PUBLIC ACCOUNTS COMMITTEE

INQUIRY INTO HOSPITAL TRUST ACCOUNTS IN THE WA PUBLIC HOSPITAL SYSTEM

TRANSCRIPT OF EVIDENCE TAKEN
AT PERTH
ON MONDAY, 18 FEBRUARY 2002

Members

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

Committee met at 9.40 am

LARKAN, MR TERRENCE ARTHUR,
Principal, Business Risk Services,
Ernst and Young,
Perth, examined;

COPP, MR JOHN WALTER,
Chartered Accountant/Partner,
Ernst and Young,
Perth, 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 form?

The Witnesses: Yes.

The CHAIRMAN: Did 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 a parliamentary committee?

The Witnesses: Yes.

The CHAIRMAN: Have you made a written submission to the committee?

Mr Copp: Yes, we have.

The CHAIRMAN: Has the committee received the submission?

Mr Copp: Not at this stage, I have it with me.

The CHAIRMAN: Do you want the submission to be incorporated as part of transcript of evidence?

Mr Copp: I see no reason why not.

The CHAIRMAN: Do you want to make any statement about the submission before we ask you any questions?

Mr Copp: I am a partner and Terry Larkan is a principal with Ernst and Young. We are here in response to your summons on 12 February 2002. We appear before you in the spirit of cooperation and look forward to assisting you with your inquiries concerning hospital trust accounts. We have prepared a written submission for each indicative question in one bound and one unbound copy, and we wish to present to the committee a file containing collated reports and correspondence relating to the trust accounts, internal audits and business process review. We are a professional services firm within Perth and as a courtesy to our clients, and in light of existing and future client relationships, we ask the chairman of the committee to consider conducting the session in camera. We will provide the committee with a written reply to its

indicative questions. As the committee has not had the opportunity to review the submission, we will be happy to return later today, or another day, if it wishes to review the material.

The CHAIRMAN: We are reluctant to conduct the hearing behind closed doors. At this point in time we prefer that names are not put to the various problems and we prefer that you talk in general terms about the accounts. We will ask you questions with regard to supporting evidence for those claims but we will not ask you to name anybody. The committee will review whether there is a need for that information to be made public at a later date.

Mr HOUSE: You can ask for evidence to be given in camera at the end of the session.

The CHAIRMAN: If you want to tell us anything specific in camera, we are happy to take that on board. However, this an open inquiry. We have already had a number of hearings and there is a large swag of evidence. It is also appropriate that we put your evidence on the record. I record that those documents have been tabled and given to us. We will try to address all our questions today. If we need to, we will get you back at another time. However, what we discuss with you today is fundamental to this whole inquiry and your findings form a large part of it. Is there anything you want to formally say before we start this process?

Mr Copp: We have nothing else to add other than that we are here to answer your questions.

Mr HOUSE: What is the current position of your firm with regard to the hospitals?

Mr Copp: As one of your questions states, our relationship with the hospitals was terminated in late January this year, which is indicated by correspondence on the file.

The CHAIRMAN: Was it terminated or not renewed?

Mr Copp: Originally there were discussions that the contract would extend to June 2002. We were then advised in our committee meeting in January that our services were not required as Mr John Doyle, who is the internal audit manager of the Department of Health, would be taking over that role and responsibility. We then asked for written confirmation of that from Dr Beresford.

The CHAIRMAN: Can you explain how you became involved in auditing the trust accounts? Were you approached to formally start a process or did it happen through an open or invitation to tender process? Tell us how this process was initiated, when and how it occurred and what was your brief.

Mr Larkan: We were the contracted internal auditors working at King Edward Memorial Hospital and Princess Margaret Hospital for Children. We were requested by the then chief executive, Mr Moodie, to do an internal audit on the financial books, administration procedures and the general control environment surrounding hospital finances around July 1999. One of the findings of that report was that we could not reconcile the cash held in the hospital for trust accounts to the trust account ledger, which was excluded because they were seen as two different sets of books. We tried to perform that reconciliation and found differences for two consecutive months. We were going to perform a reconciliation for the last year to see if the accounts were controlled. There were large differences between the so-called cash and the actual account balances with the reason being given that funds were owed by the trust accounts to the operating accounts. We pursued it further and put in the report a

recommendation that the trust accounting be reviewed because it was excluded from the scope of that audit. This was an indicator that there were issues underlying the trust accounts.

The CHAIRMAN: Therefore, sums were owed by the trust account to the operating account?

Mr Larkan: That was the reason we were given.

The CHAIRMAN: What was the understanding that created that position?

Mr Larkan: The understanding we were given was that transfers had not taken place from the trust accounts to the operating accounts. Our main concern was that it appeared that there were no regular controls to ensure that the transactions needed to keep the books in balance between the trust and the operating accounts were taking place.

[9.50 am]

Mr DEAN: Why would the trust accounts owe money to the operating accounts? What debt would be owed?

Mr Larkan: I cannot give you any set reason. There could have been a number of reasons.

The CHAIRMAN: You did not investigate that, so you obviously have no -

Mr Copp: No, at that point our brief was to review the financial records. The key thing we were looking at was the control account for investments for trust accounts. We wanted to see that the control account reconciled with the database of all the trust accounts, so that it gave an indication that they were under control. The difficulty is that that reconciliation was not performed, so we went back and tried to look at how big the difference was. If I recall correctly, we came up with a difference of roughly $163 000 between what was in the hospital's general ledger control account and what was in an access database, which was used to manage these trust accounts. We raised the question that this reconciliation should have been performed. It was not, and we said it should be investigated. At that point, it did not go any further.

Mr WHITELY: Sorry, was the balance in the trust accounts greater than you expected?

Mr Copp: No, if I recall correctly the balance in the trust accounts was less than expected. I will have to check that.

Mr WHITELY: Roughly $163 000?

Mr Copp: Roughly $163 000.

The CHAIRMAN: That was not the basis upon which you -

Mr Copp: That was not the basis of our original assignment.

Mr Larkan: Based on that finding that we had concerns, Mr Moodie said that they would like a general control environment of trust accounts conducted, similar to what we had done for the other financial statements. From there, the findings were that the administrative and accounting controls were not what one would expect to find in any system of accounts. That gave rise to a further audit. There were conflicting opinions about who owned the money - whether they were hospital funds or belonged to some other person or third party. Mr Moodie asked us to try to do an analysis to establish what funds belonged to whom and what could be consolidated, because the huge

numbers with a scarce resource were probably half the cause of the problems on the administration side of the issue. He wanted an inventory, if you like. That was basically the last audit we did for Mr Moodie.

The CHAIRMAN: Was there any indication at any time that the audit should take a particular angle or be bent towards a particular point of view?

Mr Copp: Sorry, in what respect?

The CHAIRMAN: When you were appointed, were you given a task to try to come up with a solution that was aimed at doctors or the hospital?

Mr Copp: No, our review was an independent review.

The CHAIRMAN: No pressure was put on you to come up with any particular result?

Mr Copp: No. I would be somewhat offended if people thought that. We are independent. We report as factually as we can based upon the evidence we have. What we highlighted in our reviews was that management should investigate the matters that we had raised. It was not our role to resolve the issue. We said that there were problems that they might want to investigate further. We queried a series of items and we duly reported, based upon the evidence we had.

The CHAIRMAN: Did you get full cooperation when doing your audits? Did you get cooperation from clinicians and all the people involved in the process? Was access to material denied to you at any time?

Mr Larkan: No. The material was made available. Access was not denied. There was full cooperation. The detailed analysis of the trust accounts was done with the full cooperation of the clinicians. It was because we had full cooperation that a number of issues raised concerns. Relationships within the hospital were pretty strained by July 1999, which we became aware of during our normal business duties. Given the environment at the time, we tabled an appendix to that report of items that our team suggested for further investigation, which would not be part of the audit. The audit was a financial controls audit and analysis rather than an investigation. We felt that management would be in a better position to approach some of the issues or items that we felt to be quite sensitive.

Mr Copp: We were reviewing the nature of the trust accounts - who were the "trustees" or holders of the trust accounts. We were given cooperation when we did the review to find the nature and type of transactions. The clinicians were fine. We started having a concern because it appeared that people were starting to get toey because of the review. A letter in our submission shows that we suggested to the chief executive officer that we would not dig deeper because of the environment in the hospital.

Mr BRADSHAW: Which people were getting toey, as you put it, about the investigation or audit?

Mr Larkan: We were dealing with a range of clinicians. Comments were made. A lot of these accounts were based on discussions to find out the underlying concerns, because documentary evidence was not available for all the issues. They were starting to feel as if they were being interrogated. There were other things on the go and they felt they were being targeted. Some of the clinicians were getting a little testy. Mr Moodie gave us feedback that he was experiencing difficulties with the clinicians. I think his words were that they were not being as cooperative with him,

so he did not want to rock the boat too much in that regard. It got sensitive. It was a long process and there were other issues at play, which I think were starting to play on the people within the hospital.

Mr BRADSHAW: You said earlier that there were strained relationships within the system. Was that between Mr Moodie and the clinicians, or between administration and the clinicians, or somebody else?

Mr Larkan: This is purely my opinion.

Mr BRADSHAW: You picked it up in your general -

Mr Larkan: Yes, in general dealings with people.

The CHAIRMAN: Who was it between?

Mr Larkan: There has always been rivalry between administration and the clinicians about who has a say on certain issues. It was basically between administration and the clinicians.

Mr BRADSHAW: You earlier indicated that you had full cooperation from the clinicians.

Mr Larkan: Yes. I have no reason to believe that they were not being cooperative. They were expressing feelings.

The CHAIRMAN: What feelings? That they were being targeted, that someone was having a go at them, or what?

Mr Larkan: Yes. They had a bit of angst that the trust accounts were being targeted and they, as part of the trust accounts, were being targeted as well. When I say they felt they were being targeted, I do not mean that they were being targeted by so and so, but rather they were saying, "Come on guys, you are really giving us a rough ride on this."

The CHAIRMAN: When you started this audit, were you aware that there was a 1996 report by Arthur Andersen which showed that there was a problem with the trust accounts?

Mr Larkan: No, we came across that during our first audit of the trust accounts. It was a detailed audit.

The CHAIRMAN: Did the Andersen report give you a basis upon which to look at some of the areas that were highlighted in that report?

Mr Larkan: Yes. Our report went beyond theirs in a couple of areas. It went into a lot more depth. We refer to the Andersen report in our initial report.

The CHAIRMAN: Were the issues in the Andersen report basically the same as yours? I know you went further, but did the same issues underlie it?

Mr Larkan: Very much so.

The CHAIRMAN: Did you find that any changes had occurred between 1996 and 1998?

Mr Larkan: No.

The CHAIRMAN: So the Andersen report highlighted these areas and nothing happened from the point of view of administration?

Mr Copp: Yes, from our observations.

Mr HOUSE: Do you think there was a reason for that? Could you pick up any nuance in your dealings with the hospital?

Mr Copp: The hospital had gone through a fair amount of change from the point of view of administration and governance. I sat back and asked how that situation could arise. It had a new CEO and a new oversight board.

[10.00 am]

We really had a new finance director so to speak so there has been a fair amount of change in that regard. When we do have change within personnel perhaps history does go with individuals so that we did lose a layer of management within that which would have a history of the area. The difficulty with these reviews was a bit like trying to piece together paper that has been wetted as to why did these things come about and what was the rationale.

The CHAIRMAN: Report 96 by independent auditors highlighted a whole pile of errors and more than two years later nothing has happened.

Mr Copp: That raises some questions.

The CHAIRMAN: Absolutely, especially when the issues are exactly the same. There is no control. It makes one wonder why nothing has occurred and why people are getting worried now when they knew two and a half years ago that there was a problem.

Mr Copp: Good question!

Mr HOUSE: Do you think there was a view that nobody should question this or that the prevailing view was that everything was okay, they were doing it okay and nobody should really question them? A range of trust accounts are operated in the real estate industry and in legal firms; however, it seems to me that the people involved in administering these funds felt that they were so different that nobody should ask any questions. Is that a fair comment?

Mr Copp: I would say it is fair. One of the misnomers that we had to get over is that, really, a lot of them are not trust accounts; they are basically general ledger accounts which for some reason are treated offline and not through the normal operating statements. I asked the question of clinicians because clinicians are there to provide medical services to the public and they do need guidance from management and administrators on how things are accomplished. I spoke with one clinician who said that he was just there to look after people and he expected guidance - what we were doing is what we had been told to do! That is fair enough. There is the issue of guidance and direction by management on how things should happen.

You referred to the Andersen report. I do not think, if I remember correctly, Andersens were acting in the capacity of auditors in that regard. I think they came in on an outsource finance management function and they raised the report as a review of this as an issue. I think one of the issues with trust accounts in the past was that the focus was on the expenditure side. That was signed off, ticked off, without being questioned.

Mr HOUSE: We have to make positive recommendations about how this system should operate. I am trying to discover from you guys whether you have a model - given the things that you have just said - of how these trust accounts - we keep calling them trust accounts but we know they are not - could be made to work in a way that is accountable and that everybody agrees they could be sensibly managed.

Mr Copp: That has happened. I recall, when this issue came up, that we had a chap from our office assisting in drafting some procedures in that. Then I read in the transcripts that PMH got Andersens in there to prepare procedures. It is fine to have policies and procedures drafted but they have to be implemented and put in place and make people accountable for those policies and procedures and that is management's role. Therefore, models do exist and they are not just models that we have come up with. Other firms have come up with models but they have not been implemented. It really comes down to governance oversight of accountability and also by the same token education of clinicians. In most cases the accountable people who are put in these roles are doctors or medical people; they are not businesspeople or administrators. Therefore, they need to be trained and educated on their roles and responsibilities and the risks they face. One of the roles of management also is to ensure that when it gives people a role and responsibilities, they have to be made aware of what those respective roles and responsibilities are.

The CHAIRMAN: The other criticism of your audits is that you are private auditors working in the private sector and public hospitals are a different kettle of fish with different operations. What is your view on these comments and is your approach any different? Are the accountabilities any different and do you have public service knowledge to be able to do those sorts of reports?

Mr Copp: This is one area that always confounds me. I agree that the public sector is markedly different in certain areas to the extent that there is public scrutiny through the FAAA and forums like this whereas the private sector is not subject to the same scrutiny. However, the business processes and the way things are accounted for - accountabilities - should be basically the same - there should be no difference. The payroll process is a payroll process. There may be slight modifications because some of the taxation structures may be a little different in the public sector perhaps, but not markedly different. Therefore, in the case of a pure trust account, you have to account for it in accordance with the legal structures and deeds and the accountable areas. Therefore, to have an intimate knowledge of the workings of the public sector, there could very well be 10 to 15 per cent of nuances of which you are not aware but those nuances are not so significant that an outside party looking at it will come up with invalid conclusions. When we review things also, we ask some of our other counterparts what they see and we run things by them also to see whether we are so far out that we really have it wrong because you do get somewhat concerned when you are standing in a room full of people and 12 of them are saying you have it wrong and you do not understand. That is where your independence comes in and you say, "Please prove us wrong."

We do audits of other quite large public sector organisations and I will be honest and say that the one of which I am thinking is run quite well compared with some private sector organisations, in my view.

The CHAIRMAN: In relation to these audits could you give a chronological order of the reports, because there are so many of them?

Mr Copp: We can. We will refer to our notes and also we have put the reports in the binder in chronological order also for you to refer to later.

Mr Larkan: I think question 6 is probably the easiest one. The trust funds audit was completed in December 1999 and that considered the general administration and accounting controls over trust funds. Trust account analysis part 1 was conducted on what one would term blended trusts - two different types of trust, blended and

unblended. Blended trusts form part of the hospital consolidation accounts so far as we were given to believe. That looked for trust consolidation - true trusts or those which we believed were true trusts and trusts which we recommended could be closed basically on consolidation. One of the appendices to that report was appendix 3 which included items recommended for further investigation. Trust account analysis part 2 was issued at the same time as part 1 for discussion and review with hospital management but never progressed further because of the diversion of resources into trust account analysis part 1. The MHS committee at that stage asked us to focus on specific issues.

There was a draft report - trust accounts draft 1 issued in September 2000 for discussion at the MHS audit committee. It was never finalised as it stood there. However, after receiving further instructions from the MHS, that was finalised and issued in November 2000. That was the final report and that looked specifically at issues to do with bulk-billing arising from appendix 3.

Two further reports were done last year at the request of the Commissioner of Health - business process review - and that was done on Sir Charles Gairdner Hospital, Fremantle Health Service and Royal Perth, followed by an internal audit follow-up at King Edward and PMH on items pertaining to trust accounts raised in the previous reports.

The CHAIRMAN: How many people were involved in the trust fund audit and analysis part 1, and to how great a depth were those audits done? We are aware that there are 230 trust accounts just at PMH and probably hundreds of transactions in each of those accounts. What process did you use and can we be reliably informed that there are the problems that you indicated based on what you have seen?

Mr Copp: We reviewed principally all the accounts of each of these clinicians. We took a sample of practically 600 transactions. That is quite a large sample. In addition, we also ran some software on the payment side, which is detailed in our report, to see whether there was any unusual items going through the accounts and the findings are in the report also. It was quite an in-depth review. Basically, an internal audit looks at process, for its strengths and areas in which it needs to be improved and usually in-depth testing is nowhere near 600 items. We were trying to get a real good feel of what is going through the accounts. The findings are noted in the report and in most cases we highlight certain areas that need to be investigated just to make sure that the facts are correct. That is where management would have the opportunity to go and explore. It was a fairly rigorous review. It was not what I would refer to as an oversight. We actually sat down and said, "What is in each of the accounts, may we see your trust deed and is it properly constituted?" We would not normally look at all the accounts. However, there were concerns and therefore they said they wanted to understand what was going on. The overall knowledge at that point in time of trust accounts was perhaps lacking in that regard and that is why they need to get a handle on the size of the trust accounts and really what the heck they are.

The CHAIRMAN: How many people were involved in the investigations?

Mr Copp: Half a dozen people would have been involved.

The CHAIRMAN: Can you explain the substantial differences between the various internal audits on these trust account reports?

Mr Copp: Basically, they started out as a review of a process; then we started drilling down and they began to lose the flavour of what I would call an audit into

more of a forensic review or being concerned about fraud allegations. Therefore, it went from a process down to another level looking at the accounts and then after the MHS looked at one issue it said, "We want you to investigate one issue in detail." That was the only issue out of the whole report. It really evolved into a special investigation.

The CHAIRMAN: Okay. Do you want to provide a summary of some of those substantive investigations?

Mr Copp: In regard to the final one?

The CHAIRMAN: Yes.

Mr Copp: Okay. We were asked to look at the bulk-billing issue. Historically, bulk-billing has happened in cases represented to us by clinicians and if I recall correctly it ceased in the early 1990s. There were two trust accounts in which it appeared the practice was continuing which the audit committee asked us to investigate a bit more because of the allegations.

[10.15 am]

In summary, what came out of it was that we really do not know the whole story about whether bulk-billing has taken place, because the practitioners' records and Medicare records must be looked at. That investigation should be done by the Health Insurance Commission, so that it can match up information from the doctor's records and its own. One of thedeficiencies is in the hospital information system, in the sense that if people want to be seen as private patients, they would fill in a certain field. It appears that people have not been putting down the proper election of whether they wish to be public or private patients. Certain evidence in the reports indicates that there could be a problem with the system. In a nutshell, we came to the conclusion that there is still some evidence of bulk-billing, but if that is to be tracked down fully, the Health Insurance Commission needs to be involved. We are receiving various interpretations of certain schemes. Where we thought the interpretation was not quite right we said the only way to get it right was to go to the Health Insurance Commission and get its ruling.

The CHAIRMAN: Some of the summaries of your findings in the draft internal report of June 2000 are quite startling. The findings are that revenue from bulk-billing for public patients is being used to fund some accounts, while other have historically obtained money in this manner. That is quite startling. What evidence do you have to back that up?

Mr Larkan: Money going into trust accounts has been traced back specifically to a receipt which says "Medicare cheque", and to a claim from Medicare provided by the commission, with all the patients' details and the amounts claimed. It is money that has been obtained through bulk-billing; these are public patients, and the revenue is going into the trust accounts.

The CHAIRMAN: You actually have that evidence. Can it be tabled as part of this process? The committee would like to have that as part of its further investigations.

Mr Larkan: I do not have those documents with me.

The CHAIRMAN: Will you make them available?

Mr Larkan: Yes.

The CHAIRMAN: The other claim you made is that the trustees diverted revenue from the public hospital to their own individual trust accounts. Were these real trust accounts or were they referred to as special accounts?

Mr Larkan: For all intents and purposes they are regarded as trust accounts. They are indeed special purpose accounts. Most of them have trust account deeds in the hospital format, and they are kept separately.

The CHAIRMAN: I understand that, but for this committee investigating this matter, it is very important, because if money is placed into a special account, it is actually revenue of the hospital and not trust funds. Your comment that trustees diverted revenue from the hospital to their trust accounts, meaning real trust accounts, is separate from money transferred to special accounts, which are actually the revenue of the hospital.

Mr Copp: That is correct.

Mr Larkan: The special accounts are the revenue of the hospital, but they do not appear in the hospital's ledgers as operating accounts.

Mr HOUSE: Where are they accounted for?

Mr Larkan: They are accounted for under the trust accounts.

Mr Copp: In another set of books, so to speak.

The CHAIRMAN: This other set of books is a problem in itself. Are you saying that those accounts were under the control of those specific doctors?

Mr Copp: It would have been a doctor or an administrator. It is not necessarily a doctor; it could be someone else within the hospital.

The CHAIRMAN: The problem is that if they are not trust accounts, then they must be hospital accounts. If an administrator is looking after them, and they are put into the wrong category, then it is an administrative problem. If it is a separate trust account, controlled by the trustee, who is a doctor, then it is private expenditure, which is a different ball game altogether. We need to make sure that these two things are separate. Is it a special account, or a trust account, which had special structures, controlled by the doctors? I know you are saying that they are treated as one and the same, but they are two separate issues.

Mr Copp: I recall that there are some accounts specifically set up for a special purpose. Those are trust accounts. There are other special purpose accounts which, for instance, if I recall correctly in the case of King Edward Memorial Hospital, would contain the proceeds from the sale of motor vehicles. That money should perhaps have gone into the operating account of the hospital, but went into a special purpose account instead. It is parked on the side, and does not appear on the operating statement of the hospital.

The CHAIRMAN: Are you saying that money from the sale of vehicles was placed into trust funds?

Mr Copp: Yes, it was parked.

The CHAIRMAN: For whose benefit was this done?

Mr Copp: That is a big question. The money could be brought in and used for expenditure for the hospital some way down the road. One of the comments in our reports states that it appears some of these accounts were used in the old cash basis accounting of the past. Before the Government went to full accrual basis accounting,

they would try to spend the money in advance. If they could not, they would show it as an expenditure and park it in a trust account. There are some examples, if I recall correctly, of a deal being made. I have to compliment them on being innovative in trying to save money and raise money for the hospital. In one case, they entered into a leasing transaction, and there was an agreement between the administrator and the department head that any savings on the deal would go into a special trust account, used for the department. That is fine; we do not have a problem with that as long as it is subject to the same process of controls, is properly accounted and budgeted for, and meets the normal operating account of the hospital. They are the hospital's funds, even though it was a saving. In some examples we have seen consolidated revenue funds being put into trust accounts, and we have questioned why this is being done. It is just to park the money.

The CHAIRMAN: Will you provide us with that evidence? That is quite crucial to what we are doing You are saying that consolidated revenue is being put into trust funds. For whose benefit is this being done?

Mr Copp: Basically, it is done for the benefit of the hospital. We raised these questions with the trustees and the people who account for the money. We asked if they were subject to the same process of controls as the operating accounts. There are weaknesses.

The CHAIRMAN: I will take you back to bulk-billing, because that is critical to the whole equation. Have you any evidence that bulk-billing revenues went to trust funds that were specifically for the purposes of a particular clinician, and used for purposes which were directed to him; in other words, were they salary for the doctor?

Mr Larkan: We only have evidence of funds going into the trust accounts and special purpose accounts. What they used out of that is at the discretion of the trustees. Ostensibly they are for the benefit of the department.

Mr Copp: That is where the difficulty is - getting transparency. The money comes into the account, and expenditure is then made, perhaps for travel, education or whatever. The question we are raising is whether that expenditure is directly related to the work of the hospital, or is private expenditure. That is where it gets very difficult. We have gone down to the level of detail to determine whether the expenditure was of a personal nature. Where it appears that the expenditure is of a personal nature, this has to be investigated. This is done firstly to make sure that the trustee and the clinician are covered. If a structure is set up to minimise taxation for doctors, it must be squeaky clean and done right. Certain things have been said around the traps. It has been referred to in other transcripts. If I recall correctly, it was said that at Royal Perth Hospital there was an issue about taxation, and an agreement was reached with the Australian Taxation Office. That is something you should ask them. Our big concern is that if funds are being put into the trust accounts, which are effectively the salaries of clinicians or doctors and they obtain the benefit of a tax receipt, that is all right, as long as the doctor declares it on his tax return. We have no way of verifying that it has been declared.

Mr HOUSE: In summary, are you saying that there is a clear line of money going into these account, but there is no clear line of money coming out?

Mr Copp: That is correct. There is documentation supporting the expenditure, but we are raising the question of whether it is expenditure related to the hospital or expenditure of a personal nature.

Mr HOUSE: You are saying that that is unclear. Is that correct?

Mr Copp: That is correct. We do not have the answers.

Mr HOUSE: In all cases?

Mr Copp: No. We are just raising examples in some accounts. This is the difficulty I have with things going out into public forums. People think it is widespread. Misappropriation or evildoing is not necessarily widespread. There are probably only a handful of cases.

Mr HOUSE: I think that is really important. You are right in saying that there is a perception created that a lot of these accounts are not being used correctly. Are you indicating that only a small percentage are not being used correctly?

Mr Copp: That is correct. I have great difficulty when people leak things to the media. Without knowing the full facts, they focus on a couple of issues and say they are rampant throughout the system. They say bulk-billing is rampant through the system. There are two accounts. It is not rampant, and we said that in our reports.

Mr WHITELY: Did you do spot checks, or were all accounts checked? Did you just discover two, or are there likely to be others?

Mr Copp: For Princess Margaret Hospital for Children and King Edward Memorial Hospital we went through the accounts and, of 266 accounts, we found just two that still have issues.

Mr WHITELY: Are you saying that no bulk-billing is going into those other accounts?

Mr Copp: I cannot say unequivocally, but we have not seen any indication of it.

Mr WHITELY: What volumes are you referring to? If 264 accounts are not high volume accounts, and the other two are very high volume accounts -

Mr Copp: I do not know the specifics on that.

Mr Larkan: Those two accounts were primarily funded through bulk-billing and basically used for that purpose. In the other trust accounts, historically those practices have occurred but they have now ceased. Those cases were negligible, from what we can gather.

Mr WHITELY: Do you have any idea what the turnover was?

Mr Larkan: Offhand, no.

Mr WHITELY: Is the clinician who is generating the bulk-billing funding that is going into the account also the trustee of the account?

Mr Larkan: Yes.

The CHAIRMAN: I will take one step back, to your reports. You say you have only two accounts. In the reports you say you only looked at six. Now you are telling the committee that you looked at 283 accounts -

Mr Copp: Not for bulk-billing. In our review of the 266 accounts, we said that there are some which have issues with bulk-billing.

The CHAIRMAN: Let me get this right. Are you saying that you went through the 266, and checked every one for bulk-billing?

Mr Copp: We looked at each account, its source of revenue and so on.

The CHAIRMAN: Did you only find six with bulk-billing issues?

Mr Copp: Yes.

The CHAIRMAN: Only two of those -

Mr Copp: Only two were current.

The CHAIRMAN: Two out of the six accounts still had money going into them.

Mr Copp: We looked at those and tried to get to the bottom of it. I am trying to say, in relation to claims that this practice is rampant throughout the system, that at King Edward Memorial Hospital and Princess Margaret Hospital for Children we found only two accounts that were active. We told them to get in there, find out what is going on and stop it. Either it is proper or it is not. To find out whether the practice is proper is like trying to find Noah's Ark. There are always different views and interpretations. The concern I had was that the administration did not know whether it was proper or not. I would have thought that, if this kind of thing were going on they would make sure that it was approved. Nobody could give us a straight answer in that regard, so we raised questions as to how they knew the practice was appropriate. We got some comments from individuals that this was the practice in the eastern States, and it is accepted practice. We then had to say that being accepted practice was one thing; the other was whether it was appropriate and legal.

Mr HOUSE: I would like to follow that through. In answer to one of the written questions you used an example of a trust account for a doctor drawing a salary, who went off and did some private work. He refunded the part of his salary that was applicable to that private work time to the hospital, but he put it into a private trust account. After that, there is a series of other questions. Are there many examples like that, where trust accounts may be seen to be not used properly? That is the way I would see it. There certainly must be some questions about that sort of thing.

[10.30 am]

Mr Copp: We have come across certain areas in which revenues are raised that go into special purpose or trust accounts that are not controlled by what I would call the normal process.

Mr Larkan: For example, Sir Charles Gairdner Hospital has a maintenance contract whereby its maintenance department does maintenance work at Joondalup Private Hospital, for which Joondalup pays. The revenue being used for Sir Charles Gairdner's engineering department goes into the special purpose account and is controlled by the person who runs the engineering department. Likewise, revenues for television rentals go into a commission, which is paid by the company that does it, and it then goes into a trust account, not into the hospital revenues.

Mr HOUSE: It would be interesting to see how this particular example I have used of the trust account is dealt with by the hospital's administration and then how the tax return looks.

Mr Copp: It is interesting because we raised the matter of an activity being undertaken by the hospital. Nothing untoward is happening, but we are saying that the controls need tightening up because revenue activity is being generated. What is the full cost? For instance, somebody who tried to generate income and receive revenue could decide not to park the revenue in his own personal account but into the hospital's account. That person could draw upon that revenue because the controls on it are not very strong, and nobody would question that person. We are highlighting

that the controls need to be tightened. People can open an account, and there are processes by which people will question why a number of little accounts are going through it. I am concerned that in this case maintenance work revenue, which should hit the operating account of a hospital, shows income coming in, because the account discloses the hospital's account; however, only the trust account balance can be seen, not the throughput. The account is not subject to the normal budgeting process and oversight procedures. How does the hospital know it is getting all the income? I do not know. What controls are there? We did not examine that side of the business. I would expect in that case that it would be subject to the normal business processes.

If I had an account for a work order for a maintenance job to make sure the revenue is coming in, I would determine how much this activity is costing; for example, whether it is profitable or neutral. Therefore, there is no cost to the hospital. We do not know that. Should maintenance work for Joondalup Private Hospital be done out of Sir Charles Gairdner Hospital? I do not know. That is why we are raising questions about these trust accounts. What is a proper oversight or review to ensure these activities are being undertaken appropriately?

The CHAIRMAN: We will refer to these other reports as they come up. Was there any evidence that any money from Medicare went to other than the trust funds or special accounts? Was there any evidence to show that Medicare was bulk-billed for hospital patients and that that revenue went into private accounts?

Mr Larkan: We have an instance whereby a large cash deposit was made into a trust account, which was primarily funded with Medicare funds, and we questioned the clinician. We asked about these cheques. There was a huge cash amount, which was an odd amount because it had a couple of cents on the end. We were told that the money went into so and so's account by accident. We were told that he drew the cash out and put it back into the trust account. Based on that example, what you say, Mr Chairman, is possible because the cheque is made out in the name of the clinician, not the hospital.

Mr Copp: To cover the loop, the clinician's Medicare billings would have to be matched up with the actual funds he received and checks would have to be made to find out whether he had put the funds into the account. We cannot check that because that is a personal affair. We can find out only what money is in the account and raise questions. A Medicare cheque is received, which is fine, and hopefully that is for the full amount. However, in the case of a cash amount deposit, is it possible to know whether all the cash has been received?

The CHAIRMAN: Is there a loophole whereby a clinician could be paid to work at the hospital and also bulk-bill the patient and put the money into the clinician's private account? In that case, we would never know.

Mr Copp: The only way to check that is to get the Health Insurance Commission to match up the Medicare billings to the funds received and trace it. Was the clinician bulk-billing while he worked for the hospital? That would require third-party help to find out.

The CHAIRMAN: Did you see any evidence of that?

Mr Copp: I would love to give evidence of that to the committee, but we are limited in what we can do; a third party would have to do that. We recommend that the HIC do that because it could close the loop.

Mr Larkan: We found in only one instance of the sample we conducted that the money had gone through the clinician's personal account back into the trust account.

The CHAIRMAN: How much money was transferred back to the trust fund in payment of this cash?

Mr Larkan: About one HIC cheque disbursement.

Mr DEAN: Would that clinician also have obtained tax relief from that payment?

Mr Copp: I do not know. I would have to look at his tax return.

Mr Larkan: That payment was in the order of $17 600 for one cheque.

The CHAIRMAN: We do not know whether the $17 000 that went into a private clinician's account, which he put back into the trust account, was all of it.

Mr Larkan: Or whether it was the only one.

The CHAIRMAN: Did you discover that example during a sample study of the accounts?

Mr Larkan: Yes. It was a sample of transactions to that specific account out of one of the two that still has bulk-billing revenues.

The CHAIRMAN: Was $17 000 put back into the account? Was it recorded in the revenue base of the hospital accounting system as a donation or a refund?

Mr Larkan: It goes straight to the trust as a donation.

Mr Copp: The receipt specified a cash donation.

Mr DEAN: Who writes the receipt?

Mr Larkan: That was a manual receipt, so it was specified as a donation; it is a computer generated system.

Mr DEAN: Was it on a hospital letterhead?

Mr Larkan: Yes.

The CHAIRMAN: Are you saying that the $17 000 was given as a donation to the trust account?

Mr Copp: That is what the receipt discloses. Again, we are just raising the question.

The CHAIRMAN: The bigger issue is whether a tax deduction for the donation will be given.

Mr DEAN: A few times in my life I have tried to get tax deductibility status for various trusts and have found it to be very hard. Did you check whether any of these ledger accounts had tax deductibility status from the Commonwealth Government?

Mr Copp: No, because they are not trust accounts. The hospital's tax status would have been used.

Mr Larkan: The hospitals have tax deductibility status.

The CHAIRMAN: Have we any evidence that hospital patients who were treated by the hospital were private patients and were also bulk-billed? Was there any evidence that some of the private patients were also billed for these visits?

Mr Larkan: Do you mean the clinician's own personal patients?

The CHAIRMAN: We have a situation in which the hospital pays for that session, the patients have been bulk-billed, the funds have gone into a private account. Has

your research found any evidence that the accounts of private patients were also bulk-billed? Can that be checked?

Mr Larkan: We never examined that and we would not be able to check it.

Mr Copp: That could be checked if the patients got a Medicare receipt and that was matched up to the session, or if the patients were found and gave their representation.

The CHAIRMAN: Could their records be checked with the private health funds to find out whether they have been charged for those visits?

Mr Larkan: With those doctors, correct.

The CHAIRMAN: The patients' Medicare numbers have been highlighted in the report; therefore, it would not be difficult to trace the patients and find out whether a third charge has been imposed on them.

Mr HOUSE: We are getting a bit out of our tree. We are now talking about fraud. To indicate that there is widespread fraud would be right out of bounds.

Mr Copp: I have highlighted that that has happened in two accounts out of the 266 accounts we checked. Bulk-billing did happen in the past but the majority of it ceased. That occurred in only two of the accounts that we examined. The committee should not get bogged down on that issue. The problem should be fixed and if it is happening, it should be stopped. If the practice is to continue, the Government should make sure it is conducted appropriately and legitimately. The processes and controls should be strengthened. What do we do now? We should proceed and let what occurred in the past remain in the past. The committee could spend a lot of time and effort looking for issues, which it will find - I will not deny that - however, from this point on, the slate should be wiped clean and the problem should be fixed.

The CHAIRMAN: The report found that trust account activities may have been construed as tax evasion. Do you have specific evidence of that?

Mr Copp: That is what we have just discussed. That is a risk. A doctor could make a donation to the hospital and put $17 000 or whatever amount into an account. He could draw on that for his own expenditure, which might not be tax deductible expenditure. That is the nut of the issue.

The CHAIRMAN: The report states that personal benefits can be gained from the trust fund expenditure. What evidence backs up that statement?

Mr Larkan: That referred to travel, training and conferences.

The CHAIRMAN: Does this have anything to do with the two funds about which we just referred?

Mr Larkan: No. Generally, it refers to payment of mobile phone costs whereby people have made a deposit into a trust account and then have paid the mobile phone costs.

Mr Copp: Somebody could possibly buy a laptop or computer on the trust account to get around the authorised capital expenditure authorisation.

Mr Larkan: They would do that by donating money to the trust fund .

Mr Copp: Perhaps they would donate the money to the trust fund or the money would come from elsewhere. The money goes to the trust fund. Somebody could buy a laptop computer, which is a fixed asset of capital expenditure, by not going through the normal process and the transaction would not hit the registers. Where does the

laptop go? Again, we are highlighting that there is a risk that this could happen because it is not subject to the normal processes and controls.

The CHAIRMAN: Are there any specific examples of this? The committee would like to trace those examples to find out whether or not they are real cases. Will that information be provided to the committee?

Mr Larkan: Yes.

The CHAIRMAN: Is there any blatant misuse of trust accounts, or are they all questionable and it is a matter of interpretation?

Mr Larkan: A lot of the misuse is a matter of somebody's interpretation as to whether the account has been used for either an individual or departmental benefit or whether it is a benefit to the hospital.

Mr WHITELY: A clinician could authorise the expenditure, so there would be nobody oversighting it; the loophole is enormous.

Mr Larkan: The clerical function exists whereby the processes that need to be gone through do occur; however, the account holder decides on what the money is spent.

Mr Copp: We are concerned about how good is the finance department to question the authority or whether the department can be bullied? Some clinicians refer to the funds as their own. Eventually, the mindset and culture wears people down so that it becomes accepted that the funds belong to the clinician and that he can do what he wants with them.

Mr WHITELY: It is a strange way to deal with a donation.

Mr Copp: That depends on one's view. Have we seen blatant examples of the misuse of trust funds? I have not been intimately involved in that case - it was referred to in a transcript about a hospital. From what I understand, litigation occurred and the misuse could have been construed as blatant. In some areas we have questioned whether some expenditure is extravagant or blatant. I do not know whether that is the case, but we raise the issue of whether the expenditure is extravagant.

[10.45 am]

Mr Larkan: When we did the detailed testing, items that we felt needed to be highlighted from that specific viewpoint were highlighted in appendix 3. The only ones that were not were the bulk-billing issues.

The CHAIRMAN: Of the 230 accounts, how many had substantial donations from the clinicians themselves? Has an exercise been done to see how many donations came from clinicians?

Mr Larkan: That would be quite difficult to do.

The CHAIRMAN: Of the samples studied, how many accounts had direct donations from clinicians; that is, receipted as donations?

Mr Larkan: I cannot tell you offhand because the receipts do not always have details. The receipts often just show "received from". Receipts often come from an organisation with a tax status.

Mr Copp: The receipting process needs improvement to provide a better trail so that it is easy to find out the nature of receipted funds.

Mr Larkan: There is nothing stopping someone using a receipt received from Princess Margaret Hospital for Children or King Edward Memorial Hospital or any other hospital as a tax deduction.

The CHAIRMAN: I am trying to determine how widespread are donations into trust accounts. Is it just one or two doctors or is it widespread? How many doctors are donating to trust accounts and using the funds for expenditure that may or may not be "normal".

Mr Copp: With due respect to clinicians, I understand the budgetary restraints that they are under. They are trying to raise revenue and funds for the hospitals. A number of them will undertake lectures or other activities on their own, and put the lecture funds into the accounts of their own departments. It is a way to raise money. Technically, that is income to the doctors - I am assuming that - unless the doctor is representing his hospital. The question then is who the cheque is made out to. I do not want to get into technical details. There are many examples of doctors undertaking activities and the doctors think that they are hospital activities. The doctors believe that the work is done on behalf of the department and therefore the money should go to the appropriate trust fund for the department's use. I do not have a problem with that, as long as it is subject to normal controls and procedures and is properly budgeted. As to how many examples of donations there are, that depends on how one construes "donations". We have come across examples where, for instance, $17 000 is recorded as a cash donation.

The CHAIRMAN: That is connected with bulk-billing. I am talking about the next step. You commented that, across the board, such expenditure was unusual. How widespread are the donations to these accounts? There needs to be some sort of audit of how many donations have been made and how widespread is the practice. It may all be legitimate, but it would be nice to know, as part of the process, how many donations are involved. If you have details of specific accounts where that has occurred, it would be good for our people to take that one step further and investigate the amounts and some of the expenditure involved to see whether arrangements are kosher, notwithstanding that the committee has to recommend something to fix the process.

Mr Copp: Keep in mind that we had limited resources when we were doing this. We could not dig deep into every issue. The role of management is involved: it must say that it has a problem that it must fix up and, if need be, things must be investigated. That is not the role of an internal auditor unless he is ordered to specifically investigate certain items. We did that on two accounts, the bulk-billing accounts. The audit committee of the MHS asked us to do more work on those two accounts. We have not delved into other areas or modification of other areas. We were not instructed to do so.

Mr HOUSE: Your evidence indicates that you have done exactly what an internal auditor would be expected to do. To summarise: a number of doors are open but you are unsure which had been used, but the administrators of this process should be having a good look to determine that they are not being used. Did you see any evidence to suggest that another level of investigation should be done? There will always be people doing little things on the side that they should not. Is there any evidence to support the need for a more in-depth audit?

Mr Copp: Only in those that we highlighted as being specific exceptions.

Mr HOUSE: There are no major issues?

Mr Copp: I am not looking at someone's concerted effort. There may be a few little areas. There are examples of certain things having happened in little areas, but it is not the norm. If you are asking whether there is widespread collusion between the administration and others, I do not think so. It is just that we have not really addressed the issues.

The CHAIRMAN: Some trust accounts have been checked. We know what are the starting and finishing balances, but in some of the accounts that you have looked at specifically - not the bulk-billing ones - what volumes of transactions are going through the accounts?

Mr Larkan: On average, they turn over once a year. If an account has $10 million in it at the beginning of the year and $10 million in it at the end of the year, the transactions will show that about $10 million has flowed through it.

Mr Copp: They roughly involve a one-time turnover.

Mr Larkan: They do not turn over that much; they turn over about once a year.

The CHAIRMAN: What if an account has $100 000 at the start of a year and $100 000 at the end of the year -

Mr Copp: It would probably have a $100 000 throughput.

Mr Larkan: It may actually have none but, on average, most accounts have a turnover factor of one.

Mr HOUSE: Do we have any examples of those? Can you show us any line by line examples?

Mr Copp: We have distributed to the committee copies of a follow-up review. They are in the binders. The figures relate to 155 trust accounts. The throughput to 30 June 2001 shows expenses of about $5 million and revenues of about $5 million.

The CHAIRMAN: Did you break down the figures? It seems like a very large account.

Mr Copp: It involves 155 accounts. The value of the accounts at the end of June was $7.2 million.

The CHAIRMAN: Those accounts have seen $5 million go through them? Did you break the figures down further?

Mr Copp: No.

Mr Larkan: We tested some of the transactions, but not specifically on each account. The testing was conducted across the transactions.

The CHAIRMAN: Like a normal audit? Using 10 per cent and then testing them?

Mr Copp: Yes. It is shown at page 1 in the last report.

The CHAIRMAN: In the sampling of the accounts, what was the error factor? In other words, how many questionable transactions where there that would normally be reported in an audit process?

Mr Larkan: I do not have that to hand.

Mr HOUSE: Do the accounts show where the money came from?

Mr Copp: Yes. They often show whether they were donations or came from elsewhere.

The CHAIRMAN: Are they all itemised?

Mr Copp: Yes. We have to get all the details from the hospital system.

The CHAIRMAN: Did you do that through this process?

Mr Larkan: Yes, we did. The report has appendices that itemise sources of revenue, the purpose of the fund, the expenditures, wind up instructions and recommendations from hospital management. That was the purpose of the trust fund analysis report. Part 1 shows the analysis for blended trusts for the year, and part 2 shows the analysis for unblended trusts.

The CHAIRMAN: For the record will you explain what are blended and unblended trusts? People need to understand what they are.

Mr Copp: Unblended trusts are funds that are not under the control of hospital. They are what I consider to be more of a true trust. They may be the result of a specific bequest and have separate terms about what the money can be used for. A blended trust, which is the majority of trusts, technically falls within the control of a hospital. Money may be derived from lectures or other activities. Instead of being put into the general budgeting process, it is accepted that department XYZ has the right to spend such money if it raises it. Blended trusts are set up on a department's balance sheet as it is deemed to be the department's money. The money does not go through the operating accounts.

The CHAIRMAN: Can you explain why, where and how you came to the conclusion that certain accounts should be investigated in a manner consistent with that of a fraud investigation?

Mr Larkan: That was in appendix 3.

The CHAIRMAN: It is dated 9 June 2000. It is the first one.

Mr Larkan: The report highlights a range of issues that we believed, in our opinion, required further investigation due to the limitations of obtaining personal information of individuals concerned, such as income tax returns or other corroborating information. The emphasis is on fraud investigation methodology to ensure that the forensic evidence required is far more rigorous than that used to develop internal audit recommendations.

The CHAIRMAN: You are not suggesting there is fraud; you are suggesting a broad ranging investigation? When I read the report I could see no evidence of fraud. One cannot start a fraud investigation just because someone is kite flying.

Mr Larkan: No. The reason is that there must be a rigorous investigation because some of the items may be construed as looking a bit suspicious. They should be investigated rigorously and all detailed information should be obtained so that allegations can be refuted. It is very difficult to refute anything because the systems are not accurate. Allegations can be made but the processes are not there to refute them.

The CHAIRMAN: Once again, processes and administration control are not evident. We are talking about the interpretation of circumstances.

Mr Larkan: Exactly.

Mr WHITELY: Are you suggesting access to Health Insurance Commission records and individual tax returns?

Mr Larkan: For particular items that may look suspicious there needs to be a more rigorous process so that questions can be answered one way or the other about whether things are above board.

Mr WHITELY: You cannot do that with the powers you have.

Mr Larkan: No.

Mr Copp: That is correct in respect of the bulk-billing issue because one is dealing with third party information. We would need the cooperation of the third parties. We did not go that far. With the other items we highlighted, a more detailed review was recommended to make sure that nothing untoward has happened. By the same token, my concern about these reports is that people zero in on certain things. I have always highlighted that where the words "trust accounts" are used, it is usually a very high profile and very sensitive issue. For the protection of trustees or people in a position of responsibility, they have to understand what is required so that there can be no comeback on them. It is very hard to find information in the current system and to obtain a documentary trail of evidence. When you do not get answers right away you get a little nervous. Systems and processes must be put in place to make it all transparent and accountable. That is what we are trying to see in the thrust of these things. We must be able to support the belief that there is an issue and to fix it up. One of the stumbling blocks in the process - and which we never got involved with - is the fear of the doctors that they will lose the funds that are under their control and that they can use for various purposes. That was the cause of a lot of tension. There was fear that it was a money grab. We do not know. If I was the administrator and I saw this going on and I had no control, I would say this is the process from now on.

[11.00 am]

All the moneys go into normal consolidated revenue funds because they are revenue funds. They go through the normal proper budgeting process in revenue allocation, and this indicates what will be spent so that overspending does not occur in certain areas resulting in a situation in which a trust account, so to speak, is overdrawn.

The CHAIRMAN: We will discuss that point a bit further down the track and move to the next recommendation in that same report, which referred to a doctor working at a different hospital and transferring that expenditure, or making a donation, to that account. Will you explain what is meant by the comments in section 46 of the trust analysis report? Reference is made to a clinician who has obviously worked at a different hospital and has then transferred his salary from that hospital to his trust fund at another hospital - which is obviously going to be treated as a donation - and which will then be used for the purposes of expenditure on personal items. What evidence do you have to support this? How widespread is this practice, because that is direct income earned from one hospital going into the trust fund of Princess Margaret Hospital for Children and then being used for other expenditure? Obviously, we must have the evidence to back that up. I am worried about how widespread is the practice of moneys from working at the different state hospitals going into the trust fund and then being used for whatever purpose.

Mr Larkan: That is the only account for which we have seen evidence of that type of practice. We stated in the report that there is a risk that the clinician is defrauding the hospital.

The CHAIRMAN: What is the risk, because that hospital does not actually lose anything; it is just giving a donation?

Mr Larkan: The hospital does not control that donation -

The CHAIRMAN: That is true.

Mr Larkan: It does not have control over that fund.

The CHAIRMAN: How are the hospitals being defrauded?

Mr Larkan: They are paying the clinician a salary for his services when he is not there to deliver those services. In fact, he is delivering his services elsewhere and is being paid for that.

The CHAIRMAN: This opens up a different area. I thought that this doctor was working at the hospital and was being paid and was then transferring that money to the trust fund so that he could have control over that account himself. However, you are saying that this doctor is supposed to be working at one hospital from which he is being paid when he is actually working at another hospital.

Mr Larkan: He is taking what he is being paid by his primary employer and what he deems as part of the salary earned while at the other hospitals and is putting that into his trust account.

Mr Copp: Again, this is detailed in appendix 3 of the report that is contained in the binder that we prepared for the committee.

Mr BRADSHAW: Was that money put into his own trust account?

Mr Copp: Yes, into the account that he controls, which originated from a personal cheque.

The CHAIRMAN: There are two issues here: First, he is being paid by the state system when he is working at a different hospital. He has taken the revenue from that hospital and put it into a trust fund at the hospital at which he is supposed to be working and into an account over which he had total control.

Mr Larkan: Question 13 of our initial submission details that particular case more fully.

The CHAIRMAN: If you have the evidence to back that up then it is clear that the situation is corrupt.

Mr Larkan: Yes, it would appear that way. However, we do not have the forensic evidence to prove that. The clinician volunteered this information, and we have traced the transactions and they seem to back him up. However, we have not gone right up the trail. We are asking management to have a look at that arrangement because it may be okay and authorised.

The CHAIRMAN: If a doctor is being paid to work at a hospital and is then being paid to work at a different hospital from which he takes the revenue and puts it into his own trust account, over which he has control, how can that be okay?

Mr Larkan: That is why we have raised the question and stated that management must have a look at it and investigate the matter further to decide whether it is okay and to give reasons why.

Mr Copp: We have highlighted this in appendix 3 and that is why we have put together this binder. The problem is that there are so many reports supporting the information, but there is evidence. Keep in mind that in this case the evidence was offered by the clinician; therefore, it does not appear that he was trying to hide anything. Out of this we are exposing the risk to the hospital and raising questions.

We have stated that this is what is happening, that these are the risks the hospitals are running and that the issue must be investigated further to determine whether it is acceptable.

The CHAIRMAN: Therefore, you did not see any physical evidence of this so-called wrongdoing?

Mr Copp: I am saying that it looks funny and unusual because I have not seen arrangements like this in other places. It just does not make sense. We usually sit down and ask if what is being done makes sense. This does not make sense. These are the risks being run and this is what could happen.

Mr BRADSHAW: Does that come back to the administration paying him while he is not at their hospital?

Mr Larkan: Yes. They pay him while he is not there. Again, it comes back to the governance and administration process of these accounts. These issues are trying to support the fact that there is no governance in the administration process that would stand up to scrutiny or be able to provide answers rapidly and with conviction. That is the message of all the reports.

The CHAIRMAN: It will be fairly hard to justify being paid by one hospital while working somewhere else. It is hard to say that it is okay to work in one hospital while being paid by another when the money is then put into the doctor's own fund.

Mr BRADSHAW: An audit was done in 2000 and another in 2001. Did you see any improvements in the way trust accounts were administered and looked after? Was there an improvement in the administration as well? Previously you stated that the administration in that particular case was not too good.

Mr Copp: What happened in August 2001 was followed up by committees at PMH.

Mr BRADSHAW: It might have been done in August but it is dated October 2001.

Mr Copp: That is the business process review and follow-up internal audit.

Mr Larkan: We did not do an audit or review in those areas prior to that; therefore, it would be difficult to establish whether there have been improvements.

Mr BRADSHAW: Under the business process review there is an overview of the trust account management framework. In the previous audit there were indications of some problems.

Mr Copp: The only ones reviewed were at King Edward Memorial Hospital and Princess Margaret Hospital for Children; the other hospitals were not involved. In the cases at King Edward and PMH we were eventually able to get in there to look at some follow-ups. We made some initiatives in the progress of what we call research accounts, but in non-research accounts management still has not investigated any major significant initiatives. It has indicated that it intends to embark on further initiatives to address non-research accounts, so the processes still have to be put in place.

Mr BRADSHAW: Was it not Mr Moodie who originally asked for an audit on these trust accounts to see whether they were kosher? Was he not still there in the 12 months leading up to October when you state that not a great deal of change had been put into place?

Mr Copp: He was not there in October 2001; he left in September 2000.

The CHAIRMAN: The next item that has been highlighted is that the trustees have diverted revenue that should have been recorded as hospital revenue. Obviously, you have specific examples in which revenue that should have been in the hospitals went to the trust accounts. What type of revenue are we talking about?

Mr Larkan: In relation to King Edward and PMH it is items such as sterility-testing facilities. Work is carried out within the hospital for private companies and payment for these services is deposited into the trust account and not through the general operating accounts.

The CHAIRMAN: Therefore, the hospital was carrying out sterility tests for private companies, but the money went to a private account?

Mr Copp: It went to the special purpose trust accounts. It did not go through what we call an operating account or general ledger.

The CHAIRMAN: Did you check to see whether that was at the direction of the administration or of the clinicians? Is this beyond the scope of what was asked? Was that organised by the hospital for the purpose of providing services to a company, and did the administration then put the money into the trust account so that it could spend it on discretionary expenditure; or did the specific clinician who organised the work put the money into his account when there should have been a payment to the hospital for the use of its facilities? What were the circumstances?

Mr Larkan: When looking at the clinicians and Mr Moodie's administration we were told that the clinicians had arranged this and that the people who owned the trust accounts would do the work -

The CHAIRMAN: Therefore, the hospital did not know anything about it even though it was providing the equipment and processes for the doctors to do the work?

Mr Larkan: I am pretty sure that the hospitals knew about it.

Mr Copp: It is my understanding that this practice was happening and when Michael Moodie came on board there was an agreement for this to continue but that five per cent of the gross revenue for the month would be paid to the hospitals as a facility fee to cover overheads and the use of the hospital's infrastructure.

The CHAIRMAN: If the money went to a proper trust account -

Mr Copp: That is correct.

The CHAIRMAN: - that money is not going to the doctors. Was it a proper trust account?

Mr Copp: It was a proper trust account. There is no trustee, and no governing deed. It is just another operating account that is not going through the chart of accounts.

The CHAIRMAN: Why would you want to get a five per cent return if you have got 100 per cent? If it is your account, and it is not a trust account -

Mr Copp: I do not know the answer to that question.

The CHAIRMAN: That means that the account was controlled for the purpose of the individual doctor. That is the only conclusion that I can draw.

Mr Copp: I do not know the answer to that question.

The CHAIRMAN: From the point when you highlighted that the process had been put in place was a percentage of the revenue being paid to the hospital as part of the operating process?

Mr Larkan: Yes. However, I am not sure that it has been put in place.

The CHAIRMAN: We can highlight that issue and have it looked at. How much money are we talking about?

Mr Copp: The balance in that account was about $30 715.

The CHAIRMAN: That is a substantial sum of money.

Mr Copp: I do not know what the throughput is. Again, I do not know why this is treated as a separate function to the hospital.

The CHAIRMAN: Do you know if the work being carried out, such as the sterility testing, is capable of being carried out at another hospital? Is there a specific need for the hospital to be involved?

Mr Larkan: I cannot comment on that question.

[11.15 am]

The CHAIRMAN: The committee has a copy of that account, so it will investigate it further to ascertain the basis of it. You make a specific claim on page 9 about the refurbishment of a VIP flat in Agnes Walsh House. Would you explain that to the committee and give us your opinion of the appropriateness or the nature of the expenditure, who were the approving authorities and how it got to the point that the flat was refurbished?

Mr Larkan: That flat was refurbished from an educational fund, or an account set up for further education.

The CHAIRMAN: Was it a separate trust account? In other words, did it have trustees, or, again, was it one of those -

Mr Larkan: It was one of those special accounts.

The CHAIRMAN: That is important, because if it is just an ordinary account for the hospital's business, and that expenditure was for the hospital's business, can we say that it was not appropriate? That trust number is 307834, and the other one is 307829. The house is out of trust No 307829.

Mr Larkan: That is taken out of the draft report - trust fund analysis - part II. These are unblended accounts, so they are meant to be full trust accounts.

The CHAIRMAN: This is a proper fund, and it has all the proper trustees and safeguards in place?

Mr Larkan: No, I will not say that they have. They are just classified as unblended

The CHAIRMAN: They should have them?

Mr Larkan: They should have, yes.

Mr Copp: Donations by doctors is trust No 307834.

The CHAIRMAN: The professional development fund is trust No 307834, and you say that donations are put into that fund by doctors who bill privately. I am not sure what that means. Is that when they are working for the hospital, or is this totally separate from the hospital and does it become a straight-out donation to the hospital or to the fund? What do you mean?

Mr Larkan: These are the schedule A and B-type doctors. Some of them put through money to one of the bigger funds, and others have obviously put through money to the smaller fund.

The CHAIRMAN: So they donate money?

Mr Larkan: They donate, yes.

The CHAIRMAN: That is their private business. They work as doctors, generate income, and choose to make a donation to a fund. Is that the nature of the beast?

Mr Larkan: As far as I can recall the trust accounts for these, the funds are due to the hospital.

The CHAIRMAN: Say that again.

Mr Larkan: The doctors are able to have a private practice at the same time as they work as employees of the hospital. A portion of that money is donated to trust accounts.

Mr BRADSHAW: From a private practice?

Mr Larkan: From their private practice receipts. A whole formula must be gone through. It is fairly complex. I think this is one of those.

The CHAIRMAN: Yes, but would the private practice component not be billed separately and go to the doctor direct?

Mr Copp: That is correct.

The CHAIRMAN: Basically, the doctor is making a donation out of his private income?

Mr Copp: That is correct.

The CHAIRMAN: There is no problem with that.

Mr DEAN: However, if he controls the expenditure, there is a problem.

Mr Copp: Yes.

Mr HOUSE: The doctor may well have declared it for taxation purposes.

Mr Copp: He may have. We do not know. We are just saying that we want to make sure the doctors are aware of their obligations. In this case, doctors will make a donation. Under this arrangement, a certain percentage will go towards a donation. Basically, these monies will fund the various conferences that are held. Again, all we are highlighting is that we want to make sure that the donations are not being used to circumvent tax rules; and also that it is private practice patients, not public patients, who are being billed.

The CHAIRMAN: You are highlighting the fact that they can make donations - there is no problem with that - but the end use of the donation is under their own control.

Mr Copp: Exactly.

The CHAIRMAN: However, you say in this document that this is one of those funds that is supposed to have the proper controls in place.

Mr Copp: Yes, it should have, because it is unblended.

Mr DEAN: It does not necessarily mean that it should have proper controls but that there is a trustee. Can that trustee not be the clinician?

Mr Copp: Yes. I guess that the issue, though, is that if a person is a trustee -

Mr DEAN: That person carries out the objects of the trust.

Mr Copp: Yes, and that person must be careful in the sense that if a trustee is getting some sort of benefit from the trust, from a taxation point of view that donation may not be allowed to be deducted. Those people must be careful of that in the structure of the trust. For instance, if I make a donation of $50 000 to build a Foundation 36 yacht, but I have an agreement that I get to use the yacht so many times a year, that is not a tax deductible donation because I am getting a benefit from it. The trustee of a fund must be careful with that if he is getting payments for travel and benefits to further himself. The ideal situation is that it is more transparent, and the trustee of the fund has nothing to do with any of the benefits from it. That is what we are highlighting.

The CHAIRMAN: For example, if that person were to take a trip, even though it was for purposes that are legitimately associated with the business of the medical practice -

Mr Copp: Yes, that is what he must be careful with.

The CHAIRMAN: However, if I make a donation, do I still not get the benefit?

Mr Copp: That is what I am saying. If I make the donation, and I am the primary beneficiary of the trips out of that, I have to be careful of how the trust is structured. My understanding is that the Australian Taxation Office may say that the donation is not tax deductible. The trust then pays for my trip, and it may be of business benefit, for argument's sake, but the trust does not have any assessable income; therefore, the tax deduction is lost. These people must make sure that the structure is right in that sense.

Mr HOUSE: We are getting way beyond our -

Mr Copp: I think so. All we are highlighting is that those involved should make sure that it is legitimate and that it is structured properly, because when the questions are asked, people do not understand what is going on.

The CHAIRMAN: I understand that. However, in evidence before the committee, it was put to us by some clinicians that they have a fund into which they want to donate money to help other clinicians who are juniors whom they want to support. What is wrong with that process? If the trust has trustees -

Mr Copp: Yes, if a properly constituted trust is in place and the trustees are truly independent, that is fine.

The CHAIRMAN: Do you say this one is or is not?

Mr Larkan: It is under appendix 5, which is trust funds to be investigated further. I am not sure about that one.

The CHAIRMAN: Our people will look at that.

Mr Larkan: The education fund, with the schedule A and B doctors, is all to do with that Australian Medical Association agreement. It is a huge trust account with that in it. There are issues surrounding the taxation arrangements.

chair: The second point concerns Agnes Walsh House. You obviously did some further investigations into that?

lark: No. We recommended it. It was refurbishment of a flat in Agnes Walsh House that was paid out of that fund. We wanted to know whether investigation was required by any -

The CHAIRMAN: How much was paid out of that fund for the refurbishment of this flat?

Mr Larkan: Offhand, I could not say.

Mr Copp: I would have to look it up.

The CHAIRMAN: Was it substantial? Was it thousands of dollars?

Mr Larkan: I think it was a few thousand.

The CHAIRMAN: Do you know what that flat is used for?

Mr Copp: I understand it is for accommodation for international visitors.

The CHAIRMAN: It is not used by any of the locals?

Mr Larkan: I am not sure.

Mr Copp: I do not know. In this case, it is a refurbishment. The question is whether it is a type of capital expenditure that should be subject to capital expenditure budgeting procedures. Why would it not come out of normal operating accounts?

Mr Larkan: It is also on hospital premises, so what alterations were made to the assets?

The CHAIRMAN: The amount was paid out of a trust fund, and the flat is still part of the property of the hospital?

Mr Larkan: Yes.

The CHAIRMAN: The hospital uses it for international visitors?

Mr Larkan: Yes, that is the reason we were given.

Mr WHITELY: The purpose of the trust fund was educational?

Mr Larkan: Yes.

Mr WHITELY: Was this consistent in the broadest -

Mr HOUSE: It could be.

Mr Larkan: We did not take a view on that. That is why we are saying to the hospital management that it should look at it and take a view on it.

The CHAIRMAN: Do you know whether this fund has proper trustees in place?

Mr Copp: We would have to go back and detail a working paper on that for the committee.

Mr Larkan: Most of these funds did not have proper trustees.

The CHAIRMAN: I refer to the internal review draft of King Edward Memorial Hospital for Women and your follow-up review of the issues. Would you give the committee a brief report on the findings?

Mr Larkan: The follow-up report covered a whole list of reports. Do you want the feedback on all those?

The CHAIRMAN: Just give a brief summary, if you can.

Mr Copp: This is the July 2000 report.

Mr Larkan: We had a whole raft of recommendations to improve the accounts payable process. That was on hold at that stage pending a decision by the

Metropolitan Health Service on the centralisation of the function. Therefore, management had not actioned most of those items.

The CHAIRMAN: Why would you worry about centralising the MHS when these are specific things at specific hospitals that can be done with the stroke of a pen by getting the finance people to fix them?

Mr Larkan: That is right.

The CHAIRMAN: Are you saying that the excuse given was that it was going to centralise it, but it did not do anything?

Mr Larkan: Yes.

The CHAIRMAN: I refer to your findings. Did you have a direct relationship with the audit committee of the Metropolitan Health Service Board that was set up for Princess Margaret Hospital for Children?

Mr Larkan: Yes. That relationship changed. Prior to Mr Moodie's arrival, there was an audit committee at the hospital level. After he arrived, he wanted the reports to go to the MHS audit committee, so we reported on King Edward Memorial Hospital and Princess Margaret Hospital for Children matters straight to the MHS audit committee. We already had an existing relationship on non-teaching hospital issues, because we did the internal audit work for them as well.

The CHAIRMAN: What was your relationship? Evidence has been given to this committee previously that the audit committee was trying to do all sorts of things to stifle the outcomes of the process. Did you find that; and, if so, what were the circumstances?

Mr Copp: When you say "stifle the outcomes", in what sense do you mean?

The CHAIRMAN: To make the outcomes other than what they originally were.

Mr Copp: I will focus on bulk-billing. The audit committee's concern was whether the allegations were appropriate. We told the committee what our findings indicated. It got to the point that the committee said that it was a fraud investigation - more legalistic etc. It asked us whether we had solid evidence, and we said that we could go only so far. After that point, we would have to go to the Health Insurance Commission and ask whether or not this was a problem. The interesting thing is that when the report first hit the table, the comment was, "This is an accepted practice over east. It is being done all the time, and we have been doing it for years." To be honest, I sat there somewhat stunned and said, "Well, that's fine, but is it the right and appropriate way?" That is when people were starting to question the audits and us etc. I just said, "If you can demonstrate to me that these are appropriate arrangements, that is fine." Therefore, the audit committee told us to go back and get it more evidence that it was wrong.

[11.30 am]

It was difficult to get evidence wherever we turned. The system is not as robust as it should be. At the end of the day we said that if they wanted to close the loop, they should go to the Health Insurance Commission and get a determination. Did they try to bury all the other information that came out of the trust account reports? I do not think so because they were fixated on bulk-billing. Nothing else was done in the other areas that gave rise to any action. That area did not get the due attention it should have which is very disappointing, keeping in mind that every time this issue

came up, it appeared in the media. I always got nervous when reports went to management and the audit committee and were then appearing in the Press.

The CHAIRMAN: Where was that leak coming from?

Mr Copp: I have no idea. This sub-audit committee comprised many people. Very few were what I would call independent members of the committee as many of them were involved with the hospitals.

The CHAIRMAN: It would not have been in their interest to make the information public.

Mr Copp: It was disappointing that it would get blown out the way it did. In the review we said that there were risks that needed to be managed to enable the process to be fixed. It came down to who was really in charge and running the place.

The CHAIRMAN: Was there any evidence of anybody suggesting that documents should be removed, changed or destroyed?

Mr Copp: No. After the information had hit the Press, the concern was that the documents needed to be collected to reduce the problem of managing the documents that were floating around after the committee had left the room. A request was then made for all copies of the documents to be handed over. I read in the transcript that someone said that they should be destroyed. That was not really intended. However, by leaving the documents sitting around, they would probably have hit the Press the next day. Therefore, the documents were collected.

The CHAIRMAN: So nobody said that evidence should have been destroyed that would affect the outcome of your finding?

Mr Larkan: It was more of an action of control to collect the reports and destroy them. That comment was made but the next comment made at that meeting was that the documents should be collected and controlled.

The CHAIRMAN: You said you were worried about the leaks to the Press the next day. The suggestion was made that one of the issues for the trust accounts was the removal of the chief executive officer. Did you find any evidence to support that or were any comments made to you by the clinicians or by the Metropolitan Health Service Board that that had a role? I may be going outside your limitations here.

Mr Copp: I cannot comment on that. Many things were happening in the background of which we were not aware. I was not involved in any intimate discussions in that regard.

Mr BRADSHAW: Did the recommendation to follow it up with the HIC to see if it was a legitimate process occur?

Mr Copp: They were undertaking that action and were following up on the HIC recommendation.

Mr Larkan: It was more in line with those two accounts.

The CHAIRMAN: A letter was sent to Dr Stokes that highlighted the use of the word “fraud” and that there was concern raised by your people. Can you explain to us what that concern was?

Mr Copp: Does this regard the business process review report?

The CHAIRMAN: Yes.

Mr Copp: We used the word "fraud" in the report and Dr Stokes' concern was that people think that "fraud" means misappropriated money etc. We debated that issue and said that fraud entails more than that, such as misrepresentation and intent to deceive. They did not want to have the word "fraud" in the report just in case it got out and was sensationalised. He was also concerned that when the word "fraud" appeared there might be an obligation to report the matter involved to the Anti-Corruption Commission. I said that there was a high risk of fraud because of the system's processes and that we could remove the word "fraud" and replace it with "questionable activities and events". I like one syllable words because they grab the attention of the reader. If one reads the report a little more, one should find that it still has the same context.

The CHAIRMAN: Here we have the Acting Commissioner for Health suggesting to you to use different words in the report. However, it is your report, not his.

Mr Copp: The word "fraud" is quite strong but I do not have a problem with it. However, when the report states "questionable events and transactions" it may indicate the misuse of funds in questionable tax transactions, which has a stronger meaning than the word "fraud".

The CHAIRMAN: If you have the evidence to back up your report, then as a company one would think you would stand by the use of such language.

Mr Copp: I decided it was just semantics. The essence of the report did not change. Were we pressured to change the report? The only changes to the draft report are what we have highlighted in the binder given to you. The change did not take away from the thrust of the report. Again, Dr Stokes' concern was that somebody would get the report, see the word "fraud" and it would then be sensationalised because it is an easy word to hang onto.

Mr WHITELY: You have not watered it down but simply added some clarity to what you were saying.

Mr Copp: We just expanded on the word "fraud".

The CHAIRMAN: You removed some relationship to some of those comments in the report in which there appeared to be less evidence in the conclusion. There was some watering down. As I read the report last night I thought that the wording had changed from where you said what should be done to the point of saying that somebody should review the process.

Mr Copp: Could you highlight that so I know where that comment is in the report?

The CHAIRMAN: We will get to it eventually as I have highlighted it as an issue to discuss.

You said that this letter and your changes were not necessarily influenced by the pressure that was put on you.

Mr Copp: No. We had a debate in our office and said that if we changed one word, "fraud", to "questionable practices", the thrust of the report would still be the same.

Mr Larkan: The debate in the office centred around the fact that the previous report on trust funds had an appendix of items for further investigation and the focus had shifted onto those issues which were, in the context of things, two accounts. The general administration and accounting processes that desperately needed fixing were left to one side.

Mr BRADSHAW: There is a difference between questionable practices and fraud. Questionable practices could mean that things were being done by the hospital naively or inappropriately without it believing it was doing so. Fraud means that there is illegal wrongdoing.

Mr Copp: Intent to deceive.

Mr BRADSHAW: Yes. There is a difference between questionable practices and fraud and you have therefore watered down that report.

Mr Copp: This is a difficulty I have with people not fully reading the report and zeroing in on one or two words. The report is quite scathing of governance and administration processes. The issue here is fraud, of which there are about four or five definitions. Fraud is not only about taking money, but also about misrepresentation.

The CHAIRMAN: Fraud indicates that the process is consciously being carried out illegally.

Mr HOUSE: That is not the issue. The issue here is was this company pressured by a government department to change the word. It does not matter what our interpretation of it is. The answer to that is yes and we are debating the semantics of the consequences and will make a decision on that later.

Mr Copp: They did not like the word "fraud" and we debated if, by replacing the word, the thrust of the report would be taken away. We felt that it would not and we were comfortable with that and, again, it was a draft. If it was a sticking point and a do or die issue, we would have said no and left it as it was. To wrap up this review, we went to the commissioner and said that we could be working on this report for another three months, however we thought that it was at the stage where it was ready to be released.

The CHAIRMAN: Was this done at any other political level? Were you pressured by any other people, such as the Commissioner for Health?

Mr Copp: There was a meeting with the Commissioner for Health, the Under Treasurer, the members of the reference group and Mr Michael Pervan, who I think was the health department solicitor. There is a letter in the submission that highlights who was at that meeting. It was pretty heated and not a nice meeting when we stood our ground.

The CHAIRMAN: It is an action of bureaucracy to have a go at you guys and not necessarily the politics of the issue.

Mr Copp: We had a pretty good discussion with the people in that room.

The CHAIRMAN: In your general audit report of King Edward Memorial Hospital for Women of 23 December 1999, you made some interesting comments about non-adherence to investment policy, which we have not covered so far. What does that mean?

Mr Copp: Normally an organisation would have certain parameters into which moneys can be put to invest surplus funds. In essence, there was a policy outlining the manner in which the funds were to be invested - I cannot recall the exact nature - but the hospitals were not falling within those investment policy guidelines.

The CHAIRMAN: What do you mean by that? Were the hospitals not doing what they were supposed to?

Mr Copp: Not according to the policy. When we reviewed it we concurred with them that the policy needed to be updated. When there are surplus funds, the hospital is directed in certain ways as to how that money should be invested.

The CHAIRMAN: So there was no inappropriate use of funds?

Mr Copp: No, there was no inappropriate use. There was a policy stating how the funds should be invested. I cannot remember the exact nature of the policy, but the hospitals were not following it. When we looked at the policy we found that it was not up-to-date.

The CHAIRMAN: This is not about investing money in shares is it?

Mr Copp: No, nothing like that. It was about which bank accounts the investments should go into, if I recall correctly, but it did not involve investing in the share market.

The CHAIRMAN: There was some evidence given to us that some moneys were invested in share market transactions. Did you find any of that occurring?

Mr Copp: No, not at the hospital and not to my knowledge.

The CHAIRMAN: What does that mean? Is it happening somewhere else?

Mr Copp: In the transcript you referred to Megazone and the Princess Margaret Hospital for Children Foundation, but we had nothing to do with that.

The CHAIRMAN: So you never looked at those transactions?

Mr Copp: No.

The CHAIRMAN: What does it mean when you refer to impractical audit trails for receipt documentation in this report?

Mr Larkan: It means that to trace an entry in the ledger back through the books of account to where it came from is nigh on impossible.

Mr Copp: It is very difficult to do.

Mr Larkan: It is time consuming and not as simple as it should be.

The CHAIRMAN: Could you explain that? If someone writes a receipt, you know who you got it from. What are you getting at?

Mr Larkan: No. Somebody writes a receipt and it is put on the system, but it is a different system to the ledger. We are working from the ledger backwards for completeness.

[11.45 am]

You then have to find the person responsible for that account and ask him what documents he has to support a transaction, because those documents are not kept at the source. If you go to the source, all you have is a copy of a receipt. There is nothing else; no other documentation goes with that. The actual administration and accounting function within the hospital was to keep those documents. The people responsible for those accounts had to keep that documentation. That is where the control breakdown happens, because their standards might not be what one would normally expect within accounting and administration functions.

The CHAIRMAN: If they were in an account that was being controlled by the hospital, why were those processes not in place?

Mr Larkan: That is the question.

The CHAIRMAN: Did you see any illegal activity resulting from that conduct? That is what I am really getting at.

Mr Larkan: Not that I can recall.

The CHAIRMAN: One of the comments you made about the reconciliation processes was that you found trust funds that were overdrawn.

Mr Copp: Yes.

The CHAIRMAN: First, I find it intriguing that a trust account can be overdrawn. Second, they were overdrawn for more than a year and no-one seems to know how that could happen.

Mr Larkan: We raised the same issues.

The CHAIRMAN: Do you have those specifically identified so that I can track through them?

Mr Larkan: They will be on the listing.

Mr Copp: They are on the listing and in appendix 2.

Mr Larkan: Perhaps not this account. They will be in the working papers. It will be on the list of the next report.

The CHAIRMAN: When that account was formed, was there any evidence that the trustees were the strict beneficiaries, or was it one of the blended or unblended accounts? What was the process with the account being overdrawn?

Mr Copp: I guess really -

The CHAIRMAN: In other words, was it one of those special purpose accounts which is not a trust account, or was it a trust account for which there was no excuse for it being overdrawn?

Mr Copp: I would have to look at the specific account.

The CHAIRMAN: That could easily happen if it were a normal account. If it were an ordinary account at the hospital, the account could be overdrawn, but if it were a real trust account, how could it be overdrawn?

Mr Larkan: We asked those questions to find out the true nature of these accounts - whether they were trust accounts or hospital accounts.

The CHAIRMAN: When you found an account that was overdrawn, and had been overdrawn for more than a year, did you not then ask the next question about whether it was a real account or a special account?

Mr Copp: That is what we would have looked at for the nature of the accounts. If I recall correctly, where there is a proper trust account, it is not overdrawn. It is in the so-called other accounts.

The CHAIRMAN: Legitimately, if it is only one of those special purpose accounts -

Mr Copp: It is an overspending of one's budget.

The CHAIRMAN: So it is not really a problem. However, if it is one of the trust accounts -

Mr Copp: It is an issue.

The CHAIRMAN: It is a major issue.

Mr Copp: That is correct. It has destroyed the obligation of the trustee. The trustee would put his hand in his pocket and make up the shortfall.

The CHAIRMAN: Exactly. That is why I am asking the question. You are saying that if it were one of those special purpose accounts, there would be no problem.

Mr Copp: My understanding in most cases was that if they were overdrawn, they were special accounts.

Mr Larkan: Blended and unblended.

Mr Copp: If I recall correctly, there were no issues when a proper trust was in place.

The CHAIRMAN: In that case, when it is a special purpose account, it is one of those accounts in which the trustee has sole trustee power. In other words, it is an account that the doctor controls.

Mr Copp: Yes. It could very well happen in that case -

The CHAIRMAN: Do you know whether it was or was not in the case that you highlighted? In other words, did you check whether it was the doctor's own account, which he approved?

Mr Copp: I would have to refresh my memory from the work that we did.

The CHAIRMAN: Can we have that sort of stuff? That is evidence. We obviously want to follow it through.

Mr DEAN: There is no guarantee that if the ledger accounts are overdrawn, they will ever be repaid.

Mr Copp: That is correct. It is like an overspending in an operating account.

Mr DEAN: There is no guarantee that they will be topped up.

Mr WHITELY: If you add that to the possibility that they have been used for private purposes -

Mr Copp: There is a risk that somebody would overspend on his account.

Mr DEAN: A person could, and then could leave it.

Mr Copp: Exactly.

Mr WHITELY: In a sense, that person does not have ownership of the account, in that he does not have to fund the overdrawing.

Mr Copp: That is correct.

Mr WHITELY: The obligation falls on the hospital. It might be treating it as a special account, but ultimately the legal obligation falls on the hospital. There is a huge problem.

Mr Copp: Yes. Again, it comes down to normal business process. One normally has budget expenditure and budget revenue. If one has to overdraw the account, he will think, "Oops, I had better not incur that expenditure." In that case the hospital would be on the hook, because it is normal operating expenditure.

Mr DEAN: Coincidentally, in your investigations did you identify any overdrawn accounts that had been refurbished?

The CHAIRMAN: There was one account that was overdrawn for more than a year, that is why I -

Mr Copp: Yes, it just sits there. Again, that comes down to the administration of those accounts and whether those funds should be disbursed because they are overdrawn.

Mr Larkan: Some people do a cross-subsidy to repay overdrawn accounts from another account that that person has control over. Those sorts of transactions are occurring.

The CHAIRMAN: That can happen if it is just the hospital account which no specific trustee controls.

Mr Copp: Correct.

The CHAIRMAN: One account has been overdrawn for more than a year and has not been repaid. You said that there have been numerous other accounts that have gone into debit and they went to credit. Money was being spent in advance of actually getting it. Those issues all need to be looked at.

Mr Copp: The hospital refunded it. That is correct. There is an example in which for us it was the timing of the receipt of funds. An account is effectively overdrawn, so you could say that the hospital has to finance that expenditure until it gets the funds in. That is not a trust account; it is an operating account. However, it is overdrawn because it has not yet earned the revenue. For instance, if someone was sent on a conference and there was no money in the education fund to pay for it, but the hospital writes a cheque for that expenditure, that account will be overdrawn and somebody will have to make good. Who makes good? Normally, it would be the hospital, unless for instance the doctor left his employment and the hospital wanted to try to recoup the funds. The bottom line is that the hospital is responsible for that expenditure.

The CHAIRMAN: Right, so you have all those accounts listed in the report.

Mr Copp: Yes.

The CHAIRMAN: That is in this document?

Mr Copp: That is why we brought it. It lists all the accounts and balances and shows which ones are overdrawn.

The CHAIRMAN: That went in and out. Can we get our people to chase through that?

Mr Copp: Yes.

The CHAIRMAN: Excellent. The executive summary of the audit report of 9 June contains a recommendation for a further review. I am not sure whether a further review means an Ernst and Young review or a review that goes the next step; in other words, a more in-depth fraud investigation. Is that what you were referring to with that comment? The summary says that due to the report findings of the two previous reviews commissioned by the chief executive, a further review was commissioned in this area. Is that the review that you reported in November or is it -

Mr Copp: It is this one.

The CHAIRMAN: In one place you recommended a further investigation. Is this over and above that?

Mr Larkan: Yes. In appendix 3 of that report we recommended that further work be done, but not necessarily by us.

Mr Copp: Basically, it should be undertaken.

The CHAIRMAN: One of your recommendations was that hospital management obtain exclusive mandate from the Metropolitan Health Service Board for further action to be taken. Why did you make that comment? Would you not say that the administration of the hospital should control it? Why would you want a mandate from the board to tighten up processes in individual hospitals? Would that not be the role of the chief executive or administration of the hospital?

Mr Larkan: No. That related to a number of actions, not just the tightening up of the administration. We recommended that a number of those funds be consolidated into hospital revenue or funds and be used as hospital funds. That required the authority and backing of the Metropolitan Health Service Board because it was going to be a controversial process. It is not something you want to go it alone on.

Mr Copp: The basic issue is about who is really giving the direction or calling the shots. There is a chief executive, but the hospital at that time was under the umbrella of the Metropolitan Health Service. If something significant is to be changed, one wants to make sure that there is a policy direction. It was our understanding that this would impact on other hospitals as well. If I were the chief executive and this had been happening for some time, and keep in mind what the situation was like at that stage, I would want to make sure who is determining policy - is it the board or me? We were not clear about who was calling the policy shots. We said that the board was the authority that would ultimately be accountable, so it should give some direction to the chief executive. That is my view. It was a major issue.

The CHAIRMAN: Are you saying that all the trust accounts of all the hospitals should have been done at one time to get an overall policy?

Mr Copp: That is highlighted in one of our reports. This is indicative of Princess Margaret Hospital for Children trust accounts, but we understand it is right across the board. Therefore, what is needed is an across-the-board policy and not a policy for each hospital.

Mr HOUSE: Was that prior to Michael Moodie trying to pull the thing into gear?

Mr Copp: No, I think that was a result of -

Mr HOUSE: Of your direction?

Mr Copp: Yes, well -

Mr HOUSE: So he acted after that?

Mr Copp: Sorry. No, this is as a result of our review of the trust accounts. We understood that the trust accounts in the other hospitals might be operating like this. I understand that the government procedure was that it should be a process across the health system, and not just one hospital. Our understanding of how the government structure worked was that there was the Metropolitan Health Service Board. We looked at it as a business process. The business process should be similar across the various hospitals. It should not be any different.

Mr DEAN: One would think so.

Mr Copp: We were saying that someone needed to make a decision, call the shots and say how it would operate in the future, and not just one hospital on its own.

The CHAIRMAN: Do you know whether the Metropolitan Health Service Board gave it such a direction?

Mr Copp: I do not know.

The CHAIRMAN: Did you find that financial controls were a problem because there was no centralised reporting? Was the fact that no-one knew a contributing factor? The Health Department did not know what was happening at each of the hospitals. Was that a factor in causing the problem?

Mr Copp: The fact that they treat them as different from normal accounts contributed to the problem. They did not have the scrutiny and oversight that one would normally put them under.

Mr Larkan: One of our internal QA procedures into root cause analysis indicated that oversight or central reporting might well have contributed to improved structures.

Mr BRADSHAW: I noticed that when you did the report in 2000 you said management freeze trust accounts where identified as containing suspicious transactions. When you came back in 2001, did you find that any of those trust accounts had been frozen?

Mr Larkan: No.

The CHAIRMAN: In other words nothing happened.

Mr Larkan: Not as far as we can comment on.

The CHAIRMAN: One issue that has been highlighted for us is the Megazone, which has received a lot of media publicity. You must have known that we would eventually get to the Megazone at Princess Margaret Hospital for Children. Did you have a look at this process?

Mr Copp: No. We were not involved with Megazone until Mr Moodie, and then Mr Weeks asked us to look at the Whiteman fund. We were not involved with Megazone at all.

The CHAIRMAN: I know you were not involved with the Megazone side of it, but did you have a look at the approval processes, the structures or use of the funds?

Mr Copp: No.

Mr Larkan: We conducted the review on Megazone only as it pertained to the Whiteman funds. It posed a lot more questions.

The CHAIRMAN: That was what I was alluding to - the funds going in and out. The transactions would have appeared to fix the process. As auditors, you obviously took a look at that.

Mr Copp: We did not look at that process. The only thing we looked at was the Whiteman funds. If I recall correctly, it was an amount of $500 000.

[12 noon]

The CHAIRMAN: I thought it was $2 million.

Mr Copp: It was $2 million, but there was a $500 000 shortfall.

The CHAIRMAN: Explain that.

Mr Copp: I understand from the transcript that there was a $500 000 shortfall.

Mr Larkan: The Whiteman funding made up the shortfall for the Megazone development. One of the clinicians raised that issue with Mr Moodie, and he asked us to look at it. We told him that this money effectively came from the Princess Margaret Hospital for Children Foundation, which is an external body that we could

not audit. That raised a number of other questions about the destination of bequeathed money, and the processes for building within the hospital premises etc. That was the sum total of our review. We were excluded after that.

Mr Copp: The funds were meant for PMH, and we asked why they ended up in the foundation.

The CHAIRMAN: That is the question I was going to ask. Did you look at that process? You asked the question; you obviously had concerns.

Mr Copp: We had concerns, but we were not able to look at the process. We asked why the money went into the foundation when it was willed to the hospital.

The CHAIRMAN: What answer did you receive?

Mr Copp: That they would deal with it.

The CHAIRMAN: To whom did you ask the question, and who gave the reply?

Mr Larkan: We asked Mr Moodie, and he took it to the Metropolitan Health Service. He said that they were dealing with the issue. We met with Mr Weeks and Mr MacCall, and they looked after it from there.

The CHAIRMAN: Were you aware of only the transfer; not the decision to take the money back?

Mr Copp: No. I read that in the transcript. KPMG looked at the Megazone issue. I did not know about the discussion with the Office of the Auditor General. We were not involved in that.

The CHAIRMAN: How much of a problem is the Australian Medical Association agreement with the hospitals? You state in the reports that the AMA agreement for arrangements A and B and so on is a problem in itself. Why is it a problem and how does it create problems? You obviously see it as concern, and the issues are clouded. How is it a problem, why is it a problem and what can we do to fix it?

Mr Larkan: The agreement is a concern because it is not specific in a number of areas, which has resulted in different interpretations at each hospital about where the moneys from the private practice arrangements should go. The agreement states that they are to go into the trust, but there is no trust; they are special purpose accounts. When the administrators were questioned about that, they said that in this case they were trusts. However, the accounts do not conform to the requirements for trusts. The trust is not named in the agreement; there could be a number of trusts. A range of issues surrounding the agreement need to be tidied up.

The CHAIRMAN: I have read all your reports and recommendations. You make comments in the bulk of the report but do not give any recommendations about how the arrangements in the AMA agreement can be fixed. That is fundamental. You address the trust, and say that the AMA agreement is a problem because it allows grey areas. Is that the only grey area? Do the arrangements themselves need to be questioned?

Mr Larkan: There are a couple of issues. Those are outlined in more detail in other draft reports. We defined this to make it more pertinent.

The CHAIRMAN: We do not have those reports.

Mr Larkan: No.

The CHAIRMAN: Can you give us a copy of those reports? I think they are fundamental to fixing the problem. You mention in one report that the agreement is a problem in itself. Will you talk about some of those issues? The agreement is fundamental to our report, and we need to highlight why it is a problem.

Mr Copp: We will get that information for the committee. The information suggests in a more explicit and definitive manner how the agreement should be structured to remove the various shades of interpretation within it. If I were the administrator, I should be able to ascertain from the agreement exactly how the accounts should be set up and so on. It comes back to governance structures - how they should be set up and who will be accountable for them.

Mr Larkan: Certain areas in the current agreement state that the process shall be A, B, and C, and then gives option D, which is "or by any other arrangement". We cannot audit that exception.

The CHAIRMAN: Does this mean that people can sign up to this agreement and have the ability to influence the process? In other words, if I signed up to this agreement, could I write my own arrangements?

Mr Larkan: The factors with which it might be necessary to comply may be sidestepped through some other arrangements, as long as the parties agree to them. That is the sort of issue we are getting at with the AMA arrangements. I will get those details.

Mr WHITELY: The executive summary of your report dated 20 September states -

> We have obtained sufficient documentary evidence from all four of the tested accounts to prove that clinicians have been bulk billing Medicare in their own names for attending patients who have elected to be treated as public patients.

You have described potential problems with funds from bulk-billing being used to avoid tax. That statement highlights a problem at the other end of the equation; that is, the fact that people who are paid by the State are also bulk-billing Medicare and getting paid by the federal Government. Do you want to elaborate on that, or have I misread the statement?

Mr Copp: No, you have not misread it. The clinicians would be paid by the State and also bulk-billing for the session.

Mr WHITELY: Are there any circumstances in which that is legitimate behaviour?

Mr Copp: That is the question we raise. We ask if that is appropriate.

Mr Larkan: That relates particularly to the cleft lip and palate scheme at Princess Margaret Hospital and the country diabetic outreach program. Again, it comes down to those few accounts, and they are the two main areas. The clinicians are attending to patients and then bulk-billing Medicare. There are two possibilities. One is that they are bulk-billing Medicare and the money is going into the trust or into special purpose accounts, which is what we talked about earlier. That is the process that is being used.

Mr WHITELY: Are there any legitimate circumstances in which somebody who is paid by the State can bulk-bill? I cannot think of any answer to that question. It seems that the doctor is being paid twice. Can you put any other spin on it?

Mr Larkan: That is the potential. The AMA agreement allows that possibility to happen. It is very difficult to control.

Mr BRADSHAW: As far as I know, if a patient goes to a public hospital, there is no way the clinician should bulk-bill Medicare, because the hospital is managed by the State. I think there are special arrangements through which the hospital leases an area to a doctor, but that is a different story. I thought that it was illegal to bulk-bill under those circumstances.

Mr Copp: It comes down to whether the patient elects to be a private patient or public patient. The patient has to indicate that when he signs in so that it is keyed in properly to what is called the "TOPAS" patient administration system.

Mr Larkan: Everyone had an opinion about when people were and were not able to do that. We said the best thing was to get the Health Insurance Commission to rubber-stamp whichever model was chosen.

Mr WHITELY: For a public patient, what are the circumstances in which that could occur? I cannot imagine any.

Mr Larkan: There are none as far as I know.

Mr WHITELY: It is pretty straightforward.

The CHAIRMAN: I refer to the last special purpose accounts audit, which is dated September 2001. That was delivered a few months ago. These are the accounts that we were talking about earlier, but everybody calls them trust accounts.

Mr Copp: Standard hospital term.

The CHAIRMAN: In essence they are not trust funds; they are special purpose funds.

Mr Larkan: Yes.

The CHAIRMAN: I was worried by the statement -

> The Trust And Special Purpose Accounts at SGCH, FH and RPH are all formed under the auspices of s36 (2) of the Financial Administration and Audit Act 1985 (FAAA). The Reference Group have received verbal advice from the office of the Auditor General and State Treasury that the hospitals should apply Section 36(2) and section 21 of the FAAA to address Trusts in the hospital scenario. Both parties acknowledge that the application of these sections . . . is not strictly legal but it is a compromise.

I find it extraordinary that the Auditor General and/or Treasury would make a comment that this practice is not legal but a compromise. Is there not another way of doing it to make it legal?

Mr Larkan: The Auditor General expressed concern about the wording. He believed that it gave the impression that we heard that first hand. A subsequent letter explains that the reference group was verbally provided with that feedback from one of its members. We did not hear it directly.

The CHAIRMAN: Does that mean that the Auditor General is not saying that things should be done that way?

Mr Larkan: Definitely, according to the representative I spoke to.

The CHAIRMAN: I thought it extraordinary that an Auditor General would suggest a way of doing something that was not legal. My interpretation of the Auditor General's role is to make sure that practices are legal.

Mr Larkan: That was the representation one of the committee members made to the committee.

The CHAIRMAN: Did the process that was adopted conform to section 36(2) of the Financial Administration and Audit Act?

Mr Copp: No.

The CHAIRMAN: Are you saying that, despite whatever the Auditor General is saying, the advice to the reference group was to operate the accounts in a way that is basically illegal, and that that is what is happening?

Mr Larkan: The administrators have been using the auspices of section 36(2) for some time, but the accounts do not comply with that. They do not meet the requirements of section 36(2), which relates to holding money for third parties. Special purpose accounts cannot be held for third parties; therefore, the administrators should not use section 36(2) as the mechanism.

The CHAIRMAN: That raises a range of issues. If that is happening, the Auditor General might have to be questioned about why it is being allowed. Is it correct that it basically takes the accounts out of the normal audit processes of the hospital system? You say the administrators are using section 36(2), which relates to third parties. If no third parties but only the hospital has control of the accounts, they should go through the normal auditing process. Is my understanding correct?

Mr Larkan: As far as I am aware, yes.

The CHAIRMAN: We obviously need to ask the appropriate authorities. Did you find that process right across the board or in specific hospitals?

Mr Larkan: Every hospital was using section 36(2) of the Financial Administration and Audit Act as the mechanism.

The CHAIRMAN: As a layperson who does not understand what that means in real terms for auditing, what is the difference between the two processes?

Mr Larkan: The special purpose accounts were called trust accounts when they were put together. The administrators are saying that they come under the terms of sections 36(2) and 21 of the Act, which means money can be received and spent under a deed, and invested in separate bank accounts. The accounts do not meet the requirements of section 36(2) in that in the main they are not trust accounts for moneys held for third parties; therefore, they should be normal ledger accounts.

Mr Copp: They are the main operating accounts.

Mr Larkan: They should be subject to normal budgeting oversight, reporting and activity monitoring; that sort of thing. They are not.

[12.15 pm]

The CHAIRMAN: Who actually makes up the reference group? This obviously is a bureaucracy dealing with a bureaucracy. Who was on the reference group that gave this direction?

Mr Larkan: It comprised Mr Mike Blake, Mr John Burns, Mr John Doyle, Mr Philip Aylward, and a representative of the Australian Medical Association, whose name I do not recall at the moment.

The CHAIRMAN: Can you, as auditors, explain to us what the possibilities might have been as a result of doing it this way, under section 36(2)? Could any questionable conduct arise as a result of this process?

Mr Larkan: The whole premise on which the trust accounts are based needs to be questioned. If they meet the requirements for using section 36(2), why do we even go down that track? That is the question that needs to be asked. I have just remembered that the other person on the reference group was Dr Geoffrey Dobb.

The CHAIRMAN: The other question you raised is the initiative not being developed in a manner that enables standardisation across all hospitals. That obviously refers to the implementation processes. Have you made recommendations in relation to that? Tell us why there is no standardisation of processes. I appears to be quite simple. It is not reinventing the wheel. What must be done appears to be fairly clear-cut, and yet you are saying that the initiative has not been developed in a manner that enables standardisation across all hospitals. I find that amazing. Can you tell me why this has not occurred in a form that is acceptable?

Mr Copp: The reason there is no standardisation - again, this is my own opinion - is that each hospital tries to have a separate, unique identity, and tries to look at itself as a stand-alone group. I would have expected, where there are common processes in the hospitals, that there would be one way to do it, which would be determined by an oversight authority. My understanding is that each hospital had its own board for some time, and they were treated somewhat autonomously. That culture is quite strong. If someone then comes along and tries to impose some standardisation of process across the hospitals, there would be some cultural impediments.

The CHAIRMAN: They would be cultural impediments to doing the right thing.

Mr Copp: From an efficiency point of view, I would expect that. As in my earlier example, a payroll process is a payroll process. In any organisation, in principle the same process happens. It would be easy to put a standardised process in place for these accounts. Looking into the business processes, even the terminology for referring to certain accounts was quite different between the hospitals. Overall, it comes down to the simple fact that if there is a common process, it should be the same across all the hospitals in which it is implemented. The question is, who will drive that implementation and say that this is how it will happen in the future?

The CHAIRMAN: You have made another comment here, that the closure of some accounts should be compliant with legislation.

I have just been advised that the audio system has failed, and the committee will therefore adjourn until 1.30 pm. That will allow an hour and five minutes to get the system working again. If there are any problems with some of the evidence just taken, will Hansard please inform the committee so it can obtain that evidence again?

Proceedings suspended from 12.25 to 1.30 pm

Mr Copp: I was commenting on the history of how the hospitals came to the MHS. We looked at only one hospital at the start. We did a review and to us the process could have been standardised across the hospitals. I guess one size fits all. The hospitals are there to make people better. I understand the teaching hospitals are there to provide teaching and do some research, if that is one of the core requirements. We should stand back and ask what are the core processes and apply them across the hospitals.

The CHAIRMAN: You also referred to taxation and the implications of the specific transactions conducted through the accounts. It is your view that it creates exposure to fringe benefits tax. Where does the fringe benefits tax come in? What about payroll tax, superannuation, workers compensation and the issue of taxation donations? Where does the fringe benefits tax problem arise?

Mr Copp: If I recall, there was a change in legislation in April 2000, whereas previously hospitals were exempt from fringe benefits tax.

The CHAIRMAN: I am not sure how fringe benefits tax affects this operation.

Mr Copp: For instance, if anything of a personal nature is incurred through these accounts that the hospital has paid for, some fringe benefits tax implications may arise for the hospital.

The CHAIRMAN: We are now talking about the special accounts not the trust accounts. The trust accounts would be a separate issue.

Mr Copp: In the case of a trust account with a separate trustee that is properly formulated; that is the trust's obligation because it is separate from the hospital.

The CHAIRMAN: There is no fringe benefit there.

Mr Copp: Fringe benefits tax deals with special accounts.

The CHAIRMAN: Are you saying that if someone uses funds from a special account for personal benefit, it could be a problem?

Mr Copp: If the hospital paid a benefit to an employee, that could also have fringe benefits tax implications. The hospitals would have to be aware of their remuneration programs and schemes to ensure they are calculating fringe benefits tax liability appropriately.

Mr Larkan: Particularly for training, entertainment and that sort of thing - overseas travel and extended stays beyond or before a course or seminar.

The CHAIRMAN: That would not be paid out of those accounts would it?

Mr Larkan: Yes. The special purpose account is used to pay for the training; it is not a real trust.

The CHAIRMAN: The training is okay. If someone goes to a conference there is no problem; there is no fringe benefit there. Only if the stay were extended and the person went to Hawaii for a holiday would fringe benefits tax be incurred.

Mr Larkan: Yes.

The CHAIRMAN: Do you have evidence that they were getting extra holidays paid for?

Mr Larkan: We were given to believe that people extended their stays either before or after conferences or courses, and it is important to look at the process to ensure that they accounted for it correctly in terms of fringe benefits tax.

The CHAIRMAN: Do you have evidence that these extended stays were being paid for by the trust fund?

Mr Larkan: I cannot answer that offhand.

Mr Copp: Before this change in taxation in relation to fringe benefits tax, I assume there was no need to maintain travel diaries and items of that nature to justify expenditure to get around fringe benefits tax. We were highlighting that where

expenditures come out of special purpose accounts and some personal benefit arises from that, they would have to be aware of the fringe benefits tax implications.

The CHAIRMAN: I understand that. There was no evidence that there was any personal benefit. Are you saying that if there was any personal benefit, people should be aware that they could be seen as fringe benefits?

Mr Copp: Yes.

The CHAIRMAN: You also suggested we should get legal and taxation advice on variations in the application of the AMA agreement by the hospitals in relation to the allocation of private practice receipts. Are you referring to real private practice receipts rather than the bulk-billing stuff? It is their right to have private patients and bill privately. Are you suggesting that some of those receipts were put into their trust accounts?

Mr Larkan: We are suggesting that treatment required under the agreement is different at each hospital and we need to look at that to ensure they are exactly the same and that the funds go into the right place and are controlled correctly.

The CHAIRMAN: Why would private funds from private practices go into any account to do with the hospital?

Mr Larkan: Because under schedule A and schedule B of the agreement, revenues are split between what the doctor can keep in his private capacity and a proportion that must be paid into the hospital.

The CHAIRMAN: Is the proportion for the hospital a lease fee or hire fee for service?

Mr Larkan: They go into the trust.

Mr HOUSE: Is this not for the administrators to examine?

The CHAIRMAN: It is, but I am not sure why we need the legal advice.

Mr HOUSE: We do not need it, do we? Surely this is not a job for this committee.

Mr Larkan: Yes.

The CHAIRMAN: The issue concerns how the funds are paid into a trust fund. I am asking if some untoward activity occurs that warrants legal advice.

Mr Larkan: The suggestion was to look at the AMA agreement to ensure it is being applied correctly, in the way it was meant to be applied. Again that is open to interpretation. People give us different interpretations. That is our personal interpretation. It might be different from that of the administrator or the clinic. We are saying the committee should receive some concrete legal advice so that it is signed and sealed. We can apply them on a consistent basis.

The CHAIRMAN: Is the issue of research funds and trust funds that are used and ownership of the intellectual property a great problem?

Mr Copp: I guess it is something to look at in the sense of who is undertaking research: is it the hospital or the individual clinician? If the research is done by the hospital, who owns that research outcome. Is it the individual doctor or the hospital?

The CHAIRMAN: Is this being done out of the trust funds? Is that what you are asking?

Mr Copp: Yes, they would go to a medical company of some sort. They would effectively want the hospital to run studies, but through the doctor.

[13.45 pm]

Normally a research trust fund account would be set up to oversee and administer the research. In this case, the doctor would say that the funds are his for his specific research grant; therefore, he had run off a separate trust account. He would expect to then be able to dispense the funds for the research in an appropriate manner as he saw fit. The issue is about whether the hospital or the individual doctor controls the research project. The hospital may delegate some control of it, but also the doctor must be accountable to the hospital for the outcomes of that research. The accounts appear to be treated as though they are not hospital funds; rather, they are regarded as being the doctors' funds.

At the end of the day, if something goes astray or must be accounted for or audited properly, the hospital must have some direct accountability over that account. In other words, the hospital administration cannot say that a particular doctor was doing the research and the funds are his and, therefore, the hospital does not have to worry about it. By the same token, the doctor cannot say that he does the research that the medical company wants him to do and therefore the funds are his and he can do with them what he sees fit. Who does the research, and on what basis? Is it the hospital's research? Hospital resources, including equipment, are being consumed. Doctors would undertake research that has been properly costed. What consumables other than time and staff expenses are involved? We do not understand why funds must go into a special purpose account unless there is a reason for it. A separate chart of accounts should be kept track of. We suggest that the responsibility for research could be taken away from the hospital and a separate research committee or fund could be established to oversee and monitor the fund. Therefore, a research company would focus on research and the hospitals would do pure clinician work and look after the public. I do not understand why a special purpose account for research funds would have to be established unless they are specifically dictated that that is how it should be done.

Mr Larkan: There is a real risk that the research conducted by the Royal Perth Hospital may result in something that can generate a lot of funds for the hospital and that ends up in a clinician's personal capacity although the hospital had funded it and provided the funds to conduct that research. That risk must be addressed.

Mr Copp: That is an opportunity for revenue. We have highlighted the question: who owns the intellectual property? Is it the doctor conducting the research under the guise of an employee or who is contracted by the hospital? Does the intellectual property belong to the doctor or the hospital?

The CHAIRMAN: The report summarises a pile of the Government's administration, most of which have been covered already. However, the overdrawn balance existing in some of the accounts has not been covered. The report indicates that that is contrary to hospital policy, which prohibits this occurring. Were discussions had with some of the finance administrators at the hospitals? Did they give reasons for why these accounts were overdrawn?

Mr Larkan: In a nutshell, we had discussions with the administrators and the reasons provided were timing differences between revenue and expenditure, which would be addressed.

The CHAIRMAN: How can revenue be spent in a trust account that does not have any money? Do the administrators anticipate that it will be paid over so that they make the decisions in advance?

Mr Larkan: I do not know whether decisions were made, it just happens. Until somebody asks the question, it is not considered.

Mr BRADSHAW: Are there bank accounts for each trust, or is it a global account with book entry?

Mr Larkan: It is the book entry type. Each trust does not have its own account; they are consolidated accounts.

The CHAIRMAN: The report states that no interest was charged on those accounts. What did the financial controllers of the hospitals say about that inadequate process of having no interest and having overdrawn accounts?

Mr Larkan: What did the financial controllers of the hospitals say about -

Mr Copp: There have been attempts at interest allocation, which we found interesting.

Mr Larkan: That is interest received.

The CHAIRMAN: Tell the committee why you found them interesting.

Mr Larkan: Interest is received on the consolidated accounts and that is distributed to the accounts. Mechanisms that vary from time to time are dependent on the management's discretion. However, interest is not charged on overdrawn accounts. How can interest be paid on accounts that have funds available while interest is not charged on overdrawn accounts? Management's discretion was cited as the reason.

The CHAIRMAN: The administration likes subsidising private accounts.

Mr Larkan: I could not pass a comment on that.

Mr Copp: Either improper allocation of finance charges occurs or the right policy is not followed.

The CHAIRMAN: What is meant in the report when it states that there is a lack of hospital boards and that the Metropolitan Health Services board has helped result in fuzziness of these accounts? Have boards not had enough control over the process?

Mr Copp: The fuzziness refers to who has the real understanding within the hospital and the board about how these accounts are meant to work and what they are.

Mr Larkan: That includes the governance in terms of the consistency. For instance, at the Fremantle Health Service, the chief executive takes a keen interest on certain expenditures within those trust accounts, although certainly not all of them. He reviews some of the expenditure with great interest. However, at some other hospitals there is no indication that they look at any of it; therefore, there are inconsistencies. Other than the person who controls the account, a body does not oversight the account.

The CHAIRMAN: That is a problem because the beneficiary of the account could oversight it.

Mr Larkan: Absolutely. Nobody is looking at the financial activity of those accounts. By connotation, a special purpose account has a special purpose. It must come to an end and progress must be made towards that end. People have not monitored that progress and the expenditure of funds and the completion of the special purpose. The general governance of the administration does not seem to gel.

The CHAIRMAN: The report states that revenue that should have gone to the hospital operating funds went to the trust accounts. Does that refer to normal

operating funds that have been allocated by the Government? The committee was told of money for the Sir Charles Gairdner Hospital that was meant to be allocated as part of the normal operating budget went to a trust fund and suddenly the hospital came up with millions of dollars that had been siphoned off into a trust account.

Mr Larkan: We have termed "normal operating" as activities conducted by the hospital that generate revenue; not funds that go to the hospital's operating accounts, but which go to the special purpose or trust accounts.

The CHAIRMAN: Therefore, it is not operating money that has come from a government source. Is it operational money?

Mr Larkan: Yes. Some of it may be for radiology, which comes from federal funding.

The CHAIRMAN: Are you saying that in the case of radiology, work that was done by radiologists that should have gone to the hospital accounts went to private accounts?

Mr Larkan: It was done at the hospital and it has gone into the special purpose account.

The CHAIRMAN: Did the money come from the bulk-billing system?

Mr Copp: It could be bulk-billing. Say in the case of -

The CHAIRMAN: Someone would have had to pay for those X-rays.

Mr Copp: Exactly. The money would have been paid. It did not hit what I would normally call the consolidated revenue account, which is the operating statement; it would have gone into this special purpose account.

The CHAIRMAN: Radiology is done at a hospital and the revenue from that, which could have come only from the federal Government - a private patient does not have private X-rays and pay. Are you saying that that money went into a trust account - a private fund?

Mr Larkan: Yes, certain activity by the hospital went into one of those specific funds.

The CHAIRMAN: Does that not throw different scenarios into the equation including that there are only two trust bulk-billings?

Mr Larkan: No, those two trusts involved the King Edward Memorial Hospital for Women and the Princess Margaret Hospital for Children.

The CHAIRMAN: The process is still the same: Money coming from the federal system is going to supposedly private accounts; those accounts are special accounts but are under the control of trustees.

Mr Larkan: The report states that funds from Medicare need to be looked at in the business process review, which we did not look at.

The CHAIRMAN: You have seen examples whereby funds from Medicare that should have gone to the hospital operating account -

Mr Larkan: I am not sure where they should have gone. However, there are funds from Medicare in those accounts at the other hospitals. Whether they should be in there or not is what we say should be examined. We never went down that path under the business process review.

The CHAIRMAN: Do you not know whether they are bulk-billing patients or not?

Mr Copp: Exactly; that was not the intent of our inquiry.

The CHAIRMAN: You were not examining that issue but this committee will. Will you identify those accounts so that our people can take that one step further and investigate whether they are funds that should have gone to the hospital that went into private accounts?

Mr Copp: They would be in the report.

Mr Larkan: I will examine which ones we can identify. We have loaned about 30 or 40 files to the Office of the Auditor General for its investigation. That office might have some of that information. I will see what we can do.

The CHAIRMAN: That is critical to the argument because it opens up a different area. Item 6 of the report states that revenue from Medicare is receipted to the accounts and that occurs with Medicare revenues to the hospital. At other times it relates to doctors depositing their Medicare cheques into trust accounts. Is this bulk-billing or some other thing I do not understand?

Mr Larkan: It refers to the bulk-billing that I referred to previously.

The CHAIRMAN: What is meant by revenue from Medicare is receipted to the accounts? Does that mean the revenue goes into operating funds.

Mr Larkan: No, it goes into the special purpose or trust accounts.

The CHAIRMAN: Do the doctors give cheques to a hospital to put into this account in their own names? Is that legal?

Mr Copp: That is the question we raised in this business process review.

The CHAIRMAN: Revenue from pharmaceutical companies has been received, which the ethics committee could not directly link to a particular review. In other words, are pharmaceutical companies giving money to anything, or do they know what it is for? I do not understand what that means.

Mr Larkan: Generally, the ethics committee examines why funds are given; for example, for medical testing and trials. However, some receipts were made that did not go via the ethics committee and could not be tied to specific trials.

The CHAIRMAN: Is it known where those moneys went?

Mr Larkan: The moneys went into special purpose accounts.

The CHAIRMAN: Did the funds go to specific people? Were the funds given to specific programs; for example, the cleft palette program or special tests? Was the investigation taken one step further to determine whether moneys were spent on legitimate programs?

Mr Larkan: We could not tie that funding back to a specific review.

The CHAIRMAN: Why would a pharmaceutical company make a donation for no specific reason?

Mr Larkan: I am not sure.

Mr Copp: I do not know.

Mr HOUSE: You tell us, Mr Chairman.

The CHAIRMAN: I am not sure. If I knew the answer, I would not have asked the question. The report also states that moneys were expended that may be considered

extravagant in some cases. What are these extravagant expenditures? So far I have not seen any examples of it.

Mr Larkan: One good example is when a $100 bottle of wine was ordered with dinner.

The CHAIRMAN: Please tell me that again.

Mr Larkan: In one instance a rather expensive wine was purchased.

The CHAIRMAN: Was it purchased with money from a trust account?

Mr Larkan: Yes.

[2.00 pm]

Mr HOUSE: Do any of the trust accounts have credit cards or cheque books attached?

Mr Larkan: Not that I am aware of.

Mr HOUSE: How do the doctors withdraw the money? Do doctors have to ask hospital administrators for a withdrawal?

Mr Larkan: Yes. Money is refunded when receipts are produced or through the normal hospital ordering system.

Mr HOUSE: A reimbursement system?

Mr Larkan: Yes, and through the normal purchasing processes. We were told about two months ago, in December, that the accounts clerks do not query those sorts of things because they are not in a position to do so.

The CHAIRMAN: Surely an accounts clerk would query a $100 bottle of red wine?

Mr Larkan: No.

The CHAIRMAN: Obviously there is a problem with the system. Someone should be able to query such expenses. How would anybody know whether the whole dinner was paid for by a trust account?

Mr Larkan: It is an oversight. Again, it is form over substance.

The CHAIRMAN: Do you have a number of such examples of such expenditure?

Mr Larkan: We should be able to provide some.

Mr Copp: I have never spent more than $100 for a bottle of red wine.

The CHAIRMAN: Especially paid for by a trust fund.

Mr HOUSE: After this hearing not many doctors will invite you out for dinner!

Mr Copp: I have not received any invitations for a long time!

The CHAIRMAN: The report contains a comment that expenditure was claimed on a refund basis quite regularly and that that bypassed all controls and approvals. Is that the norm or just isolated cases?

Mr Larkan: For some types of expenditure it seems to be the norm. Other items are generally bought through the hospital using the trust account.

The CHAIRMAN: It seems strange, even ludicrous, that things can be claimed after the event. It seems that there are no controls; no nothing. Do you have further examples that investigators should look at?

Mr Copp: What sorts of examples do you want?

The CHAIRMAN: The comment in the report was obviously made based on some evidence otherwise it would not have been made. You knew the statement would come into the public arena so you must have examples.

Mr Larkan: Maybe I should forward copies of this report cross-referenced to examples that we have.

The CHAIRMAN: Thank you, that would be great.

Mr HOUSE: I would like to see the details of what came in and went out of a particular operating account over a 12-month period.

The CHAIRMAN: I understand that but if we can identify where the accounts come from we can ask our people to physically examine all the transactions of an account. If we are provided with examples we can ask our people to examine the transactions. It has currently only been done on a sample basis.

Mr Larkan: We looked at very few samples just to see how the process was working.

Mr HOUSE: That is why I think some of these things should be examined in context, all jokes aside. I would like to see what fits into the spectrum.

Mr Copp: The committee is looking for exceptions. There is no sampling process involved that is consistent.

The CHAIRMAN: You looked at about 10 per cent of the samples?

Mr Larkan: Probably less than that.

The CHAIRMAN: It was a very small sample?

Mr Larkan: It is very difficult to look at the accounts because they contain a number of journal entries. It is not clear like a normal account such as a bank statement. It is very difficult to go through and pick out the entries.

Mr Copp: You end up doing a reallocation of expenditure through journal entries. You have to compare the journal entries with when they were raised.

The CHAIRMAN: You made the comment that the high number of transfers between funds, the clouding of the special purposes and the portfolios of accounts were the cause of many journals being inconsistent with hospital accounts. What did you mean? Did you mean there were transfers going in and out without control?

Mr Larkan: Some hospitals managed the accounts as a portfolio so that Dr X had six or seven accounts. The hospitals were responsible for them and treated them as a portfolio and could do anything between the accounts. Other hospitals did not treat the accounts that way. They created lots of journal entries that simply cloud the issue when it comes to tracing transactions.

The CHAIRMAN: Did you recommend a way to fix the problem?

Mr Larkan: It requires a fundamental look at the accounting systems and processes.

The CHAIRMAN: I note that capital projects managed through trust accounts caused some concern. Some hospitals required large transfers between operating accounts and trust accounts. Why are they doing that? Are there any controls? Control can be lost if capital is put into trust accounts as it can bypass the process. Did you find any examples of that happening?

Mr Larkan: We did not look at capital expenditure from trust accounts. Ostensibly, the accounts were created to isolate the money and make sure that it is spent on what it is meant to be spent on. That system is operational in only two of the hospitals.

The CHAIRMAN: Did you see accountable processes for those trust accounts? If money is put into a trust account, whether or not it is spent, it is spent from the Government's point of view.

Mr Larkan: We did not look at those trust accounts. We asked for a complete list of trust accounts and it was provided to us after we found another set of accounts that were not described as trust accounts. They were described as special purpose accounts. When we finalised the report we asked them to ensure there were no other accounts that should have been disclosed to us.

The CHAIRMAN: The accounts were hidden?

Mr Larkan: They were not proffered as trust accounts when we looked at the trust accounts business processes. These and another four accounts were not shown as trust accounts.

The CHAIRMAN: How much money is involved with the accounts?

Mr Larkan: I am not able to say offhand.

The CHAIRMAN: Is it thousands of dollars or millions of dollars? I only want a round figure; I do not need specifics.

Mr Larkan: I will not hazard a guess. Are you interested in all accounts across the system?

The CHAIRMAN: No, just these accounts. To a layperson, they appear to be a way of not accounting for money.

Mr Larkan: I can get the details but I do not have them at hand.

The CHAIRMAN: Will you pass them onto our staff? Although you say these accounts are not trust accounts, are they reported in the normal reporting processes for expenditure for hospitals? Are they reported to the commissioner, the minister and the Government?

Mr Larkan: I was given to believe that they were.

The CHAIRMAN: The records show clearly that money was spent at a specific hospital for a specific purpose and reported back to the Government?

Mr Larkan: That is what I recall.

The CHAIRMAN: The report comments on trust accounts and special accounts being transferable between hospitals. I found that intriguing. How can there be transferability between trust accounts? If Dr X moves from a hospital is he able to take the trust funds with him?

Mr Larkan: Yes, we found an example of that. That flew in the face of the claim that the funds belonged to the hospital. That is why that was raised as an issue.

The CHAIRMAN: The comment was made that the funds transferred were substantial. Can you provide the committee with account numbers so that that can be checked? A finance administrator or somebody had to transfer the funds. It obviously begs the question, why were the transfers made? What were the responses?

Mr Larkan: That it was what the trust account holder wanted.

The CHAIRMAN: That the trustee, who was also the beneficiary, wanted the funds transferred?

Mr Larkan: That is right.

The CHAIRMAN: In that example, the funds went from Princess Margaret Hospital for Children to where?

Mr Larkan: I think it was from Sir Charles Gairdner Hospital to Royal Perth Hospital.

The CHAIRMAN: We have looked at King Edward Memorial Hospital and Princess Margaret Hospital. It seems that the problem of trustees and controlled accounts is spreading to Royal Perth Hospital and Sir Charles Gairdner Hospital. Is that what you are saying?

Mr Larkan: The processes are very similar across the hospital system.

The CHAIRMAN: It is not just Princess Margaret Hospital and King Edward Memorial Hospital - the accounts exist in all hospitals?

Mr Copp: All five teaching hospitals.

Mr Larkan: The schedule shows 1 093 trust accounts across all the hospitals.

The CHAIRMAN: Did you find that the problems you alluded to are endemic to them all?

Mr Larkan: The vast majority.

The CHAIRMAN: All the hospitals?

Mr Larkan: Yes.

The CHAIRMAN: We have received evidence that suggests the committee should approach Fremantle Hospital because the chief executive officer of that hospital is the guru of how trust accounts should or should not be managed. What is your view of that? Have you looked at those accounts? Have you formed a different opinion on the operation of those accounts?

Mr Larkan: No, Fremantle Hospital accounts show more control but not to the standard we would expect.

The CHAIRMAN: Are there problems with those accounts as well?

Mr Larkan: Yes.

The CHAIRMAN: Would you like to provide further comment? We were told that if we wanted to look at how things should be done we should look at Fremantle Hospital. Those were not the exact words, but it is essentially what was meant.

Mr Copp: There is clearly more scrutiny at Fremantle Hospital. The basic process and cultural issues also exist. It is an area on which we had some debate as to how the accounts came about. The review shows that they need some work. The committee has our reports on that. It may be better for representatives of Fremantle Hospital to put their views on how they should operate.

The CHAIRMAN: We will do that. We are intrigued as you obviously know this area quite intimately and it would be nice to get your view of this.

Mr Larkan: A few years ago Fremantle Hospital had an overhaul of its trust accounts. It trimmed back the number of accounts. The amount and value of the funds used at Fremantle Hospital are a lot smaller. It is a much smaller set-up. The

cultural and accountability issues exist there as in the other hospitals. The same governance issues exist. Governance of the accounts is kept at Fremantle Hospital. No-one else has oversight over this. There is no transparency outside Fremantle Hospital.

The CHAIRMAN: The documentation refers to an incident involving doctors at Princess Margaret Hospital in which one of the clinicians was referred to as undertaking questionable activities that should have been referred to an outside authority. That was referred to you formally to look at. Through your investigations, did you think there was any substance to the allegations? If so, was the matter referred to the appropriate authorities?

Mr Larkan: We did not actually investigate that. In the draft report of September 2000 we acknowledged that some incidents needed to be referred to an outside authority for further investigation. That caused some concern to the audit committee as it believed that fogged the report somewhat.

[2.15 pm]

We took that out of the report and submitted it in a letter to the audit committee detailing their responsibilities in terms of reporting it to the external or outside agency.

The CHAIRMAN: However, to do that you had to carry out a basic inquiry. I am trying to establish if that matter was referred on, and did it have substance in the way it was being operated because there was an allegation from another clinician about a clinician which was referred to you to look at.

Mr Larkan: It was possible that it had some substance. However, we did not take a view on that. We did not do a forensic investigation but referred it on -

The CHAIRMAN: Can you provide the committee with a copy of the letter that was sent to the audit committee?

Mr Copp: Yes. There is a copy of it in the file. Basically, there was allegations of defalcation. We were forwarded a copy of correspondence from the clinician who did not want to cloud the report with that one specific incident. We reported it to the audit committee and advised it to seek legal opinion on the issue and on the reporting requirements of that issue.

The CHAIRMAN: Did you get cooperation from the audit committee?

Mr Larkan: I have only got a copy of the correspondence from the acting chief executive of the King Edward Memorial Hospital for Women stating that the matter had been dealt with in-house. I have no other knowledge of any other action.

The CHAIRMAN: Was any member of the audit committee part of the allegations?

Mr Larkan: As far as I can recall, no.

The CHAIRMAN: You mentioned King Edward but I was referring to Princess Margaret Hospital for Children.

Mr Copp: I am interchanging them.

The CHAIRMAN: Is the PMH one -

Mr Copp: Yes.

The CHAIRMAN: Another example referred to was a diabetic clinic.

Mr Copp: Yes.

The CHAIRMAN: Did you investigate that one?

Mr Larkan: It is the same one.

The CHAIRMAN: This is the same one?

Mr Copp: Yes.

The CHAIRMAN: A sleep clinic is another example. In fact, two incidents were referred to and I just want to check that you were able to investigate both.

Mr Larkan: I cannot recall that one.

The CHAIRMAN: As the auditors you commented that nothing has changed. Is there anything that you can advise this committee to focus on in terms of the way these trust funds work or do not work? From your point of view as the auditors - I do not want you to tell us how to do our jobs - is there anything we could be particularly focusing on?

Mr Copp: At the end of the day, where does the buck stop? Who is really accountable for the hospitals? In our committee meetings I have asked who is in charge and who is supposed to run the hospital and get things done? The biggest concern that I have is the structure that is in place because there are some cultural and management issues to get over before implementing change. However, if you really want to achieve progress and improve the process you need somebody who will put the torch on if it does not happen. In May 1999 when looking at the internal audit process at the Metropolitan Health Service Board, we experienced some frustration in trying to find out to whom we report and how to perform the internal audit function etc. There was a request for information in April 1999 so we went through processes basically at our own cost. We interviewed people etc and put a paper together detailing how we would see an internal audit function operate effectively across the MHSB. However, nothing happened. I am not really sure -

The CHAIRMAN: What level did that go to? Did that go to the commission itself or the board?

Mr Copp: It went to the board of the MHSB. In addition, with the Acting Commissioner of Health, I gave copies of correspondence to show some of the ideas that we had that it could look at implementing. The concern I have is that ideas are put forward, a lot of people have the same ideas, but nothing happens. Therefore, how will change happen in these organisations?

The CHAIRMAN: Tell me the solution!

Mr Larkan: The key issue of that report was elevating the governance and transparency outside of the silos to a key oversight which is not there, and your internal audit function is directed and managed and basically you are reporting within the organisation that it was meant to be reporting on.

Mr HOUSE: Health must be the only structure in the world that I can think of in which free enterprise and socialism live side by side in the same bed while trying to get along. We have a free-enterprise driven industry on the one hand and on the other a social responsibility that Government's acknowledge. There is the greatest interface between federal and state governments of any agency. It is the greatest struggle between total free enterprise - for example, doctors wanting to earn money - and a public health service that must be delivered to people at very low socioeconomic level. There is no other structure like it. If you can answer **The CHAIRMAN**'s question, we will all listen because health is a huge issue.

Mr Copp: You have to come back and ask what it is you are really trying to achieve with your health system. You are here to help people get better. However, is hospital research part of your mandate? Does the Government want to be in the research business?

The CHAIRMAN: Of course!

Mr Copp: Okay, so what structure do you put in place? Does the Government want to be in the teaching business or the medical profession - is that the Government's role?

The CHAIRMAN: It has to be; it is part of the process.

Mr Copp: That is quite a wide-ranging mandate because basically the medical profession is really putting it upon Government to provide facilities and infrastructure for teaching etc. Therefore, do you have those three functions quite closely intertwined or do you break them apart? In other words, do you have an overseeing body for each of the three functions or do you have one overarching, overseeing body for all three? There are a lot of various inputs and stakeholders that are quite different from those three activities.

Mr HOUSE: That is only the start of it. At the other end there is the service delivery to people such as those in my area who are hundreds of miles from the metropolitan area. These people expect, need and deserve a service.

The CHAIRMAN: We need centralised control which we have not had. Hospitals are operating under their own umbrellas, independent of each other, doing whatever they like and they are not answerable to anybody.

Mr Larkan: The hospitals operate as their own entities.

The CHAIRMAN: That is part of the problem.

Mr Larkan: The way they see it, the purchaser-provider model that they have implemented within health entrenches the view that the Department of Health will purchase the service and the hospitals will provide it. Hospitals are not really a part of the Department of Health. That would seem to be the culture.

Mr WHITELY: One of the recommendations of the 20 September report was that MHSB and its officers perform their statutory obligations and inform the relevant authorities etc. Has that happened?

Mr Larkan: I am not sure.

Mr WHITELY: One of your earlier reports raised the fact that in 1995, the Australian Medical Association formerly raised the issue of the legality of bulk-billing practices in hospital administration on behalf of its members. How was that raised and what happened from there?

Mr Larkan: I have got a file of correspondence on the toing-and-froing of the bulk-billing between the AMA, hospital administrations and individual doctors because it did not sit comfortably with a lot of people. They were looking for a clear mandate and I do not believe -

The CHAIRMAN: Can we get a copy of that correspondence?

Mr WHITELY: The report of 13 November stated that the draft report was to be finalised under different circumstances and it referred to changes in the chief executive officers, access to documentation and of removing previously imposed restrictions in terms of audit process transparency. Can you elaborate on that?

Mr Larkan: I have a letter which we wrote to the Executive Chairman of the MHSB which stated that the reason we concluded that the accounts required further investigation was because the operating environment was not suitable for us to apply more rigorous processes in the pursuit of gathering detailed evidence of all the historical transactions involving bulk-billing. It was our opinion that such rigorous procedures may have resulted in operational risks at the MHSB at the time. That was written at the end of July 2000. At that time the issues between the clinicians and the administration were fairly open; therefore, to ask the type of questions that we have just been asking about bulk-billing and private practice receipts would not been appropriate at that time. We reported them as requiring further investigation by management at the later stage.

Mr WHITELY: Therefore, the environment was too volatile and you highlighted the issue stating that it needed to be pursued further?

Mr Larkan: In the second report there was discussion between the MHSB and the clinicians that laid the path for us to go and have a chat with everyone on some of those issues, particularly those involving bulk-billing.

Mr Copp: Basically, we did want to hit our heads against the brick wall.

The CHAIRMAN: With regards to bulk-billing there are two issues; the first is bulk-billing and the different name for it of "cost-shifting"; the second issue related to bulk-billing going to private doctors who were using it as their income. "Cost-shifting" is nothing new. It is always going to happen and Victoria and New South Wales are clear examples of where it is happening because there is cost-shifting using the bulk-billing system for Medicare etc. There is that line and we can understand why that is happening. On the other side, Medicare is actually going to private doctors for their income. Was there a delineation in the correspondence in 1995 on those two issues?

Mr Larkan: The delineation was more to do with the cost-shifting aspect of it.

The CHAIRMAN: Most State Governments try to cost-shift. It is normal practice because the federal Government will pay for it rather than the State Government. If it is going into the operation of the hospital, one could say that this is a process adopted because I know Victoria and New South Wales are doing it. However, if it is going to supplement doctors' incomes, that is a different ball game.

Mr Larkan: Absolutely. The cost-shifting is what we were referring to and the bulk-billing was to just make sure that the model is right and that you are not going to cross with the HIC the bounds of what is acceptable and the processes and methods that are needed to do that. That is what we were referring to.

The CHAIRMAN: So there was no evidence of the doctors receiving it to supplement their income.

[2.30 pm]

Mr HOUSE: Did you receive cooperation when you did this audit and was there a healthy spirit of wanting to get to the bottom of the issues?

Mr Copp: I spoke to certain clinicians after this letter and, as I mentioned earlier today, this chap said that they just wanted to practice medicine. They did not want to be tied up with this administration stuff. They were just trying to do what they thought they were meant to be doing. When we started to dig around a little more, there were a few areas in which things were becoming a little volatile. We thought

we should slow down a bit with the review and back off because we were not going to achieve anything at that point in time and then duly report back. We did not want to inflame and perhaps put the hospital at an operational risk.

Mr HOUSE: What about cooperation from the administrators?

Mr Larkan: With regard to the process review?

Mr HOUSE: Yes. Did you feel that they really wanted you to help them?

Mr Larkan: Absolutely -

Mr Copp: I must admit I was quite surprised.

The CHAIRMAN: Can you finish that sentence off Mr Larkan: Absolutely -

Mr Larkan: One hospital did not want our help and we were not welcome visitors. The other hospitals were cooperative but not heart-warming. There was a little resistance to having us look at the business process reviews. At King Edward Memorial Hospital for Women and Princess Margaret Hospital for Children, they acknowledged their shortcomings as their resources are short, which is a problem they sit with.

The CHAIRMAN: Tell us off the record, which hospital did not want your help?

Mr Copp: We will tell you that off the record.

Keeping in mind that we were dealing with a sensitive issue that was in the Press for sometime, I would have expected a bit more of a response from the hospitals along the lines of "Great, come on in, we have nothing to be concerned about." I was surprised and would have thought that the hospitals would have said that they had identified these issues and dealt with them and were looking forward to a clean bill of health.

Mr HOUSE: I would have also thought that the hospitals would be saying that they needed help as they had a problem that needed to be resolved and your company had the expertise to help them.

This health system is almost dysfunctional. It is like an octopus that is not too sure which leg is doing what and the evidence we have taken supports that view. It gets back to the question that

The CHAIRMAN asked you about what is the solution and how should we pull it together. We have little operations all over the place without a directing functional head. The units are operating individually whether it be nurses or doctors, teaching hospitals, other hospitals or the country service that provides the service. There is no synergy in this system at all and there does not seem to be an overall driving objective. Is that a fair comment or am I way off the mark.

Mr Copp: That would be a good solution.

Mr Larkan: If John had not agreed with you, I would have disagreed with him.

Mr Copp: I recall people bandying around the figure of $1.5 billion as the amount of expenditure.

Mr HOUSE: $2 billion.

Mr Copp: There are many larger disparate organisations that have much larger revenues and different types of operations. It is not an overwhelming amount to spend and it should be manageable.

Mr WHITELY: Earlier, you used the term "operational risk" when asked about how hard you should push on a particular issue. Can you expand on that?

Mr Copp: I just got to the point of saying that if the review was going to get too hard, I did not want anyone to use it as an excuse to stop work. That is what I was concerned about. I was also concerned about the review process becoming inflamed and out of control, which it did in the Press, and that is not the way in which change can be adopted or fixed.

The CHAIRMAN: It is a worry that there have been so many reports and nothing has happened.

Mr Larkan: It has been frustrating and worrying.

The CHAIRMAN: There does not seem to be any motivation for change.

Mr WHITELY: What did you base the "down tools" comment on? Was it just an overall impression?

Mr Copp: I was afraid of the risk of something going horribly wrong.

Mr WHITELY: Were you aware of any discussions along those lines?

Mr Copp: No, it was just a general feeling about the environment. I did not want to have my people exposed to a job that was so tough that they were not going to get any cooperation. It is not the way one goes about doing a job.

The CHAIRMAN: Knowing the culture now and being in it for a while, do you think it would be appropriate for a committee like this to make recommendations and encompass some of your recommendations through the process, which are only process changes, and then have a further public inquiry in 12 to 18 months to ensure that some of those recommendations have been enacted? It appears that we have done many of these reports internally but if we come back in six to 18 months time, nothing has happened. It was interesting to note that as soon as we announced our first inquiry and had our first sitting, all these changes happened overnight.

Mr Copp: Why should this committee become the accountable authority?

Mr HOUSE: Absolutely. You are dead right.

The CHAIRMAN: I understand that, but at the same time we want to implement change.

Mr Copp: Why do you have an infrastructure in place? Is that your role?

The CHAIRMAN: It is not our role but if we are going to make a change, we need to make one. There needs to be some form through which this change can happen.

Mr Larkan: Governance structures normally operate in an environment that an audit committee can follow up and maintain vigilance over the actions required to be implemented. They have the oversight and the capacity to ensure that the directors responsible for that business unit action that process. I do not believe that the governance structures set up for the hospitals were adequate for that process.

Mr BRADSHAW: Tell them to come down on the administrators rather than governance structures.

Mr Copp: Yes. However, the administrators are put in place by the board, or the overseeing accountable authority, and they have to implement that board's strategies. One would expect to have appropriate normal systems, processes and controls put in place by the administrators. I agree with that as it is the basic structure. However, in

areas such as research, how do we perform research and what is our policy with respect to research approval? Who determines those policies and strategies? I do not know where that fits in as I have not reviewed it but does each individual hospital determine the policy and strategy on what type of research they are going to do, or is that left to the accountable authority, whoever that is? As you say, that is where the interplay between the various stakeholders takes part in research; for example, universities, doctors and medical companies. Who is able to conduct what research on your facilities and what are the rules? I do not know what they are because I have not been involved with that process but I ask that because someone may want you to show them the rules relating to research in your public teaching hospitals.

Mr HOUSE: When you do these sort of audits, does a company like yours do any parallels with partners in other countries? Do you look at a system that works in a European country or somewhere else?

Mr Copp: Yes. We have also made inquiries within Australia about what happens in the other hospitals with which we work. There are not too many other clients in Western Australia who have a teaching hospital, but we work with private hospitals in Australia and I have not seen these issues arise in that area. The rules of the game are usually extremely clear.

The CHAIRMAN: They must be because those hospitals must be held accountable to the shareholders.

Mr Copp: And who are these people accountable to?

The CHAIRMAN: That is the problem. Is there anything else that you want to relate to us that we should be aware of or review?

Mr Copp: There is a fair amount of material in the binder, which we tried to put in chronological order. Perhaps the committee can work with its people on how they want the information presented. Time is also of the essence for us. We have tried to be as factual as possible with our findings and maintain our independence. There have been times during this exercise when I thought could we really have it wrong because we could not understand why nothing was right. However, we stuck with it, even when things did not make sense. When things are unduly complicated and you cannot get answers, as an auditor you are concerned. Therefore, you look to the management and administrators for answers and when you do not get them, a red flag goes up and you search for evidence. I was really disappointed that information, which is private information, gets left out of the review. I wish that the standard would be a little better in certain cases. However, that is a fact of life.

The CHAIRMAN: Each of these individual units has its own financial controls. Would you see some benefit in centralising that financial control so that the trust funds at each of those hospitals are controlled by the same process with the same guidelines rather than each hospital running a finance section and being understaffed and not having the ability to relate to an overall -

Mr Copp: It is not a critical, strategic process but a support process. People need to be put in place who will question certain things and say that this is what has to happen and this is how we will do it.

The CHAIRMAN: Are you saying that it is better to have centralised financial control rather than having five, six or seven different financial units under different guidelines?

Mr Copp: If you are running it as a health service across the metropolitan area and if you are in a support process such as financial accounting, the system should be the same. There should be no difference.

The CHAIRMAN: Would you then extend that to the other areas such as those providing medical services and dealing with purchases?

Mr Larkan: The area of purchasing, such as supply chain one. At one stage the system had limited success but that has improved slightly. However, if it is done properly, it does hold some benefit.

Mr Copp: There is infrastructure maintenance and it is no different from having a number of buildings that must be maintained. Rooms and facilities are being provided for doctors to practice their trade. Therefore, do you need to have special maintenance teams and different heads, or do you have one maintenance group across all hospitals?

The CHAIRMAN: Why do you need nine chiefs?

Mr Copp: There are opportunities to streamline but, again, it is a change management issue.

The CHAIRMAN: And a change of culture issue.

Mr Copp: It is not just an issue in the public sector. When we have introduced a new computer system to an organisation, there must be some merit for it. However, some organisations say that that is not the way they do things and instead of adapting and changing to best practice, they change the software or the screens. They then go back to what they have been doing all the time which is not best practice. Why do they do that? Because they are reluctant to change.

Mr BRADSHAW: Do you understand why there was reluctance to get the trust accounts in order? There was an audit that said that they would have to be fixed up and yet, five years later, they were still the same.

[2.45 pm]

Mr Larkan: Resource and lack of guidance had been an issue at King Edward Memorial Hospital and Princess Margaret Hospital for Children because there was a change to the acting chief executive. When that happened there was a change within the administration side, which again diverted resource attention. That would answer that question.

The CHAIRMAN: A number of reports have been produced about trust accounts in other States. Did you look at any of those findings or the problems that were identified? If so, how did they differ from those in Western Australia and were they resolved?

Mr Copp: No, we have not looked at them.

The CHAIRMAN: You have no knowledge of them?

The Witnesses: No.

The CHAIRMAN: Okay, we will have to do that ourselves. Gentlemen, you can tell us in camera which hospital does not want them changed. I suppose we should go in camera, so that the names will not be repeated.

Mr Copp: I would prefer that.

[The committee took evidence in camera.]