STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

INQUIRY INTO PEEL HEALTH CAMPUS PAYMENTS

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 19 NOVEMBER 2012

SESSION TWO

Members

Hon Giz Watson (Chair)
Hon Philip Gardiner (Deputy Chair)
Hon Liz Behjat
Hon Ken Travers
Hon Ljiljanna Ravlich

Hearing commenced at 1.09 pm

FEELY, MS NICOLE
Chief Executive, South Metropolitan Health Service, sworn and examined:

STRACHAN, MR SHAUN
Group General Manager, Corporate Operations, South Metropolitan Health Service, sworn and examined:

The CHAIR: On behalf of the committee, I would like to welcome you to the hearing this afternoon. Before we begin, I am required to get you to take either an oath or an affirmation. If you prefer to take the oath, there is a copy of the Bible on the table. The question is: do you solemnly swear or affirm that the testimony that you give is the truth and nothing but the truth under penalty of false evidence and contempt of Parliament?

[Witnesses took the oath or affirmation.]

The CHAIR: You will have signed a document entitled "Information for Witnesses". Have you read and understood this document?

Ms Feely: I have.

Mr Strachan: Yes.

The CHAIR: The proceedings this afternoon are being recorded by Hansard. A transcript of your evidence will be provided to you. It would assist the committee and Hansard, if you do refer to any document, if you could please quote the full title during the course of the hearing. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during this afternoon's proceedings, you should request that the evidence be taken in closed session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Please note that until such time as the transcript of your public evidence is finalised, it should not be made public. This prohibition does not, however, prevent you from discussing your public evidence generally once you leave the hearing.

I might start with some questions. Other members will join in at some point, I am sure. If I could ask from the outset: can you tell the committee about your particular roles in relation to the Peel Health Campus?

Ms Feely: As chief executive, south metro, the Peel contract sits within the south metropolitan area of responsibility. So, from a governance perspective, in an operational sense it reports ultimately to me, through to the director general and then the Minister for Health. Mr Strachan, as head of corporate operations, has day-to-day operational management of the Peel Health Campus contract, and he reports to me as a direct report and manages all the contracts in south metro.

The CHAIR: The committee's particular inquiry to a large extent centres on the operation of the clinical decision unit operated at the Peel Health Campus. I wonder if you could tell the committee about the operation of that clinical decision unit and any issues you had with that?

Ms Feely: I might refer that to Mr Strachan to answer.

Mr Strachan: My understanding in terms of the structure of the clinical decision unit at Peel was it was established by Health Solutions on or around about 9 May 2010. With the advent of the four-hour rule, which commenced on 17 May 2010, I think it was really a proposition that Health Solutions felt that it needed to put in place as a consequence of dealing with the flow and the

amount of services through the ED into the inpatient profile within the campus. It is fair to say that, in terms of monthly contract meetings that do take place in terms of discussing the activity profile and other challenges associated with the contract, it has always been the subject of active discussion in terms of the CDU. Around the period—this is in the 2010–11 financial year—there was a particular spike that was occurring between October–November–December of that year, where we saw, as a consequence, the activity for the inpatient profile moving upwards of around about 16-odd per cent over and above the first quarter, and the ED presentations, interestingly enough, were only showing about a six per cent growth for the same period —

Ms Feely: Across other areas of south metro.

Mr Strachan: — across other areas of south metro. So, combined between the ED and the inpatient profile, there was a 20 per cent growth through that second quarter. Clearly, there were active discussions associated with the ongoing management and concern that we wanted to really understand whether or not Peel had a very solid understanding of the operational directive, particularly the admissions process for inpatients—that operational directive was 17/3—and, in particular, we were in active discussions through the chief executive's office associated with the profile.

Ms Feely: As a matter of governance, on a monthly basis Mr Strachan and delegates from south metro meet with Peel Health Campus, and that has been happening on a monthly basis since I started and, I think, prior to me as well. But we did tighten up governance across the board in relation to setting up a corporate governance unit, and so the monthly meetings were becoming a real focus for us understanding better what was happening with Peel. That is why we noticed in those last three months of 2010 that the activity was changing and, as a result of those discussions on a monthly basis, that is when we entered into discussions with Peel to better understand why and what was causing it. Was it the CDU or was it an increase in activity; what was happening down at Peel? But it was because of the close management that we had with them that we were able to notice that.

Mr Strachan: If I can continue, following discussions through that period through the chief executive's office, the chief executive asked me to explore in particular detail what was actually really occurring behind the inpatient growth of that period. We certainly had ongoing discussions with Peel at the monthly contract meetings. I obviously have a fairly good and integrated working relationship with key officers at Peel. At that stage, they had seemed to be moving through a process with the former chief operating officer in Phil Hatt, and then the appointment of Justin Walter through that process in a variety of roles. There seemed to be some convergence associated with other people at an officer level being involved, particularly Aled Williams and others. But, at that stage, we pretty much put Peel on notice in around about December 2010 that there was going to be a very active and, in fact, investigative compliance-based approach to particularly the profile and growth of the inpatient services or DRG profile at that stage.

The CHAIR: Can I just stop you there, Mr Strachan? Why did you put them on notice? What were your concerns?

Mr Strachan: The growth in the inpatient DRGs for that period.

The CHAIR: What about the growth?

Mr Strachan: The 16 per cent growth in the first quarter.

The CHAIR: But what were your concerns about the growth?

Ms Feely: From my perspective, two things: one is we have a set budget; it is a budget SMHS-wide. But also the MPA with Peel is a set area, so if there was an increase in activity, I needed to understand that, again, to make sure that we could cater properly for the people of the Peel region. If there was an "explosion" of activity going through Peel, I think we would have a responsibility to properly understand that and, if necessary, take that increase in activity in discussions when we

renegotiate the contract on an annual basis. So, from my perspective, it was higher than I was seeing across the rest of south metro, but we did not go into it with anything particularly negative; I just wanted to understand it better.

[1.15 pm]

Mr Strachan: If I could also add, at that stage we had had discussions with Peel, and, I think, from memory, it was Phil Hatt, as the chief operating officer, who was alluding to the fact that on top of the growth in pressure of really what was going on through the demographic and everything down there through Peel, they were alluding to the fact that they may, when they looked at their forecast for the full 2010–11 financial year, be somewhere in the order of $6.3 million over the approved budget for that year. That was, again, cause for great concern. With that in mind, obviously, December being December and January being January, we obviously were commencing some fairly solid discussion between late January and early February. From memory, Phil Hatt wrote to us in February 2011 to explain the basis under which they thought they were going to expend over and above the MPA by $6.3 million with regard to the minor growth through ED, but, in fact, particularly the increase in profile through the surgical and medical profile of the inpatient expansion.

Outside of all that, though, when you look back in terms of the discussions at that stage, that obviously formed the basis for a clear scope. I, at that stage, again through the CE's office, started discussions informally in around about March with Pricewaterhouse to build a clear profile. At that stage, with the added interest and an inquiry through the chief executive's office around wanting to understand what was going on, we had to wait, and we agreed to wait within reason, for Peel to complete their internal review, but it is fair to say that the pressure that the department put on was clearly the driver at the end of the day to make sure Peel undertook their own review.

Ms Feely: So is that the sort of thing you are looking for in relation to CDU?

The CHAIR: Sure. We will go to Hon Liz Behjat.

Hon LIZ BEHJAT: You hold monthly contract meetings with the Peel Health Campus, and the CDU structure comes into being on about 9 May 2010.

Ms Feely: Around the same time that the four-hour rule was announced.

Hon LIZ BEHJAT: Presumably you were holding monthly contract meetings prior to that time. Was there discussion at those monthly contract meetings in the lead-up to the formation of the CDU? Were you being told that that is what they were planning to do—"This is how we plan to do it. This is what we are going to achieve"?

Mr Strachan: Look, in all honesty, no. I mean, in many respects the way that Peel goes about managing its activity profile and its business by and large is really for Peel to work through. If there are particular problems associated with how they are to meet the activity profile and stay within the budget, that is obviously subject to ongoing and active discussions across the table, but, you know, in terms —

Hon LIZ BEHJAT: So you did not know about the existence of the CDU until it gets born, basically.

Mr Strachan: Not in intricate detail, no.

Hon LIZ BEHJAT: Are you aware of any other health campus in this state that was running a CDU at that time or was planning to do CDU sort of things, or is this unique to Peel Health Campus?

Ms Feely: No. Hospitals across the board have varying areas attached to emergency departments where patients that actually meet particular criteria can be referred to for intensive assessment and

treatment. So whether it is called a CDU—we might have a medical unit or we have surgery special units—there are various departments across the board, so in and of itself a CDU is not —

Hon LIZ BEHJAT: Is not a unique thing.

Ms Feely: — particularly unique, and it is one of the management tools that can be put in place by a hospital to manage their flow.

Hon LIZ BEHJAT: And separate payments to doctors to encourage admissions to a CDU—that is normal across other health campuses as well?

Ms Feely: I am sorry; no, no-one should be paying a special fee—I am sorry, can you repeat the question?

Hon LIZ BEHJAT: Well, evidence given to this committee is that—this is how it has been put to us: a patient arrives at ED. They are triaged. They then get put off—they are seen by an RMO. The RMO then makes a decision that perhaps this person needs further investigation or admission, but they do not have admitting rights. The FACEM is the one that has the admitting rights. The FACEM makes a decision that this patient is going to be there longer than four hours and one minute; needs to go to the CDU. If that patient then is admitted to the CDU, the FACEM is paid a $200 incentive payment.

Ms Feely: No, that does not happen anywhere.

Hon LIZ BEHJAT: It does not happen anywhere?

Hon LJILJANNA RAVLICH: Well, it happened at Peel.

Ms Feely: Other than at Peel Health Campus.

Hon LIZ BEHJAT: Other than Peel. So that is the only health campus you have ever heard of that happening.

Mr Strachan: Can I just —

Ms Feely: But I understand that that is not the nature of the $200 payment. The $200 payment, according to Dr Neale Fong, was to ensure they had the appropriate level of overnight and medical support, and that $200 was not an admission payment, but a payment made to doctors to stay on shift as such. So, no. But, in any event, that was not something we ever approved; did not know about —

Hon LIZ BEHJAT: You did not know about that at all.

Ms Feely: No.

Hon LIZ BEHJAT: That is what I really wanted to know. The health department was never aware of any of those sorts of arrangements or payments.

Ms Feely: No, and would not have authorised it.

Hon LIZ BEHJAT: You would never have authorised it.

Ms Feely: No.

Hon KEN TRAVERS: You are saying —

Ms Feely: That is how I understand the nature of the payment, and this is just in recent times, not at the time.

Hon KEN TRAVERS: Right. So you are saying that your knowledge about those payments is informed by Mr Fong; is that correct?

Ms Feely: Yes—mine is just recently, yes, when the issue was raised through here. That is how I became aware of it, and then reading some correspondence in relation to that. But as far as south

metro is concerned, we do not authorise the payment for people to actually admit patients other than that which is paid through the normal DRG health process.

Mr Strachan: Sorry, just to clarify, just in terms of, I think, a question that the committee had raised, there was a letter that was written to us on 20 June 2012 by Miss Ashton Foley and, as Nicole has said, that was the first time that any reference ever had ever been made to a fee-for-service component within that letter, and then that subsequently also then led to a further letter from Dr Fong, received on or around mid-October, to again clarify further Peel's understanding to the health department in terms of what that was in relation to.

Hon LIZ BEHJAT: So between the structure coming into being on 9 May 2010 and you receiving Ashton Foley's letter on 20 June 2012, at the monthly contract meetings you have where the CDU is discussed, this $200 payment is never discussed in any of those meetings with the Department of Health.

Mr Strachan: What is actively discussed at the monthly meetings—we separate the meetings into two parts. One is in relation to the MPA and the activity case mix profile. We deal with the case mix profile as a broad, overarching review of the service and the services that are being performed for that particular month in question, and we have a separate part of the meeting associated with other issues to do with the contract. But, no, the CDU was not the subject of an active discussion in any of those meetings. It was the case mix profile—the full activity profile for Peel, which is otherwise referred to as the MPA.

The CHAIR: Would you have expected them to talk about that $200 payment? You would not know about it, because you would not know to ask because you did not know about it. Would you have expected Health Solutions to have informed you about that arrangement?

Ms Feely: The arrangements that they have with their individual clinicians are matters for Peel Health Campus. They are not something that I would have expected would have been raised in the first instance, no.

Hon LJILJANNA RAVLICH: But it was funded by the public purse.

Hon LIZ BEHJAT: No, it wasn't; the $200 was not, no.

Hon LJILJANNA RAVLICH: The $200?

Hon LIZ BEHJAT: No, it was paid by Health Solutions.

Hon PHILIP GARDINER: The implications could have an effect on the public purse, though, of anything like that, which we found out subsequently did have an effect on the public purse, so I would have thought that anything that any hospital does which is going to have an impact upon the public purse would have been open for discussion, at least advising what they were doing, with the Department of Health.

Ms Feely: The way I was answering the question was: would I have expected it to have been raised? On the basis of what a particular doctor is paid down at Peel Health Campus is a matter between, as far as I am concerned, the Peel Health Campus, Health Solutions and the individual doctor, so, from our perspective, we monitor the contract from an activity perspective and also in general in a financial sense. So, provided Peel Health Campus are not breaching their overarching financial requirements and are meeting their activity issues, their relationship, and contractual relationships they have with their doctors on a day-to-day basis, is not something that I would be asking my team to inquire about because it would be a matter of commercial-in-confidence between the doctor and Health Solutions. So, in relation to the $200, the reason it would become an issue for statewide was because it may be precedent setting once it gets out into the system. But, again, as the chief executive, south metro, I would never authorise it, so it would not move ever past Peel, and had I known about it, I would have instructed that it stop.

Hon PHILIP GARDINER: Can I just follow that through just a little bit. In the evidence that I have read, there is a suggestion that at the end of the 2010 financial year, the CDU was a measure by which the Peel Health Campus or Health Solutions would be able to meet their maximum performance amount, I think it is, which meant that what they were doing with the CDU was going to have an impact upon the money they could get from the Department of Health to meet their MPA. So I would have thought, like any other corporate being, really, that if there is going to be an implication which would affect expenditure, in your case, of the public purse, you should have expected that they would talk to you about it, because that is what they had in mind; and, if they had that in mind for themselves, and it is drawing more money out of the public system—out of the Department of Health, that is—then I would have thought that you would have expected them to talk to you about it.

Ms Feely: On a monthly basis we discuss the activity. When the activity started to become greater than that which I expected, that is when we started to look at the mechanism.

Hon PHILIP GARDINER: I understand.

Ms Feely: So I cannot put myself in a position of what Peel Health Campus —

Hon PHILIP GARDINER: Except in the expectations of what they should have been telling you of a particular measure they were doing because it had that impact.

Ms Feely: But the CDU, in a normal sense, is a mechanism simply by which you manage your patient flow, so it is not something I would look at —

Hon PHILIP GARDINER: So you would not have seen it having an impact.

Ms Feely: No, it is not something you would look at as a revenue-raising issue or trying to divert—it is about managing patients, and also consistent with the four-hour rule management, so it is not something that would have been in my mind as a revenue-raising concept. That sort of mechanism is not in any other way in any other hospital, so, no, I would not have been alive to it because it is not something that I would have been expecting.

[1.30 pm]

Hon PHILIP GARDINER: So it is not something that you would have seen before?

Ms Feely: No.

Hon PHILIP GARDINER: So the actual agenda and the implied agenda were two different things?

Ms Feely: Two different things, yes. It is tight management. It is because we were looking at it so carefully—because it is public money, and we were very aware of that—and it is also part of what we were trying to do in south metro, which was to tighten up management of all the contracts that we had. The fact that we were able to see it probably is more testament to the fact that we were managing the contract very hard and then looking at it very closely.

Hon PHILIP GARDINER: In contractual terms—I have not read them; I do not think I have a copy of those—is there any obligation for an operator to actually advise you if there is going to be any impact of what they do on public expenditure? Is there an obligation on their part to talk to you?

Ms Feely: I will get Mr Strachan to answer the detail of that.

Mr Strachan: There is. The first obligation—first and foremost, and last—is to manage your activity within the MPA profile set for that year. So in the original notice that was set for the 2010–11 year, the budget was set at $75.9 million —sorry; there are some commercial-in-confidence issues with the contract. So, yes, there is an obligation to act in good faith and to bring any those commercial challenges that they have to the table and open those up for a full and frank discussion. We do so within reason at every meeting. We talk about the challenges associated with the financial

issues of meeting the activity profile, and in addition to that we also stringently cover the safety and quality issues in terms of the day-to-day operation of the campus.

Ms Feely: From where I am sitting, we have a responsibility for not only the contract but also the people of the Peel region. There is a dual way of looking at the contract. It is the fundamental legalities and the financials, and also I need to understand if there is an issue happening in a particular area that may need a further submission, whether it be to the director general or to Treasury for further funding. So we always assuming that everything is managed tightly within the financial parameters of the contract. But if there is a 20 per cent increase in activity suddenly going through a site, that is something that, from a chief executive, governance and having a responsibility for delivering health care to people in the region, I would want to be alive to and maybe making some decisions in relation to whether or not we need to look at the SMHS budget for a re-diversion of money—not that there is any spare, anyway, but those are the sorts of things that we would sit around as an executive and look at. The same considerations, though, would happen whether it be at Royal Perth or Rockingham—across the board.

Hon KEN TRAVERS: That raises one question, and then I want to go on to a couple of others. I am still unclear. Who first identified that there had been a problem that people who were not eligible for a DRG payment had been submitted for payment by the health department?

Ms Feely: Initially we saw the increase in activity, and then we asked—two things happened. One, there was an indication that the budget of Peel was under pressure to about $6.3 million, so that was the first issue. Then I asked Mr Strachan to arrange an audit of the activity at Peel for the last 12 months to find out why this increase had suddenly happened, after they had done their own internal review.

Hon KEN TRAVERS: So did they, when they were doing their own internal review, identify to you that they thought there might be a problem with the invoices they had submitted to you for DRG payments?

Ms Feely: Yes, they did, and I will hand over to Mr Strachan for the detail of that.

Mr Strachan: During the process of their audit, the outcome of their audit revealed that there were 393 —

Hon KEN TRAVERS: No. I want to go back earlier. I want to know who first identified that there was a problem and brought it to the attention of the health department. Did you identify that there was a problem, or did they identify that there was a problem and bring it to you? I understand what happened once the audit was done. I want to get to who first brought it. Did they tell you, or did you ask them?

Ms Feely: In relation to the problem, we were the ones who noticed first of all that there was an issue, and then as a result of the audits, that is when the issue of the payments arose.

Hon KEN TRAVERS: So the internal audit or review, did you ask them to do that or did they offer to do that?

Mr Strachan: We strongly suggested—strongly suggested—that they do an audit associated with the inpatient admissions through the CDU, in accordance with the operational directive.

Hon KEN TRAVERS: So that was at your initiative, not at theirs?

Mr Strachan: Absolutely.

Hon KEN TRAVERS: Okay. That has clarified it. I am interested in terms of your subsequent conversations with Dr Fong about how the CDU came to be established. Has he gone into the detail? You say he has told you about it being a fee for service. But has he gone into detailing to you how the CDU was established?

Ms Feely: No. When it was raised, we asked him what it was—we asked for clarification around the $200. But not with me in detail, no. There was just that one letter where he clarified it in writing; but, no.

Hon KEN TRAVERS: Right. So would it surprise you, then, if you were advised, in light of all of the conversations you have now with Peel about this issue, that the original impetus for the establishment of the CDU came about as a way of getting their income up to their MPA towards the end of the 2009–10 financial year?

Ms Feely: Would it surprise us?

Hon KEN TRAVERS: Yes. Have they ever told you that that was their original impetus—that it came out of their own internal workings to work out how they could make sure that they had done enough activity to be able to claim the total MPA?

Ms Feely: I have never had that discussion with them and I would be very disappointed if that was the strategy.

Mr Strachan: We were more concerned about a letter that we received from Phil Hatt, the then chief operating officer, in February of 2011, suggesting that there was a $6.3 million blow-out over and above the MPA for the year.

Hon KEN TRAVERS: In terms of the issue, there has been a the lot of comment that it was a fee for service. But we have received a significant number of documents, I think it is fair to say, that refer to it in various terms as either a bonus or an incentive payment. Is that something that you have had a discussion with them about since this matter became public?

Ms Feely: I have no idea.

Hon KEN TRAVERS: I will quote you some of the language in the emails that people like Dr Williams down there has been sending out to different people, saying, "It's basically the same as before except you get the additional patient care payment for bringing on patients from ED to CDU who would be expected to stay in at least four hours. So spend more time hunting patients in the ED than you would have before." Does that surprise you? Would that be of concern to you if that was part of the structure of this incentive payment? Do want me to read it again?

Ms Feely: Yes, please?

Hon KEN TRAVERS: It states, "It's basically the same as before except you get the additional patient care payment for bringing on patients from ED to CDU who would be expected to stay in at least four hours. So spend more time hunting patients in the ED than you would have before."

Hon LIZ BEHJAT: So do doctors usually go hunting?

Ms Feely: No, they do not. I am just not in a position to comment on what was in the writer's mind when he wrote that.

Hon KEN TRAVERS: There are other documents that we have got here: "I am trying to get a feeling for the number of patients that we might be losing because we have no driver pull mechanism in place." There are plenty of documents that talk about incentive payments and bonus payments

Ms Feely: Those matters were not part of the matter that south metro was aware of at the time.

Hon LJILJANNA RAVLICH: Do you feel as though you were out of loop, Ms Feely? You do not seem to know much about this matter at all.

Ms Feely: The day-to-day operations of Peel is not something that I at my level am expected to know about.

Hon LJILJANNA RAVLICH: This has been going on for a couple of years. Some of these matters go back to 2010. I would have thought that just through the health networks you might have

picked up that there was something extraordinary going on down there—something out of the ordinary, unusual, probably even corrupt?

Ms Feely: No.

Hon LJILJANNA RAVLICH: You say no?

Ms Feely: No.

Hon KEN TRAVERS: There is another one here, just so that you can be aware of the sort of language that was being used, which clearly you were not at the time, "Frequent visits to ED to spot potential CDU patients." That is probably a little bit better than hunting them, but nonetheless. The other issue that they raise, when they were looking at the original trial back in April 2010, and again they talk about the incentive payments, one of the officers—it is minuted—asked if the incentivised doctors will also be responsible for completing the timely completion of discharge summaries and was advised that this would be their job. Sorry; no; it is the next line. Someone asked if the increase in admissions would raise alarm bells at DOH. All agreed that there was no reason for DOH to be concerned; these would be appropriate admissions—which we later found out many of them were not. Someone else commented that "patients will now be admitted for reasons that were not previously admitted and hence might attract some reaction from some of these patients that did not expect to be admitted into the hospital." Then another staff member, it is noted, "offered that we use the four-hour rule as one reason for this new process." I think they tried to argue that that was the motivation, whereas that comment would suggest that this was actually all about trying to get—that was at a meeting; that is minutes of a meeting to discuss how to address the projected $2 million MPA underspend prior to the end of the 2009–10 financial year. So none of this has been made aware to you? In your conversations with Dr Fong, has he brought any of this to your attention about the establishment and the processes and the sorts of issues that were going on in the health campus at the time?

Ms Feely: Dr Fong has been managing director now for three months. It is just recently that he has come on board, and prior to that, as I understand, he was a member of the board but not an operational member. So prior to that, there were no chief executives of Peel health campus that we were having these discussions with. I am just sitting here thinking about how it is that I was to know if there was anything happening down at Peel that they did not want us to know about that other than in open and transparent meetings and probing into activity I could have found those things out other than someone telling me. That is always the difficulty in these sort of organisations. But, no, Dr Fong has not—I have not had detailed discussions with him, because the CDU has now closed. The audit has indicated that we have uncovered issues in relation to incorrect admissions, and we are pursuing those with both recovery and further audits on a six-monthly basis.

Hon KEN TRAVERS: I accept that you might not have known about it at the time. But has Peel Health Campus tried to present to you that they have tried to be full and frank with you about the history of the establishment of the CDU and the overcharging? Have they tried to present that they are now being open and upfront in giving you all the relevant information and details?

Ms Feely: I believe the relationship in the last 12 months has probably become more forthright and more open. But in relation to their own audit when they themselves discovered that there were overpayments and the fact that we then went back over that with the PWC team to actually uncover it, we have now a very clear understanding because the money has been repaid and we have agreed to better controls both internally and with us and agreed to a six-monthly audit which is about to start again.

Mr Strachan: It is in action now.

Hon KEN TRAVERS: I guess my point is that I would have thought that part of that process since this first became aware was to try to get an understanding of how it arose and for you to have those full and frank conversations with each other, and that these sorts of issues might have been raised if

that was a full and frank conversation rather than just giving you the information they want you to hear. I am just trying to find out. Has there been an attempt to try and have those discussions, and have they tried to present that they are giving you all of the history of this matter as part of those discussions ?

Ms Feely: I am aware that Dr Fong has had discussions with the director general on this issue as well as myself. But in relation to the correspondence, he has indicated his version of why it occurred and how it occurred, and I cannot take it much further than that, I am sorry.

Hon KEN TRAVERS: No; you can only rely on what he gives you.

Ms Feely: On what is said, yes.

Hon KEN TRAVERS: We have had the benefit of other documents that go a bit further.

[1.45 pm]

Mr Strachan: Just in terms of adding to what Nicole said, there has been an ongoing line of inquiry with Peel at the monthly meetings. It culminated in the letter from Ashton Foley dated 20 June 2012 and then the subsequent letter that Nicole has referred to in terms of the recent letter from Dr Fong dated 16 October 2012. There has been a constant line of inquiry wanting to understand in great detail the operation of the CDU and where it is at, and particular changes that Peel are now effecting as a consequence of what they now refer to as a short-stay medical unit and a longer stay medical unit. We are keen to continue those discussions associated with getting a full understanding of what adjustments they are now making to their business.

Hon LJILJANNA RAVLICH: I am just going to now refer to the evidence given to us by Ms Ashton Foley when she appeared before the committee. She said —

> Shaun Strachan is the group manager for south metro health services. He directly reports to Nicole Feely, their chief executive. He was also the designated contract manager for the state that attended all the contract meetings and had responsibility for the management of Peel Health Campus's contract with the state. He also was very much against Peel Health Campus, in the sense that he was aware of improprieties. From my understanding, a number of my predecessors had confided in him about some of the financial improprieties and other scenarios that had transpired there, and the board believed that Shaun Strachan was a threat to the redevelopment campaign …

Is it true that you were a threat to the redevelopment campaign?

Ms Feely: I would ask that we go into closed session.

The CHAIR: Okay, so at this point we will consider that request and clear the room while —

Hon LJILJANNA RAVLICH: Why?

The CHAIR: People might have a view about whether to do that.

Hon LJILJANNA RAVLICH: I am just wondering why we need to go into closed session.

The CHAIR: What I am proposing to do is to ask Ms Feely on what basis she is going to do that, and then we will make a decision.

Hon LJILJANNA RAVLICH: Yes, okay. Sorry, Madam Chair.

Hon KEN TRAVERS: I was just going to ask whether Ljiljanna is happy for us to defer that so we stay in open session and then we come back to those issues so that we do not have to go in and out of public and private sessions.

The CHAIR: I think that is a very sensible suggestion.

Hon KEN TRAVERS: Unless she feels she needs to get those questions asked now before we move on to the next topic.

Hon LJILJANNA RAVLICH: I am relaxed.

The CHAIR: I have something else I want to ask in private, too, so in that regard, hold that thought and I suggest that what we might do is allow some time later to go into private session.

Hon KEN TRAVERS: Going back to the issue of who raised it first, Peel Health Campus have said they came to DoH and raised the issue with you first, but that is not correct—am I correct in saying that that is what you are putting to us today? That you raised it with them first?

Mr Strachan: We were very concerned, both on the grounds that we wanted to make sure that the local community at large, based on discussions that Nicole had had with us internally, were being, first and foremost met; and the second issue was that we were very concerned then about the financial ramifications associated with it at that stage, although they had not put it in writing to us prior to December 2010 that they had a massive potential overrun of their forecast financial position.

Hon KEN TRAVERS: The other question that comes out of all of that is: what provision is there for a person working in a privately run hospital delivering public health services to be a whistle-blower if they are bound by confidentiality agreements with their direct employer—in this case, Peel Health Campus? Is there a mechanism by which one of those staff members can come and blow the whistle, if they are aware of anything untoward, to the health department?

Ms Feely: Just one moment. I might take that on notice, but my understanding is that the legislation protects across the board, but I might take that on notice.

Hon KEN TRAVERS: I thought it might be something that you would be aware of in terms of—that would be a fairly fundamental issue in terms of the relationship with privately run hospitals, and I think you have been involved in the most recent contracting-out of services at the future Fiona Stanley Hospital. I am just wondering what mechanism—that is not a mechanism that has been high on your consideration in terms of negotiating those contracts, to ensure that there is a mechanism for staff where they are employed by a private company that then make them sign confidentiality agreements, that they have some provision to blow the whistle to the department without being in breach of their confidentiality agreements?

Ms Feely: I might take that on notice. Is it high on my priorities? Because I understand the legislation does cover, and the bulk of contracts do, make allowance for all the policies for Western Australian health and the government to actually apply in those contracts, so I understand —

Hon KEN TRAVERS: And if you could also check whether the Peel Health, because of the timing of the Peel Health Campus contract, whether there are provisions in that, too.

[*Supplementary Information No B1*.]

The CHAIR: If there is a pause in proceedings, I might jump in there. Obviously, there are audits taking place and you have mentioned some of the follow-up in terms of now six-monthly auditing. Are there any other follow-ups or further actions that need to be taken as a result of the audits and what you now think about the arrangements with Peel Health Campus?

Ms Feely: I might defer to Mr Strachan to answer that.

Mr Strachan: Across the reviews to date there have clearly been recommendations provided by PricewaterhouseCoopers across both the—again, these have been formally shared with Health Solutions WA—but we are obviously very concerned about the quality of the processes leading to recording patients, admitting patients, the patient file, the coding, the coding processes and the framing and education of that process within Health Solutions. The process of financial management around that, we would like clearly to see a more robust process around that. In terms of then the other issue that we were concentrating on, remembering too that the audit was not just restricted to the issue of the CDU; it was restricted to the processes that were starting from the ED through the CDU, and from the ED into the wards, the sinking fund was then the subject of further

recommendations through the review in terms of making sure that the state's interest in relation to the two per cent that was withheld from the annual MPA was appropriately being invested and appropriately being used to replace group 3 items as they showed up with the ongoing maintenance and administration of the campus. Remembering too that the group 3 items amounted at the time of signing the contract back in 1997 to about 5 000 assets. So, yes, there is a very active, ongoing process associated with strengthening the relationship with Health Solutions, but also the internal controls around the activity management and the administration of the sinking fund.

The CHAIR: So the issue to do with group 3 assets and asset replacement, are you now confident that that process is being handled appropriately and transparently?

Mr Strachan: We are auditing that process to check with current compliance associated with the agreement that we struck with Health Solutions a number of months ago to ensure they were putting sufficient processes in place. I am not at this stage comfortable with it on the basis that I have asked for what they refer to as an asset life cycle maintenance program. One of the discussions I had with the chief executive was to make sure that the interests of the state were being well planned and administered over the remainder of particularly the current contract period through to August 2017, but at this stage we are yet to see that process come to fruition in terms of what I would deem as a comfortable process, and to meet contractual compliance.

The CHAIR: So at the moment, I guess there is a question mark over there until you get the result of that audit?

Mr Strachan: Correct.

The CHAIR: When is it anticipated that will be?

Mr Strachan: PWC are in there at the moment in terms of their current program. They will have their draft report for discussions with Peel in December and I am envisaging a final report on or around about late February–March next year.

The CHAIR: Is that before any agreement is struck about the continuation of the contract? Will it be before that process?

Mr Strachan: In terms of where we sit at the moment with Health Solutions through the contract, at this stage, it is not until the seventeenth year of the contract in 2014 that we are under any obligation to sit at the table in good faith with the operator and talk about either an extension, which at this stage is referred to in the contract as may be renegotiated for a period of a further five years over and above 2017. So, no, at this stage, we will just be continuing on with our audit program and —

Hon KEN TRAVERS: Can I just ask, does that include a renegotiation of any private hospital on the site, or negotiation of—because there is a small private component there at the moment. Is that under a separate contract?

Mr Strachan: There is a separate lease agreement with the state associated with the private facility that is within the overarching contract. Sorry, your second question?

Hon KEN TRAVERS: I am just asking—you have said that there is no requirement to negotiate until 2014 in good faith on the public component, but is there the capacity or ability for you to negotiate a new private contract on that site with the same operator before 2014?

Mr Strachan: Look, I —

Ms Feely: I will be recommending that the Peel Health Campus negotiation be done as one thing moving forward; one campus.

Hon KEN TRAVERS: That is fine. Certainly, from my knowledge of the Joondalup Health Campus, there are two separate contracts and they have different life terms. When does the private health campus run out at Peel?

Mr Strachan: My understanding, but I am happy to take it on notice, too, is that they run concurrently.

Hon KEN TRAVERS: They do, right. Whereas at Joondalup, they did not; they had a different time. But at this stage, as far as you are aware, there is no intention to separate the renegotiation of those two contracts?

Ms Feely: Not as far as I am aware, no.

The CHAIR: Could I just go back to the audit processes? There seemed to be a number of audits. Was it unusual to have a series of audits in that way?

Ms Feely: No, there is an annual audit as part of the contract. What changed from my perspective was the tighter management of the contract moving forward and as a consequence of reviewing the overarching management and the lapsing of the existing auditor's agreement, when we started looking at the whole management of contracts across south metro, I wanted to make sure that we brought in some very hard-hitting contractual management of all our contracts, and as such that is when we moved through to introducing PWC into the process. But it may well have just been as a result of an annual review of Peel, but because of the issue raising up with the increased activity, that, in effect, historically is now the reason why Peel Health Campus has had more oversight than would have been usual under the contract as such.

The CHAIR: Obviously part of the audit process went to the question of the payments—the $200 paid to doctors and —

Ms Feely: May I just say, the actual audit was in relation to the activity increase and trying to understand why the activity was much higher and had increased at that rate in comparison with the rest of the activity increase in the south metro. At the time of the audit we were not actually aware of the $200 issue, so that is not what we went in looking for. We wanted an explanation as to what was happening, because for all intents and purposes, at the time of the audit, we knew about the $6.5 million pressure on the budget, but we were not aware of $200 issue at that stage.

The CHAIR: But it became apparent in the process that that was happening, did it not?

Ms Feely: No, it did not come through the audit process.

Hon LIZ BEHJAT: Back on CDU, it is your understanding that the CDU is set up to assist in the four-hour rule and that it is going to streamline the way that they would administer their four-hour rule. That is what you said earlier, I think, was it not?

Ms Feely: Yes, across the board. It is not unusual to have a patient who comes in who may not be able to be assessed and treated within four hours and may need —

Hon LIZ BEHJAT: So that is what you would have automatically thought—CDU, that is how they are going to administer this new four-hour rule? So, would it surprise you, then, that if in August 2010—I am going to read to you from a bulletin that was a staff bulletin on CDU FAQs—frequently asked questions. It reads —

> **Does CDU have anything to do with the Four Hour Rule project?**
>
> No, the Four Hour Rule project is a completely separate project, nothing to do with CDU at all. The fact that the CDU care model trial commenced just prior to the commencement of the Four Hour Rule project has understandably created some confusion amongst staff.

Does it surprise you that they have actually come out and said it is nothing to do with the four-hour rule?

[2.00 pm]

Ms Feely: CDU could be established totally independent of the four-hour rule. It is, as I said, a method of managing patients through an emergency department for —

Hon LIZ BEHJAT: That was in August 2010. The next thing I am going to read to you was earlier than that. On 4 May 2010 there is an email. I will not name the people that are in this email, but this is what the email says, in part —

> And, finally, there are patients that we are currently transferring to Fremantle Hospital and elsewhere — who are costing us for the transfer, and no DRG payment. It may be that some of this group are able to stay at PHC if they traverse the CDU on their way to the wards (for a period of stabilization) thereby saving us the cost of a transfer and generating a high value DRG payment. I'm not at my computer with PHC stats on it, but my memory is that there are about 7 patients per day being transferred. Some of them clearly require the care of a big hospital but many don't.
>
> For those reasons, I think we should pay $200 / patient (in addition to salary) for the CDU for the first two weeks and gauge the effect on transfers, ward occupancy, admissions and so on, and at that stage make a decision about whether we continue or otherwise. We don't need to generate too many extra DRG payments to make up for a large number of $200 / patient fees. I think it's a small price to pay for potentially a big return.

Does that surprise you that that is what the hospital was doing at that time in relation to the CDU?

Ms Feely: With hindsight, yes.

Hon LIZ BEHJAT: And the Department of Health had no knowledge of this at all, did they?

Ms Feely: No, but we are not party to this correspondence, and I would never have seen it, so it is not —

Hon LIZ BEHJAT: Had you known that at the time—if on 4 May you somehow and Mr Strachan had been copied into that email—what would you have done if you had seen that in writing at that time, with hindsight?

Mr Strachan: Immediately raised it with the chief executive.

Ms Feely: We were at that stage encouraging sites to try to keep their own patients, because of this issue of transferring people around. There is both a clinical issue about safety of patients being moved if necessary, and it is part of trying to make sure that the tertiary patients are kept at the tertiary hospitals and the non-tertiary patients are kept in the general hospitals. So that was part of the discussions that were happening all across south metro. But I would not have authorised that.

Hon LJILJANNA RAVLICH: Ms Feely, I am just wondering whether you would have authorised people going through emergency and then being put into virtual beds on virtual units by this group of doctors who were a part of the CDU arrangement, who were then getting kickbacks for doing that.

Ms Feely: You are asking me would I have authorised that?

Hon LJILJANNA RAVLICH: Do you think that that is the right thing to do?

Ms Feely: No, I do not.

Hon LJILJANNA RAVLICH: You do not? Okay.

Ms Feely: What, organising kickbacks for the doctors in relation to admitting patients?

Hon LJILJANNA RAVLICH: Yes.

Ms Feely: No. I find that is insulting.

Hon LJILJANNA RAVLICH: Can I ask you whether you are aware that the doctors may have been involved in altering time stamps on the records or the timing records or altering —

Ms Feely: No, I was not, and there is no way that I could have been aware of that.

Hon LJILJANNA RAVLICH: Would that concern you?

Ms Feely: Of course.

Hon LJILJANNA RAVLICH: Do you think that that is a criminal offence?

Ms Feely: I am not in a position to answer that. It is not an acceptable practice as far as hospitals under my control are concerned.

Hon LJILJANNA RAVLICH: What follow-up has there been with the doctors who have been involved in this practice?

Ms Feely: I would have to take that on notice. I was not aware that they were. May I get some clarification on some further details on that? I do not know anything about that.

Hon LJILJANNA RAVLICH: Okay.

The CHAIR: I can dig something out in a minute. I do not have it to hand.

Hon KEN TRAVERS: It is an issue about whether or not the records were being changed with respect to the timing of admissions, so that they then met the four hours. Subsequently they may have been picked up as part of the review, that those changes had been made and that is in fact why the time stamps were implemented. Has that ever been raised with you that there had been issues with people backdating the time claims so that it would appear that the doctor had been in the hospital for more than four hours—sorry, the patient had been in the hospital for more than four hours so that they qualified for a DRG payment, because obviously if they are less than four hours, they only get the emergency department payment?

Ms Feely: It has not been raised with me and I will ask Mr Strachan.

Mr Strachan: I can tell you the same: no.

Hon KEN TRAVERS: So as part of their audit they did not highlight that that was one of the issues that came out of their audit, that people had not been in the hospital for four hours

Mr Strachan: Part of, again, a little bit about the process with PwC in terms of —

Hon KEN TRAVERS: No, this is the internal audit by the health department.

Mr Strachan: No, they certainly did not raise any issue with us that would cause us concern to immediately investigate further.

Hon KEN TRAVERS: You see, that is one of the issues that we are interested in, or I am fascinated by; that is, if people were changing the records and then they got a bonus payment for it, why these matters would not have ever been referred to the fraud squad for that.

Hon LJILJANNA RAVLICH: Exactly right.

Hon KEN TRAVERS: Because there would be an issue about fraud, but they have never raised that with the health department.

Mr Strachan: I would like to just probably take that again on notice. I am happy to go back and talk to or we will go back and talk to PwC further. In terms of the audit that they undertook for the 393 admissions that were reversed—in other words, making up the 1.4—they sampled 100 of those 393 and went back to the patient record direct. So I would like to get clarification just to come back and complete the question in full. So, part of the analysis in terms of the outcome of that, as I understand it, from reading their draft report, was that clearly there were a number of those that did not meet what would otherwise be considered as a valid admission for under four hours. But I would like to take that on notice.

[*Supplementary Information No B2.*]

Hon LJILJANNA RAVLICH: We did hear that there would have been some of these people who had gone through this process who were given treatments that perhaps they did not need as a part of this whole process. Can you make some comments in relation to that?

Ms Feely: No.

Hon LJILJANNA RAVLICH: Can I just ask you, of those people whose admissions were —

Ms Feely: May I ask of those people, sorry?

Hon LJILJANNA RAVLICH: — whose admissions were invalid. Okay?

Ms Feely: Right.

Hon LJILJANNA RAVLICH: So, of those people whose admissions were invalid, what were there, 170?

Mr Strachan: In the follow-up review, yes.

Hon LJILJANNA RAVLICH: Sorry?

Mr Strachan: There were 393 to do with the CDU.

Hon LJILJANNA RAVLICH: Yes.

Mr Strachan: And then in their follow-up reviews from the EDU and for the 2008–09, 2009–10 year there were 170 additional cases identified for reversal.

Ms Feely: If I may jump in here, though, the issue of whether or not someone was referred to the CDU is a different issue as to whether or not their clinical care whilst at Peel Health Campus was appropriate or not. And without going back and looking at every single one of those cases, I am not in a position to do anything than take that on notice.

Hon LJILJANNA RAVLICH: Okay. Are you going back to have a look at each of those clinical cases, though? And, you know, have you written to some of the people who have been involved in this scam?

Ms Feely: No, I have not.

Hon LJILJANNA RAVLICH: So, this has all gone under the radar. So, anybody who came to Peel and was in fact put through this process into a virtual bed in a virtual room somewhere, but still was there in the emergency department, may have been sent off for some testing that they may or may not have needed—but let us assume they may not have needed. None of these people has been advised that they may have been a part of this process.

Ms Feely: Just to repeat: I am not in a position to infer that any of the clinical treatment at Peel Health Campus put any patient at risk. So, whether or not they were put into a —

Hon LJILJANNA RAVLICH: But have you asked the questions yourself, Ms Feely?

Ms Feely: No, but I am saying —

Hon LJILJANNA RAVLICH: Have you asked the question whether any of these patients have been put at clinical risk, because all we have got from you today is that you do not know, you were not made aware of it. Basically you do not indicate as though you know of anything that has gone on in relation to this matter. And I am saying that these are very serious matters, and I am also asking you what inquiries have you made to make yourself aware, because surely that must be a part of your responsibility? So, what inquiries have you made to make yourself aware that the people who might have been caught up in this scam have been notified and have been made aware, if any?

Ms Feely: No, I have not.

Hon KEN TRAVERS: Can I just quote in one of the documents I have in front of me some issues that were raised by, I assume, a doctor, certainly to the director of medical services down at Peel, where they talk about early on —

> … the number of patients on the medical unit and in the CDU has been increasing over the last few weeks and the workload has become too much for one RMO.

I admit this is back in August 2010, which is actually before the big spike that was identified, and —

> We have a very efficient group of RMOs in the medical team at the moment but the patient load and turnover rate is becoming so high that patient safety is being put at risk and discharge efficiency is decreasing.

It then goes on to list, and in fact what we might try to do is see if we can make a copy of this public so you can have a look at it in your own time, and raise issues about —

> 1. Discharge summaries and prescriptions are taking longer to get completed, which is delaying patient discharges. …
>
> 2. Nurses are having to wait longer and longer for RMOs to respond to requests for medications to be written up or for IVC insertion. Patients are therefore receiving intravenous antibiotics or other medications later than they should be, which is unacceptable and unsafe.

There are a number of other ones. I will go to number five —

> 5. CDU patients are only receiving quick reviews on the ward round, rather than a proper medical review of their presenting history and then thorough examination to ensure the correct diagnosis and management.

So that is an internal document about some of the problems that have been identified, which I might add also contradicts the argument they were getting paid a fee for service for additional work. Does that concern you when you hear me read out lines like that and that that was a document being sent internally to the head, the director of medical services?

Ms Feely: Yes, it does.

Hon PHILIP GARDINER: Just one final part about this sequence. It seems that the Department of Health did a good job in identifying that there was an issue with the rise in admissions. After that, even though you prompted an internal audit in the Peel campus, that is also fine, but to go to the cause and effect of this after that, given that public money is on the table here, I think is a gap in what you did. Does that make sense to you or not?

Ms Feely: Yes, I understand the question. I will hand it over to Mr Strachan.

Mr Strachan: It is a good question, but I would like to stress, though, that in terms of the first review which was around about June 2011, we immediately went back at the time with them as early as June 2011 in terms of the outcomes and the observations that PwC had formed; that we were very concerned about the quality of the patient file, the admission process, the compliance with operational directives, the issues around the administration of the sinking fund; and from that date on in terms of active and ongoing discussions with them, it had always formed the basis of what we felt was going to be a very strong push in the direction of Health Solutions to improve their administration and their internal controls and so on. So it has not been the case that we have waited; in fact it is quite the reverse. As soon as we have had some initial findings, as soon as we have dug into the detail, we have been back at the table with them to strengthen what we fundamentally believe is stronger contractual compliance expected of the operator, and that has also then formed the basis of ongoing observations from PwC.

Hon PHILIP GARDINER: Okay. I see you have gone part of the way, but I mean you did miss one of the key parts, which is the $200 thing.

Mr Strachan: But we did not know about that.

Hon PHILIP GARDINER: No; I accept that. It is just a matter of what one has to do to find out, because there may have been fraud. I do not know whether there was fraud amongst the doctors or

not. We asked the questions of the medical director and we did not really get an answer. But I mean it is just those things which I would have thought you would have needed to go into greater depth.

Mr Strachan: Again, in my opinion, in discussions with the chief executive, we increased, clearly, the overarching compliance through the whole contract. So we, probably more so than ever before, went through every single issue from accreditation through to, you know, letters of credit through to operational directives, to the admissions process, to compliance with the sinking fund, to the publishing of annual reports, to the compliance with the short form statutory financial accounts, to the probity issues associated with trust accounts et cetera, et cetera. We opened up the entire contract, sat at the table with Health Solutions and engaged them with what was going to be a very strong, rigid process associated with strict contract compliance through the whole contract, and that process was active from June 2011 forward.

[2.15 pm]

Hon PHILIP GARDINER: So you tried.

Mr Strachan: I think we are actively managing.

Ms Feely: We deeply tried, but this information was not forthcoming.

Hon KEN TRAVERS: Is there a process by which doctors or nurses can fill out incident forms if they think there is a problem, such as a shortage of staffing, and do they stay in Peel or do they come through to you as the health department?

Ms Feely: In the hospitals that I manage, yes, that is an incident form that goes to the executive director and we look at the quality and safety review. In relation to Peel, that would stay at Peel Health Campus. But we would discuss any issues. If there was an ongoing issue that required remedy, that is where I would expect it to be raised, at the monthly meeting.

Hon KEN TRAVERS: How would you know if there were incident forms being lodged at Peel if Peel management did not bring them to your attention?

Mr Strachan: That is a very good question. We have just recently reviewed the entire quality report associated with everything from incident reporting to general compliance with the ACHS and new standards that are currently in play. At the moment we hope to settle that new report in terms of a balanced scorecard report approach across incident reporting and a whole range of other matters. It is the subject of very active discussion at the moment to ensure that the transparency of how Health Solutions is managing its business across those areas is actively reported. Nicole has instigated a process at the moment where the clinical indicators report for the entire area will incorporate Peel. We are going the next step.

Hon KEN TRAVERS: This was back in the early days of the establishment of the trial. There is an email here that was sent to, I think, the then director of the emergency department. There were clearly some issues around and it was linked back to the establishment of the CDU and it just says —

> It looks like we had a few issues over the long weekend.
>
> - We are at crisis point with nursing numbers and skill mix - 4 separate incident forms were generated by nursing staff over unsafe staffing numbers and skill mix over the weekend and staff sick leave.
> - Nurses are telling me that a patients was recently left in a soiled bed for over an hour because no one was free to help them.
> - Patients are going hours without being offered food or fluids as staff too busy.
> - We have had another incident of a staff member getting a needle stick injury from a suture needle found on the floor on the weekend.

That was being raised in the context at the time of the establishment of the trial of the CDU. Were those sorts of things ever brought to your attention in these meetings by Peel?

Mr Strachan: No. In fact, as I was saying before, one of the key concerns we had was to improve the whole issue of clinical indicator reporting, quality of care, and we have spent quite a bit of time at the table in the last six months with the DCS, Aled Williams, and with different forms of the executive management to settle that final report and get it updated with our corporate governance material at south metro. Again, I am happy to table a copy of that if that is requested in terms of where that sits at the moment.

[*Supplementary Information No B3.*]

The CHAIR: I might take up another line of questioning. Some of the evidence that has been presented to the committee is to do with the culture and the nature of the workplace, Peel Health Campus. Do you have a view as to the workplace culture and whether it is a happy campus?

Ms Feely: It has had its challenges, as you can indicate by the turnover of chief executives, but running a hospital is a very hard job. So, to that extent I think it is with Neale Fong; he has undertaken that he is going to try to turn things around down at Peel and hopefully get more stability in there, but I can understand from staff and what has been just intimated that it has been a trying time for Peel in many ways as far as the culture is concerned.

The CHAIR: As to the allegations of bullying and intimidation, does any of that information come to you and do you act on that?

Ms Feely: No allegation other than one, which was never substantiated, has ever been raised with me from Peel Health Campus.

The CHAIR: In particular with regards to the —

Hon KEN TRAVERS: Can I just check, was that about bullying within the campus?

Ms Feely: No.

Hon KEN TRAVERS: About people outside bullying?

Ms Feely: The latter.

Hon KEN TRAVERS: They have never raised concerns about a culture of bullying internally within Peel Health Campus?

The CHAIR: Have any concerns been raised with you regarding the work practices of Mr Jon Fogarty in particular.

Ms Feely: Not with me directly, no.

The CHAIR: As part of the contract, is there a process for considering whether a person is the appropriate person to hold the role that Mr Fogarty holds? Is that part of the process of assessing the arrangements with Health Solutions?

Ms Feely: He is chairman of their board and —

Mr Strachan: He was.

Ms Feely: He was? He has now been replaced. At the time this was happening, he was the chairman of the board. That is not a matter that I have control over in relation to the corporate structure of Health Solutions.

Hon LIZ BEHJAT: Does the department have a relationship with the board at all?

Ms Feely: The director general may, but I have met once with Mr Fogarty when I first started, as an introduction, but on a day-to-day basis the majority of the relationship was with the relevant chief executive or operations people. But those, chair, were higher than I.

The CHAIR: That is a higher level.

Ms Feely: I would anticipate that, yes.

Hon PHILIP GARDINER: What if one of the board members has got a separate consultancy arrangement which takes into account the executive responsibilities of the organisation, which may well be occurring, as we understand it, at Peel? So, it is not just a chairman of the board that some of those people are, or directors; they may have executive responsibilities, which, I would have thought, would come into the area in which you might be engaging.

Mr Strachan: In terms of the provisions in the contract, the contract is very specific about what actually refers to as a potential default or a particular event that particularly the state would be concerned about in terms of the operation of the contract. It is not overly detailed associated with this particular issue that you are raising. It is around the issue that if particularly the company—in this particular case Health Solutions WA Pty Ltd as a subsidiary to the holding company of Health Solutions Australia Pty Ltd, obviously—were to move into an insolvency event, but in terms of the day-to-day management of Health Solutions WA Pty Ltd, it is not within the remit of the contract for us to make those inquiries.

Hon LIZ BEHJAT: With consultancy agreements, are you aware of other health campuses that would have consultancy disagreements and under what terms those consultancy agreements might be—what the monetary value of a consultancy agreement might be?

Ms Feely: There are consultancy agreements all across Western Australian health. I would need to take that on notice. Unless there is something particular —

Hon KEN TRAVERS: We have heard evidence that there is a consultancy agreement between Health Solutions and Mr Fogarty; that he then provides services, but we cannot quite work out what those services are; and that the remuneration is in something of the order of 2 million per annum retainer plus 50 per cent of all profits over the first $500 000 every month. Now, we were advised that that would mean he would be getting something in the order of $10 million from that consultancy agreement in the last financial year. Is that something that you would be aware of? I would assume the funding structure of the health campus—to be taking that amount of money in a single consultancy—I think the total wages bill according to their financial statements was $40 million. To be taking out somewhere in the order of $10 million in a single consultancy before getting a dividend as a shareholder—this is purely from consultancy. How a health campus would be able to effectively run when that amount of money is being taken out and paid to a single person—that is the evidence that we have received so far, that has been happening.

Ms Feely: We pay on the basis of a contract. What happens once the money is paid from the Department of Health, the contractual arrangements behind it is not a matter I have a line of sight over.

Hon KEN TRAVERS: How do they then deliver the services they are required to? Because surely your contract was not structured on the basis that a single individual would be able to be paid an annual consultancy of approximately $10 million, that there would be that much fat, for want of a better term, that you could take that out. It has got to have some flow back into their ability to deliver services which they are being contracted to provide. There has got to be a point where it becomes a concern to you if that is occurring.

Ms Feely: That is when we started looking back at that activity and their request for extra funding came through. But prior to that they are clinically delivering against their activity; they are not following their budget; their quality indicators for all apparent purposes were being met. The contractual relationship of HSWA and others is not a matter I have line of sight over.

Hon KEN TRAVERS: Are they required under their contract to be paying their staff, for instance, the equivalent to the public sector for wages and conditions for their staff? Is that part of their contract?

Ms Feely: It is silent on that, but we make an adjustment to their annual payment if there are award variations in relation to standard staffing.

Hon KEN TRAVERS: You do not then follow through the money to ensure that has passed on to the staff?

Ms Feely: It is a private company; it is a matter between them and the individuals.

Hon KEN TRAVERS: I have seen emails and the like and public comments where the Minister for Health's office, for instance, has been asking Peel Health Campus about the salaries of their staff and they have advised in responding to those emails that their staff are paid equal to or better than the public sector and yet clearly I think that is not the case. Again, at what point do you check to see whether the information they are providing you is accurate and at what point does it become a problem if the information they are providing you is incorrect in terms of the management of this contract?

Ms Feely: There are a number of issues there. In relation to what Health Solutions pay their staff, there is competitive tension in that. They are not government or Department of Health employees, so I cannot direct what they have to pay their staff. Whether they are paying a particular doctor X or Y is a matter between the doctor and Peel Health Campus. Similarly, in relation to all their staff down there, it is a matter for individual negotiation. As to whether or not they are paying the same terms and conditions comes back to a competitive tension. They have to be able to attract staff and to Peel and unless they are competitive, they will not do that. It is not part of my responsibilities to determine what the precise rate is that is being paid to a PCA or a nurse down there. It is if not part of what we need to look at.

Hon KEN TRAVERS: When they are providing incorrect information, when they are asked by, say, the minister's office—if they send an email to the minister's office saying, "No, we are paying our staff equal to or better," if they are providing wrong information, at what point does it become an issue in terms of the contract?

Ms Feely: Until it is demonstrated that it is incorrect, we approach them on the basis that it is correct. There is no presumption of going in and anything that has been said is incorrect.

Hon KEN TRAVERS: If they had a report prepared that showed they are paying their staff well below and when they are asked they are giving out advice that says, "We are paying our staff equal to or better," would that approximate an issue that you would take up with them?

Ms Feely: It would be a matter of the contractual relationship with us too. It is not how we would operate and I would raise that, but I am not aware that has been occurring so we would not do that.

Hon LIZ BEHJAT: Back to that consultancy agreement—I do not need you to take this on notice—in your own experience are you aware of any other consultancy agreement where somebody with the experience of someone like Mr Fogarty would be receiving $10 million per annum for consultancy at a health campus?

[2.30 pm]

Ms Feely: The experience of Mr Fogarty? There are some large consultancy agreements that do operate across Western Australia in health. But without being able to take that on notice, I cannot give you the quantum of them. But are you saying the experience of Mr Fogarty?

Hon LIZ BEHJAT: We are not sure what he has actually been contracted to do under the terms of his consultancy agreement. But he is not a medical practitioner, we know that, so it is not that he is, obviously, advising them on how they are running their hospital from a medical point of view; it is other experience, I guess. I do not know; I do not have experience of these things. To me, $10 million a year seems a lot for somebody to earn under a consultancy agreement, but that might be a benchmark for those sorts of agreements in the health system. I do not know, but in your experience, does that seem right?

Ms Feely: I am not aware of that contract —

Hon LIZ BEHJAT: I understand that.

Ms Feely: — and therefore I cannot add anything to that discussion.

Hon KEN TRAVERS: And if you were, you would be using it in your next pay negotiations, I suspect!

Hon PHILIP GARDINER: As you can see, we are all very anxious about the evidence that we have heard in relation to this. What worries all of us, I am sure, is that this is just an added cost on to the cost of health, which is already ballooning up more than we want it to do, when it may be being distributed in the wrong ways—not to the people who are deserving of the health treatment.

Ms Feely: I will get Mr Strachan to run through how the contract is actually put into place, but I can assure you it has nothing to do with multimillion-dollar payments to consultants. It is a very strict formula under which we negotiate and set the MPA payments down to Peel Health Campus and, because of commercial-in-confidence, I would rather you give that evidence in closed session. But it is nothing to do with all this. So, it is a set formula in how we negotiate that arrangement each year.

Hon PHILIP GARDINER: Fair enough. I do not think I am going into a private session area, but it is just that it may be the set formula has actually got so much cushion in it that it allows these surpluses to be generated. Because the payments which are being made out of this small enterprise, relatively speaking—$100-odd million turnover—seems to be something like $10 million to one of the top people, plus dividends as a result. The last dividend payout was $10 million as well to the shareholders. Now, I admit that that also drew on accumulated earnings from previous years, so you cannot take that as an annual thing, but it is something like $12 or $13-odd million, which is going to an individual and/or plus the company, where there might be other shareholders, out of a small business. That suggests either that the money that you are allocating to the hospital is not being spent in the way that we think it should be for the benefit of the patients and the clinical work that is required, or is what I consider to be an exorbitant cost, as a result, going to one or two individuals in the organisation in a way which it should not. So, is the formula you are using flawed?

Ms Feely: I will take that one on notice.

Hon PHILIP GARDINER: And if you have any doubts about where some of the money is coming from, all we have to do is look at the accounts and we can see that there has been some pretty big areas. For example, "Office costs", have we ever said: what are those office costs? In one year it is $11.3 million, the next year it is $15.3 million—a $4 million increase.

Ms Feely: We do not have access to that sort of information. These are the Health Solutions —

Hon PHILIP GARDINER: This is of Health Solutions (WA) Pty Ltd.

Mr Strachan: Is this their special purpose accounts for 2010–11?

Hon PHILIP GARDINER: No, it is just financial statements.

Mr Strachan: At the top of the financial year, in terms of two columns?

Hon PHILIP GARDINER: This looks like it is out of the ASIC, is it not?

Mr Strachan: So, the 2010–11 financial year showed a reporting profit of about $12.7 million, showed a tax liability of about $3.7 million, showed an operating surplus or profit of around $7 million.

Hon PHILIP GARDINER: That is roughly it. That is right, for the last year? That is it.

Mr Strachan: If I could perhaps, without the commercial detail, there is a framework in the contract. The contract provides for the formula under which the activity profile is set. The framework then is underpinned by a costing methodology, and the costing methodology uses the

lower of the two price points. I can confirm that for the current MPA we used the lower of the two price points. But as a consequence of that, that is the framework that contractually we are bound to follow, that we are bound to build against it and we are bound to, ultimately, put on the table for Peel. We do that and we do that within the confines of the contract, but there are clearly discussions that go into play prior to February each year, where we are required by 28 February to settle the notice for the pursuant financial year. I would say, though, apart from the process that is clearly outlined through the provisions in the contract, there is not a lot of opportunity for the state at all to interpret how it would like to come back to the table and open up discussions in the domain of Health Solutions about how they run their business. I am just taking you through the process. I think you were just saying before in terms of the contract, again, I can make available the central provisions in the contract, but they are very prescriptive in terms of how it works. As I said, the state has the benefit of the lower two benchmarks and for the current year we have used the lower of the two benchmarks associated with a price point.

Hon PHILIP GARDINER: Maybe you could get additional information of the contract to which you referred, but —

Mr Strachan: But I am very familiar with the 2010–11 special purpose financial reports for a private company, which is audited by Ernst and Young, in terms of the provisions there. I also note, too, that there are a couple of other challenges, particularly in note 19, of those set of accounts in terms of a current discussion through Pricewaterhouse around the sinking fund.

Hon PHILIP GARDINER: Just as a general observation, it is not just in health, but in other areas where government has been involved over the years. My observation, for the short time I have been around here, is that government is not good at negotiating contracts which can be revised if it is that things change where they need to be revised. I am concerned at what you say. I can accept there may not be anything you can do about it, but I am concerned about what you say.

The CHAIR: I have just got a couple more questions around the MPA and then we might go to private session. So, have there been any negotiations with Health Solutions (WA) about the MPA last financial year, this financial year, about the payments?

Ms Feely: To put it as a negotiation is probably not characterising it the right way. We look at the contract and we determine the payment and then we advise Health Solutions as to what it is the Department of Health or SMHS is going to pay for the next year and then we have a discussion as to the quantum. We have to put that out in February next year. But again, Mr Strachan handles those negotiations, so I will ask him to answer in detail.

Mr Strachan: We have struggled from time to time in terms of sitting down at the table with Health Solutions in terms of setting the MPA for the pursuing financial year. As Nicole has said, though, we take the activity profile, taking into account a whole range of issues like the whole-of-health cost model, but also particularly the activity profile for, in this case, the Mandurah region. We adjust where appropriate. You are always almost 18 months behind in terms of, particularly, the profile, but we roll that forward in terms of their activity profile for the current financial year. We set that, we provide the notice. As I said, you have got to provide the notice by 28 February for the pursuant financial year, so that obviously comes with a few challenges associated with making sure we get everything right. At monthly contract meetings, it is always the subject of discussion about whether or not the activity profile at an inpatient and outpatient level is tracking according to the intention set through the activity profile, so we may adjust at the margin associated with knee and hips in terms of whether we have got the volumes right and so on. But generally we hold the MPA, or the financial threshold within the MPA, constant and we may vary at the margin the activity profile in terms of getting that right through the course of each year. So, it is a little bit flexible, but a lot of planning goes into, as you would imagine now that the contract has moved in the last three years, noting that this particular year for 2012–13 has seen an increase in funding of just under 16 per cent.

The CHAIR: So that is the most recent —

Mr Strachan: If we track back the last three years, this current notice for the MPA, for 2012–13, is about $104.7 million. The prior year was about $90-odd million and the prior year before that was, you take it through the formulae, you have got around 75.9 plus an adjustment of 2.7 to arrive back at 1.4 and an EBA increase reflected in that settled their figure at about 78.4 off the top of my head.

The CHAIR: That is all my questions regarding the MPA.

Hon KEN TRAVERS: One of the issues that has been raised, and it follows on from that issue about the funding, is the standard and the quality of the fittings and the floor coverings and a range of other issues. I think it is the Australian Council on Healthcare Standards—I was just trying to find the original document where the Peel Health Campus has relied on their accreditation. Peel Health Campus relies on the national accreditation and they talk about they have 15 extensive achievement accreditations from one of the national accreditation bodies —

Ms Feely: Is it the ACHS?

Hon KEN TRAVERS: Yes, it is the ACHS. I am just trying to understand, how does that accreditation process work? Is it subject to actual inspections of the hospital or is it subject to the hospital providing their own internal reports that are then audited?

Ms Feely: It depends. If they have a full accreditation, normally a team would be put together by the ACHS from all over the country and they would spend, depending on the size of the hospital, three, four or five days reviewing whatever they want to look at as far as the things that they are focusing on that year. In preparation for that accreditation, normally a hospital prepares an entire compendium on all the key deliverables under the accreditation system and that would go off to the accreditation team prior to their turning up. It is usually every four years that happens. Every two years, sometimes, they have a smaller accreditation or they might do a desk review. It depends on what it is they are actually looking for or looking at at the time. But our hospitals go through a routine accreditation process every four years. It is usually every two years they really do focus; we have to put a lot of effort into the accreditation process on that sort of regular basis.

Hon KEN TRAVERS: Because I saw a document that sort of suggested that it was part of an audit, so I wondered where would the audit come into it. In fact, one of your Department of Health audits going back into 2008, I think it was—or it might have been delivered in 2008, so on the previous years—talks about them auditing the integrity of the data. How does that come?

Ms Feely: Through the accreditation process?

Hon KEN TRAVERS: Yes, the integrity of the data reported by the operator in its quality indicator reports for ACHS quality indicators. So, it sounds like your auditors then audit the quality of the data that they provide.

Ms Feely: No, the accreditors themselves are very, very focused on making sure that there is appropriate data and examples of implementation as a consequence of that. So again, without understanding exactly where that is coming from, the quality of data may have been a matter of discussion by the actual accreditors themselves.

Hon KEN TRAVERS: So that was in the audit that was then done by 2020 Global, which I think they used to do the audits for the health department of Peel Health Campus.

Ms Feely: Up to 2010, yes, they did.

Hon KEN TRAVERS: So, in one of theirs they talked about the executive, the integrity of the data reported by the operator in its quality indicator reports for the nominated Australian council on health standards quality indicators.

Ms Feely: That is a different issue again. I hope I am hearing you properly. In accreditation, the ACHS standards sit there all the time, so the data as it applies to those can be looked at at any time.

An accreditation process is where the actual accreditors turn up and go through it themselves. So again, listening to you, it may well have been that the company picked up that they did not think that the data was appropriate to actually on a day-to-day basis support —

Hon KEN TRAVERS: To be able to support the ongoing accreditation.

Ms Feely: Yes—or meet it.

Hon KEN TRAVERS: I think I understand it now. Do you know when they were last subject to a physical inspection?

Mr Strachan: A physical ACHS audit?

Hon KEN TRAVERS: Yes.

[2.45 pm]

Mr Strachan: Last year.

Hon KEN TRAVERS: When last year?

Mr Strachan: Again, on notice—June last year.

Hon KEN TRAVERS: In 2011?

Mr Strachan: Yes. They are required to do that under contract to remain accredited in accordance to those standards, and I am happy to give you a copy of that report, clearly.

Hon KEN TRAVERS: Yes, if you could get that report.

[*Supplementary Information No B5.*]

Hon PHILIP GARDINER: I will just go on to another bit. Just on the sinking fund, we have heard evidence about the sinking fund and we know that under the terms of the agreement, the balance of the sinking fund is to be handed back to the state upon expiry or termination of the agreement, and from out of that sinking fund there is expenditure made for category 3 items, we understand. But, there is confusion; there are two things. One is: are you satisfied that the asset register and the maintenance of the asset register is of sufficient quality to know what you have really got in that sinking fund and what state the asset is in?

Mr Strachan: Good question; the answer is, no. Where we are at at the moment in terms of the outcomes of both reviews with PWC is that we are rebuilding the asset ledger associated with group 3 items. That said, at the time of striking the original agreement in 1997, about 5 000 items sat in that group 3 list—I am talking about the number referenced relative to the schedule in the contract. I have not been happy at all, and I have explained this in discussions with Nicole in terms of wanting to make sure that that asset register is built. As you may be aware, in, again, the special-purpose accounts of Health Solutions (WA) Pty Ltd, you will note there is a reference in their accounts to, I think, note 19. That makes specific reference to the fact that they hold a particular trust account and by definition they are holding an independent asset register. So I am asking for a capital life cycle asset replacement program relative to group 3 items, and my understanding of the current balance is about $4.3-odd million and we want to see a very active process. The other thing to take into account is that in terms of active contractual management through this particular provision in the contract, as you would appreciate, a lot of those reference points in terms of group 3 items may not be appropriate to the current description and function, so there is an active process associated with rebuilding clearly everyone's understanding of what group 3 items are about. I hope as a consequence that where we will land on this in the next months is that there will be a very solid program in terms of active replacement of group 3 items through to the end of the current contracted term.

Hon PHILIP GARDINER: So you are onto that part.

Hon KEN TRAVERS: My understanding is that concerns were being raised with the sinking funds. That audit report I was talking about was delivered in March 2008, but refers to the 2006–07 financial year, and even back then it was raising issues about the way in which the sinking fund was operating. Do you know why it has taken so long to get to the point that you are at now? I congratulate you for doing it, but why has it taken so long to get to the point at which there is the rigorous approach you now seem to be applying with auditors and the like in terms of getting across that?

Mr Strachan: It may have something to do with the fact that in another life I am a chartered accountant and have worked with KPMG, Pitcher Partners, Touche Ross and a range of others. So, it is more just the intuition to make sure that all provisions in the contract are being adhered to.

Hon KEN TRAVERS: We have heard evidence that there have been internal arguments in the health campus itself where people have been arguing that there has been expenditure that is not appropriate, even to the point of refusing to sign off on the expenditure, because they did not feel it was appropriate group 3 expenditure to be booked against the trust fund.

Mr Strachan: I start with a general provision and, again, my understanding with Nicole here, in terms of making sure that nothing poses an adverse risk to a patient, a visitor or a staff member on the campus—that is always the opening provision. We then go to the relevant provisions in the contract. We look at whether or not the technology profile has moved on and we make a relatively informed decision around where we go in terms of each individual item. We have taken extra advice from the State Solicitors and so on, but, again, this is a fairly fluent process at the moment that we have associated with this area.

Ms Feely: We are serious about tracking it.

Hon KEN TRAVERS: No, no—I understand and I think both of you are relatively new in your positions. I accept that you were not there in 2008. I do not think either of you would have been there in 2008 when that report was —

Mr Strachan: To answer your question, Ken, it is very much around making absolutely sure all provisions of the contract of being adhered to.

Hon KEN TRAVERS: It strikes me that there clearly has been expenditure where even internally people have been saying that that is not appropriate group 3 expenditure.

Mr Strachan: We have an issue at the moment where PWC are following up some of the outstanding issues associated with the admissions discussion from the first review. Clearly, the issue of the sinking fund still has a few questions in it, and I am asking for copies of those invoices, which at the moment have not been forthcoming.

Hon KEN TRAVERS: This actually goes back to your mission, in terms of the audit. The thing I am a bit intrigued about is because it was a sample—I understand that it is sort of limited; they have got down to a point that with some of them there were only very small negative—certainly in the middle group of, I think, it was four to 15 hours, there was a small sample that was still identifying problems, but they have not been required to repay. You have not then gone back to do a full audit of all of the payments during that time. It would suggest on the sample size that you would actually get—I did some rough calculations—potentially up to another $900 000 if you got the same hit rate for every admission that fit into that category. I know there was some work done about trying to identify streams, but it then says, "We can't identify streams." Are we still missing out some money that we could reclaim that was overcharged?

Mr Strachan: This is going from memory here, but in terms of the issues associated with the initial audit and the follow-up audit, as you are referring to, I think the sample size they took in relation to the issues around the ED and then for the prior years was an initial sample size of about 800 extra—747 off the top of my head. So, in terms of the profile where PWC statistically went through and had a look at the groupings between zero to four, four to 15 and then the 15-plus, that then

obviously has come through. From their point of view, noting that, again, everyone has gone back to the table and had a look at the appropriate admitting process through the operational directive 17/3, a number of those have been knocked out of the margin where, I think it is fair to say—again, I do not have clinical background—there are issues around mental health and other bits and pieces. The outcome of that is that Peel clearly agreed to refund the extra $380 000 or $390 000 —

Hon KEN TRAVERS: Because it is only a sample —

Mr Strachan: Sorry, just in terms of where we are at the moment with PWC, we have asked them to have a look at some of the other key challenges in that grouping, particularly the re-admittance process within 24 hours. This actually picks up your point where, no, I am not 100 per cent satisfied, although PWC have offered opinion, and I want to go back and test that further, which is one of the reasons we are having a look at the cohort between zero to four and four to 15.

Hon KEN TRAVERS: So, there could be more money still to be claimed back. I guess my final question is probably more a question for you than Mr Strachan, because I think it is probably a bit hard for him. It strikes me that he has been pretty rigorous in getting the best interests of the state put forward; has that led to a response in terms of him being targeted or trying to get him pushed out of—have you come under any pressure to have him pushed out of managing the contract because of the rigorous way in which he has been applying and putting the state's interests first?

Ms Feely: Under pressure? I think the rigorous management of the contract has caused some resistance and I think it would be fair to say that it was the preference that Mr Strachan not stay the contract manager, but I specifically said that under no circumstances would I be moving him from that role—that he is the contract manager and he is head of corporate operations, and that is where he will be staying. There was a request to move him and I refused that request.

Hon KEN TRAVERS: Has it been a bit more than that request? Has there been a bit of a campaign to try to put pressure on you and the health department to improperly or besmirch his reputation to try to get him away from managing the contract?

Ms Feely: That is the sort of thing I would like to discuss in private.

Hon KEN TRAVERS: I do put on the record that I think you have been rigorously pursuing it, and there does seem to have been a bit of a backlash as a result of that.

Hon PHILIP GARDINER: Sorry, one more thing. It just comes back to—are you familiar with the formula or the setting of the fees or whatever —

Ms Feely: Yes. Of the actual DRGs or the actual contract at hand?

Hon PHILIP GARDINER: At least the contractual generation of revenue—but what did you call it before?

Ms Feely: The MPA.

Hon PHILIP GARDINER: Not the MPA; it is really, I think, the charges for each —

Ms Feely: The DRG charge?

Hon PHILIP GARDINER: Okay; let us call it the DRG charge.

Ms Feely: That is for each episode of care.

Hon PHILIP GARDINER: Yes, each episode of care.

Ms Feely: There is a particular amount paid, and it is all weighted.

Hon PHILIP GARDINER: That is the one I am after—with the formula. I just show you how generous this is. We know that you have to earn sufficient capital to encourage people to participate in this, but for the investment of $300 000 with this company—that was in 1997, and we are now in 2012—it has made roughly 38 times the investment. I think we would all be pretty happy with making 38 times the investment. Plus you have the dividends that have come out, which I have not

included in that, which is at least twelve and a half for the past three years—I do not know what dividends were taken out before that. Plus there is a very generous profit share in this case to the major investor. You have really got a very, very generous financial proposition here, which, if I was Treasurer of the state, I would say that it is just going too far, and if I was Treasurer of the country, I would say the same. I take the point that Mr Strachan has made—you cannot do anything about it—I just hope we do not make the similar kind of errors of the past or at least have some recourse so that it is reasonable that the cost of health that we are all going to be experiencing is just not going to rocket out of control as a result of this kind of structure.

The CHAIR: I think we will take that as a statement rather than a question!

Hon PHILIP GARDINER: I am sorry there is no question!

Hon KEN TRAVERS: As Tony Jones would put it, we will take that as a comment!

The CHAIR: I will take that as a comment, honourable member.

Hon PHILIP GARDINER: I am sorry about that.

The CHAIR: No; you are not sorry at all; come on!

Hon KEN TRAVERS: It is a fair comment when you have potentially over $10 million going out in a consultancy and the total wages bill is $41 million.

The CHAIR: The committee has indicated that it wishes to hear some evidence in private session. I ask that members of the public vacate the gallery, please.

Proceedings suspended from 2.56 to 3.02 pm

[The committee took evidence in private]