



PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO HOSPITAL TRUST ACCOUNTS

Report No. 5

36th Parliament

2003

Published by the Legislative Assembly, Parliament of Western Australia, Perth, December 2003.

Printed by the Government Printer, State Law Publisher, Western Australia.



Public Accounts Committee

Inquiry into Hospital Trust Accounts

ISBN: 1 920830 01 4

(Series: Western Australia. Parliament. Legislative Assembly. Committees.
Public Accounts Committee. Report 5)

328.365

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PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO HOSPITAL TRUST ACCOUNTS

Report No. 5

Presented by:

Mr J.B. D'Orazio, MLA

Laid on the Table of the Legislative Assembly
on 4 December 2003

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COMMITTEE'S FUNCTIONS AND POWERS

The Public Accounts Committee inquires into and reports to the Legislative Assembly on any proposal, matter or thing it considers necessary, connected with the receipt and expenditure of public moneys, including moneys allocated under the annual Appropriation bills and Loan Fund.

The Committee may:

- 1 Examine the financial affairs and accounts of government agencies of the State which includes any statutory board, commission, authority, committee, or trust established or appointed pursuant to any rule, regulation, by-law, order, order in Council, proclamation, ministerial direction or any other like means.
- 2 Inquire into and report to the Assembly on any question which:
 - (a) it deems necessary to investigate;
 - (b) is referred to it by resolution of the Assembly;
 - (c) is referred to it by a Minister; or
 - (d) is referred to it by the Auditor General.
- 3 Consider any papers on public expenditure presented to the Assembly and such of the expenditure as it sees fit to examine.
- 4 Consider whether the objectives of public expenditure are being achieved, or may be achieved more economically.

INQUIRY TERMS OF REFERENCE

On 5 November 2001, the Public Accounts Committee resolved to conduct an inquiry into hospital trust accounts, and adopted the following terms of reference:

That the Public Accounts Committee examine and report on issues relating to the administration and use of hospital trust accounts in the Western Australian public hospital system, with particular reference to:

1. the nature and purpose of trust accounts;
2. the sources of funding;
3. the use, administration and management of trust accounts;
4. the statutory requirements, accountability and compliance;
5. the costs, benefits and potential liabilities to the health system of trust accounts;
and
6. any other matter that the Committee deems necessary to investigate.

CHAIRMAN'S FOREWORD

It is with great pleasure that I table the Public Accounts Committee's report into hospital trust accounts in the Legislative Assembly. The inquiry has taken over two years to complete, due to the enormous range of issues to examine and several concurrent investigations that the Committee waited to be finalised before releasing its report.

During the course of the inquiry, the Committee took evidence from a total of 43 witnesses at public, closed and in-camera hearings, conducted a number of briefings, and received an enormous amount of documentary evidence.

The issue of hospital "trust" accounts has received considerable public and media scrutiny over the past two years. The allegations of fraud and misappropriation of public funds surrounding hospital trust accounts were of serious concern to the Committee, as the people of Western Australia have a legitimate expectation that the public health system is managed with integrity and credibility.

The Committee acknowledges that it has been difficult for doctors and administrators working within the State's public hospitals to endure several high level investigations into these issues. Doctors have felt the subject of gratuitous "doctor bashing" and witch-hunts. I wish to reassure them that the Committee recognises their commitment and tireless work in our community. In undertaking this inquiry, the committee has sought to investigate the matter once and for all, resolve any systemic problems, and to enable everyone involved to move on.

Despite much anecdotal evidence to the contrary, the Committee is satisfied that the real cause of the problems was the grossly inadequate policy frameworks and control processes in the administration and management of hospital accounts, together with an appalling lack of documentations to support payments, work arrangements and patient records.

These problems appear to have been entrenched by custom and practice within the public hospital system over many years. The fundamental deficiencies in the system created the potential for misuse of funds, leaving the hospitals and their staff open to attack and criticism.

I am confident that the Committee's inquiry has been the catalyst for significant change. Since the Committee resolved to conduct a thorough investigation in November 2001, a range of improvements has been initiated, both within individual teaching hospitals and the Department of Health. This impetus for reform is welcome, but well overdue. The endemic nature of the problems requires structural as well as cultural change, and this process will take time and commitment to permeate the public health system. The Committee hopes this report will assist to restore public confidence in this process.

Many of the Committee's findings in relation to past unsatisfactory practices at the four metropolitan teaching hospitals and the Department of Health are disturbing. The Committee expects that improvements will continue to take place and that doctors, hospital and departmental administrators, and members of the public will now focus on the future.

I wish to thank my fellow Committee Members for their tireless efforts in conducting the inquiry:

Mr Monty House, MLA (Deputy Chairman)

Member for Stirling

Mr John Bradshaw, MLA

Member for Murray-Wellington

Mr Tony Dean, MLA

Member for Bunbury

...and until 30 October 2003

Mr Martin Whitely, MLA

Member for Roleystone

Each of the Members has brought valuable parliamentary, industry, personal, and technical experience to the issues before the Committee. It has been a pleasure to work with each of them.

The Committee's research staff have also played an invaluable role throughout the inquiry. On behalf of the Committee I thank the Research Officers Mr Simon Kennedy and the late Mr Alf Opie. In particular, I wish to thank the Committee's Principal Research Officer, Ms Andrea McCallum, for her consistently professional advice and research.

MR J.B. D'ORAZIO, MLA

CHAIRMAN

ABBREVIATIONS AND ACRONYMS

“ACC”	Anti-Corruption Commission
“AHCA”	Australian Health Care Agreement
“AMA”	Australian Medical Association
“ATO”	Australian Taxation Office
“CEO”	Chief Executive Officer
“CSA”	Clinical Staff Association
“CSO”	Crown Solicitor’s Office
“FAAA”	<i>Financial Administration and Audit Act, 1985</i>
“FHHS”	Fremantle Hospital and Health Service
“GP”	General Practitioner
“HIC”	Health Insurance Commission
“KEMH”	King Edward Memorial Hospital for Women
“MBS”	Medicare Benefits Schedule
“MHS”	Metropolitan Health Service
“MHSB”	Metropolitan Health Services Board
“Minister”	Minister for Health
“MOU”	Memorandum of Understanding
“NHMRC”	National Health and Medical Research Council
“OAG”	Office of the Auditor General
“Committee”	Public Accounts Committee
“PMH”	Princess Margaret Hospital for Children
“RPH”	Royal Perth Hospital
“SCGH”	Sir Charles Gairdner Hospital
“SPA”	Special Purpose Account

FINDINGS

Page 11

Finding 1

Most of the hospital accounts that have been generically termed “trust” accounts are not true trust accounts. They are actually Special Purpose Accounts. The misleading terminology of “trust” accounts has added significantly to the speculation and confusion about the entire issue of hospital accounts.

Page 11

Finding 2

Hospital accounts holding moneys belonging to third parties constitute true trust accounts. Those accounts holding moneys belonging to the hospital, albeit for a specific purpose, constitute a Special Purpose Account. That is, they are cost centres for special projects or purposes within the hospital’s general ledger account.

Page 12

Finding 3

Special Purpose Accounts were generally treated incorrectly by hospitals as “non-operational” funds and recorded separately from operational funds in hospital accounting systems to keep the moneys apart.

Page 13

Finding 4

The provisions of the *Financial Administration and Audit Act, 1985* were incorrectly used as the basis for establishing many Special Purpose Accounts, as the relevant sections of the FAAA only apply to private moneys.

Page 21

Finding 5

Throughout the 1990s a number of public patients who presented at the public teaching hospitals were treated as private patients, with the relevant treating doctor billing Medicare and receiving rebates from the Health Insurance Commission made payable directly to the doctor.

Due to the lack of proper documentation maintained by the hospitals, it is difficult to gauge the extent of this practice. Furthermore, it was not possible for the Committee to conclude whether this practice was ultimately for the benefit of the hospitals or the individual doctors. There is clear evidence that hospital administrators encouraged doctors to bulk-bill Medicare as a way of raising additional revenue for the hospitals. However this does not preclude the possibility that some doctors inappropriately derived personal benefit from the expenditure of these funds.

Page 27

Finding 6

The offer by the Director General of the Department of Health on behalf of WA taxpayers to indemnify the individual doctors named in the Health Insurance Commission report into inappropriate billing of Medicare is tantamount to an admission of liability.

It was premature for the Director General to agree to indemnify the individual doctors without first investigating and being satisfied that the doctors did not benefit personally from the funds obtained from bulk-billing Medicare, notwithstanding that this practice may have been encouraged by successive hospital administrators.

Page 28

Finding 7

It is possible that some doctors received an indirect personal gain from the practice of bulk-billing Medicare, as they deposited the Medicare rebate into Special Purpose Accounts that they controlled, as a “donation”, thus claiming a tax deduction. It is arguable that they subsequently benefited from the same funds by using them for overseas travel and expenses, which may also attract a taxation liability for individual doctors and a fringe benefits taxation liability for the State.

Page 32

Finding 8

The lack of adequate and consistent policy frameworks at both departmental and individual hospital level over the years led to a proliferation of Special Purpose Accounts. There is still a large number of Special Purpose Accounts being operated by the four metropolitan teaching hospitals.

The Committee is not in a position to determine the appropriate number of Special Purpose Accounts. However these accounts need to be properly controlled and managed.

Page 35

Finding 9

It was inappropriate for the Whiteman estate funds to be utilised for the Megazone project at Princess Margaret Hospital, as Mr Whiteman specified a condition in his will that he wanted the funds to be applied for the research and treatment of cancer in children.

Page 35

Finding 10

As Mr Whiteman gifted the money to Princess Margaret Hospital, it was inappropriate for Princess Margaret Hospital to transfer the funds to PMH Foundation, which was a separate legal entity outside the control of Princess Margaret Hospital.

Page 40

Finding 11

The Committee was extremely disturbed by the evidence that body parts such as spinal columns were removed during hospital autopsies conducted at two metropolitan teaching hospitals throughout the 1980s and early 1990s without obtaining the prior consent of the patient or the relatives of the deceased. The Committee is satisfied that this practice no longer occurs and that hospitals now adhere to a rigorous consent process.

Page 40

Finding 12

Although there is clear evidence that body parts such as spinal columns were removed during hospital autopsies at some metropolitan teaching hospitals from the early 1980s to the early 1990s, and that mortuary attendants were paid small sums of cash to remove them, there is no evidence that the funds came from hospital SPAs. Rather the funds came from federal research grants to the specialist involved, who deposited them into a university general purpose account for research.

Page 41

Finding 13

Most of the problems with hospital trust and Special Purpose Accounts relate to fundamental control weaknesses in their administration and management. These problems were both endemic and systematic over a number of years at the metropolitan teaching hospitals in WA.

In addition, there was a complete lack of proper documentation in relation to patient records, doctors' employment arrangements with the hospitals, revenue and expenditure from the accounts.

Page 42

Finding 14

The Committee considers that some expenditure from Special Purpose Accounts verged on misuse and personal gain, particularly in the areas of travel and entertainment. It is arguable whether the attendance by doctors at overseas conferences and entertaining visiting specialists at expensive restaurants constitutes legitimate use of hospital funds.

Page 43

Finding 15

In the case of the separate bank account registered to the home address of a clinician holding moneys purportedly for the benefit of the hospital, the Committee finds this to be a completely unacceptable practice.

Page 46

Finding 16

The lack of adequate controls over hospital trust and Special Purpose Accounts was so great that it was not possible to detect any misuse even if it had occurred. The absence of systematic control both facilitates abuse and makes it impossible to substantiate allegations of misuse.

It also allows innuendo to develop, which reflects adversely on the integrity of doctors generally, the majority of whom work very hard for the benefit of the public health system.

Page 46

Finding 17

A fundamental cause of the problems with Special Purpose Accounts relates to a widespread culture that developed over a considerable period of time whereby doctors had a sense of “ownership” of the funds and accounts. This is because they often raised the funds themselves through research grants and other activities, and therefore expected to have control over the administration, management and expenditure of those funds.

Page 46

Finding 18

Doctors had effective control over trust accounts and SPAs for many years, even though they were not ultimately accountable for the funds. They were afforded too much discretion in relation to expenditure from these accounts, and their dual status of trustee and potential beneficiary created a conflict of interest.

Page 47

Finding 19

The failure of hospital finance and administration to improve such lax control processes, and tolerating “trustee” doctors having unfettered latitude in the management of accounts and in determining the appropriateness of expenditures, demonstrates major shortcomings in hospital and Departmental management. In the absence of being cautioned or advised that more stringent procedures were to be followed, one can assume that doctors thought they were acting appropriately.

Page 47

Finding 20

Both the Metropolitan Health Services Board and the Department of Health were ultimately responsible for allowing poor practices to develop and continue unchallenged for a number of years. Although the practice of doctors administering Special Purpose Accounts was never expressly authorised by these accountable authorities, their indulgence of the practice and the prevailing culture of ownership amounted to tacit authority.

It demonstrates grossly inadequate supervision and accountability on their part. It also demonstrates the absence of a coherent policy and administrative framework and the fact that the governance structure and processes in place for the public health sector were unclear and inappropriate.

Page 53

Finding 21

The Committee supports the Auditor General's finding that the appropriateness of payments from unofficial bank accounts requires full investigation by the hospitals, particularly in light of the uncertainty and lack of adequate internal controls surrounding the use, administration and management of Special Purpose Account transactions.

The Committee is disappointed that the Auditor General did not conduct this investigation himself as part of his audit, or at least say why he chose not to conduct the investigation as part of the audit.

Page 53

Finding 22

The Auditor General's report, states that he could not be certain that all unofficial bank accounts had been identified. The Committee believes that this uncertainty should have been resolved by the Auditor General.

Page 54

Finding 23

The administration of Special Purpose Accounts was so poor that the Auditor General could not provide “reasonable assurance” that all hospital moneys due and received were deposited into either hospital operating accounts or Special Purpose Accounts. This represents a serious inadequacy on the part of hospitals and the Department of Health, as it is impossible to determine whether fraud occurred.

Page 54

Finding 24

There was a lack of guidelines for the proper identification and classification of Special Purpose Accounts.

Page 62

Finding 25

The Committee finds that there have been some improvements by the hospitals and the Department of Health. However, there remains a lack of coordination and consistency across the hospitals, especially in the areas of monitoring, reporting and approval processes.

Page 74

Finding 26

Unlike the privatised clinics operating in other states, the privatised clinics operating at King Edward Memorial Hospital / Princess Margaret Hospital did not operate at “arms length”. There was no clear separation between the employment of the doctors and their role in operating the privatised clinics, and no controls to ensure patient referrals were not being manipulated.

Page 75

Finding 27

Six of the eight doctors identified in the Health Insurance Commission's report were full-time salaried doctors, and two were sessional doctors.

As salaried doctors do not maintain timesheets, the doctors and the hospital are not able to establish the duration of the doctors' time spent on public versus private patients, or to demonstrate whether the time spent on private patients interfered with the doctors' normal duties of attending to public patients and performing public hospital duties.

Page 75

Finding 28

Due to the lack of doctors' attendance records and rosters, and patient treatment information to establish public versus private patient status, and the lack of clearly defined private practice arrangements, together with the unavailability of Health Insurance Commission records, the Committee is unable to clearly establish whether the doctors were "double-dipping" by receiving remuneration from the hospital and a Medicare cheque for performing the same service.

Page 75

Finding 29

Based on the amount of Medicare funds deposited into the relevant Special Purpose Accounts, it is clear that King Edward Memorial Hospital / Princess Margaret Hospital failed to claim all facility fees payable by the doctors for the use of hospital premises and facilities to conduct privatised clinics.

Page 75

Finding 30

The majority of the salary of one salaried doctor was funded from a Special Purpose Account, into which he deposited (donated) funds received from bulk-billing Medicare.

The doctor in question bulk-billed Medicare for an average of seven patients per day, totalling \$859 per day, during the period from 1 July 1998 to 30 October 2000.

Page 76

Finding 31

Lack of documentation made it impossible for the Committee to verify whether some sessional doctors actually worked the required fortnightly sessions. The documentation was either not available or was not adequately controlled.

Page 76

Finding 32

One of the two sessional doctors identified in the Health Insurance Commission's report was required to work 2.5 sessions per week at a privatised clinic operating at King Edward Memorial Hospital / Princess Margaret Hospital. However, the Committee's investigation indicates that only six sessional payments were paid from the relevant Special Purpose Account from 1 July 1998 to 30 October 2000.

Page 76

Finding 33

Seventeen payments totalling approximately \$30,000 for secretarial services were made from a Special Purpose Account to the wife of a doctor who controlled the account. The payments were inappropriate as:

- The appointment of the doctor's wife represents a potential conflict of interest;
- It is not clear who authorised the engagement of the doctor's wife, and there is no evidence to establish whether the appointment was based on open and competitive process as required by government supply policies;
- The basis of payment for 18 hours per week at \$16 per hour is not clear;
- As the payments were made without the provision of timesheets, the hospital did not ensure that payment was based on actual hours worked; and
- In many instances, payments were made in advance of services being performed, and therefore, should not have been authorised.

Page 76

Finding 34

The same sessional doctor invoiced the hospital for the use of his private clinic rooms to see the hospital's "private" patients.

Page 77

Finding 35

Approximately five percent of funds from the relevant Special Purpose Accounts were used for doctors to travel to interstate and overseas conferences, and intrastate travel to regional clinics. However, there is no evidence that this had been approved by the hospital Chief Executive Officer as required by hospital and Departmental policy.

Page 77

Finding 36

Some of the funds from the relevant Special Purpose Accounts were spent on doctors' medical journal subscriptions, conference registrations, professional association memberships and indemnity insurance premiums.

In some cases, the doctor benefiting from the expenditure approved the transactions. In other cases, the transactions were approved by a nurse or educator, which does not represent appropriate or sufficient authorisation.

Page 77

Finding 37

Forty six percent of the relevant Special Purpose Accounts related to hospitality and entertainment expenditure for items such as staff functions, food for lunchtime meetings, Christmas parties and staff retreats. Some of the expenditure involved the provision of hospitality, such as movie tickets, to research participants.

Page 77

Finding 38

None of the hospitality and entertainment expenditure complied with the Department of Health's guidelines that require details of who was entertained to be recorded. Therefore, the Committee is not able to establish whether the doctors in question benefited directly or indirectly from entertainment expenditure.

Further, expenditure on departmental functions does not comply with government guidelines and raises the possibility of a Fringe Benefits Tax liability for the hospital.

Page 78

Finding 39

A number of transactions from the relevant Special Purpose Accounts did not comply with the purposes set out in the account statements, ninety two percent of which related to hospitality expenditure. There were insufficient details on the remaining eight percent to determine whether the expenditure complied with account statements.

This demonstrates that hospital internal control processes were not operating effectively to ensure that all payments had been checked for appropriateness.

Page 78

Finding 40

Over a third of the transactions were not supported by adequate documentation. Many of the payments lacked invoices or had insufficient detail on the invoices to establish whether a valid claim for payment existed.

These requests for payment should not have been accepted by hospital incurring and certifying officers.

Page 78

Finding 41

There has been an uncoordinated and fragmented approach to establishing privatised clinics and a failure by King Edward Memorial Hospital / Princess Margaret Hospital to adequately monitor the operation of these clinics by doctors.

This has exposed the doctors and the hospitals to allegations of “cost shifting” from the State to the Commonwealth, breaches of Medicare principles, tax avoidance, and fraud.

Page 83

Finding 42

Hospitals did not ensure that fundraising activities were appropriately authorised and licensed in accordance with legislative requirements.

Page 86

Finding 43

A lack of clear lines of responsibility and authority allowed unsatisfactory accounting and reporting processes to continue unchallenged. It is apparent that nobody assumed ultimate responsibility for the management of trust accounts and Special Purpose Accounts. This was caused in part by the entrenched organisational culture within individual hospitals that treated special purpose funds as the sole dominion of those who raised the funds.

Page 89

Finding 44

Provided that Special Purpose Accounts are managed appropriately and that the various recommendations of both the Auditor General and the Committee are implemented, they can still serve the beneficial functions intended by doctors and hospital management.

Greater transparency and accountability should provide doctors with confidence that they will not be exposed to criticism or risk unintentional wrongdoing.

Page 93

Finding 45

Mr Moodie's attempts to address the problems with hospital trust accounts, Special Purpose Accounts and other problems at King Edward Memorial Hospital / Princess Margaret Hospital were both legitimate and necessary. However, his actions were opposed by some clinicians and administrators, and were not supported by the Metropolitan Health Services Board.

Page 94

Finding 46

Mr Moodie's concerns and decision to initiate investigations into a number of serious allegations that had been brought to his attention, especially those relating to the bulk-billing of Medicare by doctors, were both legitimate and an entirely appropriate response by a hospital Chief Executive Officer.

Furthermore, the Health Insurance Commission's findings that the long-standing bulk-billing practices at Princess Margaret Hospital were inappropriate vindicate Mr Moodie's actions.

Page 97

Finding 47

The performance of the Metropolitan Health Service Board was inadequate for all parties concerned, especially Michael Moodie, who can feel justifiably aggrieved by his treatment from the MHSB.

Mr Moodie fulfilled his role as Chief Executive Officer of King Edward Memorial Hospital / Princess Margaret Hospital in the manner he saw fit, and at no time was advised to alter his style, which had been subject to so much speculation. According to Mr Moodie, the MHSB provided little reason for him to believe it was dissatisfied with his performance and, in fact, reassured him that he was doing a good job despite the campaign undertaken by the Clinical Staff Association.

Page 99

Finding 48

Michael Moodie's removal as Chief Executive Officer of King Edward Memorial Hospital / Princess Margaret Hospital was not justified and was handled poorly.

Page 102

Finding 49

The mismanagement and poor oversight of hospital trust accounts and Special Purpose Accounts by the individual hospitals and the Department of Health established an environment in which fraud and waste was difficult to detect.

Successive audits and investigations revealed extremely low standards of management and control, a serious lack of documentation and poor record keeping. Those policies and procedures that were in place were not applied.

Page 103

Finding 50

Oversight of Special Purpose Accounts by hospital management, the Metropolitan Health Services Board and the Department of Health was at best ineffectual, at worst, non-existent. The severe breakdown in effective governance structures and processes demonstrated an appalling lack of accountability.

Page 103

Finding 51

As the accountable authority, the Department of Health is required to take ultimate responsibility for the operation of the State's teaching hospitals. The Committee considers that the Department of Health abrogated this responsibility for many years in respect of trust accounts and Special Purpose Accounts.

RECOMMENDATIONS

Page 15

Recommendation 1

The Department of Health should have a clear policy regarding the identification and classification of special purpose funds and trust funds, and ensure that the policy is implemented in a consistent manner by each of the teaching hospitals in WA as soon as possible.

Page 15

Recommendation 2

There is a need for accurate and consistent terminology. Special Purpose Accounts should cease to be referred to as “trust” accounts by the Department of Health and public hospitals. Only those accounts that constitute true legal trusts should be referred to as “trust” accounts and accounted for appropriately.

Page 15

Recommendation 3

There should be full public disclosure of the nature and details of all true trust accounts operated by public hospitals, to be included in the hospitals’ annual reports.

Page 15

Recommendation 4

The Auditor General should include as part of his annual audits of the metropolitan teaching hospitals, an examination of whether funds have been appropriately identified and classified as being either special purpose funds or true trust funds.

Page 28

Recommendation 5

A report should be prepared by the Department of Treasury and Finance on the fringe benefits tax liabilities to the State on the operation of Special Purpose Accounts.

Page 28

Recommendation 6

A report on the taxation implications of the operation of Special Purpose Accounts should also be prepared by the Department of Treasury and Finance in relation to the arrangements that operated whereby Medicare funds were “donated” to SPAs and then used for the direct or indirect benefit of individual clinicians.

Page 33

Recommendation 7

The hospitals should continue to consolidate and rationalise Special Purpose Accounts.

Page 54

Recommendation 8

The Department of Health and the metropolitan teaching hospitals should implement the Auditor General’s recommendations in relation to Special Purpose Accounts immediately.

Page 54

Recommendation 9

As a matter of urgency, the Department of Health should fully investigate the 13 unofficial bank accounts identified by the Auditor General. The investigations should be conducted as full forensic audit investigations.

Page 54

Recommendation 10

As a matter of urgency, the Department of Health should conduct a full examination to confirm that there are no further unofficial bank accounts holding hospital funds.

Page 55

Recommendation 11

The Department of Health should ensure that its employment arrangements with doctors are clearly identified and that the terms of any private practice arrangements are fully set out in doctors' employment contracts, with appropriate accounting practices strictly enforced.

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Recommendation 12

The Committee recommends that the Department of Health ensure that all staff, including doctors, attached to the four metropolitan teaching hospitals, are formally notified in writing of the necessity to comply with established Special Purpose Accounts policy and procedure.

Page 62

Recommendation 13

The Department of Health must coordinate the reform initiatives of the hospitals in the area of trust and Special Purpose Accounts to ensure consistency.

Page 63

Recommendation 14

The Department of Health should implement a best-practice model and standards for the management of Special Purpose Accounts in all the State's public hospitals.

Page 63

Recommendation 15

The Department of Health should develop and implement a comprehensive training programme for relevant staff of the States' public hospitals in relation to the management of Special Purpose Accounts.

Page 63

Recommendation 16

The Auditor General should review the management of Special Purpose Accounts at the four metropolitan teaching hospitals within 2 years to examine the level of implementation and success of the reform initiatives to date.

Page 63

Recommendation 17

Public hospitals should identify the number, purpose and amounts held in trust and Special Purpose Accounts in their annual reports. The Department of Health should also report on the operation of Special Purpose Accounts as part of its reporting function to the Minister of Health.

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Recommendation 18

The process by which facility fees charged by hospitals for allowing doctors to conduct private practice clinics on hospital premises should be transparent and accountable.

Page 79

Recommendation 19

Salaried and sessional doctors be required to maintain timesheets.

Page 79

Recommendation 20

Private practice funds should be controlled and managed by the individual doctors privately, and should not be processed through hospital Special Purpose Accounts. Money owed to the hospital for exercising private practice rights should be invoiced and accounted for separately.

Page 79

Recommendation 21

The Department of Health and the State's public hospitals should establish clear and comprehensive policies and a transparent administrative framework for the provision of private services and the management of private patient billings, fees collection and revenue distribution.

Page 79

Recommendation 22

The Federal Police and the State's anti-corruption body should investigate the payments made by both the Health Insurance Commission and the State health system, and expenditure relating to the doctor referred to in Findings 32, 33 and 34.

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Recommendation 23

The Department of Health should develop guidelines in relation to fundraising activities in accordance with legislative requirements, and ensure that the guidelines are implemented and adhered to fully by all public hospitals.

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Recommendation 24

The Department of Health should ensure that hospitals comply with State legislation and government policies and guidelines relevant to Special Purpose Accounts. Compliance should be tested as part of the hospitals' annual reporting and auditing requirements.

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Recommendation 25

The Commissioner for Health should fulfil his accountability function by ensuring that there is a satisfactory level of coordination across the hospitals, and that policy and administrative frameworks are implemented consistently.

MINISTERIAL RESPONSE

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Public Accounts Committee directs that the Minister for Health, Hon. J. McGinty, MLA, and the Treasurer, Hon. E. Ripper, MLA, report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the Committee's recommendations contained in this report.

CHAPTER 1 INTRODUCTION

1.1 Background

Throughout the period from 1999 to 2001, a significant amount of media attention was focussed upon the troubled state of the public health system in WA. Particular concerns were raised in respect of management and clinical practices at King Edward Memorial Hospital for Women /Princess Margaret Hospital for Children, which led to a special investigation being commissioned by the current State Government. During the course of the investigation, it became apparent that KEMH/PMH maintained 204 hospital “trust” accounts worth approximately \$8.3 million, which were being managed outside the normal hospital financial administration system, and which did not appear to comply with the financial control processes required for public moneys. However, this sum does not account for the throughput of funds in these accounts, which was significantly greater than \$8.3 million.

In September 1999, Mr Michael Moodie, the then Chief Executive Officer of KEMH/PMH, became increasingly concerned about the management of hospital “trust” accounts and engaged the hospitals’ auditors, Ernst & Young, to conduct an internal audit of the hospitals’ general financial control environment. Due to the paucity of documentation regarding large surplus amounts of money allocated to account balances in both 1998 and 1999, Ernst & Young advised that:

The trust account reconciliation issue is of concern and the processes over the controlling and management of trust accounts should be reviewed.¹

Acting upon Ernst & Young’s recommendation, Mr Moodie requested that they conduct a second internal audit, specifically in relation to the administrative and accounting control environment of the hospitals’ “trust” accounts. The preliminary findings of Ernst & Young were extremely alarming. They reported in December 1999, *inter alia*, that:

- Some expenditure transactions could be classified as “inappropriate”;
- There was inadequate information to effectively manage trust accounts;
- Investment policy had not been adhered to;
- There was a lack of current practical investment policy and framework;
- Reconciliation processes were inadequate; and

¹ Ernst & Young, *Detailed Financial Records Audit*, September 1999, p.6.

- The audit trails for receipt documentation were impractical.²

Michael Moodie then requested a further internal audit on the hospitals' "trust" accounts. In June 2000, Ernst & Young provided two more reports expanding upon their initial concerns. They found that:

- The emotive issue of ownership of the funds appeared to be legally clear, but in practice the account holders viewed the funds as their personal accounts;
- Governance processes over the accounts needed to be implemented;
- Revenue from alleged bulk-billing of public patients was being used to fund some accounts;
- Trustees had diverted revenue that should have been recorded as hospital revenue to "their" trust accounts;
- Hospital administration was accountable for funds over which they had no effective control;
- Trust funds were being spent at the discretion of the trustees;
- Trust accounts may have been used for activities that could be construed as tax evasion;
- Trustees had benefited personally from trust fund expenditure;
- Hospital financial statements did not adequately reflect trust account transactions; and
- Trust fund administration was inadequate.³

In conclusion, Ernst & Young recommended that certain accounts be investigated in a manner consistent with that of a fraud investigation, and that:

*...management freeze trust accounts identified as containing suspicious transactions.*⁴

Appendix 3 of Ernst & Young's report Part II raised serious concerns about doctors bulk-billing Medicare for the treatment of public patients and depositing the HIC funds into "trust" accounts for which they were also the trustees. They were therefore

² Ernst & Young, "Trust" Funds Audit, December 1999, p.8.

³ Ernst & Young, Trust Funds Analysis - Parts I and II (draft), June 2000, p.4 (Part I) and p.3 (Part II).

⁴ *Ibid* (Part I), p.4.

requested to conduct yet another preliminary investigation into this specific matter. The second report remained a draft report only and was never issued as a final report.

Ernst & Young's final report, issued in November 2000, was somewhat more circumspect in its findings and recommendations than the previous draft. It concluded that of the 260 "trust" accounts at KEMH/PMH, 14 required further investigation, 11 of which related to the bulk-billing issue.

Given the grave findings in relation to KEMH/PMH, it is not surprising that Mr Moodie raised the alarm about hospital trust accounts and decided to pursue the matter further. He reported the findings to the Metropolitan Health Services Board's Audit Committee, which subsequently became involved and consulted with Ernst & Young in relation to their draft final report. It has been alleged that the MHSB's Audit Committee argued for all copies of the Ernst & Young reports to be destroyed because of the serious concerns they raised.⁵

Concerns were also raised about Ernst & Young's methodologies, claiming they were deficient as the auditors were prevented from talking to the doctors to clarify issues, and that they drew conclusions based on unsubstantiated findings.⁶ The PMH Clinical Staff Association also said that staff at KEMH/PMH were largely unaware of any suggestions of illegality or impropriety until media coverage in September 2000, and did not have access to the internal audit reports until much later.⁷

Finally, the then Commissioner of Health engaged Ernst & Young to conduct a Business Process Review of "trust" accounts at the other metropolitan public teaching hospitals in WA, namely, Sir Charles Gairdner Hospital, Royal Perth Hospital and Fremantle Hospital, as well as a follow-up at KEMH/PMH. Ernst and Young claimed that the Business Process Review was conducted under difficult circumstances due to the poor attitude toward the review and poor level of cooperation from management at some of the hospitals.⁸

In their report issued in October 2001, Ernst & Young made the following findings of deficiency in governance, administrative, accounting and management practices at the hospitals.⁹

⁵ Mr M. Moodie, Transcript of Evidence, 07/11/01, p.13 and p.18.

⁶ Mr A. Weeks, Transcript of Evidence, 21/12/01, p.9-10.

⁷ CSA Submission, 10/12/01, p.3.

⁸ Correspondence from Ernst & Young to Bryant Stokes, then Commissioner of Health, dated 25/09/01.

⁹ Ernst & Young, *Summary of the Business Process Review of Trust and Special Purpose Accounts*, October 2001.

Governance and Administration

- The governance structures in place within the MHS and the hospitals are not adequate to provide the level of accountability and transparency required for effective corporate governance;
- There is no consistency of governance and oversight for “Trust Accounts” at the various hospitals and the accountable authority. The lack of hospital boards, an MHS board and historical “fuzziness” over these funds makes it unclear as to whether or not there is any body managing the governance functions appropriately;
- Management structures within the hospital do not adequately manage the activities of the individual accounts with sufficient integrated governance and oversight;
- The accounts’ activities are not managed against budgets, activity reports and other regulations as required by other moneys for which the accountable authority is responsible;
- Account holders are generally not questioned on the activities of the accounts;
- Structuring of the Trust Accounts is inconsistent between the hospitals and overly complex in some areas;
- Outside of the hospital operating accounts (Fund 1), the blended Trust Accounts were disclosed in anything from one to four Funds;
- Categorising of funds is done differently in each hospital;
- The FAAA has not been complied with in that it does not accommodate the existence of the majority of these accounts outside of the operating (Fund 1) accounts;
- Defining documents for “Trust Accounts” do not constitute legal trust documentation and are in reality simply account maintenance forms;
- Defining documents are not maintained in a manner that permits the effective administration of the accounts;
- Most of the accounts that should be / are true trusts lack adequate founding statement documentation;
- Existence and need for accounts that should be accommodated as part of the hospitals’ operating budget;
- The vast majority of “Trust Accounts” are not true ‘trusts’; and

- Debit (overdrawn) balances exist in the accounts. This is contrary to policy that prohibits this from occurring and is more than mere timing differences. Some debit balances are over a year old with no action plan on how to make up the shortfall. No interest is charged on debit balances.

Revenue

- Lack of receipting evidence, poor audit trail and ineffective receipting methods;
- No receipt specific for tax donations is issued;
- No “acceptance of conditions” process exists to protect the hospitals from inappropriate contractual liabilities arising;
- Revenue that should accrue to the hospital operating fund is going to “Trust Accounts”;
- Donations from doctors and subsequent accounting and management processes could give rise to tax evasion risks;
- Revenue from Medicare is receipted to the accounts. This occurs as actual Medicare revenues to the hospital and other times relating to doctors depositing their Medicare cheques into Trust Accounts;
- Revenue from pharmaceutical companies/suppliers is received which the Ethics Committee could not directly link to a particular review; and
- The AMA Agreement clause on private practice revenues was not applied in a consistent manner within and across hospitals.

Expenditure

- Expenditure is not consistent with the stated purpose of the “Trust Account” document;
- Policy, procedure and regulations are not consistently adhered to (e.g. FAAA, tendering practices and good governance practices);
- Lack of supporting documentation for expenditure;
- Authorisation processes not consistently evidenced (eg. FAAA, tendering practices and good governance);
- Expenditure that may be considered extravagant was found in some cases;

- Expenditure, effectively transferring funds out of the accounts to other organizations, was found; and
- Expenditure was made in advance and claimed on a refund basis effectively bypassing all controls.

Journal Entries

- Large journals caused by accounting system inadequacies. Issues include the need for opening journals at the start of each new financial year to “recreate” balance sheet account detail;
- High number of transfers between funds. The clouding of “special purposes” and the “portfolio of accounts” were the cause of many journals. Neither system was standard across the hospitals; and
- Transfers of trust accounts between hospitals were found. It is difficult to determine whether the funds followed the clinician or whether the hospital had a contractual requirement to pay the other hospital for the work being done. This is an indicator that funds were in fact not considered by hospital management to be the hospitals’ funds.

Other

- Interest apportionment policy is not consistent within or between the hospitals;
- The administrative files for the “Trust Accounts” contain duplicate, outdated information as well as being deficient in some areas;
- There needs to be closure of old accounts that have completed their ‘purpose’;
- Capital Projects are managed through the “Trust Accounts” at some hospitals resulting in large transfers between the operating accounts and the “Trust Accounts”; and
- There is no analysis and reporting of both benefit and cost relating to the research and training activities funded through the “Trust Accounts”.

Evidence to the Committee suggested that Dr Bryant Stokes, the then Commissioner of Health, persuaded Ernst & Young to amend a couple of crucial words in the draft final report.¹⁰

The final report was certainly a much watered-down and sanitised version of the previous draft. References to “fraud”, “theft” and “potential tax evasion” in the draft

¹⁰ Mr J. Copp and Mr T. Larkan, Transcript of Evidence, 18/02/02, pp.30-32.

report were ultimately changed to “questionable use of funds and hospital assets” and “questionable events and transactions”.¹¹

Rarely a day passed in 2000 and 2001 without media coverage on the issue of hospital trust accounts, detailing allegations of tax evasion, fraud, money laundering and personal gain by doctors. Ernst & Young’s internal audit reports in respect of KEMH/PMH were leaked to the media, providing seemingly scandalous “evidence”, the veracity of which had not yet been tested or substantiated.

At KEMH/PMH, hostility escalated between Michael Moodie and the hospitals’ clinicians. Michael Moodie was perceived by clinicians and the AMA as a trouble-making bureaucrat, unsupportive of doctors and fabricating scandal to their personal detriment and to the detriment of the public health system generally. Both the AMA and the CSA submissions to the Committee claimed that unlike previous CEOs, Michael Moodie did not represent the interests of clinicians, and thus the hospitals’ public image.

The CSA claimed that the allegations relating to trust accounts did untold damage to public confidence in KEMH/PMH, evidenced by abusive telephone calls and a reduction in donations to the hospitals from individuals and organisations.¹² The AMA claimed that the allegations damaged the goodwill and commitment of medical practitioners in the public health system, who have sacrificed personal financial gain in order to work in public hospitals, and that the allegations have had a severe impact on morale in public hospitals.

Whilst the AMA and CSA acknowledged that there were administrative deficiencies with hospital “trust” accounts, and that the system needed improving,¹³ they felt that doctors have been victims of a witch-hunt. Their perception that Michael Moodie was instrumental in a campaign against them led them to conduct a campaign to have him removed as CEO, which eventually occurred in September 2001.

Evidence was also provided to the Committee that actions of the former Premier, Richard Court, and the then Minister for Health, John Day, contributed to this outcome. The issues related to Michael Moodie are discussed in more detail in Chapter 8 of the report.

¹¹ Correspondence from JW Copp, Ernst & Young, to Prof. B Stokes, then Acting Commissioner of Health, dated 25/10/01.

¹² CSA Submission, 10/12/01, pp.6 and 9.

¹³ For example, Mr Boyatzis, Chairman of the AMA (WA) admitted of hospital trust accounts that “[a]dministratively they are a nightmare and everyone recognises that”, Transcript of Evidence, 03/12/01, p.25.

1.2 Basis for and Scope of Inquiry

The Committee was approached in late 2001 by a member of the public about the allegations of fraud and misuse of trust funds in WA's public hospitals. Due to the serious nature and implications of the allegations in respect of public moneys, the Committee resolved on 5 November 2001 to conduct an inquiry.

The Committee has not approached the inquiry as a witch-hunt of doctors. On the contrary, as was stated during the course of an initial public hearing:

*We want to make sure that processes are in place to protect doctors and the system. They are not at the moment; the system is in a shambles. That is bad not only for doctors, but also for the hospital and the health system.*¹⁴

The previous Minister for Health, Hon. Bob Kucera, MLA, echoed a similar view in Parliament on 16 October 2001:

*[A]s a Government we are absolutely committed to ensuring that there can be and will be no abuse of this system. I am also confident, having spoken to the doctors, that the vast majority of doctors want the trust system to be improved so that they will be protected and public money will be protected.*¹⁵

It is understandable that many doctors have felt unfairly targeted during the course of the investigations involving "trust" accounts over recent years, and seek to be vindicated from suspicion. In conducting the inquiry, the Committee has sought to clarify past practices and assist in the process of ensuring that doctors and the public generally are protected from similar problems in the future. In this endeavour, one of the doctors who gave evidence to the Committee acknowledged that the Committee was actually doing them a favour.¹⁶

After the Committee commenced its inquiry, the Auditor General for WA also decided to conduct an investigation into hospital accounts. The Auditor General embarked on an extensive audit of accounts at the four metropolitan teaching hospitals, and tabled his report in the Legislative Assembly on 7 November 2002.

The Office of the Auditor General conducted its investigation based to a large extent on the terms of reference of the Committee's inquiry. Its audit, however, was restricted primarily to transactions in 2001. The OAG expended significant resources on its audit, comprising over six months of intensive fieldwork by a large team of senior audit staff. However, the Committee also considers it necessary to report on the

¹⁴ Chairman, Mr J. D'Orazio, MLA, Transcript of Evidence, 03/12/01, p.20.

¹⁵ Hansard, 16/10/01, p.4333/2.

¹⁶ Dr A. Duncan, Transcript of Evidence, 03/12/01, p.30.

period prior to 2001, when the problems with hospital “trust” accounts were at their worst, as well as since 2001, when some improvements occurred.

The Committee’s inquiry has been the impetus or catalyst for a number of reform initiatives. As a result of the Committee initiating the inquiry, the metropolitan public teaching hospitals have reviewed their policies and implemented some useful changes, increasing the transparency of their structures and processes.

Most significantly, the Department of Health has also become more pro-active in relation to hospital accounts, assuming a greater degree of responsibility and oversight than occurred previously. The Committee welcomes this development, as one of the report’s key findings is the lack of governance, accountability and coordination demonstrated by the Department of Health throughout the 1990s in respect of hospital “trust” accounts.

The scope of the inquiry has also been affected by a concurrent investigation by the Health Insurance Commission into the practice of doctors bulk-billing Medicare for treating public in-patients as essentially private patients, and depositing the Medicare rebates into hospital “trust” accounts. The Committee was not able to obtain a copy of the HIC’s report until 13 August 2003, whereupon the Committee resolved to conduct further investigations into the issues raised in the HIC’s report. The Committee’s findings in respect of the Health Insurance Commission report are contained in Chapter 5.

Several specific allegations were referred to the Anti-Corruption Commission for investigation in October 2000. Unfortunately, the ACC chose not to investigate the matters, however, as the Auditor General announced that his Office would audit hospital accounts generally, and the HIC was conducting a separate investigation. In evidence to the Committee, Mr O’Connor QC, Chairman of the ACC, stated that the ACC did not have sufficient resources to investigate all matters referred to it.¹⁷

The Committee is disappointed that the ACC chose not to pursue the specific matters referred to it, notwithstanding other concurrent investigations, as these were of a general nature only and did not relate to specific allegations of misuse. As a result of the ACC’s failure to fulfil its obligations adequately, the Committee resolved to pursue several matters more thoroughly, thus creating further delay in finalising the inquiry.

¹⁷ Mr T. O’Connor, Transcript of Evidence, 02/04/03, p.2.

CHAPTER 2 NATURE AND PURPOSE OF TRUST ACCOUNTS

Most hospital accounts that have been generically termed “trust” accounts are not true trust accounts. They are actually Special Purpose Accounts. In fact, of the 1201 “trust” accounts held by the four metropolitan teaching hospitals in 2001, only 95 of these constituted true trust accounts, in that they held moneys belonging to third parties. The remaining 1106 accounts were technically SPAs, containing moneys belonging to the hospitals.

The misleading terminology of “trust” accounts has added significantly to the speculation and confusion about the entire issue of hospital accounts. Throughout the inquiry, evidence provided to the Committee has perpetuated the uncertainty. The terms “trust accounts” and “special purpose accounts” were used interchangeably by witnesses. In response to a query from the Committee, the Director General of the Department of Health stated that:

First, whenever we talk about trust accounts and SPAs we are pretty keen to clarify the distinction between them, but we also fall into the trap because of common usage. People talk about trust accounts alongside special purpose accounts and we recognise that it is a trap that we too occasionally fall into, although we are trying to avoid it with others.¹⁸

Finding 1

Most of the hospital accounts that have been generically termed “trust” accounts are not true trust accounts. They are actually Special Purpose Accounts. The misleading terminology of “trust” accounts has added significantly to the speculation and confusion about the entire issue of hospital accounts.

Finding 2

Hospital accounts holding moneys belonging to third parties constitute true trust accounts. Those accounts holding moneys belonging to the hospital, albeit for a specific purpose, constitute a Special Purpose Account. That is, they are cost centres for special projects or purposes within the hospital’s general ledger account.

SPAs differ from normal operating accounts. They are really cost centres for special projects within hospital general ledger accounts. SPAs, however, were being

¹⁸ Mr M. Daube, Transcript of Evidence, 13/11/02, p.6.

accounted for separately by the hospitals, and were not going through the normal operating statements. SPAs were used for non-operational purposes and were not integrated into the mainstream budgeting, monitoring and reporting systems.¹⁹ They were generally treated incorrectly by the hospitals as “non-operational” funds and recorded separately from operational funds in the hospitals’ accounting systems to keep the moneys apart. This has caused many of the problems found during the inquiry.

Finding 3

Special Purpose Accounts were generally treated incorrectly by hospitals as “non-operational” funds and recorded separately from operational funds in hospital accounting systems to keep the moneys apart.

As to the nature of SPAs and how they developed, the Auditor General reported that:

The establishment and use of these accounts have evolved over many years and have been commonly referred to as ‘trust accounts’. These accounts hold moneys from many different sources such as donations and bequests, grants for research purposes and fees and charges received from business activities. In many cases, the moneys received or placed in these accounts are subject to certain conditions or restrictions that allow the moneys to only be used for specific purposes. These restrictions are at two different levels:

- *Moneys with external restrictions on their use, such as bequests provided to fund specific medical research. In these cases, the management of the hospital has an obligation to only use these moneys for that particular purpose.*
- *Moneys internally allocated or restricted by the hospital for a specific purpose (ie internal restriction). In these cases, the hospital has discretion on the ultimate use of the moneys and the moneys could generally be used for any hospital purpose.*

While there may be restrictions on how these moneys can be used, the hospital controls the moneys as they are used to fund hospital activities. In view of the nature and purpose of these moneys, the terms special purpose accounts (SPAs), rather than trust accounts more accurately describes these accounts.

...The use of the term trust accounts has predominantly occurred as three of the hospitals consider that many of these accounts have been established

¹⁹

Auditor General, *op cit*, p.5.

under the authority of the FAAA.²⁰ This view has not been held by SCGH who has referred to them as special purpose accounts since the mid 1990s.

The situation has arisen as the FAA contains a number of provisions relating to private moneys which are moneys received or held for or on behalf of a third party. In the health sector, 'private moneys' has been misinterpreted to include moneys received from private sources.

[T]he hospitals used these FAAA provisions as a mechanism to set aside these moneys from operating funds. However, these provisions only apply to private moneys, or true trusts...

As most of these moneys are considered 'non-operational' funds by the hospitals, they are recorded in a separate section, or fund(s) within the hospital's accounting system from normal operating funds. This approach to using separate funds has been adopted to keep these moneys apart from operating expenditures and operating budgets of the hospitals. It also assists in identifying and controlling income and expenditure against the different funding sources and eliminating cross-subsidies between operating and special purpose funds.

At RPH and KEMH/PMH, most true trust moneys are accounted for in separate financial systems operated by these hospitals to further segregate 'true trust' accounts from the hospitals' accounting records...

Finding 4

The provisions of the *Financial Administration and Audit Act, 1985* were incorrectly used as the basis for establishing many Special Purpose Accounts, as the relevant sections of the FAAA only apply to private moneys.

As to why these accounts were established in the first place, the Committee understands that SPAs were originally established to circumvent the perceived constraints imposed by the former cash accounting system. They provided a mechanism whereby hospitals could divert consolidated revenue funding into a SPA, thus holding the funds for a specific purpose such as future equipment purchases, without accounting for them to the government.

The Auditor General provided documentary evidence to the Committee that he discussed the need for clear identification and classification of funds with the hospitals in the early 1990s, but they continued to use separate bank accounts, except SCGH

²⁰ Chapter 6 contains further information about the establishment of hospital trust accounts and SPAs and the application of the FAAA as set out in the Auditor General's report, *op cit*, p.59.

which amalgamated its SPA bank accounts with its operating bank account and referred to them as SPAs.²¹

The documentation, recording and reporting requirements for SPAs and true trusts differ. It is therefore crucial that they each be clearly identified and categorised. The Auditor General includes as an appendix to his report useful guidelines on the identification and classification of special purpose funds.²² The guidelines set out five categories of hospital funds:

- Moneys that are external to and independent of the hospital;
- Moneys held in trust (eg. patients' private money);
- Special purpose moneys with an external restriction (eg. donations and bequests with specific conditions);
- Special purpose moneys with an internal restriction (eg. funds raised from business activities); and
- Hospital operating funds.

Similar guidelines were developed in Victoria in 2001. Both sets of guidelines correctly classify funds as either a true trust or a special purpose fund depending upon the ultimate ownership of the benefit or money, and the degree of control and discretion that the hospital has over the ultimate disposal of the money or benefit.

*Control relates to the capacity of the hospital to benefit from the moneys in the pursuit of its objectives and to deny or regulate access of others to that benefit.*²³

The Committee acknowledges that distinguishing between whether funds constitute a true trust or simply a special purpose fund with conditions attached is often a complex legal issue, especially in the case of donations, grants and bequests. For this reason, guidelines such as those provided by the Auditor General and the Victorian model should be finalised by the Department of Health and implemented consistently by each of the hospitals as soon as possible.

²¹ Correspondence from DDR Pearson, Auditor General, dated 09/05/02.

²² See Appendix Four.

²³ Auditor General, *op cit*, p.62.

Recommendation 1

The Department of Health should have a clear policy regarding the identification and classification of special purpose funds and trust funds, and ensure that the policy is implemented in a consistent manner by each of the teaching hospitals in WA as soon as possible.

Recommendation 2

There is a need for accurate and consistent terminology. Special Purpose Accounts should cease to be referred to as “trust” accounts by the Department of Health and public hospitals. Only those accounts that constitute true legal trusts should be referred to as “trust” accounts and accounted for appropriately.

Recommendation 3

There should be full public disclosure of the nature and details of all true trust accounts operated by public hospitals, to be included in the hospitals’ annual reports.

Recommendation 4

The Auditor General should include as part of his annual audits of the metropolitan teaching hospitals, an examination of whether funds have been appropriately identified and classified as being either special purpose funds or true trust funds.

CHAPTER 3 SOURCES OF FUNDING

In 2001, approximately \$27.9 million was received into SPAs in addition to operational funds by the four metropolitan teaching hospitals.²⁴ These funds come from a variety of sources:

3.1 Donations

When members of the public donate money to public hospitals, the funds are generally deposited into SPAs rather than the hospital's general ledger account. Donations to hospitals are either of a general, unspecified nature, without conditions, or are given for a specific purpose, such as for cancer research or the purchase of particular equipment. Donations are also made to hospitals by suppliers of goods and services, such as pharmaceutical companies.

Many doctors employed by public teaching hospitals also "donated" money derived from private practice fees, research grants and other sources to the hospitals, which was deposited into SPAs that they usually controlled as the "trustee". The funds were then used for a variety of purposes, such as the purchase of medical equipment, engaging research staff, or to pay for conference expenses such as airfares and accommodation. This contentious issue is dealt with in more detail in the following chapter.

This latter practice has raised concerns of tax evasion, as doctors donated funds to the hospital, which were deposited into "trust" accounts, which they controlled and from which they received benefits such as conference travel, whilst also receiving a tax deduction for the amount of the donation. Tax evasion could result if the donated income was not declared in the doctor's individual tax return. There is also a potential fringe benefits tax problem with this arrangement. For this reason, the Committee was told by one witness that he preferred to use hospital SPAs instead of university accounts so as to avoid paying Fringe Benefits Tax.

3.2 Bequests

As with donations, bequests to hospitals take the form of either a gift without conditions, or the testator may specify the purpose for which the funds are to be spent. In this case, the hospital has both a legal and moral duty to comply fully with the instructions contained in the will.

²⁴ Auditor General, *op cit*, p.11.

3.3 Grants to Conduct Clinical and Drug Trials

It is common practice for pharmaceutical companies to fund hospitals and/or individual doctors to conduct clinical and drug trials, provided that such trials have been authorised by the hospital's ethics Committee. These funds were deposited into SPAs managed by the relevant doctors or departments.

3.4 Research Grants

Individual doctors at the major teaching hospitals often receive grants to conduct research in their areas of specialisation from a range of external organisations such as universities, pharmaceutical companies, the NHMRC, and other research funding bodies.

The fact that the grants are made to individual doctors raises complex questions about ownership and control of the funds. Doctors employed by public teaching hospitals apply for research grants, and if awarded a grant, enter into research contracts with the funding body. These contracts often stipulate how the funds can be spent, how expenditure must be accounted for, and who has daily control of the funds. In these circumstances, there is less likelihood of the funds being misappropriated or used for personal gain due to the additional safeguard of the funding body independently scrutinising the application and management of the funds.

Doctors in receipt of research grants may conduct research in their own time, albeit using hospital facilities and equipment. They have therefore historically developed a sense of ownership of the funds and the accounts. This category of funds is more akin to a true trust account than a SPA.

One witness gave evidence before the Committee that in the case of research grants, the funds were usually intended for the doctor in his/her individual capacity, not for the hospital generally, but that doctors frequently chose to deposit the funds into hospital accounts by way of a "donation". Public hospitals enjoy the taxation status of "charitable institutions", so doctors considered it beneficial to donate research grant funds into SPAs, in order to be exempt from paying tax on the funds and Fringe Benefits Tax, thereby increasing the funds available for research and related purposes.²⁵

3.5 Reward for Teaching

In the event that hospital staff receive payment for external teaching, lecturing, conducting workshops, presenting conference papers or writing medical reports, the accepted practice is for these funds to be deposited into SPAs and spent on goods and

²⁵ Name and position of witness withheld upon request.

services related to a particular department. As such, the funds are kept separate from the hospitals' normal operating accounts.

3.6 Revenue Raised from the Sale of Pharmaceuticals

Funds raised from the sales of pharmaceuticals are also deposited into SPAs, as above.

3.7 Revenue Raised from Production and Sale of Goods

Hospitals raise funds from operational activities such as the production and sale of booklets, videos and training courses, which are also managed through SPAs, as above.

3.8 Bank Interest

Some hospital accounts hold significant sums of money, and are contained within the hospital's bank accounts, earning interest that is credited to the individual accounts.

3.9 Money Held on Behalf of Third Parties

This category of funds held in hospital accounts constitutes true trust accounts as understood in a legal sense. They are moneys held by the hospitals on behalf of third parties, such as voluntary organisations attached to the hospitals, and patients' private funds. As such, the funds do not belong to the hospitals and cannot be used for hospital related activities. The hospitals have a legal obligation to hold the funds as trustee for the true beneficial owner of the funds.

This is an important difference from other so-called "trust" accounts, which are really SPAs that hold money belonging to the hospital, but which are required to be spent on specific purposes, as detailed above in relation to donations and bequests.

According to the Auditor General, only 95 of a total of 1,296 hospital accounts constituted true trusts in 2001.²⁶

3.10 Fees from Private Practice Clinics

A substantial number of SPAs have traditionally been used to hold doctors' fees from private practice clinics, a practice that should be discouraged.

The 1999 Workplace Agreement between the MHSB and the AMA allows certain senior doctors, such as consultants, to exercise rights of private practice whilst

²⁶ Auditor General, *op cit*, p.12.

employed at public hospitals. Clause 25 of the workplace agreement provides that up to 65% of these fees are to be deposited into an “approved trust fund for hospital/departmental purposes”.²⁷ Another percentage is paid as a fee to the hospitals to cover the use of hospital facilities whilst seeing private patients. The doctors retain the balance as supplementary income.

However, the extent of their private practice earnings is limited by the workplace agreement. Further, salaried doctors are only authorised to exercise rights of private practice on the basis that it does not interfere with their normal duties of 40 hours per week devoted to public hospital patients and activities.

Each public teaching hospital has operated this system somewhat differently. For example, RPH charges a facility fee of 16-17% of private practice earnings, and the balance is divided equally between the doctor and the clinical staff education “trust” account.²⁸

SCGH’s revised policy in relation to trust accounts requires true trusts to be established for the receipt and disbursement of private practice fees. The trusts are now to be managed by the hospital’s Private Practice Trust Account Management Committee according to explicit guidelines, including that “management of these funds must be at arm’s length from the recipients of the private practice income, or the beneficiaries of these accounts”.²⁹ It is stipulated in SCGH’s Research and Special Purposes Fund statement that that account receives any excess private practice fees from doctors employed on a full-time basis by the hospital.³⁰

Since 26 October 2001, KEMH/PMH has had a draft MOU with “Arrangement B” doctors, that is, those doctors who are allowed to render accounts directly to patients in the course of conducting a limited amount of private practice work whilst employed by the hospitals, which sets out a number of guidelines governing the arrangement.

Allegations have been made that this practice is tantamount to money laundering, but doctors and hospital management consider it an incentive to work in the public hospital system, in which doctors earn substantially less than their private colleagues. Doctors claim to “donate” their private practice funds to the hospitals by depositing them into the SPAs which they personally manage, and using the funds for such purposes as employing research staff, purchasing equipment, and travel to medical conferences in their areas of speciality.

²⁷ Metropolitan Health Service Board & AMA Medical Practitioners Collective Workplace Agreement, 1999.

²⁸ Dr P. Montgomery, Transcript of Evidence, 10/06/02, p.15.

²⁹ Sir Charles Gairdner Hospital, *Financial Administration and Governance of Hospital Special Purpose, Trust and Blend Accounts*, Hospital Policy No. 153, p.2.

³⁰ Sir Charles Gairdner Hospital, Trust Statement No. 3.

3.11 Bulk-Billing Medicare

(a) Background

Until recently, a substantial source of hospital SPA funds was derived from bulk-billing Medicare. This has been one of the most contentious issues in the inquiry and has received considerable media attention. Although the practice all but ceased pending the outcome of a detailed investigation by the HIC, it was rife throughout the 1990s in WA.

A number of public patients who presented at the public teaching hospitals were treated as private patients, with the relevant treating doctor billing Medicare and receiving direct rebates from the HIC. The doctors then “donated” the funds to hospital SPA accounts, which they often managed personally, and claimed to use the funds to supplement hospital services.

Finding 5

Throughout the 1990s a number of public patients who presented at the public teaching hospitals were treated as private patients, with the relevant treating doctor billing Medicare and receiving rebates from the Health Insurance Commission made payable directly to the doctor.

Due to the lack of proper documentation maintained by the hospitals, it is difficult to gauge the extent of this practice. Furthermore, it was not possible for the Committee to conclude whether this practice was ultimately for the benefit of the hospitals or the individual doctors. There is clear evidence that hospital administrators encouraged doctors to bulk-bill Medicare as a way of raising additional revenue for the hospitals. However this does not preclude the possibility that some doctors inappropriately derived personal benefit from the expenditure of these funds.

Therefore, according to Dr Geelhoed, Emergency Department at PMH and Chairman of the PMH Clinical Staff Association:

If Medicare fraud has occurred, it should be seen in the context of staff trying to support the hospital.³¹

From the Commonwealth’s perspective, the states had signed Medicare Agreements to the effect that in consideration for receiving federal health funding, they would

³¹ Dr G. Geelhoed, Transcript of Evidence, 03/12/01, p.17.

provide appropriate inpatient and outpatient services free of charge. The Commonwealth Department of Health & Aged Care stated in an Information Sheet in January 2001 that:

The manipulation of referrals with the intention of providing out-patient services to patients as private patients where they would otherwise have been treated free of charge as public patients, and shifting costs to the Commonwealth through charges against the MBS, represents a breach of the AHCA between the Commonwealth and the State.³²

Section 128C of the *Health Insurance Act, 1973* provides that a medical practitioner, or a person acting on behalf of a medical practitioner, must not charge a fee for the provision of a public hospital service, or receive any payment for the provision of a public hospital service if the medical practitioner or person acting on behalf of the practitioner knows that the patient is or intends to be a public patient in the hospital.

The only exception recognised by the HIC is where a patient is referred by a GP to a specific doctor with rights of private practice at a public hospital, in which case, he/she can charge for the service and Medicare benefits are payable provided that the doctor retains the patient in a fully private capacity. The work must be undertaken in their own time and at locations external to the hospital, unless the hospital charges the doctors commercial fees for rent and use of other hospital resources.³³ In other words, the private work must be conducted at arm's length from normal hospital activities.

By the mid-1990s, many doctors at KEMH/PMH were concerned about their potential liability and wrote to the hospitals' executive seeking clarification and assurance that they were not acting illegally and could not be held personally liable, even retrospectively. The AMA became involved in the issue due to the potential risk of doctors being prosecuted under the *Health Insurance Act*. In its submission to the Committee, the AMA states that it warned the State Government for years that the cost-shifting it imposed on doctors was a "recipe for disaster" and may be illegal.³⁴

PMH/KEMH management obtained legal advice from the CSO on three separate occasions from 1995-1997. The advice was that the practice was legal provided that the doctors raised Medicare cheques and then donated the money back to the hospital, so that they did not benefit personally, as even though their income was higher on paper, their take-home pay was the same.³⁵

³² Commonwealth Department of Health and Ageing, 1998-2003 Australian Health Care Agreements, *Information Sheet Number 2*, January 2001, p.2.

³³ Correspondence from Adrian Kelly, State Manager, HIC, to Dr W. Beresford, Acting Chief Executive, PMH, dated 28/12/01.

³⁴ AMA Submission, 10/12/01, p.3.

³⁵ Correspondence from Senior Assistant Crown Solicitor, CSO, to Director of Medical Services, KEMH/PMH, dated 03/02/97.

Dr JA Cumming, the then Medical Services Director of KEMH/PMH, wrote to the ATO in 1995 asking for advice about the taxation liability of doctors who bulk-bill and then donate the Medicare rebate to the hospital. The ATO's response was that the doctor would be assessed on their gross fees, but could then receive a deduction for allowable disbursements. However, the donation to the hospital "trust" account would not be considered as a gift, as it was actually a contractual obligation with the hospital.³⁶

The practice of bulk-billing Medicare was significantly curtailed in WA in 1997. Some doctors suspended or closed clinics due to their fear of engaging in illegal activities. KEMH/PMH retained two clinics after 1997, the Cleft Lip and Cleft Palate Clinic and the Diabetes Clinic. Subsequently, the HIC confirmed that registered doctors from the Cleft Lip and Cleft Palate Clinic could continue to bulk-bill. It reserved its decision, however, in relation to the Diabetes Clinic.³⁷

The PMH Sleep Unit and country diabetic clinics at KEMH/PMH used to be bulk-billing clinics, but ceased around November 2001. The Sleep Unit has been fully funded by the hospital since approximately May 2002 pending the outcome of the HIC investigation. In a draft letter to patients of the Sleep Unit, PMH management stated that:

Many services currently available in WA are unsupported by the state and exist only by virtue of cost-shifting arrangements. These arrangements have been authorised and encouraged by hospital administrators and implemented by doctors in good faith with the intention of improving the health of Western Australians.

In a similar letter to parents of children with diabetes attending PMH Diabetes Clinics in metropolitan and regional centres, Dr Timothy Jones, Head of the Diabetes and Endocrinology Department, stated:

Some of you will know that we bill Medicare when you attend a regional clinic or adolescent appointment. Therefore it is important that you be made aware that the Hospital has directed us to do this and also that the funds raised in this way are used to help run the Diabetes clinics. All the funds generated from this billing are donated to Princess Margaret Hospital (and held in Trust funds) and none go to the doctors who are doing the billing.

The diabetes team visits all parts of the State...These trips have been funded in the large part through the mechanism of doctors billing Medicare and then giving the money received back to the hospital so it can pay for the nurses and other staff as well as the travel costs associated with doing these clinics. This

³⁶ Correspondence from Deputy Commissioner of Taxation, ATO, to Dr J.A. Cumming, Director of Medical Services PMH, dated 17/08/95.

³⁷ Correspondence from Andrew Weeks, CEO, Metropolitan Health Service, to Dr W. Beresford, Acting Chief Executive, KEMH/PMH, dated 23/02/01.

*was set up because the State government has been unable or unwilling to pay for the service out of its own funds. I emphasise again, the doctors do not receive any of these funds and were instructed to do this by the Hospital and Health Department.*³⁸

The HIC decided to conduct a full investigation into the WA situation, especially in respect of KEMH/PMH, following Ernst & Young's final report in September 2000 that dealt exclusively with the issue of bulk-billing clinics at KEMH/PMH. The MHSB Audit Committee requested Ernst & Young to undertake further investigations to find documentary evidence to test the allegations after the issue was first raised in their report on "blended" trust accounts.

Ernst & Young were asked not to divulge the nature of the investigation to staff, especially those under investigation. They were also asked not to investigate those instances where Medicare funds were deposited into doctors' private accounts, recommending that these matters be referred directly to the ACC.³⁹ Dr William Beresford, then Acting Chief Executive of KEMH/PMH, was also required to sign a confidentiality agreement with the Commonwealth that he would not advise specific doctors that the HIC was investigating them.⁴⁰

(b) Health Insurance Commission Investigation into Allegations of Inappropriate Billing of Medicare by King Edward Memorial Hospital / Princess Margaret Hospital for Children⁴¹

Following two unsuccessful attempts to obtain the HIC's report from the Commonwealth, the Committee summonsed a copy of the report from the Director General of the State's Department of Health on 13 August 2003.

The HIC conducted a comprehensive investigation from November 2000 to approximately June 2002 into allegations concerning bulk-billing practices at KEMH/PMH. Investigators obtained a number of documents and interviewed 51 witnesses, including doctors, former hospital administrators and chief executives, the former Health Commissioner, Alan Bansemer, the AMA, and auditors. They also obtained details of patient elections and event histories for nominated patients.

The report identified eight doctors who were involved, and a total of 448 cheques made payable to these doctors during the period 1 July 1998 to 30 October 2000 were traced by the Reserve Bank of Australia. The HIC concluded that:

³⁸ Correspondence to Parents from Dr T.W. Jones, Head of Diabetes & Endocrinology Department, PMH, dated 31/10/01.

³⁹ Ernst & Young, Internal Audit Report (KEMH/PMH), *Investigation of revenues alleged to have been raised through the bulk billing of public patients*, 20 September 2000, p.3.

⁴⁰ Dr W. Beresford, Transcript of Evidence, 20/03/02, p.3.

⁴¹ February 2002.

*Overwhelmingly, the largest number of cheques were deposited into the hospital accounts,...into the KEMH/PMH Board of Management account or the PMH Number 2 account.*⁴²

The HIC's investigations revealed that most of the Medicare funds were donated by the doctors to hospital SPAs and ultimately controlled by the hospital. Some clinics even paid doctors their wages from SPAs, thus bypassing the Human Resources department. However, the report states that in "some very few cases", the funds went into the doctors' private accounts,⁴³ but that there was insufficient evidence to prove fraudulent intent by any of the doctors, due in part to the lack of documentation retained by the hospital.

The HIC originally sought reimbursement of approximately \$1.25 million from the Department of Health, which it claims was inappropriately claimed by the eight doctors at PMH between 1 July 1988 to 30 October 2000. The timeframe of the HIC investigation is curious given that the Committee was led to believe from several witnesses that the private clinics which led to the bulk-billing of Medicare all but ceased in WA by 1997.

In evidence to the Committee on 29 October 2003, Mike Daube, Director General of the Department of Health stated that the Department is disputing the findings of the HIC on legal grounds, and that the HIC subsequently agreed to reduce its claim for repayment by half, to \$627,462.

The Committee understands that the Department of Health and the HIC are still negotiating a "without prejudice" pragmatic settlement of the claim, without recourse to lengthy and expensive legal proceedings.

Although the HIC claims to have evidence that doctors at PMH were inappropriately bulk-billing Medicare since the early 1990s, the period for which reimbursement is sought is from 1 July 1998 to 30 October 2000, based on the current Australian Health Care Agreement between WA and the Commonwealth. The HIC claims to have evidence of a further \$568,437.15 claimed prior to 1 July 1998, but has not sought to recover this additional amount.⁴⁴

The Commonwealth has a right to recover money obtained in breach of the *Health Insurance Act, 1973*. Under the legislation, each doctor is potentially liable to pay a

⁴² *Ibid*, p.13.

⁴³ *Ibid*, p.31.

⁴⁴ *Ibid*, p.2.

maximum fine of \$5,500.00 for each offence.⁴⁵ The MHSB's potential liability is five times higher, that is, a maximum fine of \$27,500.00 for each offence.⁴⁶

However, the HIC has agreed to pursue the State for the money instead of the individual doctors at the request of Mike Daube, Director General of the Department of Health, who claimed that to seek reimbursement from the individual doctors would destabilise the hospital system.⁴⁷

The Committee considers that the Director General's offer on behalf of WA taxpayers to indemnify the doctors is tantamount to an admission of liability. It also tends to confirm evidence obtained by the HIC and outlined above, that doctors were encouraged by hospital administrators to bulk-bill Medicare as a way of raising additional revenue for the hospital.

When questioned about this at a public hearing on 29 October 2003, the Director General defended his position on the basis that as doctors acted at the behest of successive hospital administrators in conducting privatised clinics, and that the money was used to benefit the hospitals, it would be unfair to hold them liable personally.⁴⁸

He said that there was no evidence of wrongdoing by any individual doctor. However, he did acknowledge that if there was sufficient evidence that any doctor acted outside the scope of hospital or departmental policy and used the funds to their personal benefit, he would pursue the matter.

The Committee considers that it was premature for the Director General to agree to indemnify the individual doctors without first investigating and being satisfied that the doctors did not benefit personally from the funds obtained from bulk-billing Medicare, notwithstanding that this practice may have been encouraged by successive hospital administrators. The report addresses these issues in more detail in Chapter 5.

⁴⁵ Section 128C(2) *Health Insurance Act*, 1973 provides that each penalty attracts "50 penalty units". Section 4AA(!) *Crimes Act*, 1914 provides that a "penalty unit" is \$110.00.

⁴⁶ Section 4B(3) *Crimes Act*, 1914 deals with bodies corporate as opposed to natural persons.

⁴⁷ HIC report, *op cit*, pp.2-3.

⁴⁸ Mr M. Daube, Transcript of Evidence, 29/10/03, p.3.

Finding 6

The offer by the Director General of the Department of Health on behalf of WA taxpayers to indemnify the individual doctors named in the Health Insurance Commission report into inappropriate billing of Medicare is tantamount to an admission of liability.

It was premature for the Director General to agree to indemnify the individual doctors without first investigating and being satisfied that the doctors did not benefit personally from the funds obtained from bulk-billing Medicare, notwithstanding that this practice may have been encouraged by successive hospital administrators.

In addition to the recovery of funds, the HIC report recommended that:

- the doctors investigated receive awareness sessions in relation to the inappropriate claiming of Medicare benefits;
- a Medicare educational package be developed and delivered to relevant public hospital staff;
- a formal liaison group be established between the HIC and State health departments to discuss any concerns regarding cost-shifting arrangements; and
- the Commonwealth Department of Health and Ageing be advised of the outcome of the investigation so the ramifications of the matter can be considered in the current round of Health Care Agreements negotiations.⁴⁹

The HIC report also states that other parties interested in its findings include the WA Police and the ATO, which warned in 1985 that doctors may be liable to pay tax on income derived from Medicare. It is possible that doctors received an indirect personal gain from the practice, as they deposited the Medicare rebate into SPAs that they controlled, as a “donation”, thus claiming a tax deduction. It is arguable that they subsequently benefited from the same funds by using them for overseas travel and expenses. The Committee is uncertain whether the ATO intends to investigate this matter fully, but understands that the Department of Health has conducted a review of the potential taxation liability across the entire Department of Health.⁵⁰

⁴⁹ HIC report, *op cit*, p.37.

⁵⁰ Correspondence from P. Aylward, A/Group Director, Finance and Information, Department of Health, dated 25/09/03.

Finding 7

It is possible that some doctors received an indirect personal gain from the practice of bulk-billing Medicare, as they deposited the Medicare rebate into Special Purpose Accounts that they controlled, as a “donation”, thus claiming a tax deduction. It is arguable that they subsequently benefited from the same funds by using them for overseas travel and expenses, which may also attract a taxation liability for individual doctors and a fringe benefits taxation liability for the State.

Recommendation 5

A report should be prepared by the Department of Treasury and Finance on the fringe benefits tax liabilities to the State on the operation of Special Purpose Accounts.

Recommendation 6

A report on the taxation implications of the operation of Special Purpose Accounts should also be prepared by the Department of Treasury and Finance in relation to the arrangements that operated whereby Medicare funds were “donated” to SPAs and then used for the direct or indirect benefit of individual clinicians.

CHAPTER 4 **USE, ADMINISTRATION AND MANAGEMENT OF TRUST ACCOUNTS**

4.1 **Number of Special Purpose Accounts and Trust Accounts**

The lack of adequate and consistent policy frameworks at both departmental and individual hospital level over the years led to a proliferation of SPAs. Fortunately, the number of SPAs has gradually been reduced over the last two years as a result of this inquiry and the audit conducted by the Auditor General.

The following tables set out the total number of SPAs and true trust accounts at each of the four metropolitan teaching hospitals from 1999 to 2003.

In 1999, the number of SPA and trust accounts at each of the hospitals was.⁵¹

Table 4.1

SPAs and True Trust Accounts in 1999

Hospital	Special Purpose Accounts	Trust Accounts	Total
SCGH SPAs True trusts	328	2	328 2
RPH SPAs True Trusts	375	51	375 51
FHHS SPAs True Trusts	107	2	107 2
KEMH/PMH SPAs True Trusts	199	2	199 2
TOTAL	1009	57	1066

In 2000, the numbers were as follows:⁵²

⁵¹ Data provided by Department of Health on 27/02/03.

⁵² *Ibid.*

Table 4.2**SPAs and True Trust Accounts in 2000**

Hospital	Special Purpose Accounts	Trust Accounts	Total
SCGH SPAs True trusts	351	2	351 2
RPH SPAs True Trusts	366	51	366 51
FHHS SPAs True Trusts	106	2	106 2
KEMH/PMH SPAs True Trusts	177	2	177 2
TOTAL	1000	57	1057

As at June 2001, the number of SPAs and true trust accounts, and the financial throughput at each of the four metropolitan teaching hospitals was:⁵³

Table 4.3**SPA and True Trust Accounts in June 2001**

Hospital	No. of Accounts	Expenses \$M	Revenue \$M	Value of Accounts
SCGH SPAs True trusts	403 2	11.8 2.3	12.8 2.3	20.7m 2.4m
RPH SPAs True Trusts	329 71	6.6 9.7	8.2 9.8	21.1m 14.0m

⁵³

Ernst & Young, Letter to Prof. Bryant Stokes, then Acting Commissioner of Health, dated 25/09/01, p.4.

Hospital	No. of Accounts	Expenses \$M	Revenue \$M	Value of Accounts
FHHS				
SPAs	106	1.2	1.4	4.1m
True Trusts	16	0.2	0.3	0.2m
KEMH/PMH				
SPAs	155	5.1	5.1	7.2m
True Trusts	11	1.8	1.3	0.6m
TOTAL	1000	38.5	41.2	70.3m

However, according to the Auditor General, as at 31 December 2001, there was a total of 1,296 accounts at the hospitals, of which 1201 were SPAs and only 95 which were true trust accounts with a combined balance of \$51 million.⁵⁴

As at November 2002:⁵⁵

Table 4.4

SPAs and True Trust Accounts in November 2002

Hospital	Special Purpose Accounts	Trust Accounts	Total
SCGH			
SPAs	335		335
True trusts		2	2
RPH			
SPAs	351		351
True Trusts		64	64
FHHS			
SPAs	125		125
True Trusts		23	23
KEMH/PMH			
SPAs	140		140
True Trusts		10	10
TOTAL	951	99	1050

As at November 2003:⁵⁶

⁵⁴ Auditor General, *op cit*, p.6.

⁵⁵ Correspondence from Mr P. Aylward, Acting Group Director, Policy and Resources, Department of Health, dated 26/11/02.

Table 4.5**SPAs and True Trust Accounts as at November 2003**

Hospital	Special Purpose Accounts	Trust Accounts	Total
SCGH SPAs True trusts	353	2	353 2
RPH SPAs True Trusts	347	51	347 51
FHHS SPAs True Trusts	191	3	191 3
KEMH/PMH SPAs True Trusts	163	2	163 2
TOTAL	1054	57	1111

In evidence before the Committee on 29 October 2003, Mr Andrew Chuk, Deputy Director General, Corporate and Finance, Department of Health, explained that the increase in SPAs from the 2002 figures is due to the inclusion of SPAs held at several smaller hospitals such as Rockingham and Armadale.⁵⁷

Finding 8

The lack of adequate and consistent policy frameworks at both departmental and individual hospital level over the years led to a proliferation of Special Purpose Accounts. There is still a large number of Special Purpose Accounts being operated by the four metropolitan teaching hospitals.

The Committee is not in a position to determine the appropriate number of Special Purpose Accounts. However these accounts need to be properly controlled and managed.

⁵⁶ Correspondence from Mr Mike Daube, Director General, Department of Health, dated October 2003.

⁵⁷ Transcript of Evidence, 29/10/03, p.10.

Recommendation 7

The hospitals should continue to consolidate and rationalise Special Purpose Accounts.

4.2 Use of Special Purpose Accounts and Trust Accounts**(a) General**

Hospital SPAs and trust accounts have been used for a wide variety of purposes including:

- Purchase of medical and hospital plant and equipment;
- Purchase of furniture;
- Staff amenities;
- Professional development and training, including conference registration and accommodation expenses;
- Conference and educational travel;
- Subscription to professional medical journals;
- Annual membership fees for professional medical associations;
- Research materials;
- Employment of research and administrative assistants;
- Research projects;
- Outreach clinics;
- Laboratory administration; and
- Official entertainment expenses.

Detailed below are several other specific uses of SPAs and trust accounts that have attracted considerable controversy but were not dealt with by the Auditor General in his report.

(b) Megazone

Considerable hospital account funds were spent on the Megazone facility at PMH, which is unquestionably an excellent recreational facility for children, incorporating sophisticated design and state-of-the-art equipment. It comprises the Starlight Room, Radio Lollypop, Club Ado, a discharge lounge, Telethon Theatre, coffee shop, Sensory Room, large games area and an outdoor basketball court.

Whilst nobody could deny the benefits of such a facility to assist in the recovery and comfort of sick children, it has been the subject of a great deal of controversy due to its cost, the sources of funding, and the lack of accountable management of the project.

The Megazone facility cost a total of approximately \$2.5 million,⁵⁸ five times its original budgeted cost of \$500,000. It was the idea of Dr Gareth Goodier, a former CEO of PMH, to build a multi-purpose recreational facility for patients and their families on the basis that happy children get well faster.⁵⁹

Funding for the project was derived primarily from public donations that were held in hospital accounts, and financial support from the PMH Foundation. Dr William Beresford gave evidence to the Committee that no hospital money from either operational or non-operational sources was utilised, and that it was funded purely by donations.⁶⁰

In addition, the sum of \$300,000 from the estate of a Mr Lewis Cyril Whiteman, was put towards the project. This source of funding has attracted a great deal of criticism. Mr Whiteman specified in his will that his total bequest to PMH of \$2.25 million be applied for the research and treatment of cancer in children, under the direction of PMH's Board of Management, which was later replaced by the MHSB by the time Mr Whiteman died. Despite the conditions attached to the bequest, the MHSB resolved in August 2000 that the entire funds were to be managed by the PMH Foundation, on the strict condition that they be expended in accordance with the terms of the Mr Whiteman's will.⁶¹ As such, the funds were never deposited into KEMH/PMH's general bank account.

⁵⁸ The exact cost was \$2,485,478.27 million - Dr W. Beresford, Transcript of Evidence, 20/03/02, p.19.

⁵⁹ *PMH Megazone Evaluation, July 2001 - March 2002*, p.3.

⁶⁰ Dr W. Beresford, Submission, 20/03/02, p.2.

⁶¹ *Metropolitan Health Services Annual Report 2000/2001*, p.230.

Finding 9

It was inappropriate for the Whiteman estate funds to be utilised for the Megazone project at Princess Margaret Hospital, as Mr Whiteman specified a condition in his will that he wanted the funds to be applied for the research and treatment of cancer in children.

Finding 10

As Mr Whiteman gifted the money to Princess Margaret Hospital, it was inappropriate for Princess Margaret Hospital to transfer the funds to PMH Foundation, which was a separate legal entity outside the control of Princess Margaret Hospital.

Notwithstanding the conditions contained in the will, the executors of the Whiteman estate authorised \$300,000 to be put towards the Megazone facility. Dr David Baker, Director of the Haematology Oncology Department at PMH and one of the trustees of the estate, opposed this decision. Dr Baker wrote a letter to the PMH Foundation stating:

I wish to put on record my vehement opposition to any further allocation of Whiteman Estate Trust moneys toward the completion and/or maintenance of the Megazone.

*From the outset, I have stated that the Oncology patients use of the Megazone facility would be negligible to non-existent because of the risks of cross-infection in immuno-compromised hosts in open public hospital areas. On this basis, I was opposed to the initial allocation of \$300,000 and at no time have I verbally or in writing supported the use of this bequest in this fashion.*⁶²

A legal wrangle ensued over whether the funds should have been managed by PMH or PMH Inc. Both the MHSB and the PMH Foundation received conflicting legal advice. As a compromise solution, the funds were returned to PMH for accounting purposes, then entrusted again to the PMH Foundation to manage, with regular reporting to the MHSB. The distinction between PMH, PMH Inc. and the PMH Foundation is outlined below.

Prior to the completion of the Megazone facility, a number of clinical staff at PMH were highly critical of the project, saying that it was a waste of money which could be

⁶² Correspondence from Dr D. Baker to Mr R. Brine, Chairman of the PMH Foundation, dated 16/04/99.

better spent on research, equipment and treatment.⁶³ It seems now, however, that at least some of those staff have changed their minds and are now advocates of the facility. When the Committee met informally with staff as part of a site-visit to PMH on 26 June 2002, the general opinion of the staff present was that the facility is an important component in assisting children's recovery through having fun and relaxation time, facilitating outdoor play, social contact with peers, and a place for families to spend time together. Staff also remarked that the facility helps them to manage other areas and patients, as the children are now fully supervised in the Megazone area.

The Committee had received criticisms that the facility was a "white elephant" with low usage. When questioned about this by the Committee, staff admitted that not many children used the facility initially because of inadequate supervision by nursing and activity staff. They stated that the number of children who use the facility has increased substantially since the PMH Foundation commenced funding the appointment of appropriate staff.⁶⁴ According to Dr W. Beresford:

*On average some 400 people utilise it per week, this includes patients, siblings and their parents as well as staff.*⁶⁵

As stated previously, the Committee does not dispute the benefits of such a facility in the treatment of sick children. The merits of the Megazone are not in issue. The Committee is concerned, however, over the management of the funds held in SPAs.

Mr Andrew Weeks, the then CEO of the MHSB, held the view that the project proceeded without appropriate authorisations in internal control.⁶⁶ In response to criticisms raised, particularly by some outspoken doctors at PMH, Mr Michael Moodie initiated an internal audit review of Megazone, and KPMG in Canberra were requested to assist. The internal audit found other problems with the entire project, including:

- Non-compliance with state government tendering processes for the purchase of a \$40,000 piece of equipment;

⁶³ For example, in a letter from Dr P. King, Paediatric Surgeon at MPH to Gareth Goodier, dated 22/12/97, Dr King states that several nursing staff at PMH told him that they were all "...horried at the thought that the Hospital should want to spend so much money on what they felt was unnecessary entertainment." He also states that "[t]wo million dollars is a lot to be spent on a non essential item when wards are being closed, elective surgery is being cancelled and essential items like ultrasound machines cannot be purchased because of budget constraints.

⁶⁴ As at March 2002, 25% of visitors to Megazone were in-patients, 25% were parents, siblings, or other family members, and 50% were "others" - PMH Evaluation, *op cit*, p.3.

⁶⁵ Dr W. Beresford, Submission, 20/03/02, p.2.

⁶⁶ Memorandum from Mr A. Weeks to Hon. Ian McCall, Chairman, dated 28/06/99.

- Lack of a defined project manager, resulting in problems with direction, responsibility and accountability (the project was controlled by a steering group only); and
- Lack of formal approval by PMH's Board of Management for the project to go ahead in the first place.⁶⁷

The accounting for the project was conducted through the KEMH/PMH ledger, but the PMH Foundation employed its own accountant to perform the necessary control processes, effect payments and maintain the financial records.⁶⁸ The Committee understands that the PMH Foundation continues to fund Megazone by approximately \$137,000 per year.

(c) Princess Margaret Hospital Foundation

PMH Inc. became an incorporated body when the hospital became public in 1978. Prior to that, it was a private hospital for children. The incorporated body was created to hold funds that were not part of the hospital once it became public. In 1997, PMH handed over its fundraising activities to PMH Inc.

The PMH Foundation was established as a charity by Deed of Trust as a separate legal entity for tax reasons. PMH Inc. retains the role as trustee of the PMH Foundation. In other words, the PMH Foundation is a subsidiary of PMH Inc. The PMH Foundation has representatives from PMH Inc. and PMH's Board of Management. As a charity, the PMH Foundation forwards its independently audited accounts to the Minister for Consumer Protection for examination pursuant to section 20 of the *Charitable Collections Act, 1946*.

Some criticism was levelled at the PMH Foundation before and during this inquiry, partly due to the Whiteman funds going towards the Megazone project, but also due to allegations such as:

- It was investing substantial sums of money on the stockmarket;
- 74 % of its funds were spent on administration costs rather than on PMH itself; and
- The CEO, Mr Darryl Black, was on a very high salary package, driving a BMW, spending significant sums of money entertaining, and buying flowers for family members.

⁶⁷ Ernst & Young, Internal Audit Review of the Megazone Project, p.2.

⁶⁸ *Ibid*, p.4.

Many of these allegations were unsubstantiated, and made by former staff of the PMH Foundation. KPMG Consulting's report into the PMH Foundation in August 2000 concluded that:

*In our view, although Mr Black's actions were not in accordance with what would be considered as 'best practice', they do not, in our view, appear to be demonstrably dishonest and, accordingly, would not warrant suspension or more serious disciplinary action.*⁶⁹

The Committee does not intend to make any findings on these issues, as they are secondary to the issue of the management of hospital trust accounts and SPAs. The Committee understands, however, that Mr Black's contract as CEO was not renewed in July 2002.

(d) The Removal and Retention of Body Parts

Allegations that funds from hospital SPAs were being used to pay mortuary technicians at two public hospitals to remove body parts, namely spinal columns, at non-coronial hospital autopsies without the permission of relatives, prompted the Committee to conduct a preliminary investigation into the matter.

The Committee did not consider the issues of whether the removal of body parts complied with the *Human Tissue and Transplant Act, 1982* and other relevant legislation, or whether consent had been obtained from the relatives of the deceased to remove, retain and use the deceased's organs. The issue of consent was already the subject matter of a report by the Department of Health, and these issues fell outside the scope of the inquiry.⁷⁰

The Committee was extremely disturbed by the evidence that body parts such as spinal columns were removed during hospital autopsies conducted at two metropolitan teaching hospitals throughout the 1980s and early 1990s without obtaining the prior consent of the patient or the relatives of the deceased. The Committee is satisfied that this practice no longer occurs and that hospitals now adhere to a rigorous consent process.

The Committee held a number of closed hearings during September and October 2002 and obtained evidence from six witnesses. One witness alleged that during the period from 1987 to 1994, money from a hospital "trust" account was used to fund the removal, retention and use of spines following post-mortem examinations at two of the teaching hospitals. He alleged that money was paid to mortuary technicians on an *ex gratia* basis to remove the spines, and he undertook to provide the Committee with

⁶⁹ KPMG Consulting, *Internal Audit Review of Megazone Project: Princess Margaret Hospital for Children*, August 2000, p.7.

⁷⁰ Department of Health, *Final Report: Removal and Retention of Organs and Tissues following Post-mortem Examinations, a Report to the Minister of Health*, undated.

documentation to substantiate the allegations. The witness claimed that he had also provided copies of the relevant documentation to the ACC, which was conducting its own investigation into the matter.⁷¹ The witness did not, however, supply the Committee with any documentation, and the ACC advised the Committee that it had closed its investigation into the matter.

The Committee considered the available evidence and determined that there was no evidence to substantiate the allegations that funds from hospital accounts had been used to pay for the removal of spines. The evidence indicated that although the practice did occur:

- The money paid to mortuary attendants to remove spinal columns was from a university general purpose account held by the particular specialist requesting the spines, not a hospital account;⁷²
- The main source of funding for this practice was federal grants to support the specialist's medical research;⁷³ and
- During the period 1981 to 1992, a total of 15,863 hospital autopsies were conducted, of which 896 related to the specialist's area. Thus, over the 11-year period, there were approximately two autopsies per week. The total sum involved was \$8,742 or \$794 per year, which was divided among four technicians.⁷⁴

The specialist who authorised the removal of spinal columns acknowledged that:

- He authorised payments to the mortuary technicians, although he was not involved in the payment process;⁷⁵ and
- The technicians were paid from his university general purpose account for the additional workload and skill required to remove spines in a manner suitable for proper examination. The industrial award applicable to mortuary technicians did not acknowledge the extra skill required to remove spines.⁷⁶

In the absence of evidence to either substantiate the allegations or refute the explanation provided by the specialist, the Committee resolved to conclude the preliminary investigation.

⁷¹ Transcript of Evidence, Closed Hearing, 18/09/02, p.10.

⁷² Transcript of Evidence, Closed Hearing, 06/11/02, p.8.

⁷³ *Ibid*, p.9.

⁷⁴ *Ibid*, p.15.

⁷⁵ *Ibid*, p.8.

⁷⁶ *Ibid*, p.9.

Finding 11

The Committee was extremely disturbed by the evidence that body parts such as spinal columns were removed during hospital autopsies conducted at two metropolitan teaching hospitals throughout the 1980s and early 1990s without obtaining the prior consent of the patient or the relatives of the deceased. The Committee is satisfied that this practice no longer occurs and that hospitals now adhere to a rigorous consent process.

Finding 12

Although there is clear evidence that body parts such as spinal columns were removed during hospital autopsies at some metropolitan teaching hospitals from the early 1980s to the early 1990s, and that mortuary attendants were paid small sums of cash to remove them, there is no evidence that the funds came from hospital SPAs. Rather the funds came from federal research grants to the specialist involved, who deposited them into a university general purpose account for research.

4.3 Administration and Management of Trust Accounts

(a) Background

Most of the problems with hospital trust accounts and SPAs relate to control weaknesses in their administration and management. As outlined in Chapter 1, Ernst & Young reported a number of serious concerns about trust accounts at KEMH/PMH, culminating in an overview of trust accounts at the other three metropolitan teaching hospitals in WA which confirmed that the problems were endemic.

Many of these problems were apparently long-standing, as accounting firm Arthur Andersen produced a report in 1999 that rang warning bells in relation to KEMH/PMH. Unfortunately, the warnings remained unheeded for several years. It was not until Mr Michael Moodie, CEO of KEMH/PMH, requested internal audits from Ernst & Young in 1999, 2000 and 2001, and subsequently alerted the MHSB and the Department of Health that the problems became the subject of serious scrutiny.

Finding 13

Most of the problems with hospital trust and Special Purpose Accounts relate to fundamental control weaknesses in their administration and management. These problems were both endemic and systematic over a number of years at the metropolitan teaching hospitals in WA.

In addition, there was a complete lack of proper documentation in relation to patient records, doctors' employment arrangements with the hospitals, revenue and expenditure from the accounts.

Much of the Auditor General's report deals with the gross inadequacies in respect of the management and administration of hospital SPAs, but the primary focus of his audit was on the 2001 calendar year. It is important to outline the nature of problems prior to the audit period, however, as the situation had improved by 2001, albeit marginally.

In addition to the findings detailed in the Ernst & Young internal audit reports for KEMH/PMH summarised in Chapter 1, some of the earlier specific allegations relating to the administration and management of SPAs which suggested misuse and personal gain included:

- A doctor paying for his pilot license renewal from a "trust" account that he controlled;
- Refurbishment of executive office suites;
- A doctor paying his spouse a salary for secretarial services connected with his private practice and paying a fee to his private practice company for the use of his private rooms to conduct clinics;
- A cheque for \$60,000 donated by a Ladies' Auxiliary was misplaced and not cashed for several months;
- Expensive dinners, gifts and items such as leather chairs and a wig funded by "trust" accounts;
- Transfers of funds between accounts, between the universities and the hospitals, and between hospitals;
- Mobile telephones being purchased and telephone bills being paid;
- Some accounts were overdrawn;

- Hospital finance departments occasionally authorised withdrawals from the wrong account due to confusion caused by excessive numbers of “trust” accounts being operated;
- Doctors signing research contracts directly with third parties instead of through the hospitals, when their facilities were being used and not paid for;
- “Trust” accounts being established to buy equipment and then maintained after purchase for general purposes; and
- A separate bank account containing trust funds that was registered to the home address of the managing clinician.

These expenditures were first raised by Ernst & Young as cases of potential misuse, and reported by the media as such, but when fully investigated by the Auditor General, each was justified as appropriate in the circumstances. For instance, the Auditor General stated that the pilot’s license renewal was obtained in the doctor’s own time so that he could fly to remote Aboriginal communities to conduct clinics instead of paying for commercial flights. The wig was purchased for cancer patients who had undergone chemotherapy. The leather chairs were for the comfort of patients undergoing blood transfusions. The dinners and gifts were for thanking visiting doctors, and involved staff contributing some of their own money.

Some of these expenditures are a “grey area” in terms of whether they constitute misuse or personal gain. It could be argued, for instance, that paying for mobile telephones and calls from SPAs is tantamount to personal gain. Doctors claim, however, that they were necessary for them to be contacted easily and out of hours in relation to legitimate hospital business. Similarly, some of the entertainment expenditure could be considered extravagant, but it was arguably spent upon legitimate hospital purposes.

Finding 14

The Committee considers that some expenditure from Special Purpose Accounts verged on misuse and personal gain, particularly in the areas of travel and entertainment. It is arguable whether the attendance by doctors at overseas conferences and entertaining visiting specialists at expensive restaurants constitutes legitimate use of hospital funds.

Finding 15

In the case of the separate bank account registered to the home address of a clinician holding moneys purportedly for the benefit of the hospital, the Committee finds this to be a completely unacceptable practice.

Unfortunately, the Ernst & Young internal audits were not full-scale forensic investigations, and their auditors were unable to verify the appropriateness of expenditures directly with the individuals concerned. Therefore, what appeared to them at first instance to be “highly questionable”, could ultimately be explained satisfactorily. According to the Auditor General, the vast majority of allegations of impropriety were unfounded:

The vast bulk of those concerns are misplaced: no evidence of categoric improper use was found.⁷⁷

There is only one instance of which the Committee is aware that a doctor was found to have improperly withdrawn donated funds from the hospital accounts that the doctor controlled. In that particular case, the doctor was suspended by the hospital and subsequently had all clinical privileges revoked by the MHSB. The doctor involved issued proceedings in the Supreme Court to overturn the decision, but was unsuccessful on technical grounds. The Committee understands that legal action in this matter is ongoing, and for this reason, does not intend to deal with the case in this report.

The real problem lay with the poor quality of administration and management of hospital trust accounts and SPAs over a number of years. These problems were both endemic and systemic at all the metropolitan teaching hospitals in WA. The lack of strong controls over hospital trust accounts and SPAs was so great that it may not have been possible to detect any misuse even if it had occurred. The absence of systematic control both facilitates abuse and makes it difficult to substantiate allegations of misuse.

A contributing factor to the development of these problems may have been the ongoing workload in the public hospitals, such that hospital trust accounts and SPAs received inadequate priority.

Another fundamental cause of the problems relates to a widespread culture that had developed over a considerable period of time whereby doctors had a sense of “ownership” of the funds and accounts. This is because they had often raised the funds themselves, through research grants and other activities, and therefore expected

⁷⁷ Auditor General, *op cit*, p.5.

to have control over the administration, management and expenditure of those funds. This issue is considered in more detail below.

Notwithstanding that the Committee accepts that in most cases the funds were raised and expended for the benefit of patients and the hospitals, this was inappropriate and should not have been allowed to occur. Despite a lack of knowledge and expertise, doctors had effective control over SPAs for many years, even though they were not ultimately accountable for the funds. They were afforded too much discretion in relation to expenditure from these accounts, and their dual status of trustee and beneficiary created a conflict of interest.

Unfortunately, hospital management did not curb the practice, although they were responsible to ensure that hospital moneys were properly administered, managed and spent. Hospital finance officers tolerated poor accounting practices. For instance, they routinely authorised payments from accounts based on e-mails, memos, photocopied invoices and inadequate supporting documentation. They often forwarded unopened envelopes containing cash and cheques to doctors who were the “trustees” of SPAs, instead of complying with accepted accounting standards and FAAA requirements regarding incoming mail, banking, and the receipt of public moneys.⁷⁸

One doctor gave evidence in a closed hearing before the Committee⁷⁹ that, as the principal signatory and trustee of a number of “trust” accounts since the 1970s, he was able to prescribe the purpose of the accounts, and amend their purpose in order to widen the scope of allowable expenditure. In this way, the categories of allowable expenditure became understood as illustrative rather than comprehensive. The witness stated that amendments were regularly approved without question by hospital management.

When questioned by the Committee about whether the expenditure from the accounts was for legitimate hospital purposes, the witness explained that it had been accepted practice for many years for doctors to “donate” funds from a variety of external sources to hospital “trust” accounts, on the mutual understanding with hospital management that they would have control over the disposal of funds. Thus, expenditure on items such as dinners for visiting doctors, entertaining staff, business class airline tickets overseas, and subscriptions to medical journals may not benefit the hospital, but the doctor claims that the funds did not really belong to the hospital even though they deposited funds into hospital accounts by way of “donation”.

The beneficial ownership of the funds is arguable, but the witness also told the Committee that over a period of many years, hospital finance officers and executives knew what the funds were being spent on and made no adverse comment. The

⁷⁸ *Ibid*, p.24.

⁷⁹ Name and position of witness withheld upon request.

Committee understands and accepts that such liberal practices were being condoned by hospital management for so long that doctors assumed they were acting legitimately, notwithstanding the taxation implications.

The failure of hospital finance and administration to improve such lax control processes, tolerating trustee doctors having unfettered latitude in the management of accounts and in determining the appropriateness of expenditures, demonstrates major shortcomings in hospital and Departmental management. In the absence of being cautioned or advised that more stringent procedures were to be followed, one can assume that doctors thought they were acting appropriately.

The Committee suspects that this culture was condoned partly as a result of a misplaced fear of challenging doctors due to their perceived authority and status. Organisational cultures are inherited over time and internalised by staff. Ernst & Young echoed this view in 1999 when they reported that they had experienced hostility from clinicians at KEMH/PMH who:

...voiced their opposition to hospital management conducting reviews into trust accounts that they clearly perceived to be their personal domain.

The strength of the resistance to change in this area cannot be underestimated and management will need to have the fortitude to complete the changes required.⁸⁰

Both the MHSB and the Department of Health were ultimately responsible for allowing poor practices to develop and continue unchallenged for a number of years. Although the practice of doctors administering SPAs was never expressly authorised by these accountable authorities, their indulgence of the practice and the prevailing culture of ownership amounted to tacit authority. It demonstrates grossly inadequate supervision and accountability on their parts. It also demonstrates the absence of a coherent policy and administrative framework, and the fact that the governance structure and processes in place for the public health sector were unclear and inappropriate.

The previous Minister for Health, Hon. Bob Kucera abolished the MHSB in February 2001. Established in July 1997, the MHSB was originally intended to have a coordinating function for public hospitals, as opposed to the previous autonomous boards that managed them, but it failed to achieve its purpose.

After the MHSB was abolished the Minister conferred oversight authority in the Commissioner of Health as the accountable authority for the Minister for Health. The current Director General of the Department of Health is also the Commissioner of Health and recognises the need for significant culture change in this area but conceded

⁸⁰ Ernst & Young, Part 1 report, *op cit*, pp.11 & 18.

to the Committee that changing culture takes a long time.⁸¹ Notwithstanding this, the cultural change required should be an urgent priority for the Department.

Finding 16

The lack of adequate controls over hospital trust and Special Purpose Accounts was so great that it was not possible to detect any misuse even if it had occurred. The absence of systematic control both facilitates abuse and makes it impossible to substantiate allegations of misuse.

It also allows innuendo to develop, which reflects adversely on the integrity of doctors generally, the majority of whom work very hard for the benefit of the public health system.

Finding 17

A fundamental cause of the problems with Special Purpose Accounts relates to a widespread culture that developed over a considerable period of time whereby doctors had a sense of “ownership” of the funds and accounts. This is because they often raised the funds themselves through research grants and other activities, and therefore expected to have control over the administration, management and expenditure of those funds.

Finding 18

Doctors had effective control over trust accounts and SPAs for many years, even though they were not ultimately accountable for the funds. They were afforded too much discretion in relation to expenditure from these accounts, and their dual status of trustee and potential beneficiary created a conflict of interest.

⁸¹ Mr M. Daube, Transcript of Evidence, 13/11/02, p.13.

Finding 19

The failure of hospital finance and administration to improve such lax control processes, and tolerating “trustee” doctors having unfettered latitude in the management of accounts and in determining the appropriateness of expenditures, demonstrates major shortcomings in hospital and Departmental management. In the absence of being cautioned or advised that more stringent procedures were to be followed, one can assume that doctors thought they were acting appropriately.

Finding 20

Both the Metropolitan Health Services Board and the Department of Health were ultimately responsible for allowing poor practices to develop and continue unchallenged for a number of years. Although the practice of doctors administering Special Purpose Accounts was never expressly authorised by these accountable authorities, their indulgence of the practice and the prevailing culture of ownership amounted to tacit authority.

It demonstrates grossly inadequate supervision and accountability on their part. It also demonstrates the absence of a coherent policy and administrative framework and the fact that the governance structure and processes in place for the public health sector were unclear and inappropriate.

(b) Auditor General’s Findings

The Auditor General’s report found the following problems in respect of the administration and management of SPAs and trust accounts, many of which had previously been identified by Ernst & Young as early as 1999:

- Documentation detailing the purpose and restrictions of accounts was often incomplete or out of date which made it difficult for hospitals to demonstrate that moneys had been used in accordance with any restrictions;
- The hospitals have not always correctly classified or categorised these accounts to ensure all true trust moneys have been identified and moneys with differing types of restrictions have been separately recorded;

- General record keeping standards across the hospitals were inadequate with key documentation, such as legal agreements, often being filed on an ad hoc basis or, in some cases, not able to be located;⁸²
- The hospitals did not have adequate procedures in place to ensure that all moneys due to the hospital were recorded and all monies received were accepted and deposited in the hospital's bank accounts;
- Thirteen unofficial bank accounts were identified that contained hospital moneys and were operated by hospital staff outside the hospitals' control environment in breach of the FAAA. **Audit cannot provide assurance whether the transactions through all these unofficial accounts were for official hospital purposes or were appropriate** [Committee's emphasis];
- Fundraising activities were conducted on behalf of the hospitals without authorisation and licensing as provided or under the Hospitals and Health services Act 1927 and the Charitable Collections Act 1946;
- SPA revenue was not adequately recorded in hospital accounts to enable hospitals to ensure specific funding obligations and restrictions were applied;
- Donations and other gratuities were received by the hospitals from various sources without being evaluated to determine if the donor and the use of the funds were appropriate and acceptable to the hospitals;
- Donations received by or at two hospitals were forwarded to affiliated fundraising bodies contrary to the provisions of the FAAA;⁸³
- Around 80 percent of payments made through SPA accounts are of a routine nature such as salary payments and hospital equipment and building addition expenditures. However, the controls and processes for checking and authorising expenditures from SPAs were not operating effectively to ensure proper control and accountability was maintained;
- These weaknesses make it difficult for hospitals to demonstrate that all SPA expenditure was in accordance with the purposes for which moneys were received and for Audit to verify the appropriateness of payments. Many examples of inadequately supported payments, payments not evidenced as being reviewed or authorised by hospital staff and payments that did not comply with the stated purpose of the account were identified;

⁸² Auditor General, *op cit*, p.15.

⁸³ *Ibid*, p.23.

- No payments from these accounts for **categoric** personal benefit, fraudulent purposes or purposes not related to hospital activities were identified from audit testing;
- The integrity of staff was effectively the only safeguard against abuse in many instances;
- **The appropriateness of payments from unofficial bank accounts will need to be fully investigated;** [Committee's emphasis]⁸⁴
- SPAs were not subject to the same budgeting requirements as for normal operating accounts and budgets were not prepared for most accounts; and
- The extent of financial monitoring and reporting varies from good through to inadequate and does not allow for effective oversight and review at all levels within the hospital and through to the accountable authority.⁸⁵

In summary, the Auditor General found that 80 percent of SPA transactions were well controlled and subject to comprehensive approval processes, and expenditure was of a routine nature such as building additions, staff conferences and travel, and salaries for research staff.⁸⁶ The remaining 20 percent of SPA transactions, however, were problematic, and most of the Auditor General's findings relate to these.

(c) Auditor General's Recommendations

The Auditor General made a number of useful recommendations to improve the administration and management of SPAs and trust accounts, many of which were also made by Ernst & Young but were not implemented by the hospitals. These include:

(i) *Management and Use - the Accountable Authority Should:*

- Develop a comprehensive policy and administrative framework for the management of both trust and special purpose accounts. This should include the establishment of accounting policies, procedures and business rules to assist hospitals in implementing a consistent approach to managing these accounts. These should include guidance on:
 - The identification of trust moneys and categorisation of SPAs with either internal or external restrictions;
 - The classification of accounts by type of activity; and

⁸⁴ *Ibid*, p.31.

⁸⁵ *Ibid*, p.42.

⁸⁶ *Ibid*, p.70.

- Account documentation and record keeping standards to ensure completeness and accuracy of records and compliance with the *State Records Act, 2000*;
- Set a timetable for hospitals to implement these policies and frameworks and ensure the revised arrangements put in place by the hospitals are progressively reviewed for compliance during this implementation process; and
- Prepare revised trust statements covering all private moneys, or ‘true trusts’ held by the hospitals and ensure these statements comply with the provisions of the FAAA.

(ii) *The Hospitals Should:*

- Ensure these policies, associated frameworks and business rules are implemented with variations only being made to suit specific or unique circumstances;
- Review existing account documentation and ensure that complete documentation is available for each SPA and that it is up to date and accurate;
- Review and rationalise SPAs. This should include categorising moneys with different restrictions by either placing them in accounts with like restrictions or establishing separate accounts or tracking mechanisms where there is no similar account; and
- Ensure staff responsible for administering trust and special purpose accounts are made aware of the nature, purpose and ownership of the moneys held in these accounts.⁸⁷

(iii) *Financial Management and Control - The Accountable Authority/Hospitals Should, as a matter of urgency:*

- Implement appropriate control procedures for the raising of invoices and the recording of sundry debtors. These procedures should ensure:
 - recoverable fees and charges are recorded on debit notes and procedures are put in place to ensure invoices are raised for all revenue;
 - invoices are recorded in a debtors system so that appropriate recovery action can be instituted for any amounts outstanding;
 - invoices are issued on official hospital stationery; and

⁸⁷ *Ibid*, p.21.

- debtors' balances are included in the hospitals' financial statements.
- Ensure all mail received at the hospitals is opened in a secure environment and that all moneys sent to the hospitals are immediately recorded and where appropriate, receipted and banked in a timely manner;
- Ensure all moneys belonging to the hospital is receipted and banked into official hospital bank accounts. Unofficial accounts should be fully investigated by the hospitals and any hospital moneys transferred to hospital controlled bank accounts;
- Ensure fundraising activities conducted on the hospitals' behalf are appropriately authorised and licensed in accordance with legislative requirements;
- Review moneys placed into SPAs and ensure funds are allocated to the operating fund if the moneys are of an operating nature. Where material revenues are received and placed into a SPA, costs associated with earning that revenue should be recognised in that account;
- Develop policies covering all forms of donations and other gratuities received by the hospital and ensure such funds and gratuities are evaluated prior to acceptance;
- KEMH/PMH and SCGH should record all donations received by the hospital and either receipt and bank the moneys if the donation is for the hospital or record details and only forward the moneys to their respective Foundation if there is evidence the donation is for the Foundation.⁸⁸

(iv) ***Expenditure - the Accountable Authority/Hospitals Should -***

- Review the incurring and certifying functions and implement procedures that comply with the requirements of the FAAA. For expenditure from SPAs, it is further recommended that:
 - the Incurring Officer should be a person with appropriate knowledge of the requirements of the SPA and is able to ensure the accuracy of account classifications and confirm that goods and services have been satisfactorily received. It is suggested that the business managers who are located in each division of the hospitals would be suitable officers to be responsible for incurring payments from these accounts; and
 - the Certifying Officer should be a person with appropriate knowledge of and access to information about the requirements and balances of

⁸⁸

Ibid, p.30.

these accounts. It is suggested that the trust accountants be appointed as certifying officers, given that these officers already perform some of the certifying officer functions;

- Ensure Incurring and Certifying Officers are trained and made fully aware of the responsibilities of these positions. These officers should ensure no claims for payment are processed unless adequate supporting documents are provided, sufficient explanations for expenditures are obtained and recorded and all relevant hospital and government policies are complied with;
- Review or prepare policies on hospitality expenditure that incorporates the principles and requirements outlined in the Premier's Circular 'Guidelines for Expenditure on Official Hospitality'. The policy should be communicated to all staff and any hospitality expenditure should not be incurred unless it complies with the policy;
- Ensure State Supply Commission supply policies, such as the use of common use contracts and the obtaining of quotes, are complied with;
- Develop and reach specific agreements with the universities to govern the activities of university staff that involve the operation of SPAs. This should include the clarification of ownership of moneys administered by university staff at the hospitals, approval procedures for transfers between university and hospital accounts and travel approvals involving University staff from hospital funds; and
- Ensure Public Sector Standards in Human Resource Standards are applied to all staff appointed to positions funded through SPAs.⁸⁹

(v) ***Budgeting, Monitoring and Reporting - The Accountable Authority/Hospitals Should Ensure that:***

- Budgets are prepared for SPAs where appropriate. This should apply to accounts used for research, business or similar activities that have ongoing commitments (eg salaries), contractual and other obligations and/or where the hospital has specifically invested or assigned resources; and
- Reporting standards are established for the various levels within the hospitals and to the accountable authority. These standards should include the minimal level of information necessary for review and monitoring functions to be effectively undertaken. It is suggested that business managers would be

⁸⁹ *Ibid*, p.41.

suitable officers to be responsible for monitoring, reporting and analysing SPA activity within each hospital division (similar to operating account activity).⁹⁰

(d) Committee's Observations on the Auditor General's Report

The Committee is satisfied that most of the Auditor General's report represents the overall status and problems regarding hospital SPAs fairly and accurately for the period of the audit focus, namely, the 2001 calendar year.

The Committee endorses most of the findings and recommendations contained in the report. Considerable resources were devoted to the audit by the OAG, and the Committee is confident that for the purposes of this inquiry, it can rely upon the audit's approach and conclusions of a technical and process nature. Therefore, the Committee expects the Department of Health and the hospitals to implement the Auditor General's recommendations in a timely manner.

There are, however, a number of issues that the Committee wishes to raise in respect of the audit. It is not the intention of the Committee to criticise the report, as it is recognised that the audit was already extensive and could not address all aspects of SPAs, but to ensure that the public has a comprehensive understanding of the historical context of this inquiry.

Finding 21

The Committee supports the Auditor General's finding that the appropriateness of payments from unofficial bank accounts requires full investigation by the hospitals, particularly in light of the uncertainty and lack of adequate internal controls surrounding the use, administration and management of Special Purpose Account transactions.

The Committee is disappointed that the Auditor General did not conduct this investigation himself as part of his audit, or at least say why he chose not to conduct the investigation as part of the audit.

Finding 22

The Auditor General's report, states that he could not be certain that all unofficial bank accounts had been identified. The Committee believes that this uncertainty should have been resolved by the Auditor General.

⁹⁰

Ibid, p.44.

Finding 23

The administration of Special Purpose Accounts was so poor that the Auditor General could not provide “reasonable assurance” that all hospital moneys due and received were deposited into either hospital operating accounts or Special Purpose Accounts. This represents a serious inadequacy on the part of hospitals and the Department of Health, as it is impossible to determine whether fraud occurred.

Finding 24

There was a lack of guidelines for the proper identification and classification of Special Purpose Accounts.

Recommendation 8

The Department of Health and the metropolitan teaching hospitals should implement the Auditor General’s recommendations in relation to Special Purpose Accounts immediately.

Recommendation 9

As a matter of urgency, the Department of Health should fully investigate the 13 unofficial bank accounts identified by the Auditor General. The investigations should be conducted as full forensic audit investigations.

Recommendation 10

As a matter of urgency, the Department of Health should conduct a full examination to confirm that there are no further unofficial bank accounts holding hospital funds.

Recommendation 11

The Department of Health should ensure that its employment arrangements with doctors are clearly identified and that the terms of any private practice arrangements are fully set out in doctors' employment contracts, with appropriate accounting practices strictly enforced.

(e) Recent Initiatives - Department of Health

The Director General of the Department of Health stated in evidence to the Committee on 13 November 2002 that there have been significant improvements in the administration and management of SPAs and trust accounts since the Committee initiated its inquiry. He said that the governance structure had been simplified so there was now a single financial committee that served as an oversight body for the financial performance of the Department of Health, creating a more open, transparent and accountable process.⁹¹

On 5 September 2002, the Department of Health produced an Accounting Manual, part of which deals with trust accounts and SPAs. The relevant chapters were circulated to members of the Trust Review Group with the intention that, when endorsed, the chapters would be added to the accounting manual.⁹² The Department has also developed a draft Donations Policy.

The MHS commenced the trust review process in 2001, and in March 2002 a revised executive group was formed to develop appropriate and consistent policy across the health sector. The group comprises the senior finance executive from each of the teaching hospitals, a representative the Department of Treasury and Finance and the Department of Health's Principal Accounting Officer.

The Committee understands that other reforms being undertaken include:

(i) Cost Centre Set-Up

In relation to the receipt of funds that are controlled by the Health Service with a condition of use imposed, a special purpose cost centre is established by adopting the following procedure⁹³:

- Completion of a standardised request form for a cost centre;

⁹¹ Mr M. Daube, Transcript of Evidence, 13/11/02, p.2.

⁹² Correspondence and attachments from Department of Health, dated 05/11/02.

⁹³ *Ibid*, pp.2-3.

- The request is referred to the business manager/analyst or financial services;
- The source and nature of funding is determined by means of the “control” test. If the Health Service does not control the funds, they are classified as true trusts;
- If the funds are controlled by the Health Service and there are no restrictions, the funds are accounted for by using an operational account. If, however, the funds are controlled by the Health Service and there are restrictions, the funds are classified as special purpose funds;
- If a special purpose cost centre is required, approval must be obtained from senior management of the Division and the Executive Director, Finance;
- The cost centre set-up documentation is completed and forwarded to financial services;
- The cost centre number is allocated and forwarded to the originator and business manager/analyst; and
- Upon receipt of the funding, the amount is credited to the special purpose cost centre and funds are deposited in the special purpose bank account.

(ii) *Expenditure*

Expenditure from SPAs must comply with the following procedures⁹⁴:

- Identification of the SPA that will be charged with the expenditure;
- Ensure expenditure is for the purpose as specified in the request for cost centre documentation. If not, the expenditure is disallowed;
- Approval for expenditure must be sought from a signatory as listed in the request for cost centre documentation;
- Ensure signatory has sufficient delegation of authority to approve the expenditure and that all policies are complied with; and
- Ensure that a completed purchase requisition is forwarded to accounts payable.

⁹⁴ *Ibid*, pp.5-6.

(iii) *Management Oversight and Reporting*

In relation to the management and reporting of SPAs, senior management is responsible for the management and reporting function and must now comply with the following procedures⁹⁵:

- Prior to the commencement of each financial year, management prepares the scope of budgets;
- The Health Service prepares monthly reports detailing movements of money to and from SPAs ;
- After receiving advice from financial services, ensure that new special purpose cost centres are included in the monthly report;
- Management of hospitals or Health Services determines the interest to be credited to SPAs;
- Analysis of movements to SPAs, including a summary and comments in the report;
- SPAs previously credited are checked to ensure compliance with conditions;
- A request to close an SPA through non-movement is reviewed and any instruction to close the account is made by financial services;
- Any surplus funds on cessation of the SPA could be transferred to other SPAs with a similar purpose or be utilised at the discretion of management;
- The completed SPA report is sent to senior management of Heath Services for inclusion into the consolidated Health Service SPA report. A summary is forwarded to the Department of Health on a monthly basis; and
- At the end of each financial year, all movements and balances of SPAs are blended with the operating accounts.

Standard forms have been developed for SPAs to assist in determining the procedure relating to identification, authorisation and control. SPAs have each been provided with a dedicated cost centre number and committees were established to oversee the various SPAs with different delegated authorisations required for different expenditure items.⁹⁶ The Department of Health now has a single internal audit function across the

⁹⁵ Mr M. Daube, Transcript of Evidence, 13/11/02, pp.7-8.

⁹⁶ *Ibid*, pp.7-10.

health care system to ensure that the implementation of changes occurred at an approved rate and that control mechanisms are in place.⁹⁷

The Committee is pleased that the Department introduced more rigorous travel procedures in March 2002. All interstate travel must now be approved by the Director General, and all overseas travel must be approved by the Minister personally. Such accountability measures contribute significantly to public confidence in the management of public moneys.

Most recently, the Committee was advised by the Director General that the following further actions have been taken:

- Accounting policies, procedures, and business rules (aligned to FAAA, Treasurer's Instructions and other legislative and regulatory requirements) have been established;
- Additional chapters have been inserted into the Accounting Manual and the trust chapter is being revised;
- All hospitals have completed reviewing the status of each account held;
- All hospitals have categorised their SPAs according to internal/external restrictions and by type of activity;
- The hospitals are using standard business rules for documenting the establishment of SPAs;
- Hospitals are reviewing their record keeping practices in relation to financial documents;
- The Department is introducing annual internal audit procedures to ensure ongoing compliance to relevant standards;
- Revised Trust Statements for the metropolitan area health services have been discussed with the Department of Treasury and Finance and submitted for approval;
- Hospitals are continuing to review the number of SPAs with a view to rationalisation where appropriate; and
- All hospitals have taken appropriate steps to ensure that staff responsible for administering accounts, are aware of the nature, purpose and ownership of the moneys held in the accounts.

⁹⁷ *Ibid*, pp.7-14.

(f) Recent Initiatives - Hospitals

(i) *King Edward Memorial Hospital for Women / Princess Margaret Hospital for Children*

Some of the most significant improvements have occurred at KEMH/PMH, no doubt because they were in the public spotlight prior to the other hospitals, and have therefore given greater priority to reform initiatives. In late 2001, KEMH/PMH commenced a comprehensive restructure of its SPAs, including:

- Moving trust accounts and authorised signatories to SPAs of the Health Service and setting them within the hierarchy of segmented reporting of the operational accounts;
- SPAs are now placed into groups based on either the department or function concerned with the account;
- Each group of accounts is now placed under the responsibility of an SPA sub-committee based around the directorate;
- All responsibility for the establishment and operation including expenditure and reporting has been removed from the previous authorised signatories and vested with the sub-committee; and
- The sub-committee reports to the Finance Committee of the Health Service on a monthly basis.⁹⁸

The advantages of the structural changes include:

- Strengthening controls by removing the possibility of misuse of funds by authorised signatories;
- Reporting to a sub-committee and no longer to the authorised signatory;
- Expenditure must be approved through the appropriate sub-committee; and
- SPA details relating to revenue, purposes/restrictions are now subject to detailed scrutiny.

Other recent improvements at KEMH/PMH include:

- A number of inoperative SPAs have been closed and the amount of SPAs overall has been reduced;

⁹⁸ Correspondence from Womens' and Children's Health Service, dated 01/07/02, pp.1-2.

- Most general purpose accounts have been amalgamated into a single account and research accounts have been amalgamated into a single account;
- Travel and conference expenses are now subject to increased monitoring to ensure that guidelines regarding purposes of account are complied with, apart from obtaining approval from the Director General of the Department of Health and the Minister, where appropriate;
- A new donations policy has been established; and
- Budgets for SPAs are now prepared and monitored.

(ii) *Sir Charles Gairdner Hospital*

The Committee understands that the following recent changes to the control aspect of SPAs have occurred at SCGH⁹⁹:

- Updated form used to establish and approve a new cost centre within the Special Purpose Fund (SPF) by requiring approval by either the Executive Director of Medical Services, the Executive Director of Nursing Services, or the Director of Finance and Corporate Information Services. The new form requires details such as the purpose of the fund, investment and disposal of funds;
- In March 2001, a Committee was established to oversee the governance of all SPAs relating to the receipt of money to and expenditure of money from private practice;
- In June 2001, existing practices were formalised into a new Hospital Policy 153 with the intention of improving the governance of funds. Applications for new accounts now require proper approvals, all funds credited to hospital accounts are now clearly under the control of the hospital; expenditure can only be made for approved purposes; and the use and distribution of surplus funds is now solely at the discretion of the hospital; and
- SCGH now has three bank accounts for all its funds, one of which is for normal operating funds and two of which are for special purpose funds. One of the SPAs relates to research funds and the other to travel and education, but Mr Craig Bennett, CEO of SCGH, admitted in his evidence to the Committee that the research SPA did not receive the same level of oversight as the travel and education SPA.¹⁰⁰

⁹⁹ Correspondence from Walter Gilmore, Area Director of Finance & Information Services, SCGH, dated 09/10/02.

¹⁰⁰ Mr C. Bennett, Transcript of Evidence, 10/06/02, p.16.

(iii) *Royal Perth Hospital*

By 4 November 2002, RPH had reviewed 15-20% of its trust accounts and SPAs, with the balance to be completed by the end of June 2003.¹⁰¹ As at November 2002, the number of trust accounts and SPAs totalled 415.

RPH management also advised the Committee that an internal working group had rationalised a number of SPAs; and that it had revised its donation and fundraising policies in July 2002.

(iv) *Fremantle Hospital and Health Service*

In evidence before the Committee in June 2002, senior hospital executives stated that the improvements at FHHS include:

- The creation of a new Trust Officer position to coordinate all SPA and trust account activities;
- Revision of its travel policy; and
- Communicating SPA policies and procedures to all staff.¹⁰²

4.4 Committee's Observations on Recent Initiatives

The initiatives developed by the Department of Health and individual hospitals to remove responsibility for the establishment and operation of SPAs from individual signatories and to vest that responsibility with a sub-committee serves to enhance accountability.

In evidence before the Committee, the AMA endorsed the strengthening of procedures with regard to SPAs and trust accounts and favoured regulation for purposes of accountability.¹⁰³ Formal written notification to and adoption by all relevant parties, including doctors, of the necessity to comply with SPA policy and procedure would serve to protect their interests and serve as notice that they would be expected to abide by such policy and procedure.

The Committee is pleased that this inquiry and the audit conducted by the Auditor General has prompted the Department of Health and the hospitals to initiate a number of improvements to the management of SPAs and trust accounts.

¹⁰¹ Correspondence from Mr P. Montgomery, Deputy Director of Clinical Services, dated 11/04/02.

¹⁰² Mr J. Burns and Dr S. Kelly, Transcript of Evidence, 10/06/02, pp.13-14.

¹⁰³ Mr P. Boyatzis, Transcript of Evidence, 10/12/01, p.26.

In his report, the Auditor General refers to “management letters” provided during the course of the audit which should assist the Department of Health to progress its reform initiatives. Unfortunately, the report does not disclose the content of the management letters. The Committee would have welcomed more comments in the Auditor General’s report on the nature and extent of the improvements to date, as well as an analysis of their adequacy and merits.

The Committee requested each of the four teaching hospitals to provide a summary of their reform initiatives to date and although their efforts are promising, it is apparent that they are each approaching the task in a different manner. Of course, some differences between the hospitals will be necessary, but there is an overriding need for overall consistency.

Finding 25

The Committee finds that there have been some improvements by the hospitals and the Department of Health. However, there remains a lack of coordination and consistency across the hospitals, especially in the areas of monitoring, reporting and approval processes.

Recommendation 12

The Committee recommends that the Department of Health ensure that all staff, including doctors, attached to the four metropolitan teaching hospitals, are formally notified in writing of the necessity to comply with established Special Purpose Accounts policy and procedure.

Recommendation 13

The Department of Health must coordinate the reform initiatives of the hospitals in the area of trust and Special Purpose Accounts to ensure consistency.

Recommendation 14

The Department of Health should implement a best-practice model and standards for the management of Special Purpose Accounts in all the State's public hospitals.

Recommendation 15

The Department of Health should develop and implement a comprehensive training programme for relevant staff of the States' public hospitals in relation to the management of Special Purpose Accounts.

Recommendation 16

The Auditor General should review the management of Special Purpose Accounts at the four metropolitan teaching hospitals within 2 years to examine the level of implementation and success of the reform initiatives to date.

Recommendation 17

Public hospitals should identify the number, purpose and amounts held in trust and Special Purpose Accounts in their annual reports. The Department of Health should also report on the operation of Special Purpose Accounts as part of its reporting function to the Minister of Health.

CHAPTER 5 COMMITTEE INVESTIGATION INTO THE HEALTH INSURANCE COMMISSION REPORT INTO ALLEGATIONS OF INAPPROPRIATE BILLING OF MEDICARE

5.1 Background

Although the HIC's report determined that eight doctors at KEMH/PMH inappropriately bulk-billed Medicare, and traced 448 HIC cheques made payable to these doctors, finding that most of the cheques were deposited into hospital SPAs, the report did not disclose the ultimate expenditure of the funds.

Consequently, the Committee resolved to conduct its own audit to investigate whether the funds were ultimately spent on legitimate items in accordance with the purpose of the SPAs, and whether any of the doctors benefitted personally from the funds. The audit findings would be crucial to determine whether the doctors or the Department of Health was liable to reimburse the HIC.

The Committee also wanted to ascertain whether the doctors were receiving payment from the HIC for services, whilst also being remunerated by the hospital at which they were employed. If so, it is possible that the doctors were inappropriately "double-dipping", or being paid twice for performing the same service.

Although the Auditor General's report into SPAs does not deal with the issue in great depth, it does state that Medicare cheques were being deposited directly into SPAs, bypassing the correct procedure of all cheques going through hospitals' central accounting system.

The potential for abuse to occur was extremely serious, and highlights the lack of adequate control mechanisms by the hospitals and the Department of Health in relation to SPAs.

As stated in Chapter 3.11, the HIC investigation revealed that "in some instances", the Medicare cheques were deposited into the personal accounts of the doctors. The Committee sought to obtain the names of these doctors and the amount of money involved. However, despite several requests, the HIC refused to provide the information to the Committee on the grounds of privacy. Therefore, the Committee is unable to ascertain whether the funds deposited into private bank accounts were used to benefit the hospital or the doctors personally, and whether the doctors were paid by the health system at the same time they were paid by Medicare.

5.2 Committee Audit - Summary

The Committee conducted a review of the SPAs controlled by the eight doctors identified by the HIC and examined the contractual and/or employment arrangements applying to these doctors during the period from 1 July 1998 to 30 October 2000.

(a) Receipt of Medicare Funds

As stated in Chapter 3.11, privatised clinics were first proposed by doctors and established in the early 1990s with the approval of hospital administration. The operation of privatised clinics led to concerns in the mid-1990s that the hospital and doctors were “cost shifting” from the State to the Commonwealth, breaching Medicare principles, and engaging in tax avoidance and/or fraud because:

- there was no clear separation between the employment of the doctor and their role in operating the clinics; and
- rather than retaining the revenue after payment of fees for the use of facilities and other clinic costs, the doctors deposited the revenue to SPAs at the hospital by way of “donations”.

There has been little progress by the hospital in resolving these concerns. In addition, the hospital did not monitor the operation of privatised clinics to ensure that all Medicare funds were deposited into SPAs. Patients treated at privatised clinics were not considered patients of the hospital. Therefore, the responsibility for operating privatised clinics and maintaining patient treatment records and billings resided with the individual doctors.

There are claims that funds have been received from the State and/or patients by the eight doctors, where Medicare funds were claimed for the same procedure or service, either by bulk-billing public patients or bulk-billing private non-inpatients whilst being remunerated by the hospital, that is, “double-dipping”. However, the Committee is not able to establish that “double-dipping” has occurred due to lack of doctors’ attendance records, clearly defined rosters, and patient treatment information to establish public versus private patient status.

Hospital receipting data for the period July 1998 to December 2001 revealed that \$874,881 comprising 235 Commonwealth Government cheques, that may all or in part relate to Medicare funds, was deposited into four SPAs by five of the eight doctors in question.

(b) Expenditure of Medicare Funds

Of the \$874,881, an amount of \$630,899 (72 percent) was deposited by a doctor into a privatised clinic SPA, with the purpose of increasing services for that clinic. Eighty

two percent of the funds in the SPA were used to pay the salaries of hospital employees working in the clinic, including part of the clinician's salary, and other costs associated with the clinic's operations.

An amount of \$130,162 was deposited into another clinic SPA by two further doctors, with an additional \$30,667 deposited into the SPA from other sources. Around 47 percent of the funds were used to pay the salaries of hospital employees working in the clinic and associated regional clinics. Funds were also used in connection with the operation of these clinics, including:

- routine travel by one of the doctors and other hospital employees to regional clinics (totalling \$20,720); and
- 11 travel allowance payments to the same doctor and his wife (totalling \$4,642) for travel to regional clinics.

There were also 17 payments for secretarial services (totalling \$29,952) to the doctor's wife for the period October 1999 to November 2001. There are concerns over the appropriateness of these payments because:

- the appointment of the doctor's wife represents a potential conflict of interest;
- it is not clear who authorised her engagement and there is no evidence to establish whether the appointment was based on an open and competitive process as required by government supply policies;
- none of the payments included timesheets. Therefore, the hospital did not ensure that payments represented actual hours worked; and
- in many instances, the payments were made in advance of services being performed, and therefore should not have been authorised.

Funds were also used for travel to interstate and overseas conferences, and research by two of the doctors and other hospital staff. One doctor travelled once to Melbourne (\$1,107); another doctor travelled once to the United States (\$8,906), once each to Sydney (\$1,829), Brisbane (\$1,502) and Cairns (\$740). There was no evidence that this travel had been approved by the hospital Chief Executive Officer.

There was no expenditure in relation to the other doctors in question from the four SPAs reviewed.

In total, the Committee conducted a detailed review of 320 accounts payable expenditure transactions directly relating to the doctors in question and other items of interest, such as travel and hospitality expenditure (totalling \$169,322), which represented 46 percent of total accounts payable expenditure.

Other than administrative deficiencies identified in the incurring and certifying of payments, the Committee identified that 74 transactions (valued at \$20,329) did not comply with the purposes set out in SPA Statements. Ninety two percent of these related to hospitality expenditure. There were insufficient details on the remaining eight percent to determine whether the expenditure complied with SPA statements.

5.3 Committee Audit - Specific Issues

(a) The amount of funds received from the State by the eight doctors, where Medicare funds were claimed for the same service

In the period July 1998 to December 2001, the doctors in question were employed as salaried or sessional medical staff and were exercising rights of private practice.

Doctors with rights of private practice are permitted to treat private inpatients, provided that it does not interfere with their normal duties. Therefore, it is feasible for a full-time doctor to see a mixture of public and private inpatients during a working day, provided that over the week, the doctor has spent 40 hours attending to public inpatients and/or performing public hospital duties.

The income-sharing provisions of the AMA Medical Practitioners Collective Workplace Agreement relating to rights of private practice do not extend to private non-inpatients. Doctors are able to treat private non-inpatients, but the accounts and income generated from these patients are not due or payable to the hospital. However, the arrangements, formal and otherwise, by which privatised clinics were established required private non-inpatient income earned by the doctors to be “donated” to hospitals to fund the operation of privatised clinics, including salaries of staff working in the clinics.

In accordance with Medicare principles, however, doctors must treat private non-inpatients in a fully private capacity and not whilst the doctor is being remunerated by the hospital to treat public patients.

Six of the eight doctors in question were full-time salaried doctors and two were sessional doctors during the period July 1998 to December 2001. As salaried doctors do not maintain timesheets, neither the doctors or the hospital is able to establish the duration of the doctors’ time spent on public versus private patients, and to demonstrate whether the time spent on private patients interfered with the doctors’ normal duties of attending to public patients and/or performing public hospital duties. Therefore, the Committee is unable to establish whether funds such as salaries have been received from the State by the eight doctors where Medicare funds were claimed for the same service.

It is evident, however, that the majority of one particular doctor's salary was funded by the hospital's operating account for most of the period under review, whilst he was bulk-billing Medicare and depositing the funds into a SPA. HIC billing data indicates that the doctor provided an average of seven patient occasions of service per day (totalling \$859), almost every working day.

Two of the eight doctors identified in the HIC report were sessional doctors in the period July 1998 to December 2001. Sessional doctors are contracted by the hospital to provide a number of sessions attending to public patients. The sessional arrangements of these doctors are shown below:

Table 5.1

Doctors	Sessions	Duties
Doctor 1	10 sessions per fortnight (July 1998 to August 2001) 6 sessions per fortnight (Sept. to Dec. 2001)	Outpatient clinics, ward rounds, teaching, research, supervision of postgraduates, outreach clinics
Doctor 2	10 sessions per fortnight	Outpatient clinics, theatre sessions, ward rounds, teaching, research, supervising hospital surgical trainees, admin. Duties

The Committee found that the hospital is unable to adequately demonstrate that sessional doctors have worked the required fortnightly sessions. The doctors' rostered hours and privatised clinic schedules were not clearly defined. Although some rosters were maintained on spreadsheets by the relevant hospital departments, these are either no longer available for the period under review or were not adequately controlled. In addition, they do not provide evidence of sessions actually worked.

However, some information obtained from the hospital indicates that one of the doctors was required to work 2.5 sessions per week at a privatised clinic. The remaining "unscheduled" 2.5 sessions per week were required to be spent on inpatient duties, on call after hours emergencies, and teaching. Outside of his sessions at the hospital, the doctor worked at regional clinics and in his private practice.

Billing data obtained from the HIC appears to be consistent with this schedule. The doctor bulk-billed Medicare on many of the days he was required by the hospital to work at the privatised clinic. He also bulk-billed Medicare for patient occasions of service at regional clinics, supposedly worked outside of his sessions at the hospital. His airfares to the regional clinics and subsistence or travel allowances for both he and his wife were met from the SPA.

The hospital has therefore failed to operate the privatised clinic at “arm’s length”, with no clear separation between the doctor’s employment and his role in operating the clinics. These arrangements give rise to a strong perception of improper conduct by the hospital, and funds, in the form of sessional payments, being received from the State where Medicare funds were claimed for the same service, thereby “double-dipping”.

However, the Committee is not able to establish whether “double-dipping” has occurred because there is no documentation of times actually worked in the hospital by the doctor and no patient records to substantiate whether:

- some or all of the patients he treated should have been treated free of charge as public patients of the hospital; and
- some or all of the Medicare funds received by the doctor related to private non-inpatients treated at privatised clinics or private non-inpatients treated at his private practice.

Although the doctor was required to work 2.5 sessions per week at the privatised clinic, only six sessional payments totalling \$15,694 were funded from the SPA during the period under review.

(b) The amount of Medicare funds deposited into the accounts

The HIC report states that \$1,254,935, comprising 448 cheques, was inappropriately claimed by hospital doctors practising from the privatised clinics in the period July 1998 to October 2000. However, a review of HIC billing data showed an additional \$328,581 related to patient occasions of service provided before July 1998.

TOPAS receipting data for the period July 1998 to December 2001 revealed only \$874,881, comprising 235 Commonwealth Government cheques, (that may all or in part relate to Medicare funds), was deposited to SPAs by the doctors in question, as shown below.

Table 5.2

SPA	Amount (\$)
7281	130,162
7283	50,466
7318	29,238
7367	658,344
Other	6,671
TOTAL	\$874,881

Over 72 percent of these funds were deposited by one particular doctor to a privatised clinic SPA.

Table 5.3

Doctor	Amount (\$)
Doctor 1	104,815
Doctor 2	76,414
Doctor 3	29,238
Doctor 4	33,515
Doctor 5	630,899
TOTAL	\$874,881

Due to the unavailability of cheque listings from the HIC, unreliability of hospital receipting records and delays in the forwarding of cheques by doctors to hospital cashiers, the Committee is not able to establish where and when all of the \$1,254,935, comprising 448 cheques, was deposited.

(c) The stated purpose of the accounts

- SPA 7281 – to enhance clinical and research objectives of the department
- SPA 7283 – to fund projects relating to diabetes and education
- SPA 7318 – to fund post graduate education
- SPA 7367 – to increase services in a specific hospital department

The SPA Statement for account 7281 provides further details of the nature of expenditure to be funded from the account. In addition to research and clinical activities, which are closely related to the stated purpose, the SPA Statement also provides for staff salaries, journal and book purchases, staff travel and departmental functions to be funded by the account.

Account 7367 was in overdraft for most of the period under review. As at 31 December 2001, the account was overdrawn by \$120,060. This practice should not occur. In March 1999, the proportion of the relevant doctor's salary met from the account had been reduced from 100 to 20 percent. The doctor continued to treat private non-inpatients, bulk-bill Medicare and "donate" the funds to the account, but by 2002, the clinic was no longer considered viable as a privatised clinic. The account was closed and the deficit funded by the hospital's operating account. As there is still a need for the services of the clinic, the clinic continues to operate, but is being fully

funded by the hospital, with all patients provided services as public patients, and no bulk-billing of Medicare.

(d) Details of all expenditure from the accounts

In the period July 1998 to December 2001, approximately \$1.8 million was expended from the four SPAs, including:

- Approximately 69 percent of the moneys were paid out as salaries to various medical and administration staff, including the part salary of one of the doctors;
- Approximately five percent was spent on intrastate travel to regional clinics, and travel to interstate and overseas conferences by various staff; and
- Approximately five percent was spent on patient appliances and materials used in the delivery of patient services.

In addition to the above expenditure, amounts of \$2,447 and \$27,522, representing a 10 percent facility fee, were withdrawn from accounts 7281 and 7367 by the hospital. Based on the amount of Medicare funds deposited into these SPAs, it is clear that the hospital was not claiming all facility fees due.

The Committee conducted a detailed review of 320 accounts payable expenditure transactions directly relating to the doctors in question and other items of interest, such as travel and hospitality expenditure (totalling \$169,322), which represented 46 percent of total accounts payable expenditure. A number of tests were performed to determine whether:

- expenditure had been authorised by approved signatories and/or trustees;
- the doctors in question had authorised expenditure for their own entertainment, travel or reimbursements;
- expenditure was in accordance with the purposes set out in the SPA Statement;
- interstate and overseas travel had been approved by the hospital Chief Executive Officer; and
- hospitality expenditure complied with relevant Departmental guidelines.

The Committee found that 74 of the transactions reviewed (valued at \$20,329) did not comply with the purposes set out in SPA Statements. Most of these related to hospitality expenditure. Other key findings from the expenditure testing are outlined below.

The results show that the hospital's internal control processes were not operating effectively to ensure that all payments had been checked for appropriateness.

(i) *Hospitality/Entertainment Expenditure*

- 85 transactions valued at \$13,334 related to entertainment or hospitality;
- All of these transactions were from SPA 7281 and involved staff functions, such as food for lunchtime meetings, Christmas lunches and staff retreats;
- Some of the expenditure involved the provision of hospitality, such as movie tickets, to research participants;
- None of the hospitality expenditure complied with the departmental guideline that requires details of who were entertained to be recorded. Therefore, the Committee is not able to establish whether the doctors in question benefited directly or indirectly from entertainment expenditure;
- The SPA Statement for account 7281 allows for departmental functions to be funded from the account. However, the Committee does not consider any of the expenditure on departmental functions to be categorically related to the purpose of the SPA, which was to enhance clinical and research objectives. In addition, expenditure on departmental functions does not comply with government guidelines and raises a fringe benefit tax liability for the hospital.

(ii) *Expenditure on Self*

- 68 transactions valued at \$41,603 related to the doctors in question;
- The majority of these transactions involved travel, journal subscriptions, conference registrations, memberships and indemnity insurance premiums;
- Account 7281 was used to fund interstate and overseas travel by one doctor (USA \$8,906, Sydney \$1,829, Brisbane \$1,502 and Cairns \$740), and another doctor (Melbourne \$1,107). There was no evidence that this travel had been approved by the hospital Chief Executive Officer prior to the travel occurring. Therefore, the Committee is unable to establish whether the travel was deemed appropriate or necessary;
- 15 of the 68 transactions had been approved by the doctor benefiting from the expenditure. Sixty-five percent of the remaining expenditure was approved by persons other than approved signatories or trustees. In many instances, the transactions of one doctor had been approved by a nurse/educator, which does not represent appropriate or sufficient authorisation;

- The mobile telephone of one doctor was funded from account 7367 and apparently used for privatised clinic business. Analysis of mobile telephone call data and reference to residential phone listings identified that less than ten percent of calls were made to home phone numbers;
- 66 transactions valued at \$55,149 related to another doctor, his wife or his private clinic. These transactions included payments for secretarial services provided by his wife (totalling \$29,952), based on 18 hours per week at \$16 per hour. The appointment of the doctor's wife raises a potential conflict of interest. However, it is not clear who authorised her engagement, nor the basis of the hourly rate. None of the payments included timesheets. Therefore, the hospital did not ensure that payments represented actual hours worked. In many instances, these payments were made in advance of services being performed, and therefore should not have been authorised; and
- Other payments involved travel to regional clinics by the same doctor and payment of subsistence or travel allowance to both he and his wife. The basis or authority for paying a subsistence allowance to the doctor's wife is not clear.

(e) Documentation

120 transactions valued at \$102,655 were not supported by adequate documentation. Although, in the majority of cases, there was sufficient detail to establish the purpose of the payment, many of these payments lacked invoices or had insufficient detail on the invoices to establish whether a valid claim for payment existed. These requests for payments should not have been accepted by incurring and certifying officers.

5.4 Audit Findings

In relation to the majority of Medicare cheques that were deposited by the doctors directly into SPAs, the Committee makes the following findings:

Finding 26

Unlike the privatised clinics operating in other states, the privatised clinics operating at King Edward Memorial Hospital / Princess Margaret Hospital did not operate at "arms length". There was no clear separation between the employment of the doctors and their role in operating the privatised clinics, and no controls to ensure patient referrals were not being manipulated.

Finding 27

Six of the eight doctors identified in the Health Insurance Commission's report were full-time salaried doctors, and two were sessional doctors.

As salaried doctors do not maintain timesheets, the doctors and the hospital are not able to establish the duration of the doctors' time spent on public versus private patients, or to demonstrate whether the time spent on private patients interfered with the doctors' normal duties of attending to public patients and performing public hospital duties.

Finding 28

Due to the lack of doctors' attendance records and rosters, and patient treatment information to establish public versus private patient status, and the lack of clearly defined private practice arrangements, together with the unavailability of Health Insurance Commission records, the Committee is unable to clearly establish whether the doctors were "double-dipping" by receiving remuneration from the hospital and a Medicare cheque for performing the same service.

Finding 29

Based on the amount of Medicare funds deposited into the relevant Special Purpose Accounts, it is clear that King Edward Memorial Hospital / Princess Margaret Hospital failed to claim all facility fees payable by the doctors for the use of hospital premises and facilities to conduct privatised clinics.

Finding 30

The majority of the salary of one salaried doctor was funded from a Special Purpose Account, into which he deposited (donated) funds received from bulk-billing Medicare.

The doctor in question bulk-billed Medicare for an average of seven patients per day, totalling \$859 per day, during the period from 1 July 1998 to 30 October 2000.

Finding 31

Lack of documentation made it impossible for the Committee to verify whether some sessional doctors actually worked the required fortnightly sessions. The documentation was either not available or was not adequately controlled.

Finding 32

One of the two sessional doctors identified in the Health Insurance Commission's report was required to work 2.5 sessions per week at a privatised clinic operating at King Edward Memorial Hospital / Princess Margaret Hospital. However, the Committee's investigation indicates that only six sessional payments were paid from the relevant Special Purpose Account from 1 July 1998 to 30 October 2000.

Finding 33

Seventeen payments totalling approximately \$30,000 for secretarial services were made from a Special Purpose Account to the wife of a doctor who controlled the account. The payments were inappropriate as:

- The appointment of the doctor's wife represents a potential conflict of interest;
- It is not clear who authorised the engagement of the doctor's wife, and there is no evidence to establish whether the appointment was based on open and competitive process as required by government supply policies;
- The basis of payment for 18 hours per week at \$16 per hour is not clear;
- As the payments were made without the provision of timesheets, the hospital did not ensure that payment was based on actual hours worked; and
- In many instances, payments were made in advance of services being performed, and therefore, should not have been authorised.

Finding 34

The same sessional doctor invoiced the hospital for the use of his private clinic rooms to see the hospital's "private" patients.

Finding 35

Approximately five percent of funds from the relevant Special Purpose Accounts were used for doctors to travel to interstate and overseas conferences, and intrastate travel to regional clinics. However, there is no evidence that this had been approved by the hospital Chief Executive Officer as required by hospital and Departmental policy.

Finding 36

Some of the funds from the relevant Special Purpose Accounts were spent on doctors' medical journal subscriptions, conference registrations, professional association memberships and indemnity insurance premiums.

In some cases, the doctor benefiting from the expenditure approved the transactions. In other cases, the transactions were approved by a nurse or educator, which does not represent appropriate or sufficient authorisation.

Finding 37

Forty six percent of the relevant Special Purpose Accounts related to hospitality and entertainment expenditure for items such as staff functions, food for lunchtime meetings, Christmas parties and staff retreats. Some of the expenditure involved the provision of hospitality, such as movie tickets, to research participants.

Finding 38

None of the hospitality and entertainment expenditure complied with the Department of Health's guidelines that require details of who was entertained to be recorded. Therefore, the Committee is not able to establish whether the doctors in question benefited directly or indirectly from entertainment expenditure.

Further, expenditure on departmental functions does not comply with government guidelines and raises the possibility of a Fringe Benefits Tax liability for the hospital.

Finding 39

A number of transactions from the relevant Special Purpose Accounts did not comply with the purposes set out in the account statements, ninety two percent of which related to hospitality expenditure. There were insufficient details on the remaining eight percent to determine whether the expenditure complied with account statements.

This demonstrates that hospital internal control processes were not operating effectively to ensure that all payments had been checked for appropriateness.

Finding 40

Over a third of the transactions were not supported by adequate documentation. Many of the payments lacked invoices or had insufficient detail on the invoices to establish whether a valid claim for payment existed.

These requests for payment should not have been accepted by hospital incurring and certifying officers.

Finding 41

There has been an uncoordinated and fragmented approach to establishing privatised clinics and a failure by King Edward Memorial Hospital / Princess Margaret Hospital to adequately monitor the operation of these clinics by doctors.

This has exposed the doctors and the hospitals to allegations of “cost shifting” from the State to the Commonwealth, breaches of Medicare principles, tax avoidance, and fraud.

5.5 Recommendations

In response to the above findings, the Committee makes the following recommendations:

Recommendation 18

The process by which facility fees charged by hospitals for allowing doctors to conduct private practice clinics on hospital premises should be transparent and accountable.

Recommendation 19

Salaried and sessional doctors be required to maintain timesheets.

Recommendation 20

Private practice funds should be controlled and managed by the individual doctors privately, and should not be processed through hospital Special Purpose Accounts. Money owed to the hospital for exercising private practice rights should be invoiced and accounted for separately.

Recommendation 21

The Department of Health and the State's public hospitals should establish clear and comprehensive policies and a transparent administrative framework for the provision of private services and the management of private patient billings, fees collection and revenue distribution.

Recommendation 22

The Federal Police and the State's anti-corruption body should investigate the payments made by both the Health Insurance Commission and the State health system, and expenditure relating to the doctor referred to in Findings 32, 33 and 34.

CHAPTER 6 STATUTORY REQUIREMENTS, ACCOUNTABILITY AND COMPLIANCE

6.1 Statutory Requirements and Compliance

(a) *Financial Administration and Audit Act, 1985*

As outlined in Chapter 2, the majority of hospital “trust” accounts were purportedly established pursuant to the FAAA. The Auditor General concluded that this was based upon the mistaken belief that trust funds constituted private moneys and therefore came under the jurisdiction of the FAAA.

In an appendix to his report, the Auditor General sets out in more detail the background to the application of the FAAA to trust accounts:

The FAAA contains a number of provisions regarding trust moneys and how agencies such as hospitals should account for these moneys. Under section 36, private moneys must be credited to the Trust Fund or held in a bank account opened and maintained in accordance with section 21 of the FAAA. Private moneys are defined under the FAAA as moneys, negotiable instruments or securities of any kind collected, received or held by the State or a statutory authority for or on behalf of a person other than the State or a statutory authority.

Section 21 provides the authority for departments and statutory authorities to operate a bank account. Under this section, a trust statement should be prepared for each bank accounts and be approved by the Treasurer. These statements detail, in broad terms, the moneys that can be credited to the account, how those moneys are to be applied and administrative arrangements covering the operation of the account.

The hospitals prepared and obtained approval from the then Treasury Department in 1989 (RPH and SCGH) and 1997 (KEMH/PMH and FHSHS) for trust statements governing the operation of these accounts...

These trust statements included moneys such as grants for research purposes and donations as the types of moneys which could be credited to the trust account. However, as outlined above, section 36 only applies to private moneys and consequently only a small number of accounts currently operated by the hospitals would legally comply with this section of the Act.

Although moneys such as research grants can only be used for specific purposes, they are not private moneys held by the hospitals on behalf of third parties and are controlled by the hospitals.

The original justification for and agreement to use this section of the FAAA for accounts not holding private moneys is unclear. However, this situation

most likely evolved as hospitals considered many of these funds were received from 'private sources' and wanted to distinguish them from normal operating funds. Consequently, they were considered as 'private' or hospital moneys that were not available for general purposes and the use of section 36 of the FAAA was seen as a mechanism to distinguish or set aside these moneys from other operating funds.

The Department of Treasury and Finance has provided the following comments regarding the issuing of trust statements and the operation of trusts in the hospital scenario:

The reference to private moneys in section 36 of the FAAA is not defined but has been interpreted as referring to moneys which a statutory authority is holding on behalf of another party. In this regard, the trust statements are not intended nor does it purport to establish the conditions for a trust relationship in relation to moneys held in an affected account. Rather, it is a mechanism intended to enhance accountability by the formal documentation of the key elements of the affected account.

The strict legal interpretation as to whether donations, grants and bequests would constitute trust moneys in the strict legal sense or are special purpose funds with a condition attached is a complex area which in some instances can only be resolved by recourse to legal advice.

The use of the terms Trust Fund and trust account were continued from the Audit Act 1904. It has been recognised that reference to the term 'trust' in relation to the Trust Fund and trust accounts may inadvertently give the impression that all affected accounts hold trust moneys and a review has recommended that this terminology be amended in the FAAA to remove the possibility of any misunderstanding as to the purpose of such accounts.¹⁰⁴

(b) *Hospital and Health Services Act, 1927*

The Auditor General found that hospitals were not generally aware of the statutory requirement that hospital boards authorise specific persons to collect voluntary contributions and donations in relation to fundraising activities. Therefore, the hospitals had not obtained authorisation under the HHSA. In addition, the hospitals did not comply with the provisions of the *Charitable Collections Act, 1946*.¹⁰⁵

Moneys raised for the benefit of hospitals creates an obligation on the hospitals to use the funds strictly according to the purpose they were raised for. The OAG's audit indicated that such money was frequently held in "private" accounts, and as such, hospitals may not be able to demonstrate the fulfilment of obligations. Moneys

¹⁰⁴ Auditor General, *op cit*, pp.59-60.

¹⁰⁵ *Ibid*, p.27.

collected by authorised persons belong to the particular hospital and the provisions of the FAAA must apply.¹⁰⁶

Finding 42

Hospitals did not ensure that fundraising activities were appropriately authorised and licensed in accordance with legislative requirements.

Recommendation 23

The Department of Health should develop guidelines in relation to fundraising activities in accordance with legislative requirements, and ensure that the guidelines are implemented and adhered to fully by all public hospitals.

(c) *State Trading Concerns Act, 1916*

The Auditor General found that:

- Hospitals had not always obtained approval under the HSSA or the *State Trading Concerns Act, 1916* for the operation of business activities.

“Business activities” refers to a range of ancillary products and services supplied to other hospitals, the general public and private sector organisations such as the manufacture of pharmaceutical products, repair and maintenance of equipment, sale of manuals, and facilitation of courses and workshops;
- Arrangements to recover costs associated with the operation of business activities were applied inconsistently;
- Preparation and completion of budgets and financial evaluations was carried out on an inconsistent basis; and
- Fees and charges were not reviewed or approved in accordance with the FAAA.¹⁰⁷

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid*, p.46.

(d) *Health Insurance Act, 1973*

This legislation and its application are addressed in Chapter 3.11.

(e) *Compliance with State Government Policies and Guidelines*

The Auditor General also reviewed compliance with various government policies and guidelines by hospitals. Some of his findings include:¹⁰⁸

(i) *State Supply Commission Supply Policies*

Quotes are required for the purchase of goods and services in order to demonstrate that value for money has been obtained and there has been a transparent process of open and fair competition.

The audit revealed that there were numerous instances of quotes not having been provided or retained.

(ii) *Travel Expenditure*

The Auditor General found positive results with respect to funds placed in accounts for travel to conferences and overseas study as a result of the workplace agreement with doctors which permitted a proportion of money from medical practitioners' private practice income to be used for those purposes. Testing indicated that hospitals had well-documented and consistently applied procedures for assessing and approving applications for travel.

Travel funded from other sources such as research grants was not as well controlled. There were instances where approval from the relevant senior authority was not always obtained. In one hospital, 17 out of 26 (65 per cent) overseas travel related payments were not approved properly.

Travel undertaken by university staff where funding was generated from hospital SPAs was not well controlled either, in that government/hospital approval processes and reporting requirements were not followed, resulting in less scrutiny, transparency and accountability.

(iii) *Hospitality Expenditure*

According to the Auditor General's report, hospitals were not aware of the guidelines for expenditure on official hospitality for government agencies, and did not enforce internal policies that establish the same levels of accountability and transparency.

¹⁰⁸

Ibid, pp.39-40.

The audit revealed that hospital expenditure did not always meet the purposes outlined in the guidelines or meet the documentary requirements. However, the audit also revealed that the payments tested were not abnormal or extravagant, and were generally in line with expenditure of the same nature in other government agencies.

(iv) Staff Appointments

The audit indicated that staff appointments at SCGH and FHHS to positions funded from SPAs did not always comply with Public Sector Standards in Human Resource Management in terms of merit based selection processes.

Recommendation 24

The Department of Health should ensure that hospitals comply with State legislation and government policies and guidelines relevant to Special Purpose Accounts. Compliance should be tested as part of the hospitals' annual reporting and auditing requirements.

6.2 Accountability

In referring to weaknesses in the administrative and control systems at the hospitals, the Auditor General stated that:

These weaknesses have resulted in transparency, accountability and compliance with relevant legislation over the use of these moneys not always being at the level expected for public moneys.¹⁰⁹

Accountability cannot be delegated. Over the years, however, it appears that nobody assumed ultimate responsibility for the management of SPAs and trust accounts, allowing unsatisfactory accounting, administrative and reporting processes to continue unchallenged. This was caused in part by the entrenched organisational culture within individual hospitals that treated special purpose funds as the sole dominion of those who raised the funds.

A more fundamental cause related to governance and the lack of a clearly defined executive reporting structure, both within the hospitals and the Department of Health. Given that the problems with SPAs were known for many years, why wasn't anything done to rectify them sooner? The following chronology illustrates the nature of the problem and explains, to some extent, why authorities tended to "pass the buck".

¹⁰⁹ *Ibid*, p.7.

Prior to 1997, each public hospital was a separate legal entity, governed by its own Board of Management. This autonomous arrangement changed in 1997 when the MHSB was established. The MHSB was charged with overall responsibility for the management of all the metropolitan teaching hospitals until it was eventually abolished in February 2001. Since 1 July 2002, each hospital has a CEO who reports directly to the Commissioner for Health. The Commissioner for Health is also the Director General of the Department for Health, and constitutes the accountable authority of the Minister for Health.

It is imperative that the hospitals accept the Commissioner for Health as the accountable authority, instead of seeing themselves as free agents in the management of SPAs. It is also imperative that the Commissioner for Health fulfils the accountability function by ensuring that there is a satisfactory level of coordination across the hospitals, and that policy and administrative frameworks are implemented consistently.

Finding 43

A lack of clear lines of responsibility and authority allowed unsatisfactory accounting and reporting processes to continue unchallenged. It is apparent that nobody assumed ultimate responsibility for the management of trust accounts and Special Purpose Accounts. This was caused in part by the entrenched organisational culture within individual hospitals that treated special purpose funds as the sole dominion of those who raised the funds.

Recommendation 25

The Commissioner for Health should fulfil his accountability function by ensuring that there is a satisfactory level of coordination across the hospitals, and that policy and administrative frameworks are implemented consistently.

CHAPTER 7 THE COSTS, BENEFITS & POTENTIAL LIABILITIES TO THE HEALTH SYSTEM OF TRUST ACCOUNTS

7.1 Costs and Potential Liabilities

The haphazard and careless manner in which trust accounts and SPAs have been managed in the past has contributed significantly to a crisis of public confidence in WA's public hospitals over recent years.

The principal costs and potential liabilities of the accounts as they have operated to date include:

- Damage to the reputation of public hospitals, employees, and the Department of Health;
- Potential loss of donations, bequests and corporate sponsorship to hospitals due to the perceived risk that moneys will not be managed and/or directed as requested by donors;
- The Committee found in its last report to the Legislative Assembly, *Inquiry into the Use of Visiting Medical Practitioners in the Western Australian Public Hospital System*, that there was already a severe shortage of doctors working in the State's public hospitals.¹¹⁰ The record of poor management of hospital trust accounts and SPAs and the subsequent events that transpired in an effort to rectify the problems may exacerbate this situation;
- The Committee received evidence from a number of doctors who warned that the damage they consider that adverse media coverage and various investigations has had on their reputations, both personally and collectively, will cause existing and future doctors to avoid working in the public health system;
- WA taxpayers risk forfeiting significant amounts of public funds if the Commonwealth pursues its claim for reimbursement for the practice of doctors bulk-billing public patients in breach of the *Health Insurance Act, 1984*;
- Individual doctors who bulk-billed Medicare under the above arrangement also risk substantial financial penalties under the Commonwealth legislation, notwithstanding that they claim to have been directed by hospital management and ultimately the Department of Health to conduct bulk-billing practices over a number of years; and

¹¹⁰ Report No.2 in the 36th Parliament, 05/12/02.

- The administrative and financial management and oversight of trust accounts and SPAs was so poor at the teaching hospitals for a number of years that misuse and fraud could have occurred without being detected.

In a letter to the then Commissioner of Health following its Business Process Review report, Ernst & Young identified several other risks associated with the poor operation of accounts to both the hospitals and the Department of Health:

- Inability to defend criticism in the areas of financial governance, administration, management, accountability and transparency;
- Loss of benefits, both financial and reputation, from research activities;
- Inaccurate financial and activity reporting on health delivery activities;
- Poor strategic and operational decision-making; and
- Increased ethical and misuse of funds and assets related issues.¹¹¹

7.2 Benefits

According to the CSA, the costs to the health system of trust accounts and SPAs are minimal, while the benefits are enormous.¹¹² They claim that the fact that public hospital staff have had access to the accounts in the past explains why many doctors chose to work in public hospitals, and that in the absence of these funds, many would leave the system and seek employment elsewhere. The CSA states that:

The ability to raise these funds and perform research and teach is what keeps many highly qualified doctors in the public system. If such practice were banned or became so onerous as to not be worth doing many staff would leave the system. They could seek employment either in the private system which would be more rewarding financially but not as interesting or seek employment in a system that welcomes and encourages such practices.¹¹³

The CSA's rationale for sacrificing private earning potential to work in public hospitals is that through effort and commitment to public health, trust accounts and SPAs have been a means of raising significant funds to supplement hospitals' budgets, buy equipment, conduct research, employ assistants, facilitate the professional development and training of clinicians and enhance medical care generally.

This view was reinforced by a number of doctors who gave evidence to the Committee. They stressed that their use of the accounts was intended to benefit

¹¹¹ Correspondence from Ernst & Young to Commissioner for Health, dated 25/09/01.

¹¹² CSA submission, 07/12/01, p.6.

¹¹³ *Ibid.*

patients and the community, and that they did not benefit personally in any way. Instead, they claim that their motivation was derived from honourable beliefs, reflecting dedication and initiative.¹¹⁴

The Committee acknowledges the well-meaning intention of most doctors in this regard. The staff of public hospitals in WA have achieved enormous benefits for the State through medical research, training, special projects and other activities that were traditionally funded from hospital “trust” accounts. The Committee does not dispute the dedication and commitment of these health professionals, or the enormous contribution they have made to medical research.

The direct benefits to the community of special purpose funding and activities are self-evident. However, the benefits were negatively impacted upon by the cost to the community in the sense of problems associated with the use of weak internal controls and management of those controls. It is most unfortunate that the systems administering the accounts were lacking for so long, as they culminated in such disorder that doctors were open to criticism and suspicion.

There is no need for these benefits to cease. Provided that SPAs are managed appropriately and that the various recommendations of both the Auditor General and the Committee are implemented, they can still serve the beneficial functions intended by doctors and hospital management. Not only should the new systems be more transparent and accountable, but they should also provide doctors with confidence that they will not be exposed to criticism or risk unintentional wrongdoing.

Finding 44

Provided that Special Purpose Accounts are managed appropriately and that the various recommendations of both the Auditor General and the Committee are implemented, they can still serve the beneficial functions intended by doctors and hospital management.

Greater transparency and accountability should provide doctors with confidence that they will not be exposed to criticism or risk unintentional wrongdoing.

¹¹⁴ *Ibid*, p.3.

CHAPTER 8 ANY OTHER MATTER THAT THE COMMITTEE DEEMS NECESSARY TO INVESTIGATE

8.1 Dispute Between Michael Moodie, Chief Executive Officer of KEMH/PMH and the PMH Clinical Staff Association

In February 1999 Michael Moodie was appointed as CEO of KEMH/PMH. As outlined in Chapter 1, soon after he commenced his employment he became aware of difficulties associated with the management of “trust” accounts within the hospital and instigated three internal audits into this issue before July 2000.

The Committee received considerable evidence relating to Mr Moodie’s performance as CEO of the hospitals until his eventual departure from the position in September 2000. Although not strictly related to “trust” account management, many issues raised in the evidence were of significant concern. The Committee resolved to deal with a number of these issues due to the nature of some allegations and the impact on individuals’ professional reputations.

The Committee is mindful that much of the evidence comprised differing versions of events. The Committee’s inquiry process does not allow thorough examination and cross-examination of witnesses, and as a result, the Committee is reluctant to make judgement on whether one version should prevail over another.

This section of the report focuses on the dispute between Mr Moodie and hospital staff, particularly the PMH CSA, that represents the interests of clinicians.

(a) The Nature of the Dispute

It must be acknowledged from the outset that Mr Moodie acted quickly to address the problems associated with hospital “trust” accounts, which had developed unhindered for many years previously. His actions allowed thorough assessment of the situation and opportunity to install an accountable system of management.

The Committee recognises that there were difficulties at both hospitals under Mr Moodie’s responsibility, but will focus on the situation at PMH, which was much more inflamed.¹¹⁵ The relationship between Mr Moodie and hospital staff deteriorated to such an extent that the PMH CSA undertook a concerted and very public campaign for Mr Moodie’s removal.

The serious breakdown in the relationship between Mr Moodie and clinicians at PMH originated during Mr Moodie’s attempts to address the problems. Mr Moodie’s

¹¹⁵ Mr A. Bansemer, Transcript of Evidence, 28/11/01, p.30.

attempts to address the problems with hospital trust accounts, SPAs and other problems at PMH/KEMH were both legitimate and necessary. However, his actions were opposed by some clinicians and were not supported by the Metropolitan Health Services Board.

Each side holds a different view as to why Mr Moodie was subjected to conjecture and opposition from clinicians. The clinicians took exception to Mr Moodie's initial public statements about the trust accounts issue and claim Mr Moodie's public utterances were designed to deflect attention from his poor management skills. The clinicians maintain Mr Moodie's lack of communication and management style was the cause of the difficulties and the reason for his eventual departure as CEO.¹¹⁶ The AMA and doctors also perceived Mr Moodie's actions as a witch-hunt, and doctors claimed that he threatened that the MHSB would take "their" account funds from them.

For his part, Mr Moodie asserts that the clinicians raised the issue of his management style after becoming insecure about investigations into hospital "trust" accounts. Mr Moodie believes his management style was not the central cause of his demise.¹¹⁷ According to Mr Moodie, the CSA stated at an early stage that it would work to have him removed if he did not comply with their wishes regarding the investigation.¹¹⁸ By contrast, the CSA presented evidence to show it had made attempts to restore communication with management, which did not respond to the clinicians' satisfaction.¹¹⁹

The MHSB, the body to which Mr Moodie was responsible, made no formal approach to him regarding problems with management style, so it is difficult for the Committee to draw specific conclusions.¹²⁰ The Board's approach to these issues was deficient.

Poor communication created uncertainty between management and clinicians. To demonstrate the deteriorating relationship, clinicians initially cooperated fully with investigations into trust accounts and SPAs but felt increasingly threatened and insecure over time, exacerbating the existing tension towards management.

A number of witnesses commented on Mr Moodie's management style. The Committee will not pass judgment on this specifically, but acknowledges many hospital employees were unsettled by their interactions with Mr Moodie and complained of a general lack of communication from management.

¹¹⁶ Dr A. Duncan, PMH, Transcript of Evidence, 03/12/01, p.14; Hon. I. McCall, Transcript of Evidence, 21/12/02, p.8.

¹¹⁷ Mr M. Moodie, Transcript of Evidence, 12/11/01, p.9.

¹¹⁸ Mr M. Moodie, Transcript of Evidence, 07/11/01, pp.15-16; and 12/11/01, p.45.

¹¹⁹ PMH CSA, Submission, 10/12/01, pp.16-17.

¹²⁰ Mr M. Moodie, Transcript of Evidence, 07/11/01, p.16.

Mr Moodie arrived in the job with a strong administrative background and solid references. His previous roles attracted a degree of controversy that can be considered reasonable when overseeing change in established systems. Mr Moodie's direct manner and strong emphasis on financial issues may have been confronting to the existing culture within the hospitals, but ultimately he was severely let down by the performance of the MHSB, to which he was answerable.

The Committee is satisfied that both Mr Moodie and the CSA were acting in what they believed were the best interests of the WA health system. In the end, the fact that Mr Moodie was perceived by clinicians to be no longer supporting their cause probably was as significant in his demise as any issues concerning his management.¹²¹ In evidence to the Committee, Mr Moodie stated that despite the doctors' perception that he was engaged in a witch-hunt, he never actually accused anyone of impropriety:

*I must say that in all my discussions with doctors on all the issues about the trust accounts, nobody ever came to me and said "There was this amount of money. So-and-so took it", or it disappeared, or something improper had taken place. They were very much administrative, accounting, process-related matters. The nature of the inquiries was to tidy up those things, so that there would not be a suggestion that there was a problem with the accounts.*¹²²

Finding 45

Mr Moodie's attempts to address the problems with hospital trust accounts, Special Purpose Accounts and other problems at King Edward Memorial Hospital / Princess Margaret Hospital were both legitimate and necessary. However, his actions were opposed by some clinicians and administrators, and were not supported by the Metropolitan Health Services Board.

¹²¹ This view also was expressed by Mr Alan Bansemer, former Commissioner of Health, Transcript of Evidence, 28/11/01, p.29.

¹²² Mr M. Moodie, Transcript of Evidence, 12/11/01, p.20.

Finding 46

Mr Moodie's concerns and decision to initiate investigations into a number of serious allegations that had been brought to his attention, especially those relating to the bulk-billing of Medicare by doctors, were both legitimate and an entirely appropriate response by a hospital Chief Executive Officer.

Furthermore, the Health Insurance Commission's findings that the long-standing bulk-billing practices at Princess Margaret Hospital were inappropriate vindicate Mr Moodie's actions.

(b) The Perceived "Role" of the Hospitals' Chief Executive Officer

Some of the antagonism between Mr Moodie and clinicians at PMH appears to originate from differing views on the role of the hospitals' CEO. The expected attitude of the CEO was revealed in separate comments made at Committee hearings by Mr Moodie and Dr Gary Geelhoed, Chairman of the PMH CSA. Michael Moodie stated that:

*The culture at the time and the hospital's view was that, as chief executive officer, I was there to defend them. I was not necessarily there to do the requirements of the board.*¹²³

In contrast, Dr Gary Geelhoed stated that:

*Mr Moodie worked against the hospital the whole time. We asked if he was an advocate for the hospital, and he said no. He denied that he was an advocate... The staff felt he should be an advocate for the hospital.*¹²⁴

In practice the CEO was answerable to the MHSB and his responsibilities began with ensuring the best possible delivery of health service to Western Australians. Clearly CEOs must work to balance various interests within their control, particularly clinicians who may have specific needs and concerns, but the inability of PMH's clinicians to recognise that the CEO was not necessarily responsive to them was unrealistic and problematic.

Notwithstanding the eminence of clinicians within the health system, the Committee emphasises that clinicians are employed by the Department of Health, and as such, must be subject to appropriate measures of accountability and authority.

¹²³ Mr M. Moodie, Transcript of Evidence, 07/11/01, p.11.

¹²⁴ Dr G. Geelhoed, Transcript of Evidence, 03/12/01, p.16.

While recognising the sincerity of the clinicians' motives, the Committee is concerned at the degree of active campaigning by the CSA to influence decisions regarding their CEO. Its campaign became spiteful, as exemplified by the gratuitous inclusion in its submission to this inquiry of a synopsis of Paranoid Personality Disorder, presumably directed at Mr Moodie.¹²⁵ This synopsis was of no assistance to the inquiry.

(c) The Role of the Metropolitan Health Services Board

As CEO of KEMH/PMH, Michael Moodie was answerable to the MHSB, which in turn, through its Chair, was answerable to the Health Minister.¹²⁶

Mr Moodie can be justifiably aggrieved by his treatment from the MHSB. Mr Moodie fulfilled his role as CEO of KEMH/PMH in the manner he saw fit and at no time was advised to alter his style, which had been subject to so much speculation. According to Mr Moodie, the MHSB provided little reason for him to believe it was dissatisfied with his performance and, in fact, reassured him that he was doing a good job despite the campaign undertaken by the CSA.

The PMH clinicians were also poorly served by the MHSB. Initially they sought to improve the relationship with management through appropriate avenues - first with Mr Moodie himself, then the MHSB, and then the Minister. Over time, however, growing frustration made their approaches more extreme. The Committee acknowledges the strength of feeling that provoked the actions of the CSA but questions its methods.

The MHSB failed to properly address concerns regarding Mr Moodie's management and made no formal approach to Mr Moodie regarding staff concerns despite later claiming knowledge of a "considerable managerial style problem".¹²⁷ Admittedly, the MHSB was in an awkward position between the hospitals' CEO and the clinicians, but the lack of any decisive action simply made the situation worse when it was clear the problems between management and clinicians were serious.

An example of the MHSB's failure to manage the situation adequately was its inability to control the CSA's increasingly uncompromising campaign against Mr Moodie, particularly with respect to the CSA's public statements. During a period of intense media interest in these issues, Mr Moodie was instructed by the MHSB to make no further public comment on the basis that such exposure was harmful both to him and the reputation of the hospitals.

At the same time, a similar direction was given to the CSA, which was allowed to make a single further statement on the condition it would "support the good name of

¹²⁵ PMH CSA, Submission, 10/12/01, Attachment 72.

¹²⁶ MHSB Annual Report 1999-2000, p.4.

¹²⁷ Mr M. Moodie, Transcript of Evidence, 07/11/01, p.16; Mr A. Weeks, Transcript of Evidence, 21/12/02, p.4.

the hospital and the services provided by the hospital”.¹²⁸ The CSA abused this latitude by again airing its grievances regarding Mr Moodie.

The MHSB maintained that it supported Mr Moodie throughout his employment, but if so, its efforts certainly were ineffective at a public level. It failed to provide any meaningful public defence of Mr Moodie despite the media’s ferocity and neither did it seriously attempt to rein in the actions of the CSA.

The MHSB’s failure to address concerns of the CSA eroded Mr Moodie’s effectiveness and authority. It left Mr Moodie isolated and would only have worsened aspects of his managerial style considered by hospital staff to be deficient.

Mr Moodie reflected in evidence to the Committee:

*[T]he circumstances would have been different if some support had been given, particularly publicly, that that process was under way, to the effect that “Mr Moodie has done what was required of him and representations from clinical staff were dealt with appropriately”; that is, it came back to me and I had the opportunity to change.*¹²⁹

Mr Moodie’s only clear support came from the then Commissioner for Health, Alan Bansemer, who had no authority to involve himself in matters controlled by the MHSB.¹³⁰ The performance of the MHSB was inadequate and let down all parties concerned, which in the end was perhaps the sole factor common to both Mr Moodie and the hospital’s clinicians.

The public campaigning by the CSA has caused significant distress to Mr Moodie and his family. It was not surprising Mr Moodie ceased effective communication with the MHSB and ultimately agreed to be removed from his position following discussions with the then Minister.¹³¹

¹²⁸ Mr A. Weeks, Transcript of Evidence, 21/12/01, p.7; Mr M. Moodie, Transcript of Evidence, 07/11/01, p.18.

¹²⁹ Mr M. Moodie, Transcript of Evidence, 07/11/01, p.10.

¹³⁰ Mr A. Bansemer, Transcript of Evidence, 28/11/01, p.30.

¹³¹ Mr M. Moodie, Transcript of Evidence, 07/11/01, pp.20-21; Mr A. Weeks, Transcript of Evidence, 21/12/02, p.6.

Finding 47

The performance of the Metropolitan Health Service Board was inadequate for all parties concerned, especially Michael Moodie, who can feel justifiably aggrieved by his treatment from the MHSB.

Mr Moodie fulfilled his role as Chief Executive Officer of King Edward Memorial Hospital / Princess Margaret Hospital in the manner he saw fit, and at no time was advised to alter his style, which had been subject to so much speculation. According to Mr Moodie, the MHSB provided little reason for him to believe it was dissatisfied with his performance and, in fact, reassured him that he was doing a good job despite the campaign undertaken by the Clinical Staff Association.

(d) The Roles of the Former Premier and the Former Minister for Health in the Removal of Michael Moodie

It is unclear what roles were played by former Minister for Health, John Day, and former Premier, Richard Court, in the departure of Mr Moodie from his position as CEO of KEMH/PMH.

The dispute was attracting significant media interest towards the end of 2000, placing pressure on the Government as it prepared for an election due in early 2001. In meeting with the then Premier regarding its concerns over Mr Moodie, the CSA had made representations at the highest level. The Commissioner for Health, the Minister and the MHSB also were made aware of the CSA's views.

Mr Moodie was an employee of the MHSB and could only be removed from his position through a decision by that body. Mr Moodie seems to have suggested that the MHSB would follow Mr Day's instruction to remove him as CEO even though theoretically Mr Day did not have the power to make such an instruction. The evidence inferred that the Premier pressured the Minister to make the instruction. Mr Moodie claims that he had been advised by Mr Andrew Weeks, CEO of the MHSB that his position was untenable and that if he didn't leave, the MHSB would remove him. It was in these circumstances that Mr Moodie agreed to terms for his departure with the then Minister for Health.¹³²

The MHSB claimed to have had no direct involvement with Mr Moodie's departure, as explained in evidence to the Committee by Mr Weeks:

¹³² Mr M. Moodie, Transcript of Evidence, 07/11/01, p.18; and 12/11/01, pp.43-44.

The point I wish to make here more than anything else is Mr Moodie stood down from his job after he reached an agreement with the Minister for Health and the Minister for Health communicated that agreement to us.¹³³

However, Mr Weeks' evidence is at odds with a letter in the Committee's possession from Mr Weeks to Mr Moodie, dated 29 September 2000, in which Mr Weeks advises Mr Moodie:

I have come to the view it is in the best interests of the Metropolitan Health Service for you not to continue to perform your functions and duties. In my view it is impracticable to operate the public health services at King Edward Memorial & Princess Margaret Hospitals whilst you remain discharging the functions of Chief Executive of those hospitals.

A break will give you time to consider your position and options as discussed with the Minister for Health last evening. It will also diffuse the current level of adverse media interest in your continuing presence at King Edward Memorial & Princess Margaret Hospitals which is reinforcing the practical difficulties I have referred to above.

On behalf of your employer, I do not require you to perform any of the functions or duties of your contract of employment until further direction from me.

In the meantime all of the benefits under your contract of employment remain on foot.

By working towards the removal of Mr Moodie, the Minister acted contrary to advice from the Commissioner for Health.¹³⁴ The Committee notes comments made by the former Minister for Health in response to suggestions by Mr Moodie that the former Premier had ordered his removal. While not supporting Mr Moodie's claims, neither did Mr Day contradict them before he added:

...I have not known Mr Moodie to be somebody who doesn't tell the truth.¹³⁵

In light of the ambiguous nature of evidence received in the early stages of the inquiry, the Committee resolved to call Mr Day to give evidence on 22 October 2003. In response to questions by the Chairman in relation to the removal of Mr Moodie, Mr Day stated that:

...The reality of the situation was that a crisis of confidence developed in connection with PMH, in particular. Whether or not that is justified is

¹³³ Mr A. Weeks, Transcript of Evidence, 21/12/01, p.4.

¹³⁴ Mr A. Barsemer, Transcript of Evidence, 28/11/01, p.28.

¹³⁵ Premier 'ordered hospital boss out', The Australian, 08/11/01, p.7.

*another matter. I do not think it was at all justified but the reality is that is what occurred. I was seeking to resolve the issues in an amicable way so that confidence could be restored in the hospital and, hopefully, Michael Moodie could continue in his position. However, the pressure built up to such an extent that an impasse developed. My role was not to move Michael Moodie aside. If that was to occur, it was not for me to have that role. It was for the Metropolitan Health Service to have that role as his employer...My role was to be a go-between...to seek to find a way out of what was a very difficult situation.*¹³⁶

Mr Day went on to state that the former Premier, Richard Court, also had concerns about the crisis of confidence at PMH, but that neither he, nor Mr Court, took the decision to stand Mr Moodie aside. Mr Day did acknowledge, however that Mr Moodie was a scapegoat, and that his ultimate removal as CEO has affected his career.¹³⁷

Finding 48

Michael Moodie's removal as Chief Executive Officer of King Edward Memorial Hospital / Princess Margaret Hospital was not justified and was handled poorly.

¹³⁶ Hon. J. Day, MLA, Transcript of Evidence, 22/10/03, p.6.

¹³⁷ *Ibid*, p.11.

CHAPTER 9 CONCLUSIONS

The reputation of WA's metropolitan teaching hospitals and its health professionals has been hampered for many years by the "trust" accounts issue. Public confidence in the WA public health system was seriously eroded due to the plethora of allegations of fraud and misuse of public funds.

By conducting this inquiry, the Committee has endeavoured to clarify the true position and set the public record straight. As a direct result of the Committee's inquiry, a number of positive developments have ensued, such as the Auditor General allocating significant resources to conduct an extensive audit of SPAs, each of the hospitals initiating improvements in policy and procedure, and the Department of Health committing to an extensive reform agenda.

The Committee's process of inquiry has also provided a valuable opportunity for those individuals who were the subject of intense media scrutiny and public suspicion to have their say and express their version of events. A number of witnesses said they were grateful for this opportunity, as it was the first chance they had received to defend themselves in what appeared to be a campaign to discredit them as individuals and the public hospitals to which they were committed.

The Committee has been assisted by the Office of the Auditor General throughout the inquiry. The extensive audit conducted by the OAG provided a useful tool for the Committee to base a number of its technical findings and recommendations. The Committee acknowledges the extent of resources that the OAG devoted to its audit of SPAs - significantly more resources than is expended on most other audits conducted. This priority reflects the severity of the problems in relation to hospital trust accounts and SPAs, both in terms of management and public perception.

Expenditures relating to conference travel and official entertainment were often extravagant and verged on personal gain, but successive hospital and Departmental administrators did nothing to curb these unacceptable activities for a number of years.

Neither Erst & Young nor the OAG conducted a thorough forensic investigation, and several matters remain to be investigated. It is imperative that these outstanding matters be fully investigated so as to dispel suspicion and enable the credibility of the doctors and hospitals to be restored.

The mismanagement and poor oversight of hospital trust accounts and SPAs by both individual hospitals and the Department of Health established an environment in which fraud and waste was difficult to detect. Successive audits and investigations of SPAs by Arthur Andersen, Ernst & Young, the Commissioner for Health and the OAG revealed extremely low standards of management and control, a serious lack of documentation and poor record keeping. There was often both a lack of appropriate

policy and procedure in place, and a failure to apply those policies and procedures that did exist.

Oversight by hospital management, the MHSB and the Department of Health was at best ineffectual, at worst, non-existent. The severe breakdown in effective governance structures and processes demonstrated an appalling lack of accountability that must be rectified immediately.

As the accountable authority, the Department of Health is required to take ultimate responsibility, for the operation of the State's teaching hospitals. The Committee considers that the Department of Health abrogated this responsibility for many years.

The Committee is pleased with recent efforts by the hospitals and the Department of Health to improve the administration and management of SPAs. However, they are long overdue. The initiatives undertaken to date are an important first step in the reform process, but significant improvements have still to be made. The Committee is also concerned that the approach taken to date appears to be uncoordinated and fragmented due to a lack of coherent policy and administrative framework. Part of the historic problem with SPAs was that each of the hospitals administered them in a different manner, making them difficult to manage and oversight.

So far, the hospitals' reform initiatives also appear to be uncoordinated due to a lack of coherent policy and administrative framework. The Committee urges the Department of Health to ensure a coordinated approach by the hospitals. Coordination by the Department of Health should prevent similar problems recurring in the future. The Department has been developing an Accounting Manual that deals with, among other things, the management of SPAs. It is also the Department's responsibility to develop benchmarking standards for individual hospitals to apply as consistently as possible, and to ensure that the hospitals' measures are effective.

Finding 49

The mismanagement and poor oversight of hospital trust accounts and Special Purpose Accounts by the individual hospitals and the Department of Health established an environment in which fraud and waste was difficult to detect.

Successive audits and investigations revealed extremely low standards of management and control, a serious lack of documentation and poor record keeping. Those policies and procedures that were in place were not applied.

Finding 50

Oversight of Special Purpose Accounts by hospital management, the Metropolitan Health Services Board and the Department of Health was at best ineffectual, at worst, non-existent. The severe breakdown in effective governance structures and processes demonstrated an appalling lack of accountability.

Finding 51

As the accountable authority, the Department of Health is required to take ultimate responsibility for the operation of the State's teaching hospitals. The Committee considers that the Department of Health abrogated this responsibility for many years in respect of trust accounts and Special Purpose Accounts.

Finding 52

The Committee recognises the efforts to improve the system of managing Special Purpose Accounts by the Hospitals and the Department of Health since the commencement of this inquiry. However, they are long overdue.

The initiatives undertaken to date are an important first step in the reform process but significant improvements have still to be made. The Committee is also concerned that the approach taken to date appears to be uncoordinated and fragmented due to a lack of coherent policy and administrative framework.

9.1 Implementation and Review

WA is not the only State to have experienced endemic problems with hospital "trust" accounts. The Committee is confident that this inquiry has contributed to the current recovery process in WA's public health system, and expects improvements to continue. In this regard, it is imperative that the hospitals and the Department of Health adopt and implement the recommendations made by the Committee and the Auditor General.

The speedy implementation of the Auditor General's and Committee's recommendations is now the primary focus of the Committee. The Committee will actively monitor the progress of the implementation process and review the overall operation of trust accounts and SPAs in 12 months. Within that time, the Committee

expects to see significant improvements in place, as well as effective coordination and oversight by the accountable authority.

APPENDIX ONE

WITNESSES TO HEARINGS HELD¹³⁸

Date	Witness	Position	Organisation
07/11/01	Mr Michael Moodie	[former] Chief Executive Officer	King Edward Memorial Hospital for Women & Princess Margaret Hospital for Children
12/11/01	Mr Michael Moodie	[former] Chief Executive Officer	King Edward Memorial Hospital for Women & Princess Margaret Hospital for Children
28/11/01	Mr Alan Bansemer	[former] Commissioner for Health	Department of Health
03/12/01	Dr David Baker	Director, Department of Haematology/Oncology	Princess Margaret Hospital for Children
03/12/01	Dr Alan Duncan	Medical Practitioner, Paediatric Intensive Care	Princess Margaret Hospital for Children
03/12/01	Dr Gary Geelhoed	Medical Practitioner, Emergency Department	Princess Margaret Hospital for Children
10/12/01	Dr Simon Towler	Medical Practitioner	Royal Perth Hospital
10/12/01	Dr Warwick Ruse	Chairman, Medical Advisory Committee	Bentley Area Health Service
10/12/01	Mr Paul Boyatzis	Executive Director	Australian Medical Association (WA)
10/12/01	Mr Peter Jennings	Deputy Executive Director	Australian Medical Association (WA)
21/12/01	Hon. Ian McCall	[former] Chairman	Metropolitan Health Services Board
21/12/01	Mr Andrew Weeks	[former] Chief Executive Officer	Metropolitan Health Services Board

¹³⁸

Excluding witnesses who gave evidence at closed and *in-camera* hearings, whose names and details are not to be published.

PUBLIC ACCOUNTS COMMITTEE

Date	Witness	Position	Organisation
21/12/01	Professor Lou Landau	[former] Board Member	Metropolitan Health Services Board
21/12/01	Mr David Vaughan	[former] Board Member	Metropolitan Health Services Board
18/02/02	Mr Terry Larkan	Principal, Business Risk Services	Ernst & Young
18/02/02	Mr John Copp	Partner	Ernst & Young
20/03/02	Mr Brian Austin	Manager, Financial Services	King Edward Memorial Hospital for Women & Princess Margaret Hospital for Children
20/03/02	Dr William Beresford	[former] Acting Chief Executive	King Edward Memorial Hospital for Women & Princess Margaret Hospital for Children
10/06/02	Mr Craig Bennett	Chief Executive	Sir Charles Gairdner Hospital
10/06/02	Dr Mark Platell	Acting Executive Director, Medical Services	Sir Charles Gairdner Hospital
10/06/02	Mr John Burns	Chief Executive	Fremantle Hospital
10/06/02	Dr Shane Kelly	[former] Executive Director, Medical Services	Fremantle Hospital
10/06/02	Dr Philip Montgomery	Acting Director, Clinical Services	Royal Perth Hospital
13/11/02	Dr Brian Lloyd	Deputy Director General, Chief Medical Officer	Department of Health
13/11/02	Mr Alex Kirkwood	Director of Finance	Department of Health
13/11/02	Mr Philip Aylward	Acting Group Director, Policy & Resources	Department of Health
13/11/02	Mr Andrew Chuk	Deputy Director General, Corporate & Finance	Department of Health
13/11/02	Mr Michael Daube	Director General	Department of Health
02/04/03	Mr Donald Doig	Commissioner	Anti-Corruption Commission

PUBLIC ACCOUNTS COMMITTEE

Date	Witness	Position	Organisation
02/04/03	Mr Terence O'Connor	Chairman	Anti-Corruption Commission
02/04/03	Ms Moira Rayner	Commissioner	Anti-Corruption Commission
13/08/03	Mr Michael Daube	Director General	Department of Health
13/08/03	Mr Philip Aylward	Acting Group Director, Policy & Resources	Department of Health
22/10/03	Hon. John Day, MLA	Member for Darling Range & [former] Minister for Health	Legislative Assembly, Parliament of Western Australia
29/10/03	Mr Michael Daube	Director General	Department of Health
29/10/03	Mr Andrew Chuk	Deputy Director General, Corporate & Finance	Department of Health
29/10/03	Dr Shane Kelly	Chief Executive Officer	South Metropolitan Health Service
29/10/03	Mr John Carruthers	Principal Policy Officer	Department of Health
29/10/03	Mr John Young	Solicitor	Crown Solicitor's Office

APPENDIX TWO

SUBMISSIONS RECEIVED

Date	Name	Position	Organisation
12/11/01	Mr Michael Moodie	[former] Chief Executive Officer	King Edward Memorial Hospital for Women & Princess Margaret Hospital for Children
06/12/01	Ms Michele Kosky	Executive Director	Health Consumers' Council
10/12/01	Ms Premila Levaci	Research & Clinical Trial Coordinator	
10/12/01	Mr Paul Boyatzis	Executive Director	Australian Medical Association
10/12/01	Dr Gary Geelhoed	Chairman	PMH Clinical Staff Association
21/12/01	Mr Andrew Weeks	[former] Chief Executive Officer	Metropolitan Health Services Board
18/02/02	Mr John Copp & Mr Terry Larkan	Partners	Ernst & Young
20/02/02	Mr John Copp	Partner	Ernst & Young
20/03/02	Dr William Beresford	[former] Acting Chief Executive	King Edward Memorial Hospital for Women & Princess Margaret Hospital for Children
10/06/02	Mr Craig Bennett	Chief Executive	Sir Charles Gairdner Hospital

APPENDIX THREE

LEGISLATION

Legislation	State (or Country)
<i>Charitable Collections Act, 1906</i>	Western Australia
<i>Crimes Act, 1914</i>	Commonwealth of Australia
<i>Financial Administration and Audit Act, 1985</i>	Western Australia
<i>Hospital and Health Services Act, 1927</i>	Commonwealth of Australia
<i>Health Insurance Act, 1984</i>	Commonwealth of Australia
<i>Human Tissue and Transplant Act, 1982</i>	Western Australia
<i>State Records Act, 2000</i>	Western Australia
<i>State Trading Concerns Act, 1916</i>	Western Australia

APPENDIX FOUR

AUDITOR GENERAL'S GUIDANCE ON THE IDENTIFICATION AND CLASSIFICATION OF SPECIAL PURPOSE FUNDS

There are five broad options for classifying funds at the hospitals:

- moneys that are external to and independent of the hospital;
- moneys held in trust;
- special purpose moneys with an external restriction;
- special purpose moneys with an internal restriction; and
- hospital operating funds.

The appropriate classification is primarily determined by the ultimate ownership of the moneys and the degree of control the Hospital has over how the moneys are used. As a general rule, all moneys that are received on hospital premises, or by hospital staff on duty should be classified as hospital moneys unless there are obvious reasons why another party should own the moneys. However, establishing which party has ultimate legal ownership to moneys is not always straightforward and may require detailed consideration of various issues. These include:

- ownership of resources used to generate funds (eg seed capital for a research project) or resources provided as consideration for funds (eg sale of assets or scrap, provision of staff time);
- identification of the legal entity or person to whom the funds were given or granted;
- control of the legal entity that has received the funds; and
- contractual relationships between the parties involved in either providing or receiving the funds, or receiving the benefit of the use of the funds.

The following flowchart gives guidance on establishing ownership, however the question can be complex and each source of moneys should be individually considered. Where ownership cannot be clearly established, the hospital should agree contractual terms that establish the responsibilities of all parties involved.

A group of university-employed doctors working at a teaching hospital open a bank account to manage funds relating to a conference held at the hospital for doctors from other organisations. Once the conference was finalised a surplus remaining in the account was used as an advance to purchase items used at the hospital, which were later reimbursed from hospital funds.

This case illustrates the complexities related to establishing ownership as the conference was not a function of the hospital or the university. The problem is a common case of establishing final ownership of a surplus in a defunct account. Here, whichever party contributed the resources for the conference has the best claim to ownership of the surplus. Where the doctors need an advance this should either be obtained from the hospital or an alternative arrangement established (eg corporate credit card).

Control relates to the capacity of the hospital to benefit from the moneys in the pursuit of its objectives and to deny or regulate the access of others to that benefit. Thus, moneys that the hospital cannot use in pursuit of its objectives should not be considered as being hospital moneys. These moneys either should be held by the hospital in a trustee capacity or be returned to their source.

Some moneys received by a hospital can still be used in pursuit of the hospital's objectives however the contributor restricts the moneys for a particular purpose. When moneys are restricted for a single purpose the hospital has a fiduciary responsibility to apply those moneys in a manner that conforms to the contributor's stipulation's. Thus, the hospital should set up accounts that demarcate moneys contributed for separate restrictions. Some restrictions may have a limited life, for example when moneys are donated to purchase a specific item of equipment, the fiduciary responsibility is extinguished once the equipment is purchased. Once the fiduciary responsibility is extinguished, the account should be closed and any surplus moneys applied according to the contributor's instructions or where no instructions exist used to the benefit of the hospital.

The degree of control a hospital has over the use of moneys determines the appropriate accounting treatment for those moneys belonging to the hospital. Accounting treatments vary where the hospital has different reporting requirements or specific obligations to manage moneys in accordance with grant conditions, donor intentions or contractual obligations. For government agencies, specific reporting requirements are set up in the Treasurer's Instructions for administered trust accounts, unexpended balances of contributions and restricted assets. Accounts holding moneys with similar degrees of control should be grouped together to enable the application of appropriate management control procedures and complete and accurate financial reporting. For example, moneys with external restriction should be kept separate from moneys with

internal restrictions to facilitate reliable reporting of balances for restricted cash at year end.

Trust Accounts

Trust accounts are a simple mechanism used to prevent moneys belonging to different parties from being mixed so that the ultimate ownership of the moneys in the account is always evident. To keep moneys genuinely separate section 21 of the FAAA requires that all trust accounts have separate bank accounts. Managing separate bank accounts for each trust account requires significant resources so it is important to ensure that the number of trust accounts is kept to a minimum. In hospitals, most moneys traditionally called trust moneys are in fact moneys belonging to the hospital and should either be classified as SPA with external or internal restrictions.

Usually moneys must be placed in trust accounts because there is a legal document (eg bequest, trust deed) or agreement (eg industrial agreement) or act of Parliament (eg State Trading Concerns Act (1916), FAAA) that explicitly requires a trust account. Therefore, trust accounts may exist whether or not moneys belong to or are controlled by the hospital. Thus Hospital may have both administered trust accounts holding moneys belonging to others (eg patient moneys) and controlled trust accounts holding hospital moneys.

Restricted Moneys

Restricted moneys are usually received in the form of contributions usually donations or bequests or grants. However moneys are only restricted if the restriction originated from an external party and the hospital cannot change the restriction. A further requirement is that the moneys must originate from sources external to the state government so that items like capital funding from the Department of Health are not regarded as restricted moneys.

Tied Moneys (Internal Restriction)

There are many good reasons why a hospital may decide to open an account to separately account for moneys. Moneys may relate to specific projects (eg capital works), projects may run over more than one financial period, there may be reasons to focus budgetary controls or management attention on a specific area, or there may be specific reporting requirements to central agencies. However, these moneys should never be regarded as trust moneys or restricted moneys and should not be mixed with trust or restricted moneys.

Further Information

For further information on the matters covered above, refer to Statement of Accounting Concepts 4 and Treasurer's Instructions 1102 and 1103. The following

table is provided as a guide only and is not meant to be prescriptive. Each source of revenue should still be assessed individually.

Type of Revenue	Suggested Classification	Commentary
Patient Moneys	Administered Trust Account	Moneys do not belong to the hospital and must be kept separate from other moneys.
Donation for Medical Research	SPA External Restriction	Usually the donor would stipulate a purpose that should match the account, either a general research account or a more specific account where the donor's intent is more specific (eg cancer research).
General Donation	SPA Tied Moneys	The donation could be placed in hospital operating funds however a SPA account would enable the hospital to keep track of the use of donation moneys.
Research grant	SPA External Restriction	Grants usually are provided for a specific purpose and require some form of acquittal at the end of the period.
Capital Funds	SPA Tied Moneys	Moneys could be treated as operating funds however many projects go over a year end and require accounting records for a project budget.
Drug Trials	SPA Tied Moneys	These moneys represent fees for service and should be treated as operating funds unless due to the long term nature of many projects the need to account for costs using an SPA is good practice.
Deposits	Operating Funds	Unless there is a specific legal requirement for a trust account deposits can be treated as sundry creditors with moneys banked with operating funds.
Unclaimed Moneys	Operating Funds	No specific requirements to account for moneys separately so unclaimed amounts can be recorded as sundry creditors.

Table 7: Types of Revenue – Suggested treatment for hospital receipts.

Source: OAG

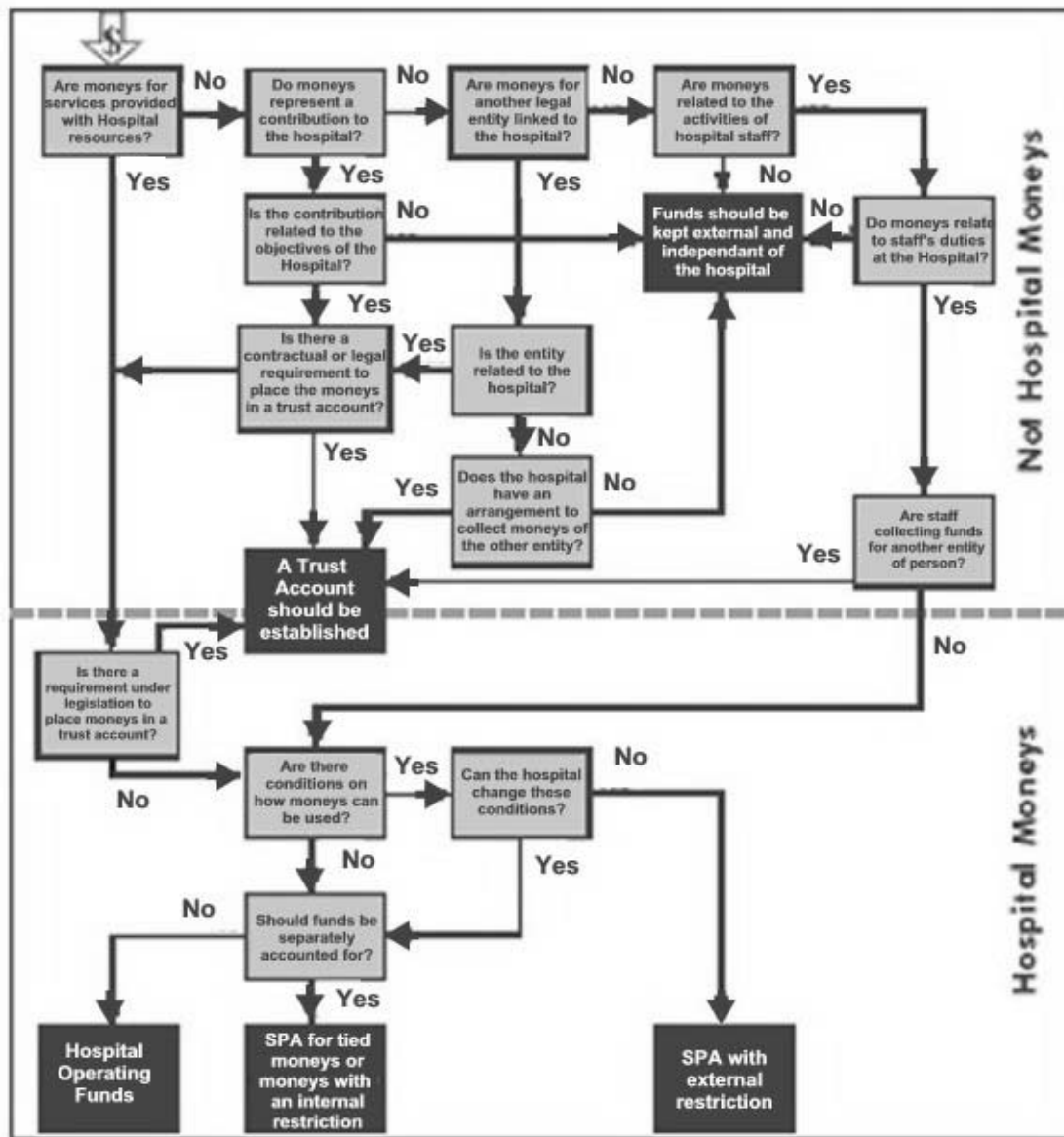


Figure 3: Classification of hospital receipts.

Source: OAG

The above flowchart covers the process of classifying hospital receipts. The broken line illustrates the division between hospital and other moneys. Trust accounts can hold both hospital moneys or moneys of others.

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