TROUBLING AMBIGUITY: GOVERNANCE IN SA HEALTH

A REPORT BY
THE HON. BRUCE LANDER QC
INDEPENDENT COMMISSIONER AGAINST CORRUPTION

TROUBLING AMBIGUITY:
GOVERNANCE IN SA HEALTH
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CONTENTS

LETTERS OF TRANSMITTAL

The Honourable Vincent Tarzia MP
Speaker of the House of Assembly

The Honourable Andrew McLachlan CSC MLC
President of the Legislative Assembly

In accordance with section 42 of the *Independent Commissioner Against Corruption Act 2012*, I present this report entitled 'Troubling Ambiguity: Governance in SA Health'.

The report has been prepared for the purpose of highlighting several areas of concern I have about governance arrangements in SA Health that contribute to risks of corruption, misconduct and maladministration. I consider it in the public interest to disclose these matters so that the manner in which public health services are administered and delivered in South Australia are as transparent as possible and to ensure that SA Health is accountable to the public.

Section 42(3) of the *Independent Commissioner Against Corruption Act 2012* requires that the President of the Legislative Council and the Speaker of the House of Assembly lay the report before their respective Houses on the first sitting day after 28 days (or such shorter number of days as the Attorney General approves) have passed after receiving this report.

Yours Sincerely

The Honourable Bruce Lander QC
Independent Commissioner Against Corruption
29 November 2019

The Honourable Vickie Chapman MP
Deputy Premier
Attorney-General

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ACRONYMS AND ABBREVIATIONS

A number of acronyms and abbreviations are used throughout this report.

CALHN	Central Adelaide Local Health Network
CE	Chief Executive
CEO	Chief Executive Officer
CTRA	Clinical Trial Research Agreement
DHW	Department for Health and Wellbeing
EPAS	Electronic Patient Administration System
FTE	Full Time Equivalent
ICAC Act	*Independent Commissioner Against Corruption Act 2012*
ICAC	Independent Commissioner Against Corruption
LHN	Local Health Network
MoA	Memorandum of Agreement
MPG employees	Other medical practitioners as discussed in the SA Health Salaried Medical Officers Enterprise Agreement 2017
OPI	Office for Public Integrity
ROPP	Rights of Private Practice
SA Health	Public authorities delivering health services in South Australia (including the Department for Health and Wellbeing, Local Health Networks and other bodies such as the SA Ambulance Service)
SA Health respondents	SA Health employees who responded to the ICAC Public Integrity Survey (2018)
SA Police	South Australia Police
Salaried specialists	Medical specialists employed on a salaried basis as consultants, senior consultants and clinical academics
SMO Agreement	SA Health Salaried Medical Officers Enterprise Agreement 2017
SPF	Special Purpose Fund

FOREWORD

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FOREWORD

I commenced writing this report after a corruption investigation I was conducting into the conduct of an employee of SA Health had become so compromised by the maladministration within the agency, that there was no longer any possibility of a successful criminal prosecution. This was not the first time this had happened. I have closed a number of corruption investigations into conduct of SA Health employees because the system is so poorly administered that it hampered my efforts to obtain appropriate evidence.

This report makes no recommendations because I have not undertaken a widespread and comprehensive review of the administration and delivery of public health services in South Australia.[1] However, as a result of my investigations and referral functions, I have formed the view that poor conduct and practices are common and accepted within SA Health. I cannot quantify the extent to which this is happening or the cost to the taxpayer. However, I can confidently state that it is not insignificant.

The manner in which public health services are administered and delivered in South Australia must be as transparent as possible so that SA Health is accountable to the public.

In this report I will highlight several areas of concern that I regard as contributing to the risks of corruption, misconduct and maladministration in SA Health. Because of the troubling ambiguity surrounding some key features of SA Health's operations, those employees wanting in integrity have been tempted to engage in improper conduct, and their conduct has been facilitated, tolerated, and even condoned by the poor processes and governance in those areas. SA Health needs to address those areas to ensure that serving the public interest is its paramount concern.

I will speak about the cultural issues within SA Health which raises risks of misconduct and maladministration. I have been told of issues of bullying and harassment that jeopardise the health, safety and morale of employees, as well as interfere with investigations into poor conduct because SA Health employees are too frightened to speak up for fear of repercussions.

I will speak about an environment where personal interests are preferred at the expense of the public interest.

I will speak about poor records management where important documentation either does not exist or cannot be found, and the obvious risks that therefore arise. As a consequence important decisions are sometimes not documented and approvals and authorisations are given in an expedient and ad hoc fashion which creates an environment that allows improper conduct to flourish.

I will speak about SA Health's inability to monitor its salaried specialists, who are its most important and collectively most highly remunerated employees, actual work time and discharge of duties for which they are being paid.

1: I have previously considered and suggested I should conduct an evaluation of the practices, policies and procedures of SA Health or some part of it. However, I was of the view that the size and complexity of the task would require resources my office was unable to put to the task without unduly interfering with my other functions.

I will speak about salaried specialists' rights to private practice, the manner in which these rights can be exercised, and the confusion that exists in the management of this practice and the concurrent risks.

'I HAVE BECOME FRUSTRATED WITH THE ADMINISTRATION OF PUBLIC HEALTH SERVICES IN SOUTH AUSTRALIA.'

I will speak about how SA Health employees fail to identify, declare and manage conflicts of interest to which they are subject, and the manner in which some clinicians with considerable private interests and secondary employments are not being properly managed against the risks that those interests and employments pose to the provision of public health services.

I will speak about the poor contractual and financial management relative to the conduct of clinical trials held in our public hospitals and the doubts I have about how appropriately special purpose funds are being used in South Australia's hospitals.

I will speak about instances of irregular and mismanaged procurement practices in SA Health, which is an agency that accounts for roughly 38 percent of the State Government's procurement activity.

These matters should be a concern to all members of the community because SA Health delivers a critical service on which all members of the community, including its most vulnerable, depend.

I have become frustrated with the administration of public health services in South Australia. My frustration will come as no surprise to successive Chief Executives (CE) of SA Health and other senior officers, with whom I have been in regular communication.

I thought as a matter of fairness that I should provide the CE of SA Health with a draft copy of this report to allow him to comment on any factual matters. In his reply Dr McGowan said that the report was a reasonable reflection of the matters raised with him, and consistent with our recent and previous communications. He brought to my attention some matters for clarification which will be referred to in the relevant sections of this report.

I have seen improvements in some areas of the administration of public health services but frankly not enough.

SA Health remains at risk because its practices, policies and procedures do not appear to sufficiently guard against corruption and serious or systemic misconduct or maladministration.

I am grateful to my Director Education and Communications, Tracy Riddiford, Ben Broyd and Andrew Russ, for their assistance in writing this report and for allowing it to be completed well within time.

THE POWER TO REPORT

Section 42(1)(c) of the *Independent Commissioner Against Corruption Act 2012* (the ICAC Act) empowers the Independent Commissioner Against Corruption (the ICAC) to make a report setting out matters arising in the course of the performance of his or her functions, that the ICAC considers to be in the public interest to disclose.

I have had regard to my statutory functions and in particular the intent of Parliament expressed in s3(1)(a)(ii) of the ICAC Act that a function of my office is to further the prevention or minimisation of corruption, misconduct or maladministration in public administration.

In order to illustrate the matters I discuss in this report I make references to conduct that has come to my attention through complaints and reports made to the Office for Public Integrity (OPI), without including any information that could identify those people who are the subject of the complaints or reports. This is consistent with the terms of s42(1a) of the ICAC Act which requires that confidentiality is maintained except in limited circumstances.[2]

In this report I do not purport to make any findings about any conduct that is mentioned.

'AN EMPLOYEE SEEKING TO NAVIGATE THIS COMPLEX ENVIRONMENT AND THE COMPETING INTERESTS IMPOSED UPON THEM IS NOT ASSISTED BY INSUFFICIENTLY DEFINED PRACTICES, POLICIES AND PROCEDURES.'

2: (1a) The Commissioner must not —
(a) prepare a report under this section setting out findings or recommendations resulting from a completed investigation into a potential issue of corruption in public administration unless —
(i) all criminal proceedings arising from that investigation are complete; or
(ii) the Commissioner is satisfied that no criminal proceedings will be commenced as a result of the investigation, in which case the report must not identify any person involved in the investigation;

INTRODUCTION

It is important to say something about the context in which this report is made and some of the limitations that arise.

Since the OPI was established, 1,166 complaints and reports have been received about conduct and practices in SA Health, which accounts for approximately 18% of all complaints and reports about public administration (not including South Australia Police).[3]

I have been involved in the assessment of the large majority of those complaints and reports, some of which I have investigated. Others have been referred to other bodies (including the CE of SA Health) to investigate and I have overseen some of those investigations.[4]

This report and the views and opinions expressed in it are based on information that I have received in the exercise of my functions under the ICAC Act, which has provided me with insight into the operations of some but not all parts of SA Health.

It is important to understand that I have not made a comprehensive assessment and evaluation of existing practices, policies or procedures of SA Health in making the observations and opinions that follow.

The extent to which the issues identified in this report affect SA Health and the administration of public funds more generally is not something presently known by me.

The matters reported upon are not an exhaustive list of learnings but represent some areas that have come to my attention as a result of the exercise of my functions under the ICAC Act.

It may be that other risks exist of which I am not aware.

This report does not contain any recommendations or solutions for the risks identified because the making of credible and useful recommendations would require a substantial amount of further work.

Lastly, I do not intend to impugn the reputation of SA Health employees, the overwhelming majority of whom are dedicated professionals who work hard to deliver quality services to the community.

Those employees are themselves affected by the issues discussed herein.

The environment in which health and hospital services are delivered is a complex one involving the delivery and funding of services by both the public and the private sector. An employee seeking to navigate this complex environment and the competing interests imposed upon them is not assisted by insufficiently defined practices, policies and procedures.

3: Because of the nature of the work of SA Police officers and the power they exercise the OPI receives a large number of complaints about the conduct of SA Police. Accordingly, statistics about SA Police are removed when considering complaints and reports about other agencies.

4: For a more detailed explanation of how complaints and reports about SA Health have been handled see Appendix A.

THE DELIVERY OF PUBLIC HEALTH SERVICES

I have used the expression SA Health throughout this report to describe the agency responsible for the delivery of public health services in South Australia. SA Health includes the Department for Health and Wellbeing (DHW) and the Local Health Networks (LHNs) within DHW.

DHW is headed by the Chief Executive (CE) who has responsibility for the Department, which provides oversight and sets the strategic direction for South Australia's health care system.

The CE is the employing authority for all employees in SA Health with the exception of LHN Chief Executive Officers (CEOs) and employees of SA Pathology.

The number of LHNs increased from five to ten on 1 July 2019 as a consequence of the former Country Health SA LHN being subdivided into six separate LHNs. The LHNs are responsible for the hospitals within their Network. Each of the LHNs has responsibility for one or more hospitals.

Since 1 July 2019, the LHNs have been overseen by individual Governing Boards who appoint their respective LHN's CEO. The Governing Boards are accountable to the Minister for overal governance and oversight for local health service delivery by their LHNs, while the CEOs are accountable to, and subject to the direction of, their Governing Boards for managing the operations and affairs of the LHNs.

CULTURAL ISSUES

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CULTURAL ISSUES

REPORTING CULTURE

The CE, the CEOs, the Governing Boards, SA Health employees and all persons performing contract work for SA Health, are obliged under the reporting directions issued by me under the ICAC Act, to report to the OPI any conduct that they reasonably suspect raises a potential issue of corruption or serious or systemic misconduct or maladministration.[5]

A public officer who complies with this obligation is recognised as having made a report. A complaint on the other hand is made by a member of the public who has no statutory obligation to report but may report any conduct of the kind mentioned on his or her own volition to the OPI.

Last year I conducted a public integrity survey which surveyed public officers across South Australian public administration and their observations and attitudes to corruption and inappropriate conduct, and the reporting of such conduct.

The results of that survey revealed the following differences between SA Health employees and the rest of public administration who responded to the survey:

- SA Health employees who responded (SA Health respondents) appear to have a lower awareness of their reporting obligations to the OPI, and are less willing to report inappropriate conduct to the OPI, than the rest of South Australian public administration. For those reasons I may be unaware of the full extent of corruption, misconduct and maladministration that may be occurring in SA Health.
- SA Health respondents also seem less willing to report inappropriate conduct internally; are more likely to believe SA Health discourages reporting; and are less confident that SA Health would take action on a report. Accordingly SA Health may itself be unaware of the full extent of corruption, misconduct and maladministration occurring.
- SA Health respondents are less aware that SA Health has policies and procedures in place for reporting; are less likely to agree that SA Health provides information about reporting; and have less confidence that SA Health has adequate protections for those who report.
- SA Health respondents have also reported being more confused about the conduct that should be reported.
- SA Health respondents also report being more worried about the security of their jobs if they report; feel more intimidated to report; are more likely to feel they will get in trouble with their colleagues as a consequence of reporting; and know of others who have experienced negative consequences as a result of reporting.

In almost all categories SA Health respondents rated below the average for the whole sample.

5: 'Directions and Guidelines for Public Officers', issued by the Independent Commissioner Against Corruption pursuant to section 20 of the ICAC Act 2012. See, https://icac.sa.gov.au/system/files/publications/ICAC_Directions_and_Guidelines_for_Public_Officers.pdf

The overall effect of an organisation that is culturally unwilling or frightened to report corruption or inappropriate conduct is that it will become an organisation that learns to tolerate such conduct as a part of its operations.

My survey also asked respondents to report if they had encountered corruption or inappropriate conduct in the last five years. The table below compares SA Health respondents and the wider public administration:[6]

CONDUCT TYPE	SA HEALTH %	SA PUBLIC ADMINISTRATION %
Financial misconduct, theft, fraud (excluding procurement issues)	10.8	10.2
Nepotism / favouritism	45.0	39.9
Falsifying information (excluding financial misconduct and procurement issues)	12.6	10.6
Procurement (distinct from general financial issues)	5.2	6.7
Inappropriate access to and / or misuse of confidential information	20.6	14.0
Bullying and harassment	51.4	41.0
Conflict of interest	29.7	26.8
Bribery / inappropriate acceptance of gifts	5.2	5.3
Perverting the course of justice	4.2	3.6
Mismanagement of those receiving care	19.7	7.2
Failure to fulfil duties (excluding other categories)	26.8	20.5
Physical abuse / assault	6.0	4.3
Misuse of power (excluding other categories)	26.6	21.3
Other types	5.3	4.4

On most conduct types, SA Health respondents reported more instances of corruption and inappropriate conduct than those in the wider public administration. A similar pattern emerged when SA Health respondents rated their organisations' vulnerability to those conduct types.

The data establishes that SA Health respondents have experienced more instances of corruption and feel more vulnerable to corruption than the rest of public administration. SA Health respondents are less willing or confident to report corruption and inappropriate conduct and have less confidence in SA Health's ability to manage and deal with corruption risks.

An analysis of the responses in the survey suggests SA Health has a low level of integrity maturity and perceives itself as possessing significant corruption, misconduct and maladministration risks, which SA Health is ill-equipped to detect, prevent or manage.

6: The figures for SA Public Administration do not include responses from South Australia Police or SA Health.

BULLYING AND HARRASSMENT

A significant cultural problem is demonstrated in that 51% of SA Health respondents reported encountering bullying and harassment. In addition, 78% of SA Health respondents rated SA Health as vulnerable to bullying and harassment.

The statistics arising out of the survey are not inconsistent with the information I have obtained during the exercise of my functions.

The reports that the OPI have received and assessed and the investigations I have conducted or overseen, indicate that bullying and harassment is a very significant issue within SA Health.

Instances of bullying and harassment are themselves misconduct and cannot be tolerated. The harmful effect of such conduct on the health, wellbeing and morale of victims is well known.

However, I suspect that bullying and harassment is also harming SA Health and its employees in a cultural sense because SA Health employees who are being bullied and harassed or fear being bullied or harassed, are less likely to report conduct in accordance with their statutory obligations. Those employees are less likely to assist in or participate in an investigation of that type of conduct, which will substantially interfere with SA Health's ability to appropriately address that conduct and the harm it is causing.

Bullying and harassment will be more likely to occur where the person suspected of engaging in such behaviour has managerial or similar informal authority or power over others because of his or her profession or status within the organisation. I have seen evidence of just such dynamics at work.

During one of my investigations a manager was alleged to have engaged in improper conduct and was removed from the workplace. A number of witnesses from that workplace who were able to give relevant evidence about the alleged conduct only became willing to cooperate with the investigation after the manager had been removed.

ATTITUDES AND TENDENCIES

During investigations conducted or overseen by me, I have observed some common behaviours that I consider pose a risk to the integrity of SA Health's operations.

These are observations based on information that has come to my attention during the exercise of my functions and are not based on any statistical data or any general survey of SA Health's operations. Accordingly, I do not know the extent to which those behaviours are representative of SA Health aside from what I have seen in my investigations.

If these behaviours are widespread, it would be a matter of concern as they are antithetical to an organisational culture which needs to promote good governance, integrity and transparency, and must use public funds responsibly to protect against corruption, misconduct and maladministration.

RELATIONSHIPS AND TRUST WITHIN SA HEALTH

In its diagnostic review of Central Adelaide Local Health Network (CALHN), KordaMentha observed that a "them and us" approach permeated many employee interactions and that this attitude involved a focus on "team" rather than the organisation as a whole.[7]

I have observed a similar approach in some other LHNs in my investigations.

'...THERE IS A LIKELY LOSS OF FOCUS THAT THE PUBLIC INTEREST IS THE GENERAL TOUCHSTONE AGAINST WHICH ALL DECISIONS OUGHT TO BE MEASURED...'

Some SA Health employees have a tendency to focus on the needs or interests of their particular unit or division at the expense of the organisational interests of the LHN or SA Health as a whole.

Some employees distrust or fail to cooperate with DHW because they think funding available for their unit or division may be appropriated by DHW and used for other purposes.

In my investigations I have observed:

- Public funds being managed in such ways that the control, visibility and scrutiny to other parts of SA Health are reduced.
- Public funds which should have been held in SA Health controlled accounts being held in separate bank accounts, including those of independent and unrelated entities, to prevent SA Health knowing of those funds. In some cases management in the LHN appeared to have consented to the conduct because they also subscribed to the view that the arrangement was needed to protect the interests of the LHN or at least those who worked within it.

These attitudes pose a risk of misconduct and maladministration because:

- A failure to cooperate with DHW makes it difficult for DHW to issue policies across SA Health which are complied with, thereby making it difficult for SA Health to effectively create and enforce standards across the whole of SA Health, which is likely to have implications for financial budgets and the regard which is paid to them.
- They encourage a culture in which decisions are made on the basis that they may suit the narrow interests of a particular unit or division without sufficient regard as to whether they might meet broader organisational objectives, which will inevitably affect the quality of decision making in SA Health and the integrity of public administration. In particular, there is a likely loss of focus that the public interest is the general touchstone against which all decisions ought to be measured and that the funds available to SA Health are public funds to be used in the public interest and for which high standards of accountability and transparency attach.

7: KordaMentha, Central Adelaide Local Health Network – Diagnostic Review, September 2018, p.34.

THE PUBLIC INTEREST

I continue to make reference throughout this report to the public interest. I do so because all services and the manner in which they are delivered and the cost of such services must be measured against the public interest. There is a tendency in SA Health for some decisions to be made in a manner that fails to have sufficient or in some cases any regard to the public interest and, in particular, the efficient and appropriate use of the State's resources.

For example:

- Employees within particular units or divisions who act to protect and preserve funds that are available to their unit or division do not properly have regard to the fact that such funds are public funds for use in the public interest. Often the broader public interest of LHNs is lost sight of when sectional work demands and priorities become dominant.
- Conflicts of interest have been allowed to exist without proper mitigation strategies being put in place to address the risk that private interests might prevail over the public interest. The failure to put such measures in place suggests that insufficient regard has been paid to the public interest.
- The existing poor practices have been permitted to continue by senior staff and are rationalised upon the basis that those practices have historically been engaged in, rather than on an assessment that those practices represent a proper use of public money or are in the public interest.

POWER IMBALANCES

The nature of the professions employed in DHW and the LHNs means that power imbalances inevitably exist between those professional persons and administration staff. Those power imbalances do not often appear to have been managed in a way that promotes good public administration.

For example:

- Although medical specialists will be formally managed by other medical specialists, some aspects of their non clinical work may need to be supervised by an administrative officer, who is almost always employed at a much lower level. Research projects conducted by clinicians are also overseen for business purposes by a lower level administrative officer. The power imbalance poses obvious difficulties for that officer if that officer wishes to challenge the manner in which a medical specialist is conducting or is proposing to conduct a research project.
- I have seen invoices payable to a SA Heath manager being approved for payment by finance officers who reported to that manager. The power imbalance between the finance officer and the manager places that officer in a difficult position, particularly if that officer forms the view that the invoice should not be paid or that further information is needed before it can be paid.

RECORDS MANAGEMENT

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RECORDS MANAGEMENT

During the course of my investigations into conduct in SA Health I have observed record management practices that are wholly inadequate for an organisation which is relied upon to deliver a critical public service and which is therefore entrusted with administering substantial amounts of public funds.

Administrators do not often know whether records have been kept, where they are kept and how they can be accessed. My investigations have made requests for conventional business records only to be told SA Health employees were having difficulty locating them. The production of such records has often not been possible or affected by significant delay.

During my investigation into the Oakden Older Persons Mental Health Service, SA Health had considerable difficulty in complying with summonses to produce documents, which had the effect of delaying the completion of the investigation.[8]

It is often the case that significant and important records have not been able to be produced which might indicate that they had never been created or if created, had not been retained or were lost.

There are a number of examples where in investigations conducted or overseen by me relevant documents were not able to be located including:

- Employment contracts, job and position descriptions, letters of offer of employment and other documents which record the duties and responsibilities of employees.
- A signed instrument of delegation by which a (previous) CE gave a LHN CEO financial delegation.
- Key documents relating to complicated arrangements which involved the use of public resources by private entities. These documents included signed Memoranda of Understanding and other documents which apparently recorded the terms on which those resources could be used.
- Cabinet and State Procurement Board approvals for a substantial procurement.
- An acquisition plan and purchase recommendation for the bulk purchase of a substantial amount of goods.

8: See section 3.5 of my report *Oakden A Shameful Chapter in South Australia's History.* See, https://icac.sa.gov.au/system/files/ICAC_Report_Oakden_0.pdf.

On other occasions important documents and agreements do not appear to have been updated to reflect changed arrangements and circumstances. In particular:

- Job and position descriptions and employment contracts are often not updated to record that the seniority, responsibilities or duties of an employee have changed. Instead new arrangements are arrived at in an informal or ad hoc fashion without any written record.
- Human Resource records are not kept up to date to reflect the fact that employees have been advised of the requirements of key policies or procedures or have received particular relevant training.

The failure to make proper records and retain relevant documentation has had significant negative impacts on the efficacy of my investigations.

The significance of proper records cannot be understated. Corruption investigations can rarely be completed in the absence of proper records because the investigations frequently involve allegations that duties have not been discharged or powers and functions have been misused. The investigation of such allegations requires the scope of duties and functions to be identified. In a modern public organisation those matters are almost always recorded in documents.

If a corruption investigation leads to a prosecution the relevant standard of proof is proof beyond reasonable doubt. That standard can be difficult to satisfy in the absence of proper records and documents. For instance:

- It is impossible to establish that a person has deliberately failed to discharge his or her duties or functions when those duties or functions are not recorded, or the record has not been updated.
- It is difficult to determine whether a use of public resources, whilst on the face of it appearing unconventional and perhaps unlawful, was unauthorised, when the records relating to the use are not retained or updated.
- It is often suggested that the use of resources or the neglect of duty was authorised or consented to by LHN management. It is difficult to determine whether such a suggestion is true let alone being able to answer it to the criminal standard when:
    - There is no record of management practices which would have proved that an approval had been given.
    - Other evidence suggests there was a practice of giving oral, or ad hoc approvals.
- It is difficult to establish that an employee was aware of a key policy requirement and failed to comply with it, without a record showing that the person had been advised of the policy requirement.
- If there is no practice which requires the disclosure of conflicts of interest to be recorded it is difficult to prove that the conflicts were not disclosed.

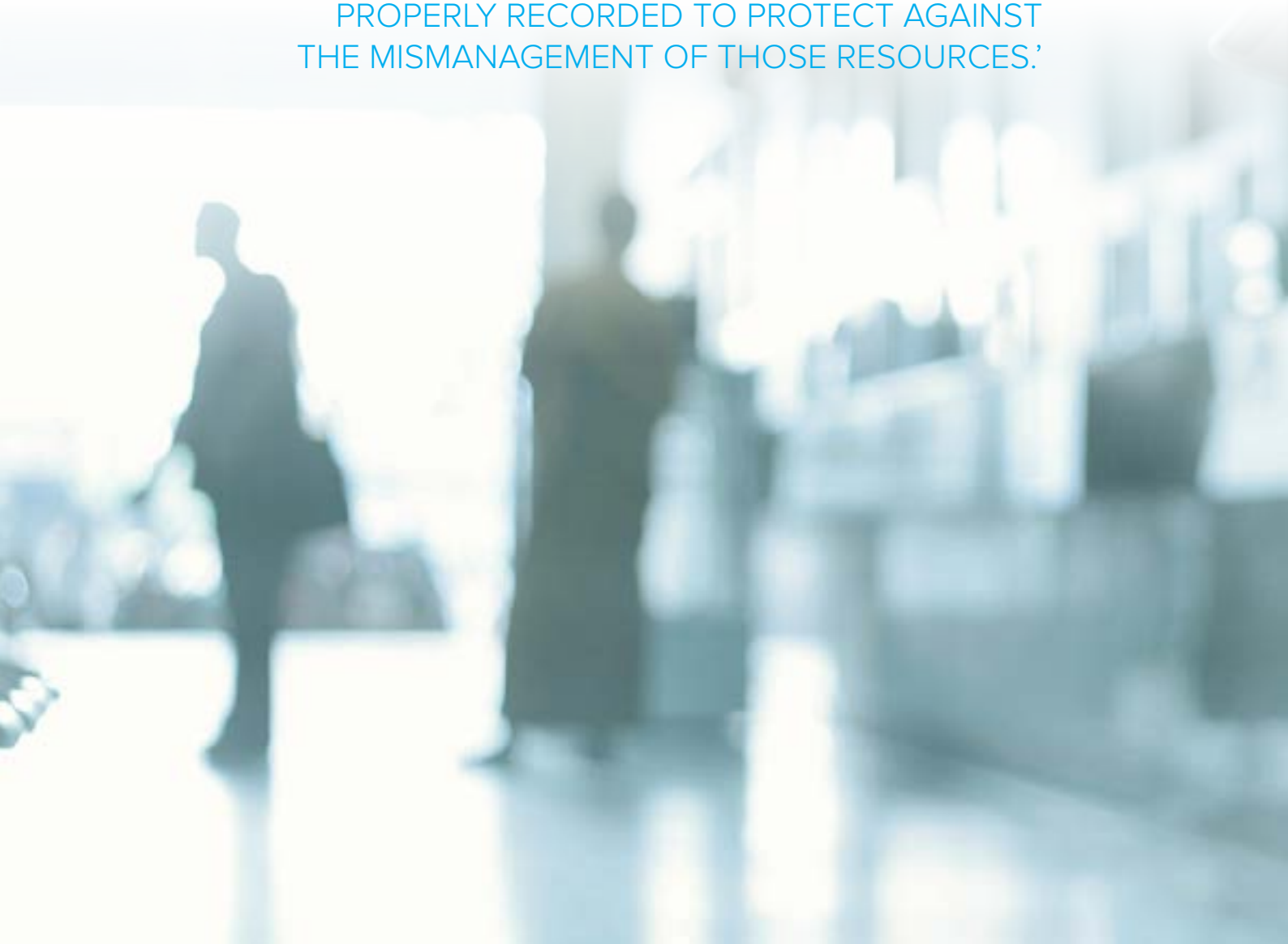
The deficiencies in records management extend beyond the efficacy of my investigations and give rise to significant maladministration risks.

A public authority should record all significant decisions so they can be seen to have been made in the public interest. The requirement to make a record of a decision will help to focus the mind of the decision maker as to whether it is in the public interest to make the decision.

The proper record of a significant decision records the basis on which the decision was made; the objects intended to be achieved; and why those objects are in the public interest. A clear record of all those matters assists those charged with implementing the decision, about what is intended to be achieved. The failure to make or retain records might indicate a concern by the decision maker that the decision cannot be justified in the public interest.

A decision that involves the use or expenditure of public resources must be properly recorded to protect against the mismanagement of those resources. It allows responsible managers to assess the use of those resources; to ensure they are not used for collateral purposes; and to measure the use of those resources against the public interest objectives that were identified.

‘A DECISION THAT INVOLVES THE USE OR EXPENDITURE OF PUBLIC RESOURCES MUST BE PROPERLY RECORDED TO PROTECT AGAINST THE MISMANAGEMENT OF THOSE RESOURCES.’



TIME AND ATTENDANCE

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TIME AND ATTENDANCE

There are some ways in which SA Health manages its employment relationships with medical specialists that raises the risk of maladministration and corruption.

THE SCOPE AND DELIVERY OF EMPLOYMENT DUTIES

SA Health engages medical specialists on a salaried basis as consultants, senior consultants and clinical academics (who I will hereafter refer to as salaried specialists).[9] Because of their expertise salaried specialists are entitled to be well remunerated.[10] Their terms of engagement including their precise duties should be clear and unambiguous. One obvious term should be the hours that the salaried specialist must work.

The evidence is that there is uncertainty about exactly what constitutes the ordinary hours of duty for salaried specialists because:

- The industrial agreement that applies to consultants and senior consultants does not define what the ordinary hours of duty are for such employees and instead states that they have "no fixed hours of duty".[11]
- The industrial agreement applicable to clinical academics does not include a similar clause but it also does not define what the ordinary hours of duty are.[12]
- Those agreements provide for the making of "job plans" which amongst other things are intended to record the average time that a salaried specialist is to spend on clinical and non-clinical duties and responsibilities. However, such plans are rarely if ever used and there does not appear to be any directive or policy that requires them to be made.[13]
- DHW has not issued any policy or directive identifying the ordinary hours of duty of a salaried specialist and the manner in which those hours should be delivered.

9: SA Health also engages specialists as visiting medical specialists or senior visiting medical specialists on a sessional basis.

10: The average salary of a South Australian full time public sector specialist salaried medical officer ($433,724) was higher than all other states and territories when measured in 2017-18. (Australian Institute of Health and Wellbeing, *Hospital resources 2017-18: Australian hospital statistics* (26 Jun 2019) AIHW https://www.aihw.gov.au/reports/hospitals/hospital-resources-2017-18-ahs).

11: The relevant clause is cl 27 of the *SA Health Salaried Medical Officers Enterprise Agreement 2017* (SMO Agreement) which is in the following terms:
Consultants have no fixed hours of duty. The salary for Consultants takes into account teaching and research work undertaken and that no separate payments are made for overtime or weekend work, except as provided in clauses 30, 31, 37 and 38 of this Agreement (provisions relating to Flexible Hour Agreements, Recall and Shift penalty payments).
This can be contrasted with the part of the SMO Agreement which relate to other medical practitioners (referred to as "MPG employees"). Clause 55 provides that "ordinary hours of duty for a MPG employee are an average of 38 per week" and "will be in accordance with the roster determined by the employing authority and applicable to each employee from time to time".

12: See the *SA Health Clinical Academics Enterprise Agreement 2018*.

13: *SA Health Clinical Academics Enterprise Agreement 2018* cl 18; *SA Health Clinical Academics Enterprise Agreement 2018* cl 33.

These matters create considerable ambiguity and uncertainty about the manner in which a salaried specialist is required to deliver his or her contractual obligations. This creates difficulties for both salaried specialists and those SA Health employees who manage or oversee them, particularly when seeking to ensure that contractual duties are fully performed.

A significant number of salaried specialists work at a fractional level of full time employment.[14] It is impossible to determine the level of input that the fractional level salaried specialists are required to deliver in the absence of a clear definition of full time employment.

A significant amount of salaried specialists have secondary employment in the private health sector. The demands of that secondary employment often compete with the demands of the salaried specialist's SA Health employment. It is difficult if not impossible for salaried specialists and their managers to know what is required of the salaried specialists because their SA Health employment is not precisely defined.

Some salaried specialists are employed at a low fractional level; some as low as 0.1 Full Time Equivalent (FTE). Because their employment may involve clinical, teaching and research duties it is difficult to determine how each of those duties are to be discharged, and over what time, when no agreement or direction as to the discharge of those duties has been recorded.

There are of course rostering practices which require salaried specialists to work a certain amount of shifts but that does not fully address the difficulties to which I have referred.

The rostering practices are not informed by any defined standard that identifies the ordinary hours of duty of the salaried specialist. Nor does it appear SA Health has made any considered assessment as to how the hours translate into rostered shifts. Consequently there is a risk the rostering practice will not require the salaried specialist to fully perform his or her contractual obligations.

Moreover, because rostering systems are only practices and do not have the authority of an agreement, policy or directive it is difficult to enforce those systems against an unwilling employee.

The nature and importance of work undertaken by a salaried specialist makes it difficult to determine whether or not services are being completely delivered. The work is largely autonomous and may be delivered at a number of different locations or campuses.

SA Health also seems to have difficulty in knowing whether or not employment obligations are being delivered, which means that it cannot be sure whether salaried specialists are meeting their obligations under their employment contracts.

Timesheets are important to validate the delivery of an employee's services. However, it is the general practice within SA Health for a salaried specialist not to record specific hours of duty but rather to record "normal hours" or similar against a date on which the salaried specialist has worked[15] which makes validating the performance of duties almost impossible.

14: A fractional level of full employment is 0.1 to 0.95 of a Full Time Equivalent (FTE).
15: The exception to this is where an allowance is being claimed in which case more specific details are recorded.

Persons who approve salaried specialists' timesheets have little or in some cases no ability to determine whether or not they are accurate. Because salaried specialists work autonomously at different locations and campuses it is inherently difficult to determine what hours have been worked.

Some salaried specialists have approved their own timesheets.

I have seen timesheets that have been approved that record that a medical specialist performed "normal duties" or similar on a particular day at a LHN. However, other evidence showed that the particular specialist was in fact working at another location and being separately remunerated.

The Auditor-General has expressed concerns about timesheet practices in SA Health and has noted the absence of processes to ensure all medical officers' timesheets are submitted and approved. He has said that there are no policies and procedures existing to check medical officers' attendance records.[16]

In 2016 in response to the concerns that the Auditor-General previously raised, DHW advised him that it would develop a formal policy and procedure for time recording processes.[17] I understand that a policy of this kind was created and applied to salaried specialists but that it has since been withdrawn.

The consequence is a troubling ambiguity about the manner in which SA Health is managing its employment relationship with salaried specialists because it does not appear that SA Health has in place an effective system by which it clearly communicates to its salaried specialists the expected level of service; and can be satisfied that the level of service it is purchasing is in fact being delivered.

The ill-defined employment obligations and insufficient means of validating the performance of contractual duties gives rise to an increased risk of corruption and maladministration in public administration.

It is obviously easier for a public officer to neglect his or her duties when the systems in place to verify whether or not the public officer has performed those duties are inadequate. It is also easier for that public officer to assert that this neglect was unintentional or inadvertent when the public officer's precise duties have not been communicated to him or her in a clear and consistent way.

Poor systems make it easier for those who might want to engage in misconduct or maladministration to do so.

In more serious circumstances an intentional neglect of duties may amount to corruption; for example where an employee misrepresents to his or her employer that the employee is at work when in fact the employee is performing other paid functions elsewhere.

Allegations that SA Health salaried specialists were not performing their duties of employment have given rise to a number of investigations conducted or overseen by me.

Those investigations were affected by the difficulties I have mentioned.

16: SA Auditor-General, Annual Report for the year 2013-14 – Part B Agency Reports Volume 2, p.818, p.824 & p.826; SA Auditor-General, Annual Report for the year 2016-17 – Part B Agency Reports, p.165, p.182 & p.218; SA Auditor-General, Annual Report for the year 2017-18 – Part B Agency Reports, p.150 & p.194; SA Auditor-General, Annual Report for the year 2018-19 – Part C Agency Reports, p.156.

17: SA Auditor-General, Annual Report for the year 2016-17 – Part B Agency Reports, p.165.

An allegation was made that a salaried specialist claimed that the salaried specialist was working full time when in fact the salaried specialist was regularly not attending work two days a week. The salaried specialist's timesheet recorded that the salaried specialist worked "normal hours" or "required hours", which as I have already remarked was in accordance with policy and practice in SA Health. It was difficult to establish that the salaried specialist was failing to attend work on the two days because of the insufficiency of the evidence. In fact the person who signed the salaried specialist's timesheets worked at a different location and had no way of knowing whether the timesheets were accurate.

In another investigation I examined an allegation that a salaried specialist was performing private work during public paid time. The salaried specialist's timesheets did not record any specific times that the salaried specialist worked, but only stated that the salaried specialist worked in AM or PM sessions. There was no system in place by which assertions on time sheets could be verified, and the salaried specialist's claims were assumed to be correct. No audits on timesheet data were conducted.

I have also investigated an allegation that a salaried specialist was engaging in other paid private activity when the salaried specialist was apparently required to be working at a LHN. The lack of precision about what exactly constituted the scope of the duty of the salaried specialist combined with insufficient systems to verify the hours that the salaried specialist had actually been working made the investigation impossible.

My investigations into these matters raise the question of whether the South Australian public is receiving the full value of taxpayer funds directed to salaried specialists and how SA Health is able to effectively monitor employees to ensure this occurs.

Salaried specialists deliver critical health services to South Australians. Most work well beyond the hours required of them and often at inconvenient times. They should not be required to 'punch a clock' when they deliver those services. However, all of them should deliver the services for which they are contracted and remunerated and SA Health should be able to know that they have done so.

INCONSISTENCY BETWEEN PRACTICES AND INDUSTRIAL AGREEMENTS

Investigations undertaken appear to have identified employment practices which are inconsistent with the terms of workplace agreements.

Information indicates that there was a practice within at least one LHN to make "recall payments" to salaried specialists for:

- Duty undertaken immediately prior to or after rostered shifts
- For rostered shifts and other work undertaken over the weekend
- Overtime
- Ward rounds

This practice appears to be inconsistent with the terms of the relevant enterprise agreements for salaried specialists who "have no fixed hours of duty", and whose salary takes into account "that no separate payments are made for overtime or weekend work" except in some other circumstances.[18]

I have been told that the existing industrial arrangements do not cater for weekend or overtime work and that recall payments are therefore used to remunerate any additional work of that kind. It is difficult to reconcile the explanation with the terms of the industrial agreements.

This is not the first time this has been commented on.

The Auditor-General has previously stated that a significant number of weaknesses and controls exist in relation to the payment of allowances, and that recall allowances were being paid when there was no entitlement to them under the terms of enterprise agreements. The Auditor-General has also said that reviews of the amount of allowances have not been regularly undertaken and the amount of allowances paid have been incorrect.[19]

I referred a matter to a LHN for investigation and an audit of a random sample of timesheets was undertaken. The audit found that claims for allowances made on timesheets were rarely if ever audited or checked for their validity and SA Health officers in charge of certifying timesheets had no real means of knowing whether the information recorded in them was accurate.

The audit resulted in three further reports being made to the OPI about improper conduct. Two of those concerned recall allowance claims that appeared to have been inappropriate, one of which became the subject of a corruption investigation and the other the subject of a misconduct investigation.

If allowances are being paid when there is no entitlement, it follows that public funds are being expended improperly. I do not know what the amount of such funds would be, but it is unlikely to be insignificant, particularly if these practices, as I suspect, are widespread and have existed over lengthy periods of time.

These inconsistencies appear to have become customary practice and appear to have been acquiesced in or condoned by senior personnel which indicate that some in SA Health have failed to realise that they are dealing with public money and there is an obligation to expend that money appropriately and according to high standards of probity and integrity.

Industrial agreements should not be ignored or selectively applied for purposes and in circumstances for which they were not designed. If the restrictions and stipulations of the industrial agreement are at odds with necessary work practices, or not relevant to the nature of the work being done, then the arrangements should be redrawn to make them consistent and supportive. If however the work practices are simply flouting the industrial agreement for reasons of expediency or benefit, then those work practices should cease.

18: Section 27 "Hours of Duty" in *SA Health Salaried Medical Officers Enterprise Agreement 2017*.
19: SA Auditor-General, Annual Report for the year 2013-14 – Part B Agency Reports Volume 2, p.760; SA Auditor-General, Annual Report for the year 2017-18 – Part B Agency Reports, pp.175-176 & p.195; SA Auditor-General, Annual Report for the year 2018-19 – Part C Agency Reports, p.198.

RIGHTS OF PRIVATE PRACTICE

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RIGHTS OF PRIVATE PRACTICE (ROPP)

WHAT IS ROPP?

Salaried specialists enjoy what is called the right of private practice (ROPP).[20]

A ROPP permits a salaried specialist to treat a private patient in a public hospital, and sometimes elsewhere, and to receive a portion of the fee paid for that treatment.[21]

The manner in which the salaried specialist and SA Health share that income depends on the particular ROPP arrangement into which the salaried specialist has entered.[22]

There are broadly two categories:

- A scheme that requires a salaried specialist to give all of the ROPP income he or she earns to SA Health and in return SA Health pays the salaried specialist a set allowance which is a percentage of the specialist's salary.
- Income sharing schemes under which SA Health and the salaried specialist share the ROPP income the salaried specialist earns, in varying proportions. Under these schemes SA Health deducts a 9% indemnity and administration fee from the ROPP income the specialist generates and the specialist keeps the remainder of that income up to a percentage of his or her salary. In most cases this percentage is 65%. Once that percentage is exceeded SA Health either receives a greater proportion of the ROPP income or retains all of it. In the latter case SA Health also pays an Attraction and Retention allowance to the specialist.

'THERE IS APPARENTLY NO OBLIGATION ON A SALARIED SPECIALIST TO MAKE UP PAID PUBLIC TIME IF A PRIVATE PATIENT IS TREATED BY THE SALARIED SPECIALIST DURING THE SALARIED SPECIALIST'S ROSTERED HOURS.'

20: The documents establishing ROPP speak only of consultant and senior consultants employed under the *SA Health Salaried Medical Officers Enterprise Agreement 2017*. No mention is made of clinical academics. However, I understand that SA Health offers the same ROPP arrangements to clinical academics as are offered to consultants and senior consultants.

21: Generally speaking, a private patient is a person whose treatment is funded by payments made by Medicare and private health insurers. A public patient is a patient whose treatment is paid for out of funding jointly provided to the public hospital system by the State and Commonwealth Governments.

22: A number of different arrangements are available, the detail of which is summarised in Appendix B.

ROPP IN PRACTICE

I have had cause to consider ROPP arrangements and it has become apparent that there is no comprehensive policy framework, which informs and governs the exercise of the ROPP.[23] For the reasons that follow I think that gives rise to a risk of maladministration.

It is necessary to say something about the manner in which ROPP operates in practice and the potential impact it has on service delivery and public resources.

The practice appears to be that ROPP can be exercised during the ordinary hours of duty of a salaried specialist, meaning during the specialist's "paid public time". However, for the reasons already mentioned that actual time is difficult to define.

The practice can be exercised where a private patient is an inpatient in a public hospital and is being treated in that hospital, for example, for elective or emergency surgery, or where a private patient is an outpatient and is being treated at a clinic held at the public hospital or at another place.

There is apparently no obligation on a salaried specialist to make up paid public time if a private patient is treated by the salaried specialist during the salaried specialist's rostered hours.

The arrangements also do not limit the extent to which ROPP can be exercised during paid public time. Nor does any SA Health policy or directive.

In some cases, particular units appear to impose limitations on the extent of ROPP that can be exercised during paid public time but there is no consistent or universal practice. For example, I have been told that it is customary within some LHNs for a full time salaried specialist to be permitted to exercise ROPP for one day per week which is of course 20% of the salaried specialist's paid public time. I am not aware how widely this practice is adopted.

The lack of clarity or direction about the extent to which ROPP can be exercised in paid public time makes it very difficult for those who have the responsibility of administering those arrangements.

ROPP Agreements and Deeds into which salaried specialists are required to enter, require them to agree to "carry on your private practice in such a manner as will not interfere with your duties and responsibilities as a Specialist with the (hospital) which will, with due allowances for clinical priorities, be overriding". However, there is no formal direction, policy or guidance about how it is intended that objective will be achieved.

23: Some terms of ROPP arrangements are set out in the *Department of Health Salaried Medical Officers Agreement Private Practice Agreement 2008* and template Memoranda of Agreement and Deeds which form Schedules 1 to 3 of that agreement. Some parts of the *SA Health Salaried Medical Officers Enterprise Agreement 2017* also deal with ROPP. However, these documents do not deal in any great detail with the other matters discussed in this part of the report.

Determining the part of public duties that can be spent exercising ROPP is likely made difficult by the fact that the scope of duties is not precisely defined because salaried specialists have “no fixed hours”. It is even more difficult when a salaried specialist is employed part time, which is commonly the case.

With written permission ROPP can be exercised offsite at a location other than the public hospital.

I am not aware of any policy or direction that informs the circumstances in which written permission may be given. For example, there is no requirement that the exercise of ROPP at a location other than the hospital must have some particular benefits for the public hospital at which the salaried specialist is employed or any particular benefits for public health services generally.

I am not aware of any assessment that SA Health might have made as to whether the exercise of ROPP at a location other than a public hospital provides a public benefit. If SA Health has done so, the circumstances ought to be clearly set out to assist those who have the discretion to grant permission.

It would seem that a salaried specialist could be granted permission to exercise ROPP in private rooms.

ROPP is likely to have an impact on the service delivery to public patients in the following ways:

- A potential reduction in the availability of salaried specialists to treat public patients.
- There is a financial incentive to treat private patients for salaried specialists with income sharing arrangements because the salaried specialist will receive part of the fee, often a substantial part of it, which might mean that private patients will be treated differently and more favourably than public patients, for example, by being placed on surgical lists ahead of public patients.

ROPP could affect the level of public resources available to the hospital because:

- The hospital incurs costs when treating the private patient. Such costs include the use of its infrastructure, nursing and other employees and the salary of the specialist. The nine percent fee that is levied against ROPP income relates to indemnity and administrative costs and does not seek to recover the other costs incurred by the hospital. The intention might be that the ROPP income received by the hospital after the relevant percentage is reached, which commonly is 65% of base salary, is intended to cover these costs. But that will not occur until such time as a considerable amount of ROPP has been exercised and when the financial incentive to exercise ROPP is less.
- Commonwealth funding for a patient is reduced when the patient is treated as a private patient rather than a public patient because the funding takes into account other payments the hospital receives for the patient from Medicare and private health insurers, which will include allowances for accommodation and the patient's treatment by the salaried specialist. However, when those payments for the patient's treatment are largely passed on to the salaried specialist the overall funding SA Health receives for the treatment of the private patient is reduced.
- It might otherwise affect the amount of Commonwealth funding the South Australian public hospital system receives.[24]

I have not conducted any evaluation, assessment or audit to establish whether ROPP is having the mentioned effect on services or resources and it follows that if there is such an effect I do not know how significant it is.

I am not aware of any review into the effects of ROPP being conducted by SA Health or any other body.

I am however aware that other jurisdictions have seen fit to explore these questions. The Auditor-Generals' of Queensland and Victoria have both conducted audits which considered whether or not ROPP arrangements caused private patients to be treated differently to public patients. Both found that this did occur in some circumstances.[25]

24: A recent report of the Victorian Auditor-General identified two other ways ROPP could affect public funding:
(1) Where the payment a hospital would have received for a public patient in fact exceeded that was received when the person was treated as a private patient.
(2) A person being treated as a private rather than public patient can ultimately affect the level of growth funding the Commonwealth Government will make available to a State in succeeding years.
(Victorian Auditor-General, *Managing Private Practice in Public Hospitals*, June 2019, p.9 & pp.25-31). It may be that similar risks and effects are encountered by SA Health.

25: Queensland Audit Office, *Right of private practice in Queensland public hospitals*, Report to Parliament 1, 2013-14, p.4 & pp.36-38; Victorian Auditor-General, *Managing Private Practice in Public Hospitals,* June 2019, p.10 & pp.35-37.

THE POLICY FRAMEWORK

As mentioned I have not seen a SA Health policy or direction providing comprehensive guidance to specialists and other SA Health employees about how and when ROPP is to be exercised.

In response to my draft report the CE of DHW provided me with a document entitled *Rights of Private Practice Operations and Communication Material – Support Kit* apparently issued by DHW in April 2016. Whilst this document deals with some financial and administrative matters relating to ROPP it does not deal with important questions such as the extent to which ROPP can be exercised in paid public time or when the conduct of ROPP at a location other than the hospital should be authorised. It does not deal in any substantive way with the question of how ROPP is to be administered so that it has a manageable and acceptable effect on services to public patients and on public resources.[26] Nor have I seen any other policy that does so.

ROPP allows a salaried specialist to use the hospital's resources including its employees, to generate income for that specialist. If such a practice is to be permitted, the arrangements between the LHN and the salaried specialist must be very clear and unambiguous. That is not presently the case.

The intended outcomes or objectives of ROPP also do not appear to me to have been sufficiently considered, identified or articulated. The industrial agreement acknowledges that there are "mutual benefits" for ROPP but does not define what they are.

The Support Kit issued by DHW in April 2016 refers to the benefits of ROPP as being:

- The opportunity for a salaried specialist to earn extra additional income.
- The opportunity for the hospital to receive additional income from the charging of administration fees, the receipt of income after the relevant income threshold for a salaried specialist has been met and the receipt of accommodation fees for private patients from health insurers.

However, it is not clear to me that sufficient consideration has been given to why these benefits are in the public interest. In particular, it is not clear to me to whether any detailed consideration has been given to the deleterious effect that these benefits might have on services and public resources and whether or in what circumstances the benefits will outweigh such an effect. The Support Kit does not deal with these matters.

ROPP arrangements in other jurisdictions are described as being for attracting and retaining quality staff as well as to provide patients in public hospitals with a choice of public or private medical services. I can understand the benefits that could flow from such arrangements and this might be the case for ROPP in SA Health. However, because ROPP allows salaried specialists to use public resources and earn other income while they are being paid to provide public services, the arrangements must be clearly identified and transparent and tightly controlled.

26: The Support Kit does state all SA Health public patients are prioritised on the basis of clinical need but does not state how this is achieved.

RISKS ARISING FROM UNREGULATED ROPP

The fact that SA Health has not recorded any of the matters I have laid out in an overarching ROPP policy framework might indicate that SA Health has not considered them.

In particular, it may be that SA Health:

- Has not sufficiently considered and identified the intended objectives and outcomes of ROPP; why they are in the public interest; and why they justify the use of public resources.
- Has not analysed the likely financial consequences of ROPP arrangements and determined the kind of financial impact which is acceptable to achieve the intended objectives of ROPP by the use of public resources, and the policy measures that need to be put in place to achieve the objectives by limiting the extent to which ROPP can be exercised. It may be that the true cost of the arrangements is unknown.
- Has not analysed the impact that ROPP arrangements might have on the delivery of services to public patients and determined what impact is acceptable to achieve the objectives of ROPP and what policy measures need to be put in place to achieve the objectives by limiting the extent to which ROPP can be exercised and where it can be exercised.

If it is the case that these matters have not been considered it is also unlikely that the operation of ROPP has been reviewed to assess whether ROPP is achieving its intended objectives and whether its financial and other impacts are appropriate.

In the absence of clear guidance and direction, administrative officers who are at a pay level very much below a salaried specialist and who do not have the status that accompanies a salaried specialist, and who are responsible for managing or administering ROPP, will find their task difficult and confusing. In particular such employees are likely to experience confusion about the extent to which ROPP can be exercised during the salaried specialist's rostered paid public time and the circumstances in which ROPP can be exercised other than at a public hospital.

It is not fair to ask SA Health employees to regulate these matters without any clear guidance. There is no guarantee that these matters will be efficiently and effectively regulated to achieve the public interest objectives of the scheme, unless they are coordinated by an informed policy approach designed to achieve those ends.

For all of those reasons ROPP creates a risk of maladministration because there is a substantial risk of public resources being mismanaged where:

- The objectives to which those public resources are to be applied are ill defined;
- The means by which the resources are to be used to achieve the objectives have not been properly considered or are themselves ill defined;
- There are no clear instructions and guidance provided to SA Health employees who have to administer the resources; and/or
- There is no assurance that the objectives are being achieved or that the resources are being effectively and efficiently used to achieve those objectives.

ROPP contributes to the ambiguity surrounding the employment of salaried specialists which must be addressed. The salaried specialists hours of duty; the use that the salaried specialist might make of SA Health resources for private gain; the amount that may be earned in ROPP; and when that ROPP may be exercised should all be addressed.

Whilst those matters remain unaddressed, a salaried specialist who exercises ROPP has an ongoing conflict of interest between the salaried specialist's duties as an employee and the salaried specialist's exercise of ROPP.

Lastly, it should be observed that a lack of formal direction about when and how ROPP is to be exercised contributes to the ambiguity surrounding the discharge of salaried specialists' public duties and creates a risk of misconduct and maladministration which contributes to the risk of corruption.

CONFLICTS OF INTEREST

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CONFLICTS OF INTEREST

A number of SA Health investigations I have conducted or overseen have uncovered conflicts of interest held by SA Health employees. There are serious problems with the way in which conflicts of interests held by SA Health employees are being identified, declared and managed.

I have seen examples of obvious conflicts of interest which have not been identified, declared or managed, in circumstances where the conflicting private interest posed a real risk of compromising the proper discharge of public duties and use of public resources.

SA Health's operations mean conflicts of interest on the part of its employees are likely to frequently arise and when a conflict of interest does arise it is likely to pose risks which need to be addressed and managed.

This is unsurprising because SA Health is a substantial user of public funds and regularly purchases substantial equipment, consumables and infrastructure.

Some SA Health employees have secondary employment in the private health sector or other interests in private entities involved in healthcare delivery. Often this secondary employment or interest will conflict with public duties.

What is surprising is that the practices, policies and procedures of SA Health have not been, and may not presently be commensurate with the risks that conflicts of interests pose to its operations.

WHAT IS A CONFLICT OF INTEREST?

Conflicts of interest remain a source of confusion and apprehension for public administration in South Australia. Some public officers seem oblivious to the risks that conflicts of interest pose. For these reasons it is necessary to set out some context for conflicts of interest in SA Health.

A conflict of interest arises when the private interests of a SA Health employee conflicts or could be reasonably perceived to conflict with the duties that employee has agreed to discharge by undertaking his or her employment.

Conflicts of interest or perceptions of conflicts of interest arise routinely. When they do the public officer must declare that conflict. The conflict of interest must then be managed so that the public officer's private interests cannot be, or be perceived to be put ahead of the public officer's public duties.

Conflicts of interest held by SA Health public officers must be declared and managed because public officers are bound by their employment to act in the public interest. The State has entrusted to them the power to spend and allocate its resources and relies upon them to do so in the public interest and not to further their own private interests. Management of a conflict of interest is thus required to address any risks that the conflicting private interest might pose to the public interest.

THE POLICY FRAMEWORK

Although all SA Health employees have been subject to statutory obligations to declare conflicts of interest for some time, SA Health's internal conflict of interest policy framework has not developed or matured as would be expected for an organisation of its size and kind.[27]

DHW did not have a conflicts of interest policy until 1 July 2016 and that policy was only developed after the Auditor-General remarked upon its absence.[28] The DHW policy provided that it would be mandatory for LHNs to develop appropriate procedures in line with the policy by developing and maintaining conflicts of interest registers.

Information obtained by me during an investigation has suggested that as at February 2019 there was still no consistency across SA Health on how declared conflicts of interests were to be managed and at CALHN there was no process for capturing conflicts of interest.

I do not know the extent to which there is now appropriate policy infrastructure in place to manage conflicts of interest across SA Health because I have not undertaken that kind of evaluation. However, given the lack of direction indicated by the other information I have obtained, I doubt whether such documents exist consistently across SA Health.

I understand that current policy requirements mean that SA Health employees whose level of employment is less than 1.0 FTE, are not required to seek approval for or declare any secondary employment. In his response to the draft of this report, the CE of SA Health confirmed this was the current state of affairs but it is the subject of an industrial dispute between DHW and the South Australian Salaried Medical Officers Association which is currently in the South Australian Employment Tribunal.[29]

Many salaried specialists in SA Health, perhaps a majority, are employed less than full time and consequently those salaried specialists are also most likely to have secondary employment at non-public health facilities.

27: SA Health employees have obligations under s 92 of the *Health Care Act 2008* (SA) to declare conflicts of interests. Similar obligations arise for them under the *Code of Ethics for the South Australia Pubic Sector*.

28: The Auditor-General noted that DHW did not have a specific conflicts of interest policy detailing how conflicts of interest are to be monitored and reported on by DHW. It also noted that it did not maintain a register of interests. The Auditor-General observed that [as] a result, the risk of perceived or actual conflicts of interest is not adequately mitigated and could negatively impact on Department operations, including procurement activities.' The Department responded that it was committed to establishing a conflicts of interest policy and developing an associated register of interests: see Auditor-General, *Annual Report for the year 2014-15– Part B Agency Reports*, p.164.

29: In his letter dated 25/11/19 responding to the draft of this report the CE of Health wrote, "While this is factually correct, I wish to advise you that the Department has been in dispute with the South Australian Salaried Medical Officers Association (SASMOA) about aligning the relevant DHW policy to the Code of Ethics for the South Australian Public Sector which requires such approvals to be in place. This dispute was lodged in the South Australian Employment Tribunal on 24 July 2019."

Part time salaried specialists must declare any conflict of interest that arises from secondary employment whether or not they need to seek approval for that secondary employment. However, there is a real risk that such salaried specialists either will not recognise a conflict of interest or will mistakenly assume there is no requirement to declare that conflict because there is no requirement to declare secondary employment.

There is likely to be a considerable population of salaried specialists with private interests that are not visible to SA Health because their secondary employment is not declared. It is therefore difficult for SA Health to manage any conflicts that might arise.

OBSERVATIONS FROM INVESTIGATIONS

I am concerned that there are deficiencies in SA Health's policy framework because during the course of my investigations and the exercise of my other functions, I have observed serious shortcomings in the identification, declaration and management of conflicts of interest.

I have become aware of the following:

- An SA Health manager being in control of rosters for part of both a public and private hospital where SA Health employees worked at both locations. That manager had an interest in the private hospital but there did not appear to be sufficient processes in place to manage the manager's conflicting private interest.
- An SA Health manager, engaged to provide advice on the delivery of certain services at a public hospital which were delivered by a scheme in which the manager derived a benefit. This conflict did not appear to be identified or declared.
- An SA Health employee provided advice to a LHN about a substantial purchase of goods by the LHN from a supplying company, which had agreed to fund another entity with which the employee was associated. This conflict did not appear to be properly declared or managed.
- An SA Health employee was involved in making decisions about the circumstances when a LHN would provide services to another health service in which the employee had an interest. This conflict did not appear to be properly managed.
- An SA Health employee managed and administered the provision of a health service at locations separate from where the employee worked. That health service was delivered by engaging other SA Health employees to perform services for a fee. The SA Health employee who managed the scheme obtained a financial benefit from the operation of the health service. Despite the obvious conflict, the employee controlled and managed the financial arrangements associated with the service, and made decisions about the SA Health employees who would work for the service. This conflict did not appear to be appropriately identified, declared or managed.

I have also observed that LHNs have entered into complex and significant commercial arrangements, which involved the use of its resources or services by another entity, in circumstances which gave rise to conflicts of interest for one or more of its employees. Those arrangements were largely undocumented or poorly documented and the resultant conflicts of interest carried the real risk of the compromise of the LHNs proper and efficient use of resources. However, notwithstanding the substantial risk posed by the conflicts of interest, those conflicts were not identified or declared and if they were identified, the conflicts were not effectively managed.

I doubt whether these poor examples of conflicts of interest management are isolated to the cases I have mentioned. Due to the number of incidents I have observed, they are more likely a reflection of deep seated organisational and cultural issues.

A failure to properly declare and manage a conflict of interest carries a real risk of misconduct, maladministration or corruption in public administration. An organisational culture that is not capable or willing to properly manage conflicts of interest carries the same risks.

'...I HAVE OBSERVED SERIOUS SHORTCOMINGS IN THE IDENTIFICATION, DECLARATION AND MANAGEMENT OF CONFLICTS OF INTEREST.'

CLINICAL TRIALS AND RESEARCH

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CLINICAL TRIALS AND RESEARCH

Medical practitioners and other health employees within the public hospital system perform clinical research trials in which new treatments, interventions or tests are conducted as a means of preventing, detecting, treating or managing various diseases or medical conditions. They are an important and necessary part of the public hospital and indeed the public health system.

Clinical trials can be investigator led, that is, driven by one or several medical practitioners conducting research in a particular area. Sometimes they are publically funded.

Clinical trials can also be commercially funded, that is, conducted at the initiative of, or in cooperation with, a commercial entity external to the hospital. Commercial research trials are generally sponsored by a company or other body which has an interest, usually commercial, in the subject of the research.

Commercially sponsored clinical trials are conducted at LHNs. The public health system is a desirable site for such activities due to the level of medical services, expertise and infrastructure available which is required for such trials. Public hospitals also provide ready access to patients in the public health system who are willing to participate in the research.

In such cases, the sponsor (often a therapeutic goods company) pays for the clinical trial to be conducted. Information obtained from the clinical trial assists the sponsor to develop its products or obtain necessary approvals for its products which will be sold and used in the health system.

It is SA Health's intention that commercially sponsored clinical trials should be conducted on a cost neutral basis, which in my view is the appropriate basis. It is intended the sponsor will pay the public hospital to cover any costs it incurs in the conduct of the trial.

I have examined commercially sponsored clinical trials undertaken at a LHN where a number of governance and administrative deficiencies were revealed.

'I HAVE EXAMINED COMMERCIALLY SPONSORED CLINICAL TRIALS UNDERTAKEN AT A LHN WHERE A NUMBER OF GOVERNANCE AND ADMINISTRATIVE DEFICIENCIES WERE REVEALED.'

The following are some of the issues identified during my investigations:

- One investigation uncovered multiple irregularities concerning Clinical Trial Research Agreements (CTRAs) entered into by a LHN with commercial trial sponsors. A CTRA is the contractual agreement which governs the conduct of a trial. The CTRAs listed a third party research institute as the contracting institution. The contracting institution clearly should have been the LHN on whose premises the trial was to be conducted. However, senior LHN employees signed the CTRAs and failed to identify the error which created doubt and uncertainty about who had responsibility and liability for the conduct of the clinical trial, which raised a significant maladministration risk.

- Examination of other CTRAs revealed that some commercial sponsor payments, which were intended to compensate the LHN for hosting trials, were not paid to the LHN, but to a third party entity connected with the trials. While this arrangement was provided for in the CTRA, which was again signed by senior LHN staff, it contravened SA Health policies which required the funds to be paid to the LHN. The LHN should never have agreed to the arrangement because it left the LHN exposed to the risk of incurring unrecoverable costs associated with those trials.

- My investigations also uncovered practices in which parts of clinical trials were not being conducted by SA Health employees, but rather by staff engaged by third party institutions independent of the LHN. The LHN was therefore unable to regulate the persons engaged to perform clinical tasks involved in the trial, some of whom were treating or performing procedures on the LHN's patients. There was no mechanism by which the LHN could be assured that the staff were appropriately qualified; that they adhered to the rules and standards necessary for the trials; or that they managed the acquisition and use of patient's personal information appropriately.

- Investigations I have conducted have identified shortcomings in the governance arrangements surrounding research trials at some LHNs. As I have mentioned clinical trials are intended to be run on a cost neutral basis. However, the LHNs do not appear to be able to adequately quantify the costs the LHNs incur or have incurred. Systems that calculate the costs of conducting clinical trials appear to be poor, and the practices involved unlikely to lead to accurate assessments of costs incurred. I have seen evidence suggesting hospital finance departments were not involved in the research approval process, and cost schedules were negotiated by staff without financial expertise who were unaware of the budgetary scope of such trials. Thus, the financial obligations imposed upon commercial sponsors to recoup costs were potentially less than the expenses incurred by the LHNs.

Many of these observations related to one particular LHN. I understand this LHN has since taken action to address some of these issues by introducing an improved governance process surrounding the conduct of clinical research trials. I was also advised that the issues would be considered in the future development of research policy.

Nevertheless, I regard it as appropriate to make public these observations to encourage a robust reform process. Governance of clinical research trials and the contracts made to provide for them is a complicated and risk-filled area of public administration. SA Health must draw on the experience of previous governance failures so that it can provide proper reform.

The degree to which similar or other poor practices are present at other LHNs is also unknown to me. These observations should be considered by all SA Health sites conducting clinical research trials.

SPECIAL PURPOSE FUNDS

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SPECIAL PURPOSE FUNDS

Each LHN in SA Health operates special purpose funds (SPF).

A SPF is a separate fund used by the LHN to separate money that is intended to be used for a specific purpose from general operating funds.

For example, an advance payment of money by a commercial sponsor to conduct a clinical trial might be held in a SPF so that the costs of the trial can be charged against the SPF.

As it presently stands LHNs are only permitted to operate three types of SPFs, namely:

- Rights of Private Practice – These are SPFs used to receive monies earned by DHW employees under ROPP arrangements. For example, under the *Scheme Two Option B – Private Practice Ceiling in Excess of 65%* arrangement a proportion of ROPP income earned over 65% of base salary is paid into SPFs.
- Research – A research SPF holds funds which relate to an agreement with a third party entity independent of a LHN to undertake research.
- Donations – to hold donations made to the LHN which are not required to be provided to the Hospital Services Charitable Gifts Board for some reason.

Funds in a SPF can be used to fund the purposes or objectives for which the SPF has been created. The purposes and objectives are set out in a terms of reference document for each SPF. Any expenditure made out of a SPF must also be made in accordance with financial delegations.

HISTORICAL CONCERNS AND CHALLENGES RELATING TO SPFS

Historically, proper governance and accountability for SPFs has been an area of concern and posed challenges for SA Health.

In 2013 in response to concerns expressed by the Auditor-General, SA Health commenced a review of SPFs and the governing policy framework.

Prior to the review commencing there was no standard process across the LHNs as to how SPFs were managed. Those processes existed at a LHN level and were not necessarily consistent.

As a result of that review a SA Health wide policy was issued for the first time. That policy restricted the categories of SPFs to the three categories I have mentioned. Prior to the release of the policy there was no such restriction.

MY INVOLVEMENT WITH SPFS

During the course of the exercise of my functions, I have considered the manner in which SPFs were used in some parts of SA Health and I have identified two areas of concern.

In 2013 after SA Health announced that SPF policies and procedures were to be reformed, some SA Health employees became concerned that DHW or the State Government would cause the funds in SPFs to be absorbed into general revenue and therefore would no longer be accessible to those employees.

As a result some funds which should have been placed in SPFs were directed to accounts of third party entities independent of LHNs, and some funds then held in SPFs in LHNs were transferred to those third party entities.

Apparently there was a view in some parts of SA Health that those employees who managed or had control over the SPFs were in some way entitled to the monies in the SPF.

That view appeared to me to be inconsistent with the terms of the arrangements.

For example, funds provided for research at a public hospital and held in a SPF are intended to cover the costs of the hospital for that research. Such funds accordingly appear to be public funds and belong to the hospital. If after the conduct of a trial a surplus of funds remain it is difficult to see how that could be considered to belong to anyone else other than the hospital or the sponsor who provided the funds.

ROPP arrangements mean that some ROPP billings in excess of the income cap are placed in a SPF. I understand the practice is that the salaried specialist who generated the income can have some input into how the funds in that SPF are used or spent, for example whether they should be used to purchase specific equipment or fund extra staff.

However, it is a significant step from that situation to the suggestion that those funds are not public funds.

ROPP arrangements treat the funds distributed to SPFs from ROPP activity as part payment for the services and facilities the LHN provides to the specialist. Template Memorandum of Agreement (MoA) for ROPP income sharing arrangements, that I have seen, specifically refer to payments to DHW made after the income cap has been reached as being “consideration for the supply of resources and facilities under this MoA”.[30]

I also observed that there appeared to be a lack of precision about what could be legitimately expended from an SPF. The task of determining whether or not a proposed expenditure is legitimate or appropriate is not easily made.

30: Template Memorandum of Agreement for Capped Private Practice (Schedule 1 to the Department of Health Salaried Medical Officers Private Practice Agreement 2008) cl 7.4; see also Template Memorandum of Agreement for Option B Non Payover Private Practice (Schedule 3 to the Department of Health Salaried Medical Officers Private Practice Agreement 2008) cls 7.3.1 & 7.3.2.

RISKS ARISING FROM SPFS

It seems to me that the administration and management of SPFs is an area that poses risks for SA Health.

The examples from the investigations mentioned above arose from the management of SPFs which occurred before the new policy framework was introduced.

I have not examined the implementation of the new framework so I do not know how effective the framework now is.

However, I am concerned about the risks arising from existing controls on expenditure from SPFs and in particular whether they are sufficiently directed towards ensuring the appropriate use of those funds.

It seems that although the existing DHW issued policy directive provides that the expenditure is required to meet the objectives of the SPF and adhere to relevant policies, the directive does not specify how this is to be achieved. The policy directive also does not allocate responsibility to any particular person for ensuring that expenditure will achieve the objectives of the SPF or is within the terms of reference The terms of reference for the SPF and the permitted scope of expenditure are often broadly drafted. This particularly appears to be the case in respect of the ROPP SPFs, some of which were established some time ago and may not have been updated.

It may be that there are other policies or measures in place in SA Health that address these issues but if there are I am not aware of them.

PROCUREMENT

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PROCUREMENT

Procurement is an activity with persistent maladministration and corruption risks and which is highly vulnerable to exploitation and mismanagement because it involves a cluster of overlapping dynamics which include:

- Large sums of money.
- Widespread and devolved decision-making powers.
- The overlap of public and private sector interests.
- Complex and opaque policies or procedures.
- The need for various multi-levelled oversights (and their risks of failure).
- Employees with varied levels of training and understanding.

Procurement activity in public administration is very large. In 2017-18, procurement activity across South Australian public authorities amounted to approximately $5.13 billion. SA Health's procurement spending was approximately $1.96 billion, or roughly 38% of the overall state government procurement spend.[31] Operationally, SA Health procures goods and services from approximately 18,000 suppliers, and manages over 20,000 purchase orders per month.[32] Self-evidently the corruption, misconduct and maladministration risks involved in SA Health procurement activities are considerable.

I have investigated some procurement matters involving SA Health. The issues explored in this section came to light through a handful of investigations. One matter can expose numerous procurement integrity risks due to the complex and compound nature of procurement. Procurement is a continuing recurrent activity, especially in long running projects. One long running procurement which lacks integrity will often demonstrate multiple instances of impropriety and governance failures.

'PROCUREMENT IS AN ACTIVITY WITH PERSISTENT MALADMINISTRATION AND CORRUPTION RISKS AND WHICH IS HIGHLY VULNERABLE TO EXPLOITATION AND MISMANAGEMENT...'

31: South Australian Productivity Commission, *Inquiry into Government Procurement Stage 1: Draft Report*, 25 March 2019, p. 117. See, https://www.sapc.sa.gov.au/__data/assets/pdf_file/0012/50115/Government-Procurement-Inquiry-Stage-1-Draft-Report.pdf.

32: SA Health, Second Annual Supplier Conference 2018, *Better Business: Better Healthcare Brochure*, 26 October 2018, Adelaide Convention Centre, p. 5 and 13. See, https://www.sahealth.sa.gov.au/wps/wcm/connect/e44864cf-a9cd-422f-ab0b-04cddce46036/SAH%2BSUPPLIER%2BCONFERENCE%2B2018-ProgramBook-FINAL.pdf?MOD=AJPERES&CACHE=NONE&CONTENTCACHE=NONE.

In a matter that I investigated, the following integrity risks and inappropriate behaviours were identified:

- Planned procurement strategies and approaches for a two stage Information and Communications Technology project suddenly being abandoned and alternative procurement strategies adopted, without proper documentation to identify the sudden change. It was not clear who approved the decision not to proceed with the originally planned, documented and approved stage of the procurement.
- The engagement of suppliers was inconsistent with the stated procurement approach and outside various pre-qualified and approved provider lists.
- Acquisition plans or purchase recommendations were missing.
- Employees approving large expenditures without financial authority, contradicting Treasurers Instruction 8[33] requiring contracts of a certain value to be approved in writing by Cabinet, the Minister or an employee nominated by the Minister.
- An inability to find contracts between SA Health and a supplier for a procurement in excess of $1 million.
- Employees initiating and approving procurement processes without authority.
- Possible collusion with vendors to ensure invoicing was within an employee's financial authority.
- The improper use of power or influence to engage closely associated / affiliated contractors at inflated rates.

Another investigated revealed:

- The improper acquisition of products at a LHN involving a significant amount of product being purchased at a significant cost where approximately half the stock was never used and was never likely to be used by the LHN.
- The procurement was contrary to the published LHN practice.
- No proper assessment of the risks or benefits to the LHN from the purchase.
- No proper assessment of the LHN's need for the product before the purchase.
- The purchase served to partially fund an entity which had a connection to an employee involved in the purchasing decision.
- Evidence of procurements being authorised by an employee outside that employee's delegation, resulting in a substantial loss to a LHN.
- A lack of procurement documentation for the value of the procurement purchase. After extensive but unsuccessful searches the evidence suggested there was no acquisition plan or a purchase recommendation generated for the procurement, which was in contravention of DHW policies and procedures.

33: Department of Treasury and Finance (29 May 2014) *Treasurer's Instruction 8 Financial Authorisations.*

Another investigation involved a commercial arrangement where the supplier offered 'donations', calculated as a percentage of dollars spent by the hospital on its products, into a SPF that was earmarked for medical education purposes. Those funds were later used for purposes not related to education activities which was an example of historical financial arrangements that became open to abuse due to poor oversight and governance.

The misuse of the funds was investigated but the manner in which this particular procurement arrangement was structured raised obvious risks. A supplier offering 'donations' based upon the amount of product purchased is a clear example of grooming behaviour by a commercial entity by offering inducements to influence decision-making. It is no answer to that conduct to say that those 'donations' are said to be reserved for publicly beneficial purposes.

There was no suggestion that those who entered into the arrangement personally benefitted. Nevertheless, the existence of procurement activities of this type may encourage suppliers to attempt to influence procurement officers with favours and enticements. The risk is that some of these enticements will not be for the public benefit. The tolerance of such procurement practices opens the door to offerings and inducements being made by suppliers to improperly benefit SA Health employees personally. The slippery slope nature of procurement activity of that kind should not be underestimated.

Allegations have been made in other matters of significant conflicts of interests on the part of salaried specialists who have been involved in making purchasing decisions from suppliers with whom they have other commercial arrangements. Such procurements are likely to be compromised by salaried specialists seeking to benefit themselves and by suppliers gaining unfair advantage by exerting financial influence over decision-making.

The catalogue of governance issues to which I have referred represents only a few matters that I have investigated. They relate to pockets of procurement activity within various parts of SA Health, and I have not had the relevant or requisite oversight to make a valid assessment of the overall procurement culture and conditions in SA Health. However, other oversight agencies have reviewed a considerable number of SA Health procurement activities.

I referred a matter to the Ombudsman to investigate procurement issues involved in SA Health's Electronic Patient Administration System (EPAS). The Ombudsman made no findings of maladministration but expressed concern about the 'cumulative procedural errors' behind such a large scale project with a significant public interest in its implementation.

He listed various failings in the summary to his final report which included:

- Insufficient information in Acquisition Plans as to the rationale to justify the direct engagement procurement approach.
- Use of default, or template based statements which had not been tailored to the relevant procurement.
- Contracts not reflecting the scope of the actual work performed by the supplier.
- Ongoing engagement of the supplier despite contracts having expired.
- Insufficient detail in relation to risk management.
- Incorrect contract amounts.
- A lack of probity reviews.[34]

The Auditor-General in his 2018-19 annual report criticised the manner in which SA Health appointed the corporate advisory firm KordaMentha to oversee finances at CAHLN. The Auditor-General found that SA Health did not properly assess potential risks and conflicts of interest associated with appointing the firm and could have better documented their assessments.

Very recently the Auditor-General has released a report into the property and asset maintenance arrangements at the regional LHNs, and found them to be ineffective. Asset maintenance is an activity involving significant acquisition, procurement and contractual undertakings. Relevantly the Auditor-General found that the regional LHNs had not established foundational strategies, policies and plans for asset management; that their maintenance budgets were not based on current and ongoing needs and priorities; and that there was no effective certification of work by external contractors to ensure that contracted work was performed and completed to an appropriate standard and for an appropriate price.[35]

Considering the quantum and range of goods and services that SA Health procures, and the purposes to which they are put, it is essential that the administration and governance of its procurement functions is above reproach.

34: Ombudsman SA, *Summary of Final Report in Relation to SA Health's EPAS Procurement Issues*, May 2018. See, https://www.ombudsman.sa.gov.au/wp-content/uploads/Summary-of-final-report-in-relation-to-SA-Healths-EPAS-Procurement-Issues.pdf.

35: South Australian Auditor-General's Department, *Report of the Auditor-General: Report 10 of 2019 – Country health property maintenance*, 26 November 2019, p.2.

CONCLUSION

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CONCLUSION

The ICAC Act defines corruption, misconduct and maladministration.[36] Corruption must be a criminal offence. For SA Health public officers, misconduct is a breach of the Code of Ethics under the Public Sector Act which provides for a disciplinary process.

Maladministration is a little more difficult to explain and to understand.[37]

A public authority (SA Health, the CE of SA Health or the LHNs) will engage in maladministration if the public authority has a practice, policy or procedure that results in an irregular and unauthorised use of public money or substantial mismanagement of public resources.

A public officer (an employee of SA Health or the LHNs) will engage in maladministration if the public officer's conduct results in an irregular and unauthorised use of public money or substantial mismanagement of public resources or involves substantial mismanagement in or in relation to the performance of the public officer's official functions.

In the course of over six years I have had the opportunity to observe some of the issues affecting integrity in SA Health, through the perspective of a statutory office holder charged with exposing and investigating potential issues of corruption, misconduct and maladministration. I do not know the full extent of SA Health's operations, systems and arrangements.

The insights that I have had have identified an inappropriate integrity culture for an organisation entrusted with administering substantial public resources and charged with delivering a critical public service.

More work needs to be done to determine the extent to which those practices, policies and procedures are having that effect and what remedies need to be put in place to obviate the risks.

I have said that maladministration and corruption in public administration are inextricably linked on a number of occasions.

As I have mentioned in this report, and publicly, I have embarked upon a number of investigations where I have suspected SA Health public officers have engaged in corruption but those investigations have been frustrated by SA Health's poor record keeping and vague and ambiguous practices and policies. On too many occasions I have been told at a senior level that SA Health cannot be sure whether the particular conduct had been condoned or tolerated.

36: Section 5 of the ICAC Act 2012.

37: Maladministration in public administration-

(a) means-

(i) conduct of a public officer, or a practice, policy or procedure of a public authority, that results in an irregular and unauthorised use of public money or substantial mismanagement of public resources; or

(ii) conduct of a public officer involving substantial mismanagement in or in relation to the performance of official functions; and

(b) includes conduct resulting from impropriety, incompetence or negligence; and

(c) is to be assessed having regard to relevant statutory provisions and administrative instructions and directions.

Too many decisions appear to have been made for the sake of convenience, or to suit sectional interests, whilst insufficient regard has been had as to whether those decisions constitute an appropriate use of public funds.

‘I WOULD REGARD THE SITUATION IN SA HEALTH AS ONE CHARACTERISED BY TROUBLING AMBIGUITY.’

Some parts of SA Health seem to have lost sight of the fact that the touchstone for the appropriate use of public funds is the public interest.

Existing governance and probity arrangements appear to be insufficient and characterised by vagueness and uncertainty. Ill-defined documents create environments in which poor conduct and bad administration are silently supported and allowed to flourish.

I would regard the situation in SA Health as one characterised by troubling ambiguity. Through years of experience, which is increasingly supported by research and academic evidence, it is known that dishonest and improper behaviour flourishes in situations where practices, policies and procedures are surrounded by ambiguity.

There are few areas of public administration that experience more pressure to perform than our public health system. This report makes plain that the governance of this pressed-upon sector is ambiguous and uncertain, which is an unfavourable combination of factors for ensuring SA Health’s integrity.

Some might say that the governance arrangements in SA Health, or lack thereof, are necessary to provide the system and its employees with the flexibility and the ability to respond necessary for a modern health setting. Some may argue it is inappropriate to prescribe the duties and obligations of senior clinicians in SA Health because overly prescriptive administrative constraints will only hinder the clinical flexibility and quality of services. Flexibility and responsiveness are necessary qualities for all public administration. But flexibility is not the same thing as ambiguity.

Others may argue that an increased governance and administrative burden affects not only the flexibility of clinical work but restricts the time available for clinical work because further governance and administrative burdens will divert time away from SA Health’s primary function of attending to the health needs of the South Australian community.

Those arguments, if advanced, would mischaracterise the point I seek to make in this report. While SA Health does not have appropriate governance and administrative arrangements SA Health cannot be confident that the full level of clinical care is being delivered. The proper governance and administration of health services and excellent levels of clinical care are not either or propositions. The former helps support the achievement of the latter.

This report should not be understood to challenge the reputation of SA Health employees. Nothing in this report should be taken to suggest that the level of clinical care is not of the highest standard.

I am concerned that the governance and administrative arrangements in SA Health are ripe for exploitation by corrupt employees. I accept that for every employee who is failing to perform his or her duties there may well be many who are working hours for which they are not remunerated. I accept that for every employee with private interests, that compromise their duties to public health, there may be many whose connections and affiliations advance policy and practice, and enhance the provision of public health services.

But the existence of corrupt and inappropriate practices is not something to be tolerated for those reasons.

If SA Health's practices, policies and procedures are of a kind that increase the risks of maladministration and thereby allows corruption to occur, they must be addressed.

If SA Health's policies, practices and procedures can disguise conduct of SA Health's public officers which amounts to corruption, misconduct or maladministration then they must be addressed. How they should be addressed is ultimately a matter for government.

'IF SA HEALTH'S PRACTICES, POLICIES AND PROCEDURES ARE OF A KIND THAT INCREASE THE RISKS OF MALADMINISTRATION AND THEREBY ALLOWS CORRUPTION TO OCCUR, THEY MUST BE ADDRESSED.'

APPENDICES

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APPENDICES

APPENDIX A – COMPLAINTS AND REPORTS ABOUT SA HEALTH

Over the last six years the Office for Public Integrity has received 1,166 complaints or reports[38] containing allegations of poor conduct and practices in SA Health which accounts for approximately 18% of all complaints and reports about public administration.[39]

Of the complaints and reports received, 435 have been assessed as requiring no further action because the complaint or report is trivial, vexatious or frivolous or the matter has already been dealt with and does not require re-examination, or for some other good reason.

A further 482 complaints and reports were assessed as raising potential issues of misconduct or maladministration. Most of these matters were referred to the CE of SA Health for investigation and action, often with directions to report back to me in respect of the findings and outcomes.[40] On very rare occasions a matter has been referred to the Ombudsman for investigation.

A matter can only be assessed as corruption if the matter raises potential criminal conduct which is liable to be the subject of a prosecution which will itself depend upon whether a prosecution would be in the public interest. If there is seen to be little likelihood of prosecution, the matter is assessed as raising a potential issue of misconduct or maladministration which is best examined by the CE of SA Health so he can potentially discipline wrongdoers and rectify relevant policies practices and procedures. The general nature of misconduct and maladministration referrals to SA Health tend to be matters involving:

- Bullying and harassment
- Inappropriate or unprofessional conduct
- Failure to follow procedure/fulfil duties
- Misuse of departmental resources
- Inappropriate access/use of information or documents
- Irregular recruitment and procurement practices

I can elect to investigate a misconduct or maladministration matter if I determine that the matter gives rise to potentially serious or systemic issues of misconduct or maladministration and it is in the public interest for me to conduct an investigation.

38: Combining the numbers of different assessment outcomes will not equal 1,166. This is due to some matters being assessed as duplicates of existing matters, containing secondary matters or being subsequently split into multiple matters.
39: Excluding complaints about South Australia Police.
40: The CE of DHW is the public authority for SA Health employees.

Of the 1,166 complaints and reports received relating to SA Health 151 matters have been assessed as raising a potential issue of corruption in public administration.

The majority of the matters assessed as corruption were referred to SA Police to investigate, especially those matters involving conduct that SA Police frequently investigates in the normal course of its duty. The general nature of SA Health matters referred to SA Police tend to be matters involving:

- Low level theft
- Assaults and excessive force
- Drug offences
- Minor timesheet fraud

I have investigated 35 of the more complex, serious or significant matters being matters that might involve substantial amounts of evidence or matters that involve a significant volume of work to establish whether or not an offence has been committed.

APPENDIX B – ROPP ARRANGEMENTS

Name	***Scheme One – Capped Private Practice***
Detail	▶ After a 9% administration and indemnity fee has been deducted the salaried specialist keeps all private practice receipts up to the cap applicable to them. For most categories of specialist that cap is 65% of his or her base salary. ▶ After the cap is reached receipts are paid to SA Health and divided in the following way: ◆ 52% to a Special Purpose Fund. ◆ 13% to an Equipment Fund (defined as a fund managed by the Health Service for the purchase of equipment at the discretion of the Health Service). ◆ 35% to DHW. ▶ A SA Health employee who uses this scheme also receives an Attraction and Retention Allowance in addition to his or her salary and ROPP entitlements. The amount of that allowance varies according to type of specialist. The most common amount is 30% of base salary.
Name	***Scheme Two – Option A – Private Practice Allowance***
Detail	▶ All private practice receipts are paid over to DHW. ▶ Specialists are paid a private practice allowance of 30% of base salary (or 45% if they work at certain country or regional hospitals). ▶ A SA Health employee who has this scheme is not paid an Attraction and Retention Allowance.
Name	***Scheme Two – Option B – Private Practice Ceiling in Excess of 65%***
Detail	▶ After a 9% fee administration and indemnity fee has been deducted the salaried specialist receives: ◆ All billings up to 65% of base salary. ◆ One third of billings between 65% and 100% of base salary. The remainder is distributed between a Special Purpose Fund (20%), Equipment Fund (33.34%) and DHW (13.33%). ◆ 15% of billings over 100%. The remainder is split between the Equipment Fund (42.5%) and DHW (42.5%). ▶ A SA Health employee who has this scheme is not paid an Attraction and Retention Allowance.
Name	***Status Quo Arrangements***
Detail	▶ The Private Practice Agreement does provide scope for salaried specialists to retain “status quo agreements” which were in place before 14 April 2008. ▶ A SA Health employee who has this scheme is not paid an Attraction and Retention Allowance.
Name	***Arrangements specific to SA Pathology and SA Medical Imaging***
Detail	▶ Certain specialists attached to SA Pathology and SA Medical Imaging receive a private practice loading of 65% of Base Salary in lieu of capped private practice scheme and in addition to any Attraction and Retention Allowance.

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TROUBLING AMBIGUITY:
GOVERNANCE IN SA HEALTH
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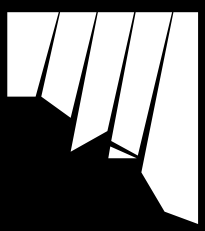

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