AN OVERVIEW OF THE AUDITS OF THE ACT 97 HOSPITALS

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A REPORT TO THE GOVERNOR AND THE LEGISLATURE OF THE STATE OF HAWAII

SUBMITTED BY THE LEGISLATIVE AUDITOR OF THE STATE OF HAWAII

THE OFFICE OF THE LEGISLATIVE AUDITOR

The office of the legislative auditor is a public agency attached to the Hawaii State legislature. It is established by Article VI, Section 8, of the Constitution of the State of Hawaii. The expenses of the office are financed through appropriations made by the legislature.

The primary function of this office is to strengthen the legislature's capabilities in making rational decisions with respect to authorizing public programs, setting program levels, and establishing fiscal policies and in conducting an effective review and appraisal of the performance of public agencies.

The office of the legislative auditor endeavors to fulfill this responsibility by carrying on the following activities.

1. Conducting examinations and tests of state agencies' planning, programming, and budgeting processes to determine the quality of these processes and thus the pertinence of the actions requested of the legislature by these agencies.
2. Conducting examinations and tests of state agencies' implementation processes to determine whether the laws, policies, and programs of the State are being carried out in an effective, efficient and economical manner.
3. Conducting systematic and periodic examinations of all financial statements prepared by and for all state and county agencies to attest to their substantial accuracy and reliability.
4. Conducting tests of all internal control systems of state and local agencies to ensure that such systems are properly designed to safeguard the agencies' assets against loss from waste, fraud, error, etc.; to ensure the legality, accuracy and reliability of the agencies' financial transaction records and statements; to promote efficient operations; and to encourage adherence to prescribed management policies.
5. Conducting special studies and investigations as may be directed by the legislature.

Hawaii's laws provide the legislative auditor with broad powers to examine and inspect all books, records, statements, documents and all financial affairs of every state and local agency. However, the office exercises no control functions and is restricted to reviewing, evaluating, and reporting its findings and recommendations to the legislature and the governor. The independent, objective, and impartial manner in which the legislative auditor is required to conduct his examinations provides the basis for placing reliance on his findings and recommendations.

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Foreword

Since 1966, each public (Act 97) hospital has been the subject of a fiscal and/or management audit by this office or by a private accounting firm. In addition, in 1968 and 1969, this office issued special reports on the implementation of Act 203, SLH 1967.

Each of the audit reports discusses the problems existent at the particular institution under examination, and the Act 203 implementation reports are limited in scope. This overview attempts to provide an overall perspective to some of the more common problems of the public hospitals, a perspective which was not possible in the reports of the specific, individual hospitals; it also explores the implications of Act 265, enacted by the legislature at the recent 1969 session, which placed direct, as well as ultimate, responsibility of administering the hospitals in the State.

It is hoped that this overview will be useful to both the legislature and the administration as the State assumes a more direct role in public hospital administration under Act 265.

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AN OVERVIEW OF THE AUDITS OF ACT 97 HOSPITALS

During the past year, this office audited the financial transactions and records of five Act 97 hospitals–the Kauai Veterans Memorial Hospital and the Samuel Mahelona Memorial Hospital on the island of Kauai; and the Honokaa, Kohala and Kona hospitals on the island of Hawaii. With the completion of these audits, all Act 97 hospitals have now been audited in one respect or another, at least once, since 1966. In 1966-67, we conducted a management audit of the Kula Sanatorium on Maui, and in 1967-68, we examined the fiscal records of the Hilo Hospital. The Maui Community Hospitals (the Maui Memorial Hospital and the Hana Medical Center) and the Maluhia Hospital on Oahu were audited recently by independent accounting firms.

This overview is NOT a summary of the various audit reports. Its purposes are as follows. *First,* this overview provides a total, public hospital system perspective to some of the more common problems subsisting at the Act 97 hospitals. While these problems, as they relate to each specific hospital, are discussed in each audit report, a total system view permits us to emphasize those aspects of the problems which cannot be given sufficient stress in a report of any single hospital. *Second,* this overview explores the implications of Act 265, the new piece of legislation relating to public hospitals which the legislature enacted at the 1969 session. Some of the implications, particularly as they affect our recommendations contained in the various audit reports, are noted briefly in the footnotes to the reports on the audits of the two Kauai and the three Hawaii hospitals conducted during the past fiscal year. However, since Act 265 was enacted after our reports were put together, neither time nor space permitted a full discussion of the implications in those reports.

Specifically, this overview is concerned with the following: (1) hospitals' legal status under Act 265, SLH 1969; (2) funding hospital operations; (3) enforcement of State policies; and (4) hospital accounts receivable.

Hospitals' Legal Status

Act 265, SLH 1969, provides in section 1 that effective January 1, 1970, "all functions pertaining to the operation and maintenance of public hospitals and other public health and medical facilities heretofore performed by the several counties on behalf of the State pursuant to Act 203, Session Laws of Hawaii 1967, shall...be directly administered and performed by the State..."[1] The enactment of this statute "completed" the State takeover of all public hospitals,[2] which began in 1965 with Act 97.

While it completes the State's assumption of all responsibilities and functions regarding public hospitals, Act 265 also provides for the establishment of a management advisory committee for each hospital. The members of the committee are to be appointed by the governor for overlapping terms. The committee is empowered to *nominate* (and the governor to *appoint*) the hospital administrator. It is "to be responsible to and under the director of health for advising and assisting in the carrying out of all policies of the department of health."[3] Both the House and the Senate committees which reported the measure out for adoption by the respective houses explained that this provision was inserted to provide "some measure of local participation in the daily operation and control of the hospitals."[4]

Although Act 265 unequivocally places the ultimate and direct responsibility for operating and maintaining public hospitals in the State, it does not specify, except to indicate that there should be some local participation through the management advisory committees, the manner in which the State is to carry out these functions. The burden, thus, is upon the State department of health to delineate the method in which these functions are to be discharged.

There are many facets which the State department of health must consider in implementing Act 265 and in shaping the mode in which the public hospitals are to be operated and maintained. We mention two which we think are worthy of noting: (1) the need, if any, for a county-wide approach to administration in each county; and (2) the role of the management advisory committees.

1. County-wide administration. Technically, each hospital is an entity; the legislature appropriates money separately for each institution. However, pursuant to the provisions of Act 203, SLH 1967, each county has

[1] At the same time, Act 265, SLH 1969, reassigns certain functions from the State to the several counties, but these functions are minor in nature (e.g., ambulance and first aid services in counties with a population of 200,000 or more; medical care of inmates of county jails; physical examinations of county employees; etc.)

[2] House Standing Committee Report No. 559 and Senate Standing Committee Report No. 921, Fifth State Legislature, Regular Session 1969.

[3] There is an anomaly in the manner in which Act 265 is constructed. Section 1 of the act does not specify the State department of health as the State agency which will be responsible for the functions of operating and maintaining public hospitals and other public health and medical facilities; it states that these functions shall be administered and performed by the "State department or departments designated by the governor." However, section 7, which relates to the establishment of a management advisory committee for each hospital, assumes that the State department of health will be responsible for these functions. Given the nature of the functions, it is probably safe to assume that the governor will designate the State department of health, and this overview is written on that assumption.

[4] House Standing Committee Report No. 559 and Senate Standing Committee Report No. 921.

established a county hospital advisory council which advises the State director of health on matters concerning the planning, construction, improvement, maintenance and operation of public hospitals within the county. Each advisory council is empowered to coordinate its efforts and activities with the administrators of the various hospitals within the county.[5] In addition, the counties of Kauai and Hawaii have established other systems or units to assist in the administration of the hospitals. The county of Kauai has created an advisory committee on hospital management to advise the county council on all aspects of hospital management and operation in Kauai.[6] The county of Hawaii has organized what is known as the "Hawaii county hospital system" to which all public hospitals in the county belong. The Hawaii county hospital system is under the supervision of a single, administrative director.[7]

[5]Section 8, Act 203, SLH 1967. See our reports entitled, *Status Report on the Implementation of Act 203, Session Laws of Hawaii 1967,* dated February 1968, and *Second Annual Status Report on the Implementation of Act 203, Session Laws of Hawaii 1967,* dated February 1969.

[6]See our reports, *Status Report on the Implementation of Act 203,* and *Second Annual Status Report on the Implementation of Act 203.* See also our reports no. 69-5, *Financial Audit of the Samuel Mahelona Hospital,* and no. 69-9, *Financial Audit of the Kauai Veterans Memorial Hospital,* both dated June 1969.

[7]See our reports, *Status Report on the Implementation of Act 203,* and *Second Annual Status Report on the Implementation of Act 203.* See also our audit reports no. 69-6, *Financial Audit of the Honokaa Hospital,* June 1969; no. 69-7, *Financial Audit of the Kohala Hospital,* June 1969; and no. 69-8, *Financial Audit of the Kona Hospital,* June 1969.

The Hawaii county organizational setup has enabled all of the hospitals in that county, on occasions, to act as a unit. For example, in 1968, the administrative director issued directives relating to collections of hospital revenue which apply to all hospitals in the county uniformly,[8] and in 1967 and again in 1968, he entered into a single contract with a radiologist for radiological services to be provided to all of the Hawaii county hospitals.[9] In the various county advisory councils and the Kauai county advisory committee on hospital management, although they are purely advisory and quite unlike the Hawaii county hospital system, there is a mechanism which might conceivably permit the viewing of problems common to all hospitals in a county on a county-wide basis.

Act 265 will terminate the county systems of hospitals. The county advisory councils will be abolished, and they will be replaced by an advisory committee for each hospital. Each hospital will have a hospital administrator nominated by the advisory committee and appointed by the governor. Under Act 265, then, there will be no single body or a single administrator who can act for all hospitals in the

[8]Our audit reports nos. 69-6, 69-7, 69-8.

[9]Our audit report no. 69-6.

county or who can view problems common to all hospitals in the county on a county-wide basis.[10]

There is perhaps something to be said for a county-wide approach to the administration of some aspects of hospital operations. Some problems, though not necessarily common to all hospitals in the State, are common to all hospitals in a single county—problems which are difficult, impractical or economically unfeasible to be resolved on a hospital-by-hospital basis. If, indeed, such county approach is appropriate, it would appear that under the new legislation, the State director of health will have to provide that leadership (which currently is being supplied by the administrative director in the Hawaii county hospital system) or provide other mechanism which will permit the resolution of problems on a county-wide basis.

2. Local participation. The lack of a clear delineation of authorities and responsibilities and the absence of firm lines of communication between the State and the counties have characterized the relationship between the two jurisdictions under Acts 97 and 203. Moreover, the parties affected by Act 203 have disagreed as to the true intent of that act, the State contending that its jurisdiction extends to every facet of hospital administration and some counties contending that the State's jurisdiction is limited to state-wide policies and that the internal management of hospitals is the responsibility of the counties.[11]

[10]On the island of Maui, the Hana Medical Center and the Maui Memorial Hospital are incorporated within the Maui Community Hospitals. Unlike the Big Island case, however, the Maui Community Hospitals is a creature of statute (section 66-11 HRS) and it does not include all public hospitals in the county of Maui (it excludes the Kula Sanatorium). Its continuing existence is not likely to be affected by Act 265.

Act 265 attempts to put an end to the fuzziness surrounding Acts 97 and 203 and the disagreements shrouding Act 203. However, while it now clearly places the ultimate and direct responsibility and authority for operating and maintaining public hospitals in the State, Act 265 does not remove entirely the problem of defining the roles and responsibilities of the counties. Under the act, the counties are expected to participate in the operations of the hospitals. This is precisely the reason for the provision in the act establishing an advisory committee for each hospital. If the counties' participation is to be a meaningful one, care must be taken in outlining the roles and responsibilities of the advisory committees. Creating the advisory committees is one thing; making them meaningful participants is another, and it surely is of little comfort that the act places ultimate responsibility and authority in the State.

We mention the two items above because, as we stated earlier, they are worthy of note. We believe that the State department of health must

[11]See our reports, *Status Report on the Implementation of Act 203,* and *Second Annual Status Report on the Implementation of Act 203.*

commence *now*, if it has not done so as yet, to set up the system through which it can administer the hospitals efficiently and effectively come January 1, 1970. Implementing Act 265 involves people, both at the county and State levels. It is thus not expected to be a simple task. It would appear that the State department of health would do well to formulate its plans in consultation with the various counties.

Funding

Of the ten Act 97 hospitals, the operations of four are funded entirely by the State general fund, and the operations of six are funded through special funds. The four general fund and the six special fund hospitals are as follows:

General Fund	Special Fund
Honokaa Hospital	Samuel Mahelona Memorial Hospital
Kohala Hospital	Kauai Veterans Memorial Hospital
Kona Hospital	Hilo Hospital
Maluhia Hospital	Maui Memorial Hospital
	Hana Medical Center
	Kula Sanatorium

A general fund hospital depends entirely on legislative appropriations for moneys to defray the costs of its operations. The moneys are appropriated out of the State general fund. Correlatively, the receipts of the hospital are not used directly in the operations of the hospital, but are deposited into the State general fund as a part of the general revenue of the State to be used for any purpose as the legislature sees fit. Thus, in appropriating moneys to the hospital, the legislature does not consider the potential receipts of the hospital.

A special fund hospital pays for its operational costs from a fund specially set aside for that purpose. The fund derives its resources from the receipts of the hospital. The hospital receipts are earmarked by law to be deposited directly into the fund and to be used to pay for the hospital's costs. The legislature does appropriate moneys annually to each special fund hospital, but it does so only to the extent that the hospital's estimated expenditures exceed its anticipated receipts. The moneys appropriated are deposited into the special fund along with the hospital receipts.

This dichotomy in the funding of public hospitals raises a number of issues of import. Among them are: (1) the legality of the continuing use of the special funds under Act 97, SLH 1965, and Act 203, SLH 1967; (2) the equity in the treatment accorded the hospitals when some are funded through special funds and others not; and (3) the propriety of certain practices which have been followed in the past in an effort to equalize the fiscal resource availability of the various hospitals.

1. Legal status of special funds. Special funds are established by law,[12] and the special funds of all six hospitals were initially authorized by statutes.[13] Since their initial authorization, the special funds have been used by the six hospitals without interruption. However, there is currently some doubt as to the legality of the continuing use of these special funds. Whether intended or not, one of the effects of Act 97, SLH 1965, and Act 203, SLH 1967, was to repeal the existing statutes establishing these special funds.[14] No specific legislation has been passed since Act 97 and Act 203 to allow the continued use of the funds.

The hospitals' continuing use of the special funds may lie in the fact that the legislature, despite the repeal of the statutes, has kept on appropriating funds to these hospitals as if the statutes authorizing the special funds had never been abrogated.[15] This behavior of the legislature might be interpreted to imply a legal sanction to the continued use of the funds. However, in the absence of specific statutes, it would appear that such implied sanction, if it can be implied at all, is of a temporal nature—one which is given (and can be given) only on an year-to-year basis.

Perhaps the continued use of the special funds might well have been tolerated, even in the absence of specific statutes, so long as the legal status of the hospitals remained in doubt under Act 97 and Act 203.[16] But, with the enactment of Act 265, SLH 1969, the nebulous status of the special funds warrants legislative attention. The question is, should any or all of the Act 97 hospitals be allowed special funds and if so, under what restrictions? The answer to this question, we believe, should be preceded by a careful consideration of the matters discussed in the following sections.

2. Equity in treatment of special and general fund hospitals. The intent underlying the series of legislations relating to public hospitals has been to insure uniform and equitable levels of services and facilities throughout the State.[17] We find, however, that such uniformity and equity are difficult to achieve when some hospitals are permitted the use of special funds and others not.

[12] *Hawaii Revised Statutes,* sec. 37-1.

[13] *Revised Laws of Hawaii 1955,* sec. 147-24 (Samuel Mahelona Memorial Hospital); sec. 147-21 (Kauai Veterans Memorial Hospital); sec. 146-63 (Supplement 1965) (Hilo Hospital); sec. 148-23 (Maui Memorial Hospital and Hana Medical Center) (this section does not expressly create a special fund, but its provisions imply one); sec. 148-25 (Supplement 1965) (Kula Sanatorium).

[14] See "Table of Dispositions," volume 8, *Hawaii Revised Statutes,* p. 3.

[15] See Act 99, SLH 1965, sec. 1; Act 8, SLH 1966, sec. 1; Act 54, SLH 1967, sec. 1; Act 74, SLH 1968, sec. 1; Act 154, SLH 1969, sec. 1.

[16] To the State attorney general, however, the legal status of the hospitals has never been in doubt. In his opinion, the full responsibility and authority for the planning, construction, improvement, maintenance and operation of the hospitals resided in the State government. See attorney general's opinion no. 65-17 and another dated August 3, 1967.

[17] See, for example, Conference Committee Report No. 18, 1967 Session.

The level of service that a hospital can provide depends to a large degree upon the resources available to it. In this respect, the special fund hospitals have an advantage over those funded by the State general fund. Other than to specify the purpose to which it is to be put, statutes which create special funds generally contain very little restrictions on the use of the funds; much discretion is left to the administrative unit to which the fund is attached. This means, in the case of hospitals, that the special fund hospitals can utilize any receipts in excess of that anticipated for any fiscal year to pay for items not included in the budget for the year.

It is true that every appropriation act passed by the legislature has contained a section stating,

> "Where the operation of a department of a program is financed by general appropriation as well as by non-general appropriation funds, the general appropriation portion shall be decreased to the extent that the receipt of non-general appropriation funds approved in this Act are exceeded, provided, that such decrease shall not jeopardize the receipt of such increased non-general appropriation funds;..."[18]

This section, however, has not prevented the special fund hospitals from using their excess receipts for unbudgeted expenditures. Thus, in fiscal year 1967-68, the Kauai Veterans Memorial Hospital and the Samuel Mahelona Memorial Hospital used their excess receipts, with the consent of the State departments of health and budget and finance, for certain expenditures which were not included in their budgets when the legislature passed on the appropriations for these hospitals.[19] Apparently, the authority for permitting such use of excess receipts has been two-fold: (1) the statute creating the special fund itself which authorizes the use of hospital receipts for hospital purposes, subject to the allotment procedures set forth in chapter 37, part II, HRS; and (2) the second proviso, added by the legislature in 1961 to the section of the appropriation act quoted above (a proviso which has been in all appropriation acts since 1961) which reads,

> "provided further, that this section shall not apply to any fund if such excess receipts are to be expended for a purpose or purposes approved by the Governor or the director of the Department of Budget and Finance if such authority is so delegated by the Governor."

There is some question as to whether or not this second proviso was meant to apply to special fund excess receipts. This question is explored in the next section of this overview. Aside from this question, the delimiting effect

[18] See, for example, section 15, Act 54, SLH 1967.

[19] Our report no. 69-9.

of the above-quoted section on the use of non-general fund receipts in excess of that anticipated in the appropriation act does not appear to apply to that portion of the receipts which exceed the total general fund appropriation amount in those rare instances (such as that which occurred at the Kauai Veterans Memorial Hospital in fiscal year 1967-68) when the total non-general fund receipts far exceed the total hospital budget. In those instances, all of the appropriated amount might be returned to the State, but there would still be enough of an excess to pay for unbudgeted items. The requirement of securing the governor's or the director of budget and finance's approval contained in the second proviso appears to apply only to that portion of the excess receipts which the hospital is required to return to the State to decrease the general fund amount and not to that portion of the excess receipts beyond the general fund amount.

Such internal financial flexibility enjoyed by special fund hospitals is not available to general fund hospitals. In fiscal year 1967-68, some efforts were made by the State administration to lessen the disparity in fiscal flexibility existing between the special fund hospitals and the general fund hospitals. Thus, some of the excess receipts of the Hilo Hospital were permitted to be transferred to the Honokaa[20] and the Kona[21] hospitals to pay for their unbudgeted expenditures, and the surplus which existed in the special fund of the Maui Memorial Hospital at the close of the 1965-66 fiscal year was allocated among all public hospitals for equipment purchases.[22] These transfers of funds from the special fund hospitals to the general fund hospitals were apparently had under the authority of the second proviso.

Again, aside from the question of whether or not the legislature intended the second proviso to be applied in this manner, the fact that special fund moneys may be transferable to general fund hospitals does not in and of itself negate the decided advantage which the special fund hospitals have. It would appear that a transfer of excess receipts of a special fund hospital to a general fund hospital would occur, in practice, only if the special fund hospital with the excess receipts cannot itself utilize the excess for its own unbudgeted expenditures.

The only real recourse that a general fund hospital has, in case of unexpected expenditures, is to apply for a deficiency appropriation to the legislature as provided in the appropriation act.[23] Applying for a deficiency appropriation means, of course, that the hospital's unbudgeted expenditures will be subject to legislative scrutiny—scrutiny to which the use of excess receipts of a special fund hospital for its unbudgeted expenditures is not subject.

[20] Our audit report no. 69-6.

[21] Our audit report no. 69-8.

[22] Our audit reports no. 69-5, no. 69-6, no. 69-7, no. 69-8, no. 69-9.

[23] See, for example, section 13, Act 54, SLH 1967.

3. Transfer of special fund moneys to general fund hospitals. The practice of transferring excess non-general fund receipts of special fund hospitals to general fund hospitals to pay for the latter's unbudgeted expenditures raises the question of the intent of the legislature when it initially added in 1961 that proviso which permits the use of non-general appropriation funds received in excess of that approved in the appropriation act for "a purpose or purposes" approved by the governor or the director of budget and finance. The question is, did the legislature intend this proviso to apply to the non-general fund receipts of special funds? More specifically, was this proviso meant to permit the transfer of the non-general fund receipts of a hospital, which are earmarked by law to be deposited into a special fund and to be used for the specific purpose of operating *that* hospital, to another hospital? Several factors seem to point to a negative reply.

First, a special fund is generally intended for the benefit of the organizational unit or the program to which the fund is attached, and not for others. *Second,* since 1959, every appropriation act has included a section setting forth the procedure to be followed by agencies, such as the hospitals, whose appropriations are based on population and workload data, in the event the amount of the appropriations is insufficient for their purposes. The section reads as follows:

> "In allotting funds to the Department of Health, Department of Social Services, tubercular hospitals, and other departments, commissions, and agencies having appropriations which are based on population and workload data as specified in this Act, only so much as is necessary to provide the level of services intended by the legislature shall be allotted by the Department of Budget and Finance. For this purpose, the department and agencies concerned shall reduce expenditures below appropriations as prescribed by the Department of Budget and Finance in the event actual population and workload trend is less than the specified figure. In the event that the trend is higher than the specified figure, or the reasonable average daily cost of medical care for the needy and medically needy exceeds the anticipated average sum per patient day upon which the appropriation therefor was based, the department is authorized to submit a deficiency appropriation request to the extent and on such basis as may be prescribed by the director of the Department of Budget and Finance."[24]

To be sure, this section is permissive—"the department *is authorized* to submit a deficiency appropriation." But, in the light of a *specific* provision relating to the process to be followed by hospitals in case of a deficiency, can it be said that the proviso, relating in a broad and general way to the use of non-general fund

[24]Section 13, Act 54, SLH 1967.

receipts, apply equally to hospital receipts? In this connection, it must be remembered that the route of a deficiency appropriation permits legislative review, but the route of the general proviso does not. It is questionable in the light of this deficiency appropriation section specifically for institutions such as the hospitals, that the legislature intended by the second proviso to forego its right to review hospital expenditures in excess of the budget.

Third, there is some reason to believe (by the nature of the climate against special funds prevailing in the late 1950's and the early 1960's when the second proviso was attached) that the legislature intended the proviso to apply to no more than the possible receipt of *federal funds* in excess of that anticipated at the time of appropriation.

There is one other provision which has always been included in the appropriation acts. That provision reads,

> "Except as otherwise provided, transfer of funds between program appropriations within a department may be made by the head of the department upon his certification, and approval by the director of the Department of Budget and Finance, that appropriation balances are or will be available for such transfers after the program objectives intended by the legislature have been accomplished and that such transfers are necessary to accomplish program objectives authorized by the legislature."

Ostensibly, this provision seems to permit transfers of fund between the special fund and the general fund hospitals, since they are all within one department—the department of health. However, the word, "fund," as used in this provision, appears to have been limited to the moneys *appropriated* (note the phrase, "that *appropriation balances* are or will be available...") and not to include non-general fund moneys. Moreover, this section begins with the words, "except as otherwise provided," and the manner in which hospitals may secure additional general fund moneys might be said to be "otherwise provided" in that section relating to deficiency appropriations.

4. Suggested remedial actions. The doubtful status of the existing special funds, the inequity in the treatment accorded the hospitals when some are funded through special funds and others by the general fund, and the questionable propriety of the practice of transferring special fund hospital's moneys to general fund hospitals for the latter's use call for some remedial action by the legislature. The initial question which must be resolved is whether or not any or all of the hospitals should be specially funded. The second question is, what, if anything, should be done about transfers of funds from one special fund hospital to another special or general fund hospital? The second question is pertinent only if it is resolved that all or some of the hospitals should have special funds.

With respect to the first question, in our view, the objectives of our public hospitals can be served by funding them all through the State

general fund. *First,* we have already pointed out the inequity which results if some hospitals are funded by special funds and others by the general fund. *Second,* granting all hospitals special funds will not necessarily lead to equity and uniformity in the levels of services to be provided. The amount of fiscal flexibility available to each hospital will depend upon the amount of receipts that the hospital is able to generate, and all of the hospitals are not equal in this respect. There is, for example, a wide disparity among the hospitals in their daily occupancy rates which influence to a large degree the amount of the non-general fund receipts. In fiscal year 1967-68, at the five hospitals we audited, the occupancy rates ranged from a low of 47% at the Kohala Hospital[25] to a high of 89% at the Kauai Veterans Memorial Hospital.[26]

Third, the hospitals currently rely very heavily upon the State general fund to pay for the costs of their operations. So long as this situation continues or is expected to continue, special funds for these hospitals are hardly justified. A special fund for a government function is probably appropriate if that function is closely akin to that of a private business—that is, if the *full* cost (including the costs of capital improvements) of the services rendered by that function is expected or can reasonably be expected to be paid for solely (or substantially) by an identifiable clientele rather than by taxpayers generally, or if the expenditures for the function are to be or can reasonably be expected to be limited to the revenue derived therefrom.[27]

Admittedly, the Act 97 hospitals have some characteristics of a private enterprise. They each serve an identifiable group of clients and they charge (or are authorized to charge) their clients for services rendered. But there the similarity to a private enterprise ends. Over the years, the hospitals have not met, and the legislature has never expected them to meet, all of their fiscal requirements from the charges made to patients, nor have their expenditures been limited generally to the amount of the revenue generated from patient services. In 1967-68, the State general fund expenditures (State subsidy) for all hospitals, including the special fund hospitals, was 38% of the total expenditures of all hospitals. Not included in this calculation are those amounts paid for from the State general fund for employee fringe benefits, central services and capital improvements. On a hospital-by-hospital basis, the State general fund accounted for the following portion of each hospital's total operating cost (exclusive of employee fringe benefits, central services and capital improvements):

[25] Our audit report no. 69-7.

[26] Our audit report no. 69-9.

[27] Public Administration Service, *Special Funds and Budget Administration in the Territory of Hawaii: A Survey Report,* pp. 14-21. (This *Survey* was conducted in 1958-59, pursuant to Act 320, SLH 1957.)

Hospital	General Fund Portion[28] of Total Cost Amount	Percent
Oahu:		
Maluhia	$1,314,927	55%
Hawaii:		
Hilo	655,477	20
Honokaa	70,475	22
Kohala	100,010	45
Kona	102,629	28
Maui:		
Kula Sanatorium and General	584,318	46
Maui Memorial	490,629	24
Hana Medical Center	61,483	84
Kauai:		
Samuel Mahelona Memorial	658,731	90
Kauai Veterans Memorial	None	None
	$4,038,679	38%

While the Kauai Veterans Memorial Hospital did not require any general fund moneys to pay for its operational costs in 1967-68, this situation was unexpected and is not likely to occur too frequently, if again. In addition, if the costs of its fringe benefits, central services and capital improvements are included, the Kauai Veterans Memorial Hospital was not really free of State subsidy. For fiscal year 1969-70, the total general fund moneys appropriated by the legislature to all ten hospitals constitute 35% of their total anticipated requirements (exclusive of employee fringe benefits, central services and capital improvements.[29]

It is hardly likely that any of the hospitals will in the future be *fully* self-financing, despite the efforts of the State department of health, now going on, to revise the hospital rates of the various hospitals to reflect more closely the actual cost of operating the hospitals. The legislature's willingness in the past and its apparent willingness in the future to subsidize the hospital operations indicate that the government has accepted responsibility for underwriting a minimum hospital program. The enactment of Act 97, Act 203 and Act 265 should allay any doubts about this.

Government's acceptance of this responsibility and the negation of any expectation of reimbursement of general fund expenditures from the users of the hospitals' services rob the hospitals of much of their "business enterprise" attributes.[30]

Some argument might be advanced for special funds in the name of "fiscal flexibility." It might be contended, for example, that the

[28] See our audit reports nos. 69-5, p. 16; 69-6, p. 13; 69-7, p. 12; 69-8, p. 15; 69-9, p. 16; *Finance Director's Annual Financial Report, City and County of Honolulu, Fiscal Year Ended June 30, 1968,* p. 55; *County Auditor's Annual Report, County of Hawaii, for the Fiscal Period July 1, 1967 to June 30, 1968,* p. 54; *Annual Report of the Auditor, County of Maui, Fiscal Year Ended June 30, 1968,* p. 52; *Report of the Comptroller, State of Hawaii, Fiscal Year Ended June 30, 1968,* p. 57.

[29] See Act 154, SLH 1969.

[30] Public Administration Service, *Special Funds and Budget Administration in the Territory of Hawaii: A Survey Report,* pp. 17-18.

fluctuating nature of patient population justifies the existence of a special fund—that is, there should be a fund available in the event the patient population exceeds that estimated. Such argument, however, overlooks the following. *First,* a special fund for a function which is truly self-supporting and the "fiscal flexibility" which comes with it find their justification not in the fluctuating nature of the number of people requiring the serices rendered by that function, but in the fact that the consumers of that service who pay for the entire cost of that function, no matter what the number, are entitled to have management be responsive to their needs and demands.[31] *Second,* experience has shown that hospital receipts have often been used not to meet the increased costs of patient population rising above that estimated, but to pay for expenses clearly not intended in the budget.[32] *Third,* contingencies such as population increases beyond that estimated can be accommodated by means other than a special fund—for example, through deficiency appropriations.

Since the State has accepted the responsibility of operating and maintaining these public hospitals as a part of government functions, there is no reason for treating this program any differently from other government programs in the budgeting process. To the extent that the hospitals are permitted special funds and the hospitals use their receipts for unbudgeted purposes, the legislature's resource allocation responsibility and function are hindered.[33] Restricting the use of hospital receipts in excess of the State general fund appropriation by requiring first the concurrence of the governor or the director of budget and finance does not alleviate this intrusion into the authority vested in the legislature.

Our recommendation, then, is that all of the hospitals be funded through the general fund. However, in the event special funds are authorized, we believe that that section of the appropriation act which permits the use of non-general fund receipts in excess of that anticipated for any purpose approved by the governor or the director of budget and finance be made inapplicable to the special fund excess receipts of the hospitals and that transfers of excess receipts from any special fund hospital to any other hospital be prohibited. The present practice of siphoning special fund excess receipts to general fund hospitals further removes hospital expenditures for unbudgeted items from legislative review.

[31]Public Administration Service, *Special Funds and Budget Administration in the Territory of Hawaii: A Survey Report,* p. 16.

[32]For examples, see our audit reports no. 69-6 (Honokaa Hospital), no. 69-7 (Kohala Hospital), no. 69-8 (Kona Hospital) and no. 69-9 (Kauai Veterans Memorial Hospital).

[33]Public Administration Service, *Special Funds and Budget Administration in the Territory of Hawaii: A Survey Report,* p. 19; Public Administration Service, *Modernizing Government Budget Administration* (a report prepared for the Agency for International Development) Chicago, 1962, pp. 39-40.

Enforcement of State Policies

In our reports on the audits of the Kula Sanatorium (report no. 67-2, dated February 1967) and the Hilo Hospital (report no. 68-8, dated April 1968), we discussed certain practices that were then existing at those institutions and recommended certain corrective actions. Among the practices discussed were those relating to employee perquisites, the use of revenue from vending machines situated in the hospital buildings, and automobile allowances for hospital staff personnel. With respect to each, we made the following findings and recommendations.

Employee perquisites. At the Kula Sanatorium, employees were being charged for meals at rates which were insufficient to cover the raw food cost, much less the total cost of producing meals. We noted in our report that the State policy provides that meal charges should be based on the total cost of producing meals, and that, pending the accumulation of cost data, meal charges should be based on the cost of raw foodstuffs. We recommended that a meal cost study be undertaken at Kula so that meal rates could be established which would reflect the total allocable cost of producing meals and that the State department of health review and revise its policy so that proper guidelines could be set for all hospitals under its jurisdiction in establishing reasonable meal rates for employees.

At both the Kula Sanatorium and the Hilo Hospital, living quarters were being furnished some of their employees, and they were being furnished at rates which were obviously insufficient to recover at least the cost of maintaining and operating the quarters. We noted that the State policy discourages the furnishing of living quarters, except in cases of standby services, geographic isolation and extreme inadequacy of private housing facilities, and emergencies involving the care and preservation of government property and the safeguarding of human life. We recommended that at both institutions, living quarters be gradually phased out and, pending the complete termination of housing, the rates reflect the actual cost of operating and maintaining them.

Use of vending machine revenue. At both the Kula Sanatorium and the Hilo Hospital, we found that revenues from vending machines situated in the hospitals were being used by patients or employee associations of the hospitals. We stated in our reports that revenue generated from the use of public buildings constitutes public funds, and, while there may be some merit to the use of the revenue for patients' and employees' benefit, in the absence of some specific statute earmarking the revenue for such use, it should be discontinued and the revenue should be deposited into the State treasury.

Automobile allowances. At both institutions, certain staff personnel were being given automobile allowances at flat monthly rates. We noted in our reports that the State policy generally allows flat monthly rates only in exceptional cases when the use of private

automobile for public purposes is so extensive that it is administratively impossible to separate the public use from the non-public use. At none of the institutions did we find the public use of the private automobiles to be so extensive as to justify the flat monthly rates. We recommended that the flat monthly rates be discontinued and that the staff personnel be paid on the mileage basis.

Our findings and recommendations contained in our audit reports of the Kula Sanatorium and the Hilo Hospital were made not only for the guidance of the Kula Sanatorium and the Hilo Hospital, but for the guidance of all State and local agencies similarly situated. In his response to our audit report of the Kula Sanatorium, the State director of health himself acknowledged the applicability of our findings and recommendations to other Act 97 hospitals. He stated,

> "Many of the recommendations refer to other hospitals operated by this department and we can certainly profit by the many recommendations, especially if the State does take over active management of the Act 97 hospitals on July 1, 1967."

However, in our audits of the five hospitals during the past fiscal year, it was distressing to find that the problems encountered at the Kula Sanatorium and the Hilo Hospital persisted in the five hospitals. For example, the Kohala[34] and the Kona[35] hospitals were charging their employees for meals at rates which were not sufficient to cover at least the raw food cost; the Samuel Mahelona Memorial[36] and the Kohala[37] hospitals were charging their employees for rental quarters at rates which did not cover the total operating and maintenance costs of the quarters; all hospitals were using vending machine revenues for either the benefit of patients or employees; and the Honokaa Hospital[38] was paying a staff personnel automobile allowance at a flat monthly rate in excess of what appeared to be reasonable.

Clearly, the action taken by the State department of health, since it assumed control of all Act 97 hospitals on July 1, 1967, to resolve these problems which we first pointed out two years ago has not been equal to the task. The inadequacy of the efforts of the State department of health is exemplified by the following action taken with respect to perquisites. On April 2, 1968, nine months after the department took jurisdiction over the Act 97 hospitals, the State department of health

[34] Our audit report no. 69-7.

[35] Our audit report no. 69-8.

[36] Our audit report no. 69-5.

[37] Our audit report no. 69-7.

[38] Our audit report no. 69-6.

issued a document entitled, *Policies and Procedures Pertaining to County Hospitals and Related Public Health and Medical Facilities.* In it, the department stated that "all hospitals will follow the Department of Health perquisite policy." The department's perquisite policy to which the document refers is one which had been approved back in 1964. The policy contains fixed rates at which employees are to be charged for meals and living quarters. No guidelines are furnished in the policy by which the bases upon which the fixed charges were set can be determined. The fixed charges, however, are obviously outdated—they were outdated as far back as 1967 when we audited the Kula Sanatorium; the charges noted in the policy are much less than the charges that we found inadequate at the Kula Sanatorium. The department of health is currently in the process of reviewing its employee meal charge policy for the purpose of establishing uniform guidelines for determining meal rates at the various hospitals. To our knowledge, there is no similar review underway at present on rental charges for living quarters.

We believe that appropriate action by the State department of health to establish up-to-date policy and standards on issues of statewide concern and to prescribe the procedures for the enforcement of such policy and standards is overdue. We recommend that the State department of health take immediate action to revise or formulate such policy and standards and to develop the procedures by which to insure uniform application thereof by all hospitals within its jurisdiction.

Hospital Accounts Receivable

Included in the assets of all hospitals are accounts receivable. Some of these accounts are "delinquent" (that is, not fully paid within a certain specified period of time). Some others are, at best, of dubious collectibility, because the statute of limitations has intervened or the debtors are dead, have been declared bankrupt, or are absent from the jurisdiction of the State. The State's incremental assumption of direct responsibility of the hospitals has affected the manner in which the delinquent accounts and the uncollectible accounts are to be handled. They are as follows.

Delinquent accounts. Prior to Act 97, all hospitals in the county of Hawaii were authorized by statute (section 146-65, RLH 1955, as amended) to hire private collectors to handle the collection of delinquent accounts, and the hospitals have from time to time referred their accounts for collection to private collection agencies. After Act 97, the hospitals have continued to utilize collection agencies. As late as July and December 1968, the administrative director of the Hawaii county hospital system issued instructions to all hospitals in the county that all accounts that are 90 days overdue are to be turned over to a collection agency, with the approval of the superintendent of the responsible hospital, after all efforts to collect the unpaid balances have failed.[39] (The hospitals in none of the other

[39] Our audit reports no. 69-6, no. 69-8.

counties have had any statutory authority to hire private collectors; their collection problems have generally been handled by the county attorneys.)

In our reports on the audits of the various county of Hawaii hospitals, we recommended that the hospitals adhere to the instructions issued by the administrative director of the hospital system. We did so, however, with some reservation about the continuing authority of the hospitals, since the passage of Act 97, to hire private collectors.

Act 97 superseded all statutory provisions then existing relating specifically to individual public hospitals. Among the statutory provisions apparently repealed by Act 97 was that one which authorized the county of Hawaii hospitals to hire private collectors to handle the collection of delinquent accounts. Thus, the provisions of section 146-65, RLH 1955, as amended, do not appear anywhere in the Hawaii Revised Statutes.[40] Presumably, a new piece of legislation will be required if the hospitals are to be permitted to continue their practice of hiring private collectors.

We believe that some mechanism is required to assist the hospitals in the collection of delinquent accounts. However, whether or not a new piece of legislation should be enacted to allow the hospitals to hire private collectors is a question which ought to be considered in the light of the adequacy of the present methods available generally to all State agencies in the collection of accounts.

There are other State agencies which collect moneys from the public. Their problems in collection are perhaps no different from the problems of public hospitals. At least, the fact that a special statute on hospital collection existed only for the county of Hawaii and not the other counties seems to indicate so. If this be the case, then there appears to be little reason to provide a special collection method only for public hospitals.

Uncollectible accounts. On the books of the hospitals are two kinds of "uncollectible accounts." The unpaid balances of hospital charges for services rendered *prior* to the effective date of Act 97 (July 1, 1965) are county receivables; the unpaid balances of hospital charges for services rendered *since* the effective date of Act 97 are State receivables. With respect to State receivables, section 40-82 HRS permits the removal of uncollectible accounts from the hospitals' accounting records with the approval of the State attorney general. But, for county receivables, there is no statutory authority to permit the deletion from the records of clearly uncollectible accounts. This means that in the case of county receivables, the accounts of debtors who are dead, out of the jurisdiction of the State or bankrupt and accounts with respect to which the period of the statute of limitations has passed must continue to be carried on the books of the hospital perpetually. In our reports on the audits of the various hospitals, we recommended that some legislation be enacted to allow those county accounts which are clearly uncollectible to be removed from the records, in much the same vein as section 40-82 HRS does for State receivables.

Subsequent to the writing of our reports, the legislature enacted Act 265, SLH 1969. The act calls in part for the transfer of all "personal property" used in the operation and maintenance of the hospitals from the counties to the State. The term, "personal property," as used in the act, is broad enough to encompass those accounts receivable which represent unpaid charges for services rendered prior to the effective date of Act 97. If such county receivables are in fact transferred to the State, our recommendation regarding the enactment of legislation to provide for the deletion of county receivables from the books of the hospitals would be moot. However, section 3 of Act 265 authorizes the department of health to determine which of the various personal property should be transferred to the State and which should be retained by the counties. If the department chooses not to transfer any of the county receivables to the State, then our recommendation for legislation to enable the removal of clearly uncollectible county accounts would be appropriate. In deciding whether or not any of the county accounts receivable should be transferred to the State, the department of health might well take the non-existence of legislation to remove county accounts from the records into consideration.

[40] See "Tables of Disposition," volume 8, *Hawaii Revised Statutes*, p. 13.

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