SALARIED SPECIALISTS

REPORT 1 of 1997

1. REPORT SUMMARY

1.1. INTRODUCTION

The Canberra Hospital obtains specialist medical services through a combination of contracting Visiting Medical Officer's (VMOs) and employing salaried specialists. This report relates to the salaried specialists.

Salaried specialists public sector duties include caring for patients at the Hospital[1]. Also research, teaching, managing departments and attending conferences and meetings.

The Canberra Hospital's salaried specialists may also be entitled to engage in private practice at the hospital as well as outside the hospital both after and within normal working hours. Approximately two thirds of The Canberra Hospital's salaried specialists engage in some form of private practice and for some, the earnings are quite considerable.

The hospital pays in excess of $6 million in annual salary and allowances to the salaried specialists. At the time of conducting this audit there were 63 salaried specialists.

1.2. CHIEF MINISTERS REQUEST

In April 1996 the Chief Minister, following a motion in the Legislative Assembly, wrote to the Auditor General asking that consideration be given to an audit being performed of the private practice activities of the then Woden Valley Hospital's salaried specialists. In view of the considerable Legislative Assembly and public interest in relation to these activities it was agreed to conduct an audit.

[1] A small number of specialists also perform duties at other ACT Health Facilities e.g. Woden Health Clinic - Phillip.

This Report presents the results of a performance audit of the internal control exercised by the hospital's management to provide assurance that the salaried specialists' use of private practice rights is within their entitlements and that the transactions generated by the use of these rights are correctly accounted for.

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1.3. AUDIT OBJECTIVE

The objective of the audit was to provide an independent opinion to the Legislative Assembly on whether there are adequate internal controls over the management of salaried specialists' private practice arrangements at The Canberra Hospital in relation to:

- the level of compliance by salaried specialists with the terms and conditions of their private practice agreements;
- charges paid by salaried specialists for use of The Canberra Hospital facilities in their private practice activities;
- patient billing and receipting procedures for revenue generated by the salaried specialists' private practice activities; and
- impacts of salaried specialists' private practice activities on the usage levels of Visiting Medical Officers.

The independent opinions formed from the audit are set out on *page 7.*

The audit did not extend to the quality of work performed by The Canberra Hospital's salaried specialists and nothing in this Report should be

construed to be a reference to, or be relevant to, the quality of the work performed.

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1.4. 1994 INTERNAL AUDIT

The Audit Office was aware that a major internal audit of private practice arrangements had been carried out for the Hospital in 1994. With this knowledge, and in order that this audit should be carried out as efficiently as practical, the principal approach for this audit was to conduct a follow up of the 1994 internal audit. The purpose was to ascertain whether the significant issues identified in the 1994 audit had been effectively addressed. The results presented in this Report therefore represent mainly those derived from reviewing the current position in relation to the recommendations made in the 1994 internal audit report.

1.5. IMPLEMENTATION OF THE 1994 INTERNAL AUDIT RECOMMENDATIONS

The following table summarises the implementation of the internal audit recommendations made as a result of the 1994 internal audit.

Table 1.1 Summary of the Implementation of Recommendations Made to Management of The Canberra Hospital in 1994

	Main Issue	**Implemented**	**Not Fully Implemented**	**Not Implemented**
Chapter 2	**Compliance With Private Practice Rights**	1	1	4
Chapter 3	**Facility Charges**		1	1
Chapter 4	**Private Practice Billing and Receipting**	2	4	4
Chapter 5	**Mix of Private and Public Patients**		2	
Chapter 6	**Leave Matters**		1	1

Total Recommendation		**3**	**9**	**10**

As the table indicates few recommendations from the 1994 internal audit to improve control over private practice arrangements have been fully implemented. This is inconsistent with the Hospital management's written advice provided to the audit office before the commencement of the audit that implementation of the recommendations had generally been effected.

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1.6. PRIVATE PRACTICE ARRANGEMENTS IN THE ACT

In order to ensure that the ACT was able to maintain its competitiveness with NSW and other State public hospitals for the recruitment of salaried specialists during the ACT's growth period in the 1960s and 1970s, rights of private practice arrangements were introduced into the ACT's public health system.

Additionally, the former Commonwealth Public Service Board decided in 1986 to grant approval for all salaried specialists employed in various Commonwealth agencies, such as Veterans' Affairs and the then ACT Health Authority to undertake 'outside employment' of two sessions (or half days) per week.

As a result of subsequent changes which occurred in 1993, to outside employment arrangements, private practice entitlements became no longer automatically available to the salaried specialists who commenced employment in the ACT from that year.

Amended arrangements in the form of three '*new*' contracts were introduced in 1994 in an attempt to bring arrangements into line with those of NSW. Many specialists however are still covered by "*old*" contracts which predate the introduction of the "*new*" contracts. The "*new*" contracts allow specialists to conduct private practice at the hospital or to receive an

allowance in lieu of private practice earnings. Under the *"new"* contracts private practice away from the hospital may also be conducted subject to the written approval of a senior member of the Hospital's management.

Specialists are public servants employed under the Public Sector Management Act (1994) who therefore should only engage in outside employment with the approval of the Chief Executive Officer of The Canberra Hospital *(sec 244 of the Act).*

Rights to private practice at the hospital enable the salaried specialists to receive a bonuses of up to between 25% and 113.3% of their gross salary depending upon which type of private practice agreement the specialists enter into. The bonuses are met from the fees paid by their private practice patients after a facility charge of between 20% and 60% is deducted by the Hospital. The facility charges are of Hospital equipment, etc. for the used by the specialist in conducting their private practice activities. The specialists may also be reimbursed for the costs of their professional indemnity insurance from private practice fees.

The Canberra Hospital acts as an agent for the specialists and receipts patient fees into the Private Practice Official Account or Election Account which are accounts maintained by the Hospital for this purpose. Any funds not distributed to the specialists by the end of each financial year as bonuses are donated to the Hospital Private Practice Account or the Hospital Operating Account according to the specialists private practice agreements.

Salaried specialists can apply for funds from the Hospital Private Practice Account for travel, travel allowances, accommodation, conference fees, research, computer equipment, phones and other uses. A range of other people can also apply for funds from the Hospital Private Practice Account for similar

purposes, and the Private Practice Account Funds can be used to acquire capital equipment for use by the Hospital.

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AUDIT OPINIONS

- Management has inadequate internal controls to be able to identify the level of compliance or non-compliance by salaried specialists with their private practice agreements;
- There are no current management policies in relation to the purpose of facility charges being made to salaried specialists for Hospital facilities and other resources used in their private practices, e.g. are the charges intended to be sufficient to cover the full cost of using the facilities;
- Management has not calculated the actual costs of specialists using hospital facilities and other resources in their private practices;
- Management has inadequate internal controls over billing and receipts for private practice services provided by salaried specialists at both outpatient clinics and to hospital in-patients; and
- Management does not have adequate internal controls to review activity levels of VMOs and salaried specialists to ascertain whether a cost effective combination of VMOs and salaried specialists is being used to meet the Hospitals work load demands for specialists.

1.7. BASES FOR AUDIT OPINIONS

The bases on which audit opinion was formed are set out following:

- ***It was established in the 1994 Internal Audit that arrangements for outside employment***

were not being controlled: Accordingly it was suggested that the rights of outside employment be through the Executive Director Clinical Services to having the authority to withhold approval where appropriate. Private practice arrangements for salaried specialists formulated subsequent to the 1994 internal audit enable outside private practice away from the Hospital with senior management approval however, the administration of these approvals appears to be ineffective;

- ***applications for private practice at premises away from the Hospital by salaried specialists have not been consistently made in a written form although this is required by the specialists' contracts; some specialists are relying on "old approvals" which do not relate to their current outside arrangements;***

- ***Only 50% of responses to a management survey of salaried specialists on the "old" scheme gave management some indication of how salaried specialists would make up the time they spend conducting outside private practice in normal working hours;***

- ***data is not being collected to facilitate monitoring by Hospital management of salaried specialists activities; there is no evidence to indicate that any monitoring through other methods is occurring; and***

    - ***contracts for new private practice arrangements for salaried specialists formulated subsequent to the 1994 internal audit do not contain "sunset clauses" enabling termination upon the giving of a period of notice as recommended by the internal audit.***

    - ***While filing for new contracts is adequate, The Canberra Hospital still does not have***

some contracts negotiated before 1990. This means some specialists may not have a written contract with the Hospital.

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1.8. COMPLIANCE WITH PRIVATE PRACTICE RIGHTS

The opinion that ***management has inadequate controls to be able to identify the level of compliance or non-compliance by salaried specialists with their private practice agreements*** is based on the following findings:

- It was established in the 1994 Internal Audit that arrangements for outside employment were not being controlled; Accordingly it was suggested that the rights of outside employment be limited through the Executive Director, Clinical Services having the authority to withhold approval where appropriate; private practice arrangements for salaried specialists formulated subsequent to the 1994 internal audit still enable outside private practice away from the Hospital with senior management approval however, the administration of these approvals appears to have been ineffective.

- applications for private practice at premises away from the Hospital by salaried specialists have not been consistently made in a written form although this is required by the specialists' contracts; some specialists are relying on "old approvals" which do not relate to their current outside arrangements;

- data is not being collected to facilitate monitoring by Hospital management of salaried specialists activities; there is no evidence to indicate that any monitoring through other methods is occurring; and

- contracts for new private practice arrangements for salaried specialists formulated subsequent to the 1994 internal audit do not contain "sunset clauses" enabling termination upon the giving of a period of notice as recommended by the internal audit.

Comments

Salaried specialists who are not complying with agreements for private practice are may be performing less than their potential workload for The Canberra Hospital. As Hospital management does not collect data, approvals are not current and contracts do not allow for termination or variation, the Hospital's management has effectively no control over the specialist's use of their rights to private practice and does cannot know whether specialists are performing less than their potential workload for the Hospital.

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1.9. FACILITY CHARGE

The opinions that ***there are no current management policies in relation to the purpose of the charges being made to salaried specialists for Hospital facilities and other resources used in their private practices,*** **and** ***management has not calculated the actual costs of specialists using hospital facilities and other resources in their private practices*** are based on the following findings:

- Work undertaken in 1994 by the Hospital's management indicated that facility charges being levied at that time were not adequate to recover full hospital overheads and in some instances did not appear to cover direct costs; the same facility fees continue to be charged in 1997; some work has been carried out to determine whether current charges are reasonable in recouping full costs of the

hospital however the work remains incomplete;

- Preliminary assessment by Hospital management indicates that costs of providing facilities for private practice in many clinics exceed the Medicare rebate.

- Enquiries of management indicated that no policy is in place on the requirements of whether facility fees should cover full or part costs of Hospital facilities and other resources used by specialists in on site private practice.

Comments

The facilities fees charged in 1997 are not adequate to cover full hospital overheads or direct costs of providing services. Additionally the Medicare rebate which is received by the hospital on the doctor's behalf does not cover the cost of services provided to patients. This is significant because only 20-60% of the rebate is paid by the doctor to the hospital as a facility fee. This lack of cost coverage demonstrates that for some specialists, onsite private practice is being subsidised by The Canberra Hospital i.e. from public funds. It is understood that there is no formal policy which states that subsidisation is an acceptable practice, Hospital management advised that parity with NSW arrangements was of importance.

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1.10. PRIVATE PRACTICE BILLING AND RECEIPTING

The opinion that ***management has inadequate internal controls over billing and receipts for private practice services provided by salaried specialists at both outpatient clinics and to hospital in-patients*** is based on the following findings:

- although patient office procedures for billing have been introduced, no documented bill preparation procedures have been designed for use in the Hospital's clinics;

- clinic billing procedures do not incorporate instructions on the requirement for referral documents to be received before a patient can be billed and the need to record non-charge patients so that all services are recorded for Casemix purposes;

- patient referral documents are still not being maintained as required by Section 5.8 of the Medical Benefit Schedule (MBS) Guidelines;

- some patients are still being treated and a charge not being raised; the non recorded services prevent the hospital from having a basis to receive Casemix funding;

- the MediLiNC Billing System for outpatients has not been linked to the MediLiNC Outpatient's Booking System; not all specialists are using the MediLiNC outpatient's booking system;

- no uniform procedures have been developed to ensure that all services provided to private in-patients by salaried specialists are recorded prior to the raising of an invoice by the patients office; and

- no review has been conducted on the most appropriate arrangements for arranging private practice accounts and the conduct of private practice within the hospital.

Further findings Indicating Inefficiency

- In some outpatient clinics an additional support position exists to cover if one staff member is on leave because of the unique

billing and receipting procedures in the clinics; and

- Information is being recorded at individual clinics and again at the Patient Office instead of once only on a centralised system.

Comments

The audit found that there has been implementation of some of the recommendations from the 1994 internal audit in relation to billing and receipting. In particular, all private patients are now billed through the Patients Office. This has resulted in improved controls over the billing of private patients but the way in which outpatients clinics prepare source documents for billing remains ad hoc.

Although there have been some improvements there are still weaknesses in internal controls surrounding the billing of services for private in-patients who were treated by salaried specialists.

There has been no overall review of the billing arrangements within clinics at the Hospital and consequently there has been no formulation of consistent policies and procedures for the financial administration of private practice within the clinics at the Hospital.

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1.11. COMBINATION OF VMOS AND SALARIED SPECIALISTS

The opinion that ***management does not have adequate internal controls to review activity levels of VMOs and salaried specialists to ascertain whether a cost effective combination of VMOs and salaried specialists is being used to meet the Hospital's work load demands for specialists*** is based on the following findings:

- The Canberra Hospital management does not have consistent procedures across clinics or

collect data centrally in order to be able to identify the levels of activity of individual VMO's and salaried specialists. They are therefore not able to monitor whether the most cost effective combination of VMOs and salaried specialists is being used; and

- public/private patient mix for outpatients by type of doctor e.g. specialist, VMO or other means of assessing specialist activity is still not able to be collated in most clinics or is not centrally collected for management evaluation; and

- where both groups of specialists are performing duties there are no mechanisms in place to determine the extent of using VMOs to treat public patients while salaried specialists are treating private patients in the clinics or attending outside employment.

Comments

The impact of salaried specialists rights to private practice on the use of VMOs to undertake hospital work demands is still not collated by the Hospital's management. The lack of information on activities prevents management from determining the extent that VM0s may be performing hospital work while salaried specialists attend to private practice patients or are engaged otherwise. Without the information management cannot assess the cost effectiveness of their use of medical specialists in total.

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1.12. LEAVE MATTERS

In the course of the audit it was also noted that:

- The extraordinarily high and costly salaried specialists' leave balances observed during the 1994 internal audit are now greater than at the time that the 1994 audit was conducted.

Comments

The continuing accumulation of leave balances since the 1994 audit further indicate a lack of control by the Hospital's management.

Some changes to leave management procedures have been proposed including requesting that all leave taken is recorded however unless compliance with the new procedures is monitored leave will continue to be accrued in excess of acceptable guidelines and also of the requirements which have been in place since 1987 in the salaried specialists' industrial award.

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CONCLUSION

As can be seen from the audit opinions formed, and the audit findings, internal controls over the private practice arrangements of salaried specialists at The Canberra Hospital in many aspects are either non existent or inadequate. This conclusion is basically the same conclusion which the 1994 internal audit made.

An implication of the lack of internal control is that a proportion of the $6m paid annually by the hospital to salaried specialists may not be generating 'value for money' as some specialists could either intentionally or inadvertently be utilising time paid for by the hospital for private practice activities without the Hospital's management being aware. This is not to say that specialists are doing this but that if they were the Hospital's management would not have any objective information to use as a basis for rectifying the situation.

In well run organisations management uses the application of policies and procedures for directing, regulating and co-ordinating activities in a way to attain the organisation's aims. Good management

obtains feedback to ensure that polices and procedures are being applied - and implements change (based on feedback) where there needs to be adjustments made so that resources are always being applied efficiently and effectively. Control includes the examination of results produced by management information systems and use of this information to facilitate co-ordination and increase effectiveness and efficiency. Control is clearly a prime responsibility accepted and met by a good management team.

The results of the audit show that the activities of The Canberra Hospital's salaried specialists are "out of control" by the Hospital's management and have been in this situation for several years. It is a situation which should be corrected quickly.

In view of the lack of management control the Audit Office is conducting an extended audit on the salaried specialist activities. A report on the extended audit will be provided to the Legislative Assembly in the latter part of 1997.

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1.13. FUTURE ACTIONS

Virtually none of the recommendations from the 1994 internal audit have been implemented. The recommendations which have not been implemented have necessitated fresh and renewed recommendations being made as a result of this audit. The list of recommendations is contained in *Appendix 1* to this Report.

It is emphasised that some of the recommendations made in the 1994 audit and the further recommendations from this audit may prove to be not fully practical or more efficient methods of addressing the findings may be identified by management. The major issue is that the findings are addressed effectively.

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1.14. AUDIT APPROACH AND SCOPE

The audit considered the implementation of the most important recommendations from a previous ACT Health Internal Audit Review titled *"Private Practice Arrangements of Salaried Specialists - May 1994"*. The overall conclusion of this internal audit, which was a comprehensive examination, was that generally internal controls over private practice arrangements were ineffective.

The current audit also considered internal controls in relation to the changes made to the system as a consequence of recommendations made in the 1994 internal audit report.

Information available to, and used by management to monitor the activity levels of salaried specialists were assessed in this audit and the Private Practice Agreements of salaried specialists were reviewed.

Not all speciality areas were visited. For consistency purposes, audit testing was undertaken for the same specialists (where possible) who were visited as part of the 1994 internal audit. The following clinics were part of both the 1994 audit and this audit:

- endocrinology;
- nuclear medicine;
- radiology;
- renal;
- haematology;
- psychiatry;
- radiation oncology; and
- vascular surgery.

In the course of these visits, individual specialist's private practice arrangements were reviewed. The

audit procedures conducted also obtained information concerning specialists as a whole.

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2. COMPLIANCE WITH CONDITIONS OF PRIVATE PRACTICE AGREEMENTS

2.1. INTRODUCTION

One objective of the 1994 internal audit was to determine whether salaried specialists were complying with the terms and conditions of existing Private Practice Agreements including the private practice contracts of that time and the ACT Health Policy Statement *"Outside Employment - Full Time Medical Specialists"*.

In this Chapter "outside employment" and "outside private practice" refer to salaried specialists' activities at premises away from The Canberra Hospital.

In relation to the audit objective the 1994 internal audit concluded that:

- rights to outside employment and private practice suffered from the weakness of not being easy to control and that future contractual arrangements should limit the opportunities for outside private practice and contain "*sunset clauses*" ;

- applications for outside employment and private practice did not fully provide details of proposed outside employment, times of absences from normal employment and importantly, arrangements proposed to make up lost time;

- mechanisms were not in place (such as monitoring patient activity levels) to ensure that the rights to outside employment and private practice were not being abused particularly through non-attendance at The Canberra Hospital as a result of outside employment; and

- some contracts and other documents relating to the private practice arrangements and outside employment could not be located.

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2.2. FINDINGS FROM THIS CHAPTER

- ***It was established in the 1994 Internal Audit that arrangements for outside employment were not being controlled: Accordingly it was suggested that the rights of outside employment be through the Executive Director Clinical Services to having the authority to withhold approval where appropriate. Private practice arrangements for salaried specialists formulated subsequent to the 1994 internal audit enable outside private practice away from the Hospital with senior management approval however, the administration of these approvals appears to be ineffective;***

- ***applications for private practice at premises away from the Hospital by salaried specialists have not been consistently made in a written form although this is required by the specialists' contracts; some specialists are relying on "old approvals" which do not relate to their current outside arrangements;***

- ***Only 50% of responses to a management survey of salaried specialists on the "old" scheme gave management some indication of how salaried specialists would make up the time they spend conducting outside private practice in normal working hours;***

- ***data is not being collected to facilitate monitoring by Hospital management of salaried specialists activities; there is no evidence to indicate that any monitoring through other methods is occurring; and***

- ***contracts for new private practice arrangements for salaried specialists formulated subsequent to the 1994 internal audit do not contain "sunset clauses" enabling termination upon the giving of a period of notice as recommended by the internal audit.***

- ***While filing for new contracts is adequate, The Canberra Hospital still does not have some contracts negotiated before 1990. This means some specialists may not have a written contract with the Hospital.***

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2.3. PRIVATE PRACTICE ARRANGEMENTS

Current private practice arrangements are determined by whether the salaried specialist has signed a contract since 1994 or remains under the '*old scheme*'.

Under the '*old scheme*', specialists can receive up to an additional 25% (or up to 35% where professional indemnity insurance has been entered into) of their salary for on site private practice conducted at The Canberra Hospital.

In addition, under the 1985 ACT Health Policy Statement (C85/1396) "*Outside Employment - Full Time Medical Specialists*", specialists are allowed to undertake up to two sessions per week engaging in outside private practice at premises away from the Hospital subject to permission being granted by the Hospital and continual compliance with conditions set out by the Hospital. Specialists retain all the proceeds from these activities away from the hospital.

Salaried specialists who entered into contracts since 1994 are eligible for three new schemes. These are:

Scheme A: specialists may choose to be paid 20% of their annual gross salary in lieu of private practice earnings from within the hospital;

Scheme B: in addition to their salary, specialists may earn up to 50% of their annual gross salary in onsite private practice income from their activities within the hospital; and

Scheme C: specialists receive 75% of their gross salary and may then earn additional amounts from onsite private practice within the hospital, up to 113.3% of the salary paid to the specialist in a financial year.

Under *Scheme A* arrangements specialists "*must not conduct private practice, during usual working hours, at a place other than a health facility or Calvary Hospital"*. The agreement allows for periods of paid leave (e.g. recreation leave) if written permission is given by the Executive Director, Clinical Services for a specialist to conduct private practice outside the scope of this Agreement.

Under *Scheme B and C* arrangements, no specialist may "*conduct private practice, during usual working hours, at a place other than a health facility or Calvary Hospital without the prior written approval of the Executive Director, Clinical Services of ACT Health*". These agreements also allow for periods of paid leave if written permission is given by the Executive Director, Clinical Services for a specialist to conduct private practice outside the scope of this Agreement.

The following table is a summary of the schemes under which current salaried specialists are operating.

Type of Contract	**Number**
New - scheme A	22
New - scheme B	5
New - scheme C	4
Old	25
Pathology (no contract)	6

Part-time - no contract	1
Total	**63**

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2.4. IMPLEMENTATION OF 1994 INTERNAL AUDIT RECOMMENDATIONS

The following sections of this Chapter summarise the relevant recommendations from the 1994 internal audit and describes the current position indicating whether the recommendations have been implemented or not.

At the conclusion at the 1994 internal audit Hospital management provided responses to each of the recommendations made from that audit. In most cases the response was positive stating the recommendation would be adopted or examined further. For readers information Management's 1994 responses in relation to each recommendation are included in this Chapter.

Additionally in 1996 Hospital management was requested by the Audit Office to advise of the current status of the 1994 recommendations. The 1996 responses are also presented in this Chapter.

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2.5. LIMITATIONS ON OUTSIDE PRIVATE PRACTICE

Summary of 1994 Internal Audit Recommendations

- ACT Health should address the appropriateness of rights of outside employment in the formulation of contracts for salaried specialists incorporating comments from the ACT Government Solicitor's Office and ensuring compliance with the new ACT Public Sector Management Act. *(recommendation 3.2.2.)*

- It should be recognised that for ACT Health to meet its obligations to be accountable for

expenditure of public funds, consideration should be given in future contractual negotiations to limiting the opportunities for "outside private practice". Any phasing out of existing arrangements should be staged at a rate which does not expose ACT Health to the risk of industrial upheaval. *(recommendation 3.3.2)*

Need for the 1994 Recommendations

The internal audit recommended that consideration be given to limiting the rights of outside private practice largely because:

- similar rights to outside private practice did not apply to salaried specialists operating in NSW hospitals;
- the level of control and accountability over specialists' attendance was weak and doctors could attend outside employment in excess of approved sessions; and
- salaried specialists were able to be paid a salary whilst concurrently earning an outside private practice income.

Management Response to the 1994 Internal Audit

"The recommendation is accepted and will be implemented."

1996 Management Response to the Audit Office

"This has been achieved in the new private practice arrangements. Within these arrangements, there is no provision for outside employment of full time staff."

The Current Position

The limiting of rights of outside employment away from the Hospital in future contractual negotiations has not been fully achieved within the current contract

arrangements which were developed in 1994 *(Schemes A, B and C).*

The arrangements for outside private practice under each of the schemes is summarised following.

Scheme A- Specialists can conduct private practice during usual working hours at a health facility or Calvary Hospital, and at any location outside of usual working hours. The fees generated should be receipted into The Canberra Hospital's Private Practice Election Account. This arrangement differs from the old arrangements in that fees from outside employment during usual working hours are now to be received through The Canberra Hospital.

Scheme B and C - Under these schemes specialists are not to conduct private practice, during usual working hours, at a place other than a health facility or Calvary Hospital without the approval of the Executive Director, Clinical Services (EDCS) or equivalent at the Hospital. Under the agreements, the EDCS cannot withhold approval to conduct outside private practice if it does not interfere with the normal hospital duties of the specialist and the private practice is part of a regional service which would not otherwise be available. All fees generated through private practice at a health facility or Calvary Hospital at any time, or private practice conducted during usual working hours at any location, are to be collected by The Canberra Hospital on the specialists behalf and deposited in the Private Practice Official Account.

Comment

Salaried specialists are public servants under the Public Sector Management Act (1994). In accordance with Section 244 of that Act they are therefore only able to engage in outside private practice with the approval of the Chief Executive Officer of The Canberra Hospital. Although the provisions within the new agreements which allow private practice do not contravene the terms of the Public Sector

Management Act it would not be expected in the public sector for this leave to be granted by a Chief Executive if a conflict of interest could arise, or the level of outside work performed could impact on the "on call" arrangements or efficiency and work performance of the public servant. Management would also need to have feedback which provided assurance that compliance with S.244 approvals was occurring.

It is difficult to understand why rights of outside private practice were incorporated into the new contracts given the recommendations contained in the 1994 internal audit and that the recommendations were accepted by the hospital's Chief Executive at that time.

The 1996 Hospital management response to the Audit Office was clearly a misstatement of the actual position.

It is noted that Section 244 of the PSM Act (1994) allows all public servants to conduct outside work if the work is approved by their Chief Executive. However it would be a very rare case indeed for approval to be granted for outside work during the normal working day.

In this case Hospital management does not have controls in place to monitor whether outside private practice is occurring without S244 approval or whether outside private practice is complying with S244 approvals *(Section 2.7).* Furthermore approvals from applications have been "ad hoc" *(see later).*

Recommendations From This Audit

- The original 1994 recommendations should be implemented.

- Unless the Hospital can ensure there are adequate controls and that mechanisms exist to monitor compliance with outside employment approvals,

new contracts should not contain rights for outside private practice. Approval should be necessary from the Chief Executive to engage in outside employment using the provisions of Section 244 of the *Public Sector Management Act (1994).* This approval should be subject to strict internal guidelines as well as the guidelines of the Act and Public Sector Management Standards.

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2.6. TERMINATION OF CONTRACTS

Summary of 1994 Internal Audit Recommendations

- The contracts signed before 1991 are open ended as these contracts lacked any termination, variation or renewal procedures. Any new contracts should incorporate:

  – a "sunset" clause; and

  – recognition of the Clinical Management Roles, e.g. Department Head roles;

- Current private practice arrangements which result as a consequence of the contracts should be reviewed in light of the recent Medicare Agreement 1 July 1993 to 30 June 1998 which has the effect of using a different basis for funding. *(recommendation 3.3.3)*

Need for 1994 Recommendations

As the original contracts were open ended ACT Health is not able to vary arrangements if the arrangements in place become no longer appropriate for effective and efficient delivery of health care services.

As many private practice arrangements were currently being conducted in outpatient clinics within the public hospital, these arrangements needed to be reviewed to

ensure there were no issues arising from the Medicare Agreement 1 July 1993 to 30 June 1998.

1994 Management Response to the Internal Audit

No specific response was provided.

1996 Management Response to the Audit Office

No specific response was provided.

The Current Position

Advice from the ACT Government Solicitor indicates that *Clause 15* of each of the new contracts deals with the term of the agreement and with a process for either party to request changes to the new contracts after 30 June 1999. The clause however does not specifically deal with termination. There are no other sunset clauses or other provisions in the agreements for terminating the agreements, e.g. by the giving of a period of notice.

The omission of sunset type clauses was against the 1994 advice of the ACT Government Solicitor to the Hospital's management. The Government Solicitor's advice was that the agreements should contain a provision which enabled termination upon the giving of a period of notice. The current clause in the contracts means that in effect The Canberra Hospital cannot terminate or change private practice arrangements without the approval of either the specialists or "Conciliation Committee".

Clinical management roles have not been incorporated into the contracts and apparently there is only a general understanding within The Canberra Hospital that the private practice arrangements are not affected by the Medicare Agreement 1 July 1993 to 30 June 1998.

Comment

It appears that the recommendations from the 1994 internal audit and the ACT Government Solicitor's Office advice were not acted upon by the Hospital's management.

The original recommendations have not been actioned by The Canberra Hospital

Recommendations from this Audit

- The original 1994 recommendations should be implemented;
- Future contracts should contain "sunset" clauses and provisions for terminating contracts, e.g. by the giving of a period of notice; and
- The Canberra Hospital should ensure any new contracts are consistent with the requirements of the Medicare Agreement 1 July 1993 to 30 June 1998, particularly in the area of operating private practice arrangements within a public hospital outpatients' clinic. Such a review is important because cost shifting activities identified as contravening the Health Insurance Act 1973 may result in prosecution of Medical Practitioners[2].

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2.7. MONITORING OF SPECIALISTS' OUTSIDE PRIVATE PRACTICE

Summary of 1994 Internal Audit Recommendation

In granting the right of "outside private practice" there should be mechanisms in place to ensure the right is not abused. The current policy statement does not provide such mechanisms particularly by allowing "two sessions" of outside private practice a week, without defining a "session."

[2] Ministerial Review of Medical Staffing in Victoria's Public Hospital System 1995

(*Recommendations 3.3.2 and 3.3.3)*

Need for 1994 Recommendations

The 1994 internal audit considered it a matter for management policy that ACT Health should determine a level of accountability and control over specialist staff. The level of accountability needed to be comparable to other professionals employed by Government e.g. lawyers, but there did need to be recognition of out-of-hours work which is different from other professionals.

1994 Management Response to the Internal Audit

No specific response was provided to this issue.

1996 Management Response to this Audit Office

There had been complete resistance to timesheets from salaried specialists through their union. Currently, we do not ask and cannot enforce timesheets from staff specialists. It is left up to the individual medical directors to ensure that staff specialists do comply with their 38 hour per week award. There is no reason to suspect that this is not so. All staff specialists have timetables that define when they are in the hospital and when they are pursuing private practice outside. We have also had audits of their diaries that have indicated a high degree of compliance with their duties.

The Current Position

There are currently no formal mechanisms in place to ensure that outside private practice rights are not misused.

During this audit and the 1994 internal audit it was noted that specialists' diaries as they are currently maintained do not provide evidence of attendance. The diaries contain many gaps. When requested for explanations for the gaps specialists have responded that they represent time used for ward visits, research,

reading and other professional activities around the hospital, however this cannot be verified.

Two sessions of outside private practice has become commonly accepted to be one day.

Comment

The lack of mechanisms in place to ensure accountability of the salaried specialists through attendance can impact The Canberra Hospital in several ways. Importantly at a staff level, it de-motivates other Hospital salaried staff who see one standard of accountability for salaried specialists and another for themselves. It also de-motivates other salaried specialists who look to management to ensure that all salaried specialists work and contribute on an equitable basis.

The conclusion is that there are no formal mechanisms have been put in place to ensure that salaried specialists comply with their rights to outside private practice.

Further Recommendations

- The use of information systems to monitor salaried specialists performance should be implemented - one option being time sheets;

- Specialists approving time and leave records for other specialists should not be operating in a position of conflict where they may also be conducting outside practices with the same specialists. *(Chapter 6);* and

- Guidelines should be implemented and monitored to prevent doctors from obtaining a commercial advantage for their outside private practice whilst engaged as salaried specialists.

****

2.8. APPROVAL OF APPLICATIONS FOR OUTSIDE EMPLOYMENT

Summary of 1994 Internal Audit Recommendation

ACT Health should ensure that applications for outside employment (under the *"old"* arrangements) provide full details of:

- proposed outside employment (including times of session);
- times of absences from normal employment; and
- arrangements proposed to make up time lost.*(Recommendation 3.3.2)*

Need for 1994 Recommendation

Applications for outside employment did not comply with the "Policy Statement on Outside Employment" as "arrangements proposed to make up time lost were not outlined".

1994 Management Response to Internal Audit

"The contracts currently being negotiated with salaried specialists will include a requirement for specialists applying for outside employment to make up lost time."

1996 Management Response to the Audit office

"This has been achieved in the new private practice arrangements. Within these arrangements, there is no provision for outside employment of full time staff."

The Current Position

Since the previous audit several specialists covered either by the "old arrangements" or by the new Schemes have commenced outside private practice.

Arrangements include outside private practice both within and outside normal working hours. Various

forms of documentation to support the outside employment are held.

Although the old and new agreements are quite specific in requiring written requests for outside private practice, the level of documentation available varies from non-existent for some "old arrangements", to approval by annotations on newer agreements. Some specialists are relying on approvals for prior outside employment arrangements which may no longer reflect their actual current outside employment arrangements.

Comment

The ACT Government Solicitor advised that as salaried specialists are Public Servants under the *Public Sector Management Act (1994)* they are required under *Section 244* of that Act to obtain written approval of the relevant Chief Executive to "*engage, or continue in the private practice of any profession, occupation or trade, or enter into any employment, whether remunerative or not, with any person, company or firm who or which is so engaged*". Approvals are required for outside employment at any time.

The old Outside Employment Policy Statement which relates to prior to the adoption of the current contracts might be of some use in interpreting contracts entered into at the time the Policy Statement was current, however it has no independent legal effect. The terms and conditions of employment of each individual salaried specialist is governed by the Public Sector Management Act (1994) and the individual contract in force.

In an attempt to comply with the 1994 recommendation management requested "old" scheme doctors to supply the details set out in the recommendation. The survey responses have been reviewed, the result is that only 50% of responses gave management some indication of how salaried

specialists would make up the time which they spend conducting outside private practice in normal working hours. Considering the level of response it is clear that the Hospital management has not complied with the relevant 1994 recommendation as it has not obtained from Specialists operating under "old arrangements" full details of:

- proposed outside employment including times of sessions);
- times of absences from normal employment; and
- arrangements proposed to make up time lost.

Further recommendations

- Hospital management should be aware of whether outside employment conducted within or outside normal working hours is affecting the efficiency of salaried specialists duties at the Hospital. Where employment is outside normal working hours and approval has not been obtained specialists would be in breach of the Public Sector Management Act (1994).

- The Canberra Hospital should obtain from all salaried specialists who have previously approved outside employment clear documentation outlining:
  - outside employment session times;
  - arrangements to make up time lost; and
  - declaration that no commercial advantage will be obtained from undertaking outside employment; and

- All documentation relating to the operation of private practice arrangements (on-site and off-site) should be filed centrally and be in accordance with the appropriate agreements.

****

2.9. ASSESSMENT OF PERFORMANCE THROUGH MONITORING OF ACTIVITY LEVELS

Summary of 1994 Internal Audit Recommendation

Statistics such as the patient activity levels for individual specialists if collated, could provide a useful tool not only in assessing performance but also as an indicator of the non-availability of staff.

It is recommended that management regularly utilise the available information to identify unusual or significant trends so as to ensure appropriate specialist resources are available. *(Recommendation 3.3.2)*

Need for 1994 Recommendation

Management was not reviewing data on the level of activity of specialists within each speciality area. Accordingly, specialists achieving low activity levels were not being held accountable for their performance.

1994 Management Response to the Internal Audit

"The recommendation is accepted and will be implemented."

1996 Management Response to the Audit office

"Sophisticated mechanisms for tracking specialists' time within the Hospital are currently not available. There is an agreement within the latest enterprise agreement that staff specialists will undertake performance agreements as part of their employment but this is yet to be ratified."

The Current Position

Information regarding the specialist attending a patient (but not the activity of individual specialists) is available through MediLiNC for in-patients and

there are other stand alone information systems for out-patients by specialty. Information concerning the performance and activity levels for individual specialists however, is not consistently maintained across all specialty areas and is not collected by management for evaluation of individual doctors' performance. ***(Chapter 5)***

Comment

The 1984 *"Outside Employment - Full Time Medical Specialists":* Policy Statement requires that where a specialist undertakes outside employment in normal working hours the specialist may be fully remunerated where the salaried specialist is *"in a position to make up the time spent in performing such outside employment"*.

The inconsistency in data collection across clinics and the inability to provide data for individual specialists does not permit monitoring by Hospital management of compliance with this requirement.

The monitoring of performance levels will also become increasingly important to The Canberra Hospital as the enterprise agreement with staff specialists will require performance agreements as part of their employment. Data will be needed to assess the performance of specialists under these agreements.

Further Recommendations

- Action such as the withdrawal of approval for outside private practice should be taken against salaried specialists where it is demonstrated that a salaried specialist's outside employment is affecting the operations of The Canberra Hospital.

- Although information reported in The Canberra Hospital Information Bulletin- Patient Activity Data co-ordinated by Casemix, provides activity data by specialty it would seem appropriate that the

Hospital management require statistics by individual salaried specialist to fully discharge their responsibilities in managing not only the staff specialists but also the activities of Registrars, VMOs and Locums.

****

2.10. FILING OF LEGAL DOCUMENTS - RETENTION OF CONTRACTS

Summary of 1994 Internal Audit Recommendation

ACT Health should adopt more formal procedures for the retention and filing of legally binding contracts.*(Recommendation 3.3.1)*

Need for 1994 Recommendation

Some private practice contracts could not be provided to the internal audit team.

1994 Management Response to the Internal Audit

"The procedures for retention and filing of private practice contracts will be examined as it appears that the only contracts negotiated before 1990 have been difficult to locate."

1996 Management Response to the Audit office

"All contracts are held centrally at ACT Health in a secure and referenced filing cabinet. The Hospital has also retained copies of these contracts with the individual personnel files."

The Current Position

The Canberra Hospital has implemented improved procedures.

All copies of new contracts have been retained with the individual personnel files in the Financial

Planning (Private Practice) area at The Canberra Hospital. These are secured in a filing cabinet.

As in the case of the 1994 internal audit however The Canberra Hospital does not have copies of some of the old contracts which were negotiated before 1990.

Comment

The Canberra Hospital has implemented improved procedures for filing of private practice contracts however some old contracts relating to the 'old' scheme are still missing. The situation is still not satisfactory and some specialists may be engaged without a written contract.

Further Recommendation

The Canberra Hospital file securely and completely, all contracts and approvals associated with private practice arrangements of salaried specialists**.**

****

2.11. CONCLUSION

Many of the recommendations from the 1994 internal audit have not been actioned or little progress has been made towards improving the systems which were in place at the time of the previous audit.

The consequence of this lack of action is that salaried specialists are not accountable and management cannot determine whether terms and conditions of Private Practice Agreements are being complied with.

3. FACILITY CHARGES

3.1. INTRODUCTION

An objective of the 1994 internal audit was to ensure the appropriateness of the facility charges paid by salaried specialists. The 1994 internal audit found that there was little basis for the amount of the facility fees charged or in fact, any clearly set out rationale for the making of the charges. It was therefore impossible to assess whether amounts being levied for facility charges were correct.

The major issues arising from the internal audit included:

- a lack of documented basis for the charging of facility fees;
- lack of clear definition of the facility charge including whether the charge represented a full cost of providing the resources to the specialists.

*****

FINDINGS FROM THIS CHAPTER

- ***Work undertaken in 1994 by the Hospital's management indicated that facility charges being levied at that time were not adequate to recover full hospital overheads and in some instances did not appear to cover direct costs; the same facility fees continue to be charged in 1997; some work has been carried out to determine whether current charges are reasonable in recouping full costs of the hospital however the work remains incomplete;***
- ***Preliminary assessment by Hospital management indicates that costs of providing facilities for private practice in many clinics exceed the Medicare rebate; and***

- ***Enquiries of management indicated that no policy is in place on the requirements of whether facility fees should cover full or part costs of hospital facilities and other resources used by specialists in on site private practice.***

*****

3.2. BACKGROUND

There are a number of facility charges levied on specialists depending on the area in which the specialist is employed. It is also possible for a salaried specialist to be levied at different rates depending on the services provided because of variations due to the type of equipment being used.

Current facility charges are as follows:

Specialty	Rate
Anaesthesia	20%
Cardiology	20%; 40%; 50%
Endocrinology	20%
Gastroenterology	20%
Medical Oncology	20%
Nuclear Medicine	20%; 40%
Occupational Medicine	20%
Paediatrics	20%
Pathology	20%
Psychiatry	20%
Radiation Oncology	20%; 40%
Radiology	60%
Renal	20%
Thoracic Medicine	20%; 40%; 50%
Vascular Surgery	20%; 40%; 50%

These rates are the same as applied during the 1994 internal audit.

****

3.3. BASIS OF FACILITY CHARGES

Summary of 1994 Recommendation

The basis of facility charges for any future contractual arrangements should be clearly documented and retained. *(recommendation 4.3.1)*

Need for 1994 Recommendation

Under the old arrangements the basis upon which the original facility charges were set could not be established. Charges may or may not have been sufficient to cover costs.

1994 Management Response to the Internal Audit

"This recommendation is being implemented"

1996 Management Response to the Audit office

No specific comment was supplied.

The Current Position

There has been no change to the method of determining the facility charges to be levied. The bases for facility charges remain undocumented. The new contracts which have been signed have the same facility charges as the old agreements. Management had undertaken limited work based on a cost model produced in an *"Ambulatory Care Outpatient"* survey.

Comment

The original recommendation has not been actioned. The basis of the calculation of facility charges has still not been documented.

Further recommendation

- The Canberra Hospital should fully investigate the adequacy of the facility charges currently being levied. For clinical areas early findings - based on the cost model from the Ambulatory Care Outpatient Survey (dated 30 April 1996) - show

that costs in many clinics exceeded the Rebate from Medicare.

****

3.4. FUNDING ARRANGEMENTS

Summary of 1994 Recommendation

Doctors in areas of high equipment costs were keen to see some incentive driven mechanism incorporated into any new arrangements which would act as an impetus for staff to provide services by the return of a portion of the facilities charge to the specialist area. ACT Health should consider these concerns when formulating new arrangements or contracts. *(recommendation 4.3.3.1)*

Need for 1994 Recommendation

Doctors in some high return specialties saw a lack of return to their areas in terms of equipment replacement.

1994 Management Response to the Internal Audit

"ACT Health will consider how such an incentive might be applied."

1996 Management Response to the Audit office

No specific response was supplied.

The Current Position

There has been no change in the manner in which funding is allocated within The Canberra Hospital in relation to the payment of facility charges.

Comment

The Internal audit recommendation has not been actioned. Accurate allocation of resources is dependent upon management knowing the cost coverage of facility fees levied. As stated previously

management do not have a complete knowledge of which facility fees cover full cost and those which do not. It also seems however that the Hospital management is aware that facility fees in many clinics do not cover the full cost of equipment and resources used.

Further recommendation

- This issue should be addressed by the working party established as part of the previous recommendation.

****

3.5. PATIENT COSTING

Summary of 1994 Recommendations

In the formulation of any new contracts or the determination of any new facility charges, a clear definition of the facility charge should be developed. This definition should consider incorporating the full costs of all resources attributable to salaried specialists in servicing their private practice patients. Specifically nursing costs should be included. *(recommendation 4.3.3.1)*

During the developmental stage of the implementation of a Patient Costing System at Woden Valley Hospital by the Casemix Development Unit consideration be given to incorporating a system to enable costs to be mapped to the Medical Benefits Schedule (MBS) item numbers used to bill private patients or detailed costing studies should be performed to ascertain the true facility costs.*(recommendation 4.3.3.3)*

The audit team believed that to achieve a full assessment of the recoverability of facility costs a comprehensive costing study was required which should encompass full cost principles. The definition of the costs attributable to the specialists needs to be

fully developed to encompass full cost recovery principles.*(recommendation 4.3.4)*

Need for 1994 Recommendation

The 1993 private practice agreements did not clearly define the full costs to be charged to the specialists in facility fees.

There was no accurate information available for Hospital management to determine whether the Hospital is recouping the costs of salaried specialists serving their private patients or if the facilities charges are reasonably based on a sound method of full costing.

Work undertaken by the internal audit indicated that for some of the areas under review, the facility charges levied were not adequate for the recovery of full hospital overheads and in some cases did not appear to recover direct costs.

1994 Management Response to the Internal Audit

"In negotiating new contracts or determining new facility charges the basis of the charge will be recovery of full costs as defined.

The recommendations are accepted, consideration will be given to including a facility to enable costs to be linked to MBS items in the Costing System.

A comprehensive costing study is expected to be a product of the implementation of the Patient Costing System."

1996 Management Response to the Audit Office

"A study performed with Commonwealth funding has determined the salary component of the outpatient services provided at most clinics at Woden. These have as yet not been finalised and distributed but it is hoped that this will allow an extrapolation of the true

costs to the facilities. Most of the services so far finalised have exceeded the Medicare rebate."

The Current Position

The Canberra Hospital management has made some assessment based on the cost model developed in the Ambulatory Care Outpatient Survey. This review found that for *"many of the clinics salary costs alone would require a facility fee in excess of the total medical benefits schedule rebate."* Despite these findings facility charges have not been adjusted. The implication of this is that the private practice arrangements of salaried specialists within those particular clinics are being subsidised by The Canberra Hospital.

This is particularly significant within the context of Casemix funding received by The Canberra Hospital. All costs attributable to a service need to be allocated to enable the accurate calculation of the Hospital's costs in providing that service. Any cross subsidisation including that of salaried specialists incomes needs to be transparent to identify the true cost of service provision and employment costs of specialists.

Comment

Although further work has been undertaken to establish costs to the Hospital of private practice arrangements there has been no change to the basis of facility charges. Hospital management are not aware of the level of facility fees required to be charged to salaried specialists to cover the full costs to the Hospital of specialists providing on site private practice services.

Further Recommendation

- Facility charges should be reviewed and set at a level to ensure all costs are recovered and The

Canberra Hospital is not subsidising the private practice of specialists.

CONCLUSION

Little progress had been made to resolve the issues noted as part of the 1994 internal audit. As a result facility charges applied to private practice earnings within the Hospital may not adequately cover the costs incurred by the Hospital.

Management have advised that facility fees in the States may also not cover full costs - however the audit considers that management should be in an informed position as to the cost of providing facilities for private practice. This would assist them in knowing the cost of any subsidy of salaried specialist's private practice. Future negotiations with salaried specialists and consideration of clinic operations would also benefit from this information.

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4. PRIVATE PRACTICE BILLING AND RECEIPTING

4.1. INTRODUCTION

The objectives of the original 1994 internal audit included ensuring the completeness and accuracy of the billing and receipting arrangements relating to the Private Practice Official Account; and to ensure compliance by specialists with their private practice contracts.

Major issues highlighted as part of the 1994 internal audit included:

- a lack of consistent procedures in relation to billings with the result that a wide variety of systems and procedures were in place;
- billings were not centralised through the Patients Office;
- referral advices had not been consistently retained;
- inadequate documentation had been retained in relation to non-charge patients;
- insufficient controls over the private patient billings for salaried specialists;
- no uniform procedures for the recording of private in-patients seen by salaried specialists; and
- lack of consistency in determining the most appropriate arrangements for private practice accounts.

*****

4.2. FINDINGS FROM THIS CHAPTER

Implementation Of Centralised Billing

- ***Patient Office procedures for billing have been produced; and***

- ***billings of private patients have been centralised through the Patients Office.***

Uniform Billing Procedures

- ***no documented procedures have been produced by The Canberra Hospital for use in clinics;***

- ***billings procedures in clinics have not incorporated instructions on referral and non charge patient requirements;***

- ***patient referrals are still not being maintained as required by Section 5.8 of the Medical Benefit Schedule (MBS) Guidelines; and***

- ***evidence was found that treating of non-charge patients is continuing; this prevents the proper recording of all services performed and denies the hospital a basis for Casemix funding.***

Procedures To Ensure The Recording Of Consultations By Specialists To Private Inpatients

- ***no uniform procedures have been produced for the recording of services to private inpatients; uniform procedures to ensure that all private inpatients consultations are recorded by specialist have not been implemented.***

MediLiNC Booking And MediLiNC Billing System's Interface

- ***the MediLiNC Booking System for outpatients has not been linked to the MediLiNC Outpatients Billing System; not all specialists are using the MediLiNC Outpatient's Billing System; if the systems were linked a check***

could be implemented to provide assurance that all booked patients have been billed for their service.

Inefficiencies Noted

- ***There is significant duplication of information between the clinics and the Patients Office; information is being recorded by individual clinics using clinic unique booking and patient record systems and then being rekeyed to the MediLiNC system; and***

- ***the variety of practices within the clinics produces inefficiencies; for example in some clinics one and a half positions exist to cover situations where a staff member goes on leave to avoid the situation of no one knowing the unique clinic procedures.***

Recommended Review by the 1994 Internal Audit

- ***no review has been conducted to identify the most appropriate arrangements for arranging private practice accounts and the conduct of the private practices within the hospital.***

****

4.3. BILLINGS PROCEDURES AND PATIENT BOOKING

Summary of 1994 Recommendation

ACT Health should develop procedures and systems to ensure that systems exist to capture all bills raised for all patients able to be billed. *(recommendation 5.3.1)*

Consideration should be given to centralising the account raising for both in-patients and outpatients.

ACT Health should develop a documented billing procedures manual, perhaps modelled after the NSW Health Manual. *(recommendation 5.3.2)*

The documented Billing Procedure Manual should incorporate Medicare Guidelines on bulk billing. *(recommendation 5.3.6)*

Need for 1994 Recommendation

ACT Health could not be assured that all private patients seen by salaried specialists are billed and receipted by ACT Health. This affected the level of facility charge received by ACT Health. Specialists may bill and retain fees direct, unintentionally or intentionally, and therefore not donate surplus collections to the Private Practice Fund.

There were a large number of systems to bill private patients with no documented procedures for billings. Procedures for the recording of patient bookings and raising of accounts might not reflect "best practice" nor be based on procedures and practices which are efficient and correct.

1994 Management Response to the Internal Audit

"ACT Health will examine the development of procedures and systems to capture information regarding private patients during the implementation of the outpatient booking system.

ACT Health will examine the feasibility of developing a documented billings procedures manual.

Standardised procedures on the billing of patients will be developed."

1996 Management Response to the Audit office

"There is a centralised billing system, all outpatients are registered on MediLiNC and billed through the Patients' Accounts.

The hospital now has a common centralised computer registration for all patients who are seen in the staff specialist clinics. The system is called MediLiNC. The former fragmented registration process has now

been replaced and all patients are registered on MediLiNC."

The Current Position

In the specialist areas visited as part of the audit, it was found that a variety of procedures continue to exist in relation to the procedures leading to the billing of patients by the Patient's Office.

A number of changes have occurred in relation to billings since the 1994 internal audit. In particular, all billings including invoices are raised through the Patients Office. There are documented procedures for Patient Office staff on the raising of outpatient accounts and bulk billing procedures.

This has improved the controls in operation surrounding the billing of patients. In addition, there have been changes in relation to whether bulk bills or accounts are raised within clinic areas. However, decisions to change the method of billing (i.e. bulk bills or accounts) are taken within the specialist clinic and the Hospital does not have a policy in relation to the most effective and efficient approach for the billing of private patients.

The review of specialist clinics found that no central written procedures are available in relation to the billing of private patients such as the Medicare bulk billing. In the areas visited, several had developed their own procedures however, these had not been approved through the Patients Office or other central area to ensure that procedures are within Medicare Guidelines.

Management stated in 1996 that the hospital has a common centralised computer registration for all patients who are seen in the staff specialists clinics.

As can be seen from *Table 4.1* 12 clinics do not use or are not connected to the MediLiNC patient booking system. Using the Central booking system can assist

in ensuring private patients are billed. It can also be used to assess the activity levels of specialists and clinics *(Chapter 2)* and for a basis for assessing funding issues.

A variety of practices have developed for billing and booking. The following table highlights the different procedures which are currently utilised within the Hospital outpatient clinics. This is inconsistent with the Hospital management's' 1996 response to the Audit office

SALARIED SPECIALISTS - REPORT 1

Specialty	"Schedule" (1)	Bulk Bills (2)	Invoices (3)	Central Booking	Comments
Sampled Specialities					
Endocrinology	✓	✓	✓	✓	The schedule maintained by the Out patients clinic is attached to the bulk billing forms and sent to the Patients Office. No change in procedures.
Medical Oncology	✓	✓	✓		"Schedules" are a computerised booking schedule generated for each clinic. Generally out-patients are bulk billed and in-patients invoiced. No change in procedures.
Nuclear Medicine	✓		✓		Bookings are maintained through Detente. A listing from the is sent to the Patients Office on a daily basis. Invoices are now prepared (previously bulk billed).
Psychiatry	✓	✓			Generally, out-patients are bulk billed. No change in procedures.
Radiation Oncology	✓	✓			Out-patients are bulk billed. Accounts are now raised in the Patients Office rather than by Clinic staff.
Radiology	✓		✓		Bookings are maintained through Detente. A listing from the system is sent to the Patients Office on a daily basis. Invoices are now prepared (previously bulk billed).
Renal	✓	✓	✓		Generally, bulk bills for out-patients and invoices for private in-patients. No change in procedures.
Vascular Surgery		✓	✓	✓	In general, out-patients are bulk billed on receipt of bulk bill forms. No schedule is provided to the Patients Office. In-patients are invoiced by the Patient's Office.

Specialty	"Schedule" (1)	Bulk Bills (2)	Invoices (3)	Central Booking	Comments
Specialities not sampled					
Anaesthesia & Pain Relief	✓	✓	✓	✓	It is rare for bulk bills to be prepared.
Cardiology	✓	✓	✓		Generally out-patients are bulk billed and private in-patients are invoices.
Gastroenterology	✓	✓	✓		Generally out-patients are bulk billed and private in-patients are invoices.
Geriatrics	✓	✓			Bulk bills have been prepared over the last 12 months.
Infectious Disease	✓	✓	✓	✓	Generally out-patients are bulk billed and private in-patients are invoiced
Intensive Care	✓		✓		Private in-patient accounts are prepared.
Obstetrics	✓	✓	✓		Generally out-patients are bulk billed and private in-patients are invoices.
Paediatrics	✓	✓	✓	✓	Generally out-patients are bulk billed and private in-patients are invoices.
Thoracic	✓	✓	✓		Generally out-patients are bulk billed and private in-patients are invoices.

Note: 1."Schedules" generally refers to a listing of patients seen on a particular day or for a particular period. The types of schedules produced vary greatly as does the information they contain.

Note: 2.In-patients are never bulk billed. An invoice is raised for private in-patients.

Note: 3.Where above table indicates invoices are raised this refers to in-patients and out-patients. Invoices are raised by the Patients' Office. Where table indicates that out-patients are bulk billed, this is the general case. If for some reason a bulk bill raised is invalid the patient is invoiced.

Comment

The variety of practices operating within the clinics produces many inefficiencies. Visits to specialist clinics undertaken as part of the audit highlighted that in some cases, one and a half support positions were held. This was due to the necessity of being able to provide for staff members who go on leave. In another clinic where there was one support staff, the audit was informed that when the support staff member takes leave, the specialist does not hold clinics as no relief support staff are available. These situations are unsatisfactory and result in resources not being effectively utilised.

The introduction of common procedures in all clinics would avoid these situations. Relief support staff could then be utilised by all clinics. The development of common procedures for booking and billing of patients for all outpatient clinics would enable the use of support staff on a rostered basis. This would result in resource savings as there would no longer be a need for additional part-time support staff to cover leave requirements, particularly in the smaller clinics.

As explained most of the major 1994 internal audit recommendations have been implemented such as centralised billing, the recording of outpatients and procedures for outpatient billing at the Patient's Office however little progress has been made on developing standardised policies and procedures within the clinical areas with 12 out of 17 clinics not using the central patient booking system.

Further Recommendations

- Policies and procedures should be developed for staff at clinics on their role in the manner in which patients will be billed.

- A review should be undertaken of all clinics to determine the most appropriate and efficient way of recording patients for billing services through the Patient's Office. The aim should be to standardise the approach as much as possible and develop a policy, approved by Hospital management, as to the manner in which each clinic is to undertake patient billings. This should also ensure that clinics do not operate in contravention of Medicare Guidelines.

- Support staff should be rotated through clinics, resulting in improved controls over salaried specialists billings and also provide resource savings.

- All clinics should be required to use the MediLiNC outpatients booking system or other systems able to be updated into the MediLiNC Outpatient's booking system. This should assist in ensuring that all private patients seeing salaried specialists are billed and receipted. It may also aid in assessing the number of services performed (*Chapter 2*) and all services are recorded to form a basis for assessing funding issues.

****

4.4. RETENTION OF REFERRALS DOCUMENTATION

Summary of Recommendation

Billing procedures should incorporate procedures relating to the retention of referrals documentation. *(recommendation 5.3.7)*

Need for Recommendation

Section 5.8 of the Medical Benefit Schedule (MBS) Guidelines requiring the retention of referrals was being contravened.

1994 Management Response to the Internal Audit

"The Billing Procedures Manual will include procedures on retention of referral documents."

1996 Management Response to the Audit office

No specific response to this recommendation was supplied.

The Current Position

The audit of referrals found a variety of methods of filing. Most clinics file referral documents on the patient file maintained either in the specialist area or in Medical Records.

However on several occasions, referrals could not be located in patient medical records. The following areas had instances of non-compliance:

Specialty	Number of Referrals Not retained on patient file	Number of Patients Tested
Nuclear Medicine	2	5
Endocrinology	3	4
Radiology	1	5
Vascular Surgery	1	5
Renal	3	5

Comment

The original recommendation has not been actioned.

Further recommendation

A procedures manual should be developed which includes instructions relating to the requirements for

the retention of referrals documentation based on the instructions in the Medical Benefits Schedule (MBS). The procedures should be widely promulgated to specialists and their staff to ensure there is an awareness of the requirement to retain referrals documentation with the patient's records.

****

DOCUMENTATION OF PATIENTS NOT CHARGED

Summary of 1994 Recommendation

Billing procedures should incorporate procedures for the documentation of non-charge patients.(5.3.4)

Need for Recommendation

Specialists were in contravention of their contracts and statistics of the number of patients being seen were being understated. ACT Health cannot be assured that a fee is charged for all private patients or that patients have been billed and the proceeds not received by the Private Practice Official Account.

1994 Management Response to the Internal Audit

"The private practice contracts are quite specific in respect to the specialist's responsibility regarding private patients who are treated free of charge. This requirement will be reinforced."

1996 Management Response to the Audit office

"This information is currently being gained through the ambulatory care service review funded by ACT Health. The information is being assessed currently. All billing areas have ensured that no-charge patients are correctly recorded by all specialists. It is also written into the new agreements that no charge patients must be flagged and justified by specialists."

The Current Position

The recording of non-charged patients is important within the Casemix funding model. If activity is not recorded, there will be no basis under which to receive funding.

Salaried specialists under all contracts are required to document any patients who are not charged. In addition, under the new contracts, specialists are required to notify the Executive Director, Clinical Services of any instances where a patient is not charged.

In addition, specialists' diaries show appointments with patients who do not appear on the billing schedules. The audit was informed that this is due to patients cancelling or not attending the appointments. However, no such notes had been made in the specialists' diaries.

Comment

The 1994 internal audit recommendation has not been actioned.

The new private practice agreements require justification and documentation of non-charge patients however there are no procedures to ensure this occurs.

Further recommendation

The procedures manual developed relating to the billing of patients should include a requirement that the reason for any patients not being charged be documented clearly on the billing schedule.

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4.5. CONTROL OVER PRIVATE OUTPATIENT BILLINGS

Summary of 1994 Recommendation

It was suggested that the MediLiNC Billing System for Outpatients be given priority in being interfaced

with MediLiNC Outpatient's Booking System. This is an important step in addressing control of the private patient billings for salaried specialists. *(recommendation 5.3.2)*

Need for 1994 Recommendation

The linking of the MediLiNC Billing System for Outpatients with the MediLiNC Outpatients Booking System would ensure that accounts for all patients would be created.

It would also assist in the prevention of bills being raised directly by specialists instead of by the hospital on behalf of the specialist and being paid to the Private Practice Fund.

1994 Management Response to the Internal Audit

"ACT Health will consider the priority of the interface between the MediLiNC Outpatients and Booking Systems."

1996 Management Response to the Audit office

"This has now been resolved by the centralisation of outpatients and the connection of all outpatients areas to MediLiNC."

The Current Position

MediLiNC Outpatients Booking System does not link to the MediLiNC Billing System for Outpatients to enable the production of billings. The hospital has advised that they are upgrading the current MediLiNC system and the linking of the Booking and Billings will be resolved during this process. It is still the responsibility of staff within clinics to complete a schedule which highlights to the Patients Office staff the patients who must be billed.

As part of the visits to specialists' clinics, a significant amount of duplication of effort was noted due to some areas using computerised booking and

patient record systems other than MediLiNC. In particular, the Imaging Department (Radiology and Nuclear Medicine) uses the "Detente" system. Information required to undertake billing is keyed into MediLiNC by staff within the Patients Office.

In the Radiation Oncology and Haematology Oncology areas, separate systems are used for maintaining patient records and bookings which do not link to MediLiNC in any way. As a result, all information which is keyed into the main patient systems is then re-keyed into MediLiNC.

This duplication requires a significant amount of resources and potentially affects the reliability of the systems, given the double handling of information.

Comment

The original recommendation has only been partially implemented. The linking of MediLiNC Billing System for Outpatients and the MediLiNC Outpatient's Booking System is still incomplete.

Also the practices of duplicate recording of information are inefficient.

Further recommendations

The Canberra Hospital should consider the use of one system for booking patients and recording patient details to obviate the inefficiency of re-keying information or ensure that booking systems interface with the MediLiNC Billing System.

All outpatient clinics should be required to utilise MediLiNC for the booking of patients. In addition, the MediLiNC Billing System for Outpatients should be given a priority in being interfaced with MediLiNC Outpatient's Booking System to ensure that accounts for all patients who should be billed are created and funds from on site private practice flow into the Private Practice Fund.

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4.6. RECORDING OF PRIVATE IN-PATIENTS

Summary of 1994 Recommendation

ACT Health should implement a uniform system for the recording of all private in-patients seen by salaried specialists on their ward rounds who have rights to private practice. *(recommendation 5.3.3)*

Such a system should not be onerous or ward rounds may be delayed or the specialists may not record the consultations to private patients.

It was suggested that a billing sheet on the front of the patients medical record could be used to record all consultations. This billing sheet could also be used for VMO Specialists with the Patients Office subsequently raising accounts centrally from the billing sheets.

An alternative to this manual solution would be to implement a "bar code" system on patient files which could then automatically interface with a centralised billing system.

Central to both recommended recording systems is the notion of centralised billing which should ensure completeness and uniformity for the raising of in-patient accounts.

Need for 1994 Recommendation

The poor recording and billing of in-patients by many specialists results in specialists not complying with their contracts and a loss of revenue to ACT Health via the facility charge paid by the specialists.

1994 Management Response to the Internal Audit

"ACT Health will consider the introduction of a billing sheet attached to the front of patients records to detail consultations."

1996 Management Response to the Audit office

"All private in-patients of staff specialists are now billed through MediLiNC in the patients accounts system."

The Current Position

All private in-patients are billed through MediLiNC. Although this is the case, discussions held in specialist clinics indicated that there remains a problem with ensuring that all instances of services provided to private in-patients which are eligible to be billed, have actually been entered onto MediLiNC. The procedures in each of the specialist clinics varied greatly. In one clinic, details were recorded on a white board, in another in a book and in yet another, the specialist marked a sheet generated from MediLiNC.

All of these systems rely on the specialist informing support staff that a bill should be raised and also on the support staff notifying the Patients Office of the event. It is considered that this does not provide adequate control over ensuring the completeness of private in-patient billings.

Comment

The 1994 internal audit recommendation requiring uniform procedures for the identification of private in-patients' consultations has not been implemented.

Further recommendation

A uniform system for the recording of all private in-patient billings should be implemented. This system must provide adequate means of ensuring the completeness of private in-patient billings.

Accurate information on private inpatient servicing could also assist in assessing the activity and performance of salaried specialist (Chapter 2).

****

4.7. HEALTH POLICY - ARRANGEMENTS FOR CONDUCTING PRIVATE PRACTICES

Summary of 1994 Recommendations

It was recommended that management review the variety of systems in operation and formulate ACT Health Policy in relation to the most appropriate arrangements for arranging private practice accounts and the conduct of the private practices within the hospital.

In developing policies, management needed to consider:

- the optimum funding position;
- the 1993 - 1998 Medicare Agreement and in particular provisions relating to the operations of outpatient services;
- the nature of the various practices; and
- current system and new system developments e.g. MediLiNC Outpatient Booking and Billing System and Casemix Patients' Costing Systems. *(recommendation 5.3.2)*

Need for Recommendations

ACT Health needs to ensure that the operations of Private Practice Arrangements do not adversely affect the operations of the hospital.

1994 Management Response to the Internal Audit

"Management will conduct a review of the variety of systems in operation and their appropriateness for private practice arrangements."

1996 Management Response to the Audit office

"The administration is looking at alternatives of practice where the clinics would become business units responsible for their own funding and billing through Medicare."

The Current Position

There has been no overall review of the arrangements for private practice within The Canberra Hospital. The outcome of alternatives of practice as mentioned in Management's 1996 response has not been finalised.

Comments

There remains no central policy to define the operation of private practice within the Hospital to ensure maximisation of funding. The original recommendation has not been actioned.

If individual clinics bill Medicare directly then this would be a move away from the centralised billing which the audit team have advocated throughout this audit and the previous internal audit as being essential for control. Individual business units would still need to operate on a central billing basis.

Further recommendation

- A review of the arrangements for conducting Private Practice be undertaken as originally recommended in 1994.

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4.8. CONTRACTUAL ARRANGEMENTS FOR ACT HEALTH - IMPLICATIONS OF CHANGED ARRANGEMENTS

Summary of 1994 Recommendation

The implications of the changed arrangements for ACT Health from 1 July 1993, in terms of the current contractual arrangements is being addressed by the ACT Government Solicitor's Office, ACT Health and the Private Practice Fund Administration Committee. The outcomes of this review should be actioned.*(recommendation 3.3.1.c)*

Need for 1994 Recommendation

ACT Health changed from a Statutory Authority to a Department on 1 July 1993. This change in administrative arrangements required a review of the operation of the private practice arrangements and supporting bank accounts.

1994 Management Response to the Internal Audit

"The ACT Government Solicitors' Office is examining the current arrangements in conjunction with representatives of the salaried specialists on behalf of the ACT Government."

1996 Management Response to the Audit office

No comment was specifically provided for this recommendation.

The Current Position

Advice from the ACT Government Solicitor indicates that where "there is a change in the status or structure of 'health' in the ACT, there has been legislation which has provided for the transfer of rights and

liabilities from the old body to the new one." As there has been no specification by the Minister in relation to the Private Practice Arrangements, all rights and liabilities existing prior to the implementation of changes shall continue to exist.

Comment

The 1994 internal audit recommendation has been effectively actioned.

CONCLUSION

The audit found that there has been implementation of some of the recommendations of the original review. In particular, all private patients are now billed through the Patients Office. This has resulted in improved controls over the billing of private patients.

It was noted during the current audit however that there are still weaknesses in the controls surrounding the billing of private in-patients seen by salaried specialists. There has been no review of the clinical arrangements within The Canberra Hospital or formulation of consistent policies and procedures for the financial administration of private practice across patient clinics at The Canberra Hospital.

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5. COMBINATION OF VMOS AND SALARIED SPECIALISTS

5.1. INTRODUCTION

One objective of the 1994 internal audit was to assess the impact of salaried specialists rights to private practice on the use of Visiting Medical Officers (VMOs). The issue was included in the original audit because of concerns raised by The Canberra Hospital management. Attempts were made to measure any impacts through the mix of public/private patients seen by salaried specialists and VMOs. This measure was used in the absence of any other data at that time. The major issues identified by the internal audit included:

- the Hospital was unable to identify whether patients were public or private;
- information was not available to management to determine the extent of the use of VMOs in treating public patients while salaried specialists conducted private practice.
- It was recognised at this time that patients were not seen by salaried specialists and VMOs according to their financial status (public or private). However a total specialist work load is serviced by a combination of salaried specialists and VMOs. Logically when a salaried specialist is not available then a VMO would have to perform these duties. The lack of available data meant that the only way to assess if VMOs were being used to perform duties while salaried specialists conduct private practice was by attempting to record private and public patients seen by both groups and then considering whether salaried specialists were seeing a large percentage of private patients while VMOs were attending a large percentage of public patients.

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FINDINGS FROM THIS CHAPTER

- ***The Canberra Hospital management does not have consistent procedures across clinics or collect data centrally to identify the individual levels of activity of VMO's and salaried specialists. Management is therefore not able to monitor whether the most cost effective combination of VMOs and salaried specialists is being used.***

- ***public/private patient mix for outpatients by type of doctor e.g. specialist, VMO or other means of assessing specialist activity is still not able to be collated in most clinics or is not centrally collected for management evaluation; and***

- ***where both groups perform duties there are still no mechanisms in place to determine the extent of using VMOs to treat public patients while salaried specialists are treating private patients in the clinics or attending outside employment.***

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5.2. IDENTIFICATION OF PUBLIC/PRIVATE PATIENT MIX FOR SALARIED SPECIALISTS - COLLATION OF PATIENT INFORMATION

Summary of 1994 Recommendation

With the introduction of the MediLiNC Outpatients Booking System and the Casemix Patient Costing System there is an opportunity for ACT Health to establish the data on the patient's financial status, i.e. whether the patient is private or public. In the short term statistics as to the status of outpatients could be incorporated into the current statistical information which is provided to the Casemix Development Unit.

This central collection and collation on public/private patient mix will assist management in decision making concerning:

- the impact to funding changes; and
- development of policies for appropriate administrative arrangements for private practices within the outpatient areas of the hospital.*(recommendation 6.3.2)*

Need for 1994 Recommendation

The internal audit was unable to obtain information on the public/private mix of outpatients as a tool in assessing the impact of the current private practice arrangements upon the utilisation of Visiting Medical Officers (VMOs) because data was not recorded.

1994 Management Response to the Internal Audit

"The Patient Costing System incorporates information on the financial status of patients."

1996 Management Response to the Audit office

"As yet there is no field to register the private/public mix of patients attending outpatients clinics. This will be pursued in the future but currently, there is no purpose for the information."

The Current Position

The response from The Canberra Hospital stated that there was "no purpose for this information".

This ignores standard management requirements for information which allow it to properly allocate limited resources correctly between various alternatives, in this case between VMOs and salaried specialists. As a consequence management also cannot evaluate whether a cost effective combination of VMOs and salaried specialists is being used to meet specialists workload demands.

New Activity Statistics Occasions of Service Data Sheets used by the Casemix Unit requires identification of the provision of services by those "charged" and those "not charged". This is meant to equate with the private and public status of patients. This information is by clinic specialty only and will not identify the activity level of individual specialists whether they be VMA's or salaried specialists.*(Chapter 2).*

Comment

Information by specialists on public/private mix or other alternative measures is still not centrally collected for management's evaluation of any impact salaried specialists private practice arrangements may be having on VMO usage..

Further recommendation

Information regarding the patient's financial status should be maintained on an individual doctor basis across clinics. In the outpatient clinics where both salaried specialists and VMOs perform duties this would assist management in determining the work performed by VMOs while salaried specialists attend private patients or outside employment or are otherwise engaged.

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5.3. ASSESSMENT OF THE IMPACT OF PRIVATE PRACTICE ARRANGEMENTS ON THE TREATMENT BY VISITING MEDICAL OFFICERS (VMOS) - USE OF VMOS

Summary of 1994 Recommendation

In the short term public/private patient mix for salaried specialists and Visiting Medical Officers (VMOs) should be incorporated into the monthly Information Statistics Sheets prepared for the Casemix Development Unit. This would:

- enable a more accurate assessment of the use of VMOs in treating public patients across all specialties; and

- enable tracking of patients for "cross border funding".*(recommendation 6.4)*

Need for 1994 Recommendation

A public/private patient mix was unable to be calculated for Vascular Surgery.

1994 Management Response to the Internal Audit Report

"ACT Health will examine the feasibility of incorporating public/private patients mix information for both salaried specialists and VMOs in the monthly Information Statistics Sheet."

1996 Management Response to the Audit office

"As yet there is no field to register the private/public mix of patients attending outpatients clinics. This will be pursued in the future but currently, there is no purpose for the information."

The Current Position

The Casemix Unit has implemented a new "Activity Statistics" Occasions of Service Data Sheet for completion by all clinics undertaking both private and public services. These data sheets do not require the separate identification of changeable and public patients by VMO and salaried specialists dissection.

The Casemix Unit indicates that compliance by staff in completing the Data sheets is low in providing the information in a timely and accurate manner.

Comment

The recommendation has not been actioned. There is still no mechanism for determining the extent of using

VMOs to treat public patients while salaried specialists are treating private patients or attending outside private practice or otherwise engaged. This would assist management in calculating the cost of providing salaried specialists with rights to private practice. This is a cost additional to all their other costs of employment. It would also assist management in its evaluation of whether a cost effective combination of VMOs and salaried specialists is being used.

Further recommendation

- Hospital staff should complete "Activity Statistics" data accurately on a timely basis.

- Information maintained through the monthly Information Statistics Sheets prepared for the Casemix Development Unit should identify the status of the patient by VMO and salaried specialists. This information will be useful in establishing the extent to which VMOs and salaried specialists are caring for patients. It may then be considered by management whether VMOs are being utilised to meet work load demands while salaried specialists may be conducting private practice or outside employment or be otherwise engaged.

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CONCLUSION

The audit found that there has been little action on the recommendations contained in the 1994 internal audit report despite management raising this with the internal auditors as a concern at that time. The major consequence is that in those clinics where both salaried specialists and VMOs perform duties The Canberra Hospital does not know the extent to which VMO's are being engaged to see public patients, while salaried specialists may be attending to private

practice. If this is occurring it is adding to the costs of operating the Hospital.

The more fully that the Hospital can utilise salaried specialists to provide specialist services the better it is for the Hospital financially as employment costs for salaried specialists are a fixed costs while the VMOS costs should be able to be varied in accordance with workload requirements. A consequence of management not being aware of the activity of either speciality group is that management cannot consider whether a cost effective combination of VMOs salaried specialists is being used to meet work load demands for specialists within the hospital.

6. OTHER MATTERS NOTED

6.1. BACKGROUND

As part of the 1994 internal audit, matters were noted in relation to the accuracy and appropriateness of salaried specialists leave arrangements. In particular, leave forms were not being processed by Personnel and a number of salaried specialists had very high balances of annual leave.

FINDINGS FROM THIS CHAPTER

- ***leave balances for salaried specialists have increased since the 1994 internal audit; and***
- ***changes to ensure that all leave taken is recorded have not been implemented.***

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6.2. SALARIED SPECIALISTS LEAVE BALANCES

Summary of 1994 Internal Audit Recommendation

ACT Health where practical should put in place arrangements which enable salaried specialists to take leave on a regular basis.*(recommendation 7)*

Need for 1994 Recommendation

A review of the accrued annual leave and long service leave reports indicated an extremely high level of accrued leave for many specialists indicating that leave has not been taken regularly or that some leave which had been taken may not have been recorded.

1994 Management Response to Internal Audit Report

"Salaried specialists are encouraged to take leave on a regular basis. The employment terms and conditions of many salaried specialists allow

unlimited accumulation of leave which reduces management control over leave accumulation".

1996 Management Response to the Audit office

"There has recently been an audit of staff specialists leave recording which has found no anomalies in the area."

The Current Position

The employment terms and conditions of salaried specialists as described in Clause 9(c) Annual Leave of the Medical Officers (ACTMOA) Award 1987 explain that leave should be taken within no more than twelve months of it being accrued.

This audit of salaried specialist leave balances showed that there remains a problem with the level of leave which is being carried by salaried specialists. The situation has worsened since the time of the previous audit. The largest balance is 181 days of annual leave held at the end of November 1996. The following table illustrates the amount of leave held by some specialists.

Doctor	Balance at time of original review	Balance November 1996
A	89	117
B	91	141
C	93	64
D	99	107
E	108	116
F	122	131
G	125	121
H	137	119
I	156	168
J	195	181

Comment

The audit team have noted that in the Internal Audit of Leave Recording[3] it was stated that "*there is a significant control weakness"* regarding salaried specialists.

Leave liabilities have in fact increased.

Further recommendation

- Systems be put in place which enable salaried specialists to take annual leave on a regular basis. This situation should be monitored by hospital management on a regular basis.

****

6.3. RECORDING OF LEAVE

Summary of 1994 Internal Audit Recommendation

ACT Health should review the procedures in place to ensure that all leave taken is recorded by Personnel.*(recommendation 7)*

Need for 1994 Recommendation

The audit had detected that there had been some breakdown in the procedures for recording leave taken by salaried specialists.

1994 Management Response to Internal Audit Report

"The procedures will be reviewed."

1996 Management Response to the Audit office

"There has recently been an audit of staff specialists leave recording which has found no anomalies in the area."

[3] Department of Health and Community Care, May 1996

The Current Position

There have been some changes in relation to monitoring whether all leave taken is actually recorded by Personnel. A report is prepared which lists specialist staff (both salaried specialists and VMOs) who are on leave and the arrangements for their replacement where the leave arrangements have been notified to Surgical Services. However, this generally only is prepared where there is a requirement for a replacement and therefore it cannot be certain that this list is complete.

In addition to this, procedures for the recording of leave by salaried specialists were proposed in November 1995 as a result of the overpayment of a salaried specialist by $50,000 while on leave without pay. This overpayment has since been recovered from the salaried specialist concerned.

As part of the proposed procedures, Departmental Directors were to maintain a leave book recording all leave when leave application forms are presented to them. The Departmental Director was also required to undertake, at a minimum, a six monthly check of the leave taken by all staff within their area against the leave recorded in the personnel system.

Discussions with Personnel indicate that no request has been made by Departmental Directors to obtain information regarding leave taken within their area.

It is considered that leave not being properly recorded or not recorded at all continues to be an issue for concern regarding some specialists.

Comment

Little progress has been made in controlling leave taken. Further action is necessary to improve leave administration.

Further Recommendation

The Canberra Hospital should implement the procedures in relation to the recording and monitoring of leave proposed in this Chapter. In addition, Departmental Directors' compliance with the policy and procedures should be monitored through the Service Team arrangements.

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APPENDIX 1

FUTURE ACTIONS

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Virtually none of the recommendations from the 1994 internal audit have been implemented. The recommendations which have not been implemented have necessitated fresh and renewed recommendations being made as a result of this audit.

It is emphasised that some of the recommendations made in the 1994 audit and the further recommendations from this audit may prove to be not fully practical, or more efficient methods of addressing the findings may be identified by management. The major issue is that the findings are addressed effectively

The list of recommendations follows**:**

Compliance With Terms And Conditions Of Private Practice Arrangements *(Chapter 5).*

- Unless the hospital can ensure that there are adequate controls and mechanisms exist to monitor compliance with outside employment approvals new contracts should not contain automatic rights for outside private practice. Approval by the Chief Executive to engage in outside employment under Section 244 of the *Public Sector Management Act (1994)* should be subject to strict adherence to the guidelines.

- The Canberra Hospital file securely and completely, all contracts and approvals associated with private practice arrangements of salaried specialists. (2.9)

- Where it can be demonstrated that outside employment is affecting the operations of The

Canberra Hospital, approval for outside private practice or employment should be withdrawn.

- Future contracts must contain "sunset" clauses and provisions for terminating contracts, for example by the giving of a period of notice.

- The Canberra Hospital should ensure any new contracts are consistent with the requirements of the Medicare Agreement 1 July 1993 to 30 June 1998, particularly in the area of operating private practice arrangements within a public hospital outpatients' clinic. (2.5.2)

- The use of information systems to monitor salaried specialists performance should be implemented - one option being timesheets..

- Specialists approving time and leave records for other specialists should not be operating in a position of conflict where they may also be conducting outside private practices with the same specialists. (Chapter 6); and

- The Canberra Hospital should obtain from all salaried specialists who have outside employment clear documentation outlining:

  – outside employment session times;

  – arrangements to make up time lost; and

  – declaration that no commercial advantage will be obtained from undertaking outside employment.

- All documentation relating to the operation of private practice arrangements (on-site and off-site) should be filed centrally and be in accordance with the appropriate agreements. (2.6.1)

- Although information reported in The Canberra Hospital Information Bulletin- Patient Activity Data co-ordinated by Casemix, provides activity data by speciality it would seem appropriate that the Hospital management require statistics by salaried specialist to fully discharge their responsibilities in managing not only the staff specialists but also the activities of Registrars, VMOs and Locums. (5.6.1)

Facility Charges *(Chapter 6)*

- Facility charges should be reviewed and assess whether all costs are recovered and the extent that The Canberra Hospital is subsidising the private practice of specialists.

- The Canberra Hospital should investigate the adequacy of the facility charges currently being levied given management's initial assessment based on findings of the Ambulatory Care Research Outpatient Survey (dated 30 April 1996) that costs in many clinics exceeded the total of the Medicare Rebate. (6.4.1)

- A working party should be established to investigate the facility fee structure currently in place within The Canberra Hospital. The brief of this working party should include the requirement to investigate the adequacy of the facility charge in recovering costs of providing facilities. (6.5. 1)

Private Practice Billing and Receipting *(Chapter 4)*

- Policies and procedures should be developed for staff at clinics on their role in the manner in which patients will be billed.

- A review should be undertaken of all clinics to determine the most appropriate and efficient way of billing patients (i.e. through Medicare or by raising an account) through the Patient's Office.

The aim should be to standardise the approach as much as possible and develop a policy, approved by management, as to the manner in which each clinic is to undertake patient billings. This will ensure that clinics do not operate in contravention of Medicare Guidelines.

- Support staff should be rotated throughout clinics, resulting in improved controls over salaried specialists and resource savings.

- All clinics should be required to use MediLiNC outpatients booking system or other systems able to be updated into the MediLiNC Outpatient's booking system.(4.4.1)

- A procedures manual should be developed which includes instructions relating to the requirements for the retention of referrals based on the instructions in the Medical Benefits Schedule (MBS). The procedures should be widely promulgated to specialists and their staff to ensure there is an awareness of the requirement to retain referrals with the patient's records. (4.4.2)

- The procedures manual developed relating to the billing of patients should include a requirement that the reason for any patients not being charged be documented clearly on the billing schedule. (4.4.3)

- The Canberra Hospital should consider the use of one system for booking patients and recording patient details to obviate the inefficiency of re-keying information or ensure that booking systems interface with the MediLiNC Billing System.

- All outpatient clinics should be required to utilise MediLiNC for the booking of patients. In addition, the MediLiNC Billing System for Outpatients should be given a priority in being

interfaced with the MediLiNC Outpatient's Booking System. (4.4.4)

- A uniform system for the recording of all private inpatient billings should be implemented. This system must provide adequate means of ensuring the completeness of private in-patient billings. (4.5.1)

Combination of VMOs and Salaried Specialists *(Chapter 5)*

- Information collected through the monthly Information Statistics Sheets prepared for the Casemix Development Unit should identify the status of the patient by VMO and salaried specialists. This information will be useful in assessing the individual service level of specialists. (8.5. 1)

- Hospital staff must complete "Activity Statistics" data accurately on a timely basis.

Leave Matters *(Chapter 6)*

- Systems be put in place which enable salaried specialists to take annual leave on a regular basis. This situation should be monitored by hospital management on a regular basis. (6.2.1)

- The Canberra Hospital should implement the procedures in relation to the recording and monitoring of leave proposed above. In addition, Departmental Directors' compliance with the policy and procedures should be monitored.

Attachment 1

THE NUMBER OF SALARIED SPECIALISTS AT THE CANBERRA HOSPITAL AT DECEMBER 1996

	Original Review (The Canberra Hospital)	Current Review (The Canberra Hospital)
Private Practice Arrangements	31	34
Election Account	6	22
Other (Note 1)	17	7
Total	**54**	**63**

Note 1: Includes Salaried Specialists not contributing to the Private Practice Fund or Election Account.

Predominant source: Financial Planning (Private Practice)

The salaried specialists with rights to private practice within an ACT health facility work in the following specialist areas:

Specialty	Original Review (Dec 1993)	Current Review (Dec 1996)
Radiology	4	3
Intensive Care Unit	2	1
Renal	2	2
Paediatrics	1	1
Infectious Diseases	1	1
Haematology/Medical Oncology	2	2
Radiation Oncology	3	3
Cardiology	3	3
Nuclear Medicine	3	3
Psychiatry	3	5
Thoracic	2	2
Endocrinology	2	2
Vascular Surgery	1	1

Specialty	Original Review (Dec 1993)	Current Review (Dec 1996)
Gastroenterology	1	1
Anaesthetist	1	1
Women's & Children's Health	-	1
Occupational Medicine	-	1
Pathology	-	1
STD Clinic	-	0
Total	**31**	**34**

Predominant source: Financial Planning (Private Practice)

Financial statistics for the years 1992-93 and 1995-96 concerning salaried specialists who have private practice arrangements are listed below:

	Financial Year 1992-93	Financial Year 1995-96
Amount collected	$4,150,293	$4,163,361
Facility charges paid to the Hospital	$1,644,463	$1,615,284
Gross salaries and allowances paid to Specialists with rights to private practice (excluding bonuses)	$3,367,392	$3,563,614
Bonus paid to Specialists	$1,107,416	$1,543,288

Source: Financial Planning (Private Practice)

In addition to the above, a total of $386,592 has been paid into the Election Account which represents amounts received for private practice for those doctors who have elected to receive an allowance in lieu of their right to private practice.

Not all specialty areas were visited during this review. For consistency purposes, testing was undertaken for

the same specialists (where possible) who were visited during the original review from the following areas:

- endocrinology;
- nuclear medicine;
- radiology;
- renal;
- haematology/medical oncology;
- psychiatry;
- radiation oncology; and
- vascular surgery.

Attachment 2

SUMMARY OF PRIVATE PRACTICE ARRANGEMENTS

	Old Scheme	Scheme A	Scheme B	Scheme C	Right of Outside Practice	Total
Anaesthetics	1	2	0	0	0	3
Cardiology	3	0	0	0	2	3
Emergency	0	4	0	0	0	4
Endocrinology	2	0	0	0	2	2
Gastroenterology	0	0	1	0	0	1
Dept of Geriatric Medicine	0	3	0	0	0	3
Infectious Diseases	1	1	0	0	0	2
Intensive Care Unit	1	4	0	0	0	5
Medical Oncology	2	0	0	0	2	2
Nuclear Medicine	2	0	0	1	1	3
Occupational Medicine	0	0	1	0	1	1
Paediatrics	0	0	1	0	0	1
Pathology	0	8	0	0	1	8
Psychiatry	4	2	2	0	2	8
Radiation Oncology	0	0	0	3	0	3
Radiology	3	0	0	0	3	3
Rehabilitation Services	0	2	0	0	0	2
Renal	2	0	0	0	1	2
STD Clinic	0	0	0	0	0	0
Surgical Services	0	2	0	0	0	2
Thoracic	2	0	0	0	2	2
Vascular Surgery	1	0	0	0	0	1
Women’s & Children’s Health	1	1	0	0	0	2
Total	25	29	5	4	17	63