Economic and Budget Review Committee

Report of the Inquiry into the Royal Southern Memorial Hospital

March 1984

ECONOMIC AND BUDGET REVIEW COMMITTEE

REPORT OF THE INQUIRY INTO THE ROYAL SOUTHERN MEMORIAL HOSPITAL

Ordered to be Printed

PREFACE

The Economic and Budget Review Committee is constituted under the Parliamentary Committees (Joint Investigatory Committees) Act 1982 to investigate and review matters referred to it under the following Terms of Reference:

- to inquire into and report to the Parliament on any proposal, matter or thing connected with public sector or private sector finances or with the economic development of the State where the Committee is required or permitted to do so (by or under its Act).

- to inquire into, consider and report to the Parliament on any annual report or other document relevant to the functions of the Committee which is laid before either House of Parliament pursuant to a requirement imposed by or under an Act.

- to inquire into, consider and report to the Parliament on any matter arising out of the annual Estimates of Receipts and Payments of the Consolidated Fund or other Budget Papers.

TERMS OF REFERENCE OF THE INQUIRY INTO THE ROYAL SOUTHERN MEMORIAL HOSPITAL

On 30 August 1983, the Governor-in-Council approved of the Terms of Reference of the Inquiry.

1. To inquire into, report and recommend on the structure, organisation and management of the Royal Southern Memorial Hospital, with particular reference to:

   (a) procedures relating to selection, appointment, supervision and review of personnel establishment, as well as rates of remuneration of non-medical staff;

   (b) rates of remuneration, methods of payment and hours worked by all medical personnel;

(c) methods by which reports are prepared, the contents of reports and the execution and reporting back of decisions to the Board of Management;

(d) standards and effectiveness of internal and external auditing procedures; and

(e) methods of reporting and the contents of reports made to the Health Commission of Victoria.

2. To make recommendations if necessary concerning any incorrect payment to any officer or employee of the Royal Southern Memorial Hospital.

3. To inquire into, report and recommend on the role of the Health Commission of Victoria in monitoring the activities of Public Hospitals with particular reference to;

(a) information systems;
(b) reporting;
(c) budgeting controls; and
(d) comparisons with appropriate monitoring systems developed elsewhere.

The Committee is required to report to Parliament on Items 1 and 2 of the Terms of Reference by 31 December 1983 and Item 3 by 30 June 1984, respectively, if Parliament is then sitting or if the Parliament is not then sitting within seven days after the next meeting of Parliament.

As it was not possible for the Committee to report by 31 December 1983, the Governor-in-Council on 6 March 1984, approved of an extension to 29 March 1984 if Parliament is sitting or within seven days of the next sitting.

COMMITTEE MEMBERS

Mr. B.J. Rowe, M.P. (Chairman)
Hon. D.K. Hayward, M.L.C. (Deputy Chairman)
Hon. G.P. Connard, M.L.C.
Hon. B.P. Dunn, M.L.C.
Mr. P.M. Gavin, M.P.
Hon. J.V.C. Guest, M.L.C.
Mr. J.D. Harrowfield, M.P.
Mr. A. McCutcheon, M.P.
Mr. P.J. McNamara, M.P.
Hon. J.H. Ramsay, M.P. (From 6.3.1984)
Mr. J.I. Richardson, M.P. (Till 6.3.1984)
Hon. G.A. Sgro, M.L.C.
Mr. A.J. Sheehan, M.P.

INQUIRY INTO THE ROYAL SOUTHERN MEMORIAL HOSPITAL

SUB-COMMITTEE MEMBERS

Mr. A.J. Sheehan, M.P. (Chairman)
Hon. G.P. Connard, M.L.C.
Mr. P.M. Gavin, M.P.
Mr. B.J. Rowe, M.P.

STAFF

RESEARCH

Ms. H. Silver, Director of Research
Dr. I.A.G. Brand
Miss V. Pepe

ADMINISTRATION

Mrs. E. Barbian, Secretary
Mr. G. George, Acting Secretary
Miss M. Pace

CHAIRMAN'S INTRODUCTION

This report recommends significant changes in the management practices of the Royal Southern Memorial Hospital (R.S.M.H.). The Committee has found serious deficiencies in the following areas of the R.S.M.H. :-

(i) payments made to medical and non-medical staff;
(ii) personnel and industrial relations policy;
(iii) administration and use of the medical trust funds;
(iv) reporting procedures to both the Board and the Health Commission;
(v) internal control procedures and financial management; and
(vi) external audit undertaken for the Hospital.

The Committee's major response to the serious financial and management deficiencies found has been to recommend :-

(i) the replacement of the Board of Management at the R.S.M.H.;
(ii) the investigation by the Crown Solicitor of two payments made to the staff at the Hospital and the role of the trustees of the Medical Purposes (Pathology) trust;
(iii) a detailed review of the sessional allocation for visiting specialists;
(iv) a more comprehensive external audit be instituted and appropriate internal audit control be established; and
(v) more informative and comprehensive reporting mechanisms both within the Hospital and to the Health Commission.

The Committee saw the specific inquiry into the R.S.M.H. as a micro study of the second stage of its terms of reference which requires the Committee to investigate the role of the Health Commission with particular reference to reporting mechanisms, budgeting controls and information systems. Notwithstanding this, the Committee was concerned to investigate the deficiencies at the R.S.M.H. given it had a total budget in 1983/84 of $12.5 million.

As a result of the initial study, the Committee has made a number of wider recommendations which will be pursued as part of the third term of reference. These include the following areas :-

(i) The need for an overall review of the monitoring systems of the Health Commission's Public Hospitals' budget which is in excess of $1 billion;

(ii) The need for a study of the source and use of medical trust funds under the control of hospitals. These funds are estimated to be in excess of $30 million;

(iii) A study of the market for radiologists in Victoria. As salaries account for approximately 80 per cent of the operating expenditure of hospitals and medical staff make up a significant proportion of this amount, the Committee was concerned that radiologists as a group have been paid by community standards at extremely high remuneration levels. An example of this situation is seen at the R.S.M.H. where the radiologist was paid $155,400 for the year ended 30 June 1983. The Committee notes the current cost of training radiologists is borne by the taxpayer but on the other hand the shortage of radiologists has meant substantial occupational rent has accrued to this group.

As Chairman, I would also like to record my personal thanks to the other members of the sub-Committee, and in particular to the Chairman, Mr. A.J. Sheehan, for the time and energy they devoted to this Inquiry.

The Committee wishes to express its thanks to the individuals and organisations who made submissions either in writing or by appearing in person before the Committee.

I wish to acknowledge the contributions made to this Inquiry by the staff of the Committee. In particular Helen Silver, Director of Research of the Committee, who co-ordinated the Inquiry and was directly involved in the preparation of this report. I also wish to thank Dr. Ian Brand who was employed as an adviser to the Committee and provided a valuable source of knowledge and experience of Health and Hospital administration. Vita Pepe played an integral role in the primary research for the report. Margaret Pace was responsible for the timely and accurate typing of this report.

B.J. ROWE, M.P.,
Chairman.

CONTENTS

SUMMARY OF RECOMMENDATIONS

CHAPTER 3 - RECOMMENDATIONS - PERSONNEL MANAGEMENT

1. THAT THE FINANCE COMMITTEE OF THE BOARD OF MANAGEMENT BE RE-NAMED THE FINANCE AND STAFF COMMITTEE.

2. THAT THE FINANCE AND STAFF COMMITTEE ENSURES THAT REGULAR REPORTS ARE SUBMITTED ON IMPORTANT MATTERS RELATING TO STAFF INCLUDING INDUSTRIAL RELATIONS.

3. THAT THE BOARD GIVE HIGH PRIORITY TO IMPROVING STAFF RELATIONS AND TO CONTINUE TO UPGRADE THE QUALITY OF PERSONNEL MANAGEMENT IN THE HOSPITAL.

CHAPTER 4 -RECOMMENDATIONS - NON MEDICAL PERSONNEL

1. THAT THE INTERNAL CONTROL AND INTERNAL AUDIT PROCEDURES RELATING TO SCRUTINY OF TIME CARDS, USE OF MANUAL TIME RECORDING AND CLAIMS FOR PAYMENT BE CONTINUALLY REVIEWED.

2. THAT ADVICE TO THE PAYMASTER ON CHANGES IN RATES OF PAY, ALLOWANCES OR JOB CLASSIFICATION BE SPECIFIED AND PROPERLY AUTHORISED.

3. THAT LEAVE RECORDING BE EXAMINED TO ASSESS THE NEED FOR DUPLICATED DEPARTMENTAL RECORDS AND TO UTILISE THE COMPUTER LEAVE RECORDING SYSTEM AVAILABLE WITH THE PAYROLL PACKAGE.

4. THAT A REVIEW OF THE POSITIONS PAID ABOVE THE NORMAL GRADINGS BE CARRIED OUT TO CONFIRM THEIR CURRENT JUSTIFICATION SO THAT NEW APPOINTMENTS ARE MADE AT THE CORRECT LEVEL.

5. THAT THE BOARD ENSURE EACH STAFF MEMBER COMPLETES A TIME RECORD AS REQUIRED BY THE INDUSTRIAL RELATIONS ACT 1979 (S.81).

CHAPTER 5 - RECOMMENDATIONS - MEDICAL PAYMENTS

1. THAT THE BOARD OF MANAGEMENT CONCERN ITSELF WITH THE ISSUES INVOLVED IN THE PAYMENT OF MEDICAL STAFF.

2. THAT A DETAILED REASSESSMENT OF THE SESSIONAL ALLOCATION FOR VISITING SPECIALISTS BE CARRIED OUT BY THE HEALTH COMMISSION, WITH PARTICULAR ATTENTION TO ON-CALL REQUIREMENTS AND THE INTEGRATION OF ADMINISTRATIVE AND CLINICAL SESSIONS.

3. THAT THE BOARD OF MANAGEMENT IN ASSOCIATION WITH MANAGEMENT ESTABLISH APPROPRIATE EXCEPTION REPORTING MECHANISMS TO PROVIDE ADEQUATE OVERSIGHT OF LEVELS OF PAYMENT TO MEDICAL STAFF.

4. THAT APPROPRIATE INTERNAL CONTROLS AND INTERNAL AUDIT PROCEDURES BE INTRODUCED TO CHECK THAT PAYMENTS OF SESSIONAL AND FEE-FOR-SERVICE CLAIMS ARE PROPERLY MADE OUT AND AUTHORISED.

5. THAT ALL PAYMENTS FOR VISITING MEDICAL STAFF WITH THE EXCEPTION OF FEE-FOR-SERVICE PAYMENTS BE MADE THROUGH THE PAYROLL SYSTEM WITH A SINGLE APPEARANCE FOR EACH MEDICAL STAFF MEMBER.

6. THAT ALL DISCUSSIONS RELATING TO MEDICAL PAYMENTS AT THE DIVISIONAL COMMITTEE BE PROPERLY MINUTED AND INCLUDED IN BOARD REPORTS.

7. THAT THE POLICY ON RE-CALL PAYMENTS FOR PATHOLOGISTS BE REVIEWED.

8. THAT THE NEED FOR SESSIONAL ALLOCATIONS FOR PATHOLOGY CONSULTANTS BE REVIEWED WHEN THE NEW DIRECTOR OF PATHOLOGY IS APPOINTED AND, IN THE MEANTIME, ALL SESSIONAL PAYMENTS BE MADE TO THE APPROPRIATE UNIVERSITY DEPARTMENT.

9. THAT TRANSFERS FROM OPERATING ACCOUNT FOR FEE-FOR-SERVICE PAYMENTS BE RELATED TO EXPENDITURE LEVELS AND BE MADE VIA A SUSPENSE ACCOUNT RATHER THAN BY ROUTINE TRANSFER TO A RESERVE ACCOUNT SO THAT THE OPERATING ACCOUNT REFLECTS ACTUAL COSTS.

10. THAT ACTION BE TAKEN BY THE HEALTH COMMISSION TO REVIEW THE GROUPING OF HOSPITALS NOT INCLUDED IN THE SESSIONAL MEDICAL OFFICERS AWARD TO ENSURE THAT APPROPRIATE MEDICAL PAYMENTS ARE BEING MADE.

11. THAT THE ECONOMIC AND BUDGET REVIEW COMMITTEE CONDUCT A DETAILED STUDY INTO THE MARKET FOR RADIOLOGISTS AND RECOMMEND POSSIBLE POLICY SOLUTIONS.

12. THAT THE HEALTH COMMISSION AS QUICKLY AS POSSIBLE ASSESS THE COSTS OF THE CAULFIELD COMMUNITY CARE CENTRE AND ITS ROLE INCLUDING THE ORGANISATION APPROACH OF THE CENTRE.

CHAPTER 6 - RECOMMENDATIONS - REPORTS TO BOARD

1. THAT CONTINUING ATTENTION BE GIVEN TO PROVIDING SELF SUFFICIENT INFORMATIVE MINUTES WHICH INCLUDE ALL DATA NECESSARY TO INTERPRET THE BASIS AND CONTENT OF DECISIONS.

2. THAT THE BOARD MINUTES INCLUDE AS ATTACHMENTS IMPORTANT REPORTS WHICH RELATE TO DECISIONS MADE.

3. THAT ANY MAJOR CAPITAL COMMITMENTS APPROVED INCLUDE DETAILS OF TENDERS RECEIVED AND ACCEPTED TOGETHER WITH A NOTE OF THE VALUE OF REJECTED TENDERS.

4. THAT A MAJOR REVIEW OF THE HOSPITAL BUDGETARY PROCESS BE CARRIED OUT TO DEVELOP SYSTEMS WHICH PROVIDE PERFORMANCE OBJECTIVES AND STANDARDS, GREATER RESPONSIBILITY AND FLEXIBILITY FOR BOARDS OF MANAGEMENT AND IMPROVED MONITORING OF PERFORMANCE. THE COMMITTEE INTENDS TO UNDERTAKE THIS REVIEW IN ITEM 3 OF ITS TERMS OF REFERENCE.

5. THAT STAFF REPORTING INCLUDE OVERTIME AND ANNUAL AND LONG SERVICE LEAVE OUTSTANDING MORE THAN SIX MONTHS.

CHAPTER 7 - RECOMMENDATIONS - INTERNAL CONTROL

1. THAT THE HEALTH COMMISSION, IN CONJUNCTION WITH THE AUDITOR-GENERAL, PREPARE AN APPROPRIATE PROGRAMME OF INTERNAL AUDIT FOR HOSPITALS, INCLUDING THE NECESSARY AUDIT STAFF.

7.4.1 TIME RECORDING

1. THAT THE USE OF TIME CHECKING BE EXTENDED TO REDUCE MANUAL TIME RECORDING AS FAR AS PRACTICABLE.

2. THAT FOR VISITING MEDICAL STAFF, A WRITTEN CLAIM FOR PAYMENT BE PREPARED AND SIGNED BY THE INDIVIDUAL.

3. THAT ALL CLAIMS FOR PAYMENT BE AUTHORISED BY A SENIOR OFFICER AND UNAUTHORISED OR SELF-AUTHORISED CLAIMS BE REJECTED.

4. THAT AS FAR AS PRACTICABLE, ALL SALARIES AND WAGES CLAIMS BE PAID THROUGH THE PAY SYSTEM EXCEPTING FEE-FOR-SERVICE CLAIMS AND SPECIFIED PAYMENTS WHERE INCLUSION ON THE PAYROLL IS NOT APPROPRIATE.

5. THAT USE OF THE PAYROLL COMPUTER BASED LEAVE SYSTEM BE INTRODUCED.

6. THAT ALL CLAIMS FOR SESSIONS OR FEE-FOR-SERVICE PAYMENTS BE AUTHORISED BY THE RELEVANT DIVISIONAL HEAD AND APPROPRIATE SYSTEMS BE INTRODUCED TO VERIFY THE CORRECTNESS OF THE CLAIM.

7. THAT THE RETENTION PERIOD OF TIME CARDS, LEAVE APPLICATIONS AND OTHER PAY DOCUMENTATION BE REVIEWED AND EXTENDED.

7.4.2 PURCHASING AND SUPPLY SYSTEMS

1. THAT ALL REQUESTS FOR SUPPLIES BE AUTHORISED BY SPECIFIED PERSONS IN PARTICULAR IN THE CATERING DEPARTMENT.

2. THAT PURCHASE ORDER FORMS BE NUMBERED AND BE SUBJECT TO NUMBER CONTROL.

3. THAT REQUISITIONS BE SUBJECT TO NUMBER CONTROL AND PROCEDURES ESTABLISHED TO ACCOUNT FOR CANCELLED REQUISITIONS. PROCEDURES SHOULD ENSURE THAT ALL REQUISITIONS ARE ENTERED ON THE REQUISITION SUMMARY.

4. THAT THE SYSTEM FOR PROCESSING REQUISITIONS BE TIGHTENED TO PROVIDE IMPROVED CONTROL OF CUTOFF FOR ACCOUNTING AND STOCK RECORDING PURPOSES.

5. THAT THE ACCURACY OF COMPUTER STOCK RECORDING BE IMPROVED SO AS TO PROVIDE AN ACCURATE BASIS FOR ROUTINE SPOT STOCKCHECKS.

7.4.3 PAYMENT SYSTEM

1. THAT A CREDITORS PAYMENT SYSTEM PROCEDURE MANUAL BE DEVELOPED.

2. THAT ENTRY OF NEW CREDITORS INTO THE SYSTEM BE PROPERLY CONTROLLED AND AUTHORISED.

3. THAT SUPPORTING DOCUMENTATION FOR INVOICE PAYMENT AND AUTHORISATION BE MORE COMPREHENSIVE. IN PARTICULAR, DELIVERY DOCKETS SHOULD BE ATTACHED TO SUPPLY INVOICES.

4. THAT SUPPLIES OF CHEQUES FOR MANUAL PREPARATION BE SUPERVISED BY A RESPONSIBLE OFFICER OF THE HOSPITAL.

5. THAT INVOICES AND CHEQUE REQUISITIONS BE CANCELLED MORE EFFECTIVELY ON PAYMENT WITH DETAIL OF CHEQUE NUMBER AND AMOUNT ENTERED ON THE CHEQUE REQUISITION.

6. THAT ALL PURCHASE ORDERS AND ACCOUNTS BE PROCESSED THROUGH THE NORMAL SUPPLY PROCEDURE INCLUDING PATHOLOGY AND RADIOLOGY ACCOUNTS CURRENTLY PROCESSED WITHIN THE DEPARTMENT.

7.4.4 ASSETS REGISTER

1. THAT THE ASSETS REGISTER CONTINUE TO BE DEVELOPED AS QUICKLY AS POSSIBLE AND THEN BE RECONCILED TO THE GENERAL LEDGER.

2. THAT DEPRECIATION CHARGES ULTIMATELY BE CALCULATED USING THE ASSET REGISTER.

7.4.5 PATIENTS ACCOUNTS

1. THAT THE PROCEDURE FOR WRITING OFF PATIENTS ACCOUNTS BE FORMALISED AND PROCEDURES FOR APPROVAL OF WRITE OFFS BE ESTABLISHED.

2. THAT THE DEBTORS CONTROL ACCOUNT BE MORE REGULARLY RECONCILED WITH THE DEBTORS LEDGER. AT PRESENT THE FREQUENCY OF BALANCING IS UNSATISFACTORY.

3. THAT CONTROL OF ADJUSTMENTS TO THE DEBTORS LEDGER VIA COMPUTER INPUT BE IMPROVED. ACCESS TO A COMPUTER TERMINAL PERMITS ALTERATIONS TO BALANCES. THIS REQUIRES BASIC CHANGES TO THE SYSTEM.

4. THAT THE INTERNAL CONTROL PROCEDURES BE SUPPORTED BY INTERNAL AUDIT ACTION TO PROVIDE PERIODIC VERIFICATION THAT PROCEDURES ARE BEING FOLLOWED AND THAT ACTION IS TIMELY.

7.5 RECOMMENDATIONS - EXTERNAL AUDIT

1. THAT A MORE COMPREHENSIVE AUDIT BE COMMISSIONED WITH AUDIT GUIDELINES SPECIFIED, INCLUDING THE FOLLOWING MATTERS WHICH ARE IMMEDIATELY RELEVANT TO THE ROYAL SOUTHERN MEMORIAL HOSPITAL (R.S.M.H.):-

(a) A COMPREHENSIVE INTERNAL CONTROL REVIEW.

(b) VERIFICATION OF RATES AND AMOUNTS OF PAY.

(c) ATTENTION TO COMPLIANCE WITH HEALTH COMMISSION CIRCULARS.

(d) PROVISION OF COMPREHENSVIE MANAGEMENT REPORTS TO THE BOARD.

(e) REVIEW OF EFFECTIVENESS AND ACCURACY OF COMPUTER INPUT AND OUTPUT ESPECIALLY IN RELATION TO FINANCIAL MATTERS.

(f) REGULAR REVIEW OF BALANCING OF CONTROLS.

(g) REVIEW OF TRUST ACCOUNT TRANSACTIONS WITH PARTICULAR ATTENTION TO COMPLIANCE WITH TRUST CONDITIONS.

2. THAT WITH THE APPROVAL OF THE AUDITOR-GENERAL GUIDELINES FOR AUDIT OF HOSPITALS BE DEVELOPED AND DISTRIBUTED TO BOARDS OF MANAGEMENT AND AUDITORS.

3. THAT THE STANDARD OF AUDITS IN THE GENERAL HOSPITAL FIELD IN RELATION TO THE GUIDELINES BE REVIEWED TO ENSURE THAT THEY ARE MEETING THE NEEDS OF THE BOARDS OF MANAGEMENT.

CHAPTER 8 - RECOMMENDATIONS - HEALTH COMMISSION REPORTING

1. THAT PROVISION BE MADE FOR CLOSER CONSULTATION BETWEEN HEALTH COMMISSION STAFF AND HOSPITAL STAFF, INCLUDING REGULAR VISITS BY COMMISSION STAFF.

2. THAT THE COMMISSION MONITOR ESTABLISHMENT DATA AND POSITION GRADING THROUGH COMPUTER ANLAYSIS OF HOSPITAL COMPUTER FILES.

3. THAT MATTERS IN THIS CHAPTER RELATING TO ALL HOSPITALS BE TAKEN UP IN ITEM 3 OF THE TERMS OF REFERENCE.

CHAPTER 9 - RECOMMENDATIONS - TRUST FUNDS

1. THAT THE POLICY IN RELATION TO PRIVATE PRACTICE INCOME BE REVIEWED TO PROVIDE A MORE RATIONAL ARRANGEMENT. THIS IS CURRENTLY UNDER CONSIDERATION BY THE MINISTER OF HEALTH.

2. THAT A WIDESPREAD STUDY OF THE SOURCES AND DISPOSITION OF RESERVES AND TRUSTS UNDER THE CONTROL OF HOSPITALS GENERALLY BE UNDERTAKEN TO CLARIFY ACCEPTABLE PROCEDURES AND PROVIDE BETTER CONTROL OF THESE SUBSTANTIAL RESOURCES. THE COMMITTEE INTENDS TO UNDERTAKE THIS REVIEW IN ITEM 3 OF ITS TERMS OF REFERENCE.

3. THAT THE HOSPITAL CEASE THE TRANSFER OF OPERATING FUNDS AND INCOME TO CAPITAL ACCOUNTS AND RESERVES.

4. THAT THE ROLE OF THE TRUSTEES IN THE SPECIAL PURPOSES (PATHOLOGY) TRUST AT R.S.M.H. BE EXAMINED BY THE CROWN SOLICITOR.

CHAPTER 10 - RECOMMENDATIONS

1. THAT THE HEALTH COMMISSION:-

   (a) IMPROVE INFORMATION AVAILABLE TO BOARD MEMBERS AND PROVIDE ADVICE AND SUPPORT IN DISCHARGING THEIR RESPONSIBILITIES.

   (b) THOROUGHLY ASSESS THE VALIDITY OF THE CONCEPT OF AN OPEN HOSPITAL AS ESTABLISHED AT R.S.M.H. TO DETERMINE WHETHER IT SHOULD CONTINUE OR REVERT TO A CONVENTIONAL MODE.

   (c) THOROUGHLY ASSESS THE VALIDITY OF THE "MEDICAL MODEL" AS USED IN THE CAULFIELD COMMUNITY CARE CENTRE AS COMPARED TO CONVENTIONAL CENTRES AND DETERMINE FUTURE ACTION.

   (d) REVIEW THE CASE FOR SEPARATION OF THE COMMUNITY CARE CENTRE FROM THE HOSPITAL MANAGEMENT AND BOARD.

   (e) INVESTIGATE THE ADVANTAGES OF AMALGAMATING R.S.M.H. AND CAULFIELD HOSPITAL.

   (f) ENDEAVOUR TO EXPAND THE ACCREDITATION PROCESS TO PROVIDE IMPROVED ASSESSMENT OF MANAGERIAL AND ADMINISTRATIVE PROCEDURES.

2. THAT THE PRESENT BOARD OF MANAGEMENT BE REPLACED.

CHAPTER 11 - RECOMMENDATIONS - RECOVERY OF INCORRECT PAYMENTS

1. THAT THE FOLLOWING MATTERS BE REFERRED TO THE CROWN SOLICITOR FOR AN OPINION AS TO WHETHER RECOVERY OF THE PAYMENTS SHOULD BE PURSUED:-

   (a) PAYMENTS ABOVE THE AWARD CONDITIONS MADE TO PROFESSOR NAYMAN.

   (b) TERMINATION PAYMENTS MADE TO THE FORMER MANAGER, MR. STITFOLD.

CHAPTER 12 - RECOMMENDATIONS - OUTPATIENT SERVICES AT THE ROYAL SOUTHERN MEMORIAL HOSPITAL

1. THAT THE PRIVATE CONSULTING ROOMS BE LEASED TO THE DOCTORS AT NORMAL COMMERCIAL RATES.

2. THAT THE HEALTH COMMISSION REASSESS THE ROLE OF THE HOSPITAL, IN PARTICULAR TO ESTABLISH WHETHER IT SHOULD HAVE AN OUTPATIENTS DEPARTMENT.

CHAPTER ONE

BACKGROUND TO TERMS OF REFERENCE

1.1 INTRODUCTION

On 4th July, 1983, at the request of the Secretary of the Hospitals Division of the Health Commission of Victoria, Dr. I. A. G. Brand visited The Royal Southern Memorial Hospital (R.S.M.H.).

His terms of reference were:-

1. To advise on the establishment of appropriate procedures to settle grievances and to generally improve the industrial relations environment.

2. To review and advise on ways and means of improving communications between management and staff.

3. To examine management, personnel and supervisory procedures with a view to ensuring that standards of discipline are improved.

4. To assist and advise in the review of the management and organisational structure to achieve the above objectives.

Dr. Brand discovered a number of matters which he believed were of urgent importance, and prepared an interim report dated 7th July, 1983, to the Director of the Hospitals Division.

A second report to the Director of the Hospitals Division was dated 25th July, 1983, in which Dr. Brand recommended, inter alia, that the Chief Executive Officer be sent on eight weeks leave and that a competent administrator be placed in the hospital for this period.

Accordingly, the Board requested the Chief Executive Officer to proceed on leave and Mr. G. T. J. Henry was appointed Acting Chief Executive Officer of the hospital.

Mr. Henry made interim reports dated 22nd August, 1983, and 5th October, 1983, and a subsequent report dated 2nd November, 1983, to the Board of Management and to the Director of the Hospitals Division of the Health Commission of Victoria. These reports covered actions which had been taken in regard to Dr. Brand's recommendations and other matters which had come to Mr. Henry's attention which he believed required further investigation or corrective action by the Board of Management.

As a result of these reports, on 30th August, 1983 the Government referred the question of the management of The Royal Southern Memorial Hospital to the Economic and Budget Review Committee.

On 8th September, 1983, the full Committee appointed a Sub-Committee of four members to deal with this investigation.

The Sub-Committee consists of the following members:-

Mr. A. J. Sheehan, M.P., (Chairman)
The Honourable G. P. Connard, M.L.C.
Mr. P. M. Gavin, M.P.
Mr. B. J. Rowe, M.P.

1.2 TERMS OF REFERENCE - ECONOMIC AND BUDGET REVIEW COMMITTEE

1. To inquire into, report and recommend on the structure, organisation and management of The Royal Southern Memorial Hospital with particular reference to:-

   (a) procedures relating to selection, appointment, supervision and review of personnel establishment as well as rates of remuneration of non-medical staff;

   (b) rates of remuneration, methods of payment and hours worked by all medical personnel;

   (c) methods by which reports are prepared, the contents of reports and the execution and reporting back of decisions to the Board of Management;

(d) standards and effectiveness of internal and external auditing procedures; and

(e) methods of reporting and the contents of reports made to the Health Commission of Victoria.

2. To make recommendations if necessary concerning any incorrect payment to any officer or employee of The Royal Southern Memorial Hospital.

On receiving the terms of reference the Committee called for submissions by public advertisement in the daily press and by notices widely distributed within The Royal Southern Memorial Hospital.

Nine submissions were received and the Committee held hearings, both in public and in camera.

A consultant was appointed to conduct a study based on the Committee's terms of reference into The Royal Southern Memorial Hospital (Mr. R. S. Sims of Parkhill Lithgow & Gibson, a firm of chartered accountants).

The Committee has carefully considered the report from the Consultant, the reports by Dr. Brand and Mr. Henry, the nine submissions made to the Committee, and the transcripts of the hearings. This report of the Economic and Budget Review Committee is the outcome of these considerations.

In writing the report the Committee has considered each of the terms of reference separately and made recommendations, where necessary. The Committee as a result of its findings has decided to deal with two extra issues that are not specifically stated in its terms of reference, but are intimately connected. These are the special purposes funds, and the outpatient services.

CHAPTER TWO

THE ROYAL SOUTHERN MEMORIAL HOSPITAL

2.1 GENERAL BACKGROUND

The Royal Southern Memorial Hospital (R.S.M.H.) is a community hospital located at Caulfield, a suburb of Melbourne, on a site shared with the Caulfield Hospital, which is separately managed, and the Caulfield Community Care Centre, which is responsible to the Board of Management of The Royal Southern Memorial Hospital.

R.S.M.H. has 111 beds with an average daily occupancy of about 81% and an average stay of about 8 days. There are specialist medical units in surgery, medicine, anaesthetics and community care. In the year ended 30th June, 1983, 56% of inpatients were private or compensable patients, the remainder being hospital (standard or public) patients. The total operating expenditure in the 1983-84 year was $12,848,131.

The hospital was established in 1968 and available beds increased from 48 to 84 in the 1976/77 year and to 110 in 1977/78. There is still one unoccupied ward. R.S.M.H. is classified as a teaching hospital affiliated with Monash University.

R.S.M.H. was set up to function in a novel and experimental way. The concept originated in the Hospitals and Charities Commission to endeavour to integrate the services of the hospital into an overall community health service. Considerable planning and consultation were carried out to develop procedures and staffing patterns to directly involve community doctors and paramedical services in hospital treatment and follow-up action on discharge.

The development of the community care work resulted in the formation of the Caulfield Community Care Centre. There was also a new approach here in that the director of the Centre was a doctor and a more medically oriented approach was used with active participation by general practitioners. In comparison, many other community health services have a more social service than medical bias and nearly all are under non-medical managers.

In addition, Brighton Hospital was placed under the nominal control of the Board of R.S.M.H., although it was largely administratively independent, and had its own Committee of Management.

2.2 ORGANISATION STRUCTURE

The organisation chart of the hospital (see Table 2.1) is unusual compared with other hospitals in that it has medical records, pharmacy, supply and library responsible to the Manager for administrative matters and responsible to the Medical Director on matters of medical policy. Such dual responsibility is likely to create confusion, and is not optimal.

At the time of Dr. Brand's first visit the Manager was Mr. D. H. Stitfold and the part-time Medical Director was Professor J. Nayman. Professor Nayman was also Chief of Surgery. Professor Nayman resigned as Medical Director on 21st August, 1983, and Mr. Stitfold resigned from 31st December, 1983.

2.3 COMMITTEE STRUCTURE

The Committees which report directly to the Board are:-

Executive Committee
Finance Committee
Coordinating Committee
Divisional Committee
Community Care Centre Committee
Medical Advisory Board.

2.4 CONTEXT OF THE REPORT

Dr. Brand and Mr. Henry made a number of recommendations in their reports.

In regard to the individual terms of reference of this Inquiry many of the problems identified have been or are being resolved as a result of these recommendations. The Committee throughout the report will identify those problems which have been resolved.

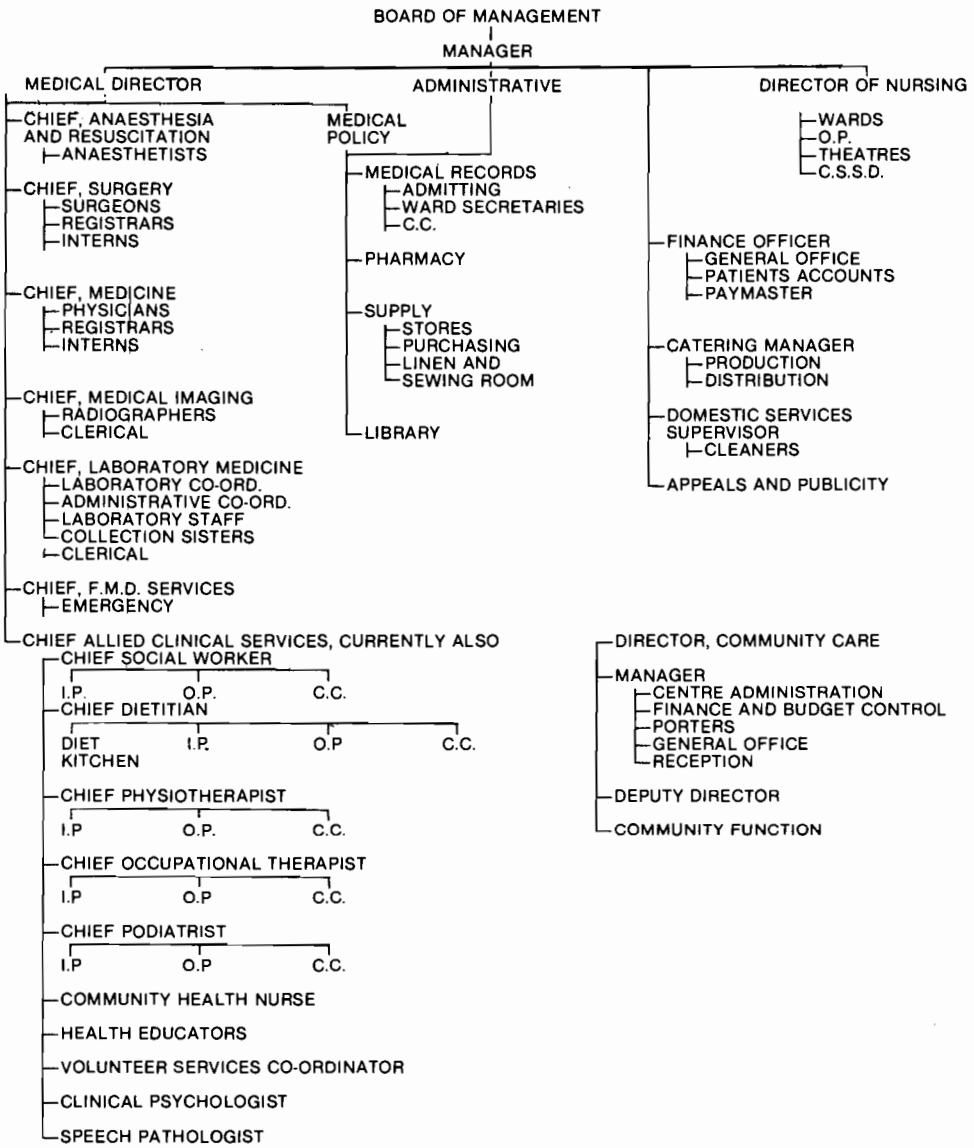
The Committee has largely concerned itself with matters in the hospital from June, 1982 to the present time.

TABLE 2.1

ORGANISATION CHART

THE ROYAL SOUTHERN MEMORIAL HOSPITAL

JUNE 1981



THIS CHART ILLUSTRATES LINES OF COMMUNICATION NOT ORDER OF SENIORITY.

(1) The Royal Southern Memorial Hospital Handbook "You, Your Job and Your Hospital".

CHAPTER THREE

PERSONNEL MANAGEMENT ISSUES

3.1 BACKGROUND

For a number of years R.S.M.H. has had industrial relations problems, and in 1982 there was a serious dispute in the catering department of the hospital. As a result of this dispute, a report was prepared by the Assistant Director (Industrial Relations) of the Personnel Division of the Health Commission which made the following comments, among others:-

> "It is clear that the Manager of the hospital could have acted more forcibly over the years to try to eliminate these problems which he admits have been occurring in this hospital in the past 16 years. This to me appears totally inexcusable.
>
> "Cooks and others have all given examples where in their respective opinions the Manager has failed to act either on one side or the other to eliminate or resolve some of the impasses which have occurred. It is inherent that the Manager:-
>
> (a) Become much more forcible in his approach to the problems; and
>
> (b) establish a well structured grievance procedure to allow access to both parties to review the problems currently existing. To that extent I strongly recommend that he discuss with his staff at all levels within the kitchen a desirable grievance procedure which might be implemented to solve disputes as they occurred rather than to allow them to snowball into insoluble disputes" (1).

(1) Report to Director of Personnel, HCV, dated 11th June, 1982, Page 11.

A year later Dr. Brand was unable to find any evidence that the Manager or the Board of Management took any significant notice of these comments. The Board still had not concerned itself in any effective way with the personnel problems of the hospital. Management had drawn up a grievance procedure but few of the staff knew of its existence, despite a copy being pinned to the board in the cleaners' locker room, while the shop stewards interviewed in Dr. Brand's inquiry did not know of the grievance procedure.

3.2 INDUSTRIAL SCENE AND PERSONNEL MANAGEMENT

Following the catering dispute in 1982 a part-time personnel officer was appointed, but as the Committee notes in Dr. Brand's report (1) she freely acknowledged that she had no experience whatever in industrial relations. Acting on Dr. Brand's advice a full-time professional personnel officer with experience in industrial relations was appointed by the Manager in August, 1983.

During the time there was no effective personnel manager, selection and appointment of senior staff was the responsibility of the Manager. The Director of Nursing and Medical Director were involved in the appointment of senior staff in their respective areas. The Sims report noted that the supervision of nursing staff was effective, but there was little administrative supervision of non-medical or medical staff (2). The review of personnel establishment was left solely in the hands of the Manager who had no professional skills in the area, and the Board of Management appears to have taken little interest in these matters.

(1) Dr. I. A. G. Brand, Report to Director of the Hospitals Division, dated 7th July, 1984, page 2.

(2) Mr. R. S. Sims, Report dated January, 1984, page 7.

3.3 THE IMPLICATIONS OF INADEQUATE PERSONNEL PRACTICES

Before Dr. Brand's initial visit industrial relations were characterised by confrontation, bitterness and poor communication particularly in the catering and cleaning areas. There were no formal personnel policies, none relating to selection, appointment and supervision of staff, or any form of executive manual. While these were prepared shortly after Dr. Brand's visit, the Committee has noted with concern that the hospital has been very slow to formally adopt them and institute a comprehensive personnel management system.

The Committee has been advised that other hospitals of a similar size, for example, Fairfield Hospital, have a full-time personnel officer experienced in industrial relations with well established personnel policy and procedure manuals. These include the hospital's policy in relation to selection, appointment and supervision of staff.

In his report to the Committee Mr. Sims stated that, ".... authority on personnel matters was delegated to departmental heads with inadequate control" (1). Personnel records, apart from those needed for pay purposes were decentralised, non-uniform and often incomplete.

The Committee notes that at R.S.M.H. the only review undertaken by the Board of the personnel establishment was in relation to actual numbers compared with the number approved by the Health Commission. This was closely monitored for budgetary control purposes.

The Committee considers that the Board's lack of attention to the development of adequate personnel practices in the hospital was a direct cause of the poor industrial relations and of the laissez-faire attitude at senior levels towards staff management.

(1) Mr. R. S. Sims, Report dated January, 1984, page 7.

However, the Committee has noted that the situation has improved since the personnel manager was appointed in August 1983 in that:-

(a) A policy manual has been prepared, although the hospital has been very slow to formally adopt it.

(b) Uniform procedures are being established for staff contracts and personnel records.

(c) There is greater consultation and improved communications with staff.

(d) Personnel files are being built up.

Given the poor industrial relations history at the hospital and the slow promulgation of the personnel policy manual, the Committee believes greater attention should be given, especially by the Board, to personnel matters. The Finance Committee of the Board of Management should be renamed the Finance and Staff Committee. This new Committee should concern itself with all matters relating to staff including industrial relations. The Board should give these a high priority.

3.4 RECOMMENDATIONS - PERSONNEL MANAGEMENT

1. THAT THE FINANCE COMMITTEE OF THE BOARD OF MANAGEMENT BE RE-NAMED THE FINANCE AND STAFF COMMITTEE.

2. THAT THE FINANCE AND STAFF COMMITTEE ENSURES THAT REGULAR REPORTS ARE SUBMITTED ON IMPORTANT MATTERS RELATING TO STAFF INCLUDING INDUSTRIAL RELATIONS.

3. THAT THE BOARD GIVE HIGH PRIORITY TO IMPROVING STAFF RELATIONS AND TO CONTINUE TO UPGRADE THE QUALITY OF PERSONNEL MANAGEMENT IN THE HOSPITAL.

CHAPTER FOUR

RATES OF REMUNERATION, METHODS OF PAYMENT AND HOURS WORKED -

NON-MEDICAL STAFF

4.1 BACKGROUND

The rates of pay for non-medical staff at R.S.M.H. were in accordance with the relevant awards, excepting that some positions were paid above the level specified for a hospital of this size. These were:-

	CURRENT ACTUAL SALARY	AWARD
	$	$
Paymaster	401.30	392.50
Supply Officer	463.00	433.10
Assistant Supply Officer	378.20	344.30
Purchasing Officer	358.98	344.30
Catering Manager	557.90	519.70
First Assistant Catering Officer	452.00	390.60
Second Assistant Catering Officer	328.30	312.30
Director of Nursing	616.20	580.50

The higher gradings for supply and catering were based on increased responsibilities for services outside the hospital, such as meals on wheels, supply and catering services to Caulfield Hospital, and supply services to Brighton Hospital. The present incumbents were engaged at these levels.

The Director of Nursing was paid at a higher level early in the hospital's history to attract a person with capacity to establish staffing and procedures for an expanding hospital. The paymaster was upgraded because of additional work on personnel matters in the absence of a personnel officer and because salaries were processed for a number of external organisations.

However, because a personnel officer had been appointed and the number of persons being paid had decreased, the new paymaster was appointed at the correct award level.

The Committee has been informed that these positions were upgraded after discussion with the Hospitals and Charities Commission and in some cases with the Victorian Hospitals Industrial Council many years ago. The Committee strongly believes that justification for these higher classifications must be reviewed before any new appointments are made to ensure new staff are appointed at the appropriate level.

4.2 TIME RECORDS

The Committee from its investigations has been disturbed at the lack of accountability in relation to time records. This is evidenced in the first report of Dr. Brand where he indicated, "the Manager informed me that only the four senior executives and sessional medical staff were not required to clock on. When we came to examine time cards selected at random, we found significant numbers of other staff who did not clock on.

"There seems to be little discipline and consistency in relation to the time cards. Many have no authorisation by a supervisor, even when a staff member is being paid on-call, re-call, shift allowances and overtime.

"A large number of payments were made off-line, and this situation should be reviewed.

"Actual times worked by staff are very frequently omitted.

"Some persons work regular overtime without any authorisation of supervisors, and other persons work large amounts of sporadic overtime, again without a record of authorisation.

"Where a supervisor does sign a clocked card this is frequently signed on one side of the card only, although overtime or penalties will be appearing on the second side of the card.

"If a supervisor calculates that certain hours have been worked on the basis of clocked figures, the salaries officer as a rule does not check that these calculations are correct. We found that frequently they were not correct.

"There is an almost complete lack of discipline in relation to part-time staff. Many of these work a larger number of hours than they have been engaged for, and no one at a managerial level seems to either notice or care" (1).

Further investigation for the Committee by Mr. Sims has confirmed that "Internal controls and internal audits on claims for payment were not adequate and there was considerable potential for abuse of the system" (2). This led to incidents of unsatisfactory time keeping as indicated previously.

The Sims report also showed that advice of pay changes and other payment details from departmental heads were sometimes made by handwritten notes with insufficient supporting data. A significant number of staff did not use the time card system, but either wrote in their attendance time (mostly paramedical staff), or had their pay cards filled in by the pay office (mostly senior executive staff).

While the situation has improved, the Committee believes there is need for greater control in this function. The Board in particular must ensure that each staff member completes a time record as required by the Industrial Relations Act 1979 (S.81).

4.3 LEAVE RECORDS

The Sims Report noted that, "Leave records are manually maintained in the pay office and are often duplicated in the operating departments" (3).

(1) Dr. I. A. G. Brand, Report dated 7th July, 1983, page 3.

(2) Mr. R. S. Sims, Report dated January, 1984, page 8.

(3) Mr. R. S. Sims, Report dated January, 1984, page 9.

These records were checked against time cards and the Committee believes that these have been accurately maintained and there is a satisfactory system for approval of leave. However, the Committee questions the necessity of duplicating leave records. This practice should be reviewed.

There are some cases of undue accumulation of leave and control should be improved to avoid this. The computer payroll facility is not used for progressive leave recording, and the Committee notes that this is very unusual in hospitals of this size.

4.4 RECOMMENDATIONS - NON-MEDICAL STAFF

1. THAT THE INTERNAL CONTROL AND INTERNAL AUDIT PROCEDURES RELATING TO SCRUTINY OF TIME CARDS, USE OF MANUAL TIME RECORDING AND CLAIMS FOR PAYMENT BE CONTINUALLY REVIEWED.

2. THAT ADVICE TO THE PAYMASTER ON CHANGES IN RATES OF PAY, ALLOWANCES OR JOB CLASSIFICATION BE SPECIFIED AND PROPERLY AUTHORISED.

3. THAT LEAVE RECORDING BE EXAMINED TO ASSESS THE NEED FOR DUPLICATED DEPARTMENTAL RECORDS AND TO UTILISE THE COMPUTER LEAVE RECORDING SYSTEM AVAILABLE WITH THE PAYROLL PACKAGE.

4. THAT A REVIEW OF THE POSITIONS PAID ABOVE THE NORMAL GRADINGS BE CARRIED OUT TO CONFIRM THEIR CURRENT JUSTIFICATION SO THAT NEW APPOINTMENTS ARE MADE AT THE CORRECT LEVEL.

5. THAT THE BOARD ENSURE EACH STAFF MEMBER COMPLETES A TIME RECORD AS REQUIRED BY THE INDUSTRIAL RELATIONS ACT 1979 (S.81).

CHAPTER FIVE

RATES OF REMUNERATION, METHODS OF PAYMENT AND HOURS WORKED - MEDICAL PERSONNEL

5.1 BACKGROUND

Salaries account for approximately 80% of the operating expenditure of hospitals. Medical staff make up a significant proportion of this, and are employed under three different awards.

(a) The Hospital Resident Medical Officers Award covers doctors appointed to a hospital on a full-time basis as resident medical officers. These are doctors in their first six years of hospital practice after graduation. At 30th June, 1983 there were 13 appointed at R.S.M.H.

(b) The Hospital Senior Medical Officers Award covers doctors employed whole time as medical superintendents, deputy medical superintendents, specialists or assistant specialists. The grouping of the hospital determines the actual level of payment (1). At 30th June, 1983 there were 3.5 equivalent full-time persons appointed under this award at R.S.M.H.

(c) The Sessional Medical Officers Award applies to all doctors providing medical services under sessional contracts. A standard session "means a continuous period of not more than three and a half hours' attendance by a sessional medical officer for the purpose of providing services for hospital patients or outpatients" (2). In addition some doctors, e.g. some radiologists, have individual contracts with the hospital to which they provide services.

(1) See page 28 for a discussion of the grouping of hospitals.

(2) Sessional Medical Officers Award.

The standard sessional rate is one-tenth of the weekly rate prescribed for the equivalent full-time classification in the Hospital Senior Medical Officers Award plus twenty five percent. 41 sessional medical officers were employed at R.S.M.H. at the 30th June, 1983.

There is a further group of doctors who are paid on a fee-for-service basis. These payments apply to doctors who render an account to the hospital for each patient seen and service performed.

The hospital pays the doctor the benefit component of the scheduled fee laid down in the "Medical Benefits Schedule Book" published by the Department of Social Security of the Australian Government. There were 163 general practitioners employed on this basis at R.S.M.H. at 30th June, 1983.

The hospital pays doctors for treating public (hospital or standard) patients. There is a separate system for private patients. For doctors employed under the Hospital Senior Medical Officers Award, payments for private patients are made into a Special Purposes Trust Fund. Resident Medical Officers do not charge private patients. All other doctors bill private patients directly.

The hospital did not have a full-time medical director and sessions (of 3 1/2 hours each) were allocated for this purpose, initially two, later increasing to five. Administrative sessions were also allocated to heads of medical departments, initially to plan the structure for the medical side of the hospital and later to co-ordinate and supervise individual sections, even though in many large hospitals with a full-time medical director sessional doctors are not paid administrative sessions.

The total medical payments made are outlined in Table 5.1.

The Committee believes the major points for discussion in relation to medical payments are:-

TABLE 5.1

MEDICAL STAFFING OF THE HOSPITAL

Sessional Allocation Including Administrative Sessions	
Medical Superintendent	5
Heads of Divisions	3
Full Time Salaried Staff:	
Pathology - 2 x 10	20
Community Care - 1 x 10	10
Family Medicine - 7 x 1/2	3.5
University Consultants	4
Total	45.5
Clinical Sessions	73
Total	118.5 sessions
Resident Medical Staff - equivalent full-time	13

(a) The effective control of disbursements and the extent of Board participation.

(b) The system for authorising payments.

(c) The rates at which payments were made.

(d) The basis and adequacy of sessions allocated.

5.2 CONTROL OF PAYMENTS

The following discussion deals in detail with the allocation and distribution of sessions at R.S.M.H.

5.2.1. ALLOCATION OF SESSIONS

Sessions were allocated to the hospital based on expected need by the Hospitals and Charities Commission, initially for administrative purposes, when clinical services were paid on a fee-for-service basis, and later an additional allocation was made for clinical purposes on changeover to a sessional method of payment.

The Committee is concerned that although there was some duplication in the two groups of sessions, there appears to have been no review of the total allocation. Furthermore the number of allocated sessions has remained unchanged even though there has been a substantial reduction in non-private days over the last three years of about 17%. As sessions are allocated on the basis of need (i.e. the numbers of public patients to be treated), this has resulted in an excess number of sessions over those needed. The Committee believes this is a serious fault in the health system, of Victoria and lays the blame with the Board of Management and the Health Commission, as it is an issue of budgetary allocation, performance and control.

Medical specialists are paid by the hospital for treating standard (public) inpatients on a sessional basis. Private and compensable patients are charged directly by their doctors. Compensable patients are those for whom payments are made by a third party, e.g. motor accident or workers compensation patients.

One important hospital statistic which reflects the workload on staff is the number of beds occupied by inpatients, and the Committee has used the measure of the number of beds occupied by standard (public) inpatients in considering the appropriate sessional allocation to R.S.M.H.

The Committee has found that the total allocation of sessions for visiting medical staff, excluding 5 sessions allocated for the medical director, was 10.5 administrative sessions and 73 clinical sessions. This was almost 2 sessions per average occupied standard inpatient bed for the year ended 30th June, 1983. This level of payment is much higher than the average for most Victorian public hospitals, especially as R.S.M.H. argues that it does not provide a medical outpatient service (1). The Committee notes that the average initial sessional allocation for Victorian public hospitals is 1.4 sessions per average occupied standard inpatient bed, and this figure includes a component for treating outpatients. After the initial allocation, the Health Commission uses a figure of 1.2 sessions.

The high level of the ratio at R.S.M.H. arises also because the total sessional allocation was set some three years ago when the non-private inpatient bed days were considerably higher than now, and also from failure to take account of the administrative sessions in determining the allocation.

The initial allocation of administrative sessions at R.S.M.H. was high because there was no full-time Medical Director. Given the appointment of a full-time Medical Director, the Committee believes there is much less need to provide administrative sessions to clinicians, and this situation should as a matter of principle be reviewed both by the Board of Management and the Health Commission.

(1) Refer to Chapter 12, Page 82 for a discussion of the status of the outpatient services at R.S.M.H.

The Board's attitude to the issue was that the allocation of sessions was an executive function and this, together with gradings of positions and rates of payment, were matters to be determined by the executives and the Health Commission. Board members stated that they were completely unaware of these matters and did not consider that such detail was their proper responsibility. In his submission Mr. R. L. Benjamin, President of The Royal Southern Memorial Hospital, said, "The Board made itself aware that the total of payments made were within, or explicably near, the budget laid down by the Commission.

"It is submitted that the Board did not have, does not have, nor should be expected to have the technical knowledge necessary to interpret and supervise these complex matters.

"It is relied, and should be entitled to rely, upon its Chief Executive Officer, its Medical Director, and the Commission in these areas" (1).

The Committee believes the Board's view is inappropriate, as this is a major area of expenditure and also determines the distribution of medical effort in the hospital. While the Board cannot be expected to be aware of all the details, it should have ensured that the internal controls (refer to page 46) did not allow improper payments to be made to staff.

The attitude of the medical staff was that, having been funded for a given number of sessions, the fair allocation and distribution of these amounts was an internal divisional matter and nothing to do with the Board. From time to time the agreed distributions were checked against the average number of inpatients treated by each sessional staff member, but apart from this there was effectively no review of sessions allocated or distributed.

On the basis of the evidence received the Committee cannot accept the doctors' position. The number of sessions obviously requires review downwards, and the Board should concern itself in these matters.

(1) Mr. R. L. Benjamin, Submission dated 24th November, 1983.

5.2.2 DISTRIBUTION OF SESSIONS

While the total allocation of sessions was determined by the Hospitals and Charities Commission, the effective control of distribution of clinical sessions rested with the Divisional Committee of the Medical Staff with the Medical Director playing a dominant role. However, the decisions of the Committee were never minuted and therefore did not come to the attention of the Board of Management, except in relation to the total allocation of sessions to the various divisions. The hospital Manager was aware of the allocations, but did not inform the Board. The Economic and Budget Review Committee was not able to establish a reason for this poor administrative control.

The funds were disbursed to the medical staff either by way of payment through the payroll system, by cheque from a capital or equalisation account, or by cheque from the hospital operating account. Some staff received payments by several methods, and the Committee on the basis of Mr. Sims' report found it extremely difficult to obtain a composite picture of the payments made.

In the case of the Division of Family Medicine, which encompassed the general practitioners on the staff, payment was continued on a fee-for-service basis. A sessional distribution was made for Family Medicine, and the equivalent funds for the division were transferred on a monthly basis initially to a capital account and later to a medical equalisation account. Payments were made from this on the basis of accounts rendered by the visiting general practitioners. For the other divisions, sessions were allocated to individuals, but some sessions were reserved as pool sessions for later distribution depending on the proportionate workload on on-call and re-call activities. In this case sessional funds were transferred to the capital account (later designated a medical equalisation account) and payments were made by cheque from the account. This account was a section of the capital account to which the sessional funds were transferred and from which payments were made to the doctors. The Committee believes this is an unsatisfactory situation since it is important to provide effective monitoring of expenditure as it occurs, rather than assume it is available for distribution or allocation regardless of activity.

The control of this aspect was largely informal, and if excessive allocations of sessions occurred, it was difficult to detect.

Not all the funds transferred to the medical equalisation account were distributed, and the account currently has a balance of the order of $100,000. Payments were also made from the surplus funds in this account for some paramedical staff approved by the Hospitals and Charities Commission on the understanding that the hospital would provide the necessary funds. These funds should have been available for reallocation by the Commission. The Committee believes the hospital gained extra staff by falsely reporting to the Hospitals and Charities Commission and later the Health Commission of Victoria. The Board stated in evidence it was unaware of these and similar transfers.

The Committee cannot accept the Board's lack of awareness of these important matters.

Further evidence of the lack of Board control appears from Mr. Sims' investigation. He found that from time to time, on the authority of the Medical Director, amounts were paid from the pool sessions, presumably by agreement within the divisions. This was in effect the payment of a dividend to the recipients without adequate records, and the Committee cannot condone this in any way. The Health Commission appears to have been quite unaware of this unusual arrangement.

5.2.2.1 MEDICAL DIRECTOR - SPECIAL ARRANGEMENT

When the hospital was established there was insufficient work for a full-time Medical Director. Professor Nayman was at first paid 2 sessions, then later 5 sessions per week as part-time Medical Director, and 1 administrative session as head of surgery. At the change from fee-for-service to sessional remuneration, he was allocated 6 sessions as clinical sessions for public patients and 3.18 sessions for on-call/re-call. In addition, he saw over 30 patients per week in the private consulting clinic and attended private patients in the hospital.

The clinical work on private patients exceeded that of public patients with some 70% of total operating time and more than half the inpatient days involving private patients. The total payment for hospital non-private work was clearly at an unacceptably high level, representing 12 half-days per week plus re-call/on-call.

The Committee believes that even though the various elements of this allocation were approved separately by the Hospitals and Charities Commission (administrative sessions), and the Divisional Committee (clinical sessions), the total package when reviewed in conjunction with his private patients and other commitments is unacceptable.

Other areas of neglect relate to the four "administrative" sessions paid to four university personnel to cover specialist consulting services which provided additional expertise in areas of pathology outside the main clinical specialty of the full-time pathologist, who was a specialist in histopathology.

The need for this support should be reviewed when the new Director of Pathology takes up duty. Mr. Henry reported that, "Professor Linnane of Monash University is paid as a consultant to the department at the rate of one medical session. Professor Linnane is not a medical graduate and I recommend that Professor Linnane be paid at a rate commensurate with his qualifications" (1).

Furthermore, sessions payable to university staff should be paid to the university department rather than the individual concerned. In the case of one professor, payment was made, on his behalf, to a trust, and in the other cases the payments were made direct to the individuals.

Substantial sums were paid outside the payroll system by cheque. In 1980/81 this amounted to over $231,576 but was reduced to $16,503 in the following year.

(1) Mr. G. T. J. Henry, Report dated 2nd November, 1983, page 11.

Statements of Earnings to the Taxation Office were not prepared for these payments. This was an administration error. Retrospective amending advice was given to the Taxation Office in July, 1983.

A consequence of the employment of a part-time Medical Director with other pressing commitments was a failure to establish adequate medical administrative practices in relation to such areas as administrative procedures, systems for claiming and authorising payments, liaison with other departments and review of gradings and payments.

Since the employment of a full-time Medical Director, there has been a substantial change in many of these matters and this can be expected to continue.

5.2.2.2 CONCLUSION

The Committee found that the procedures for allocating and distributing sessional funds were unsatisfactory in several ways:-

(a) The Board's attitude towards the payments. Medical staff salaries are a sizable component of the hospital's expenditure, and the Board must ensure that the lack of internal controls does not allow improper payments to be made to medical staff. There was no review of the total allocations of sessions to the doctors despite a substantial fall in public (standard) bed days. These problems lead to improper payments being made, with an inappropriate allocation of resources to the hospital. The Board's attitude to these payments can only be described as negligent.

(b) Transfer of operating funds to the capital or medical equalisation fund and retention of the unexpended balance as a reserve fund is improper practice as it represents a diversion of unspent operating income which will continue to be funded by the Health Commission.

(c) The allocation of unassigned pool sessions on the authority of the head of division even though it represented amounts which could have been distributed as sessions in the first instance, is not an acceptable practice, particularly when heads of division are directly involved and substantial sums are distributed, as there is no independent assessment and authority for such payments.

(d) The sessional award provides for a 25% loading on full-time salary rates for sessional staff up to a maximum of 6 sessions excluding on-call sessions, whether at this or any other hospital. This should have been applied to payments to Professor Nayman who was receiving 12 standard sessions, an overpayment of 1 1/2 sessions per week or around $8,100 per year. There were no other known cases where this reduced rate should have applied. It was an administrative error.

The Committee notes that medical officers are now being paid at a more appropriate level than previously. Systems have been established for claiming payments by staff and for the proper authorisation of these payments. Time records have been introduced.

The Committee believes on the above evidence that the additional cost of a full-time Medical Director is fully justified and overdue.

5.3 AUTHORISING PAYMENTS

The Committee has noted that the Senior Medical Officers Award provides that payments "shall be made by a hospital only after receipt from the sessional medical officer of a signed claim setting out in detail the services for which the claim is made" (1). In fact, many of the sessional payments at R.S.M.H. were made automatically and routinely without any form of claim being received. Claim forms were often only put in when a re-call claim was involved and often were not countersigned by the head of division. A major exception here was the Anaesthetics Division where claims were meticulously signed and countersigned.

(1) Senior Medical Officers Award.

Claims for fee-for-service payments by family medicine doctors were forwarded as a normal practice invoice, and were checked to ensure the patient was a non-private patient and that the charge agreed with the fee schedule. No authorisation for payment was given. This should have been done by the Medical Director.

Periodically, but infrequently, the head of the division reviewed the paid accounts for reasonableness of charges. There was no procedure for noting all visits either administratively or on the medical record. Mr. Sims checked a number of claims against the medical record entries and found ".... it is not possible to authenticate claims from this source" (1). While there is no evidence of general overservicing some claims include daily visits by the doctor.

Control of overservicing was a matter of concern and discussion within the Division of Family Medicine, but the value of total claims was less than the allocated sessions for the division. A new system has now been initiated to provide supporting evidence in these cases.

The solution to the payment of sessions which relate to intermittent visits and varying time spent which may involve both private and non-private patients is much more difficult. The Committee believes that each payment period should be covered by a signed claim and this should be countersigned by the division head or another person, as is done in a number of large hospitals. Distribution from the pool should also be externally scrutinised and authorised by the Medical Director, and there must be some documented rationale for payment.

(1) Mr. R. S. Sims, Report dated January, 1984, Appendix 2/4.

5.4 RATES OF PAYMENT

Mr. Sims reported that, "There is no problem with payments based on fee-for-service since charges are related to a set schedule. However, sessional payments are determined by the class of hospital, the grade of specialist and the number of sessions. There has been disagreement as to the correctness of each of these elements" (1).

5.4.1 HOSPITAL GROUPINGS

The Hospital Senior Medical Officers Award allots each major hospital to a particular group. The criteria for grouping are size and complexity of the hospital, and the status of the hospital in relation to teaching medical students. The Royal Southern Memorial Hospital has only recently been included in the grouping structure.

The groupings now specified are:-

Group 1A

Alfred, Austin, Fairfield, Prince Henrys, Queen Victoria, Royal Childrens, Royal Melbourne, Royal Victorian Eye & Ear, Royal Women's and St. Vincent's Hospital.

Group 1B

Geelong, Preston and Northcote, Western General and Box Hill.

Group 2

Ballarat Base, Bendigo Home, Bendigo Base, Caulfield, Kingston Centre, Mount Royal, Queen Elizabeth Geriatric and Royal Southern Memorial.

(1) Mr. R. S. Sims, Report dated January, 1984, Appendix 2/5.

Group 3

Alexander, Gippsland Base, Hamilton Base, Mildura Base, etc.

In the absence of formal grouping, R.S.M.H. selected Group 1A for all its specialists. This is the highest grouping and includes the major teaching and specialist hospitals of substantial size.

Since Group 1B includes hospitals which are larger and more complex than R.S.M.H., the selection of Group 1A was quite inappropriate. This has now been recognised and the hospital has recently been reclassified by the Hospitals Remuneration Tribunal to Group 2 for inclusion in the award.

Despite considerable effort Mr. Sims was unable to determine by whom the original decision was made. There is no reference to it in Board minutes and Board members say they were quite unaware of the grouping. The opinion is noted in the Divisional Council (Medical) minutes on one occasion that Group 1A was thought to be appropriate but there is no other mention of this which the Committee has been able to locate. The Committee is dismayed at the lack of Health Commission control in this important area.

The regrouping from 1A to 2 only affects Specialists Class 4 who must be reclassified to Class 3, and Medical Superintendents. The current award rates are as follows:-

Specialist Class 4 Group 1A	$1,057.20 per week
Specialist Class 3	$ 967.50 per week

The difference is $89.70 per week or $4,644 per year for each full-time Class 4 specialist or $11.21 per session of 3 1/2 hours for sessional staff, incorporating the sessional 25% loading.

There were 22 sessional medical staff utilising 66.18 clinical sessions being paid as Class 4 specialists prior to May 1983. The balance of the clinical sessions was paid into the medical equalization fund (refer to Table 5.1). As Group 2 is now the award classification, the difference would have been in total $38,526 per year. Class 4 is only appropriate to Group 1A or 1B hospitals and the maximum level for R.S.M.H. became Class 3 for senior specialists in a Group 2 hospital. The amount of $38,526 includes $21,518 which arose from inappropriate classification of some positions as heads of department.

5.4.2 SPECIALIST GRADING

Most of the specialists at R.S.M.H. were graded as Class 4. This is defined in the Senior Medical Officers Award as "a practitioner appointed as a head of a department or section to a teaching hospital Group 1A or Group 1B who possesses a higher qualification appropriate to the specialty in which he is employed and who has had not less than eight years practical experience in that specialty after obtaining the higher qualification.

"Provided that a practitioner may be appointed a Specialist Class 4 by the hospital concerned if he has had sufficient experience in his specialty to satisfy the Hospital" (1).

A Class 3 specialist is identically defined with the omission of the phrase "appointed as a head of a department or section".

(1) Senior Medical Officers Award.

There were only four "heads of a department or section" in R.S.M.H. who, under the accepted interpretation of Specialist Class 4, should have been Class 4. The remainder should have been classified as Class 3 if they had the defined qualifications and experience.

This was recently recognised in the hospital and all but the four departmental heads were reclassified below Class 4 prior to the regrouping of the hospital to Group 2. The Australian Medical Association states, "The allocation of sessions and the payments for sessions to the medical staff at the hospital have now been rearranged to accord with the views expressed by Dr. Brand in his report" (1). The Committee also believes this is appropriate. The 18 affected positions involved 37 sessions. The difference for this group between Class 4 and Class 3 is $21,518 per year.

A further problem arises in the case of general practitioners who have been held in the past not to hold a specialist qualification under the determination, even though they have done post-graduate studies in general practice. In other hospitals where general practitioners are attached to specialist units (a fairly rare occurrence) they have been paid as Specialist Class 1 with the concurrence of the Commission.

Mr. Sims has advised the Committee that this matter was discussed with the Commission in the planning stage for the Family Medicine Group with a recommendation to the Commission that the experienced general practitioners should be given the status of specialists. The Committee has been unable to locate any documentation to support this and there is no record in the Commission files agreeing to a departure from the accepted interpretation of the Commission instructions relating to general practitioners.

The Senior Medical Officers Award provides some discretion to the hospital to pay specialists at a higher grade if they are satisfied that the experience of a specialist is considered to justify it, and the Board of Management has obtained legal opinion which suggests it is able to pay a general practitioner at the higher rate.

(1) Australian Medical Association Submission, November, 1983, page 9.

However, it is clear such a discretion was never exercised by the Board of Management. The doctors were simply paid at the higher rate for reasons which can no longer be ascertained. The Committee believes it is inexcusable that such matters could occur without adequate documentation.

The Health Commission two years ago issued new guidelines for payments to general practitioners which allows them to be paid at higher classifications than previously, so this is no longer a problem.

Medical staff on appointment were not formally advised of the grading allocated or their sessional payment rate. The Committee believes they had no reason to question the validity of the payments and were entitled to believe that the level assigned to them by the hospital was appropriate.

5.4.3 PAYMENT OF LOADING ON SESSIONS

The Sessional Medical Officers Award provides that sessional medical staff be paid at the equivalent rate for full-time medical staff plus a 25% loading for sessions up to a maximum of six sessions per week, whether at one or more than one hospital, and at the full-time medical staff rate for more than six sessions taking account of sessions at this and any other hospital. This restriction does not apply to on-call sessions (1).

The Committee have found that this reduction of payment for sessions in excess of six was not applied by the hospital management. The only significant case which should have involved a reduction in payments if the award applied was that of Professor Nayman who was paid a total of 6 administrative sessions, 6 clinical sessions and 3 (and later 3.18 sessions) for on-call/re-call. The overpayment was for 6 sessions at 25% of the rate for salaried staff, that is 1 1/2 sessions or, at current rates, about $8,100 per year.

(1) Sessional Medical Officers Award.

5.5 ADEQUACY OF SESSIONAL PAYMENTS

The administrative sessions predated the changeover from fee-for-service to sessional payment. As previously stated the Committee believes the need for these sessions should be reviewed.

The 73 clinical session allocation appears to be based originally on 1.2 sessions per average non-private inpatient and this figure was used in discussions on the adequacy of sessional allocation.

Medical staff contend that their contribution to the hospital is far in excess of the paid non-hospital patient service. The Australian Medical Association claims "there is a deficiency in the sessional allocation in the order of 37.68 sessions per week" (1). The major factor in this argument relates to on-call payment.

The Sessional Medical Officers Award provides that, for a medical officer who makes himself available for exclusive on-call to the hospital for seven days per week, a payment of 9 sessions is payable. If each of the three specialist divisions of the hospital rostered a medical member on-call each night and each weekend day, a total of 27 sessions would result, leaving only 46 sessions for clinical work.

On the other hand the Committee believes that:-

(a) For a hospital of 110 beds without an emergency department the need for exclusive on-call for each department is unnecessary, particularly as 24 hour service is provided for each unit by registrars and residents and the family care units operate on a fee-for-service basis.

(1) Australian Medical Assocation Submission, November, 1983, page 10.

(b) Some of the administrative sessions should have been covered by the clinical session payment. Administrative responsibilities for divisional heads would normally have been considered as having been remunerated by the difference between Class 4 (head of department) and Class 3 salary. Further, the four consultative sessions to staff of Monash University, while probably appropriate in the developmental stages, as pointed out by Mr. Henry and Mr. Sims, are now difficult to justify and the Committee has not been able to find any other large public hospital which makes such payments.

The Committee notes that in submissions received it is stated that the hospital does not provide outpatient services. The sessional allocation normally includes a component for outpatients. In addition, the number of non-private inpatient days has declined over the last three years by 17%.

An examination of the correct sessional allocation is a complex and time consuming exercise beyond the scope of this inquiry. A preliminary analysis suggests that the allocations were high on an inpatient day basis by comparison with other hospials. A detailed reassessment should be undertaken by the Health Commission, taking account of both administrative and clinical work. The Committee believes that the sessional allocation is more than adequate for the present non-private patient workload, both because of the fall in standard patient bed days and the appointment of a full-time Medical Director.

5.5.1 SALARIED STAFF

Mr. Sims reported that "Resident Medical Staff and Registrars are paid in accordance with the award. Full 24 hour cover was provided for each of the divisional wards and this involved extraordinarily long hours being worked and paid as there are few persons employed. The cover has now been reduced somewhat with a reduction in payments" (1). Dr. Brand found that claims for additional hours were neither signed by the resident nor countersigned.

(1) Mr. R. S. Sims, Report dated January, 1984, page 19.

The head of the pathology department and the director of the Community Care Centre were classified as Class 4 Group 1A. The pathology department head is directly affected by the change of the hospital to Group 2. The position of the director of the Community Care Centre is not clear since there is no precedent for this position and it is not covered by the relevant awards. This matter should be discussed with the Health Commission to establish the appropriate level. The Committee believes this should not be Class 4 Group 1A, which as stated earlier only applies to specialist departments in the large teaching hospitals.

The head of pathology had the right of private practice and a Special Purposes Trust fund was set up to receive the private patient income, to pay expenses and to make distributions. The trust was set up somewhat in line with recommendations by the Hospital and Charities Commission. The trust received income from fees of private patients treated in the pathology department. The operation of the trust is discussed in detail later in the report. At this stage the personal income of the chief pathologist is only considered. The trust deed provides for the payment of a "bonus of not more than 25% of total hospital salary of the medical officer by way of income derived from private practice" and, in addition, for payment of "cost of travel within Australia and abroad of whole time Medical Officers", subscriptions to professional associations, and costs of textbooks and journals used in his work. The chief pathologist received salary, on-call allowance, re-call payments, and a bonus, travel grants and allowances for local travel, subscriptions, books etc., from the Special Purposes Trust. In addition, he received a bonus of $3,500 from Moorabbin Hospital as approved by the Hospitals and Charities Commission in 1976 and occasional travel grants from Moorabbin and Mordialloc-Cheltenham Hospitals where he also provided service.

The chief pathologist was paid the following income in addition to the salary of a Class 4 specialist ($54,974).

	Year ended 30th June 1982	1983
Bonus for previous year - Special Purposes Trust	14,275	15,717
On call	3,997	2,738
Re call	7,190	2,813
Bonus - Moorabbin Hospital	3,500	3,500
Travel Grant etc. - Moorabbin	-	1,000
- Mordialloc-Cheltenham	-	1,000
- RSMH Special Purposes Trust	2,000	18,219
	$30,962	$44,987

Note 1: 1982/83 included substantial leave.

2: These figures exclude payments for local travel, subscriptions etc. reimbursed through petty cash.

The bonus payment from R.S.M.H. Special Purposes Trust was based on 25% of total salary including on-call and re-call. The Committee believes these on-call and re-call payments should have been excluded from the calculation, as the bonus should be related to base salary alone. Future payments must be at the proper level. The level of travel grants was at the discretion of the trustees.

Both Mr. Sims and Mr. Henry reported to the Committee that re-call is most unusual at this level, although it is provided for in the award. Most payments for re-call related to weekend work and may not have been emergency re-calls. The second pathologist shared on-call and re-call payments and received bonus and travel payments from 1980/81. Payments were approved within the department and time card claims were sketchy in detail. The validity of the re-call payments cannot now be established.

5.5.2 CONTRACT MEDICAL STAFF

The only contract doctor at R.S.M.H. is the radiologist. He is under contract to provide 24 hour, 7 days a week service for a fee comprising 40% of the scheduled Commonwealth fee for all non-private patients treated. The radiologist also agrees to pay the hospital 60% of private fees collected from private patients treated in the hospital department. The arrangements are as approved by the Commonwealth Government except that the original agreement provided for 42% of the scheduled fee to be paid to the radiologist for non-private income and was reduced at the instigation of the radiologist to 40%. Mr. Sims' investigation showed "that records are meticulously kept and all payments to the hospital and the radiologists are according to the contract. Patient billings are well controlled and write-offs are properly authorised and not excessive" (1).

The gross income to the radiologist in the year ended 30th June 1983 was:-

Treatment of non private patients (40% of Scheduled Fee)	$ 67,321
Income from private patients (60% of private fees collected)	$ 88,079
	$155,400

From this income, the radiologist is required to provide full cover including relief on sick leave, annual leave, etc. This involves employment of other sessional radiologists on both a routine and locum basis.

(1) Mr. R. S. Sims, Report dated January, 1984, page 21.

It has been suggested that the use of a full-time salaried radiologist would be more economical to the hospital than the contract arrangements. After allowing for current salary rates, salary oncosts, provision of on-call and relief staff and assuming that the current right of private practice conditions applied via a special purposes fund, the Committee believes there would be no significant gain. This may not apply if new private practice conditions are negotiated for full-time staff. If the conditions for private practice for full-time staff or the contractual arrangements for radiologists vary, the situation should be re-examined.

The Committee is concerned with what appears to be a shortage of radiologists in Australia. The shortage has allowed this group to be paid, by community standards, at extremely high remuneration levels. The current costs of training radiologists is borne by the taxpayer in the form of grants to the Health Commission and thence hospitals. The number of radiologists approved to practise is determined by the College of Radiologists, which is the examining body as well as being the professional association. The shortage of radiologists has meant substantial occupational rent has been accrued to this group. The Committee believes an urgent review is required to determine whether the "high" cost of radiologists is a supply problem (i.e. low numbers of radiologists trained and or registered per annum), and/or a demand problem (i.e. a large need for radiologists). Depending on the causes, possible solutions to the problem could be an increase in the number of overseas radiologists admitted for practice in Australia, reform of exit and entry provisions, and/or an occupational licensing tax.

5.6 CAULFIELD COMMUNITY CARE CENTRE

The medical costs of the Caulfield Community Care Centre are much higher that is normal in community care centres because of the level of medical participation and the organisation of area liaison groups. The sessions used are in accordance with those approved by the Health Commission. The Centre has now been in operation long enough for a realistic assessment of costs and of the organisational approach taken. The Committee believes that the Health Commission should as quickly as possible undertake this assessment.

5.7 ACTION TAKEN

The Committee has from its investigations found that action has already been taken in the following matters:-

(i) The hospital has now been graded as a Group 2 hospital.

(ii) The sessional medical staff have agreed to reduce the number of Class 4 positions and these will be largely eliminated with the regrouping of the hospital.

(iii) Some reduction has been made in resident medical officers hours.

(iv) A full-time Medical Director has been appointed.

(v) Medical staff have been formally advised of their correct gradings and salary levels.

(vi) All medical staff are now required to submit a formal claim for sessions which is countersigned by the Medical Director.

(vii) Fee-for-service staff are required to note their attendance in the medical record.

5.8 RECOMMENDATIONS - MEDICAL PAYMENTS

1. THAT THE BOARD OF MANAGEMENT CONCERN ITSELF WITH THE ISSUES INVOLVED IN THE PAYMENT OF MEDICAL STAFF.

2. THAT A DETAILED REASSESSMENT OF THE SESSIONAL ALLOCATION FOR VISITING SPECIALISTS BE CARRIED OUT BY THE HEALTH COMMISSION, WITH PARTICULAR ATTENTION TO ON-CALL REQUIREMENTS AND THE INTEGRATION OF ADMINISTRATIVE AND CLINICAL SESSIONS.

3. THAT THE BOARD OF MANAGEMENT IN ASSOCIATION WITH MANAGEMENT ESTABLISH APPROPRIATE EXCEPTION REPORTING MECHANISMS TO PROVIDE ADEQUATE OVERSIGHT OF LEVELS OF PAYMENT TO MEDICAL STAFF.

4. THAT APPROPRIATE INTERNAL CONTROLS AND INTERNAL AUDIT PROCEDURES BE INTRODUCED TO CHECK THAT PAYMENTS OF SESSIONAL AND FEE-FOR-SERVICE CLAIMS ARE PROPERLY MADE OUT AND AUTHORISED.

5. THAT ALL PAYMENTS FOR VISITING MEDICAL STAFF WITH THE EXCEPTION OF FEE-FOR-SERVICE PAYMENTS BE MADE THROUGH THE PAYROLL SYSTEM WITH A SINGLE APPEARANCE FOR EACH MEDICAL STAFF MEMBER.

6. THAT ALL DISCUSSIONS RELATING TO MEDICAL PAYMENTS AT THE DIVISIONAL COMMITTEE BE PROPERLY MINUTED AND INCLUDED IN BOARD REPORTS.

7. THAT THE POLICY ON RE-CALL PAYMENTS FOR PATHOLOGISTS BE REVIEWED.

8. THAT THE NEED FOR SESSIONAL ALLOCATIONS FOR PATHOLOGY CONSULTANTS BE REVIEWED WHEN THE NEW DIRECTOR OF PATHOLOGY IS APPOINTED AND, IN THE MEANTIME, ALL SESSIONAL PAYMENTS BE MADE TO THE APPROPRIATE UNIVERSITY DEPARTMENT.

9. THAT TRANSFERS FROM OPERATING ACCOUNT FOR FEE-FOR-SERVICE PAYMENTS BE RELATED TO EXPENDITURE LEVELS AND BE MADE VIA A SUSPENSE ACCOUNT RATHER THAN BY ROUTINE TRANSFER TO A RESERVE ACCOUNT SO THAT THE OPERATING ACCOUNT REFLECTS ACTUAL COSTS.

10. THAT ACTION BE TAKEN BY THE HEALTH COMMISSION TO REVIEW THE GROUPING OF HOSPITALS NOT INCLUDED IN THE SESSIONAL MEDICAL OFFICERS AWARD TO ENSURE THAT APPROPRIATE MEDICAL PAYMENTS ARE BEING MADE.

11. THAT THE ECONOMIC AND BUDGET REVIEW COMMITTEE CONDUCT A DETAILED STUDY INTO THE MARKET FOR RADIOLOGISTS AND RECOMMEND POSSIBLE POLICY SOLUTIONS.

12. THAT THE HEALTH COMMISSION AS QUICKLY AS POSSIBLE ASSESS THE COSTS OF THE CAULFIELD COMMUNITY CARE CENTRE AND ITS ROLE INCLUDING THE ORGANISATION APPROACH OF THE CENTRE.

CHAPTER SIX

REPORTING TO THE BOARD OF MANAGEMENT

6.1 BACKGROUND

Mr. Henry reported, "The Committees which report directly to the Board are:-

Executive Committee
Finance Committee
Coordinating Committee
Divisional Committee
Community Care Centre Committee
Medical Advisory Board" (1).

He recommended "that the Board reviews the role of each of the committees which reports directly to it, in consultation with the Chief Executive Officer, and lays down clear items of reference for each committee" (1). The Committee supports the recommendation.

6.2 REPORTING AT R.S.M.H.

The Committee understands that normal hospital practice (indeed normal "Committee" practice) is for minutes to be kept of each of these meetings, and for the minutes to be presented at the Board meeting with the Chairman of each Committee making a report to the Board (from the minutes if necessary). These minutes should then be filed with the Board minutes and should be initialled by the Chairman of the meeting as happens with the Board minutes at R.S.M.H.

All the Consultants to the Committee found that reporting to the Board was quite inadequate. There were no minutes of the Finance or Executive Committee meetings. A report was made from these meetings

(1) Mr. G. T. J. Henry, Report dated 2nd November, 1983, pages 5 and 6.

and was presented to the Board, but neither the Finance nor the Executive Committee reports from the meetings were filed with the Board minutes, and neither of them was confirmed at any subsequent meeting. The reports were adopted by the Board and this was considered to be confirmation of the accuracy of the business of the particular meeting.

The Board minutes were incomplete in that they were very brief, and did not record recommendations or supporting information. Often Committee reports were simply recorded as "approved and adopted", even when significant recommendations were included in the report. The reports were often unsigned.

The Board minutes did not accurately reflect the amount of information provided to the Board. Routine reports were made of monthly costs, trust account balances, proposed capital purchases, and investments. Particular attention was paid to budget variances and the cash situation. Reports on Brighton Hospital were often very brief. This reflects the relative autonomy of the Brighton Committee and the limited influence exercised by the Board. In some areas, notably nursing reports and community care centre reports, more detailed information was available.

No reports on overtime, outstanding annual leave or long service leave were made to the Board.

The Committee understands it was normal practice to obtain competitive quotes for capital purchases and to closely examine such matters. However, this is not apparent from the minutes which usually simply record approval to purchase with little detail.

The Committee is concerned that the Board accepted such a low standard of reporting and recording.

6.3 BOARD'S PERCEPTION

The Board's perception of its responsibility was relatively confined. Many important functions were seen as being either the responsibility of the Health Commission or as routine executive responsibilities. In addition, the Board appears to have been inadequately informed on important matters. Reporting on many matters such as industrial problems, medical sessional allocations, and hospital grading were restricted or non-existent. Contacts between hospital staff and Board members were actively discouraged.

The major objectives of the Board were clearly the provision of good patient care within the limits of staff establishment and funding approved by the Health Commission. While the Board and management controlled overall staffing levels and costs in line with approved allocations, the Board was not aware of significant internal problem areas. Having accepted the Board's major objectives, the Committee believes these must be compatible with good hospital management, and the Board must be accountable for the financial activities within the hospital.

6.4 IMPACT OF HOSPITAL FUNDING AND BUDGETARY PROCESS

Lack of effective internal control and audit were major factors contributing to the inefficiency at the hospital. These could only come to light by a special investigation, as they would not be picked up by the normal Health Commission monitoring mechanisms. This is of concern to the Committee.

While there was lack of effective internal controls, there were also external factors in operation, notably weaknesses in the hospital funding and budget process. These include:-

(i) Detailed operations targets and objectives are not specified.

(ii) There is little flexibility for the Board of Management to move outside the staffing structures and department expenditure limits built into the budget.

(iii) There is no incentive to encourage cost reduction or creation of operating surpluses since this invariably results in reductions in future funding.

(iv) Performance reporting is largely confined to monitoring of variances between budget and actual costs.

There is a need for a fundamental review of the budget process for hospitals to improve the degree of responsibility for performance, efficient use of resources and the specification and monitoring of performance standards. The Committee intends to directly consider this problem in Item 3 of its terms of reference.

6.5 RECOMMENDATIONS - REPORTS TO BOARD

1. THAT CONTINUING ATTENTION BE GIVEN TO PROVIDING SELF SUFFICIENT INFORMATIVE MINUTES WHICH INCLUDE ALL DATA NECESSARY TO INTERPRET THE BASIS AND CONTENT OF DECISIONS.

2. THAT THE BOARD MINUTES INCLUDE AS ATTACHMENTS IMPORTANT REPORTS WHICH RELATE TO DECISIONS MADE.

3. THAT ANY MAJOR CAPITAL COMMITMENTS APPROVED INCLUDE DETAILS OF TENDERS RECEIVED AND ACCEPTED TOGETHER WITH A NOTE OF THE VALUE OF REJECTED TENDERS.

4. THAT A MAJOR REVIEW OF THE HOSPITAL BUDGETARY PROCESS BE CARRIED OUT TO DEVELOP SYSTEMS WHICH PROVIDE PERFORMANCE OBJECTIVES AND STANDARDS, GREATER RESPONSIBILITY AND FLEXIBILITY FOR BOARDS OF MANAGEMENT AND IMPROVED MONITORING OF PERFORMANCE. THE COMMITTEE INTENDS TO UNDERTAKE THIS REVIEW IN ITEM 3 OF ITS TERMS OF REFERENCE.

5. THAT STAFF REPORTING INCLUDE OVERTIME AND ANNUAL AND LONG SERVICE LEAVE OUTSTANDING MORE THAN SIX MONTHS.

CHAPTER SEVEN

AUDIT AND INTERNAL CONTROL

7.1 OBJECTIVES OF AUDIT

The objects of an external audit are to examine all books of accounts and relevant records, registers and documents, with a view to ensure that:-

(i) The books and records are properly kept.

(ii) All transactions are recorded and correctly recorded.

(iii) The statements of income and expenditure give a true and fair view of the results of operations.

(iv) The balance sheet gives a true and fair view of the assets, liabilities, and funds of the hospital.

(v) The internal controls are adequate and effective.

(vi) Operational performance criteria are satisfactory.

To provide a complete system of internal control the hospital would need:-

(i) A system of standard costing.

(ii) Budgetary control.

(iii) A perpetual inventory.

(iv) Physical safeguards and checks against theft and loss of assets.

(v) A system of internal check.

(vi) An internal audit of accounting, purchasing, personnel and pay procedures.

Internal audit requires a distinct section of staff in the hospital whose duties are to perform most of the detailed checking of the work done by operative members of the accounting, purchasing, personnel and pay staff.

The internal audit report, like the external audit report, should be made direct to the Board of Management. The Committee understands that currently hospitals have no system of standard costing, and the great majority have no internal audit staff.

7.2 INTERNAL CONTROL AT R.S.M.H.

As will be shown below, the internal controls exercised within R.S.M.H. were deficient and require substantial improvement. A comprehensive review is justified. There is an excessive reliance on delegation to departmental heads without supporting control, and internal audit is superfical and performed on an unorganised basis.

Critical areas of internal control at R.S.M.H. were:-

Time Recording System

(i) Excessive numbers of time cards manually filled out.

(ii) Cards with overtime claims not properly authorised.

(iii) Self signed or unsigned cards.

(iv) Excessive numbers of senior positions not providing a claim for wage payment.

Claims for Medical Sessions and Fee-For-Service

(v) Lack of signed claims for sessions.

(vi) Inadequate authorisation of payment and supporting evidence.

Purchasing and Payments

(vii) Inadequate authorisation of requisitions.

(viii) Lack of supporting documentation with cheque requisitions.

(ix) Acceptance of inadequate instructions for payments.

(x) Lack of control of forms and documents.

Debtors Control

(xi) Lack of formal authorisation of account write-offs.

(xii) Failure to routinely balance debtors controls.

Assets Control

(xiii) Lack of comprehensive assets register.

The Committee believes the following extracts from the evidence of Mr. Freadman are illuminating.

"THE CHAIRMAN: Does that not throw up something about management controls, whether it be a policy decision or a management decision, in terms of the need for some internal audit so that you, as board members, can be aware not only of those sorts of matters that you have mentioned but also of any other issues that you cannot identify here and now? An internal audit would provide the mechanism to report potential problems or actual problems in the running of the organisation.

"MR FREADMAN: I would go along with that.

"THE CHAIRMAN: Were any efforts made to introduce a more effective external audit or an internal audit.

"MR FREADMAN: Not up to the present time....." (1).

The Committee believes that despite the evident deficiencies in accountability and monitoring activities at R.S.M.H., the Board still has not grasped the need for urgent action.

7.3 EXTERNAL AUDIT

The external audit was not adequate for the needs of the hospital in that it was a restricted low cost audit ($3,500 in 1982/83) which failed to locate significant procedural shortcomings and administrative errors and did not provide essential advice to the Board on inadequacies in internal control and internal audit. The Board on several occasions over the last three to four years discussed the audit limitations with the auditors and requested improvement in audit programs, management reporting and greater attention to internal control.

In evidence Mr. Benjamin, the President of the hospital, said, "The cost of a full audit would be between $15,000 and $20,000 a year. The existing audit, which was really just checking the books of account and certifying the income and expenditure and the balance sheet of the hospital, cost probably between one-third and one-fourth of that. The audit cost was, I think, about $3000 or $4000 a year, so it was not a minor difference.

"My earlier comments related to it being a minimal audit because the auditors saw the hospital as being in the nature of a charitable organization and they structured their audit so that the fee would be a minimal fee for a charitable organization" (2).

(1) Public Hearing Transcript, Mr. R. Freadman, 22nd February, 1984, page 105.

(2) Public Hearing Transcript, Mr. R. Benjamin, 12th December, 1983, page 91.

Cr. M. Blair, a Board member, in evidence said, "There had been some dialogue in the past that there was some dissatisfaction with their performance, and there was discussion about whether they should be retained or whether we should look elsewhere. That question was canvassed, ..." (1).

The current situation has not changed materially and the scope and effectiveness of the audit is far below the needs of a business of this size. Even though the auditor has been replaced, the same firm continues to conduct the audit.

The Committee strongly believes the Board should have pursued this matter with more vigour as the lack of knowledge of deficiencies in internal control was undoubtedly a factor in failure to press for introduction of necessary changes. Procedures which may have been adequate in the early stages of the development of the hospital were never upgraded.

Some of the problems which arose were due to the lack of a fully professional, comprehensive audit which is essential in an organisation of this kind. A contributing factor was the lack of guidelines as to minimum audit requirements and the inadequacy of a confined financial audit which does not review operational performance criteria.

The Committee notes that a working party was set up two years ago by the Health Commission to report on the role and appointment of hospital auditors. This was disbanded because the members were unable to come to agreement. A reconstituted working party under the chairmanship of the Director of the Finance Division had its first meeting on 18 November, 1983, and has reported to the Health Commission on the role and appointment of hospital auditors. Both working parties had a member from the office of the Auditor-General.

(1) Public Hearing Transcript, Cr. M. Blair, 22nd February, 1984, page 109.

7.4 RECOMMENDATIONS - INTERNAL CONTROL

1. THAT THE HEALTH COMMISSION, IN CONJUNCTION WITH THE AUDITOR-GENERAL, PREPARE AN APPROPRIATE PROGRAMME OF INTERNAL AUDIT FOR HOSPITALS, INCLUDING THE NECESSARY AUDIT STAFF.

7.4.1 TIME RECORDING

1. THAT THE USE OF TIME CHECKING BE EXTENDED TO REDUCE MANUAL TIME RECORDING AS FAR AS PRACTICABLE.

2. THAT FOR VISITING MEDICAL STAFF, A WRITTEN CLAIM FOR PAYMENT BE PREPARED AND SIGNED BY THE INDIVIDUAL.

3. THAT ALL CLAIMS FOR PAYMENT BE AUTHORISED BY A SENIOR OFFICER AND UNAUTHORISED OR SELF-AUTHORISED CLAIMS BE REJECTED.

4. THAT AS FAR AS PRACTICABLE, ALL SALARIES AND WAGES CLAIMS BE PAID THROUGH THE PAY SYSTEM EXCEPTING FEE-FOR-SERVICE CLAIMS AND SPECIFIED PAYMENTS WHERE INCLUSION ON THE PAYROLL IS NOT APPROPRIATE.

5. THAT USE OF THE PAYROLL COMPUTER BASED LEAVE SYSTEM BE INTRODUCED.

6. THAT ALL CLAIMS FOR SESSIONS OR FEE-FOR-SERVICE PAYMENTS BE AUTHORISED BY THE RELEVANT DIVISIONAL HEAD AND APPROPRIATE SYSTEMS BE INTRODUCED TO VERIFY THE CORRECTNESS OF THE CLAIM.

7. THAT THE RETENTION PERIOD OF TIME CARDS, LEAVE APPLICATIONS AND OTHER PAY DOCUMENTATION BE REVIEWED AND EXTENDED.

7.4.2 PURCHASING AND SUPPLY SYSTEMS

1. THAT ALL REQUESTS FOR SUPPLIES BE AUTHORISED BY SPECIFIED PERSONS IN PARTICULAR IN THE CATERING DEPARTMENT.

2. THAT PURCHASE ORDER FORMS BE NUMBERED AND BE SUBJECT TO NUMBER CONTROL.

3. THAT REQUISITIONS BE SUBJECT TO NUMBER CONTROL AND PROCEDURES ESTABLISHED TO ACCOUNT FOR CANCELLED REQUISITIONS. PROCEDURES SHOULD ENSURE THAT ALL REQUISITIONS ARE ENTERED ON THE REQUISITION SUMMARY.

4. THAT THE SYSTEM FOR PROCESSING REQUISITIONS BE TIGHTENED TO PROVIDE IMPROVED CONTROL OF CUTOFF FOR ACCOUNTING AND STOCK RECORDING PURPOSES.

5. THAT THE ACCURACY OF COMPUTER STOCK RECORDING BE IMPROVED SO AS TO PROVIDE AN ACCURATE BASIS FOR ROUTINE SPOT STOCKCHECKS.

7.4.3 PAYMENT SYSTEM

1. THAT A CREDITORS PAYMENT SYSTEM PROCEDURE MANUAL BE DEVELOPED.

2. THAT ENTRY OF NEW CREDITORS INTO THE SYSTEM BE PROPERLY CONTROLLED AND AUTHORISED.

3. THAT SUPPORTING DOCUMENTATION FOR INVOICE PAYMENT AND AUTHORISATION BE MORE COMPREHENSIVE. IN PARTICULAR, DELIVERY DOCKETS SHOULD BE ATTACHED TO SUPPLY INVOICES.

4. THAT SUPPLIES OF CHEQUES FOR MANUAL PREPARATION BE SUPERVISED BY A RESPONSIBLE OFFICER OF THE HOSPITAL.

5. THAT INVOICES AND CHEQUE REQUISITIONS BE CANCELLED MORE EFFECTIVELY ON PAYMENT WITH DETAIL OF CHEQUE NUMBER AND AMOUNT ENTERED ON THE CHEQUE REQUISITION.

6. THAT ALL PURCHASE ORDERS AND ACCOUNTS BE PROCESSED THROUGH THE NORMAL SUPPLY PROCEDURE INCLUDING PATHOLOGY AND RADIOLOGY ACCOUNTS CURRENTLY PROCESSED WITHIN THE DEPARTMENT.

7.4.4 ASSETS REGISTER

1. THAT THE ASSETS REGISTER CONTINUE TO BE DEVELOPED AS QUICKLY AS POSSIBLE AND THEN BE RECONCILED TO THE GENERAL LEDGER.

2. THAT DEPRECIATION CHARGES ULTIMATELY BE CALCULATED USING THE ASSETS REGISTER.

7.4.5 PATIENTS ACCOUNTS

1. THAT THE PROCEDURE FOR WRITING OFF PATIENTS ACCOUNTS BE FORMALISED AND PROCEDURES FOR APPROVAL OF WRITE OFFS BE ESTABLISHED.

2. THAT THE DEBTORS CONTROL ACCOUNT BE MORE REGULARLY RECONCILED WITH THE DEBTORS LEDGER. AT PRESENT THE FREQUENCY OF BALANCING IS UNSATISFACTORY.

3. THAT CONTROL OF ADJUSTMENTS TO THE DEBTORS LEDGER VIA COMPUTER INPUT BE IMPROVED. ACCESS TO A COMPUTER TERMINAL PERMITS ALTERATIONS TO BALANCES. THIS REQUIRES BASIC CHANGES TO THE SYSTEM.

4. THAT THE INTERNAL CONTROL PROCEDURES BE SUPPORTED BY INTERNAL AUDIT ACTION TO PROVIDE PERIODIC VERIFICATION THAT PROCEDURES ARE BEING FOLLOWED AND THAT ACTION IS TIMELY.

7.5 RECOMMENDATIONS - EXTERNAL AUDIT

1. THAT A MORE COMPREHENSIVE AUDIT BE COMMISSIONED WITH AUDIT GUIDELINES SPECIFIED, INCLUDING THE FOLLOWING MATTERS WHICH ARE IMMEDIATELY RELEVANT TO R.S.M.H.:-

   (a) A COMPREHENSIVE INTERNAL CONTROL REVIEW.

   (b) VERIFICATION OF RATES AND AMOUNTS OF PAY.

(c) ATTENTION TO COMPLIANCE WITH HEALTH COMMISSION CIRCULARS.

(d) PROVISION OF COMPREHENSVIE MANAGEMENT REPORTS TO THE BOARD.

(e) REVIEW OF EFFECTIVENESS AND ACCURACY OF COMPUTER INPUT AND OUTPUT ESPECIALLY IN RELATION TO FINANCIAL MATTERS.

(f) REGULAR REVIEW OF BALANCING OF CONTROLS.

(g) REVIEW OF TRUST ACCOUNT TRANSACTIONS WITH PARTICULAR ATTENTION TO COMPLIANCE WITH TRUST CONDITIONS.

2. THAT WITH THE APPROVAL OF THE AUDITOR-GENERAL GUIDELINES FOR AUDIT OF HOSPITALS BE DEVELOPED AND DISTRIBUTED TO BOARDS OF MANAGEMENT AND AUDITORS.

3. THAT THE STANDARD OF AUDITS IN THE GENERAL HOSPITAL FIELD IN RELATION TO THE GUIDELINES BE REVIEWED TO ENSURE THAT THEY ARE MEETING THE NEEDS OF THE BOARDS OF MANAGEMENT.

CHAPTER EIGHT

REPORTING TO THE HEALTH COMMISSION

8.1 INTRODUCTION

R.S.M.H. makes the following reports to the Health Commission.

(i) Monthly Financial and Statistical Return

This shows cash payments, cash receipts, comparison of actual payroll with Health Commission approved budget, patient revenue and statistics, and cafeteria trading statement.

(ii) Quarterly Return

Quarterly return shows expenditure (in departments), debtors movement, patient statistics, non-budgeted income and expenditure, profit forecast, source and application of funds (every six months).

(iii) Annual Return

Complete disclosure of all financial and statistical matters.

(iv) Department of Radiology Costs

Annual return itemising payments, type and number of examinations, names of practitioners and staffing establishment.

(v) Operating Budget

Allocation of approved income and expenditure budget into monthly and year to date figures.

(vi) University Teaching Costs

Annual return indicating costs associated with teaching of university students.

(vii) Special Escalation Costs

Has only been produced once but may be required on an annual basis. Itemises costs in excess of allocated budget, e.g., electricity, briquettes, linen, telephone, for which a special case can be made for increased funds.

(viii) Hospower

Monthly report providing input data for Hospower reports.

(ix) Form 11

Quarterly patient statistical return.

In addition, a number of nursing staff returns are made to the Health Commission and the Victorian Nursing Council.

8.2 PROBLEMS OF THE REPORTING SYSTEM

It is apparent from the previous discussion that there are a number of problems with this reporting system.

(a) The Health Commission is chiefly concerned with monitoring gross operating expenditure in relation to approved budgets, and equivalent full-time (EFT) staff numbers against budget. In addition, gross revenue is monitored.

If a hospital commences with a certain approved expenditure, budgets have in the past been determined on the basis of the previous year's actual expenditure, with all salary and wage award increases being added, together with a percentage increase on non-salary items to allow for cost-of-living increases.

The Committee notes that recent attempts have been made to determine budgets on the basis of approved staff levels plus overheads plus a non-salary component, but the procedure is still so inexact that only gross deficiencies are picked up.

So long as a hospital operates within its approved operating budget and approved staff numbers, the Health Commission has no routine indicator to determine whether resources are utilised efficiently." The Committee is extremely concerned at the wider implications of the lack of performance indicators, and will consider this in Item 3 of its terms of reference.

Given the type of reporting the Health Commission had no indication of any inefficiencies or improprieties at R.S.M.H. in a financial sense. This was reinforced by the lack of internal control at the hospital.

(b) The various methods of payment of medical staff at R.S.M.H. involving many direct payments outside the payroll system until recently would have made it impossible to monitor the extent of payments to individuals without specific analysis.

(c) An examination of the relevant Health Commission files does not provide any useful information in relation to the grouping of the hospital, the grading of medical staff, the internal distribution of sessions or the total earnings of individuals.

The information available in the payroll and personnel system is not normally accessed by the Commission and comparisons of gradings against approvals are not yet fully developed. Hospitals are now required to report overaward payments but this is not routinely externally monitored.

(d) Direct contact with the Commission has been limited. With the possible exception of the nursing divison, there have been very few visits of inspection or on-site budget reviews by the Commission.

While it is understandable that a comparatively small hospital which regularly balanced its budget and had clean audit reports should not attract attention from the Commission, the Committee believes some more frequent interaction is justified.

(e) Further inadequacies in reporting to the Health Commission experienced by all hospitals are that requests for alterations to the hospital's staff establishment have not in the past included salary levels. This can lead to problems in budgetary allocation. Where variations to normal gradings occurred at R.S.M.H. these were discussed with the Commission or the Victorian Hospitals Industrial Council.

(f) Sessional allocations at R.S.M.H. were requested from the Commission as the need arose and were formally allocated and approved. This process does not provide a coherent view of the total sessional allocation and it was necessary to examine and summarise correspondence over a long period to obtain a full picture.

The Committee will investigate in Item 3 of its terms of reference whether the Health Commission has the resources to monitor in detail the operation of a hospital. Its main control is via staffing and budget approvals. From its investigations the Committee has found that it is difficult to define the division of responsibilities of the Commission and the Board of Management. It would seem that with limited resources, the efforts of the Commission are likely to be directed away from a hospital which gives no evidence of financial or patient care problems.

In the case of R.S.M.H. the Committee believes there is a definite need for strengthening the oversight function of the Commission and for improvement of the quality of information available to it. Furthermore, increased interaction between executives and staff of the Commission is desirable.

8.3 RECOMMENDATIONS - HEALTH COMMISSION REPORTING

1. THAT PROVISION BE MADE FOR CLOSER CONSULTATION BETWEEN HEALTH COMMISSION STAFF AND HOSPITAL STAFF, INCLUDING REGULAR VISITS BY COMMISSION STAFF.

2. THAT THE COMMISSION MONITOR ESTABLISHMENT DATA AND POSITION GRADING THROUGH COMPUTER ANLAYSIS OF HOSPITAL COMPUTER FILES.

3. THAT MATTERS IN THIS CHAPTER RELATING TO ALL HOSPITALS BE TAKEN UP IN ITEM 3 OF THE TERMS OF REFERENCE.

CHAPTER NINE

TRUST FUNDS

9.1 TRUST ACCOUNTS

The hospital has a program for building development, research and provision of services and a major concern is the accumulation of capital or trust fund resources. A number of trust funds have been built up and the total of reserves and trust funds held by the hospital, excluding the Special Purposes (Pathology) Account, is of the order of $2,150,000. The following funds have been identified.

Research Trust

Trustees are appointed by the Board and consist of the hospital President, the hospital Treasurer, the Medical Director, one member of the Board of the hospital as nominated by the Board and the Chairman of the medical staff committee.

Current Trustees in those positions are Mr. Benjamin, Mr. Clegg, Dr. Hudson, Mrs. Best and Dr. Cohen. Balance at 31st January, 1984 - $25,544.

The Maskiell Trust

The Trustees are the hospital President and Jacob Nayman. Each shall hold office until he shall resign or die, or ceases to hold a position on the staff, whichever shall first occur. The other Trustee is Cyril Charles Maskiell.

These Trustees are named in the Trust, but Cyril Maskiell is known as the appointor and he can remove any Trustee, or appoint a new Trustee, who then must be approved by the Board. Balance at 31st January, 1984 - $90,735.

Special Purposes (Pathology) Account

The Board of Management has the power of appointing new Trustees. The Trustees are: The pathologist contributing to the fund, the President of the hospital, and the Medical Director. Currently they are Dr. Paul Tessa, Mr. Benjamin and Dr. Hudson. Balance at 31st January, 1984 - $139,432.

Primary Care Development Fund

The Trustees are appointed by the Board and consist of the President and Treasurer of the hospital and three members of the Family Medical Division Advisory Committee, as nominated by the Committee. Current Trustees are: Mr. Benjamin, Mr. Clegg, Dr. Kline, Dr. Cohen and Dr. Combes. Balance at 31st January, 1984 - $96,999.

In addition there are two funds which have no trustees, but are separate funds within the hospital's capital account.

Ashley Ricketson Fund

Balance at 31st January, 1984 - $996,248.

General Trust

Balance at 31st January, 1984 - $94,328.

Transactions relating to some of the trust funds are questionable, as is now discussed.

9.2 TRANSFERS TO RESERVES

Some of these funds have been built up by transfer of operating income. Although the Board of Management has power under Rule 101 to transfer to reserve any surplus in the operating account, these transfers are, in the opinion of the Committee, not proper.

This practice has the effect of apparently increasing operating cost or reducing operating income and hence maintaining budget allocations above the proper levels. This problem was discussed in Chapter 4.

Instances of diversion of operating funds reported by Mr. Sims (1) are:-

(a) Routine transfer of medical sessional allocations to capital account or the medical equalisation fund without regard to actual expenditure and retention of undrawn amounts in the reserve. This fund currently stands at around $100,000.

(b) Transfer of 50% of the recovery of the hospital share of radiology charges to the capital account rather than to the operating income. This reserve stands at over $250,000 and the annual transfer is of the order of $66,000.

(c) Transfer of 20% of the recovery of the hospital share of pathology private income to the capital account rather than to operating income. The annual transfer is of the order of $90,000.

(d) Retention of a subsidy for Medical registrar service to general practitioners from the Royal Australian College of General Practitioners, which was already funded from the operating account, as part of the Primary Care Development Fund. This now stands at $96,999, although other sources of income contribute to this fund.

When questioned about the diversion of operating funds, the Board members who appeared before the Committee appeared to have no knowledge of the situation, as can be seen from the evidence.

"THE CHAIRMAN: The Committee is quite concerned about certain transfers that the board made from operating accounts to the reserves. Much of this money seems to have been taken in a most unusual way from the private patient fees to the hospital, and it has ended, in a rather circuitous route, in the hospital's capital funds.

(1) Mr. R. S. Sims, Report dated January, 1984, pages 37 and 38.

"Has it been suggested to you that this is, to say the least, a very unusual series of transactions in which your hospital has been engaged for a considerable time?

"MR. FREADMAN: I have never heard that said.

"THE CHAIRMAN: The transactions have not accurately recorded the operating costs to the Health Commission. Some people would consider that this is an improper use of the hospital's operating funds to be making transfers to reserves in the way that is done at your hospital. Are you saying that you have not heard that said?

"MR. FREADMAN: I cannot help you on that matter" (1).

9.3 THE CHARLES AND EILEEN MASKEILL RESEARCH FOUNDATION

This Foundation was set up to encourage research. The initial trustees were Mr. C. Maskiell, Professor J. Nayman and Mr. A. J. Robinson, Chairman of the Board of Management.

A substantial donation of debentures was made to establish the Foundation. Appointment of trustees is in the hands of Mr. Maskiell but the Deed requires approval from the hospital Board of Management for research expenditure.

In 1981, the Foundation held 9% debentures in Abbey Capital Finance Co. maturing in 1988 with a face value of $57,500 donated by Mr. and Mrs. Maskiell. At this time the trustees of the Maskiell trust entered into an arrangement whereby a donation of $10,000 was made by the donor and used, in conjunction with $12,500 held in the trust, to purchase 9% debentures maturing in 1988 to the face value of $22,500, though the market value was stated at $15,625.

(1) Public Hearing Transcript, Mr. R. Freadman, 22nd February, 1984, pages 115 and 116.

The net effect was to increase the real value of investments and cash in the Foundation by $3,125 and, presumably, to provide a taxation advantage for the donor.

Mr. Sims reported that, "The Board of Management communicated its concern over this transaction to the trustees on several occasions but the trustees accepted the scheme. The donor indicated that the donation was not related to the decision to purchase the shares and that the purchase was made based on the likelihood of early redemption of the debentures. This view was not supported by documentation in the hospital and the Board's attitude appears to have been justified. However, the Board had no power to alter the situation other than indirectly by representation of the Chairman who was a trustee" (1).

9.4 THE SPECIAL PURPOSES (PATHOLOGY) TRUST

This trust was set up in 1975 in accordance with a circular from the Hospital and Charities Commission to handle the income from private pathology patients treated in the hospital. The chief pathologist, a full-time salaried doctor, had the right of private practice and income from private patients was paid into the Trust.

The hospital was paid 60% of fees collected for use of hospital facilities and the remaining funds were to be dispersed by the trustees in accordance with the trust deed. The initial trustees were Dr. de Boer, the chief pathologist, Professor J. Nayman, Medical Director and Mr. A. J. Robinson, President of the hospital. Subsequently, Professor Nayman was replaced by Dr. Rees, a full-time pathologist who also had the right of private practice. Recently, Mr. A. J. Robinson was replaced by Mr. R. Benjamin, as hospital President. The hospital has power to appoint trustees.

(1) Mr. R. S. Sims, Report dated January, 1984, page 38.

Technically, the trustees are completely responsible for the operating of the Trust. The hospital and the Commission must be sent a copy of the auditor's report under the Deed and some payments, such as bonuses to medical staff other than the pathologists, are subject to agreement of the Board. The powers of the trustees to disburse income are very broad.

There were irregularities in the operation of the Trust and little, if any, participation by the Board of Management of the hospital in relation to priorities of expenditure.

In evidence, Mr. Benjamin, the President of the hospital, said "We have had a few meetings recently, because as a trustee, I am presently refusing to sign the accounts presented to me for the year 1982-83 because matters that went through the trust fund are inadequately documented.

"Decisions were made to spend large amounts of money which, as a trustee, I was not privy to and I need persuading that those amount of money were expended correctly."

Later in his evidence he said, "I attended one meeting in 1981 when the accounts were presented to me as trustee, for approval. It was obvious to me that some payments had been made which were not in accordance with the trust deed" (1).

In evidence Mr. Freadman stated, "The board had no knowledge of irregularities in relation to the pathology trust fund (Special Purposes - Medical Trust Fund). The president, who was a trustee, took the view, we believe, that the affairs of the trust were not the concern of the board" (2).

(1) Public Hearing Transcript, Mr. R. L. Benjamin, 12th December, 1983, page 99.

(2) Public Hearing Transcript, Mr. R. Freadman, 22nd February, 1984, page 108.

9.5 MATTERS OF CONCERN

The following matters give rise to concern:-

1. Payments were often made without adequate documentation and authorisation, a matter referred to by the auditor in several audit letters. Neither the Board nor anyone else followed this up.

2. Payments were not approved by meetings of the trustees except that retrospective approval was given at rare meetings of trustees. This is of particular concern considering that large payments were made to the medical members who were trustees.

3. Audits were not carried out in the years prior to 1979 as required.

4. Copies of audit reports were not forwarded to the Health Commission.

5. A number of payments do not appear to fall within the Trust Deed. Examples are:-

   (a) Payment of Christmas bonus to selected staff of R.S.M.H.

   (b) Payment of travel expenses for non-medical staff of R.S.M.H.

   (c) Payment of a salary bonus to Dr. J. Ma, a full-time salaried officer of the hospital.

   (d) Payment of a pathology department dinner.

   (e) Payment to Dr. de Boer's wife for accommodation of an overseas visitor.

   These amounts represent a small component of total payments.

6. It is not possible to establish the validity of many payments made from petty cash.

7. Payments listed as having inadequate supporting documentation were merely signed by the trustees as approved and no further action was taken.

In the circumstances, it is surprising that the auditor did not react more strongly to the situation in his reports to the trustees. There is good reason to doubt whether the trustees properly fulfilled their responsibilities and this matter should be further considered by the Crown Solicitor.

Mr. Sims reviewed the procedures for collection of patients fees, writing off of bad debts and the payments made to the hospital for use of services. These were handled largely by the hospital staff and the records confirm that the hospital was paid the appropriate share of income.

A summary of the disbursements from the Special Purposes (Pathology) Fund over the seven years to 30th June 1983 for major items is as follows:-

Equipment Purchased	$ 540,000
Travel Dr. de Boer	45,360
Dr. Rees	7,360
Professor Nayman	14,050
Others	25,040
Computer hardware cost	215,800
software cost	89,050
Salaries other staff	76,400
staff bonuses	11,850
Bonus Payments to Pathologists	
Dr. de Boer	110,020
Dr. Rees	28,280
Research - University	39,800
- Other	2,810
TOTAL	$1,205,460

There are some payments which would be considered outside the normal Health Commission guidelines which were specified at the time the trust was set up, but only a few payments could be construed as being outside the powers of the trustees.

Most of the expenditure went to items which were used in the hospital although the items would have been selected by the two medical trustees and their priorities may not have coincided with those of the hospital. Computer hardware and software costs relate to development testing and implementation of a pathology computer system. University research refers to payment of staff at Monash University engaged on a joint research project with the hospital and bonus payments to pathologists are as provided under the deed.

It might have been expected that the Board should have exerted greater influence on the activities of the Trust either directly or through the Chairman, who was a trustee. However, the Board of Management had virtually no knowledge of or influence on disbursements.

9.6 PROBLEMS OF MEDICAL TRUST FUNDS

The Committee believes this situation highlights the illogicality inherent in such Trust arrangements where the private practice income is high.

1. The Trust Deed precludes distribution of the bulk of the net income except by way of bonuses and expenses.

2. The large residual sums are available for disbursement by the trustees with no requirements to consider priorities of the hospital.

3. The medical officer has an incentive to equip and staff the department to a high service level which may be uneconomical by comparison with other demands but which encourages development of private practice in the hospital.

4. Unless close co-ordination exists between the trustees and the Board of Management, the Board has little influence on the decisions of the Trust.

The Committee feels there is a strong case for a complete review of the treatment of income from private patients in public hospitals and the disposition of net income.

In the particular case of R.S.M.H. despite the existence of audit reports, there is a reasonable presumption that the trustees may not have adequately fulfilled their duties to properly account for transactions and in exercising their responsibilities. This question should be referred to the Crown Solicitor for advice.

The trust reserve and capital funds of the hospital are invested in approved securities and these are conscientiously managed. The Committee believes it may be beneficial to change this procedure which requires each hospital committee to involve itself with investment decisions which could, perhaps, be handled more efficiently through a centralised investment authority.

9.7 RECOMMENDATIONS - TRUST FUNDS

1. THAT THE POLICY IN RELATION TO PRIVATE PRACTICE INCOME BE REVIEWED TO PROVIDE A MORE RATIONAL ARRANGEMENT. THIS IS CURRENTLY UNDER CONSIDERATION BY THE MINISTER OF HEALTH.

2. THAT A WIDESPREAD STUDY OF THE SOURCES AND DISPOSITION OF RESERVES AND TRUSTS UNDER THE CONTROL OF HOSPITALS GENERALLY BE UNDERTAKEN TO CLARIFY ACCEPTABLE PROCEDURES AND PROVIDE BETTER CONTROL OF THESE SUBSTANTIAL RESOURCES. THE COMMITTEE INTENDS TO UNDERTAKE THIS REVIEW IN ITEM 3 OF ITS TERMS OF REFERENCE.

3. THAT THE HOSPITAL CEASE THE TRANSFER OF OPERATING FUNDS AND INCOME TO CAPITAL ACCOUNTS AND RESERVES.

4. THAT THE ROLE OF THE TRUSTEES IN THE SPECIAL PURPOSES (PATHOLOGY) TRUST AT R.S.M.H. BE EXAMINED BY THE CROWN SOLICITOR.

CHAPTER TEN

ROLE OF THE BOARD, HEALTH COMMISSION, AND HOSPITAL ADMINISTRATION

10.1 FUNCTION OF THE HEALTH COMMISSION

The function of the Health Commission as laid down in the Health Commission Act 1977 Section 6 is:-

"Subject to directions of the Minister the functions of the Commission are:-

(a) the overseeing, supervision, maintaining and co-ordination of health services in Victoria; and

(b) the functions conferred on it by or under any Act."

Section 7 of the Act states:-

"(1) Subject to this Act and directions of the Minister, the Commission has power to do all things necessary or convenient to be done for or in connexion with the performance of its functions.

(2) Without limiting the generality of sub-section (1), the Commission may -

(a) promote, provide and assist in the provision of health services in Victoria;

(b) provide and assist in the provision of buildings and other facilities for health services in Victoria...."

10.2 FUNCTION OF THE BOARD

"The Accreditation Guide" of the Australian Council on Hospital Standards lays down a number of standards for Boards of Management. These are:-

1. To have overall responsibility for the conduct of the hospital in a manner consonant with the hospital's objective of providing high quality patient care.

2. To facilitate the philosophy and objectives of the hospital. An integral part of hospital organisation shall be appropriate administration records.

3. To make adequate delegations of authority and appropriate personnel available to allow the achievement of the hospital's philosophies and objectives.

4. To make overall responsibility for the provision of appropriate facilities and equipment so as to facilitate the achievement of the hospital's philosophies and objectives.

5. To provide policies and procedures to guide all staff including medical staff, patients and visitors in respect of the operating of the hospital.

6. To be responsible for ensuring continuing education, orientation and inservice programmes to enable all hospital personnel to maintain their knowledge and skills and to improve the service of the individual departments of the hospital.

7. To set up evaluation procedures by which the practice and standards of the hospital, departments, and staff, including medical staff, are assessed. These procedures should provide a mechanism to enable data obtained from the evaluation to be used effectively for the on-going improvement of patient care and associated services of the hospital.

To this the Committee on the advice of its Consultants would add:

8. To be responsible for the management of public money in an accountable way.

In examining "The Accreditation Guide" the Committee notes with concern that R.S.M.H. was accredited twice. This is a disturbing outcome given the evident problems at the hospital.

The ultimate responsibility for the efficient operation of the hospital rests with the Board of Management. The inquiry has confirmed that there were many areas of serious concern relating to the Board. The majority of the problems were due to lack of knowledge or involvement of the Board. This was partly due to a restricted perception of the role of the Board and excessive reliance on management and Health Commission procedures in critical areas.

The hospital system involves a balance of responsibilities between management, the Health Commission, the Board of Management and the external auditors. In this case, the Board was not well advised by general management and medical administration, the hospital monitoring systems were inadequate and the audit ineffective, and it is not surprising that problems occurred.

The Board could reasonably be expected to have taken greater interest and effective action in critical areas such as medical payments, personnel management, internal systems and control, and improvement of the audit function.

Mr. Freadman, Vice President of the hospital, in his submission of 16th December, 1983, said "It is clear that the Board cannot be expected to conduct the affairs of the hospital in such a manner that nothing goes wrong.

"The responsibility of the Board is to conduct the affairs of the hospital in a business-like manner, to attend Board and Committee meetings regularly, to read and understand the steady stream of reports and other material which flows to them, and when aware of irregularity which requires correction or amendment, to act to put it to rights" (1).

In evidence Mr. Freadman said, "My view is that whilst the role of the Board is obviously to deal with matters of policy, it has to have some supervisory control over the management aspect. The board has to try to exercise some controls so that matters of the kind that have gone wrong in the hospital in the past will not go wrong in future" (2).

However, it seems to the Committee that the Board has tried to absolve itself from responsibility for the hospital when, in evidence, Mr. Freadman stated, "The affairs of the hospital were, at all material times, in practice, controlled by the president, the former Director of Medical Services, Mr. J. Nayman and the former Executive Director, Mr. D. Stitfold. Board meetings, Executive meetings and Finance Committee meetings were held regularly and were well attended, but we think it not unfair to say that the board and two committees, were concerned mainly with routine and policy business. In our opinion, there has been a marked lack of communication and consultation between the persons who were concerned with the day-to-day running of the hospital and the board. The president took the view that the work of the board should not interfere in the area of management" (2).

Given the substantial problems at R.S.M.H., especially the highly visible ones such as the poor industrial relations, the Committee cannot accept the Board's very restricted approach.

(1) Submission from Mr. R. Freadman, dated 16th December, 1983, page 1.

(2) Public Hearing Transcript, Mr. R. Freadman, dated 22nd February, 1984, page 104.

10.3 FUNCTIONS OF THE MANAGER

The Manager of a public hospital is the chief executive officer. Acting within guidelines established by the Board he is continuously responsible for the management of the hospital. The Board should hold him responsible for the application and implementation of established policies, and for providing co-ordination between the Board, the medical staff and hospital departments.

He should organise the administrative functions of the hospital, delegate duties and establish formal means of accountability on the part of ther officers. He should recommend policy to the Board and the medical staff on the overall activities of the hospital.

10.4 MAJOR AREAS OF CONCERN AT R.S.M.H.

A summary of the main areas which were unsatisfactory at the hospital and the underlying causes are as follows:-

(i) Unsatisfactory industrial relations and inadequate personnel systems.

Failure to develop adequate systems	General Management
Inadequacy of expertise in the area	General Management
Lack of intervention and monitoring	Board

(ii) Inappropriate grading of hospital and medical staff grouping.

Failure to group the hospital	External Authorities
Inappropriate selection of grouping	Medical Administration
	General Management
Lack of intervention and monitoring	Health Commission
	Board

(iii) Excessive allocation of sessions to Professor Nayman.

Failure to act on the situation	Medical Administration
	General Management

Lack of intervention and monitoring	Board
Lack of monitoring and adequate control	Health Commission

(iv) Inadequate control of time cards, authorisation of overtime and monitoring of overtime, recall etc.

Failure to update procedures	General Management
Failure to establish routine control and internal control	General Management
Failure to detect flaws in internal control	Auditor
	General Management
Failure to detect irregularities	Auditor
Failure to monitor and intervene	Board

(v) Inadequate control of claims for medical payments.

As for (iv)	
Failure to institute systems	Medical Administration
	General Management

(vi) Inadequacy of audit procedures and management reports.

Failure to correct obvious weaknesses	Board
	General Management

(vii) Incorrect procedures in relation to transfers to trusts and reserves.

Establishment of mechanisms and agreement	Board
to procedures	General Management
Failure to monitor transfers	Auditor
	Health Commission
Lack of incentive in budget process	Health Commission

(viii) Poor procedures for operation of Special Purposes (Pathology) Trust.

Failure to establish acceptable procedures	Trustees

Failure to act strongly on deficiences in documentation and authorisation	Auditor
Failure to follow up audit reporting	General Management Board
Liberal interpretation of powers of the Trust on disbursement	Trustees

(ix) Overpayment of award loading on excess medical sessions.

Misinterpretation of award	General Management
Lack of system to report excess sessions	General Management Medical Administration

(x) Inadequacy of Board minutes and supporting data.

Inadequate reporting	General Management Medical Administration
Acceptance of inadequate minutes	Board

The responsibility is often fairly widespread. The Board was not well informed on a number of critical areas and, in effect but inadvisedly, delegated responsibility on many matters to the Manager and Medical Director without adequate monitoring or effective control systems.

The Committee believes the Board functioned poorly in a number of significant areas:-

(a) Failure to intervene and monitor the situation of unsatisfactory industrial relations, and failure to provide adequate personnel systems (refer pages 9 - 11).

(b) Failure to insist on grouping of the hospital in the Senior Medical Officers Award. As a consequence medical staff were inappropriately graded (refer pages 28 - 30).

(c) Failure to intervene and monitor the allocation of sessions to medical staff, especially the Medical Director (refer pages 19 - 26).

(d) Failure to ensure that appropriate systems existed for the internal control of time records, and authorisation and monitoring of overtime for medical and non-medical staff (refer pages 12 - 15, 22 - 27, 46).

(e) Failure to ensure that appropriate monitoring systems existed for the control of claims for medical payments (refer page 46).

(f) Failure to secure an adequate external audit for the hospital even though the audit was known to be grossly deficient (refer pages 48 - 49).

(g) Improper procedures in relation to transfers to trusts and reserves with the consequent failure to accurately report operating costs to the Health Commission (refer pages 22 - 23, 60 - 63).

(h) Failure to follow-up reports of the auditor about unacceptable procedures of the Special Purposes (Pathology) Trust (refer pages 62 - 64).

(i) Acceptance of totally inadequate Board minutes and supporting data (refer pages 41 - 43).

(j) Failure to be responsible for the management of public money in an accountable way.

While these matters are of varying degrees of severity, it is clear to the Committee that there was a general failure on the part of the Board to monitor the hospital's activities and to take the necessary action to remedy the great number of deficiencies.

The Committee cannot accept the Board's stated evidence that they were either unaware of, or did not perceive as part of their function, the need to monitor the activities within the hospital.

The Committee believes the Board, as the body corporate, must be held to be responsible and accountable for the management of the hospital. Even at the present time the Committee feels the Board is not fully aware of the extent of the problems at the hospital or how to deal with them.

FOR THESE REASONS THE COMMITTEE RECOMMENDS THAT THE PRESENT BOARD BE REPLACED.

The role of the hospital should be reassessed in its relationship to the Community Care Centre. The validity of the "open hospital" model with its emphasis on community medicine liaison must also be assessed as should the "medical model" used in the Community Care Centre. Both of these concepts should be carefully evaluated and a decision should be made on their continuance or reversion to a more conventional approach.

Caulfield Hospital and R.S.M.H. occupy the same site, share major services, and are closely related. There is a strong case for amalgamation, and the Health Commission should investigate this as a matter of emergency. In the meantime R.S.M.H. should not appoint a Manager.

The hospital executives and Board of Management derived considerable comfort from very satisfactory hospital accreditation reports. These were prepared on behalf of the Australian Council on Hospital Standards, which is responsible for the hospital accreditation programme in Australia.

While many of these comments may have been well founded, the failure to locate serious shortcomings suggests grave deficiences in the process of accreditation. The Committee believes that the Health Commission should endeavour to expand the accreditation process to provide improved assessment of administrative matters.

The accreditation procedure seems to be remarkably deficient in bringing to light serious managerial and administrative deficiencies in hospitals.

10.5 RECOMMENDATIONS

1. THAT THE HEALTH COMMISSION:-

   (a) IMPROVE INFORMATION AVAILABLE TO BOARD MEMBERS AND PROVIDE ADVICE AND SUPPORT IN DISCHARGING THEIR RESPONSIBILITIES.

   (b) THOROUGHLY ASSESS THE VALIDITY OF THE CONCEPT OF AN OPEN HOSPITAL AS ESTABLISHED AT R.S.M.H. TO DETERMINE WHETHER IT SHOULD CONTINUE OR REVERT TO A CONVENTIONAL MODE.

   (c) THOROUGHLY ASSESS THE VALIDITY OF THE "MEDICAL MODEL" AS USED IN THE CAULFIELD COMMUNITY CARE CENTRE AS COMPARED TO CONVENTIONAL CENTRES AND DETERMINE FUTURE ACTION.

   (d) REVIEW THE CASE FOR SEPARATION OF THE COMMUNITY CARE CENTRE FROM THE HOSPITAL MANAGEMENT AND BOARD.

   (e) INVESTIGATE THE ADVANTAGES OF AMALGAMATING R.S.M.H. AND CAULFIELD HOSPITAL.

   (f) ENDEAVOUR TO EXPAND THE ACCREDITATION PROCESS TO PROVIDE IMPROVED ASSESSMENT OF MANAGERIAL AND ADMINISTRATIVE PROCEDURES.

2. THAT THE PRESENT BOARD OF MANAGEMENT BE REPLACED.

CHAPTER ELEVEN

ACTION TO RECOVER INCORRECT PAYMENTS

11.1 BACKGROUND

1. Individual medical staff were employed at a level and grading determined by the hospital executives. They accepted these payments in good faith.

2. Payments to Professor Nayman were approved by the Health Commission in relation to administrative sessions and by the Divisional Committee with the knowledge of the Manager. Knowledge of the total payment package was restricted and although the total paid time was excessive it is unlikely that, with the exception of the next item, any money is recoverable from Professor Nayman.

3. Payments above the award conditions were made to Professor Nayman by way of 25% loading in excess of the 6 ordinary sessions maximum. This should be referred to the Crown Solicitor for an opinion as to whether it is recoverable.

4. While payment from the special purposes funds appear to have been unusual they mostly seem to have been within the power of the trustees to make.

5. The subdivision and allocation of medical sessions was carried out by the appropriate committee and was known to the executives. Although it may be considered excessive no action for recovery is warranted.

6. In regard to claims for re-call for the pathologists the claims were known to the Manager and were accepted when made.

7. Claims for overtime in the cleaning department, while giving rise to some suspicion as to their validity, were authorised by a responsible executive and it is impossible to prove at this time whether they were accurate.

8. The Manager was regarded as being incompetent in his management of the hospital, and inadequate in his relationship with staff, both professional and particularly domestic staff. His resignation was therefore requested. According to the evidence from three Board members the principal reasons were -

"(a) Failure to alert the board to the level of Mr. Nayman's salary.

(b) He had adopted a confrontationist approach to the unions and, in our opinion, we had no hope of achieving reasonable industrial relations while he remained in office.

(c) He had lost the confidence of the board and of the hospital staff.

(d) There was a number of occasions on which Mr. Stitfold had undertaken initiatives in matters involving important questions of policy without first consulting the board, thereby embarrassing the board" (1).

On legal advice he was paid one year's salary, together with accrued long service leave and similar payments prior to tendering his resignation.

The matter of these termination payments should be referred to the Crown Solicitor for an opinion on their propriety and to see whether any of the money is recoverable.

11.2 RECOMMENDATIONS - RECOVERY OF INCORRECT PAYMENTS

1. THAT THE FOLLOWING MATTERS BE REFERRED TO THE CROWN SOLICITOR FOR AN OPINION AS TO WHETHER RECOVERY OF THE PAYMENTS SHOULD BE PURSUED:-

(a) PAYMENTS ABOVE THE AWARD CONDITIONS MADE TO PROFESSOR NAYMAN.

(b) TERMINATION PAYMENTS MADE TO THE FORMER MANAGER, MR. STITFOLD.

(1) Public Hearing Transcript, Mr. R. Freadman, 22nd February, 1984, page 108.

CHAPTER TWELVE

ADDITIONAL MATTER AND CONCLUSION

12.1 OUTPATIENT SERVICES

It is normal practice in metropolitan hospitals to refer public hospital patients to the outpatient department for post-treatment consultation by specialists and to refer private patients back to the referring doctor or to a specialist as a private patient. This does not happen at R.S.M.H.

There is a limited emergency service provided at the hospital for casual emergencies presenting at the hospital. This is operated by the Community Care Unit and treated 835 patients last year. There is a large number of paramedical outpatients, such as dietary, physiotherapy, occupational therapy. In the year ended 30th June, 1983 there were 31,442 attendances, including emergencies. However, there is no medical outpatient department at the hospital.

The post-hospital treatment at R.S.M.H. is more analagous to the procedure in some small country hospitals without outpatient departments. From a community viewpoint, outpatient service at R.S.M.H. can be likened to a fee-for-service post-hospital service.

On discharge patients requiring additional consultation are either referred to their general practitioners, to a specialist outside the hospital or, if treated by the medical or surgical specialists in the hospital, to private consulting clinics. These are held on hospital premises in rooms rented from the hospital, where the patient is seen by the specialist concerned as a private patient. Fees are charged by the medical practitioners for this service.

For many years, the number of outpatients treated in the private clinics was included in the hospital statistics as outpatients seen, and correspondence with the Commission discussed these outpatients as if they were normal hospital outpatients.

Last year these outpatients were referred to in the annual report as "Medical Records Drawn for Private Consulting Clinic Patients".

With the agreement of the medical staff, all patients, whether private or public, have a standard medical record and this is also used in the private consulting clinics in the hospital. The records, therefore, include a complete picture of the patient treatment within the hospital and at subsequent specialist consultation. This involves considerable work in medical records which would have to be paid for by the doctors if the patients were treated outside the hospital. It is supported on the grounds that a complete record is available for subsequent patient care.

Rental charges for the private consulting rooms for "outpatient services" were set at a low rate and did not include many of the associated costs. The Committee believes this subsidising of the rooms was improper. The rental has been reviewed upwards, but the full cost is still not charged, and the rooms should be leased to the doctors at normal commercial rates.

The current policy of direct referral to general practitioners or specialist private clinics is well established as a result of considered planning within the hospital. The continuing validity of the principle in the light of practice in other hospitals should be reassessed, especially as the sessional allocation includes a component for treating outpatients. The calculation of sessional entitlement based on 1.2 sessions per occupied standard patient beds applies to other metropolitan hospitals where medical outpatient services are provided.

12.2 RECOMMENDATIONS - OUTPATIENT SERVICES AT THE ROYAL SOUTHERN MEMORIAL HOSPITAL

1. THAT THE PRIVATE CONSULTING ROOMS BE LEASED TO THE DOCTORS AT NORMAL COMMERCIAL RATES.

2. THAT THE HEALTH COMMISSION REASSESS THE ROLE OF THE HOSPITAL, IN PARTICULAR TO ESTABLISH WHETHER IT SHOULD HAVE AN OUTPATIENTS DEPARTMENT.

12.3 CONCLUSION

The inquiry has revealed major shortcomings in the structure and functioning of the hospital. These have many causes, some internal, but some which affect the general hospital field and which require more extensive investigation.

A number of the matters raised will be encompassed when the Committee deals with Item 3 of its terms of reference: "To inquire into, report and recommend on the role of the Health Commission of Victoria in monitoring the situation of Public Hospitals....."

APPENDIX I

SPECIAL PURPOSES FUND (MEDICAL)

1. In October, 1959 a committee chaired by J. V. Dillon made the following recommendations in relation to private practice for whole-time medical officers:-

(i) That no whole-time medical officer employed in a public hospital shall engage in private practice without the approval of the Committee of Management.

(ii) That each public hospital shall establish a trust fund to be styled a "special purposes account".

(iii) That all fees due to a whole-time medical officer for private practice shall be collected by the Committee of Management and paid into the special purposes account. The account for the services shall be rendered in the name of the medical officer concerned.

(iv) That the fund shall be administered by the Committee of Management with the advice of a committee (called the "advisory committee"), comprising the president, one other member of the Committee of Management, the chairman of the medical staff, and three or four specialists representing the body of the whole-time specialists.

(v) That the costs, direct and indirect, incurred by the hospital consequent upon a medical officer engaging in private practice shall be assessed on a basis agreed upon by the Committee of Management, the "advisory committee" and the Commission.

(vi) That such costs, and the costs incurred in administering the fund, shall be charged to the special purposes account.

(vii) That the balance of the account may be utilised for any of the following purposes:-

(a) The conduct of research, educational programmes and developmental activities not generally subsidised by the Commission.

(b) The purchase of items of equipment to improve private patient service, and or the maintenance of such equipment.

(c) The conversion or renovation of facilities necessary to maintain private patient service.

(d) The payment of salaries of special personnel, for example, research officers.

(e) The costs of travel within Australia and abroad of whole-time medical officers.

(f) The disbursement of bonuses (not exceeding 25% of the salary rate in any year to any one medical officer) to such whole-time medical officers as are approved by the Committee of Management. Note: The initial bonus was 250 pounds. It has been modified a number of times and is now 25% of the annual salary.

(g) Generally for the advancement of medical knowledge.

2. In the late 1960's the Commonwealth Department of Health ruled that medical benefits were not payable to a public hospital for medical services and stipulated that:-

(a) Any fees payable by the patient are charged by, and in the name of, the medical practitioner and the patient's liability for payment of the fees is solely to the practitioner as an individual.

(b) Except in the case of radiologists and pathologists, fees received are entirely at the disposal of the medical practitioner and are not, under the terms of his contract of employment payable wholly or in part to the hospital or any fund controlled by the hospital authorities, except to the extent that they represent a payment by the medical practitioner of bona fide charges by the hospital for the use by him for the purpose of his private practice, of hospital equipment, services and materials.

3. At this time it became necessary to establish trust funds under the control of the doctors for all specialties except pathologists and radiologists. However, in many hospitals the trust funds which were set up also included pathologists and radiologists.

4. Hospitals recover costs incurred by the full-time specialists, usually by assuming that 60% of the fee covers costs. This amount goes into the hospital's operating (maintenance) account as income.

5. For each service rendered to a private patient by a medical practitioner with the right of private practice exercising his right, it has been customary for the hospital to render the account to the patient in the specialist's name and on receiving the money issuing the receipt again in the specialist's name. The hospital's costs are first taken out and then the remainder is placed in a trust fund (not all hospitals established such funds) or in some form of special purposes (medical) account.

6. Many funds contain substantial amounts (in excess of 2 million dollars) and some hospitals experience difficulty in persuading trustees to allow the money to be used for expenditure on approved items and urgent replacement of equipment.

7. Many public hospitals follow the Dillon Committee recommendations on disbursements but there are a number of variations in the way the funds are handled.

8. Purchase of new equipment from the funds may not meet the priorities of hospitals and may involve hospitals in additional expense through the provision of extra staff and maintenance costs.

9. Some departments within hospitals do not have a high rate of private practice and have been disadvantaged in comparison to other departments. Some hospitals do not allow their doctors any private practice and these hospitals are then disadvantaged.

10. The Commission and the Victorian Hospitals Association (V.H.A.) believe that moneys in the special purposes funds may be used for any of the following purposes:-

(a) The disbursement of bonuses (not exceeding 25% of the salary rate in any one year to any one medical officer) to such participating full-time medical officers as are approved by the hospital's Committee of Management.

(b) Subscriptions or dues incurred by a participating medical officer for membership of a professional organisation.

(c) Cost of textbooks or professional periodicals or journals used by a participating medical officer in his work.

(d) The conduct of educational programmes and development activities for medical officers who are members of the Special Purposes Fund (Medical).

(e) The cost of travel for professional purposes within Australia and abroad of full-time officers who are members of the Special Purposes Fund (Medical).

(f) Contingent liabilities for expenses incurred during sabbatical leave which has commenced to accrue.

11. The Commission and the V.H.A. also believe that if at any time the level of the Special Purposes Fund (Medical) exceeds the amount required to provide for these purposes the surplus is to be transferred to a separate bank account and it will constitute a separate fund which is to be administered by the Committee of Management of the hospital. The Committee of Management should take into account the joint advice of contributing practitioners and hospital representatives when using the money which is to be used for the purchase of medical equipment and the conduct of medical research.

12. Under Medicare it is proposed that the Commonwealth legislates so that Commonwealth Medical benefits are only payable for diagnostic services provided to inpatients (and outpatients by agreement) of recognised hospitals if the service is provided pursuant to a contract between the medical practitioner providing the service and the hospital granting a right of private practice, of a form accepted by the Commonwealth minister.

This will allow State ministers of health to apply guidelines for the way the funds are used.

APPENDIX 2

SUBMISSIONS RECEIVED

Mr. A.S. Wood, 7th November, 1983.

Dr. R. McLellan & Professor P. Zimmet, 24th November, 1983.

Mr. R.L. Benjamin, 24th November, 1983.

Ms. H. Starling, 24th November, 1983.

Australian Medical Association, November, 1983.

Dr. J. Wheelahan, 30th November, 1984.

Dr. R. McLellan & Professor P. Zimmet, 19th December, 1983.

Mr. R. Freadman, 16th December, 1983.

Dr. W. deBoer, 20th January, 1984.

PUBLIC HEARINGS

Mr. G. T. J. Henry, Acting Chief Executive Officer, The Royal Southern Memorial Hospital, 14th November, 1983.

The Honourable T. W. Roper, Minister of Health, 12th December, 1983.

Mr. R. Benjamin, President, The Royal Southern Memorial Hospital, 12th December, 1983.

Mr. R. Freadman, Cr. M. R. Blair and Mr. A. Robinson, Board Members, The Royal Southern Memorial Hospital, 22nd February, 1984.

APPENDIX 3

EXTRACTED FROM THE MINUTES OF THE PROCEEDINGS
OF THE LEGISLATIVE COUNCIL
Friday, 2 July 1982

34. JOINT INVESTIGATORY COMMITTEES - The Honourable W.A. Landeryou moved, by leave, That contingent upon the enactment and coming into operation, this Session, of legislation to establish Joint Investigatory Committees:

(a) The Honourable P.D. Block, B.P. Dunn, G.A. Sgro, D.K. Hayward and A.J. Hunt be members of the Economic and Budget Review Committee;

Question-put and resolved in the affirmative.

EXTRACTED FROM THE MINUTES OF THE PROCEEDINGS
OF THE LEGISLATIVE COUNCIL
Thursday, 20 October 1982

8. ECONOMIC AND BUDGET REVIEW COMMITTEE - The Honourable A.J. Hunt moved, by leave, That the Honourable P.D. Block be discharged from attendance upon the Economic and Budget Review Committee and that the Honourable J.V.C. Guest be added to such Committee.

Question-put and resolved in the affirmative.

EXTRACTED FROM THE VOTES AND PROCEEDINGS
OF THE LEGISLATIVE ASSEMBLY
Thursday, 1 July 1982

36. COMMITTEE APPOINTMENTS - Motion made, by leave, and question - That, contingent upon the coming into operation of the Parliamentary Committees (Joint Investigatory Committees) Act 1982-

(a) Mr. Gavin, Mr. Harrowfield, Mr. McCutcheon, Mr. McNamara, Mr. Richardson, Mr. Rowe and Mr. Sheehan (Ivanhoe) be appointed members of the Economic and Budget Review Committee.

-(Mr. Fordham)-put and agreed to.

EXTRACTED FROM THE MINUTES OF THE PROCEEDINGS OF THE LEGISLATIVE COUNCIL

Tuesday, 14 June 1983

14. ECONOMIC AND BUDGET REVIEW COMMITTEE - The Honourable Evan Walker moved, by leave, That the Honourable A.J. Hunt be discharged from attendance upon the Economic and Budget Review Committee and that the Honourable G.P. Connard be added to such Committee.

Question-put and resolved in the affirmative.

EXTRACTED FROM THE VOTES AND PROCEEDINGS OF THE LEGISLATIVE ASSEMBLY

Tuesday, 6 March 1984.

5. ECONOMIC AND BUDGET REVIEW COMMITTEE - Motion made, by leave, and question - That Mr Richardson be discharged from attendance on the Economic and Budget Review Committee and that Mr Ramsay be appointed in his stead.

(Mr Fordham)-put and agreed to.

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