PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO THE HOSPITAL TRUST ACCOUNTS

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON WEDNESDAY, 20 MARCH 2002

Members

Mr D'Orazio (Chairman)
Mr House (Deputy Chairman)
Mr Bradshaw
Mr Dean
Mr Whitely

Committee met at 9.35 am

BERESFORD, DR WILLIAM,
Acting Chief Executive, Women's and Children's Health Service,
King Edward Memorial Hospital Executive,
examined:

AUSTIN, MR BRIAN MAGNUS,
Manager, Financial Services, Women's and Children's Health Service,
King Edward Memorial Hospital,
examined:

The CHAIRMAN: The committee hearing is a proceeding of Parliament and warrants the same respect that proceedings in the House itself demand. Even though you are not required to give evidence on oath, any deliberate misleading of the committee may be regarded as contempt of Parliament. Have you completed the details of witness forms?

The Witnesses: Yes.

The CHAIRMAN: Do you understand the notes attached to it?

The Witnesses: Yes.

The CHAIRMAN: Did you receive and read the information for witnesses briefing sheet regarding giving evidence before parliamentary committees?

The Witnesses: Yes.

The CHAIRMAN: Have you made a written submission?

Dr Beresford: Yes, I have.

The CHAIRMAN: The committee has received your submission, do you wish to propose any amendment to it?

Dr Beresford: No.

The CHAIRMAN: Is it your wish that the submission be incorporated as part of the transcript of the evidence?

Dr Beresford: Yes, it is.

The CHAIRMAN: Before we ask questions, do you wish to make any statement in relation to the submission?

Dr Beresford: No, thank you.

The CHAIRMAN: Could you provide some background on your role at the Princess Margaret Hospital for Children and the King Edward Memorial Hospital?

Dr Beresford: I first became involved in the King Edward Memorial Hospital for Women and the Princess Margaret Hospital for Children in September 2000. I was requested by the then Premier of the day to take over the temporary running of the organisations. At that time the trust fund audit of Ernst and Young was very topical. The chief executive officer of the Metropolitan Health Service Board, Mr Andrew Weeks, deliberately retained control of that audit and I was not involved in the audit or its implementation until the demise of the board in February. From October until the end of January, my time was spent rebuilding the financial systems of the hospitals. These are detailed in

the submission and attachments that I will leave with the committee. From January 2001 I re-established an audit and a finance committee at the Women's and Children's Health Service. The minutes of these committees are included in the documents I will provide. Prior to my taking on the job, there had previously been no audit or finance committee meeting in the hospitals as the committees had been disbanded.

The CHAIRMAN: That is not to say that the committees did not meet prior to that point, because the Metropolitan Health Service Board had set up -

Dr Beresford: The Metropolitan Health Service Board had set up an audit committee for the whole of the metropolitan area.

The CHAIRMAN: But it also set up an audit committee to specifically look at the allegations of the Ernst and Young report at PMH.

Dr Beresford: I am not aware of that. It was the same audit committee that reviewed the general audit of the Metropolitan Health Service Board.

The CHAIRMAN: It might have been general, but evidence was given to us that the committee was specifically reviewing the results of the Ernst and Young inquiry into the trust funds at PMH.

Dr Beresford: I am sure it would have been a single item on the committee's agenda. With the demise of the Metropolitan Health Service Board, I re-established the audit committee at the Women's and Children's Health Service, which has been running since. One of the major tasks, among many, has been the reorganisation and investigation of the so-called trust accounts.

I will now explain the difference between a true trust account and a special purpose cost centre. We have been talking about special purpose cost centres. The Women's and Children's Health Service has some trust accounts, which are listed in my documents. These are moneys held in trusts for external organisations such as the Kalparrin volunteer group and the volunteers at PMH and KEMH. They are held in a separate bank account with their own business number and are not under the control of the hospital; they are just looked after in trust. All other accounts that have been previously referred to as trust accounts are special purpose cost centres and belong to the hospital. It is the latter that I have been addressing and reorganising. We have now completed that reorganisation. There were 151 special cost centres in January 2001. There are now 126 of these accounts. Each one of these accounts is now managed by one of 13 independent committees with terms of reference.

The CHAIRMAN: Were there 126 accounts in January 2001?

Dr Beresford: No, 151 accounts.

The CHAIRMAN: Therefore, in your time on the job, 26 accounts have disappeared.

Dr Beresford: No, 25 accounts have disappeared. These are now managed by 13 independent committees. No longer does the signatory of an account control that account. That is the important difference from an accountability and financial reporting point of view.

Mr WHITELY: When was that change made?

Dr Beresford: That change was made progressively over the last six months. The delay was occasioned by an inability to talk to doctors in any detail from May to November because of an inquiry by the Health Insurance Commission. That is detailed in the paperwork that I will leave with the committee.

The CHAIRMAN: What was it inquiring into?

Dr Beresford: Following the Ernst and Young audit report, the Metropolitan Health Service Board referred the report to the then Commissioner of Health, Mr Alan Bansemer, who referred it to the HIC.

The CHAIRMAN: Are these allegations in relation to the misuse of funds?

Dr Beresford: That is correct.

The CHAIRMAN: Has that report concluded?

Dr Beresford: Not as far as I am aware. I have had no further contact since November with the HIC investigators.

The CHAIRMAN: Why would the investigation by the Health Insurance Commission curtail you from doing something that is just good financial management?

Dr Beresford: It does not curtail my job; it makes it more difficult. I am not permitted to talk to the doctors about those accounts that are being investigated. I am required to sign a confidentiality agreement with the Commonwealth that I will not draw to the attention of any of the doctors that an investigation by the HIC is being undertaken.

The CHAIRMAN: I understand that but that is not what we are talking about. We are talking about accounts that contain hospital moneys and are under the financial controllers of the hospital. It does not need you to talk to the doctors to sort it out.

Dr Beresford: I have now sorted them out. What I have been unable to do is address the Medicare payments issue in as timely a manner as I would have liked. It has now been addressed and I will speak on that matter separately. If the committee wishes, I will address the specific questions that it put to me.

The CHAIRMAN: We will ask you questions along the way.

Dr Beresford: The first question asked what was the current status of trust accounts and special purpose accounts of the two hospitals under my jurisdiction. I believe I have answered that in my preamble.

The CHAIRMAN: It seems strange that we have got rid of only 25 accounts. From reviewing the evidence, it appeared that most of the accounts were special purpose accounts.

Dr Beresford: That is correct, and they are still there, but they are now managed by a committee independent of the person who is the signatory.

The CHAIRMAN: However, why do special purpose accounts need to be managed by an independent committee? Special purpose accounts only need the control of the hospital. They are just normal management accounts.

Dr Beresford: I beg to differ. I established one research committee to manage the research moneys that come in for specific purposes. One of the previous problems was that the hospital was managing these accounts with a single signatory. The accountability that required a review of the expenditures was not there. The independent committees are reviewing those expenditures and are approving expenditures within the terms of reference of the grant.

Mr WHITELY: How many people are on the committee?

Dr Beresford: It varies. I have a list of all the committees and their memberships in my documents.

Mr WHITELY: What is the range?

Dr Beresford: The range starts from about 10 for the research accounts.

Mr Austin: There are 33 accounts amongst the research accounts.

[9.45 am]

The CHAIRMAN: Therefore, one committee looks after 33 accounts?

Dr Beresford: That is correct.

Mr DEAN: Can some of the 33 accounts be amalgamated?

Dr Beresford: We have amalgamated to a great extent. These accounts cannot be amalgamated because they are for the specific purpose of research. If a person undertakes a piece of research that is funded by, for example, a National Health and Medical Research Council grant, it has to be kept and accounted for separately. That is a requirement of the National Health and Medical Research Council account.

Mr WHITELY: Are you talking about separate general ledger accounts or separate bank accounts?

Mr Austin: We are talking about one bank account. These are separate departments; so the research into children's oncology cancer is in one cost-centre account, and there are others for asthma, respiratory medicine, diabetes and so on. They are separate cost centres, but all 126 are in the one bank account.

Mr WHITELY: In the committee that operates with 10 people, how many people would be required to sign-off to authorise an expenditure?

Dr Beresford: Just the chairman of that committee.

Mr WHITELY: How is that oversighted?

Dr Beresford: The oversight comes through consideration by the committee. The actual expenditure -

Mr WHITELY: Is that before or after the event?

Dr Beresford: No, the proposal is put the committee, and the committee approves it. The signature is then made with the approval of the committee. It is also checked by financial services because it checks that the approval has been given. That is reported to the finance committee on a monthly basis. I am aware of what money has moved in and out of those trust accounts.

Mr DEAN: What is the relationship between the members of the committee and the types of jobs to which that money is directed? Is there is crossover of members and people who benefit from that money?

Dr Beresford: Occasionally, people will benefit from a specific research grant. However, they would be excluded from the consideration of that account by the committee.

Mr WHITELY: Are the people who are on a research committee potentially the beneficiaries, or does somebody stand alone in their function? Does a hospital representative have the function of oversighting?

Mr Austin: In terms of beneficiaries, moneys expended might be for a research assistant and for consumables that are used in the research. That research may be oversighted by a particular doctor in charge. The doctor in charge may have arranged to put the submission into the NHMRC to get the grant, so that doctor may be a member of the research committee. The research committee is made up of a number of doctors who are involved in research, in addition to people who are not involved in research.

Mr WHITELY: Are they just doctors or is there a representative from the accounts department?

Mr Austin: I represent the finance department.

Mr WHITELY: Are you on each of the committees?

Mr Austin: I am on some of the committees. I am on the research committee, which also comprises people from the Institute for Child Health Research. That body is independent of the hospital. It has a research director, plus people who are actively involved in research. It is a research group.

The CHAIRMAN: Are those whom you mentioned just hospital people or are outsiders involved?

Mr Austin: As I mentioned, the Institute for Child Health Research is also involved.

The CHAIRMAN: Is anyone else involved? Are there other independent people?

Mr Austin: No.

The CHAIRMAN: How many doctors are on this committee?

Dr Beresford: The university department of obstetrics representative is medical, and so too is the department of paediatrics. The Women and Infants Research Foundation is represented by a doctor. The representatives from the medical advisory committee are doctors. There is a nursing representative, an allied health representative, a financial services representative, and the two chairmen of the research committees.

Mr DEAN: Of the 33 accounts that are held by that research committee, what is the aggregate of the throughput of money through those total accounts, not individually but for the last calendar year?

Dr Beresford: I do not have the figures for the last calendar year, but I can provide members with the figures for the monthly throughput. I can provide, on notice, the figures for the last calendar year.

The CHAIRMAN: What are the figures for the monthly throughput?

Mr Austin: The in and out payment received for the month of February was $177 000, and we paid out about $66 000. In a particular month, large lump-sum grants come in and provide six months worth of research.

Mr DEAN: How often does the committee meet to distribute that $66 000?

Dr Beresford: It meets monthly.

Mr BRADSHAW: In the past there has been talk that doctors' salaries were going into some of the trust accounts and then being used for trips. Where is the money coming from, and is it now specifically used for research, or is it also used in other areas?

Dr Beresford: The accounts are split into three main areas. The first area is research, and all of money is either donated for research or comes in the form of a special grant for research, such as that from the NHMRC, universities, other research funding bodies or drug firms. That is the research account. The second area is the general purpose account, which collects donations that are given to the hospital generally. Travel accounts comprise the third area, and they are covered under the AMA collective workplace agreement. A component of the private practice earnings is above 25 per cent of salary, it is paid into a trust account for the purpose of travel, education or option B doctors. I have brought along a copy of the award and I have made reference to the appropriate sections. I have also detailed that in the documentation.

The CHAIRMAN: You mentioned that there are 33 research accounts. Who looks after the remaining 90 accounts?

Dr Beresford: Twelve committees look after those accounts.

The CHAIRMAN: Why do we need 13 committees? Why cannot only one or two committees perform that role?

Dr Beresford: The reason is twofold: first, as far as possible, we try to control the accounts at a local level. For example, the surgical clinical care unit comprises 13 different groups of specialists. That committee looks after nine accounts.

The CHAIRMAN: The problem has been the local control of these accounts.

Dr Beresford: With respect, the problem has been the control by individual doctors or departments. That is no longer the case. The control is now exercised by a cross-departmental committee at a local level. I have tried to retain local ownership while maintaining accountability.

We are attempting to strike a balance. We are giving people ownership so that they are not being dispossessed, and we are encouraging them to seek research money and to raise money for the hospital. At the same time, we are trying to achieve a best practice accountable system. We are trying to strike a balance. There is no general answer to this issue. After members have read the document, I am sure they will agree.

Mr WHITELY: We heard evidence that there was a lot of disharmony when your predecessor tried to institute change. What type of resistance did you encounter, if any, when you attempted to bring these changes on board?

Dr Beresford: I encountered minimal resistance, because the environment was quite different. For a start, there had been much publicity about trust accounts. There had been the meeting of this committee, and the previous audit undertaken by Ernst and Young across the whole system. The Department of Health, the AMA and doctors were well aware that something had to change.

Mr WHITELY: Do you believe there was a realisation by the doctors?

Dr Beresford: There was the realisation that they and the hospital had been exposed. Accordingly, my job was made much easier.

Mr WHITELY: What do you mean when you say that they were exposed?

Dr Beresford: I think that the debate that had gone on in the media and elsewhere would have demonstrated that they had been exposed.

Mr DEAN: Do you refer to a lack of accountability?

Dr Beresford: I refer to a lack of transparency. Bear in mind, these accounts were audited by the Auditor General for many years. As far as I am aware - correct me if I am wrong - there was no specific finding of impropriety. However, the perception existed that there could have been. Is that not the issue being addressed by this committee?

The CHAIRMAN: At the same time, we do not want to have a bandaid treatment. We have the perfect opportunity to fix the problem once and for all. The greater the transparency and the greater the independence of approval, the better it is for everyone.

[10.00 am]

Dr Beresford: I agree.

The CHAIRMAN: It concerns me that so many committees are looking after so many things, when these are really hospital funds that could be easily managed by a decent finance department.

Mr Austin: If I may draw a parallel with the operational funds for the hospital, if I want to spend funds for a given department, under the rules that apply in this hospital as we find in almost any government department, it goes to the head of a department the way delegations are arranged. These functions are a paralleling of that, but instead of going down to a departmental level, it goes to a slightly higher level - a directorate level - and that is where the approval lies. I am sure you, Mr Chairman, do not sign for a biro. If you wanted to order a biro, an approval delegation would be required. Everything could be put to a committee, which sits once a month, including ordering a biro, but that may not be worthwhile for 50 cents. That is brought down to a directorate level, which is the in between level. These committees are a parallel to the ordinary operation of the hospital, albeit at a slightly higher and more detailed level of control.

Dr Beresford: What Brian is trying to say is that this reflects the devolved management structure; in other words, all money is delegated down to a clinical level, which is where these committees are located. There is a committee for the whole of gynaecology, for obstetrics, for paediatric medicine and for paediatric surgery. These are big budgets. These clinical care units have a budget of about $30 million. These are not small groupings. A single committee would become unworkable. If they were trying to manage 126 different accounts on a monthly basis it would become unworkable.

The CHAIRMAN: I was hoping you would get rid of the 126 accounts and have only a handful so that the financial controllers could manage them.

Dr Beresford: One of the problems they have is that when people donate money for a specific purpose, such as child counselling, child asthma, breastfeeding or obstetric research, it must have specific accountability for each one of those targeted donations. I will leave details with the committee. I would be delighted to provide further feedback, but what I have tried to put in place and what I have succeeded in doing is, to my mind, a transparent system which includes blocks and checks to ensure full transparency from an accounting point of view. It also requires accounting to myself and the finance committee on a monthly basis. I also inform the committee that it is no good putting the system in place unless it is audited. I have already booked an external audit of these committees by Pannel Kerr and Forster in June this year to ensure the system is working. I propose using the audit committee, which I now have in place, and that will continue on an annual basis. We will also have the independent audits by the Auditor General and any other audits that are put in place by the Department of Health.

Mr BRADSHAW: How long have you been associated with these hospitals? Were you associated with the hospitals when Mr Moodie was there and, if so, did you see a problem between those who were controlling the trust accounts and Mr Moodie?

Dr Beresford: I have been there only 18 months, so I cannot comment.

Mr Austin: I have been working in the hospital for 17 years. I was in the hospital at the time that Dr Beresford's predecessor was there. There was some dissension between the doctors and Mr Moodie.

The CHAIRMAN: In 1996 a problem was highlighted.

Mr Austin: I came into the financial services department in January 2000. Prior to that I was working in other areas of the hospital. I was appointed manager of financial services on 1 July 2000. I basically came in after the first audits had been carried out.

The CHAIRMAN: Were you aware of all the problems in the finance department when you took it over?

Mr Austin: There were some problems in the finance department. The issues that were raised in the audits were addressed. There were different interpretations of how accounts were perceived.

Dr Beresford: I make the point that the financial management was privatised. Andersens, under contract, provided financial management services for King Edward Memorial Hospital and Princess Margaret Hospital for Children from 1997 through to July 2000.

The CHAIRMAN: Did they provide an audit system?

Dr Beresford: No, they provided the management of financial services under contract.

The CHAIRMAN: Who was checking what was happening?

Dr Beresford: I cannot answer that. All I can say is that when I took over I terminated the Andersen contract and re-established an internal financial system and audit system.

Mr DEAN: Is this the same Andersen group of auditors that presided over HIH?

Mr Austin: It is the same company.

The CHAIRMAN: How come it was not highlighted in the previous evidence that the financial control of the hospital was being performed by an independent firm?

Dr Beresford: I cannot answer that question. Arthur Andersen held a contract and managed the financial services at the hospital. They started doing the accounts in Gareth Goodier's day and continued until I suspended their contract..

The CHAIRMAN: That means they were paying all the accounts and doing all the checks?

Mr Austin: No; the management of the financial services. The position of manager, financial services, was a contract provided to Andersens. Additionally, they had consultants come in to do budgeting and other financial controls in the hospital. Positions in financial services beneath the manager were occupied by hospital staff.

Mr DEAN: Why would you not want your own people in those positions?

Mr Austin: This was first introduced when privatisation of government services was seriously looked at. It was a case of privatising financial services, and we started by privatising the management. The decision was made in 1997.

Mr WHITELY: Who was doing the audits at that stage?

Mr Austin: We had two lots of auditors. The internal audit was carried out by Ernst and Young under a contract which continued, and external audits were conducted by the Office of the Auditor General. The Office of the Auditor General tended to do most of its audits by outsourcing to Hall Chadwick.

The CHAIRMAN: Ernst and Young was doing the internal audits and nothing happened in the financial management area, even though this was highlighted. Was there any documentation about concerns or whatever for financial management services? This is not the first time we have worked out that these were not trust funds but special purpose accounts. Nothing has been done about it since 1996, as far as we are aware; it probably occurred before then.

Mr Austin: The trust funds themselves date back to 1910. When the hospitals were set up there was always somewhere to put donations, which was separate from the government-provided money. Over time these accounts had been considered to be trust funds in the sense of how people might see a trust fund: with a trustee and that trustee overseeing the use of those funds. That is how these funds have built up and developed. The signatories to the accounts tended to regard themselves as trustees. Over time, with relevance to government accounting practice, it became clear that these funds were actually hospital funds; they were donated to the hospital and a tax deductibility was given to the person who donated, which meant that these funds were really hospital funds. They are not trust funds as such. That distinction has only been highlighted since the start of the first audits. It was further highlighted when the goods and services tax was introduced. We had to distinguish between what is controlled for GST purposes and what is not hospital controlled. We came to the realisation that these are a special form of account - they are not true trusts - because a true trust has a trustee, a trust deed and it is altogether separate from the hospital's money. This has been a development over the past few years. In all the audits that have been carried out the perceived wisdom is that these are sort of trust accounts, in inverted commas. I do not think anyone was ever distinguishing between the two.

Mr WHITELY: But a lot were donations to the hospital. I would have thought it was pretty obvious that they were not trust accounts; they were the hospital's money - or at least a significant portion were.

Mr BRADSHAW: The funds would still have to be parked in a spot for identification purposes.

Mr WHITELY: That is true, in a general ledger account.

Mr Austin: They are parked in a spot, but they are different from the sort of moneys which include the annual appropriation from government for the operation of the hospital. If somebody gave us a grant of, say, $50 000 on 29 June to spend on a particular piece of equipment, that cannot be mixed in with appropriation moneys which will be cut off by 30 June. We need to carry that over and deal with it separately, as Mr Bradshaw pointed out. They were dealt with separately, they were put to one side, but were still under hospital control.

Mr WHITELY: They may not be part of your capital funding, but they form part of the hospital's money and they were never trust accounts. It is obvious they were never trust accounts, because they were not held in a trust for somebody else.

Mr Austin: That is right.

Mr WHITELY: It is the hospital's money.

Mr Austin: They have always been accounted for.

The CHAIRMAN: The people who were getting the benefit were making decisions about them, and there seemed to be no control by the financial people in the hospital.

Mr Austin: If donations are made to an oncology ward, they are supplying equipment to the ward, they are employing research staff to engage in research projects for oncology and they are arranging for conference attendance by members of their staff to keep up with the latest trends in medical technology. The individuals themselves are not receiving a personal benefit. It is spent on the area.

The CHAIRMAN: The question is that there has been no independent monitoring of those funds; obviously there has been no hospital monitoring.

Dr Beresford: A system has been put in place. The consolidated funds are reported to the health service-wide financial meeting on a monthly basis so we can monitor the trends.

Mr WHITELY: I will outline my current understanding of how this works. Thirteen committees control 126 accounts. There is monthly reporting to you. The committees have external input and there is input from the doctors who presumably have the expertise to know best where the money needs to be spent. An audit group sits above that level on an annual basis and there are also the external auditors. There are four levels, if you like.

Dr Beresford: Yes.

The CHAIRMAN: How often does the audit committee meet?

Dr Beresford: Monthly, immediately prior to the finance committee.

The CHAIRMAN: Who is on that committee?

Dr Beresford: Myself, my director of business, my manager of finance and the internal auditor who until recently has been Ernst and Young.

Mr Austin: And representation from the Metropolitan Health Service Board audit group.

Mr DEAN: One of the problems with these types of inquiries is that they sometimes reflect badly on the participants. Have you noticed a decrease in the amount of money coming into the various accounts?

Dr Beresford: That is difficult to say. I have not deliberately gone back and looked at previous years. I would hope that donations have not suffered too much. Research definitely has not. The research has increased as we have increased the employment, for example, of additional specialists. I cannot really comment on the level of public donations.

The CHAIRMAN: In relation to the trust accounts and the research that is being done, does the intellectual property that is generated by those funds specifically belong to the hospitals? From previous evidence, it appears that trust funds were being used for research, but the research then became the intellectual property of the people doing the research, although they were using hospital funds. As part of your process of change, is it a stipulation that any of the research being done belongs to the hospital?
[10.15 am]

The second question relates to the amount of money being paid to the hospital by people doing research. They cannot have it both ways. If it does not belong to the hospital, are they paying a fee to the hospital for the use of the materials? It was mentioned in previous evidence that there was no

benefit to the hospitals as the intellectual property belonged to the specialists, yet the hospitals were paying the bills through their facilities.

Dr Beresford: The hospitals use the public sector policy on intellectual property. It is a policy we put in place. I am only aware of three moneymaking intellectual property decisions in health over the past 10 years. They were all governed by Crown Law. Problems do not normally arise with the individual; they arise with the university and the Department of Health. Many academics are paid jointly by a hospital and the university. The academics tend to do the most groundbreaking research, as that is their interest. There is usually joint ownership of the intellectual property between the university and the hospitals. If a discovery were made, it would be governed by public sector policy and it would involve Crown Law negotiations between the individual and the university.

The CHAIRMAN: There is a difference between research done through trust funds and research done through special purpose accounts. They are totally different classifications. One is independent and the other is not. One will be covered by your public policy and the other will not.

Dr Beresford: Medical health research grants are awarded to a research group. If they are hospital employees they will put the money in the hospital. The hospital will generally take the cost of consumables and other things from the grant. Grants are given to individual groups of researchers. Usually, most research is done by groups. That occurs at the university and Princess Margaret Hospital for Children. I am not trying to avoid the question; I am trying to explain that there is no simple answer. Any question connected to intellectual property would be covered.

The CHAIRMAN: As you are conducting the review, would it not be appropriate to sort out this issue so that the problem does not continue? There appears to be not so much a misunderstanding, but rather over the years the culture has developed that the rules stand as set by the people doing the activity at the time. This is the appropriate time to state that special purpose accounts must be dealt with in one way and external accounts must be dealt with in another way. There is a need to make a policy decision that is up-front and seen by everybody, rather than allow the situation to simply meander on.

Mr Austin: The committee should be aware that in the individual hospitals there will be research that is funded by special purpose and research funds. The Institute for Child Health Research is across the road from Princess Margaret Hospital for Children and its researchers work in the hospital. People from the paediatrics department at the University of Western Australia work at the hospital. Others from the obstetrics and gynaecology department work at King Edward Memorial Hospital. The Women and Infants Research Foundation is also based at King Edward Memorial Hospital. They all fund research projects, which involve staff of the hospital and people from the university working jointly. As Dr Beresford said, it is a complex issue as to whose research it is.

Dr Beresford: I take on board your point. I will send the committee a copy of the hospital's policy.

The CHAIRMAN: Is there anything else the witnesses would like to tell the committee about the processes put in place for the trust funds?

Dr Beresford: I hope that what I have said answers all your queries. Can we move to the next item?

Mr WHITELY: Who are the internal auditors now?

Mr Austin: Pannell Kerr Forster.

Mr WHITELY: For what reason?

Dr Beresford: The decision was made by the Department of Health. Ernst and Young used to be the auditors. I have given a chronology of events to the committee. Tenders were formalised in November 1995. Ernst and Young commenced the audit contract in late 1995. The contract

expired in October 2000. We progressively extended the contract in order to get continuity because of the trust fund audits. We wanted their input into the form the trust funds should take. The Department of Health decided to have a single, central internal auditor reporting to the director general, as there is now a new structure in the health system. The acting head, John Doyle, determined that the contract with Ernst and Young should cease and that we should tender to a panel. The new contract has been let until 30 June, when internal auditors will be based at Princess Margaret Hospital for Children and King Edward Memorial Hospital ex the Department of Health.

The CHAIRMAN: It is still a private contract.

Dr Beresford: No, it will not be a private contract as of 1 July.

The CHAIRMAN: From 1 July you will have your own internal auditors?

Dr Beresford: I will have an internal auditor posted from the Department of Health. He will be accountable to the director general, who is the chief executive officer of the health service.

Mr WHITELY: It is fair to characterise it as not being a hospital specific decision; it was across all the health system and it just flowed through. There were no other reasons?

Mr Austin: PKF were the auditors at Royal Perth Hospital. That hospital may have swapped them for another firm and PKF have moved to us.

Dr Beresford: Ernst and Young have taken on dental. There has been a change of guard at the request of the Department of Health. No-one formally informed John Copp so I wrote to him and thanked him for his assistance. I have a copy of the letter. I have a copy of his reply in which he states he was happy to work with me.

Mr WHITELY: They were moved elsewhere in the system? They were not cut from the system?

Mr Austin: That is right.

Mr WHITELY: In other words, the logic is that you do not want the same people sitting on the same issues for too long as you want to bring in a fresh perspective. Is that the logic behind it?

Dr Beresford: The question should be addressed to Mr Doyle. I extended the Ernst and Young contract twice. They worked with me on the audit committee, as I wanted their expertise to help me with the organisation of trust funds.

The CHAIRMAN: The witness has explained some of the controls. In relation to the continuing management of the accounts, it was indicated in the past that they were being treated like trust accounts. That is not going to happen in the future?

Dr Beresford: I assure the committee that no doctor is controlling any account.

The CHAIRMAN: They will all be reported in the annual reports and go through proper process?

Mr Austin: They always have done.

Dr Beresford: Reporting will be to the finance committee on a monthly basis, which is the way it should be. I spoke yesterday to the director general. I will report to him on a governance basis each month. We discussed the question that financial reporting should be an important component of that.

The CHAIRMAN: It is amazing the effect that an inquiry of the Public Accounts Committee has on the process.

Mr Austin: I should say that, in terms of the process, the committee might think it was just the trustees. Trustees give us a statement of the nature and purpose of a fund when it is set up. It details the nature of the revenue and the expenditure, and the principal signatories. Anything going into an account would be referred to the original statement. Anything going out of an account would be referred to the original statement. It would also be referred to the signatories. We treat the signatories as trustees. If they want to pay for something and if it is not in accordance with the

nature and purpose of the account, it will be rejected. There are controls. The control was viewing it as a trust account rather than an account of the hospital.

Dr Beresford: There was potential for abuse.

The CHAIRMAN: There were examples that were clearly unusual but they were not picked up by anyone. You are telling us that they were being checked, but our evidence is that it did not happen. There was an example of $100 for a bottle of red wine. That could not have been checked by someone. If it was checked, it would have been highlighted. It was an unusual expenditure. Someone would have asked how $100 for a bottle of red wine could be justified.

Mr Austin: All accounts were checked in accordance with the nature and purposes of the accounts and how things were done.

Mr WHITELY: Are you saying they were checked to the extent that there was an invoice to match the expenditure? You are not saying they were checked to the extent that the expenditure was appropriate? The level missing was at the bottom level when there was some oversighting?

Mr Austin: It was checked on the appropriate form. If a particular account showed entertainment expenses or allowances, we treated it as that. If necessary, we referred it back to the signatories for clarification.

Mr WHITELY: There was no process of approval prior to the event, it was all done after the event? In a sense, you had to accept the explanation and unless it stood out, your attention would not be drawn to it.

Dr Beresford: I take your point. This is why we put the system in place. It is much harder to retrospectively reject a claim than it is to prospectively reject a claim. That is why we have put this in place of the delegated committee.

Mr WHITELY: It is also much harder to determine the true intent of the expenditure after the event.

The CHAIRMAN: I know that the witness just said that everything was checked, but the evidence does not justify that comment. One of the trust accounts was overdrawn for 18 months. How could there be an overdrawn account that was checked by your finance people? It does not add up.

Mr Austin: The accounts were overdrawn with the support of the finance committee at the time of its meeting and prior to the meeting of the committee with the cognisance of the administration.

Mr WHITELY: Are there any examples of signatories - I will not call them beneficiaries - of accounts leaving the health system with a deficit in an account?

Mr Austin: Leaving?

Mr WHITELY: A signatory to a trust account moving on? In other words, a person had control of an account and moved on but the account was overdrawn.

Dr Beresford: We currently have one overdrawn account. It relates to the sleep clinic, which I will refer to later. I will explain it later.

The CHAIRMAN: Any other questions? Next item.

Dr Beresford: I have answered the question about whether doctors completely control trust funds. The answer is no.

In relation to the question about the two outpatient clinics, I must say that during the investigation we discovered that the sleep clinic and the sleep service were privatised. I will discuss that further. One clinic referred to by the committee is the cleft lip and palate orthodontic clinic. Within the cranio-facial department, the hospital treats children who are born with grossly severe deformities of the face. The Commonwealth recognises its inability to provide orthodontic services to these children. The average cost of providing these services is between $10 000 and $20 000 a year for

each child, if treated privately. The Commonwealth set up a cleft lip and palate scheme whereby assessed and approved children are issued with an identification that lasts until they are 21 years of age. At the same time a single hospital in each State is approved to provide the service. In Western Australia it is Princess Margaret Hospital for Children. Individual orthodontists are credentialled and approved to provide the service. The scheme at PMH has been investigated. It was a long and tortuous business getting clarification from the Health Insurance Commission. The HIC established that PMH was the approved location. It was quite easy to confirm that all children had the appropriate approval to bill. It was difficult to establish who were the approved practitioners, as the HIC would not release their names unless I could obtain consent from them.
[10.30 am]

I had to ask the individual practitioners, without interfering with an HIC investigation, whether they were approved HIC orthodontists. I finally got that confirmation, and it is documented here. The cleft lip and palate scheme is being run by Medicare with the approval of the HIC.

The CHAIRMAN: Are the bulk-billing payments going directly to the hospital or to the doctors?

Dr Beresford: They are going directly to the hospital.

Mr Austin: The funds go into an account to fund additional nursing and other assistant staff.

Dr Beresford: That has been built into the operation of that unit.

The CHAIRMAN: I understand that, but this is a principled decision. If the HIC approves that arrangement for one operation, why will it not allow it to be extended to all the other operations?

Dr Beresford: The scheme was specifically set up to benefit a particular group of children around Australia.

The CHAIRMAN: Are you saying that Medicare has approved that arrangement?

Dr Beresford: That is correct.

The CHAIRMAN: Are you saying that the bulk-billing funds are allowed to be put into hospital accounts, even though the hospitals are controlled by the State?

Dr Beresford: Yes. The documentation is here.

The CHAIRMAN: What about the other two accounts?

Dr Beresford: I referred the diabetes account to the HIC, which was not happy with the bulk-billing of privately referred non-inpatients. The Health Insurance Act accepts the fee for privately referred non-inpatients. This is widely used in the eastern States to promote bulk-billing in public hospitals. I conducted a review of the functionality of this process in New South Wales and Victoria for the previous Government in July 1999, and produced a report explaining how those States were able to bulk-bill for the indirect needs to increase the amount of commonwealth funding received by the hospitals. Since that time Royal Hobart Hospital has begun taking privately referred non-inpatients. However, the HIC is not happy for this State to do that. Our problem began in the early 1990s. The majority of clinics ceased bulk-billing in 1997. However, they had not followed the full letter of the law for privately referred non-inpatients. There was no clear separation between the doctor receiving a bulk-billing payment and receiving sessional payments. If the doctor is bulk-billing for privately referred non-inpatients, he should not receive his sessional payment. That money should be retained. Our doctors were receiving sessional payments, whilst Medicare payments were going into the special purpose accounts. That was not in line with the HIC policy for private referred non-inpatients.

The CHAIRMAN: Can you give us a copy of the 1999 report?

Dr Beresford: I can, but I do not have it with me.

The CHAIRMAN: Could you please provide it? It is a matter of great interest to this committee.

Dr Beresford: It was conducted on behalf of the health industry when I was at Royal Perth Hospital. It had nothing to do with Princess Margaret Hospital for Children or King Edward Memorial Hospital.

It is essential that the paediatric services are provided for the country. The cost of medical staff to provide those services has been picked up within the budget. I have ceased bulk-billing for those. We did an analysis, and I have the papers here. The cost of using the patient assisted travel scheme to bring children from Hedland, Kalgoorlie, Esperance and elsewhere to Perth to provide those services is about $290 000 a year. Therefore, I spend $55 000 in salaries for doctors to go to those areas to provide those services. It is the only way to do it.

The CHAIRMAN: Is it not possible to use the other system to cover the cost of those doctors by not making them employees of the hospital? They would still get the same bulk-billing funds but they would be paid directly rather than through the hospital system.

Dr Beresford: They would not do it. If a doctor went on an overnight trip to Esperance and saw six patients -

The CHAIRMAN: The cost would not be recouped.

Mr Austin: The doctor would not make enough money.

Dr Beresford: The country is important, so I said that we will absorb the cost to maintain essential children's services. I have included for the committee all the relevant figures and the number of children who are reviewed.

The metropolitan diabetes outreach clinics have been fully privatised. A new one was successfully opened at Joondalup Private Hospital with the assistance of Mayne Health.

The CHAIRMAN: Are they bulk-billing clinics?

Dr Beresford: They are bulk-billing clinics and they operate on a private basis. Their doctors are not paid by us. They provide that service to individual patients. The program operates at Rockingham-Kwinana District Hospital, Joondalup Private Hospital and in the research building.

The CHAIRMAN: I want to get this straight. This is a principle. Do those clinics pay rent to the campuses?

Dr Beresford: It is entirely up to them. It has nothing to do with the hospital. The clinics operate on a private basis. They will pay rent if the facility is in a hospital. It is up to the clinic to determine its private arrangements with Mayne Health. I could not tell the committee.

The CHAIRMAN: In some of the Victorian examples that have been spoken about, the hospital subsidised the clinics.

Dr Beresford: I will come to that shortly.

The sleep clinic was opened seven years ago on a privately referred non-inpatient basis, as are all the sleep services around Australia. The Medicare payment goes nowhere near to covering the cost of the operation of those services. It is fully privatised. I have asked the HIC for confirmation that the program may continue. In the meantime, I have requested that doctors do not put Medicare funds into the private clinic accounts. They are holding their private billing - to the tune of $200 000 - until the arrangements with the HIC are finalised.

The CHAIRMAN: Is the hospital carrying that cost?

Dr Beresford: I am carrying that cost as a deficit until we get clarification from the HIC. I expect that any day. The indications are that the program is in order and will be approved, provided the service is fully privatised - which it is - and that formal arrangements are in place for charging for the occupation of space, secretarial support and the incomes retained by the doctor. My problem is

that the Medicare payment does not fully fund the operation of the sleep service. The hospital must make grants for its inpatients, and pay for them to use the service.

The CHAIRMAN: Is that a way of getting around the system?

Dr Beresford: It is like any public organisation using the private sector. If the hospital needs to use the private sector, it must buy services.

The CHAIRMAN: That is very well put. Can we also do that with the emergency departments?

Dr Beresford: We already do that with the hospital at Murdoch.

The CHAIRMAN: That is another word for cost shifting.

Dr Beresford: No; it is recognising the reality.

The CHAIRMAN: We understand, and support, what you are doing.

Dr Beresford: This is all documented. When I receive the reply from the HIC, I will send it to the committee.

The committee asked if I was aware of consolidated funds going into trust accounts. I assume that the committee means the appropriations from government. The answer is no for special purpose trust accounts. However, each year we make a $16 000 grant to the Kalparrin Centre, which is a support group for disabled children. It is based at the hospital and provides a range of services for the hospital. We make a grant from the appropriation to enable it to provide those services for us.

Mr Austin: We mention that because it is one of the true trusts for which we maintain a financial service.

The CHAIRMAN: Are you saying that no consolidated revenue is going into trust accounts, as happens at, for example, Sir Charles Gairdner Hospital?

Dr Beresford: No consolidated revenue is going into any special purpose accounts. I am happy to provide the documentation, and am sure the Auditor General will be looking at it in detail.

The Whiteman estate funds are managed by the Princess Margaret Hospital for Children Foundation.

The CHAIRMAN: Let us get this clear. We have had evidence that the funds were transferred to the foundation by the board, but that the foundation does not manage the funds.

Dr Beresford: The committee asked how the funds were accounted for. I will talk about the accounting part. The Whiteman estate funds are managed by the PMH Foundation, and it provides us with a quarterly statement. The trustee of that estate is the head of the department of medical oncology, Dr David Baker. We publish an annual report and statement of those accounts. We also provide a quarterly statement of accounts to the chief accounting officer of the Metropolitan Health Service. I have attached in the file all the expenditure since the funds from the Whiteman estate fund were first received.

The CHAIRMAN: Our point is that the money was donated to PMH, not the foundation. The board gave the funds to the foundation, and we all heard the hoo-ha. The money was transferred by PMH, which you say still manages the funds. Is the money in the foundation?

Dr Beresford: We do not hold the $2.2 million.

The CHAIRMAN: Exactly; it has been given to the PMH Foundation.

Dr Beresford: Correct.

The CHAIRMAN: Even the money donated to PMH is held by the foundation. However, it was not donated to the foundation. Someone decided that the funds should be moved across, and we had this argy-bargy.

Dr Beresford: I would rather not go into the background of that today. Those questions should be asked of the board and the foundation. I was not privy to the negotiations.

The CHAIRMAN: We will ask those questions. Our concern is that although it is one thing to say that money has been given to the foundation, the foundation now has expenses. It would be very inappropriate if any of the Whiteman money, which was donated specifically to the hospital, were used for the administration of the foundation. I understand the argy-bargy. We discussed with representatives of the former Metropolitan Health Service Board how that occurred.

Dr Beresford: I have all the expenditure of that account, apart from expenditure relating to Owen Davies, which was part of the will.

The CHAIRMAN: How much of that money has been used for administration?

Dr Beresford: I cannot find any record of any money being taken for administration. I have all the records, including the statement of accounts.

The CHAIRMAN: Why was it such an important issue if no money was taken out for administration or any other purposes? Why was it so important that the money should go to the PMH Foundation and not stay within PMH?

Dr Beresford: It could not stay within PMH because it came under the Metropolitan Health Service Board. I think it was a perception. I am not the person to discuss this with.

The CHAIRMAN: Are you saying that the money was not transferred during your time as acting chief executive officer?

Dr Beresford: It was transferred years before my time.

The CHAIRMAN: It was not years.

Mr Austin: It was transferred in May 2000.

The CHAIRMAN: It was not years before your time.

Dr Beresford: It feels like it.

The CHAIRMAN: We will ask the foundation.

Dr Beresford: The committee might like to look at the statement of accounts, which I have provided.

The CHAIRMAN: Is that the statement of accounts for the hospital or the foundation?

Dr Beresford: It is the foundation's statement of accounts for the Whiteman estate.

The CHAIRMAN: We will have those tabled.

Dr Beresford: They go back to 30 April 1998. They account for the interest, the Megazone project, the sculpture, the equipment and donations to the Malcolm Sargent Cancer Fund for Children in Australia for the employment of a part-time social worker. No administration charges came out of that at all.

The CHAIRMAN: I refer to Megazone.

Dr Beresford: Megazone is a marvellous facility. I have brought with me copies of all the works, which were supervised by a small group in the hospital headed by Ian Lacey.

The CHAIRMAN: Why was the previous chief executive officer not aware of those records? He could not find any plans or any relationships.

Dr Beresford: I do not know. Everything involving contract variations, receipts and management is in these files.

The CHAIRMAN: Are you saying that those files contain information such as the approved plan, the design, who approved the design, the relevant committee, variations and contracts?

Dr Beresford: No; these are just the works supervision documents. I can provide the plans if the committee wishes. This is information about the day-to-day management of that project.

The CHAIRMAN: Who approved it?

[10.45 am]

Dr Beresford: Let me turn to the megazone.

Mr BRADSHAW: Can you explain the difference between the Princess Margaret Hospital for Children incorporated body and the Princess Margaret Hospital for Children public hospital?

Dr Beresford: The PMH public hospital is accountable to the Government and is run by a chief executive officer. It used to have a board. The Princess Margaret Hospital for Children Foundation -

Mr BRADSHAW: No, I am talking about the PMH incorporated body.

Mr Austin: The incorporated body can be found in the long history of PMH. In the 1950s, somehow under the hospitals Act - I am not sure of the history - an incorporated body was created for the hospital as part of some arrangement early in the history. For many years the incorporated body was just off to one side; in fact, if we dug up something from the 1960s at the hospital, we would find that it was a trust account of the hospital. During the late 1980s or early 1990s, a decision was made to remove from the hospital its fundraising functions. Instead of the hospital paying for its fundraising, it was put off to one side, and this incorporated body, which had basically been doing nothing, was used for this purpose; so it was resurrected. The then fundraising staff at the hospital were transferred to the separate incorporated body. Ancient historical records indicate that the board of the incorporated body comprised staff. As part of this split, it was set up as a separate body very much for fundraising purposes for the hospital. However, it is absolutely independent of the hospital. There is no formal connection.

Dr Beresford: There is a formal connection: the Chief Executive Officer of the PMH Foundation is an invited member of the board.

Mr DEAN: Are the PMH Foundation and the PMH incorporated body two separate things?

Mr Austin: No; they are the same thing. The foundation is the incorporated body.

The CHAIRMAN: Do you sit on that committee?

Dr Beresford: Yes, as did the other CEOs before me.

The CHAIRMAN: You have no problem with the PMH Foundation?

Dr Beresford: I have none. It works very well. I have been back through the minutes. There is no doubt that the PMH Foundation has delivered great benefits to the hospital. It is similar to most of the children's hospitals in Australia.

The CHAIRMAN: You have no problem at all with the administration of the PMH Foundation?

Dr Beresford: I cannot speak about the administration; I can speak only as a director of that company - if I can call it a company - for 18 months. I have had no reason to judge any inappropriate practice there and I have been very satisfied with the fundraising.

The CHAIRMAN: Do you not find it unusual that a lot of accountants have been lost from the PMH Foundation in that time?

Dr Beresford: I am not that close to it. I am aware of one dispute.

Mr Austin: It is a separate organisation from the hospital.

The CHAIRMAN: It is a separate organisation, but the chief executive officer is here. Obviously we will talk to representatives from the foundation. I just want to make sure that you are happy with everything.

Dr Beresford: Yes, I am happy with the foundation.

The CHAIRMAN: It delivers benefits to the hospital.

Dr Beresford: It delivers a lot of benefits to the hospital.

Mr BRADSHAW: Can I confirm what you said earlier? Are the PMH incorporated body and the PMH Foundation the same thing?

Dr Beresford: Yes.

Mr BRADSHAW: Our notes did not seem to say that.

Dr Beresford: A deed was signed while Gareth was there. Bill Simpson signed the deed between the hospital and the incorporated body setting up the foundation. The people from the foundation will give you all that information.

The information I have is from the Ernst and Young audit into the megazone project and its authorisation, which was commissioned by Michael Moodie. The audit report said that Dr Goodier informed them that the Premier and the Commissioner of Health were aware that projects were discussed in detail with them. Ernst and Young also said that there was no record that the megazone project had been authorised by the King Edward Memorial Hospital and PMH board of management. I cannot comment other than that.

The CHAIRMAN: Do you support those comments?

Dr Beresford: I have no idea. I have not looked into that. The question was posed to me about the Whiteman trust account.

The CHAIRMAN: I understand that, but the megazone is related. The comment by your predecessor is that he knew nothing about it, had nothing to do with the approval process and did not know who was controlling it. Now you are telling me that there are internal reports which you were able to get. Either Mr Moodie did not know what was going on with his own hospital or you have far better sources than he had.

Dr Beresford: Mr Moodie was also a member of the PMH Foundation board, which discussed the megazone progress.

The CHAIRMAN: I understand that. However, he said that as the CEO of the hospital, he had no access to information detailing who approved it and how it got there. The comment was that it was inappropriate because the location of it prevented the hospital from being extended, because it blocked any addition to the top of the hospital. It is on top of the hospital, which means that the hospital cannot be extended.

Dr Beresford: That is not true. The only area capable of expansion at the hospital is not that block. Another block, which we are having reviewed at the moment, is capable of being expanded by two floors. That block is not capable of being expanded by two floors; it was never built that way. That is my advice from our engineers.

Mr WHITELY: My understanding of the evidence from Mr Moodie was that it was impossible to determine how much money had been spent on the megazone.

Dr Beresford: I have a complete breakdown of that expenditure.

Mr WHITELY: Was that information compiled after the event or was it available during your predecessor's time?

Dr Beresford: It was available during his time and it was done at the end of the process.

The CHAIRMAN: By whom?

Dr Beresford: I do not know by whom. This was done by the hospital.

The CHAIRMAN: Do you have a date for that?

Dr Beresford: I cannot see a date on this.

Mr Austin: It was prepared from records of the foundation because the hospital did not buy it. The whole process was managed by the foundation.

The CHAIRMAN: Do you not find it unusual that your hospital is building on your property and you have no idea what the costs are?

Mr Austin: No. Most of the costs were donated services.

The CHAIRMAN: Donating is not a problem; the problem is that the hospital needs to have control of its own buildings.

Mr Austin: Our engineers were on the works progress. They were controlling all of that. No money was being paid out of any hospital accounts for it. Anything that was paid for was paid for by the foundation. We did not keep any financial records on it because we did not spend anything on it. The hospital engineers were overseeing the whole progress of the building and the construction.

The CHAIRMAN: Who paid for those costs? Obviously, you do not have engineers -

Mr Austin: The staff costs?

The CHAIRMAN: No; the costs for the structural engineers who approved all the processes and the additions.

Mr Austin: Most of that was donated services.

The CHAIRMAN: Is that documented somewhere?

Mr Austin: Yes; it is in the foundation's records among the summary of the donation to work out the cost.

The CHAIRMAN: Is there some process? There is some innuendo that work was done that was not accounted for. Is there some way the hospital can verify that the money was spent?

Mr Austin: The money was spent by the foundation.

Dr Beresford: We have receipts from the engineer in charge of that project from the hospital's perspective.

The CHAIRMAN: That was paid for by the foundation?

Dr Beresford: It was paid for by the foundation.

The CHAIRMAN: What was the total cost of the megazone?

Dr Beresford: The total was $2 485 478.27.

Mr WHITELY: That is not what the original budget was.

Dr Beresford: It depends what you term as the scope of works. The original budget was for a limited playground, which then grew into a Starlight Children's Foundation and a TVW Telethon theatre; it was a different concept.

The CHAIRMAN: Who kept approving these along the way?

Dr Beresford: I believe it was done in-house, but I do not have any notes on that. I will try to find those if you wish.

The CHAIRMAN: It is important.

Dr Beresford: I did not come prepared to discuss that in detail.

Mr WHITELY: It is quite different to be able to collate all the information at the end and say that it cost this amount. It seems that maybe the problem that Mr Moodie was highlighting - I would need to read his evidence again - was that there was a lack of control along the way. This project

grew. I had in mind a figure of $500 000 as the original budget. That is wrong. We are talking about something that is five times that amount. It may have grown in scope -

Dr Beresford: Which it did.

Mr WHITELY: You may be able to determine after the event that it cost $2.4 million, but the question is: are there controls and is there value for money along the way? That question has not been answered.

The CHAIRMAN: The other issue was that the facility was not used; that is, this wonderful megazone was built for sick people and the last thing they need is a megazone.

Dr Beresford: One must ask why it was never used. However, it is now being used. It has been open since August last year. I have heard comments from the parents and children who use it. It is well used now. It is also being used as a discharge lounge and will be geared up this winter as a discharge lounge.

The CHAIRMAN: That amount of money is equivalent to the total cost of the operation of a magnetic resonance imaging machine for three years. However, a megazone was built for a handful of sick people who could not use it anyway. That is what we were told before. You are saying that it has become a useable facility only since you took over.

Dr Beresford: It is a useable facility, and committee members should visit it before they start criticising it.

The CHAIRMAN: I am not criticising it; I am just relaying to you that your predecessor told us in evidence that it was an inappropriate facility and was not used.

Dr Beresford: Perhaps because it was not staffed. Unless a facility is staffed, it will not be used.

The CHAIRMAN: Who is paying for the staffing costs of this facility?

Dr Beresford: The PMH Foundation. I draw attention to the fact that my predecessor tried to offer it to the Department of Education and it would not have it. He offered it to the Starlight Children's Foundation, and also offered $130 000 from the consolidated funds to run it. I did not take that up when I took over. I did not go forward with that contract.

The CHAIRMAN: Was the $130 000 to man it?

Dr Beresford: No; that is what was offered. The costs were $130 000 to run it annually.

Mr WHITELY: We should have a look at the megazone.

The CHAIRMAN: We will.

Dr Beresford: I encourage you to do so. I would be delighted to show you around.

The CHAIRMAN: How many kids use the facility?

Dr Beresford: I have all the reports. Since it opened in August, 11 710 children, siblings and parents have used it.

The CHAIRMAN: Is that since August last year?

Dr Beresford: Yes. The numbers vary -

The CHAIRMAN: That is a lot of kids.

Dr Beresford: And their siblings. There is somewhere for the kids and their families to go when people visit the hospital or go to see an outpatient, instead of their being bored and playing around the place. If people are spending all day at the hospital -

Mr DEAN: Is there any breakdown on actual patient usage?

Dr Beresford: Yes, there is. The number of patients and visitors is here, and I will leave this information with you.

Mr WHITELY: How long has it been open?

Dr Beresford: Since August. It takes time to build up this information. I am also proposing to use the facility as a discharge facility. We trialled it at the end of last winter. Children who were waiting to go home could go up there and be supervised, and that would free up their beds. It is a multipurpose facility. It is also a therapy area for severely disabled children. It has an auditory stimulation room, which is part of the reason for the increased cost of the facility. A child could be taken there to have sensory experiences - that is, the visual, tactile and musical experiences - in a closed environment. I would be delighted to show you all that. I think it is worthwhile coming to see it.

The CHAIRMAN: The committee is of the opinion that we will come and have a look at it.

Dr Beresford: I have all the details on the operational megazone, including the KPMG and the Ernst and Young audits. I also have the files on the megazone expenditure.

[11.00 am]

I have a report that was done by our acting director of allied health on how we could best use it. We went through a full process with the Starlight Children's Foundation, Radio Lollipop, staff, visitors and children. Therefore, a full operational brief was prepared before we went down this track.

The CHAIRMAN: Who is running it now?

Dr Beresford: The hospital.

The CHAIRMAN: It is staffed by the hospital, and there is a payment from the Princess Margaret Hospital for Children Foundation.

Dr Beresford: The PMH Foundation has underwritten the operation of that, yes.

The CHAIRMAN: It is not coming out of consolidated revenue.

Dr Beresford: Nothing comes out of consolidated revenue at all.

The next written question from the committee is: can you explain to the committee whether the hospitals still have private practice trust funds; and, if so, what the source of the moneys going into those accounts is and for what purpose those private practice trust fund moneys can be used? Yes, we have money going in from private practice. This is as per the Australian Medical Association workplace agreement. Under option B, when the doctor earns more than 25 per cent, a proportion goes to the trust funds. I will leave a copy of the award with the committee. Section 28 provides what the money can be expended on. That money goes into the doctors' travel funds.

The CHAIRMAN: That money goes straight into the travel fund. Who approves that fund?

Dr Beresford: The doctors have their own committees. I have those details here.

The CHAIRMAN: Is that set up as a trust fund or a special purpose account?

Mr Austin: They are all special purpose accounts.

The CHAIRMAN: In this case, it is not really a special purpose account, is it? This is a real trust fund.

Dr Beresford: No, it is not.

Mr Austin: No, this is a special purpose account.

Dr Beresford: This comes under the award and is under the control of the hospital.

Mr DEAN: This is one of those 13 committees?

Dr Beresford: Yes.

Mr DEAN: And it is an independent committee?

Mr Austin: Yes.

Dr Beresford: Plus any travel that is approved would go not only through that hoop. If it is intrastate travel, it must be approved by me; if it is interstate travel, it must be approved by the director general; or if it is overseas travel, it must currently be approved by the minister.

The CHAIRMAN: When were those changes brought in?

Dr Beresford: They were one of the first things the minister did when he came in.

Mr DEAN: The option B documents are part of the payments. Do the doctors gain any taxation advantage through these payments? Are they deductible?

Mr Austin: No.

Mr DEAN: There are no taxation advantages?

Mr Austin: No.

Mr DEAN: Therefore, they pay income tax on those payments before they put them in?

Dr Beresford: No, the award is split up so that these are not paid to them at all.

Mr Austin: What happens is that under the provisions of the award, if a doctor earns more than 25 per cent from private practice, 50 per cent of anything over 25 per cent, after deduction of the doctor's operating costs, goes to the doctor, and 50 per cent is paid into this account. One group of doctors actually puts money into this account. That is provided on an annual basis in accordance with the award.

The CHAIRMAN: That is true, but the question was whether there is a tax advantage. If they are not getting 50 per cent of their income, it is a tax advantage.

Dr Beresford: But it is not going directly to them.

The CHAIRMAN: No, but if they are not getting the money, they are not paying tax on it.

Dr Beresford: That is right.

The CHAIRMAN: Therefore, there is a tax advantage.

Mr WHITELY: Only if it is for personal use and the minister oversights the accounts.

The CHAIRMAN: I understand all that. However, Mr Dean's question was whether there is a tax advantage in having this split up. There is, because they are getting only 50 per cent of their income, and there is some benefit to the profession, and maybe to you, if doctors are travelling to a conference.

Dr Beresford: This is no different from the option A doctors who receive a single payment of $3 500 to cover travel.

The CHAIRMAN: Yes, but that is not the question. The question was whether there is a tax advantage, and there is. There is no problem with that. It is just the way the award is set up.

Dr Beresford: The award has just been renegotiated. It will be interesting to see what happens.

The CHAIRMAN: There is no problem with having a tax advantage. Obviously, the doctors have organised it that way. There is an obvious advantage in that this money is going into a fund for travel by not only those doctors but also other doctors who are being trained. There are no problems; and there are probably some benefits to the individual doctors. However, at the end of the day, it is an arrangement that has been set up properly through the process. As long as it is overseen, and it is, by the minister, why should we query it?

Dr Beresford: The documentation is all here anyway. I am not certain whether we covered all the set questions.

The CHAIRMAN: We have covered all the written questions. Do you want to tell us some other things that you have done that have made this hospital work better?

Dr Beresford: I could talk all day, but I will not.

The CHAIRMAN: We are impressed with the changes. They were well overdue. There might be a discussion about whether so many committees and accounts are needed. That is really a matter of detail, and at least some process is in place. It is a pity it was not done in 1996.

Do you see any problems with the ongoing arrangement between the PMH Foundation and the hospital? Does that need to be clearly delineated and identified? One of the problems appeared to be that there was no formal relationship in the approval process, or even with financial control, and the fact that you sit on the board creates a problem.

Dr Beresford: I will address that. I shared those concerns with Rick Byrne, the chairman. We have now set up regular meetings between my director of business and finance and the chief executive of the foundation. We have reviewed the whole process for approval and acquisition of equipment. I would be delighted to send the committee a detailed statement on that new process, which I believe addresses the concerns that the committee probably has and which I had.

The CHAIRMAN: The public perception is that the PMH Foundation and Princess Margaret Hospital for Children are one and the same. Legally, they are not. The worry for some of us is that we do not want problems with the foundation, if there are any, to affect the hospital and vice versa.

Dr Beresford: I can understand that. I too would hate anything to happen to the hospital's or the foundation's reputation. By having representation on the board, regular financial meetings and a transparent process between the two, which we have, we can maintain the best of both.

The CHAIRMAN: I understand that, but if there is a problem with the foundation, your being on the board of the foundation could create a problem with the hospital. That is a matter that you need to look at.

Dr Beresford: Yes.

The CHAIRMAN: And vice versa as well.

Mr WHITELY: The alternative is that it gives a chance for better coordination, surely, does it not?

Dr Beresford: That is right. That is what I was talking about; that is, coordination of the process. The whole purpose of the foundation is to assist the hospital and to raise money for it and the kids.

The CHAIRMAN: I understand all that.

Dr Beresford: That is why it is important that we have this close relationship and share ideas, experience and parameters. I am there to convey the needs of the hospital and to represent the health system and the director general.

The CHAIRMAN: You are quite satisfied that there is no problem?

Dr Beresford: I am satisfied that there is no problem with my attendance at board meetings. My director of business and finance meets with the chief executive officer on a regular basis. We have just put in place a new process for the approval -

The CHAIRMAN: Do your financial people meet with the foundation's financial people?

Dr Beresford: My director of business and finance meets with Mr Darryl Black on a monthly basis.

The CHAIRMAN: That is not the question I asked you. Do your financial people meet with the foundation's financial people?

Dr Beresford: I am not sure what you mean by that. If the question is do we go into the books, the answer is no.

The CHAIRMAN: I am talking about the relationship between your financial controller and the foundation's financial controller.

Dr Beresford: For the acquisition of equipment, they are the same.

The CHAIRMAN: Are you telling me that your financial controller is controlling the arrangement?

Mr Austin: If you are asking whether I ring the foundation's people, I sometimes do. Do I meet with them on a regular basis? No. The director of business services meets with Darryl Black on a monthly basis. The general manager of the foundation and the director of business services meet regularly; but the finance department does not talk to the foundation's accountant, no.

Mr BRADSHAW: When Mr Moodie appeared before the committee, he indicated that one of the reasons for his demise was the controversial aspects of the trust accounts and his efforts to fix them. Others have said that his management style was the problem. As you worked at the hospital while he was there - I know this is putting you in the hot seat -

Mr Austin: It is a difficult question to answer.

Mr BRADSHAW: Mr Moodie said that his demise was as a result of a certain thing. I want to find out whether other people had the same problem with him.

The CHAIRMAN: I think the question is fair.

Mr DEAN: It calls for a personal view.

The CHAIRMAN: If you do not want to answer the question, you do not have to answer it.

Mr Austin: Some of the staff in the hospital in the past expressed certain opinions, and I would be in concordance with those opinions.

Mr WHITELY: Dr Beresford acknowledged earlier that, because of the attention of this committee and other aspects, the environment that you faced in trying to institute changes to the trust accounts was different from the environment that Mr Moodie faced.

Dr Beresford: I think there is no doubt about that. The whole debate that was going on raised people's awareness, and there is no doubt that it made people sit back and think. The doctors had in the past objected strongly to a fee for service - Medicare billing. That is documented. That is why the Government gave an additional $500 000 to PMH in 1997 to get rid of those clinics. I think complacency had set in. That is inevitable in any organisation. Periodically, there should be a bit of a revolution.

The CHAIRMAN: Are you suggesting the Public Accounts Committee should investigate you every year?

Dr Beresford: No, I said periodically, did I not?

The CHAIRMAN: Periodically. Okay, we will make it every two years.

Mr Austin: I should also point out a sequence of events within finance within the health sector. Since the creation of the Metropolitan Health Service Board, there has been a continual cloud of uncertainty in financial services across all hospitals in the metropolitan area, about whether there was to be a centralisation or a corporatisation. Therefore, the feeling was that not much should be done in an individual hospital because everything would be centralised next week. That has been an ongoing concern for the past three years. In addition to that, the first of the audits occurred in late November 1999. Normally, we would get the audit and be asked for management comments. We would be given a final report and act upon it. When the first audit was done, management comments were sent back, and no further information was received. The second audit was

instituted, and there were further parts of that. It was then escalated to the MHSB, which looked at particular parts of it. There was a third audit by Ernst and Young. The MHSB was controlling things at that stage. As a result of the first audit some comments were made, and we were going to do something, and I asked whether we should do something. I was told that we should wait until the MHSB got back to us and until the findings of the latest audit came back so that we could do something. In mid 2000, following the introduction of the goods and services tax, we were trying to deal with certain GST issues. We did not know whether we should have gone this way or that way, and there was no direction, because we were waiting on the MHSB audits. We made certain decisions at that time and instituted certain actions. However, it was not until the whole MHSB issue was sorted out that we were told that that was the final position and that we should do something about it. For about 12 months we were wondering whether we should act on this or do that; we were not quite sure.

Mr WHITELY: The MHSB was adding a layer of confusion; it was not clear who should have been laying down the accountability between you and -

Mr Austin: It was addressing issues with the Health Insurance Commission and others, but there was no clear information at the hospital finance department level about whether we should do a certain thing at that time.

The CHAIRMAN: I refer to the centralising of your financial control. Questions have been asked about why so many finance departments are needed in each of the hospitals and why there cannot be one centralised location.

Dr Beresford: I think that has been answered today. It would be virtually impossible to do the level of monitoring and to retain the level of public accountability without at least some presence on site to do that day-by-day checking and responding and to be aware of what is going on.
[11.15 am]
The CHAIRMAN: Centralised control is also needed. It is clear that the right hand does not know what the left hand is doing and central office knows nothing about anything.

Dr Beresford: Certain payroll functions could be centralised as well as certain accounts payable; for example, supplies, which are pretty well centralised.

The CHAIRMAN: Are you saying that the system will become centralised?

Dr Beresford: I believe there is still a strong need for on-site financial officers who can assure the chief executives or whoever is in management that the financial processes in place are working.

The CHAIRMAN: Evidence from inquiries into the visiting medical practitioner service suggested that a culture and an atmosphere have been created in which the hospitals compete with each other as part of the same health system. They do not know what the others are paying and they have no idea of the cumulative payments. However, more importantly, they are competing with each other and pushing up the cost of the services.

Dr Beresford: I agree that that is appalling. That is a reflection of where we have been. In the past a competitive system has been in place that encouraged individual competition. The Metropolitan Health Service Board tried to undertake reform, and it took the first steps to address that, which is the only way to go. However, the MHSB failed. The first MHSB comprised every general manager and CEO from health, which made it dysfunctional. In my opinion, the board was set up to fail. A board of management should never have been designed to have all the CEOs and general managers on it. I was not a CEO or general manager at the time, so I can comment on that.

Mr WHITELY: Did it fail because of empire building?

Dr Beresford: I have no idea why that was done. If someone wanted to design a board to fail, that was the way to do it.

Mr WHITELY: Did that structure fail because there were competing interests?

Dr Beresford: To my mind a board is supposed to be a board of governance. It must sit above the industry. Its role is not to manage in depth, but to ensure that management is undertaken in a correct and proper manner, and to ensure quality, financial accountability and safety. It must also listen to the community.

The CHAIRMAN: However, before that can work the underlying problems must be fixed. A proper reporting mechanism was not in place and data was not available in order to make decisions. The committee told the Department of Health that it was paying one doctor $760 000; the department did not even know that. The central office had no control, which means that the board will fail because the information on which the decisions are made is incomplete or non-existent.

Dr Beresford: I take the point. We must also consider the best way to deliver health services, which is a separate debate that could go all day.

Mr WHITELY: Should not the health system be viewed as one entity? We have one health system with different cost centres. For example, Sir Charles Gairdner Hospital is a separate cost centre; therefore, its accounting decisions should devolve from the higher levels of authority and reporting should transfer all the way back up.

Dr Beresford: That should be done.

Mr WHITELY: That does not mean having separate stand-alone accounting systems; it means that a cost centre of reporting should be intermeshed into an overriding system.

Mr Austin: The cost centres for the entire metropolitan area operate from a single computer system.

The CHAIRMAN:: Nevertheless, the cost of service delivery of one place cannot be compared with another.

Mr Austin: The level of patient service, labour input etc, must be taken into account.

The CHAIRMAN: There is no way that a business could operate unless its cost centres and the comparison of cost between the different arms of the business were known. If that cannot be done, there is a problem.

Dr Beresford: I will refer to patient support services. At some hospitals, the cleaning staff are employed and require superannuation and accrual contributions, and others use private contractors.

The CHAIRMAN: At least the two can be compared.

Dr Beresford: The private contractors can be listed under other goods and services. They do not have an accrued superannuation component. These disparate accounting functions make it very difficult to compare unless a true cost comparison is made.

The CHAIRMAN: A business needs to make those comparisons, otherwise it cannot run. Why are we fixing it? Why has it taken this committee to identify the problem? Why does someone in the Department of Health who spends $2.2 billion a year not solve the problem?

Dr Beresford: The issue is being addressed now. The director general is now accountable as the CEO of the whole system. It will require large expenditure on information because -

The CHAIRMAN: The Department of Health's computer system costs about $100 million a year. The Government is already spending a heap of money.

Dr Beresford: The basic framework on which the computer system is based is obsolete.

The CHAIRMAN: We have worked that out too.

Dr Beresford: We will require at least $30 million to replace it.

Mr BRADSHAW: Did Mr Moodie ruffle more feathers than just the medicos in the system?

Mr Austin: Yes.

The CHAIRMAN: From what this committee has heard so far, some feathers needed to be ruffled.

Mr Austin: Did they?

The CHAIRMAN: I made a statement. They did need to be ruffled.

Mr WHITELY: Did some feathers need to be ruffled?

Mr Austin: I worked in King Edward Memorial Hospital for 17 years and I have been involved in the Princess Margaret Hospital for Children since the two hospitals combined. In that time, the hospitals have had their ups and downs. However, in both hospitals the concentration of 99.9 per cent of the staff is always on the patients' welfare. Patients, or people involved with a patient in either hospital, would not find a better standard of service from any other hospital in the State. It was an unfortunate time that occurred. Some people might say some feathers were required to be ruffled but other people would say that a great deal of harm was done.

The CHAIRMAN: Mr Moodie instigated the inquiries into the King Edward Memorial Hospital and into doctors' trust accounts. He also brought about the changes to the system that were needed. They were major things that needed to be done and, as a result, changes to the system will be made.

Mr BRADSHAW: Was the inquiry into trust accounts brought on by Mr Moodie or the Ernst and Young audit that highlighted the problem?

The CHAIRMAN: In the end, the Ernst and Young audit was the catalyst for the inquiry. Is there anything else that you want to tell us?

Dr Beresford: No, I will leave all these documents with the committee.

The CHAIRMAN: We would like a copy of the 1999 report about the cost-shifting arrangements.

Dr Beresford: It was not cost shifting. Revenue was raised under Health Insurance Commission guidelines for private and federal inpatients; it was not cost shifting.

The CHAIRMAN: I thank you correcting my terminology. Thank you very much for your evidence; it has been frank and forthcoming.

Committee adjourned at 11.24 am