turbid, 16th February, 1928	Staphylococcus albus and stout pleomorphic Gram negative cocco-bacillus.
F4	10 a.m., 14th February, 1928	Iodine	2·0 c.cm.	On ..	Clear, 29th February, 1928	Sterile.
F5	6 p.m., 14th February, 1928	Heat	6·0 c.cm.	On ..	Turbid, 16th February, 1928	Staphylococcus albus. Large Gram negative cocco-bacillus.
F6	6 p.m., 14th February, 1928	Heat	6·0 c.cm.	On ..	Turbid, 16th February, 1928.	Staphylococcus albus.
F7	6 p.m., 14th February, 1928	Heat	6·0 c.cm.	On ..	Turbid, 16th February, 1928.	Staphylococcus aureus

AIR CONTAMINATION EXPERIMENTS CARRIED OUT AT BUNDABERG—*continued.*

—	Time Injected.	Sterilization of Cap.	Vol. Air Injected.	Fan.	Clear or Turbid.	Cultures, 22nd February, 1928.
F8	7 p.m., 13th February, 1928	Heat	6·c.cm.	Off (wind)	Turbid, with large flakes of growth, 16th February, 1928	Staphylococcus albus (haemolytic). Staphylococcus albus (non-haemolytic). Streptothrix and Gram positive diplococci.
F9	6 p.m., 14th February, 1928	Heat	2·0 c.cm.	On ..	Clear, 29th February, 1928	Sterile.
F10	6 p.m., 14th February, 1928	Heat	2·0 c.cm.	On ..	Clear, 29th February, 1928	Sterile.
F11	6 p.m., 14th February, 1928	Heat	2·0 c.cm.	On ..	Clear, 29th February, 1928	Sterile.
F12	6 p.m., 14th February, 1928	Heat	6·0 c.cm.	On ..	Clear, 29th February, 1928	Sterile.
F13	6 p.m., 13th February, 1928	Heat	6·0 c.cm.	Off ..	Clear, 29th February, 1928	Sterile.
F14	6 p.m., 13th February, 1928	Heat	2·0 c.cm.	Off ..	Clear, 29th February, 1928	Sterile.
F15	6 p.m., 13th February, 1928	Heat	6·0 c.cm.	Off ..	Clear, 29th February, 1928	Sterile.
F16	7 p.m., 13th February, 1928	Heat	6·0 c.cm.	Off (wind)	Clear, 29th February, 1928	Sterile.
F17	7 p.m., 13th February, 1928	Heat	2·0 c.cm.	Off (wind)	Clear, 29th February, 1928	Sterile.
F18	6 p.m., 13th February, 1928	Heat	6·0 c.cm.	Off ..	Clear, 29th February, 1928	Sterile.
F19	7 p.m., 13th February, 1928	Iodine	2·0 c.cm.	Off (wind)	Clear, 29th February, 1928	Sterile.
F20	6.30 p.m., 13th February, 1928	Iodine	2·0 c.cm.	Off (wind)	Clear, 29th February, 1928	Sterile.
F21	6 p.m., 13th February, 1928	Iodine	6·0 c.cm.	Off ..	Clear, 29th February, 1928	Sterile.
F22	6.30 p.m., 13th February, 1928	Iodine	2·0 c.cm.	Off (wind)	Clear, 29th February, 1928	Sterile.
F23	6 p.m., 13th February, 1928	Iodine	2·0 c.cm.	Off ..	Clear, 29th February, 1928	Sterile.
F24	6.50 p.m., 13th February, 1928	Iodine	6·0 c.cm.	Off (wind)	Clear, 29th February, 1928	Sterile.

SUMMARY OF RESULTS.

—	Fan Off.	Fan Off, Slight Wind.	Fan On.
Sterile	6	6	5
Contaminated	0	1	6

It will be noted that of six bottles inoculated when the air in the room was still, none were contaminated, but of seven inoculated when the fan was not working and when there was a mild breeze blowing, one was contaminated, and of eleven inoculated with the fan in action, six were proved to be contaminated. Variable amounts of air were injected, as will be seen in the table, and all seven contaminated bottles in the experiments had had a larger amount of air passed through them.

In Melbourne, on the 8th March, 1928, we made a further smaller experiment, in which we studied the effect of the presence of 0·5 per cent. phenol in preventing air borne contamination.

Eight rubber-capped bottles, four of batch 78A, containing no antiseptic, and four of batch 111, containing 0·5 per cent. phenol were inoculated each with 10 c.cm. of air. The syringes and needles were sterilized by boiling in water for twenty-five minutes, and the top of the rubber-capped bottles were sterilized with tincture of iodine. Air from a large fan was blowing directly on to the bench while the inoculations were being carried out.

The bottles were incubated at 26·6° C. for eighteen days and at the end of this period those which contained phenol were still perfectly clear. All four bottles of batch 78A were turbid by the fourth day, one being only very slightly so. On 13th March, 1928, subcultures of 0·2 c.cm. from each bottle were made into 10 c.cm. of broth and stroke cultures of the turbid bottles on

totalling £1,381 being charged to the amount of the contract. Thus were saved annual instalments of interest and redemption amounting to £95 0s. 8d. for a period of thirty years—the term of the loan. For its foresight in this matter the Board is deserving of warm commendation.

In view of the fact that the Government is liable under the Hospitals Act for 60 per cent. of the Board's annual deficits, your Commissioners consider, and *recommend*, that when applications for loans are made to the Treasury by any Hospital Board for the purpose of erecting hospital buildings, the granting of such loans should be conditional on the work, as under, being carried out by the Department of Public Works :—

(1) Preparation of plans and specification ;
(2) Invitation of tenders ;
(3) Acceptance of tenders ;
(4) Supervision of the work.

The question whether architectural or other services for Hospital Boards (or any Local Authority) should continue to be performed gratuitously by the Works Department is debatable. Such work may, of course, be looked upon in the light of additional Government endowment to hospitals, but the Commission favours the view that, while the Department ought not to aim at making a profit, it should be reimbursed at least to the extent of the actual cost of the services rendered. Even if the Works Department were paid in full for its services, your Commissioners consider that the cost to the taxpayers would not exceed two-thirds of that involved by the employment of private architects.

(*See* rider of Mr. Commissioner Jackson, M.B., page 60.)

The Chairman dissents (*see* page 53).

WATTLEBRAE INFECTIOUS DISEASES HOSPITAL.

There is another matter which, although not strictly within the administrative duties of the Board under "*The Hospitals Acts*, 1923 *to* 1929," has been brought under its administration by arrangement with the Brisbane City Council, i.e., the Wattlebrae Infectious Diseases Hospital.

Plans for a new building were completed in 1927 at the instance of the Brisbane City Council, but it was not until 1929 that that Council was able to make the necessary financial provision. In June of that year the Chairman of the Health Committee arranged that the plans should be available for examination by representatives of the British Medical Association, and on 20th June, 1929, Dr. Gifford Croll and Dr. Fancourt McDonald examined the plans in detail. Dr. McLean (Medical Superintendent), Dr. G. W. F. Paul (Medical Officer of Health), Alderman Stimpson (Chairman of the Health Committee), and Mr. A. J. Foster (City Architect) were in attendance.

The plans, according to Mr. Foster, took nearly two years to prepare, slowly and carefully, and were prepared in consultation with Drs. McLean and Tilling. Drs. Croll and Fancourt McDonald, who were representing the British Medical Association, expressed satisfaction at the lay-out generally, with the exception that they considered the administrative block—where it was proposed to house the doctors—was somewhat far from the ward block, and it was suggested by them that the doctor's residence might be brought nearer the ward. At the conference Alderman Stimpson said he would convey the recommendation to the Health Committee and recommend same. Obviously he could not commit the Council.

The City Architect pointed out that "a building of a temporary nature could be built close to the ward—a somewhat inexpensive building —so that when the additional blocks were built it could be readily removed; a wooden building, which the City Architect estimated at approximately £1,000. Alderman Stimpson said he would see if that would be approved by the Council; but there was no definite assurance given that it would be built, and no foundations have ever been put in for the building nor have any plans been prepared. The City Architect stated he did not think there was any agreement at that conference that it would be actually built; it was certainly agreed to recommend it.

This new building at Wattlebrae Hospital has been, and is, entirely within the province of the Brisbane City Council, and not within that of the Brisbane and South Coast Hospitals Board. The suggestion that a separate building for doctor's residence, as proposed at the conference on 20th June, 1929, was started by foundations being prepared for it must have arisen from some misapprehension. Your Commissioners find, as a fact, that no such foundations were prepared or attempted.

The buildings are not yet finally completed. The original plans have not been amended except to the extent of providing an external stairway to the ward and operating room.

The Brisbane and South Coast Hospitals Board is not responsible in this matter. It is the responsibility of the Brisbane City Council, which doubtless will, before the buildings are finally complete, make all the provision that the medical authorities consulted by them agree to be necessary.

RELATIONSHIP BETWEEN BOARD AND HONORARY MEDICAL STAFF.

Investigation has disclosed the unpleasant truth that the relationship existing between the Brisbane and South Coast Hospitals Board and the Honorary Medical Staff of the Brisbane Hospital has degenerated into a state of open hostility. This was made manifest quite early in the proceedings.

At various times during the hearing of the evidence it was strikingly demonstrated that the ill-feeling between the Chairman of the Board and the Honorary Medical Staff is deep-seated; the gulf existing appears to be unbridgeable. Both parties may be responsible to some extent for this regrettable position.

The language that the Chairman of the Board permitted himself to use with respect to the principal witness for the Honorary Medical Staff and for the profession generally, when giving evidence before the Commission, was reprehensible, and his demeanour did not commend itself to your Commissioners.

Your Commissioners are of opinion that if the attitude of the members of the Hospitals Board was truly reflected in that of their principal witness (Mr. C. E. Chuter), when before the Commission, then they must share his responsibility in the matter.

The present condition of affairs should not be permitted to continue, as, in the absence of reasonable harmony between the two bodies, the welfare of those most vitally concerned, viz., the patients, must be prejudicially affected.

ACCOUNTING SYSTEM.

The accounting system, except in one important particular in the Admission Department, appears to be satisfactory. A notable weakness, however, and one that is capable of permitting serious irregularities, was detected in this branch.

Should the Board at any time desire to know the actual amount of patients' fees outstanding the Admission Officer could not, without much expenditure of time and labour, furnish the required information. When he did arrive at a figure, by listing the debits from the patients' cards and computing the amounts, its accuracy could not be guaranteed.

A "control" account in connection with patients' fees should be opened immediately. The keeping of this account should be the duty of the accountant.

At present, fees considered uncollectable are written off by the Admission Officer. This practice should not obtain. Once amounts are taken into the books of the hospital as part of the income of the institution, no officer, not even the manager, should have authority to write them off. That is a power to be exercised by the Board only. Full details of fees considered irrecoverable should be placed before the Finance Committee periodically. This committee should report to the Board, which should pass a resolution authorising their being written off.

Under the present system any number of cards could be removed from the cabinet, surreptitiously or otherwise, without being missed. With a "control" account in operation the loss of one card would be immediately detected.

It is surprising that such an important link in the accounting chain had not long ago been introduced by the Board's auditors. In June 1926 a "control" account was suggested by Mr. Ross of the Auditor-General's Department, when he made an investigation into the working of the institution, but the recommendation has not been acted upon.

Your Commissioners *recommend* the opening of this account forthwith.

ANNUAL REPORT.

At the present time no annual report is published by the Board of the Brisbane and South Coast Hospitals. In this respect the Board appears to be unique. The authorities and public who find the money for the carrying on of the institutions have a right to know how such funds have been disbursed. For statistical and comparative purposes the report would prove most useful. There is no necessity for an elaborate and costly publication. Under the circumstances your Commissioners *recommend* that the Brisbane and South Coast Hospitals Board issue and publish an annual report.

A copy of the annual report, containing the statements of account, shall be forwarded by the Board to the Minister—and the Commission, if appointed—and to each of the contributing Local Authorities.

REFERENCE No. 9.—The duties of the Medical Superintendent of the Brisbane General Hospital and the control he should have over the general management of the hospital and over the Honorary Medical Staff.

For some years past the Medical Superintendent of the Brisbane General Hospitals has also occupied the position of General Medical Superintendent of the hospitals under the control of the Brisbane and South Coast Hospitals Board.

The Chairman of the Board in giving evidence stated that the duties of the General Medical Superintendent had been under consideration by the main Board and the Advisory Board, and as the outcome of their combined endeavours an agreement had been arrived at between the two bodies, as follows :—

"(*a*) The General Medical Superintendent should be relieved of all but administrative duties.

(*b*) He shall be the medical administrator and the executive officer in whom is to be vested the duty and responsibility of seeing that the medical, technical, and nursing organisations function properly and efficiently, and in whom, therefore, must be vested the disciplinary responsibilities and powers.

(*c*) He shall be the executive medical adviser to the Board, and as such shall be responsible to report upon and make recommendations with regard to all matters necessary for the maintenance and development of an efficient and adequate hospital service in all its branches in the district of the Board.

Honorary Staffs.

It will be the responsibility of the General Medical Superintendent to consider and advise the Board as to—

(*a*) The honorary staffs required ; and

(*b*) The assignment of the work of the honorary staffs and the fixing of the days and hours of attendance of the honorary staffs,—

subject to the approval of the Board, but with the following provisos :—

(i.) That the Medical Advisory Board may make recommendations to the General Medical Superintendent or to the Board at any time with regard to these matters ;

(ii.) That the Board shall hear the Medical Advisory Board upon every report and recommendation made by the General Medical Superintendent to the Board with regard to these matters, unless in the first instance a recommendation has been made by the Advisory Board to the Superintendent and adopted by him—which fact would be stated in his report to the Board. The Board would, however, use its discretion as to whether it would refer the matter to the Advisory Board.

Disciplinary Powers of General Medical Superintendent in so far as they relate to the Honorary Staff.

It is proposed to invest the General Medical Superintendent with power no greater than suspension, with the right of appeal to an Appeal Board, constituted by a police magistrate and a representative each of the Hospitals Board and the Advisory Board."

Your Commissioners *recommend* that the proposed duties and powers as outlined (and which, as has been previously stated, have been agreed upon) be given effect to; it being understood that the person suspended should have the right of appeal to the Appeal Board.

In the proposed medical organisation provision is made for medical superintendents of the separate institutions. Your Commissioners commend this proposal for adoption.

REFERENCE No. 10.—The advisability of placing the Ambulance Brigade under the control of Hospitals.

Apart from the Queensland Ambulance Transport Brigade there are five instances of ambulance services attached to and under the control of hospitals, i.e., Maryborough, Goondiwindi, Chillagoe, Gayndah, and Ayr.

In the case of Maryborough, evidence was given that considerable economy had resulted both in overhead and running expenses since the Hospital Board had assumed control. A charge of one shilling per mile was made for transport. On the other hand it would appear that the public were not availing themselves of the service to the same extent as previously, as the mileage had considerably diminished and voluntary subscriptions had fallen off. It is noteworthy that, although it is some years since the ambulance service was taken over by this hospital, no way has yet been found of absorbing the ambulance staff into the hospital as wardsmen or dressers, although the matter is still under consideration.

The present system of control of the Queensland Ambulance Transport Brigade by voluntary local committees is surprisingly efficient, the committees being generally composed of good business men, easily accessible to the public, and quick to hear and give effect to any suggestions for improving the service of their centre. The freedom with which the Brigade's services are available without any charge to all classes of the community and to all places to which transport is required excites the admiration of the public, as expressed in generous financial support and in the services of many honorary bearers; indeed, there are instances where the public support is so generous as to have led to some extravagance.

These few instances could, we think, be better dealt with by departmental pressure than by change of system.

The President of the British Medical Association (Dr. S. Fancourt McDonald), after obtaining the opinions of many members of the association in city and country, makes the following statement:—"Against any question of amalgamation is the undoubted fact that, in nearly all centres, there exists a high state of efficiency, largely due to a very keen *esprit de corps*. This is a delicate and most precious plant, easily withered by official interference."

It appears to the Commission that if the Ambulance Brigade were placed under control of hospitals it would increase the burden on the taxpayers. In support of this statement we give a comparative statement of the purely ordinary receipts and expenditure of the ambulances at Gayndah, Goondiwindi, and Maryborough, prior, and subsequent, to amalgamation with the hospital. (*See* Appendix I.) By reference thereto it will be seen that for the four years preceding the amalgamation the average deficit at Maryborough was £692, and the average deficit for the succeeding four years was £1,340. Goondiwindi and Gayndah also show similar results.

Your Commissioners are of the opinion that it would not be advisable to place the Queensland Ambulance Transport Brigade under the control of the hospitals, and, therefore, do not recommend same.

ACT OF INCORPORATION.

There have been representations made to your Commissioners in favour of some form of centralised control, and to that end the Brigade should be incorporated. We are of the opinion that advice available from the present parent centre would have better results in practice than authoritative control, which would tend to diminish the pride and zeal of the local committees who have attained, on the whole, such excellent results in the past.

For these reasons your Commissioners do not think it would be advisable to give effect to the suggestion that the Brigade should be incorporated in such a way as to create a centralised control.

It is, however, desirable that there should be an Incorporation Act, as suggested by the witness Mr. Victor Drury of Dalby, so that the heavy expense in connection with deed occasioned by the death of a trustee may be avoided.

(*See* rider by Mr. Commissioner Jackson, M.B., page 59.)

REFERENCE No. 11.—The equity or otherwise of the present system under which Local Authorities bear the whole cost of the treatment of cases of infectious diseases and of the detention of carriers, suspects, &c.

Your Commissioners are of opinion that the practice of placing the whole burden of the upkeep of infectious diseases upon the Local Authority is not equitable.

There already exists a Commissioner of Health to the State of Queensland who, under a Minister as official head of the State Health Department, is charged with the carrying out of the Health Act. This official is responsible for seeing that the provisions of the Acts are carried out. It is in pursuance of such provisions that persons suffering from infectious diseases, or carriers of such diseases, are isolated or segregated in quarantine. In effect, the Commissioner of Health through the officers of his Department insists on this quarantine, yet his Department is not called upon to meet any of the expenses of the proceedings so insisted upon. It seems to your Commissioners that the Department responsible for ordering the quarantine should be, in part at least, responsible for the expense incurred.

Some witnesses suggest that these cases should be a charge on the Hospital Boards, and should be paid for in the same way as any other case. Under the present system in a districted hospital the only charge upon the Consolidated Revenue is 60 per cent. of whatever deficit there may be in the annual accounts of the hospital. The Local Authorities contribute 40 per cent. of such deficit.

In a hospital working under a voluntary system the charge at present falls—£2 on the Consolidated Revenue and £1 on the voluntary subscriber.

In neither case does the Health Department contribute any part of the expenses incurred in the upkeep of such quarantine as itself orders.

It is true that laboratories for the examination of specimens for infectious diseases are maintained in Toowoomba, Rockhampton, and Townsville; but these are maintained by the Federal and not the State Government. The Brisbane laboratory concerned with the examinations referred to is maintained by the Hospital Board and the City Council in equal proportions. It is in no way a charge upon the Health Department.

Your Commissioners received evidence which seemed to suggest that a closer co-ordination of Health Department and hospital in dealing with infectious diseases and their carriers is desirable. In one case, for instance, a carrier remained for two calendar months a charge, through the hospital, on the Local Authority.

Your Commissioners suggest that a closer association between hospital and Health Department might have lessened the stay of this carrier under treatment, and that this would be more easily attained if the Health Department were in some measure responsible for the expense incurred by such quarantine.

Apart from this, however, the whole outlook as to the degree of responsibility to be put upon Local Authorities in relation to infectious diseases has been much altered in late years by the discovery of the influence of what are called "carriers." As examples, take the two most common infectious diseases in Queensland, i.e., diphtheria and typhoid. Modern opinion holds that these two diseases are spread almost entirely by carriers, and that faulty sanitation so called is but rarely responsible. This is especially so in cities. The existence of a carrier or carriers in any district is not necessarily the result of any omission on the part of the Local Authority as regards cleaning its area. It seems to your Commissioners that the State Health Department is charged with the duty of dealing with carriers in such a way that their infectivity shall be removed from them. Carriers are not, themselves, necessarily sick people. They do not require treatment in a hospital on their own behalf, yet Local Authorities often find themselves burdened with the housing and keeping of a score or more of carriers and contacts for which they are not responsible. Under any circumstances the upkeep of these cases in certain Local Authorities so affects their funds that important works in the district are delayed. It requires little stretch of imagination to conceive of a case in some far-out country district in which a child urgently ill with diphtheria might be delayed in getting to hospital till it was too late, for want of a passable road or a bridge which might have been constructed but for the impoverishment of the Local Authority by a load of infectious diseases.

Both diphtheria and typhoid or enteric fever are regarded now as due to carriers. The same applies, less certainly, to scarlet fever. These diseases are conveyed by foods or fluids, generally milk and water. The presence of a carrier handling the food of a household is likely to be responsible for an epidemic, whether in rural or city areas. The epidemic will not be stopped till the carrier is removed or till all the people not immune have been infected.

Since medical opinion, which formerly held that the chief cause of the spread of such diseases was bad sanitation and cleansing in Local Authority areas, now attributes these diseases almost wholly to carriers, it is doubtful whether Local Authorities should not be relieved of the burden of the upkeep of infectious diseases.

Your Commissioners *recommend* that infectious disease costs should become a charge on Hospital Boards. In such a case Local Authorities will be subject to their proportion of the Board's deficit, and this, it is considered, should be a sufficient monetary liability, and thus guarantee the area being kept clean. In any event their representatives are responsible to their electors for any neglect in keeping the area free of disease.

The necessary alteration to the Health Act and Regulations will have to be made to give effect to this recommendation, if adopted.

The Chairman dissents (*see* page 55).

A summary of the recommendations will be found on page 61.

ACKNOWLEDGMENTS.

In conclusion, your Commissioners desire to acknowledge the assistance afforded by officers of the various Departments of the Public Service and Hospital and Ambulance authorities; also to record their appreciation of the zeal and efficiency with which Mr. W. Morton, Secretary to the Commission, has discharged his onerous duties.

We have the honour to be,

Your Excellency,

Yours obediently,

W. HARRIS, P.M. (CHAIRMAN),

E. SANDFORD JACKSON,

S. A. GLASSEY.

Brisbane,

20th November, 1930.

ADDENDUM BY THE CHAIRMAN.

CENTRAL HOSPITAL COMMISSION (REFERENCE No. 2).

The views expressed by the majority regarding the appointment of a Central Hospital Commission do not find favour with your Commissioner.

INSPECTOR-GENERAL OF HOSPITALS.

Hospital authorities have full responsibilities of administration, but at present there is a lack of co-ordination. This deficiency in the system could be overcome by an independent supervision. During the investigations of the Commission it was forcibly impressed upon your Commissioner that in the interests of economy and efficiency there was a need for some independent supervision. Under several headings in this Report are to be found matters which call for the necessity for same. At present, also, the benefit of experience of one institution is not directly available to any other.

Your Commissioner, therefore, *recommends* that there should be appointed an officer to be designated "Inspector-General of Hospitals." Such officer should have the general administration of the Hospitals Acts under the direction of the Minister.

There should also be appointed an Assistant Inspector, if and when deemed necessary, who should be under the control of the Inspector-General.

Such Inspector or Assistant Inspector should have power, without previous notice, of visiting and inspecting any institution at any time he may think fit. He should have power to call a special meeting of a Hospital Board or Committee or require the Chairman or Secretary of such Board or Committee to call such a meeting thereof. He should be entitled to be present at any meeting of a Board or Committee and to speak at any such meeting, but should not take any other part in the proceedings thereat.

Before approval is given for the establishment of any new hospital, additions to any existing hospital involving the expenditure of loan money, the amalgamation of any two or more hospitals or districts, the creation of a new hospital district, or the alteration of the boundaries of any district, such Inspector should make inquiry into the location of hospitals in the surrounding country, condition of roads and means of transport, the needs of the district or districts affected, and such other matters as are deemed necessary, and report thereon to the Minister.

He should have power to recommend that a particular hospital should be closed, and, generally, to make any other recommendations he may consider desirable.

One of the duties of such Inspector would be to closely scrutinise the work of the Admission Department.

Such Inspector should furnish an annual report for the last preceding financial year to the Minister, giving such particulars as to the administration of the Hospitals Acts as he thinks fit or as the Minister may require.

THE ADVISABILITY OR OTHERWISE OF THE HONORARY MEDICAL STAFF BEING REPRESENTED UPON THE GOVERNING BODY OF THE HOSPITAL (REFERENCE No. 6).

Your Commissioner is unable to agree with the conclusion arrived at by the majority. On the evidence there has been no sufficient reason advanced to justify him in recommending any change from the present system, which provides that the governing bodies of public hospitals shall consist wholly of representatives of those who provide the funds. Voluntary hospitals are financed by subscribers and the State Government, and hospitals under Hospital Boards are financed by contributors, by Local Authorities, and by the State Government.

The medical superintendent of the hospital is usually in attendance at ordinary meetings of the governing body. This appears to your Commissioner to give reasonable opportunity for the expression of the views of qualified men upon matters of hospital administration.

The suggestion that the honorary medical staff should be represented upon the governing body of the hospital was generally opposed by Hospital Boards, by Hospital Committees, and by Local Authorities.

The present provisions of the Act are wide enough to enable any of the appointing authorities to appoint, if they so desire, a member of the honorary medical staff or any medical man to the governing body.

Your Commissioner does not recommend any change from the present system.

WHETHER THERE SHOULD BE MEDICAL REPRESENTATION ON THE BRISBANE AND SOUTH COAST HOSPITALS BOARD (REFERENCE No. 8).

As set out in the submission of your Commissioner with respect to Reference No. 6, there has been no sufficient reason advanced to justify him in recommending any change from the present system, which provides that the governing body shall consist wholly of representatives of those who provide the funds, i.e., the contributors (when so entitled), the component Local Authorities, and the State Government.

The General Medical Superintendent of the Board's hospitals is almost invariably in attendance at ordinary meetings of the Board, and is available for consultation by the Board on all matters upon which professional advice is required.

The proposed amendments to the by-laws of the Board with respect to the Advisory Board, which in another portion of this Report your Commissioners have recommended should be given effect to, provide, *inter alia*, for the Advisory Board having direct access to the main Board, and also for conferences between the two bodies. This will enable the Advisory Board to give expression of opinion on matters of administration.

There is nothing in the present provisions of the Hospitals Acts which prevents the Governor in Council or the component Local Authorities appointing a medical man to the Board as their representative, if they so desire.

Your Commissioner reiterates the view that it is the community as a whole and not any particular section of it that is represented upon the Boards in whom the Act vests the responsibility for the administration of hospitals, and, therefore, does not recommend any change from the present system.

BUILDINGS (Reference No. 8).

One of the matters in respect of which the administration of the Brisbane and South Coast Hospitals Board has been seriously criticised is the matter of buildings. The principal witness for the British Medical Association states—"Despite the fact that it is seven years since the Brisbane and South Coast Hospitals Board commenced activities, Brisbane is still without a modern hospital, and that a cardinal mistake was made in attempting to solve the lack of bed accommodation and building a new hospital at the same time."

It seems to your Commissioner that no reasonable administration could have avoided attempting to solve lack of bed accommodation until the new hospital was built. The actual increase in normal or designed bed capacity in the period has been 33 per cent., and when No. 2 Block is completed, as it will be almost immediately, the increase will be 75 per cent. exclusive of stretchers. The present plans contemplate provision for a bed capacity of 1,250.

Prior to the constitution of the Brisbane and South Coast Hospitals Board the Brisbane (General) Hospital was substantially carried on as a Government institution, and in September 1923, under instructions from the Government authorities, the Department of Public Works prepared a re-building scheme for the Brisbane (General) Hospital.

The complete scheme provided for five 6-story ward blocks facing Bowen Bridge road, in which the two lower floors of the middle block were to be utilised for administration purposes, &c.; a 2-story service block in the centre, containing kitchen, nurses' and staff dining-rooms, cold storage accommodation, and general stores, &c.; 5-story block at the back; one 6-story operating theatre block on the south side, facing Herston road; and one 6-story block on the north side, facing O'Connell terrace—the lower floors of this block to contain doctors' quarters and the upper floors to be utilised for special wards. A casualty ward block was provided near entrance gates in Herston road.

An architect of the Department of Public Works and the Medical Superintendent had visited the Southern States and seen what was to be seen, besides studying available literature on the subject, and the above-mentioned scheme was prepared in consultation with the Medical Superintendent.

The Board, as already mentioned, was constituted on 9th May, 1924, and Alderman M. J. Barry, Mayor of Brisbane, became Chairman. On Alderman Barry's retirement from the Board he was succeeded as Chairman by Mr. R. N. F. Quinn, then Under Secretary, Department of Public Works, who held the office until the end of the first triennial period on 25th May, 1927.

At the first meeting of the new Board, on 25th May, 1927, Mr. C. E. Chuter was elected Chairman. He was re-elected on 25th May, 1930.

The scheme prepared by the Public Works Department was submitted to and approved by the first constituted Board, and the Public Works Department commenced to build Block No. 1 in January 1925.

Before Block No. 1 was completed the Board instructed the Public Works Department to prepare plans for Block No. 2, which plans were completed in September 1926.

Later in the year, during Mr. Quinn's chairmanship, the Board, acting as an independent authority which could formulate its own policy, decided to employ its own architects. It called for applications for the position. Messrs. Atkinson, Powell, and Conrad, a firm of architects, were appointed thereto.

In December 1927 the Board made arrangements for the necessary loan for No. 2 Block, and in January 1928 the working plans and specifications, upon which tenders could be called, were formally adopted by the Board. These were submitted to the Department of Public Works for approval, in accordance with a condition laid down by the Government in connection with Loan works.

The Department of Public Works questioned the plans, and then followed a discussion between the Board and the Works Department, which was terminated at a conference on 31st May, 1928. It appears from the evidence of Mr. Chuter that the discussion had reference to purely technical matters of construction and the application of the building ordinances, but had no reference to matters relating to location, lay-out, lighting, ventilation, or any of the matters which have been mentioned before your Commissioners.

These plans were before Professor Hawkins and a consulting engineer named McWilliams, passed by the City Council, and went before the Home Secretary and Department of Public Works. Tenders were called in June 1928.

In the meantime, i.e. early in 1928, Messrs. Conrad and Atkinson, junr., at that firm's expense, visited the United States of America, Canada, France, Germany, England, Java, and Singapore to investigate the latest developments in hospital architecture, construction, lay-out, organisation, and equipment.

It will thus be seen that the Board did not go about getting the accommodation for the hospital in a haphazard way. Before the contract was completed, Messrs. Conrad and Atkinson, junr., returned from abroad. As a result of their investigations, certain extra work was done by the contractors, on the architects' recommendation.

A considerable amount of comment has been made by some of the witnesses concerning the cost of Block No. 1, carried out by the Works Department by day labour, compared with the cost of Block No. 2, carried out under contract let by the Hospitals Board. It does not appear to be necessary to your Commissioner to go into this matter in detail, for the reason that many of the items of construction of the two blocks differed materially. Block No. 1 was completed in March 1928, at a total cost to the Hospitals Board of £66,046. The final figures for Block No. 2, which include all architects' fees and the total cost of installation of certain equipment not in building contract, are £59,884 19s. 6d. (*See* Appendix K.)

There were several requirements in building accommodation brought under the notice of your Commissioners by members of the honorary staff and others—apart from overcrowded wards—such, for instance, as the quarters for the resident medical staff, the X-ray department, &c., which are all very necessary, and are under contemplation in the re-building scheme. However, in the words of the General Medical Superintendent (Dr. McLean), "the first necessity is to get up wards and get over the

horrible state of overcrowding. My first ambition is to get some buildings, and get the patients out of the verandas and the middle of wards where they are lying under bad conditions."

Your Commissioner is satisfied that the administration of the Brisbane and South Coast Hospitals Board, with respect to the erection of buildings at the Brisbane Hospital, has been entirely sound, and that the Board has exercised that degree of care which might reasonably be expected of reasonable and prudent men in regard to their own business.

THE EQUITY OR OTHERWISE OF THE PRESENT SYSTEM UNDER WHICH LOCAL AUTHORITIES BEAR THE WHOLE COST OF THE TREATMENT OF CASES OF INFECTIOUS DISEASES AND OF THE DETENTION OF CARRIERS, SUSPECTS, &c. (REFERENCE No. 11).

Your Commissioner regrets he is unable to follow the reasoning of, or agree with the conclusions of, the majority.

In support of the contention of the Local Authorities of the inequity of the present system under which they bear the whole cost of the treatment of cases of infectious diseases and of the detention of carriers, suspects, &c., their representatives submitted that whereas the Local Authorities were called upon to bear the whole cost of treatment it was impossible to determine with any degree of certainty the area in which the disease had been originally contracted by the patient.

This subject has been much discussed for many years. The liability of Local Authorities in this respect must have been more comprehensive than at present, as it is found that at one time it included all infectious diseases. Later, Local Authorities were relieved of the responsibility of smallpox, cholera, plague, and yellow fever, but the cost of treating other infectious diseases (which have been described as "domestic") was still to be borne by the Local Authority.

The principal witness for the British Medical Association, in his evidence on this question, states—

> "I heard Dr. Croll this morning say that the Council of the British Medical Association had not considered the question of responsibility for infectious diseases patients. As a matter of fact it has. Evidently he was not aware of it, or he was dealing with the purely medical aspect of it. In regard to infectious diseases, we think that each Local Authority should be responsible for the hospital maintenance of all patients in its area suffering from infectious diseases."

Your Commissioner also quotes with approval the following evidence submitted by the representative of the Council of Agriculture :—

> "In this direction also primary producers, as contributors of the great bulk of the rates in rural Local Authority areas, are unduly penalised in that infectious cases occur more frequently in townships, however small, than on farms. A general campaign of education *re* the desirability of immunisation and inoculation—facilities for such to be provided free by Local Authorities—would appear to offer the best possibilities. In course of time it may be reasonably supposed there will be a general acceptance of the proved efficacy and the almost entire absence of risk connected with such preventive measures, and it may be found equitable to release Local Authorities from any obligation *re* the cost of treatment of infectious cases preventive treatment. It is not desirable to release Local Authorities from all liability *re* infectious disease, as they are responsible for public sanitation in all its phases."

In many infectious diseases the genesis of infection is in sanitation, and should a Local Authority neglect to keep its area clean it may become a danger to other parts of the State. It is obvious that no urging or remonstrance on the part of either the Commonwealth or State Government on Local Authorities would be so effective as the certainty of

having to bear any cost that might be brought about by their neglect. The chance of one Local Authority having to bear a burden for which it may not have been responsible is about equal to that of any other Local Authority.

The incidence of infectious diseases being largely under the control of those directly responsible for sanitation, i.e., the Local Authority, it appears to be equitable that those who neglected their duty in this respect should be called upon to pay, and their vigilance in enforcing sanitation be stimulated. But for that stimulation it is to be feared that many Local Authorities would become lax. The lessened suffering and cost to the community as a whole, brought about by the increased vigilance of the Local Authority, renders the present system more effective, and is, on the whole, not inequitable.

W. HARRIS, P.M. (Chairman).

RIDER BY MR. COMMISSIONER JACKSON, M.B.

CENTRAL HOSPITALS COMMISSION (REFERENCE No. 2).

It is the opinion of your Commissioner, indicated elsewhere, that the control of hospital administration throughout the State of Queensland should be in the hands of a central and permanent Commission. Such a Commission, in my opinion, should consist of three members—

(1) The Chairman, preferably a medical man of wide experience in hospital administration in Australia in all its branches, or, failing that, a layman with no small experience of hospital management and administration inside Australian hospitals ;

(2) A medical practitioner, male or female, to act as Inspector of Hospitals and be Deputy Chairman during the absence of the Chairman. Such individual to be physically capable of travelling to the utmost parts of the State if necessary, and in every way capable of making survey of the requirements of any district, both in relation to the establishment of new hospitals and ambulances and to those already established. This officer, like the Chairman, should have experience, if possible, of all sides of hospital management and administration ;

(3) An accountant of large experience.

The salaries paid to these officers should be such as to attract the most capable individuals to the appointments. For instance, the Chairman, £1,250 to £1,500 per annum ; the Deputy Chairman, £1,000 to £1,250 ; and the Accountant, £900 to £1,100. Such persons as would be attracted by these salaries would save their salaries over and over again in co-ordinating the affairs of hospitals throughout the State. They would effect economies and improve efficiency. It is desirable that the holders of such appointments should be tempted to remain long in the hospital service, in order that they may become *au fait* with the intricacies of hospital administration, and train others in that direction. It should be borne in mind that the suggested Hospital Commission would administer a service the annual cost of which would be in the vicinity of £700,000—for 1,000,000 people.

The duties of the Commission should include the supervision of all the activities at present connected with the care of the sick throughout Queensland. It should be much more closely associated with the work of the Health Department than it is at present. It would be to the

advantage of the State if these two departments (Health and Hospital) were under the same control for various reasons. The Health Department is concerned in the prevention of disease, and the hospital with the cure of disease and the alleviation of distress caused thereby. The closest possible liaison between the two is essential. As it appears to your Commissioner, this can best be secured only where direction of the two departments is under one control. Clearly it is undesirable that either should be subject to a Government Department under which the head of the controlling body is liable to be changed every few years. Government policy changes so much with every election that little continuity can be expected in the hospital policy of the State.

In the evidence given before your Commissioners at least one instance occurred in which the plea was made that an important step, obviously in the interests of a certain hospital and its coffers, was not taken because it was not in accord with the Government policy. It is true that the witness using that plea afterwards admitted that he had made a mistake, but the fact remains that such a plea was made, showing that the individual in question was not unwilling to shield himself behind the Government. This sort of thing makes hospital policy the sport of party politics, and should be minimised as far as possible. All questions in relation to local hospital administration should be decided by the intelligent and considered opinion of the local Board, aided if necessary by the advice of the Commission, and in no other way. This argument is equally potent whatever political party is in power.

The Hospital Commission should control the administration of all activities for the care of the sick in greater or less degree. Thus the following should be within the scope of its direction :—

(1) Public hospitals for acute diseases, general and special;
(2) Public hospitals for chronic diseases, general and special;
(3) Private hospitals, general and special;
(4) Maternity homes, public and private;
(5) Hospitals for infectious diseases;
(6) Sanatoria for tuberculosis;
(7) Ambulance hospitals;
(8) Ambulance transport;
(9) Bush nursing units.

With regard to the advantages to be derived from the transfer of hospital activities from a Government Department to a permanent Commission—It would lead to greater co-ordination among the activities for the care of the sick throughout the State, and thus to more efficient and economic administration than ever before. Money for use on behalf of the sick people of the State, collected under the schemes suggested by the Commission, would be more likely to be used with that end in view, and that end only. The welfare of the hospital service and the needs of the patients to whose wants it administers should be paramount. It would co-ordinate collective purchase and the economic issue and use of all hospital stores and equipment. It would render possible a much better training of hospital officials (lay and medical) in relation to the duties of economical management.

At present there is rather a tendency in many hospitals to dispute responsibility for any want of economy which may exist in the management of hospitals. The lay clerical staff is apt to throw the blame on the

"extravagance" of the medical staff. The latter are too frequently in the habit of regarding the business side of the hospital as one with which the Board does not expect them to interfere. In any case it is the opinion of your Commissioner that since the medical man is the one upon whom depends, more than on any other, the ordering of diets, of medicines, and of surgical equipment he should be *directly* responsible to the Hospital Board to see that all his requisitions are consistent with economy as well as efficiency, and that every member of the staff (lay, medical, and nursing) is doing efficient work.

Again, far too frequently, hospital boardsmen are found to be uninformed as to the average cost per bed occupied, and as to how that cost compares with other hospitals. A uniform system of accounts would be of much help. Such deficiencies in knowledge as these are not confined to any particular rank of officials, among whom there are, of course, many exceptions. But the exceptions are all too rare. There is need then of a Commission to take an interest in the training of hospital secretaries and young medical superintendents to fulfil their duties in the hospital service.

If private hospitals had been taken into the confidence of those responsible for public hospital administration much could have been done by their proprietors to assist in meeting the demands on the crowded accommodation of public hospitals. This is a matter that should be attended to by the Inspector in making a survey of a district where existing private hospitals—maternity hospitals, for instance—are doing good work, and meeting substantially the needs of the district. No Government hospitals should erect buildings which will put good private hospitals out of action or throw difficulties in their way.

The office of General Medical Superintendent of the hospitals under the Brisbane and South Coast Hospitals Board would no longer be necessary under the control of the suggested Commission. The present occupant of that office combines it with that of Medical Superintendent of the General Hospital, and is probably overloaded. He should be relieved of that part of his duties which pertains to the office of General Medical Superintendent. This suggestion is based on the supposition that there will be a medical superintendent for each hospital. The same remark applies to the office of General Matron, or Matron-in-Chief.

In certain country districts cottage hospitals have been established, with a paid staff consisting of doctor, matron, and nursing and domestic staffs. In the districts referred to the daily average of patients is so small that the average cost per occupied bed is inevitably high. Such hospitals, as at present run, cost approximately between £3,000 and £4,000 per annum. The average cost per bed in these hospitals varies from about 12s. to 100s. per day. On the evidence before your Commission, Bush Nursing Units cost much less to establish and maintain. The maintenance of a Bush Nursing Unit, as at present managed with efficient results, costs less than £500 per annum.

Your Commissioner *recommends* that, for any district making requisition for hospital accommodation, the choice as between a Cottage Hospital and Bush Nursing Unit shall be considered by the Central Commission. The point should only be decided after careful survey of the needs of the district.

CONTROL OF AMBULANCE (Reference No. 10).

In agreeing with my fellow Commissioners in the opinion expressed in our Report that no good purpose would be served at present by the combination of hospitals and ambulance under one control, I wish it to be clearly understood that I was not influenced in coming to that decision by certain arguments used by some ambulance officials. For instance, the following pleas carried no weight with me :—

(*a*) That under combined control ambulance men would develop into glorified wardsmen. That, after all, is what an ambulance man should be.

(*b*) That they would be unable and unlikely to give the same prompt attention to the transport of patients as they did when not under hospital control.

(*c*) That ambulance drivers and bearers brought under hospital control would forthwith lose all enthusiasm, for which they had formerly been so conspicuous. Of this plea the best that can be said is that it is a poor compliment to the humanity of the undoubtedly fine men who have hitherto served the Queensland Ambulance Transport Brigade. It was a bogey raised by some misguided advocate.

I am personally of opinion that the ambulance transport would not suffer in efficiency under hospital control, such as foreshadowed in the recommendations of the Commissioners throughout their Report. I am also of opinion that under such control it would be run more economically. Less money would be spent in the building of unnecessarily expensive garages and houses for the staff.

In one or two towns the Commissioners found out-patient departments being run by ambulances without medical control, while a similar department existed in the public hospital. One or other of these departments is redundant, and such a department would be more likely to get the requisite medical supervision if it were attached to the hospital. I am personally of opinion that under combined control of ambulance and hospital the efficiency of the former would be more likely to improve than to deteriorate. The ambulance system has wide popularity, but it is not so perfect that improvements could not be made. Such improvements would be more likely to come under combined control. For example, it would be more frequently possible to send a doctor and nurse with the ambulance, if necessary, than it is at present. In districts which are for the first time seeking to establish hospital and ambulance, the two most certainly should be under one control, and this is essentially so where they are to be maintained by voluntary contributions.

It is patent that for years past under the voluntary system, in the inevitable competition between ambulance and hospital in collecting funds, the latter has been at serious disadvantage. The work of the ambulance is more spectacular. Its power to use its superintendents and drivers as collectors in every district into which its cars went on service gave it an advantage for advertisement and propaganda which told heavily against contributions to the hospital. Thus it became a factor in the difficulties of hospitals working under the voluntary system. For this reason the hospital and the ambulance should, in the opinion of your Commissioner, be under one control, if both are to be supported by voluntary contribution.

If it were possible for the officers of the hospital to spend as much time in collecting funds for their institution as is given by ambulance officials to similar appeals for their institution the position might be considerably altered. One is struck by the almost complete absence of advertisement and propaganda used by hospital officials of the most excellent work they do.

BUILDINGS (Reference No. 8).

The scheme for the lay-out of the buildings which were to constitute the Brisbane General Hospital was adopted in 1884 by the then Government architect, Mr. J. J. Clark. It provided for single-storied pavilions with their long axes running north and south on a site of about eight acres, practically the whole of which sloped from west to east. The rows of buildings would therefore be slightly raised one above the other, with their long axes running north and south. This arrangement was adopted in order to secure the maximum of sunlight and fresh air. The prevailing breezes during summer are northerly. With the long axes of the buildings running north and south, and with no part of the buildings completely filling the space between the rows, the northerly breezes of summer were permitted the freest access possible to every space on the site, at the same time that a maximum of sunlight entered the spaces between the buildings—bearing in mind that in this Southern Hemisphere the sun crosses the sky from east to west northward of the meridian. Thus Mr. Clark's plan provided as far as possible for the easy access of sunlight and fresh air to every part of the hospital site. The low height of single-storied pavilions lent itself to this scheme.

As a part of the new and gigantic scheme adopted in the recent additions to buildings in the Brisbane General Hospital, the single-storied pavilion had necessarily to disappear. The increased height of the buildings rendered the admission of sunlight an even more important matter than it was before—and a more difficult. The architects responsible for building of Nos. 1 and 2 Blocks do not seem to have recognised any importance in retaining the plan of having the long axes of the buildings running north and south. They now run east and west. This, in the opinion of your Commissioner, constitutes a real defect in the method of lay-out, either in a temperate or a tropical zone.

There are two breezes in Queensland upon which special stress should be laid in hospital construction, though from entirely different points of view. It is important—

(1) To shield the buildings as much as possible from the cold westerly winds in the winter, and

(2) To admit to the site as far as possible in the summer time the all-important northerly breezes.

1. The slope of the site at Bowen Bridge Road from west to east and from above downwards secures protection from cold westerly winds in winter.

2. The need for a moving atmosphere is greatest during the summer months, and becomes accentuated where prevailing breeze is hampered in its access. In a room to which the prevailing breeze is not admitted, the comfort, and often the safety, of the patient demand the use of artificial fanning at considerable cost.

E. SANDFORD JACKSON.

SUMMARY OF RECOMMENDATIONS.

1. The best and most equitable method of financing public hospitals would be the creation of a Hospital Fund by the collection of a Special Hospital Tax on wages, salaries, and income, with an exemption to persons in receipt of not more than £1 per week from such sources. Page 14.

2. The difference between the estimated expenditure and estimated income of Hospital Boards should be paid— Page 14.

(*a*) Eighty per cent. from such Hospital Fund;
(*b*) Twenty per cent. by the component Local Authorities.

3. The basis of computing the quota to be contributed by the component Local Authorities under the precepts issued by the respective Hospital Boards should be altered from the "value of the rateable land" to that shown in column 9, Appendix A. Page 14.

4. On the levying of a special hospital tax, in consideration of public hospitals being considerably relieved by the domiciliary treatment given to members of Friendly Societies, *bona fide* members of such societies be provided with intermediate ward accommodation at the rate of 9s. per day with the right of their own doctor. Page 15.

5. Group subscriptions, or contributory schemes with an income limit, should be encouraged for the mutual benefit of hospitals, employers, and employees. The income limit should be left to the discretion of the various Hospital Boards and Committees. Page 15.

6. Hospital Boards and Committees should give consideration to the matter of making a charge on visitors in excess of two to any one patient on any one visiting day. Page 17.

7. Since medical opinion, which formerly held that the chief cause of the spread of diseases entitled "infectious" was bad sanitation and cleansing in local areas, now attributes these diseases almost wholly to carriers, the cost of treating patients suffering from infectious diseases, carriers and suspects, &c., should be a charge on Hospital Boards. Page 50.

8. The administration of the Hospitals Acts should be placed under the control of a permanent Commission of three members. Page 23.

9. A person holding the position of Under Secretary or Assistant Under Secretary of the Home Secretary's Department should not be a Government nominee to any Hospital Board. The present Assistant Under Secretary should, therefore, cease to be a Government representative on the Brisbane and South Coast Hospitals Board. Page 34.

10. In all future appointments to Hospital Boards which administer a hospital of 100 beds or over, one of the Government nominees to such Board should be a member of the medical profession, dissociated from the Public Service, and nominated by the members of the profession in the Board's area. Page 33.

11. When application for a loan is made to the Treasury by any Hospital Board for the purpose of erecting hospital buildings, the granting of such a loan should be conditional on the following work being carried out by the Department of Public Works:—Preparation of plans and specifications; invitation of tenders; acceptance of tenders; supervision of work. Page 43.

Page 38. 12. Before any building schemes are proceeded with, the plans thereof should be submitted to all parties interested for their consideration, with an invitation to offer written suggestions. The suggestions so obtained should be submitted to a building sub-committee.

Page 28. 13. As it is not to the advantage of either the patients or the community to retire members of the honorary medical staff when their capabilities are at their best, consideration should be given to the advisableness of extending the term of members of the honorary medical staff.

Page 21. 14. A condition of appointment to the nursing staff of a hospital should be the right of the Hospital Board to transfer the appointee either temporarily or permanently to another institution under the control of the Board.

Page 30. 15. In the interests of patients and to facilitate the training of nurses, the necessary action should be taken to increase the hours of duty of the nursing staff from forty-four hours per week to forty-eight hours per week, exclusive of meal hours.

Page 25. 16. A charge of 9s. per day for the public ward. Patients, on admission to such a ward or as soon thereafter as practicable, should be required to make a declaration of their ability or inability to pay such charges.

Page 26. 17. The establishment of intermediate wards in connection with public hospitals should be permitted where the conditions are favourable, after concentration on the adequacy and efficiency of the public wards. To such intermediate wards, patients would be admitted on payment of the full charge for maintenance and nursing attendance. Such wards should be under the control of the medical superintendent; but the patients should have the right to choose their own medical attendant and make their own arrangements as to his fees.

Page 24. 18. The rule under which a medical practitioner is held liable for the hospital fees of his patients admitted to the private ward of a hospital should be deleted, and a rule substituted, allowing such patients to be admitted to such wards, provided that the admission officer is satisfied the fees can be paid.

19. Economy would be effected to a very large extent by the adoption of the following recommendations:—

Page 21. (*a*) Hospital equipment and supplies, where possible, should be standardised, with a view to economical buying, by placing combined orders for delivery at centres as required.

Page 21. (*b*) In metropolitan and city hospitals there should be a sub-committee to whom all matters affecting economy regarding the purchase of drugs or instruments should be referred.

In urgent cases or for ordinary requirements in country districts the requisition should be signed by the medical superintendent or matron, and the secretary.

Page 20. (*c*) The establishment of a central agency for replaced serviceable equipment, thus enabling some hospitals to purchase plant and equipment at a reduced price.

Page 20. (*d*) On the receipt of supplies into an institution, every attention should be given to secure correct quantity as well as quality.

20. With a view to standardising and securing uniformity in hospital accounts a uniform set of the principal books be adopted. Page 22.

21. Brisbane and South Coast Hospitals—

(*a*) Action should be taken to expedite the making of by-laws which will give effect to the agreement arrived at between the Hospitals Board and the Advisory Board in regard to extending the functions of the latter body. Page 37.

(*b*) A "control" account in connection with patients' fees be opened forthwith. Page 45.

(*c*) The nursing staff of all grades—apart from the Matron—be granted the same dietary allowance. Page 34.

(*d*) The Board should give further consideration to the advisableness of allowing the General Medical Superintendent to purchase instruments to the value of ten pounds in cases of emergency. Page 35.

(*e*) The Housekeeper be removed from under the control of the Manager and placed under the control of the Matron. Page 34.

(*f*) Should the Government not deem it advisable to appoint a permanent Hospital Commission, the Hospitals Board should finalise its proposals to remove from the General Medical Superintendent all duties other than administrative, and to give that officer the power of suspension. Page 46.

(*g*) The Board should issue an annual report. Page 45.

APPENDICES.

Appendix A.

STATEMENT SHOWING ASSESSMENT OF LOCAL AUTHORITIES' PRECEPTS.

1. Hospital Board.	2. Local Authority.	3. Valuation.	4. Number of Rateable Properties.	5. Rates Levied.	Amounts calculated on a— 6. Valuation Basis. As per 3	7. Rateable Property Basis. As per 4	8. Rates Levied Basis. As per 5	9. Suggested Basis. Valuation plus number of Rateable Properties, plus Rates Levied. As per 3+4+5 / 3
		£	£	£	£	£	£	£
Atherton	Eacham Shire ..	425,805	1,499	18,678	1,430	1,328	1,712	1,490
Precept—£2,681	Tinaroo Shire	375,711	1,527	10,566	1,251	1,353	969	1,191
					2,681	2,681	2,681	2,681
Brisbane and South Coast	Brisbane City	22,780,227	98,505	989,161	30,574	28,182	31,570	30,108
	Coolangatta Town ..	220,850	2,197	8,715	325	629	278	411
	Redcliffe Town ..	288,118	4,310	13,205	418	1,233	422	691
	Southport Town ..	272,851	2,170	12,058	395	621	385	467
	Beenleigh Shire ..	134,392	825	5,078	192	236	162	197
	Caboolture Shire ..	330,237	2,058	7,300	481	589	233	434
Precept—£34,240	Cleveland Shire ..	134,355	1,618	4,758	195	434	152	260
	Coomera Shire	67,211	456	2,794	97	130	89	105
	Nerang Shire	326,829	3,214	10,603	486	920	338	582
	Pine Shire	310,429	1,302	6,466	453	372	206	344
	Tambourine Shire ..	245,660	1,625	5,848	357	465	187	336
	Tingalpa Shire ..	102,428	990	3,881	149	283	124	185
	Waterford Shire ..	88,004	542	3,231	127	155	103	129
					34,240	34,249	34,249	34,249
Bundaberg	Bundaberg City ..	377,737	3,370	22,439	1,741	2,846	3,071	2,553
Precept—£9,062	Gooburrum Shire ..	312,887	1,595	9,125	1,472	1,347	1,249	1,356
	Isis Shire	338,158	1,622	10,989	1,591	1,370	1,504	1,488
	Kolan Shire	400,867	1,477	9,571	1,023	1,248	1,310	1,494
	Perry Shire	139,746	891	2,326	652	753	318	574
	Woongarra Shire ..	357,171	1,774	11,763	1,683	1,498	1,610	1,597
					9,062	9,062	9,062	9,062
Cairns	Cairns City	567,036	3,219	32,514	3,060	2,901	3,432	3,131
Precept—£5,932	Cairns Shire	528,766	3,364	23,684	2,872	3,031	2,500	2,801
					5,932	5,932	5,932	5,932
Central Burnett ..	Dogilbo Shire	145,822	1,422	6,967	739	946	776	820
Precept—£2,804	Gayndah Shire ..	230,283	1,791	11,424	1,168	1,192	1,273	1,211
	Mundubbera Shire ..	176,994	1,000	6,775	897	666	755	773
					2,804	2,804	2,804	2,804
Cook	Cook Town	28,843	1,038	1,562	72	229	205	169
Precept—£383	Cook Shire	125,216	701	1,358	311	154	178	214
					383	383	383	383
Gladstone	Gladstone Town ..	89,550	865	4,851	187	304	488	326
Precept—£1,823	Calliope Shire	492,129	1,956	8,259	1,025	686	830	847
	Miriam Vale Shire ..	292,411	2,373	5,017	611	833	505	650
					1,823	1,823	1,823	1,823
Goondiwindi	Goondiwindi Town ..	40,614	489	2,739	123	427	361	304
Precept—£1,421	Waggamba Shire ..	525,353	1,139	8,034	1,298	994	1,060	1,117
					1,421	1,421	1,421	1,421

In the above figures, shillings and pence are omitted.

Quota under present method, *see* Column 6.
Quota under suggested method, *see* Column 9.

Appendix A—*continued.*

1. Hospital Board.	2. Local Authority.	3. Valuation.	4. Number of Rateable Properties.	5. Rates Levied.	Precept payable on— 6. Valuation Basis As per 3	7. Rateable Property Basis. As per 4	8. Rates Levied Basis. As per 5	9. Suggested Basis. Valuation plus number of Rateable Properties, plus Rates Levied. As per 3+4+5 / 3
		£	£	£	£	£	£	£
Gympie .. .. Precept—£2,104	Gympie City	187,825	2,044	13,660	260	460	544	421
	Kilkivan Shire ..	432,682	1,080	12,571	599	243	500	447
	Noosa Shire	375,596	2,168	10,955	521	488	436	482
	Widgee Shire ..	522,720	4,054	15,675	724	913	624	754
					2,104	2,104	2,104	2,104
Mackay .. .. Precept—£4,203	Mackay City	520,193	2,500	28,209	1,209	1,336	1,778	1,441
	Mirani Shire	307,818	1,477	9,282	715	789	585	696
	Nebo Shire	161,032	336	1,855	374	179	116	223
	Pioneer Shire	646,230	2,700	21,138	1,502	1,443	1,332	1,426
	Sarina Shire	173,221	854	6,217	403	456	392	417
					4,203	4,203	4,203	4,203
Maryborough .. .. Precept—£4,880	Maryborough City ..	303,798	3,430	19,379	1,682	1,590	2,330	1,867
	Burrum Shire	353,883	4,730	12,350	1,512	2,193	1,484	1,730
	Tiaro Shire	230,067	1,716	5,781	982	795	695	824
	Woocoo Shire	164,750	651	3,089	704	302	371	459
					4,880	4,880	4,880	4,880
Rockhampton .. .. Precept—£7,236	Rockhampton City ..	1,473,078	8,881	54,417	3,670	3,917	4,784	4,124
	Duaringa Shire ..	146,845	575	2,754	364	254	242	287
	Fitzroy Shire	526,887	2,587	10,178	1,308	1,141	895	1,114
	Livingstone Shire ..	759,949	4,361	14,904	1,894	1,924	1,315	1,711
					7,236	7,236	7,236	7,236
Roma .. .. Precept—£2,685	Roma Town	135,716	1,150	6,220	492	943	1,019	818
	Bungil Shire	432,891	1,052	7,147	1,568	862	1,170	1,200
	Bendemere Shire (part)	124,003	999	2,352	440	819	385	551
	Taroom Shire (part) ..	16,938	31	283	61	25	46	44
	Warroo Shire (part) ..	31,795	44	397	115	36	65	72
					2,685	2,685	2,685	2,685
Townsville .. .. Precept—£6,237	Townsville City ..	1,234,098	7,840	60,333	3,854	4,323	4,431	4,203
	Hinchinbrook Shire ..	480,179	1,845	20,007	1,506	1,017	1,470	1,331
	Thuringowa Shire ..	280,234	1,708	4,572	877	897	336	703
					6,237	6,237	6,237	6,237
Toowoomba .. .. Precept—£6,706	Toowoomba City ..	1,032,403	8,117	50,587	1,421	2,364	3,226	2,337
	Cambooya Shire (1928)	311,726	606	3,897	429	176	240	285
	Clifton Shire	487,385	1,524	7,472	671	444	477	530
	Crow's Nest Shire ..	302,103	1,057	3,953	416	308	252	325
	Drayton Shire	154,489	663	2,575	213	193	164	190
	Highfields Shire ..	204,470	798	2,466	282	232	157	224
	Jondaryan Shire ..	800,182	2,707	8,722	1,102	788	556	815
	Millmerran Shire ..	389,952	983	4,440	537	286	283	369
	Pittsworth Shire ..	418,280	1,319	5,619	576	384	358	439
	Rosalie Shire	448,976	2,742	7,866	618	799	502	640
	Tarampa Shire ..	320,548	2,514	7,549	441	732	482	552
					6,706	6,706	6,706	6,706
Warwick .. .. Precept—£1,865	Warwick Town ..	312,277	1,806	11,559	330	563	620	504
	Glengallan Shire ..	636,723	1,396	11,919	672	435	640	582
	Rosenthal Shire ..	484,950	2,130	4,557	512	664	245	474
	Allora Shire	332,970	653	6,709	351	203	360	305
					1,865	1,865	1,865	1,865

In the above figures, shillings and pence are omitted.

Quota under present method, *see* Column 6.

Quota under suggested method, *see* Column 9.

Appendix A—*continued.*

The two following statements show the amount payable by ratepayers per £ of valuation; per rateable property; the percentage of rates required to meet the precept; and also by a combination of the three foregoing methods (divided by 3) respectively.

GLADSTONE HOSPITAL BOARD.

Precept calculated on—	Precept: Pence per £ of Valuation.			Precept: Average per Rateable Property (in the absence of Number of Ratepayers).			Precept: Percentage of Rates Levied required to meet Precept.		
	Town.	Calliope.	Miriam Vale.	Town.	Calliope.	Miriam Vale.	Town.	Calliope.	Miriam Vale.
	d.	*s.*	*d.*	*s. d.*	*s. d.*	*s. d.*	%	%	%
A. Valuation + rateable properties + rates levied / 3	0·9	0·41	0·53	7 7	8 8	5 6	6·7	10·3	12·9
B. Valuations	0·5	0·5	0·5	4 4	10 6	5 2	3·9	12·4	12·1
C. Number of ratepayers (rateable properties)	0·82	0·33	0·68	7 0	7 0	7 0	6·3	8·3	16·6
D. Rates levied	1·31	0·41	0·41	11 3	8 6	4 3	10·1	10·1	10·1

MARYBOROUGH HOSPITAL BOARD.

Precept calculated on—	Precept: Pence per £ of Valuation.				Precept: Average per Rateable Property (in the absence of Number of Ratepayers).				Precept: Percentage of Total Rates Levied to meet Precept.			
	City.	Burrum.	Tiaro.	Woocoo	City.	Burrum.	Tiaro.	Woocoo.	City.	Burrum	Tiaro.	Woocoo.
	d.	*d.*	*d.*	*d.*	*s. d.*	*s. d.*	*s. d.*	*s. d.*	%	%	%	%
A. Valuation + rateable properties + rates levied / 3	1·14	1·17	0·86	0·66	10 11	7 4	9 7	14 1	9·6	14·0	14·3	14·9
B. Valuations	1·0	1·0	1·0	1·0	9 10	6 5	11 5	21 8	8·7	12·2	17·0	22·8
C. Number of rateable properties	0·97	1·49	0·83	0·44	9 3	9 3	9 3	9 3	8·2	17·7	13·8	9·8
D. Rates levied ..	1·42	1·0	0·72	0·54	13 7	6 3	8 1	11 5	12·0	12·0	12.0	12·0

A. Method suggested $\frac{B+C+D}{3}$

B. Present basis of rating—Unimproved capital value.

Appendix B.

QUEENSLAND HOSPITAL FACILITIES AND COSTS OVER FIVE-YEAR PERIODS.

	Ended 30th June, 1918.	Ended 30th June, 1923.	Ended 30th June, 1928.	Increase 1928 period over 1923.
				%
Number of hospitals	94	101	117	15·84
Number of in-patients	38,252	46,959	59,899	27·55
Total number of in-patients' days	701,686	823,348	897,769	9·04
Number of paid staff	1,286	1,847	2,268	22·79
Wages and salaries of staff	£105,991	£197,787	£300,721	52·04
Patients' payments	£34,597	£57,046	£112,128	96·55
Endowment and precepts	£185,412	£220,104	£265,275	20·52
Voluntary contributions	£69,903	£148,527	*£116,948	*a*21·26
Expenditure	£297,362	£490,965	£664,932	35·43

* Includes a proportion of group contributions.

a Decrease.

Appendix C.

AVERAGE ANNUAL AND DAILY COST PER OCCUPIED BED IN BOARDS' HOSPITALS, YEAR 1928-29.

Board.	Hospitals.	Beds.	Average Cost per Occupied Bed.	Daily Average Cost per Patient.
			£ s. d.	£ s. d.
Adavale	2	27	652 19 0	1 15 9
Atherton	2	68	200 2 0	0 11 0
Brisbane and South Coast	4	728	190 3 0	0 10 5
Bundaberg	5	192	306 11 0	0 16 10
Cairns	3	151	169 14 0	0 9 4
Central Burnett	3	67	285 0 0	0 15 7
Cook	1	18	494 2 0	1 7 1
Gladstone	2	44	374 2 0	1 0 6
Goondiwindi	1	44	312 18 0	0 17 2
Gympie	1	64	237 19 0	0 13 0
Jericho	1	18	533 6 0	1 9 3
Mackay	1	93	176 4 0	0 9 8
Maryborough	2	109	261 14 0	0 14 4
Port Douglas	1	25	280 12 0	0 15 5
Rockhampton	4	250	176 13 0	0 9 8
Tambo	1	30	564 0 0	1 10 11
Toowoomba	2	182	235 6 0	0 12 11
Townsville	2	220	184 7 0	0 10 1
Totals	28	2,330	211 7 0	0 11 7

Appendix D.

AVERAGE ANNUAL AND DAILY COST PER OCCUPIED BED OF THOSE VOLUNTARY HOSPITALS SHOWING THE HIGHEST AND LOWEST COSTS, 1928-29.

INCLUDING MATERNITY PATIENTS WHERE PROVISION MADE—ALSO OUT-PATIENTS.

Hospitals.	Annual Cost.	Daily Average Cost per Patient.	Beds.
	£ s. d.	£ s. d.	
Einasleigh	1,123 15 0	3 1 6	8
Georgetown	1,231 17 0	3 7 9	10
Jundah	1,329 10 0	3 12 11	15
Mount Molloy	1,608 0 0	4 9 4	6
Stannary Hills	1,634 12 0	4 9 6	9
*Wallumbilla	1,723 12 0	4 14 0	3
Kynuna—F.A.	2,121 1 0	5 15 8	8
Innisfail	164 16 0	0 9 0	43
Charters Towers	168 0 0	0 9 2	117
Mareeba	173 7 0	0 9 6	45
Wondai	176 7 0	0 9 8	26
Ipswich	178 13 0	0 9 0	164
Thursday Island	181 8 0	0 9 11	41
Kingaroy	198 2 0	0 10 10	25
Charleville	199 1 0	0 10 11	33
Mitchell	200 14 0	0 11 0	22
Stanthorpe	202 2 0	0 11 1	34
Miles	219 7 0	0 12 0	20
Mount Morgan	294 12 0	0 16 2	70
Totals for all voluntary hospitals	260 19 0	0 14 4	2,021

* Since came under Hospital Board.

Appendix E.

HOSPITAL STATISTICS—COMMONWEALTH—YEAR, 1927. (*a*)

Year 1927.	N. S. Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	N. Territory *	Total.
Number of hospitals ..	165	55	107	46	76	16	5	470
Patients—								
†Number of beds, &c.	8,683	4,110	4,009	1,857	2,138	777	83	21,657
Average daily number resident	7,174	2,649	2,809	1,209	1,104	565	46	15,556
Revenue—								
Fees of patients, &c.	£233,000	£89,073	£113,632	£74,716	£76,029	£34,384	£700	£621,534
Government grants ..	£788,740	£153,379	£283,959	£250,209	£125,005	£53,159	£5,693	£1,660,144
Total revenue ..	£1,715,019	£606,685	£603,730	£375,628	£260,765	£98,393	£6,393	£3,666,613
Staff—								
Medical	1,266	‡118	340	173	64	31	1	1,993
Nursing and attendants	3,326	2,009	2,465	1,037	1,043	246	14	10,140
Expenditure—								
Salaries and maintenance	£1,125,174	£452,431	£599,926	£254,442	£247,356	£70,912	£4,733	£2,754,974
Total expenditure ..	£1,671,059	£558,927	£671,567	£388,303	£261,760	£99,581	£5,693	£3,656,890

* Previous year's figures. † Excluding outdoor or veranda sleeping places. ‡ Salaried staff only.

(*a*) Latest Commonwealth figures available.

Appendix F1.

PAY PATIENTS' FEES—PERCENTAGE TO EXPENDITURE—QUEENSLAND HOSPITALS.

—	1926-27.	1927-28.	1928-29.
Hospital Boards—			
Expenditure	£353,763	£383,134	£382,973
Patients' fees	£57,582	£71,511	£69,596
Percentage to expenditure	16·3	18·7	18·2
Subsidised Hospitals—			
Expenditure	£281,647	£281,798	£285,623
Patients' fees	£43,161	£44,266	£47,894
Percentage to expenditure	15·3	15·7	16·8
All Hospitals—			
Expenditure	£635,410	£664,932	£668,596
Patients' fees	£100,743	£115,777	£117,490
Percentage to expenditure	15·9	17·4	17·6

Appendix F2.

PAY PATIENTS' FEES—PERCENTAGE TO EXPENDITURE—HOSPITALS—ALL STATES AND NORTHERN TERRITORY.

—	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Total.
1925.								
Expenditure	1,367,092	479,007	613,334	324,449	211,706	89,265	5,693	3,090,546
Patients' fees, &c.	184,961	75,647	95,186	79,260	61,489	29,607	700	526,850
Percentage to expenditure	13·5	15·8	15·5	24·4	29·0	33·2	12·3	17·0
1926.								
Expenditure	1,510,229	524,051	652,606	382,075	237,390	92,578	5,693	3,404,622
Patients' fees, &c.	211,942	81,460	105,005	76,630	74,559	32,610	700	582,906
Percentage to expenditure	14·0	15·5	16·1	20·1	31·4	35·2	12·3	17·1
1927.								
Expenditure	1,671,059	558,927	671,567	388,303	261,760	99,581	*5,693	3,656,890
Patients' fees, &c.	233,000	89,073	113,632	74,716	76,029	34,384	700	621,534
Percentage to expenditure	13·9	15·9	16·9	19·2	29·1	34·5	12·3	17·0

* Previous year's figures.

Appendix G.

LOAN INDEBTEDNESS OF HOSPITAL BOARDS AS AT 30TH JUNE.

Board.	1926.	1927.	1928.	1929.	1930.
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.
Atherton	..	3,442 5 0	12,774 17 9	14,006 11 6	15,278 11 6
Balonne	..	..	..	..	1,157 19 9
Brisbane and South Coast	91,335 9 5	132,858 1 1	150,337 15 3	187,699 15 8	231,162 3 4
Bundaberg	..	4,395 14 4	5,859 8 11	6,106 12 0	14,910 10 10
Cairns	5,453 9 4	6,878 5 2	18,513 11 2	18,986 3 8	19,037 5 5
Central Burnett	1,520 8 6	1,685 1 8	3,829 18 10	5,560 18 4	9,333 2 6
Gladstone	..	..	2,073 10 0	10,287 5 4	11,195 0 1
Goondiwindi	..	8,861 11 8	12,762 1 10	12,718 12 6	12,556 7 8
Gympie	..	1,700 0 0	1,888 16 0	2,756 10 10	5,806 11 0
Jericho	..	..	1,501 13 3	1,456 15 9	2,159 8 11
Mackay	..	..	2,206 13 0	14,301 17 11	17,248 9 10
Maryborough	1,336 0 5	4,195 1 10	19,301 3 8	26,499 15 4	38,578 8 1
Mossman (Port Douglas)	..	..	240 5 10	220 6 10	10,664 0 0
Rockhampton	..	2,342 18 2	11,603 6 6	14,699 12 0	25,400 2 4
Toowoomba	*1,061 19 7	†24,839 6 5	42,349 2 10	50,269 0 7	54,241 1 11
Townsville	326 19 0	2,201 1 3	10,005 6 11	11,504 14 5	19,366 9 10
Totals	101,034 6 3	193,399 6 7	295,247 11 9	377,974 12 8	488,995 13 0

* Amount owing by the Toowoomba Hospital in addition to the sum of £7,835 4s. 8d.—which was taken over by the Hospital Board during the following year.

† Includes £7,764 2s. 2d., balance of loan advanced to Toowoomba Hospital, now under the control of Toowoomba Hospital Board.

Appendix H1.

GENERAL HOSPITALS—AUSTRALIA—STATEMENT OF TOTAL EXPENDITURE AND PER CAPITA—YEARS 1923–1927[a] INCLUSIVE.

——	New South Wales.		Victoria.		Queensland.		South Australia.		Western Australia.		Tasmania.		Northern Territory.		Total, excluding Federal Capital.	
Population, 1927 ..	2,400,266		1,741,390		899,176		575,771		392,292		215,862		4,361		6,229,118	
——	Amount.	Per Capita.	Amount.	Per Capita.	Amount.	Per Capita.	Amount.	Per Capita.	Amount.	Per Capita.	Amount.	Per Capita.	Amount.	Per Capita.	Amount.	Per Capita.
	£	s. d.	£	s. d.	£	s. d.	£	s. d.	£	s. d.	£	s. d.	£	s. d.	£	s. d.
Expenditure—																
1923	1,177,373	10 8	381,150	4 8	526,365	12 11	253,967	9 8	186,214	10 6	81,070	7 5	6,625	37 3	2,612,764	9 1
1924 ..	1,260,515	11 2	434,222	5 3	*526,365	12 7	286,376	10 8	202,690	11 2	85,020	7 10	5,330	29 8	2,800,518	9 6
1925	1,367,092	11 10	479,007	5 8	613,334	14 3	324,449	11 9	211,706	11 5	89,265	8 3	5,693	31 2	3,090,546	10 4
1926	1,510,229	12 10	524,051	6 2	652,606	14 10	382,075	13 6	237,390	12 7	92,578	8 7	5,693	29 3	3,404,622	11 2
1927	1,671,059	13 11	558,927	6 5	671,567	14 11	388,303	13 6	261,760	13 4	99,581	9 3	†5,693	26 1	3,656,890	11 9

* 1923 figures (1924 not available). † 1926 figures (1927 not available). *a* Latest Commonwealth figures, 1927.

Appendix H2.

STATEMENT OF EXPENDITURE AND PER CAPITA—QUEENSLAND HOSPITALS—YEARS 1927–28 AND 1928–29.

Year.	Population, 31st December.	Population, 30th June.	Subsidised Hospitals.			Hospital Boards.*			Total.*		
			Expenditure.	Per Capita, 31st December.	Per Capita, 30th June.	Expenditure.	Per Capita, 31st December.	Per Capita, 30th June.	Expenditure	Per Capita, 31st December.	Per Capita, 30th June.
			£	s. d.	s. d.	£	s. d.	s. d.	£	s. d.	s. d.
1927-28	899,176	911,737	281,798	6 3	6 2	383,134	8 6	8 5	664,932	14 9	14 7
1928-29	916,689	927,092	285,623	6 3	6 2	382,973	8 4	8 3	668,596	14 7	14 5

* Include expenditure of three Ambulance Brigades which are combined with Hospital Boards.

Appendix I.

STATEMENT OF RECEIPTS AND EXPENDITURE OF THREE AMBULANCE BRIGADES AMALGAMATED WITH HOSPITAL BOARDS.

GAYNDAH AMBULANCE.

Year.	Receipts *excluding* Endowment, Sales of Cars, Plant, Land, &c.	Maintenance Expenses *exclusive* of Plant, Cars, Land, &c.	Deficits.
Before Amalgamation—	£	£	£
1921	955	1,356	401
1922	833	1,361	528
1923	1,070	1,508	438
Totals	2,858	4,225	1,367
Average annual deficit	..	..	£455
After Amalgamation—			
1925-26	91	871	780
1926-27	62	1,029	967
1927-28	57	970	913
1928-29	100	1,063	963
Totals	310	3,933	3,623
Average annual deficit	..	..	£906

GOONDIWINDI AMBULANCE.

Before Amalgamation—			
1920-21	167	83	*Cr.* 84
1921-22	806	611	*Cr.* 195
1922-23	797	840	43
1923-24	677	850	173
Totals	2,447	2,384	*Cr.* £63
Average annual *surplus*	..	..	£16
After Amalgamation—			
1924-25	3	450	447
1925-26	48	565	517
1926-27	54	466	412
1927-28	32	506	474
1928-29	37	459	422
Totals	174	2,446	2,272
Average annual deficit	..	..	£454

MARYBOROUGH AMBULANCE.

Before Amalgamation—			
1921	2,214	2,645	431
1922	2,162	2,853	691
1923	1,862	2,671	809
1924	1,760	2,596	836
Totals	7,998	10,765	2,767
Average annual deficit	..	..	£692
After Amalgamation—			
1925-26	449	1,870	1,421
1926-27	380	1,663	1,283
1927-28	465	1,707	1,242
1928-29	240	1,705	1,465
Totals	1,534	6,945	5,411
Average annual deficit	..	..	£1,353

Appendix J.

The following instructions shall be observed in the keeping of Hospital Accounts, &c. :—

Cash Books—

(*a*) RECEIPT BOOK AND DAILY CASH BOOK (**No. 1**).—The first column—carbon duplicate—Amount received to be totalled and extended to Bank column at each banking, which should be daily or at most not longer than three days. The total amount banked to be posted to General Cash Book.

The collections are to be dissected in the relative columns; and these to be totalled monthly and posted to the Ledger summary.

Six to eight receipts may be given on each page.

(*b*) GENERAL CASH BOOK (**No. 2**).—As per specimen. Collections to be entered at each banking as indicated above, see also Purchase Journal No. 5 (4).

EXPENDITURE.—Total monthly. Totals of wages and miscellaneous to be posted to Ledger summary (where necessary, columns to be further dissected and summarised in Cash Book at end of month for posting to summary).

Post the total of "Sundry Creditors" monthly to the relative account in the General Ledger.

Minute Book (no specimen given)—

All accounts approved for payment to be recorded in detail in Minute Book and totalled. The total to be incorporated in words in the body of the Minutes—also payments actually made during the month and subsequently approved (such as wages).

Order Book (no specimen given). This should have carbon duplicate.

Original to be coloured and carbon white.

Vouchers to be certified to, as noted under Purchase Journal. The book should be a check on payment of accounts, thus preventing double payments and preventing purchasing except through authorised channels.

Wages Sheets (No. 3)—(As per specimen.)

Wages Record Card (No. 4)—For record purposes and for Income Tax requirements.

Purchase Journal (No. 5)—

Vouchers to be certified by a responsible officer as to receipt of goods, then by Secretary as to rates charged, calculations, additions, &c.

Carbon duplicate "Order Book" to be kept—the order number being quoted on the voucher by the Secretary, and the "duplicate" being noted with the date the voucher was passed for payment.

As soon as the vouchers are checked, they should be entered in the Purchase Journal Book :—

(1) Use one page for each hospital, if there are more than one ;

(2) Total the month's transactions ;

(3) At the close of the month post the totals of the individual columns to the Ledger summary and the total of "Creditors" column to General Ledger to credit of account "Sundry Creditors" ;

(4) When payments are made, the detailed payments shown in the Cash Book to be recorded in the Purchase Journal opposite the respective entries, quoting the voucher number. The Cash Book monthly total sundry creditors is posted to debit of Sundry Creditors account in General Ledger. The balance of Sundry Creditors account in the General Ledger should agree with the total of individual accounts not recorded as paid in the Journal.

Purchase (Quantities) Journal (No. 6).—Primarily for statistical purposes.

Ledger Summary (No. 7)—

Allot a page for each hospital, if there are more than one.

Post from Purchase Journal the monthly totals of the various columns, and from the Cash Book, wages, miscellaneous expenditure and receipts ; also post receipts from Cash Book monthly.

At the end of twelve months the totals of the various sections (such as maintenance, surgery, domestic, &c.) to be posted to the General Ledger.

Appendix J—*continued.*

General Ledger (no specimen given)—

The regular Assets accounts include—

Land ;
Buildings ;
Furniture ;
Investments, &c. ;

and Liabilities accounts—

Sundry Creditors ;
Treasury Loan, &c. ;

also sectional headings of Revenue and Expenditure accounts.

Any Journal entries (ordinary Journal) that cannot be adjusted through the Purchase Journal will require to be entered in the Ledger Summary to agree with the General Ledger sectional accounts.

Patients' Fees (No. 8)—

DAY BOOK (as ruled).—Total both columns monthly.

Paying Patients—

Post total monthly to undermentioned accounts in General Ledger—

Dr. Sundry Patients ;
Cr. Patients' Fees.

From Cash Book.—Credit monthly total of fees received from patients (excluding out-patients) to "Sundry Patients" Account.

Patients' Account Cards and Undertakings (combined)—(No. 10)—

Post to these cards the debits from Day Book and credits from Cash Book.

The arrears of "Patients' Fees" (totals of these cards) will agree with General Ledger Account ("Sundry Patients").

Bad debts or fees to be written off must first be approved by the Board and detailed in Minute Book. The total approved to be written off to be incorporated in words in body of minutes.

Then write off detailed amounts to credit of patients' cards, and post total to General Ledger to—

Dr. Patients' Fees ;
Cr. Sundry Patients.

Non-Paying Patients (No. 11)—

Number the undertakings and file in order in Day Book order until after audit, when they should be filed alphabetically for record purposes. (Paying patients' undertakings and cards will be filed alphabetically from commencement.)

It will be necessary for the auditors to see undertakings for patients on account of whom no fees are charged, and to do so readily they should be filed in the order as per Day Book.

Total column in Day Book of non-paying patients and transfer to a summary at the end of the book, so that total may be available for record, statistical, or comparative purposes.

Invoices (No. 9)—To be carbon duplicate, machine numbered, as per specimen.

Appendix J1.

COMBINED "RECEIPTS" AND DAILY CASH BOOK.

———	Bank.	Subscriptions.	Donations.	(a) Entertainments (b) Legacies.	Patients' Fees.			Precepts—Local Authorities.	(a) Government Precept (b) Golden Casket.	Miscellaneous	Extraordinary Revenue.
					Hospital.	Hospital.	Hospital.				
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.

..... HOSPITALS BOARD.

..... 19 .....

Received from .....

the sum of ..... pounds

..... shillings ..... pence

being .....

.....

Stamp.

....

Secretary.

Appendix J2.

GENERAL CASH BOOK.

Receipts.			Expenditure.																			
							——— Hospital.				——— Hospital.				——— Hospital.							
							Salaries and Wages.				Salaries and Wages.				Salaries and Wages.							
Date.	Daily Cash Book Receipts.	Bank.	Date.	Payee.	Folio.	Administration Salaries.	Medical.	Dispensing.	Nursing.	Other Wages.	Medical.	Dispensing.	Nursing.	Other Wages.	Medical.	Dispensing.	Nursing.	Other Wages.	Miscellaneous.	Sundry Creditors.	Cheque No.	Bank.
	£ s. d.					£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.

Appendix J3.

WAGES SHEET.

_____ HOSPITAL BOARD.

_____ HOSPITAL.

SALARIES AND WAGES FOR FORTNIGHT ENDED _____

No.	Name.	Occupation.	Rate.	Amount.	Overtime.			Uniform Allowance.	Total.	Board and Lodging.	Deductions.			Net Wages Payable.	No.	Signature.
					Hours.	Rate.	Amount.				Relief Tax.	Unemployment Insurance.	State Insurance.			
				£ s. d.			£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d	£ s. d.	£ s. d.	£ s. d.		
1															1	
2															2	
3															3	
4															4	
5															5	
6															6	

Appendix J4.

WAGES RECORD CARD.

NAME _____ No. _____

Occupation _____ Rate _____ Date of Birth _____

Value of Board and Lodging £ _____ p.a. Date of Employment _____

Value of Residence .. .. £ _____ p.a. Status—Married _____ Single _____ Dependents _____

Date.	Amount.	Date.	Amount.	Date.	Amount.	Date.	Amount.	Date.	Amount.
		B/f		*B/f*		*B/f*		*B/f*	
C/f		*C/f*		*C/f*		*C/f*		*C/f*	

NOTE.—Similar ruling will be on back of card without the heading.

Appendix J5.

PURCHASE JOURNAL (1).

PROVISIONS.									SURGERY AND DISPENSARY.						DOMESTIC.						
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
Date.	Meat.	Fish and Poultry.	Butter, Cheese, &c.	Eggs.	Milk.	Bread, Flour, &c.	Groceries.	Fruit and Vegetables.	Drugs, Chemicals, &c.	Dressings, Bandages, &c.	Instruments and Appliances.	Ice and Mineral Waters.	Wines and Spirits.	Surgery Sundries.	Renewals of Furniture.	Bedding and Linen.	Hardware, Crockery, &c.	Washing.	Fuel and Lighting.	Uniforms.	Sundries.
	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.

ESTABLISHMENT CHARGES.				MISCELLANEOUS EXPENSES.		ADMINISTRATION.							PAYMENT.		
23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39
Rates.	Insurance.	Ordinary Repairs.	Garden.	Printing, Stationery, &c.	Sundries.	Printing, Stationery—Office.					Extraordinary Expenditure.	Total.	Creditor's Name.	Date Paid.	Voucher No.	Amount.
£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.	£ s. d.				£ s. d.

Appendix J6.

PURCHASE (QUANTITIES) JOURNAL.

Month.	Meat.		Bacon.		Fish.		Milk.		Butter.		Eggs.		Bread.		Flour.		Sugar.		Jam.		Tea.		Coffee.		Oatmeal.		Potatoes.		Onions.		Cotton Wool.		Lint.		Gauze.		Fuel (Wood, Coal, or Coke).		Gas.		Electric Light.					
—	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Quarts.	Voucher.	Lbs.	Voucher.	Dozen.	Voucher.	Loaves.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.	Lbs.	Voucher.		Voucher.		Voucher.	Cubic ft.	Voucher.	Units.	Voucher.		Voucher.			
July																																												
Total (in red)																																												
August																																												
Total (in red)																																												
September																																												
Total (in red)																																												
October																																												
Total (in red)																																												
November																																												
Total (in red)																																												
December																																												
Total (in red)																																												
Six months Total—Carried forward																																												

Month.	Meat.	
January		
Total (in red)		
February		
Total (in red)		
March		
Total (in red)		
April		
Total (in red)		
May		
Total (in red)		
June		
Total (in red)		
Total for Half Year		
Brought forward July—December		
Total for Year		

DONATED AND/OR PRODUCED BY HOSPITAL.

Month.	Meat.	Bacon.	Fish.	Milk.	Butter.	Eggs.	Bread.	Flour.	Sugar.	Jam.	Tea.	Coffee.	Oatmeal.	Potatoes.	Onions.	
Total six months carried forward.																

Month.	Meat.
Brought forward.	
Total for year.	

1. Total each month *in red* separately.
2. Total of six months carried forward to next page.

NOTE.—To arrive at consumption for the year—
Show on separate sheet—
Balances at 1st July, 193 .. .. _____
Add—Total purchases during the year _____
_____
Totals .. .. _____
Less—Stock on hand 30th June, 193 .. ..
_____
Consumption for year .. .. _____

3. Bring forward six months' total from previous page.
4. Total each month separately *in red*.
5. Total for year.

SIMILAR RULING AS OTHER SIDE.

Appendix J7.

Consumption for year .. ..

Appendix J7.

LEDGER SUMMARY.

HOSPITAL.

EXPENDITURE.

Account.	July.	August.	September.	October.	November.	December.	January.	February.	March.	April.	May.	June.	Total.	Transfers Credit.	Transfers Debit.	Total.
Maintenance—																
Meat																
Fish and poultry																
Butter, cheese, &c.																
Eggs																
Milk																
Bread, flour, &c.																
Groceries																
Vegetables and fruit																
Sub-total (in red)																
Surgery—																
Drugs, chemicals, &c.																
Dressing, bandages																
Instruments, appliances																
Ice and mineral waters																
Wines and spirits																
Surgery sundries																
Sub-total (in red)																
Domestic—																
Renewals of furniture																
Bedding and linen																
Hardware, crockery, &c.																
Washing																
Fuel and lighting																
Uniforms																
Sundries																
Sub-total (in red)																
Establishment charges—																
Rates																
Insurance																
Ordinary repairs																
Garden																
Sub-total (in red)																
Salaries, wages, &c.—																
Medical																
Dispensing																
Nursing																
Other salaries and wages																
Sub-total (in red)																
Miscellaneous expenses—																
Printing, stationery, &c.																
Miscellaneous																
Sub-total (in red)																
Administration—																
Official salaries																
Office printing and stationery																
Office postages, telegrams, &c.																
Office advertisements																
Sundries																
Sub-total (in red)																
Finance—																
Extraordinary expenditure																
.....																
.....																
Totals																

REVENUE.

Account.	July
Contributions—	
Subscriptions	
Donations	
Benefits, &c.	
Legacies, &c.	
Sub-total (in red)	
Patients' fees—	
In-patients	
Out-patients	
Sub-total (in red)	
Precepts—	
Government	
Local Authorities	
Sub total (in red)	
Golden Casket	
Miscellaneous	
Extraordinary revenue	
Totals	

SIMILAR TO OTHER SIDE.

77

T&A

Appendix J8.

PATIENTS' FEES—DAY BOOK.

ADMISSION REGISTER NO. OR FOLIO.	PATIENT.	DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS.	RATE PER DAY.	PAY PATIENTS.		PATIENTS UNABLE TO PAY ANYTHING.	
						INVOICE NO.	AMOUNT PAYABLE.	UNDERTAKING NO.	AMOUNT.

Appendix J9.

ACCOUNT FOR FEES.

Account No...... .....193.....

M.....

.....

Dr. to.....HOSPITAL BOARD.

DATE. From.	DATE. To.	NO. OF DAYS.	PARTICULARS.	RATE.	AMOUNT.	TOTAL.
			Fees, Nursing, Board and Residence			
			Sundries—			
			(In duplicate—Carbon copy.)			
			Please add exchange to cheques drawn on Banks in other towns or country.			

Appendix J10.

(FRONT OF CARD.)

.....HOSPITAL BOARD.

Year.....

Name of Patient.....
(Surname first)

Admission No.....

Present Address.....Permanent Address.....

Next of Kin and Address.....

Telephone No.....

I,.....hereby declare—(1) That I am unable to pay for private attention; (2) that the particulars given by me are true in every respect.

I undertake to contribute at the rate of.....per.....for the period.....

a patient in Hospital, payable.....(Signature).....

(Witness).....(Date).....

FEES ACCOUNT.

Date of Admission.....

Dr. Date of Discharge.....Number of Days..... Cr.

Date.	Particulars.	Rate.	Account No.	Amount.	Date.	Particulars.	Folio.	Amount.

Account rendered—
1st.....
2nd.....
3rd.....

If written off—
Date of Minute.....
Minute Book Folio.....

(BACK OF CARD.)

Admission No..... (Date)..... Time..... Ward..... Doctor.....

Age..... Birthplace..... Country..... Religion.....

Condition..... Recommended by..... Admitted by.....

Are you a member of a Friendly Society?..... On which Electoral Roll does your name stand?.....

Occupation..... Employer..... Wage.....

If unemployed, how long.....

Other source of Income..... Property..... Rent.....

Family to support..... Amount Paid Privately.....

Date of Admission..... Date of Discharge..... Date of Death.....

Diagnosis .....

.....

Previous Admission Date..... Diagnosis.....

Discharge No.....

Appendix J11.

(FRONT OF CARD.)

NON-PAYING PATIENT.

.....HOSPITAL BOARD. YEAR.....

ADMISSION NO.....

NAME (BLOCK) (SURNAME FIRST)		No.	Cond.	Age	Date	Doctor
ADDRESS		OCCUPATION				EMPLOYER

WAGE	No. IN FAMILY	OTHERS EARNING

Admitted

Discharged

.....days at

£

DECLARATION.

I do hereby solemnly declare that I am unable to contribute anything towards my treatment and maintenance at the .....Hospital.

(Signature).....

(Date).....

(Witness).....

(BACK OF CARD.)

DATE	AMT.	NOTES	TREATMENT

NOTE.—Non-paying Patient Card should be in a different colour from that for a Paying Patient.

Appendix K.

STATEMENT OF COST.

DEPARTMENT OF PUBLIC WORKS.

No. 1 Block—General Hospital.

	£	s.	d.
Erection of ward	62,845	7	5
Supply and erection of hot water, sterilising, and steam heating plant	2,581	16	6
Supply and erection of electric lift	2,480	0	0
Providing and fixing wire firlles	350	0	0
Installing motor barrow hoist	11	4	10
	68,268	8	9
Less—Value of stone supplied for No. 2 Block	2,850	0	0
	65,418	8	9
Supervising, Inspector's salary	232	0	0
Workers' compensation policy	394	0	0
Fees for inspecting cranes	1	15	0
	£66,046	3	9

T. H. DINSDALE,
Accountant.

ATKINSON, POWELL, AND CONRAD.

No. 2 Block—Brisbane Hospital.

	£	s.	d.
Builders' total final claim for erection of Block No. 2	53,792	0	0
Complete installation of lift for Block No. 2	2,050	0	0
Laying of foundation stone	78	0	0
	£55,920	0	0

The following equipment (final cost) is being installed in Block No. 2, not in Building Contract :—

	£	s.	d.
Refrigerators	302	7	6
Operating lamps	197	12	0
Synchronome clocks	75	0	0
	£574	19	6

Architects' fees on all above	£3,390	0	0

ATKINSON, POWELL, AND CONRAD,
Per A. H. CONRAD.

Price, 2s.]

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F

1926–27–28.

THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA.

REPORT

OF THE

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TOGETHER WITH

APPENDICES.

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