AUDITOR GENERAL

for

Western Australia

Management of Hospital Special Purpose Accounts

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AUDITOR GENERAL
for
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THE SPEAKER
LEGISLATIVE ASSEMBLY

THE PRESIDENT
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REPORT OF THE AUDITOR GENERAL: Management of Hospital Special Purpose Accounts

This Report has been prepared consequent to an audit conducted under section 80 of the *Financial Administration and Audit Act 1985* for submission to Parliament under the provisions of section 95 of the Act. The Report presents the findings of an examination into the management of special purpose accounts at four teaching hospitals.

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AUDITOR GENERAL
November 27, 2002

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Auditor General's Overview

This report highlights a simple message – strong management is critical to building and maintaining public confidence in the public sector. The absence of effective management controls puts public funds at risk, while also making it difficult to readily satisfy stakeholders that improper use has not occurred.

The audit reported here was conducted against the background of serious concerns about the management of what are commonly referred to as hospital 'trust accounts', described in the report by the more correct term, Special Purpose Accounts (SPAs), at the four teaching hospitals. After more than six months of intensive fieldwork by a large team of experienced auditors from my Office, I am happy to be able to report that the vast bulk of those concerns are misplaced: no evidence of categoric improper use was found.

At the same time the report makes it clear that for around 20 per cent of the annual $30 million turnover, the integrity of staff was effectively the only safeguard against improper use. In these cases there was an absence of reliable management controls and consequently, public funds were put at risk.

This is not a satisfactory situation: the absence of strong controls placed an unfair burden on SPA managers – principally doctors and other medical staff. Admittedly, the amount of public funds involved was 'small' relative to total hospital expenditures. Even so, they were public funds and warrant the same standards of accountability as all other public funds.

SPAs have evolved over decades from small beginnings and on an *ad hoc* basis, which goes some way towards explaining the absence of a coherent policy and administrative framework. The fact that SPAs involved a range of related but non-operational purposes also goes some way to explaining why they have not been integrated into the mainstream budgeting, monitoring and reporting systems.

The sums of money now involved, however, made it inevitable that questions would be raised about their management, and the absence of clear policies and strong controls left managers effectively unable to conclusively respond to such allegations. Last but not least it means that a good deal more time, effort and resources than would otherwise have been required has had to be expended to provide satisfactory answers to those queries and allegations.

I am encouraged by the actions that the Department of Health and individual hospitals are taking to address the issues raised in this report. My primary concern, however, is the obvious need for unequivocal direction and coordination to be provided to ensure these initiatives are effective in practice and meet the test of time.

Executive Summary

Background

This report presents the findings of a detailed audit into the management of what has commonly been termed hospital 'trust accounts' at the four teaching hospitals[1]. Just a small number are true trust accounts, where the money should only be used for specific purposes, with most more correctly referred to as special purpose accounts (SPAs).

These SPAs hold moneys for a variety of purposes, including the funding of research activities, training and development, patients' welfare, capital and equipment purchases and various other moneys received by the hospitals.

The four teaching hospitals operated 1 296 SPAs and trust accounts during the 12 month period ending December 31, 2001. Total receipts and payments through these accounts for this period were $36.8 million and $39.7 million respectively, with the balance of these accounts at December 31, 2001 totalling $51 million[2]. These accounts fall into two major categories:

- SPAs which hold moneys such as donations and bequests, grants for research purposes, fees and charges for undertaking business activities and clinical trials, and funds received for travel, educational and other specific purposes. Approximately $27.9 million was received and held in approximately 1 201 SPAs used by the hospitals during the year.

  Much of this money is subject to external restrictions, such as a bequest to undertake research in a specified area where the hospital has an obligation to ensure such moneys are only used for that purpose. Other moneys have been internally allocated by the hospital to be used for a specific purpose, such as for future equipment purchases.

- Trust accounts that hold money on behalf of third parties, such as voluntary organisations attached to the hospitals and patients' private cash. These are true trusts as the hospitals have no legal rights to this money and cannot use these funds for hospital activities. There were 95 accounts in this category that received $9 million during the year.

Why Was this Audit Undertaken?

A number of internal audits and other reviews over the past three years have reported a range of unsatisfactory aspects of hospitals' management of SPAs. These reports attracted considerable public interest due to findings on the questionable use of funds and appropriateness of expenditure made through these accounts.

The need to improve control and accountability for these accounts has been recognised and a range of initiatives has been commenced by the Department of Health and the hospitals.

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1 The teaching hospitals are Royal Perth Hospital (RPH), Sir Charles Gairdner Hospital (SCGH), Fremantle Hospital and Health Service (FHHS) and King Edward Memorial/Princess Margaret Hospitals (KEMH/PMH).

2 These amounts and number of accounts are based on the classification of SPAs as made by the hospitals.

What Did We Do?

This audit of SPAs was conducted between January and August 2002, and focused on assessing the control framework in place to manage these accounts. It involved extensive and detailed testing of transactions made through SPAs in the 12 month period ending December 31, 2001, complemented by review and related testing of identified transactions in prior periods. The reports of previous reviews were also analysed and the conclusions reached were revisited.

What Did We Find?

The findings present a mixed picture, with the larger SPAs, such as those used for building additions, equipment purchases and staff conference and travel, well controlled and subject to extensive approval requirements. Much of the expenditure made through SPAs is of a routine nature, such as salaries for research staff.

However, there were a number of inconsistencies and weaknesses in the administrative and control systems that need to be urgently addressed to provide a reliable and coordinated framework for the management of these SPAs. These weaknesses have resulted in transparency, accountability and compliance with relevant legislation over the use of these moneys not always being at the level expected for public moneys.

This has occurred for a number of reasons. In the past, hospital management has placed less emphasis on the management of SPAs as the primary focus has been on managing operating funds used in delivering essential patient services.

In addition, individuals and hospital departments often actively seek out SPA moneys to fund activities that cannot be met from normal operating funds. This has contributed to staff having a greater sense of ownership over how these moneys are used.

These factors have contributed to accountability for the management of SPAs often residing with individuals or departments who do not necessarily have the expertise and knowledge of the requirements to satisfactorily account for SPA moneys.

Extensive audit testing did not however disclose any payments from these accounts that were categorically used for personal benefit, fraudulent purposes or non-hospital activities. In practice, the integrity of staff was effectively the only safeguard against abuse.

The Management of Special Purpose Accounts

Since much of the money placed in these accounts is subject to certain restrictions, a reliable and consistent administrative framework needs to be established to enable the hospitals to meet any obligations attached to the use of these funds.

A coordinated policy framework for the management of these accounts across the four hospitals was not developed until May 2002. This has resulted in inconsistencies in the circumstances and

purposes for which SPAs have been established and contributed to an excessive number of accounts that are used for many different purposes. It has also contributed to hospitals not always correctly identifying all true trust moneys and SPA moneys with different types of restrictions being mixed in the same account.

Financial and Management Control Issues

Irrespective of the source of moneys held, they are subject to the same accountability standards that apply to all public funds. Hospitals must ensure that transactions are 'appropriate' and comply with any restrictions attached to the use of these moneys.

This audit identified a range of shortcomings regarding the effectiveness of the control environment. These covered both the adequacy of controls to ensure that SPA restrictions were met, as well as ensuring compliance with the requirements of the *Financial Administration and Audit Act 1985* (FAAA) and other applicable legislation which governs the operation of these hospitals.

Receipts to Special Purpose Accounts

Hospitals are unable to adequately account for all moneys belonging to the hospital and Audit is therefore unable to provide reasonable assurance that all moneys have been deposited into authorised hospital bank accounts. This is due to:

- lack of adequate procedures in place to ensure that all moneys due to hospitals are received and accounted for; and
- hospital mail containing moneys often being forwarded unopened and unsecured to departments and individuals without controls to ensure that those moneys are ultimately receipted and deposited in hospital bank accounts.

This has led to some money belonging to the hospitals being placed in 'unofficial' bank accounts that are not included in hospitals' financial records. Some of these accounts were tightly controlled. However, for other accounts, transactions were not approved against government and hospital policies or it was not possible to establish how the funds in the accounts were used due to a lack of records. Under these circumstances, Audit is unable to provide assurance that transactions through these accounts were appropriate or for official hospital purposes.

Expenditure from Special Purpose Accounts

Hospitals are unable to reliably demonstrate that current systems are effective in ensuring all SPA payments are in accordance with approved purposes or restrictions. Although around 80 per cent of SPA payments are of a routine nature and subject to comprehensive approval processes, other payments that lacked adequate supporting documentation or approvals were often processed unchallenged.

Budgeting and Monitoring of these Accounts

The focus on managing operating funds has resulted in budgeting and monitoring arrangements for SPAs generally being less comprehensive than for operating funds. SPA moneys are not integrated into the annual budget process applying to hospital operating funds and budgets are not prepared for all SPAs with ongoing commitments or contractual obligations.

The adequacy of financial reporting on the operation of these SPAs also varies. Reporting through to the accountable authority provides little meaningful information and does not allow for effective oversight and review.

Individual hospitals have taken a number of steps to improve the reporting and monitoring of these accounts, however there is still room for improvement in monitoring and reporting.

Other Issues Affecting the Operation of SPAs

Various other issues were identified during the audit in respect of the types of activities conducted through SPAs as outlined below.

Business Activities: Hospitals use SPAs for a range of business activities such as the provision of facilities and running training courses. These activities have generally not been authorised as required under applicable legislation and could result in agreements involving these activities not being enforceable.

This audit found inconsistencies in determining what costs are recouped to enable the full cost of these activities to be identified and recovered through the setting of fees and charges. Budgets and financial evaluations to establish the viability of these activities, which should be undertaken for major business undertakings, were not always prepared. Furthermore, fees and charges have not been reviewed on an annual basis as required under the FAAA.

Management of Research Activities: The hospitals receive funding from various sources to undertake research and run trials which involves entering into agreements with the funding party. These agreements are not always vetted by the hospital to ensure they do not contain any unnecessary risks and were often signed by hospital staff not authorised to act on behalf of the hospital.

Privatised Clinics: One of the significant issues raised in previous internal reviews was the operation of ‘privatised clinics’ at KEMH/PMH that were operated through SPAs and whether public patients were being billed in breach of Commonwealth legislation. This issue and the operating arrangements for the clinics is currently being examined by Commonwealth authorities.

Summary of Recommendations

Over the last 12 to 18 months, a number of initiatives have been put in place by the hospitals and the Department of Health or are being developed. These include major changes in the responsibilities and the way SPAs are being managed at KEMH/PMH through to improvements in reporting practices and the commencement of reviews to rationalise SPAs.

This report and management letters provided during the course of the audit should provide assistance to the Department of Health in progressing with these initiatives.

The accountable authority should:

- ensure that a comprehensive policy and administrative framework exists for the management of both trust accounts and SPAs. This should include the establishment of accounting policies, procedures and business rules to assist hospitals in implementing a consistent approach to managing these accounts; and
- set a timetable for hospitals to implement these policies and frameworks and ensure the revised arrangements put in place by the hospitals are progressively reviewed for compliance during this implementation process.

The hospitals should:

- ensure these policies, associated frameworks and business rules are implemented with variations only being made to suit specific or unique circumstances; and
- review existing financial control structures, systems and practices to ensure compliance with the requirements of the FAAA and other applicable legislation governing the operation of the hospitals.

Introduction

Over the last three years, several internal audits have been undertaken at KEMH/PMH into what has commonly been referred to as hospital trust accounts. Findings from these reports included weaknesses in the financial control framework, inappropriate expenditure transactions, and accounts being used to hold revenues from bulkbilling public patients and the diversion of hospital funds to these accounts.

As a result, the then Metropolitan Health Service Board (MHSB)[3] requested a business process review of the administration and formation of trust accounts at RPH, SCGH and FHHS. The report resulting from this review was issued to the Commissioner of Health in October 2001. However, the management of individual hospitals did not accept many of these review findings.

It was therefore decided to undertake a comprehensive audit of the administration of these accounts at the four teaching hospitals, and to provide detailed information and findings on a range of issues to encourage development of a coordinated policy for the management of these accounts.

Hospital Funding and the Operation of 'Trust' Accounts

The individual hospitals each have a Chief Executive who, as from July 1, 2002 reports to the Commissioner of Health in his capacity as accountable authority of the entity named Minister for Health. As the accountable authority, the Commissioner is responsible for the functions of the hospitals. The Commissioner of Health is also the Chief Executive Officer of the Department of Health.

The teaching hospitals also have a close relationship with the University of Western Australia Medical School through the provision of facilities for the teaching of medical students. medical staff from the Faculty of Medicine may practise and undertake research at these hospitals. Edith Cowan University is also associated with the hospitals in the area of allied health services.

The hospitals spent about $975 million in the 2000-01 financial year primarily on day-to-day operations associated with the delivery of patient care. This expenditure is funded from subsidies received from the Department of Health, patient charges and other miscellaneous revenues.

In addition to these operational funds, the hospitals received around $27.9 million in 2001 from a range of different sources such as donations and bequests, grants for research purposes, money received for undertaking business activities and clinical trials, and funds received for educational and travel purposes.

In many cases, this money can only be used for a specific purpose. For example, bequests or donations may be received with a restriction that they can only be used for research in a specific area, such as childhood cancer. The hospitals have an obligation to ensure the funds are only used for that purpose. In other cases, the hospitals have internally set aside money to be used for a specific purpose, such as future equipment purchases.

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3 The four teaching hospitals have operated under a number of different arrangements over the last five years. Prior to 1997, they were separate legal entities with their own boards. They then formed part of the MHSB between 1997 and February 2001. In February, the MHSB was abolished and the Commissioner of Health became the accountable authority of the entity Metropolitan Health Services. From July 1, 2002, this entity is known as Minister for Health.

4 A cost centre is an accounting method of grouping transactions that relate to a specific activity or area.

To manage these moneys, the hospitals have established 1 201 cost centres[4], or accounts, in their financial system to assist in identifying and controlling income and expenses against the different funding sources and to ensure any associated restrictions are met. While they have been commonly referred to as 'trust' accounts, the term special purpose accounts (SPAs) more correctly describes these accounts.

The hospitals also receive some private moneys, such as on behalf of voluntary organisations attached to the hospital. These moneys, which are classified as 'true trusts', are managed through 95 accounts.

Financial Transactions Made through these Accounts

A summary of the number of accounts, categorised into SPAs and 'true trusts' (as classified by the hospitals) and financial transactions for the 12 month period ending December 31, 2001 is shown in Table 1.

Hospital	Number of accounts used during 2001	Receipts $'000	Payments $'000	Balance at December 31 $'000
RPH				
SPAs	411	8 365	9 227	19 114
True Trusts[5]	64	7 410	7 601	(152)
SCGH				
SPAs	434	12 510	14 029	19 202
True Trusts	Nil	Nil	Nil	Nil
KEMH/PMH				
SPAs	240	5 454	5 452	7 397
True Trusts	11	1 226	1 788	852
FHHS				
SPAs	116	1 537	1 410	4 121
True Trusts	20	319	178	501
TOTALS				
SPAs	**1 201**	**27 866**	**30 118**	**49 834**
True Trusts	**95**	**8 955**	**9 567**	**1 201**

Table 1: Number of special purpose accounts and true trusts and financial transactions for the year ended December 31, 2001[6].

At December 31, 2001, the balance of SPAs and trust accounts at the four teaching hospitals totalled $51 million.

5 Under the *MHSB AMA Medical Practitioners Agreement 1999* [replaced by the *Medical Practitioners (Metropolitan Health Services) AMA Industrial Agreement 2002* on April 23, 2002)], certain medical practitioners may be granted the right to operate a private practice which involves doctors using the hospitals' facilities and charging fees by or on behalf of the doctor. These fees are distributed between the doctors and hospitals as detailed in the Agreement. RPH provides a 'Specialist Accounting Service' (SAS) to certain doctors operating a private practice, which involves raising fees and distributing those earnings as per the Agreement. True trusts at RPH include 41 SAS accounts.

6 Balances do not include funds belonging to Foundations and Volunteer Associations for which some hospitals provide an accounting service. The totals for receipts and payments have been adjusted to overcome the effect of netting off revenues and expenses. This adjustment could only be calculated by establishing receipts and the opening and closing balances and deriving total payment (Source: OAG).

In broad terms, SPAs can be categorised into the purposes as detailed in Table 2. Major sources of funding are also shown in this table. It should be noted that these figures are indicative only as hospital records do not enable an accurate categorisation to be compiled. For example, some business activities are operated through departmental accounts.

Major Categories of Special Purpose Accounts	Major Source of Funds	Estimated Payments ($'000)
Research Activities	Grants from external bodies, fees from undertaking clinical trials, donations and internally allocated funds.	8 809
Training and Development	Percentage of private practice moneys generated by clinicians which is required to be paid to the hospital as per the *Medical Practitioners Agreement*.	2 546
Business Activities	Fees and charges generated from activities such as training courses, sale of goods, use of equipment and 'privatised' clinics.	2 731
Departmental Accounts	Donations, miscellaneous business activities and moneys from sources such as discount arrangements with suppliers.	4 360
Capital Accounts	Funds allocated by the hospitals for capital works.	678
Welfare (eg patients benefit)	Donations and other fundraising activities.	472
No Data/Unknown	Accounts without documented purposes which mostly are a mixture of the above categories.	1 689
Suspense Accounts	Account used for holding purposes.	1 255

Table 2: Major categories of special purpose accounts (based on the documented purpose of the account) and estimated payments for the 12 month period to December 31, 2001[7].

Hospitals receive SPA moneys from a variety of sources, with research activities representing a major use of these moneys.

How Significant Are these Accounts?

Transactions through these SPAs represent around three per cent of total hospital expenditures. Whilst this is not financially significant in the overall operations of the hospitals, in excess of $30.1 million of hospital controlled funds are expended each year through SPAs.

However, the general perception that these are all trust moneys and issues such as the types of moneys held in these accounts, the involvement of individuals and sections of the hospitals in actively seeking out these moneys to fund activities not met from operating funds and associated sense of 'ownership', has elevated the profile of these accounts.

7 Amounts have not been adjusted to reverse the effects of netting-off of revenues and expenses by hospitals (Source: OAG).

Audit Focus and Approach

The audit was primarily focused at addressing the many concerns raised in previous audits conducted by or for the MHSB, in the Parliament, and by the media.

There were three main phases of the audit, namely information gathering, an assessment of the processes and internal control environment at the four teaching hospitals, and detailed testing.

Information gathering involved reviewing the reports and supporting working papers from previous audits, compiling a detailed database on SPA accounts, obtaining and analysing extensive downloads from the hospitals' accounting systems and identifying and analysing the issues raised to develop an appropriate audit approach.

The third phase involved conducting audit tests to address the specific concerns previously raised and other issues identified in earlier audit phases.

A large sample of payments was selected at each hospital from the period January 1 to December 31, 2001. The sample was designed to test large payments and areas of potential risk such as travel and hospitality expenditure. The audit also involved testing in the following areas:

- receipts into SPAs, including controls over donations from the public and expenditure made from these funds;
- research agreements, drug trials and related transactions;
- transfers of moneys from hospital operating funds to SPAs; and
- business activities and privatised clinics operating from SPAs.

The audit did not focus on the activities and transactions relating to true trust accounts, as the hospitals' role is primarily limited to providing an accounting service for private parties or organisations associated with the hospitals.

The Management and Use of Special Purpose Accounts

- *Most of these accounts are not 'true trust' accounts but special purpose accounts which hold moneys that place an obligation on the hospital to only use the moneys for specified purposes.*
- *The provisions of the FAAA were incorrectly used as the basis for establishing many of these accounts as the relevant sections of the Act only apply to private moneys.*
- *Documentation detailing the purpose and restrictions of accounts was often incomplete or out of date which made it difficult for hospitals to demonstrate that moneys had been used in accordance with any restrictions.*
- *The hospitals have not always correctly classified or categorised these accounts to ensure all true trust moneys have been identified and moneys with differing types of restrictions have been separately recorded.*
- *General record keeping standards across the hospitals were inadequate with key documents, such as legal agreements, often being filed on an ad hoc basis or, in some cases, not able to be located.*

What Are these Accounts?

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

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

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

A small number of accounts managed by the hospitals hold private moneys, such as moneys belonging to other organisations, which should be classified as true trusts. The hospital cannot use these funds for hospital activities as it has no legal rights to use such moneys. Examples of these 'true trust' accounts include funds raised by volunteer groups such as Friends of RPH and patients' private moneys.

Why Have they been Called Trust Accounts?

The use of the term trust accounts has predominately occurred as three of the hospitals consider that many of these accounts have been established under the authority of the FAAA[8]. This view has not been held by SCGH who has referred to them as special purpose accounts since the mid 1990s.

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

As much of SPA moneys come from private sources and are considered 'non-operational' funds, the hospitals used these FAAA provisions as a mechanism to set aside these moneys from operating funds. However, these provisions only apply to private moneys, or true trusts, which comprise only a small number of accounts maintained by the hospitals.

How Are these Moneys Accounted For?

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

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

These arrangements are depicted in Figure 1.

8 Further details on the use and application of the FAAA as the basis for establishing these accounts is detailed in Appendix 1.

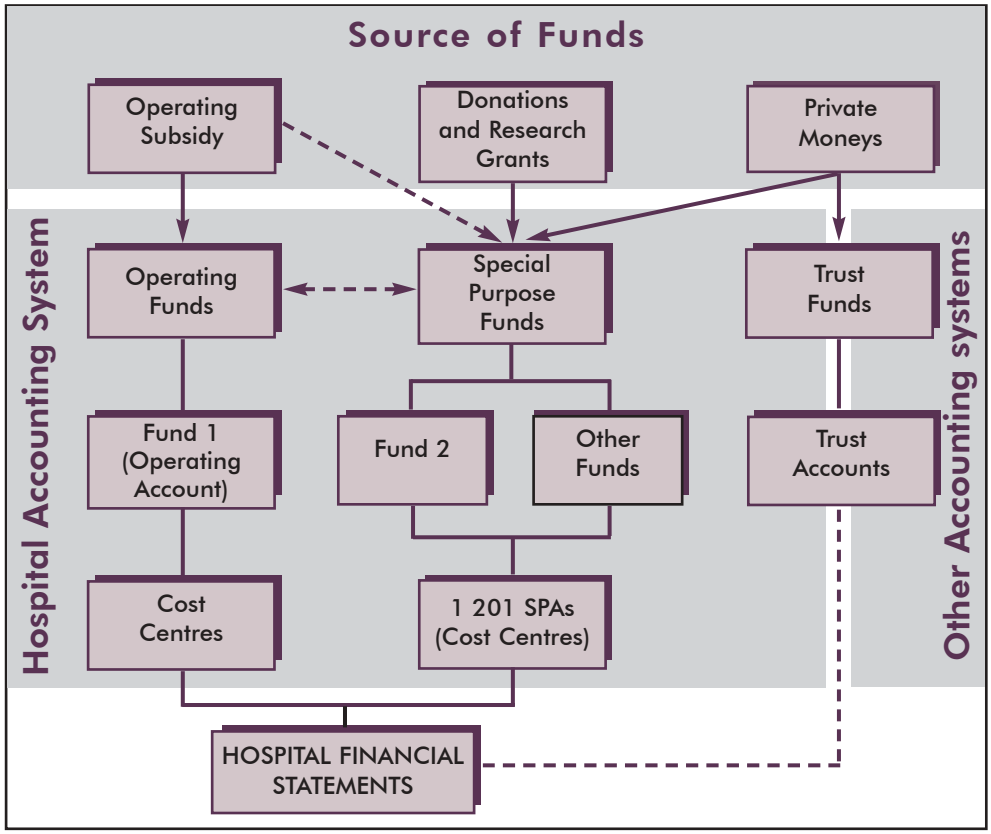

Figure 1: Accounting arrangements for special purpose and trust accounts.

The individual hospitals operate between one and four funds to account for SPA and trust accounts.

While SPAs are separately recorded from operating funds, they are consolidated with operating funds in the annual financial statements, while 'true trusts' are disclosed by way of notes to the financial statements.

The Management of Special Purpose Accounts

As many SPAs hold moneys that are to be used for a specific purpose, hospitals should have administrative frameworks and policies to facilitate the effective administration of SPAs.

This audit found that the administrative framework and procedures vary both between different types of SPAs and individual hospitals. Many SPAs are well managed, such as accounts used for staff travel and education and those used to manage capital projects.

However, the practices that have developed over time have resulted in inconsistencies and a number of inadequate procedures that impact on the management of these accounts. This has occurred for a number of reasons. Traditionally, the focus of hospital management has been on

managing operating funds as these represent the major source of funds for delivering essential patient services. This has resulted in differences in how these operating and SPA funds are managed, such as:

- Hospitals being required to prepare budgets and comprehensively report through to the hospital executive, accountable authority and Department of Health on the use of operating funds on a regular basis. However, these requirements do not apply to the same extent for SPAs and has occurred, in part, because of concerns that these moneys will be offset against the subsidies from the Department of Health.
- Hospital Divisional Business Managers who have a key role in the financial control and management of operating funds. These managers have not had an equivalent role in managing SPAs.

With this focus on operating funds, there has, in the past, been less emphasis placed on the management of SPAs. In addition, the well-publicised pressures on hospital funding have contributed to individuals or departments within hospitals actively seeking out new or different sources of moneys to fund activities that cannot be met from operating funds. For this reason, staff and individual departments within hospitals tended to have a greater sense of 'ownership' over SPA moneys and more discretion and control over how these moneys were used.

These factors have contributed to accountability for the use and management of these moneys primarily residing with individual staff or departments. These staff or departments have not necessarily had the expertise, knowledge of the FAAA or the resources to satisfactorily account for the use of SPA moneys.

Establishment of SPAs

The circumstances or purposes for which SPAs were established, and by who, varied across the hospitals and in some cases, were not supported by policies and procedures. In the past, it was primarily the responsibility of these individual staff and departments to request the establishment of SPAs.

There has not been an appropriate process for evaluating whether a new SPA should have been established or an existing SPA used, or whether the moneys were of an operating nature and should have been placed in operating accounts rather than an SPA. In those instances where moneys have been received or raised with no external restrictions placed on their use, individual staff and departments have had a large degree of discretion in deciding the purposes for which those moneys were used.

This has resulted in the creation of a large number of SPAs with differing purposes, poor standards of documentation and inconsistencies in the classification and recording of SPA moneys across the hospitals which impacted on the effective administration and control of these accounts.

Number of Accounts

Currently, the number of SPAs varies from 116 at FHHS to over 400 at RPH and SCGH. This large number of accounts causes difficulties in both managing and reporting SPAs in a concise and meaningful way.

The number of accounts at KEMH/PMH decreased from around 240 to 130 at December 31, 2001 following a review in late 2001 that resulted in the consolidation or closure of many SPAs. FHHS has maintained the number of accounts at an equivalent level for a number of years.

Documenting and Categorising Special Purpose Accounts

The primary record used to administer individual accounts is a 'Trust' Statement or Application for an SPA or Cost Centre (referred to herein as an SPA Statement). The SPA Statement is a key document that specifies the purpose of the account and any restrictions. It also discloses the sources of funding, allowable items of expenditure and the persons who can authorise expenditure from the account.

The audit identified a range of shortcomings in the manner in which SPA statements were documented that have impacted on the hospitals' ability to ensure all SPA expenditure has been appropriately authorised and used in accordance with restrictions. These included SPA statements that:

- were out of date or incomplete in areas such as details of authorised signatories, source of funds, restrictions applying to the account and allowable items of expenditure;
- contained unclear purposes, sources of funds and allowable items of expenditure; and
- had not been prepared or were unable to be located. This mainly applied to RPH where SPA statements were not always prepared prior to 1999.

General Record Keeping Standards

This audit also highlighted the generally inadequate standards of record keeping in many parts of the various hospitals. Responsibility for record keeping was not clearly defined, and access, security and the preservation of records were not being dealt with in a systematic and consistent approach.

In some cases, adequate records were kept, such as those maintained by Ethics Committees who are responsible for approving research and clinical trials and Clinical Staff Travel Committees who approve conference and study leave for hospital staff.

Key documentation such as legal documents, grant agreements and letters of bequest were not always kept on files or held by hospital staff responsible for vetting SPA account expenditure. These documents were often retained by individuals throughout the hospital and stored in manila folders or personal filing cabinets. In some cases, these documents could not be located.

Responsibility for record keeping needs to be urgently addressed, especially for key records such as legal documents, as the hospital may not be aware of all its obligations or be in a position to adequately discharge its functions.

Identifying and Categorising Special Purpose Accounts[9]

In addition to the lack of adequate documentation on the purposes and restrictions of SPAs, the following shortcomings were also identified.

Identifying Trust Moneys

While the hospitals have identified accounts that they consider are 'true trusts', this audit identified inconsistencies and inadequate recognition of the 'trust' nature for some of the money held in these accounts.

- Accounts were identified where moneys have not been correctly classified as 'true trusts' by the hospitals. For example, an account at RPH holds moneys from the Medical Board that is distributed according to instructions provided by the Board. Under these circumstances, these moneys are not controlled by the Hospital.
- FHHS has classified moneys, such as funds to undertake clinical trials as trusts, on the basis that university staff practising at the hospital manage the accounts or are in charge of the trial. However, the agreement to undertake the trial is in the name of the hospital. In contrast, the other hospitals have classified similar moneys as hospital controlled accounts.

In some cases the distinction between hospital controlled and trust moneys is not clear and the specific conditions attached to the moneys will need to be reviewed to determine the nature of these funds.

Categorising Accounts with Internal and External Restrictions

The hospitals have also not clearly identified or categorised SPA moneys with either externally or internally imposed restrictions. In addition, a further area of significant concern was the tendency for moneys with different restrictions and different purposes to be 'mixed' together in one SPA account, without disclosing all the restrictions on the SPA Statement. For example, an SPA may contain donations, research grants and internally allocated funds that have different restrictions.

This lack of categorisation, inadequate documentation and mixing of moneys:

- made it difficult for the hospitals to demonstrate that funds had been used in accordance with the different types of restrictions;
- did not allow for meaningful reporting to hospital management as to the financial value of types of activities transacted through SPAs, such as research and business activities; and
- meant that hospitals were not able to fully meet their external financial reporting requirements. Under these requirements, moneys with external restrictions should be separately reported in annual financial statements as restricted cash balances and for 'true trust' moneys to be disclosed by way of notes to the financial statements.

9 Guidance on the identification and categorisation of trust and special purpose moneys is detailed in Appendix 2.

Recommendations

The accountable authority should:

- develop a comprehensive policy and administrative framework for the management of both trust and special purpose accounts. This should include the establishment of accounting policies, procedures and business rules to assist hospitals in implementing a consistent approach to managing these accounts. These should include guidance on:
  - the identification of trust moneys and categorisation of SPAs with either internal or external restrictions;
  - the classification of accounts by type of activity; and
  - account documentation and record keeping standards to ensure completeness and accuracy of records and compliance with the *States Record Act 2000*.
- set a timetable for hospitals to implement these policies and frameworks and ensure the revised arrangements put in place by the hospitals are progressively reviewed for compliance during this implementation process; and
- prepare revised trust statements covering all private moneys, or 'true trusts' held by the hospitals and ensure these statements comply with the provisions of the FAAA.

The hospitals should:

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

Financial Management and Control Issues

Introduction

Irrespective of the nature of moneys held in SPAs, they are subject to the same accountability standards that apply to all public moneys. This includes administering SPAs in accordance with the requirements of the FAAA.

Hospital Initiatives

Over the last 12 to 18 months, some hospitals have implemented revised arrangements or put in place new policies and processes to improve the control environment at those hospitals. These arrangements include:

- The establishment of a committee structure at KEMH/PMH which became fully operational from around March 2002. Trust Account Sub-Committees, reporting to the Hospital's Finance Committee, have been established to oversee the overall operation and management of a range of designated accounts. In addition, a Research Committee has been established and is responsible for all research accounts. These committees are responsible for various activities including reviewing requests for new accounts, ensuring business plans/budgets are prepared and monitoring the operation of accounts.
- The introduction of revised policies at SCGH in mid 2001. These detail the requirements for the general administration of SPAs, including the establishment of SPAs and approval requirements for expenditures such as entertainment, travel and 'mobile' equipment.

This section of the report comments on audit findings in relation to the financial management and control framework, the results from a review of the controls put in place by the hospitals and detailed testing of specific transactions made through SPAs. It covers:

- Receipts to Special Purpose Accounts
- Expenditure from Special Purpose Accounts
- Budgeting, Monitoring and Reporting of Special Purpose Accounts

Receipts to Special Purpose Accounts

- *The hospitals did not have adequate procedures in place to ensure that all moneys due to the hospital were recorded and all moneys received were accepted and deposited in the hospitals' bank accounts.*
- *Thirteen unofficial bank accounts were identified that contained hospital moneys and were operated by hospital staff outside the hospitals' control environment in breach of the FAAA. Audit cannot provide assurance whether the transactions through all these unofficial accounts were for official hospital purposes or were appropriate.*
- *Fundraising activities were conducted on behalf of the hospitals without authorisation and licensing as provided for under the Hospitals and Health Services Act 1927 and the Charitable Collections Act 1946.*
- *SPA revenue was not adequately recorded in hospital accounts to enable hospitals to ensure specific funding obligations and restrictions were applied.*
- *Donations and other gratuities were received by the hospitals from various sources without being evaluated to determine if the donor and use of the funds were appropriate and acceptable to the hospitals.*
- *Donations received by or at two hospitals were forwarded to affiliated fundraising bodies contrary to the provisions the FAAA.*

Controlling the Receipt of Moneys

An effective system of internal control is needed to ensure the hospitals receive all moneys that are due, properly record details in their financial systems and promptly bank all moneys in hospital-controlled bank accounts. If these moneys are received for a specific purpose, it is also important to record and accept any obligations or restrictions attached to those moneys.

For State Government agencies, the FAAA sets out the minimum legal requirements that must be met for the receipt of moneys. The FAAA requires all moneys received to be banked daily in an approved bank account and prescribes the minimum requirements for opening mail, issuing receipts and conducting banking. Sound mail opening procedures normally involves two people opening mail in a secure area, with details of any cash or cheques being immediately recorded to ensure an adequate trail so that all remittances are fully accounted for.

Significantly, section 36(1) of the FAAA requires staff who receive any private or trust moneys to *"act in respect of it in the same manner as officers are required to act in relation to public moneys"*. This requires the hospitals to implement internal controls for all moneys received, no matter what the source or the ownership of the moneys.

Effectiveness of Controls Over the Receipt of Moneys

This audit identified the following control weaknesses over the raising of revenue and the collection and receipting of moneys:

- The hospitals have a central debtors system which involves preparing official hospital invoices based on advices received from various sources (eg debit notes), recording amounts due and following up outstanding debts. However, alongside this system, staff in various hospital departments were also preparing invoices which were not recorded in the central system and did not have the same controls such as following up of debts.
- Mail opening procedures and controls[10] over the recording of money received by the hospitals were inadequate. This included all mail not being opened in a secure area, with mail addressed to a person or department generally being distributed unopened. Mail distributed to departments was generally not opened by two persons or immediately recorded.

  In addition, unopened mail was not always adequately secured and cheques were, in some cases, observed lying on staff desks. The issue of official hospital receipt books was also not controlled and moneys handed to cashiers were not always reconciled to receipts issued.

These fundamental weaknesses in debtors systems and mail opening procedures meant that the hospitals were not able to properly account for all moneys due and received by the hospitals.

In addition, the chart of accounts used by the hospitals did not have codes specifically for SPA revenue. This resulted in a significant amount of SPA revenue being misclassified. From July 1999 to December 2001, forty-two per cent of SPA revenue across the hospitals was classified as non-specific or 'Other Revenue'. At RPH, as much as 75 per cent of SPA revenue was classified in this manner. FHHS classified 48 per cent of SPA revenue as donations, which included moneys that were not donations. KEMH/PMH classified over 33 per cent of revenue against expenditure codes. This misclassification of revenue makes it difficult for management to readily identify revenue that may have restrictions that need to be recorded.

Unofficial Bank Accounts

These revenue control weaknesses resulted in detailed work being undertaken to identify if hospital moneys had been placed in bank accounts other than authorised hospital accounts. This involved requesting information from various financial institutions and reviewing transactions made through hospital systems that may involve transfers or payments to other bank accounts.

These procedures are unlikely to have identified all such accounts. However, they resulted in 13 bank accounts being identified into which hospital moneys had been placed in breach of the FAAA. Payments through these accounts totalled $138 430 over the last 12 months, while the balance at the date of identification was $68 022.

10 These control weaknesses resulted in the Auditor General's opinion on the controls over the receipt of moneys for MHSB being qualified for the year ended June 30, 2001.

The type of bank accounts in which these moneys were placed were:

- Accounts opened by hospital staff to hold private moneys in relation to staff social clubs, professional bodies and associations, as well as for fundraising activities undertaken by hospital staff. However, over the years, moneys belonging to the hospitals had been placed in some of these accounts.
- Accounts specifically opened by hospital departments for the purpose of holding hospital moneys. This included moneys raised from activities undertaken by staff in the course of their employment (eg conferences, training) and other revenue such as donations and sponsorships.

Some of these bank accounts are used for a single purpose and are tightly controlled with detailed records maintained of all receipts and payments transacted through the accounts. However, as shown in the examples in Table 3, a number of significant issues were identified in relation to all these accounts, including:

- transactions through these accounts were not approved in accordance with hospital and government policies;
- the purposes for which payments were made could not always be established due to lack of records; and
- moneys placed in these accounts had been generated from activities that had not been approved by the Minister in accordance with the *Hospital and Health Services Act 1927*.

'Anaesthetic Department Special Purpose Fund' (KEMH) – opened in 1988	The original purpose and sources of funding are not clear. However, the account was primarily funded by payments to the Hospital for training provided to GP registrars. KEMH was the only hospital that did not deposit these funds into a SPA.	Bank statements and cheque butts were kept. However, invoices and other documentation required to support most withdrawals were not retained.	In May 2002, the balance of the account was $8 156 with deposits of $9 300 and withdrawals of $8 200 over the previous 17 months. Payments included: ● departmental functions and other hospitality expenditure ($3 780); ● staff uniforms ($1 135); and ● staff training courses ($1 485).
'Nuclear Medicine Research Fund' (FHHS) – opened in 1991	Over time, public donations, research grants and the proceeds from the sale of surplus hospital equipment and scrap materials have been deposited to this account. In addition, the account holds revenue from the sale of radioactive materials, an activity that has not been authorised by the Minister.	Supporting documentation was retained for all transactions.	From January 2000 to December 2001, deposits of $20 790 and withdrawals of $27 270 including: ● travel ($8 589); ● hospitality expenditure ($5 932); ● research ($3 510); and ● share of profits paid to FHHS ($1 700). The account was closed in December 2001 and the balance of $8 292 transferred to a hospital SPA.
'Nurse Diabetes Seminar Account' (SCGH) – opened around 1989	The account held sponsorship moneys and the proceeds from the sale of blood glucose machines.	Bank statements were kept. However, there are no supporting documentation for withdrawals.	At March 2002, the balance of the account was $507 with deposits of $14 302 and withdrawals of $16 058 over the preceding 27 months. Moneys have been used to fund conference attendances, travel, catering and other hospitality expenditure, and the purchase of blood glucose machines.
'Intensive Care Services Research Fund' (FHHS) – opened in 1990	Moneys received from pharmaceutical companies for drug trials and public donations.	Bank statements were retained. However, no supports for most deposits and withdrawals were kept.	The account has been used in the past to fund hospitality expenditure. It has been dormant since 1998 and has a current balance of $10 684.
'SCGH Physics' (SCGH) – opened in 1997	Sponsorship moneys solicited by hospital staff from health supply related companies to fund a one-off hospitality function celebrating a new hospital service. After the function, the account remained open and has since been used as a 'private investment account' by a hospital staff member.	Bank statements were retained. However, there are no supports for any deposits and withdrawals from the account.	Account has been used as a 'private investment account'.
'Infectious Diseases Research Account' (FHHS) – opened in 1997	To hold moneys received from pharmaceutical companies for drug trials and guest speaker fees.	Some bank statements and supporting documentation for transactions have not been retained.	The account has been used to fund minor items of equipment, travel and staff training.

Table 3: Unofficial bank accounts.

Lack of controls over the receipt of moneys has led to moneys belonging to hospitals being deposited into 'unofficial' bank accounts and used outside of hospital policy and systems.

Source: OAG

Fundraising Bank Accounts

In addition to the unofficial bank accounts containing hospital moneys, audit testing also identified many accounts that hold moneys raised from fundraising activities undertaken by staff or volunteers associated with the hospital. These moneys, which are held in bank accounts operated by hospital staff or volunteers and not in authorised hospital accounts, are used for hospital related purposes such as providing benefits to patients or equipment for a ward or department.

As these moneys are raised for the benefit of the hospitals, there is an obligation on the hospitals to ensure those funds are used for the purposes they were raised for. However, the practice of placing moneys in 'private' accounts means the hospitals may not be able to demonstrate that they have fulfilled these obligations as they do not control the operation of these accounts.

In addition, the *Hospitals and Health Services Act 1927* (HHSA) allows for hospital boards to authorise any person to collect voluntary contributions and donations. However, audit inquiries established that hospitals were not generally aware of this provision, and had not authorised persons under this Act. The provisions of the *Charitable Collections Act 1946* (CCA) also apply to the collection of money or goods for charitable purposes which includes the support of hospitals.

The Crown Solicitor's Office has advised that hospital boards should make appropriate appointments in terms of the HHSA and the appointees should be licensed under the CCA. In respect of the CCA, it may be appropriate for the hospital board or some other hospital official to be licensed under the CCA and appointments made pursuant to that licence having regard to the HHSA. The Crown Solicitor' Office also advised that moneys collected by persons appropriately authorised are moneys belonging to the hospital and must be dealt with in terms of the FAAA.

Implications of Revenue Control Weaknesses

These weaknesses over the raising and receipting of moneys, combined with staff lack of awareness of the requirements of the FAAA has, in part, led to some moneys belonging to the hospitals being placed in these unofficial bank accounts. In view of these shortcomings and the circumstances involved in establishing these accounts, Audit:

- cannot provide assurance that the transactions through these unofficial accounts were appropriate or for official hospital related purposes that would have normally been approved by hospital management; and
- is not able to provide reasonable assurance that all hospital moneys due and received have been deposited into the hospitals' operating accounts and SPAs.

Other Revenue Issues

Testing of revenue controls and a review of other activities associated with the operation of SPAs also identified a number of other issues as outlined below.

Use of Special Purpose Accounts and the 'Diversion' of Hospital Funds

One of the issues raised about the use of SPAs has been concerns that moneys which should have been recorded as hospital revenue have been 'diverted' to SPAs. Examples of these moneys include:

- miscellaneous revenues such as commissions from the hire of television sets and amounts received as recoups, subsidies, discounts or other cash back arrangements from suppliers; and
- moneys received from services provided to external parties (referred to as business activities). These activities range from conducting tests using hospital equipment through to running courses and workshops[11].

The placing of such moneys into SPAs is basically a reallocation by hospital management from one hospital account, or activity to another within the hospitals' accounting system and therefore does not represent a diversion of funds. However, the following shortcomings were identified:

- revenues are not placed in SPAs on a consistent basis between the hospitals. Instances were noted where one hospital would place moneys into the operating account whereas another hospital would use an SPA; and
- costs met from one fund are not always matched against resulting revenues. For example, a hospital invoiced a university for services provided by a nurse educator who was paid from operating funds. Approximately half the recoup received from the University was transferred to a SPA even though no salary payments were made from the SPA.

This results in the costs carried in the operating fund being overstated and can also compromise the accuracy and reliability of costing specific hospital procedures. Hospitals must ensure that where material revenues are earned, costs associated with that revenue are recognised in the same fund.

Receipt of Donations and other Funds into Hospital Accounts

Public hospitals receive donations from a variety of sources, including donations and bequests from the public, corporate bodies, suppliers to the hospital and through fundraising activities conducted on behalf of the hospital. Each hospital also has an 'affiliated' Foundation that undertakes fundraising activities for the benefit of the hospitals. Issues of concern were identified:

11 Further findings on the operation of business activities are contained in a following chapter of this report.

Donations to Hospitals

KEMH/PMH and SCGH have implemented practices to forward donations received by or at the hospital to their 'affiliated' Foundation, even though there may be no evidence to indicate the donation is for the Foundation. In cases where there is no evidence that the donation is for the Foundation, these practices do not comply with the FAAA as they are hospital moneys, which must be recorded and banked by the hospital.

Passing donations to the Foundations could also result in the donor's intent not being fulfilled, with the hospitals not having control over the timing and use of those funds.

Donations and Other Moneys Received from Hospital Staff

The hospitals receive 'donations' or other revenue from various hospital staff which is receipted into SPAs. This include funds received from activities undertaken by staff outside their hospital duties, such as income received from private practice arrangements for sessional or part-time staff and fees received for preparing medical reports and presentations. Issues identified from these arrangements, which could result in concerns being raised about the bona fides of the donation and subsequent taxation issues, were:

- the moneys are receipted into SPAs where the individual providing the funds is an authorised signatory to the account, or the purpose of the SPA includes an activity such as research which the individual is involved with; and
- the cheque is from the organisation paying for the services provided, rather than from the individual.

These issues have been addressed in a donations policy recently implemented by KEMH/PMH, the principles of which must be implemented by all hospitals. This policy requires donations to be evaluated before acceptance, including consideration of whether the offer is tied to some derivable benefit to the donor. In addition, donations of cheques marked to other persons and not payable to the hospital should only be accepted in special circumstances with the express approval of the Chief Executive.

Donations from Hospital Suppliers

The hospitals also receive donations or funding from various suppliers of goods and services, such as pharmaceutical companies and equipment suppliers. Instances were noted where these moneys were used for the benefit of staff, such as a staff dinners or other similar activities, while in other cases funding was provided for travel by hospital staff to attend conferences. In addition 'non cash' benefits, such as a company directly paying for the cost of travel for a hospital representative to assess new technology, is also provided in some cases.

These types of arrangements and practices may give rise to perceptions of conflicts of interest and potential 'bias' in supply processes and must be avoided.

Recommendations

The accountable authority/hospitals should, as a matter of urgency:

- implement appropriate control procedures for the raising of invoices and the recording of sundry debtors. These procedures should ensure:
  - recoverable fees and charges are recorded on debit notes and procedures are put in place to ensure invoices are raised for all revenue;
  - invoices are recorded in a debtors system so that appropriate recovery action can be instituted for any amounts outstanding;
  - invoices are issued on official hospital stationery; and
  - debtors' balances are included in the hospitals' financial statements.
- ensure all mail received at the hospitals is opened in a secure environment and that all moneys sent to the hospitals are immediately recorded and where appropriate, receipted and banked in a timely manner;
- ensure all moneys belonging to the hospital is receipted and banked into official hospital bank accounts. Unofficial accounts should be fully investigated by the hospitals and any hospital moneys transferred to hospital controlled bank accounts;
- ensure fundraising activities conducted on the hospitals' behalf are appropriately authorised and licensed in accordance with legislative requirements;
- review moneys placed into SPAs and ensure funds are allocated to the operating fund if the moneys are of an operating nature. Where material revenues are received and placed into a SPA, costs associated with earning that revenue should be recognised in that account; and
- develop policies covering all forms of donations and other gratuities received by the hospital and ensure such funds and gratuities are evaluated prior to acceptance.

KEMH/PMH and SCGH should record all donations received by the hospital and either receipt and bank the moneys if the donation is for the hospital or record details and only forward the moneys to their respective Foundation if there is evidence the donation is for the Foundation.

Expenditure from Special Purpose Accounts

- *Around 80 per cent of payments made through SPA accounts are of a routine nature such as salary payments and hospital equipment and building addition expenditures. However, the controls and processes for checking and authorising expenditures from SPAs were not operating effectively to ensure proper control and accountability was maintained.*
- *These weaknesses make it difficult for hospitals to demonstrate that all SPA expenditure was in accordance with the purposes for which moneys were received and for Audit to verify the appropriateness of payments. Many examples of inadequately supported payments, payments not evidenced as being reviewed or authorised by hospital staff and payments that did not comply with the stated purpose of the account were identified.*
- *No payments from these accounts for categoric personal benefit, fraudulent purposes or purposes not related to hospital activities were identified from audit testing.*
- *The integrity of staff was effectively the only safeguard against abuse in many instances.*
- *The appropriateness of payments from unofficial bank accounts will need to be fully investigated.*

The Nature of Hospital and Special Purpose Account Expenditure

For the 2000-01 financial year, the four teaching hospitals spent $975 million, of which $650 million involved payroll-related expenses and $325 million on other goods and services related to the operation of the hospitals. Most of this expenditure is routine, involving payments related to providing patient care such as the purchase of drugs, hospital equipment, medical supplies, meals and building repairs and maintenance.

In comparison, expenditure from SPAs is more varied as it involves many activities other than patient care. Although SPA expenditure is around three per cent of total expenditure, it encompasses a much greater variety of purposes. This includes expenditure on research and teaching activities, patient welfare, staff professional development, sundry business activities and capital projects.

Nevertheless, the majority of payments from SPAs are also routine and include salaries for research staff, training course expenses, capital expenditure on building additions and maintenance and staff travel. For example, salaries are paid through the hospital payroll system and staff educational travel is subject to a comprehensive approval process. A break-up of SPA expenditure is shown in Figure 2.

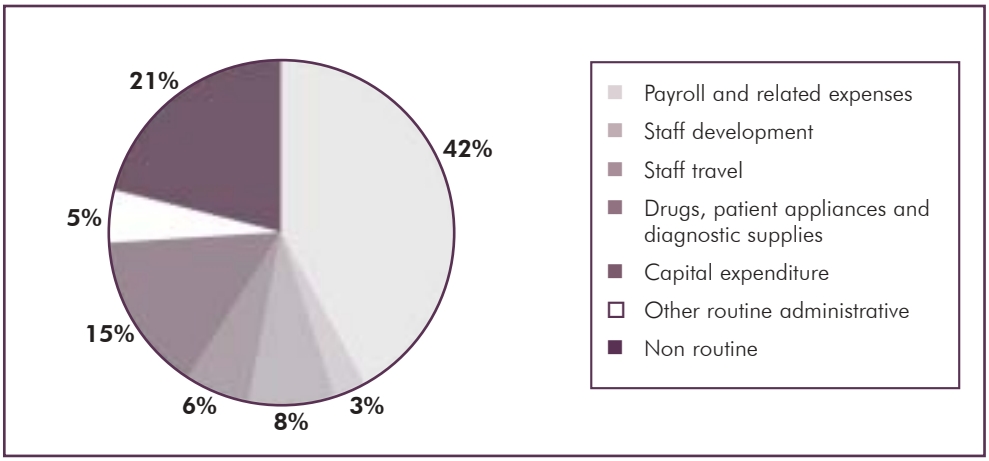

Figure 2: Analysis of expenditure from SPAs in the four teaching hospitals for the 12 months to June 2001

Of the $30.1 million spent in the financial year most related to routine payroll, capital and hospital expenses. Only about $6 million (21 per cent) related to expenditure that could not be categorised as routine from the account codes used. Even travel expenditure, which has attracted significant concerns, only amounts to eight per cent of SPA expenses.

Source: OAG

Appropriateness of Expenditure

Central to assessing appropriateness of expenditure from SPAs is understanding the source of funds and the nature of the expenditure and whether the payment is in accordance with any restrictions placed on the use of those moneys. This is not always an easy task, as illustrated in the example below:

Staff at a hospital spent several thousand dollars buying gift vouchers, which appeared to be an inappropriate use of hospital moneys. However, further investigation identified that the moneys staff were spending were provided by the Lotteries Commission of Western Australia for the purpose of generating *"Christmas cheer to patients and volunteers at the Hospital"*. Under these circumstances, the purchase of these items as Christmas gifts for patients was appropriate.

In contrast, expenditure that may appear to be an appropriate use of hospital moneys may actually be questionable given the source of funds as shown in the example below.

Certain hospital staff have a need to be contactable at all times and therefore, the use of hospital moneys to meet the operating costs of mobile phones appears appropriate. However, further investigation identified that SPA moneys comprising donations from patients and grants for specific research projects were being used to fund these mobile phones. In this case, it would have been more appropriate for mobile phone costs to be met from the hospital's operating account.

The issue of 'appropriateness' has been a source of misinterpretation and misperception and therefore, one of the main objectives of this audit was to determine whether hospitals had an adequate control framework for ensuring that all SPA expenditure is 'appropriate'.

Requirements for Effective Controls Over Expenditure

With many sources of moneys, often with different or related restrictions, managing expenditure from a large hospital to ensure all payments are appropriate requires sound internal controls, good financial records and documentation on the types of expenditure that can be made from a SPA.

The underlying principle of expenditure controls is 'division of duties' where at least two independent persons ensure all payments are adequately checked and authorised prior to payment. For State Government agencies, the FAAA prescribes the minimum internal controls and makes two appointed officers primarily accountable for the processing of each payment. These are:

- An incurring officer whose responsibilities include being satisfied that the creditor's name and address is correctly recorded, the accounts to be charged are correct and that the goods have been satisfactorily supplied or services performed. Although this officer is not required to perform all these checks personally, he or she is responsible for ensuring that the checks are performed and must sign a certification to that effect.
- A certifying officer whose responsibilities include ensuring that payments have been properly incurred and that *"money is lawfully available for the payment of that account"*. This officer must certify each payment to state that the payment is correct within the meaning of the FAAA.

Effectiveness of Expenditure Controls

Over the years, the teaching hospitals have made a series of gradual changes to their processes for making payments. These changes have resulted in incurring and certifying officers placing more reliance on computer system controls and the approvals of other officers when discharging their duties. For expenditure from SPAs, this involves two different processes:

Payments by Requisition: Under this process, a requisition is authorised and an order issued. A goods receival form and the invoice are entered into the system on receipt of the goods. The incurring officer certifies these payments relying on the authorised requisition and the matching of these various documents.

Other Claims for Payments: Claims for payments (eg invoices) without requisitions are authorised by SPA signatories. These claims are forwarded to the Trust Accountant (or equivalent) who is employed in the hospitals' finance sections. This officer is responsible for checking that payments comply with any conditions of the SPA and is approved by the account signatories. The incurring officer certifies payments relying on these prior approval processes. Most SPA payments are made through this process.

However, the results of audit testing, as outlined in the following sections, demonstrated that this process is not operating effectively. There were many payments identified that failed to meet the requirements of the FAAA. This has occurred because:

- Incurring officers, who are normally responsible for keying payment details into the computerised payment system, were not challenging claims for payments that were not adequately supported, or had not been signed as authorised by account signatories and/or were not evidenced as reviewed by the Trust Accountant.
- Certifying officers were not always sighting the claims for payment to ensure all payments were properly incurred and met legislative requirements. In many cases, the role of the Certifying Officer was limited to merely checking the availability of funds in the bank account before releasing all payments for automatic payment to meet the requirement that *"money is lawfully available for the payment of that account"*.
- Payments were not always signed as incurred and/or as certified.

A further weakness in this approval process for SPA expenditure was that the Trust Accountants did not sight claims for payment that were initiated by requisition or payroll expenses. In the case of requisition payments, reliance was placed on the initial approval of the requisition and the system matching details of the order and invoice.

Authorisation and Review of Claims for Payments

The primary reason for creating an SPA is to assist in ensuring that moneys are used in accordance with a specified purpose or restriction. Incurring and certifying officers do not have a detailed knowledge of the purposes of every SPA and therefore rely on the authorised SPA signatories and the Trust Accountant to ensure that expenditure is in accordance with those purposes or restrictions. The results of audit testing, as shown in Table 4, identified however that many payments had been processed without evidence that authorised SPA signatories and/or Trust Accountants had checked the expenditure against purposes or restrictions.

In addition, the purpose of SPA moneys or identity of SPA signatories were not always documented, which made it difficult for the Trust Accountant to perform appropriate checks. Specifically:

- Prior to 1999, SPA statements were not prepared by RPH for SPA moneys. Since then, SPA statements have been prepared but only for new SPA accounts. Consequently, SPA statements and authorised account signatories were only available for 38 per cent of sampled expenditure.
- For over ten years, SCGH has had a policy on documenting its SPA accounts and consequently, adequate SPA statements were available for a majority of SPA expenditure sampled by audit. However, only three per cent of sampled expenditure was evidenced as reviewed by the Trust Accountant.

- KEMH/PMH was the first hospital to be subject to the recent internal audit reviews and since late 2001, has taken concerted action to rationalise its SPA accounts and document purposes, restrictions and authorised signatories for its SPA accounts. Audit testing identified that 98 per cent of sampled expenditure was supported by adequate SPA statements.
- FHHS has also recently completed a process of reviewing and updating the documentation of the purpose, restrictions and authorised signatories for its SPA accounts. FHHS also has the smallest number of SPA accounts and SPA statements were available for virtually all SPA expenditure sampled by audit.

While most SPA claims for payment are forwarded to the Trust Accountants, these payments were commonly not signed or certified to evidence that the payment complied with the purpose of the SPA. Therefore, the hospitals were not able to demonstrate that SPA payments had been checked against the purpose of the SPA and were valid.

Supporting Documentation for Payments

Audit testing identified that the level of supporting documentation for many SPA payments was inadequate, as shown in Table 4. Many payments were supported by memos, e-mails, photocopied invoices and statements that made it difficult to demonstrate the authenticity of claims for payment. These supports should not have been accepted by the Trust Accountants and the incurring and certifying officers as evidence that goods and services had been satisfactorily supplied and a valid claim for payment existed.

Per cent of Sample Tested	RPH	SCGH	KEMH/PMH	FHHS
SPA had documented purpose and authorised signatories	38%	84%	98%	99%
Signed by authorised SPA account signatories	28%	85%	92%	97%
Signed as approved by the Trust Accountant	27%	3%	59%	77%
Payments were adequately supported	38%	49%	84%	80%

Table 4: Results of testing of SPA expenditure.

Audit testing identified that controls were not operating effectively to varying degrees across the four teaching hospitals.

Source: OAG

Examples of the types of payments that were processed without question or challenge through the hospital system and did not have adequate supporting documentation are illustrated below:

In July 2001, a secretary of a department at RPH sent a memo to the Trust Accountant requesting that $10 000 be withdrawn from a SPA and made payable to the Ward X1 Patient Fund. This memo did not provide any details of the purpose of this payment. This Fund was a bank account operated by staff of the department, which had been opened without the approval of the hospital or following the requirements of the FAAA. The $10 000 was expended on the establishment of a 'therapeutic garden' at the hospital.
In March 2001, a payment of $5 000 was made for the purchase of 'Asthma Genetics Consumables' to a research institute associated with KEMH/PMH. The claim for payment did not provide specific details of the type and quantities of consumables purchased and there was no evidence that the consumables had been used by or delivered to the hospital.
An e-mail was received by a Trust Accountant at RPH in April 2001 requesting a payment of $5 000 to a staff member as a special grant. No other supports were provided or requested. The e-mail did not provide sufficient evidence that the staff member had a legal entitlement to the grant nor did it state how the amount was calculated.
In 2001, four payments of $500 for petty cash were made from a SPA at FHHS. Discussion with hospital staff established that the accounting branch would pay a particular hospital department $500, the department would spend it and then request a further $500. The accounting branch would then pay the additional amount, but did not require that any receipts, invoices or other documents be provided to corroborate the expenditure.

A further specific area where insufficient documentation occurred related to payments to accounts operated at the universities. Staff from these institutions often administer research projects at both the hospital and university and numerous transfers and payments were identified between accounts at these two organisations. Some payments were supported by invoices, however other payments were for 'topping up' accounts at the university that had overrun budgets. For example:

A payment of $10 463 from a SPA at KEMH/PMH in February 2001 was supported by a memo requesting moneys to be transferred to a University research account to 'cover over-drawings'. Discussions with hospital staff indicated that this related to the use of 'surplus' or 'reserve' funds in the SPA which were transferred to support a research project at the University that had over-run its budget.
An amount of $50 000 was paid from a SCGH account relating to a research project on liver and kidney transplant recipients to a University account associated with research on stroke risks.

Mixing Moneys in Special Purpose Accounts

In addition to the lack of adequate documentation and authorisation of payments, a further shortcoming that made it difficult to audit the appropriateness of SPA expenditure was the mixing of moneys with different restrictions in the one SPA account.

These restrictions were often not disclosed on the SPA statement and numerous cases were noted where the purpose, or restriction applying to the moneys was not consistent with the purpose of the account. In addition, the hospitals generally did not have systems in place to track and separately account for moneys with different restrictions. This mixing of moneys and different expenditures from these accounts made it difficult to determine which moneys were spent on which purposes and the balance of funds remaining, as shown below.

Bequests totalling over $230 000 restricted for the purpose of physiotherapy research were placed in a SPA at KEMH/PMH which also contained other bequests, donations, and income from business activities.

Although the SPA statement did not reflect the restriction, it was the only SPA identified in the hospital for which the account holders maintained records of payments and balances for the different sources of funding and restrictions within the SPA.

A bequest of $32 031 received for the 'use and sole purpose to fund oncology cancer services' was allocated to a SPA that is also used for the receipt of patient donations for the purpose of purchasing 'ward items' for the gynaecology unit. In addition, this account was being used to manage income and expenditure relating to running a training course.

Further inquiries and audit testing from these and other similar accounts indicated the moneys were most likely spent in compliance with the purpose of the donation or bequest, however, these practices made it difficult to match expenditure against the source of funds.

Implications of Expenditure Control Weaknesses

These audit findings showed that the hospitals' internal control processes were not operating effectively to ensure that all payments had been checked for 'appropriateness'. Inadequate supporting documentation, transfers of moneys to accounts at other organisations, lack of evidence of approvals and the mixing of moneys in SPAs make it difficult for hospitals to demonstrate that SPA payments comply with authorised purposes.

Consequently, Audit was not able to provide reasonable assurance that all expenditure involving the use of moneys in hospital SPAs was 'appropriate' against authorised purposes or restrictions attached to those moneys.

The results of detailed audit testing of a sample of large payments and areas of potential risk such

as hospitality and travel payments are summarised in Table 5. For example, 62 per cent of sampled transactions at RPH were not supported by adequate SPA statements. In these instances, audit could not assess 'appropriateness' because there was uncertainty as to whether or not external restrictions existed on the use of these moneys.

In addition, between eight and 18 per cent of payments did not agree with available SPA statements across the four hospitals. These transactions could not be assessed as 'appropriate' because poor controls over the maintenance of SPA statements created uncertainty as to whether or not the purpose or restrictions on SPA statements were complete and accurate.

Per cent of Sample Tested	RPH	SCGH	KEMH/PMH	FHHS
Not supported by adequate SPA statements	62%	16%	2%	1%
Did not agree with documented purposes or restrictions	8%	10%	15%	18%

Table 5: Results of testing payments against the documented purpose of the SPA.

Assessing whether SPA payments complied with authorised purposes ie 'appropriateness' was not always possible.

The inability to assess all sampled SPA expenditure as 'appropriate' does not mean that SPA expenditure was used for personal benefit or fraudulent purposes. Extensive audit testing did not disclose any payments that could categorically and without doubt be described as such. In many cases, the lapses in controls were most likely compensated for by the integrity of hospital staff. However, whilst SPA expenditure may have ultimately been used for hospital-related activities, there is the concern that the obligations or restrictions placed on these moneys by external parties may not have been fulfilled.

The operation and use of unofficial bank accounts containing hospital moneys (as discussed in the previous section) is also of significant concern. The payments made from these accounts must be fully investigated by hospitals to determine if they are appropriate and used for official hospital purposes.

Compliance with Government Policies and Guidelines

Government agencies, including hospitals, are also required to comply with a range of government policies and guidelines. Expenditure made from SPAs was also reviewed for compliance with these requirements with the following issues being identified.

State Supply Commission Supply Policies

State Supply Commission supply policies require quotes to be obtained for the purchase of goods and services. These requirements have been established to demonstrate that value for money has been obtained and there is a transparent process of open and fair competition.

Audit testing identified numerous instances where quotes were not obtained or evidence of the quotes had not been retained or could not be provided.

Travel Expenditure

Numerous issues have been raised in relation to hospital staff undertaking interstate and overseas travel funded from SPAs. Travel payments formed a significant proportion of the sample of payments tested.

The *MHSB AMA Medical Practitioners Agreement 1999*[12] and previous agreements provide for a share of moneys earned from medical practitioners' private practice income to be distributed to an 'approved Trust Fund'. In practice, these moneys are held in SPAs operated by the hospitals. Eligible medical practitioners can apply to these accounts for payment in respect of each period of conference or overseas study leave entitlement. Testing showed that all hospitals had well documented and consistently applied procedures for assessing and approving applications for travel. Leave was supported by detailed records of staff entitlements.

However, travel outside of those entitlements that were funded from other sources of hospital moneys such as research grants were not as well controlled. Government and hospital policies requiring overseas travel to be approved by the Chief Executive Officer and/or the Director General of Health, and the Minister were not always complied with. In one hospital, 17 (or 65 per cent) of 26 overseas travel related payments sampled by Audit had not been properly approved. In addition, the purchase of airline tickets was not always supported by requisite quotations.

Two further issues identified in relation to travel were:

- Different travel allowance rates were used both across the four hospitals and within individual hospitals. This issue needs to be clarified with the Department of Health.
- The AMA Agreement refers to an 'approved Trust Fund', 'approved trust fund' and 'trustee of the Trust Fund'. The Crown Solicitor's Office has advised that, as the Agreement now stands, moneys received by the hospitals under the Agreement are special purpose moneys and in relation to these moneys, the use of those terms is not appropriate.

A further area of concern involved travel undertaken by university staff where the travel was funded from hospital SPA moneys. In these cases, university policies rather than hospital policies were applied which resulted in hospital/government approval processes and reporting requirements on the travel undertaken not being followed. In these instances, there is the potential for expenditure to be subject to less scrutiny, as the following example illustrates.

12 This agreement was replaced by the *Medical Practitioners (Metropolitan Health Services) AMA Industrial Agreement 2002* on April 23, 2002. Existing provisions relating to right of private practice continue to apply.

A university staff member authorised a payment in July 2001 to reimburse his credit card for expenses related to travel to various overseas conferences. These expenses included an amount of $25 339 for airfares which were subject to recoup from the conference organisers. Although the payment was incurred and certified, no action was taken to initiate recovery of the amount. At October 31, 2002, the moneys had not been recovered or recorded as a debtor in the hospital's accounts.

Hospitality Expenditure

Guidelines on official hospitality issued in a Premier's Circular establish general principles regarding hospitality expenditure for government agencies. These guidelines outline the circumstances, or purposes for which hospitality can be provided. They also detail authorisation and documentary requirements, such as recording the purpose of the expenditure, that ensure both accountability for and transparency of any expenditure on hospitality. Generally the hospitals were not aware of these guidelines and did not enforce internal policies that establish the same levels of accountability and transparency.

As a result, hospitality expenditure at the hospitals did not always fit the purpose outlined in the guidelines or meet the documentary requirements. However, the payments tested by audit were not abnormal or extravagant and were generally in line with expenditure of the same nature in other government agencies.

Hospitality expenditure over the period tested was also not significant either in terms of the number of purchases or the amounts spent. However, these types of payments were difficult to identify due to all hospitals coding most restaurant meals and alcohol purchases to account codes used for patient food rather than account codes for hospitality or entertainment.

Appointment of Staff

A review of the appointment process for employees to positions funded from a SPA identified that practices differed between the hospitals. At RPH and KEMH/PMH, staff are appointed following a merit based selection process in accordance with Public Sector Standards in Human Resource Management. However, audit testing at SCGH and FHHS found that appointments were not always subject to merit-based selection in contravention of these Standards.

Recommendations

The accountable authority/hospitals should:

- review the incurring and certifying functions and implement procedures that comply with the requirements of the FAAA. For expenditure from SPAs, it is further recommended that:
  - the Incurring Officer should be a person with appropriate knowledge of the requirements of the SPA and is able to ensure the accuracy of account classifications and confirm that goods and services have been satisfactorily received. It is suggested that the business managers who are located in each division of the hospitals would be suitable officers to be responsible for incurring payments from these accounts; and
  - the Certifying Officer should be a person with appropriate knowledge of and access to information about the requirements and balances of these accounts. It is suggested that the trust accountants be appointed as certifying officers, given that these officers already perform some of the certifying officer functions.
- ensure Incurring and Certifying Officers are trained and made fully aware of the responsibilities of these positions. These officers should ensure no claims for payment are processed unless adequate supporting documents are provided, sufficient explanations for expenditures are obtained and recorded and all relevant hospital and government policies are complied with;
- review or prepare policies on hospitality expenditure that incorporates the principles and requirements outlined in the Premier's Circular *Guidelines for Expenditure on Official Hospitality*. The policy should be communicated to all staff and any hospitality expenditure should not be incurred unless it complies with the policy;
- ensure State Supply Commission supply policies, such as the use of common use contracts and the obtaining of quotes, are complied with;
- develop and reach specific agreements with the universities to govern the activities of university staff that involve the operation of SPAs. This should include the clarification of ownership of moneys administered by university staff at the hospitals, approval procedures for transfers between university and hospital accounts and travel approvals involving University staff from hospitals funds; and
- ensure Public Sector Standards in Human Resource Standards are applied to all staff appointed to positions funded through SPAs.

Budgeting, Monitoring and Reporting of Special Purpose Accounts

- *SPAs were not subject to the same budgeting requirements as for normal operating accounts and budgets were not prepared for most accounts.*
- *The extent of financial monitoring and reporting varies from good through to inadequate and does not always allow for effective oversight and review at all levels within the hospital and through to the accountable authority.*

Budgeting and Monitoring Controls

One of the key issues raised about the administration of SPAs has been the extent of budgeting and monitoring that is undertaken both within the hospitals and to the accountable authority. This issue has even greater significance given:

- the obligations placed on hospitals regarding the use of moneys in these accounts;
- the types of activities and variety of purchases made through these accounts; and
- that the management of individual accounts often resides with committees, or individual(s), who are initially responsible for authorising transactions through these accounts.

The recording of SPAs in a separate fund(s) from operating moneys and the focus on managing operating moneys has resulted in budgeting and monitoring arrangements for these accounts generally being less comprehensive than for operating accounts as outlined below.

Budgeting

SPAs have not been included in the annual operating budget that is submitted to the accountable authority and the Department of Health. At the individual account and hospital level, budgets are only prepared for some key SPAs which have a large volume and value of transactions such as the General Research and Special Purposes Fund at RPH (balance of $4.45 million at December 31, 2001) and Clinical Staff Education Funds.

However, the budgets for these accounts are only prepared for internal management purposes and do not form part of the overall budgeting framework that applies to operating funds.

The receipt of funds such as donations cannot be forecast and therefore, budgets may not be relevant for some SPAs. However, hospitals have not prepared budgets for those SPAs where there is a need to ensure that:

- ongoing commitments (such as payment of salaries) are met;
- contractual or other obligations are met; and
- hospital resources and/or assets invested or assigned to revenue raising activities are used effectively.

These SPAs typically include those related to research and major business activities.

KEMH/PMH have recently taken action to introduce budgeting for SPAs, where appropriate, as part of the restructure and rearrangement of SPAs. This includes all research SPAs being brought under the control of a research committee that is responsible for ensuring budgets are prepared and monitored.

Monitoring and Reporting

Monitoring and reporting on the use of operational moneys normally involves a number of levels of review within the hospital structure. The level of monitoring and reporting on SPAs, however, has not always been subject to the same rigour, as shown in the table below.

	Level of Monitoring and Reporting of SPAs at Individual Hospitals			
Level of Monitoring and Reporting of Operating Accounts	**FHHS**	**KEMH/PMH**	**RPH**	**SCGH**
Committee or individual responsible for the account	✔	✔	✔	✔
Head of Department (or other senior management) supplemented with review by Business Managers	✘	✘	✘	✔* *but no review by Business Managers
Hospital Executive or Finance Committees	✔	✔	✔	✔
Accountable Authority (limited reporting only)	✘	✘	✘	✘

Table 6: Summary of monitoring and reporting undertaken at the hospitals.

The most significant difference in the extent of monitoring and reporting on SPAs, compared with operating accounts, is at the Head of Department (or divisional head) level.

All hospitals prepare reports at the account holder level, however as outlined above, Heads of Departments (or equivalent) do not always receive reports on SPAs for their department or division. This contrasts with monthly finance reports on operating funds that are provided to the various Heads of Department which are also supplemented with other reviews/reports prepared by Business Managers attached to each division.

Reporting to the accountable authority is limited and does not allow for effective oversight or review. A one line summary showing balances, receipts and payments for all accounts in total at each hospital is reported which contrasts with more comprehensive reporting for operating funds.

Recommendations

The accountable authority/hospitals should ensure that:

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

Other Issues Affecting the Operation of Special Purpose Accounts

Background

During the audit, various issues were identified in respect of the type of activities or transactions that are made through hospital SPAs. This section details findings relating to common categories of SPAs such as business and research activities transacted through these accounts. Comments and findings on matters raised in previous reviews, or on other issues identified through this audit are also detailed in this section. Matters covered in this section are:

- the operation of business activities which involves the provision of ancillary services and products by the hospitals to other public hospitals, the general public and private sector organisations;
- the management of research activities, which includes undertaking clinical trials for private sector firms on a fee for service basis;
- the operation of privatised clinics which involves the private billing of patients or bulkbilling Medicare; and
- the hospitals' relationships with external bodies, such as research institutions, fundraising foundations and other support and voluntary groups associated with the hospital.

Many of the findings and subsequent recommendations in this section relating to the above matters deal with common issues or themes. These include:

- hospitals compliance with applicable legislative provisions;
- issues concerning cost recovery, or matching costs to revenues for activities transacted through SPAs; and
- entering into agreements that are signed by staff authorised or delegated to act on behalf of the hospital.

Business Activities

- *The hospitals have not always obtained approval required under the Hospitals and Health Services Act 1927 or the State Trading Concerns Act 1916 for the operation of business activities.*
- *Arrangements to recover costs associated with operating business activities were inconsistent and there were no policies or guidelines on what costs should be recovered.*
- *Budgets and financial evaluations to estimate the viability of business activities were not always prepared.*
- *Fees and charges were not reviewed or approved in accordance with the FAAA.*

The hospitals provide a range of ancillary services and products to other public hospitals, the general public and private sector organisations. The provision of these services and products, which are referred to in this report as 'business activities', include the manufacture of pharmaceutical products, repair and maintenance of equipment, examinations using hospital equipment, sale of manuals, and the facilitation of courses and workshops. Commercially funded research, which involves undertaking research trials for a fee, could also be included in this classification, however this issue is discussed in the following section of this report.

The revenues and expenditures of business activities are accounted for through SPAs and are kept separate from the hospitals' operating accounts. A complete list of all business activities operated by the hospitals was either not available or incomplete with many smaller activities being mixed with other moneys in SPAs.

However, estimated expenditures for identified business activities are around $2.7 million for the year ended December 31, 2001. The size of these activities varies significantly and range from revenues of $856 000 for a pharmaceutical manufacturing facility operated at KEMH/PMH through to minor revenues received for activities such as 'one-off' training courses.

Legislative Requirements

The conduct of business activities is subject to the provisions of the *Hospitals and Health Services Act 1927* (HHSA). Under this Act, the board of a public hospital may, with the prior approval of the Minister, provide services to another person or body and receive payment. These services are defined as being *"of the kind that the board in question provides for the purpose of performing its functions, and include advice, the performance of work and the use of facilities"*.

If the business activities being undertaken by the hospitals are not 'services' of a type defined and approved in terms of the HHSA, then the provisions of the *State Trading Concerns Act 1916* (STCA) apply. This Act authorises government entities (subject to approval by the responsible Minister) to engage in certain activities with the view of making profits and/or competing with industry. These activities, which may be beyond the usual functions of government, can only be undertaken under strict administrative, accounting and reporting requirements.

Evidence was not available to show that the hospitals had obtained approval under either the HSSA or the STCA for most of their business activities. The Crown Solicitor's Office advised Audit that the issue of whether business activities fall under the HHSA or the STCA needs to be examined on a case-by-case basis but generally, courses and workshops provided to non-hospital staff would likely require approval under the STCA whereas other activities would likely come under the HHSA.

In the absence of appropriate authorisation under the HHSA and STCA, the hospitals may not be able to enforce legal agreements involving their business activities and may be exposed to losses and liabilities not covered by existing insurance arrangements.

Financial Arrangements

For the larger business activities, the hospitals have approved the establishment of separate SPAs to keep track of revenues and expenditures. Mechanisms have been put in place to recoup the costs of hospital resources used in these activities, such as staffing, facilities (utilities, rent and depreciation charges) and overheads.

These recoups typically involve a share of gross revenues or net 'profits' being transferred to a hospital operating account and the balance retained in the SPA to purchase equipment associated with the business activities or for the general benefit of the hospital department carrying out those activities. This provides an incentive for hospital departments to identify services for which payment can be received and so increase the revenue base for the hospital.

It was identified however that:

- The share of 'profits' is 'arbitrary' with no policies or guidelines on what costs should be recouped to ensure that there are no significant impacts on hospital operating resources.
- Budgets and financial evaluations or business cases to determine the viability and estimate the financial return from undertaking these activities are not prepared. These arrangements should be put in place for major business activities of an ongoing nature.
- The prices or fees charged for the provision of products and services have not been formally approved and reviewed by the hospital on an annual basis as required by the FAAA. The costs of business activities may therefore not be fully recovered, resulting in losses to the hospitals.
- Some business activities have operated without any recoup arrangement or hospital oversight. These business activities are also 'mixed' with other activities funded from the same SPA, making it difficult to assess financial performance.

Recommendations

The accountable authority/hospitals should identify and review all its business activities and ensure that:

- appropriate approval is obtained in accordance with the *Hospitals and Health Services Act 1927* and the *State Trading Concerns Act 1916*;
- arrangements for cost recovery and profit sharing are formally approved and implemented on a consistent basis;
- budgets and business cases are prepared and approved for major and ongoing business activities;
- fees and charges are based on full costing and are reviewed and approved in accordance with the FAAA; and
- business activities are properly demarcated from other SPAs and departmental moneys to allow for monitoring and review of the financial performance of these activities.

Management of Research Activities

- *Research agreements with third parties to undertake research activities were not always vetted to ensure the hospitals had not been exposed to unnecessary risks.*
- *Agreements were not always signed by an officer authorised to act on behalf of the hospital.*
- *Budgets and business cases to estimate the financial return were not generally prepared for research clinical trials, which involve a fee for service arrangement.*

A major function of the four teaching hospitals is to undertake research activities focusing on acquiring new knowledge and solving specific medical problems or applications. Research can be categorised into the following groups by source of funding:

- Competitive grant research – funded by external granting organisations, such as the National Health and Medical Research Council, for a wide range of purposes.
- Commercially funded research – funded by commercial organisations, typically pharmaceutical companies, generally for the purposes of trialing new drugs, treatments and medical devices. This type of research is funded on a fee for service basis, usually dependent on the number of patients participating in the trial.
- 'Self-funded' research – funded internally by the hospital and normally involves developing a research concept to a stage where it is able to attract external funding. It can also involve supporting an area of research where the hospital is unable to secure other sources of funding.

The environment in which research is undertaken is complex and sometimes involves a range of 'affiliated' institutions working in collaboration with the hospitals. These institutions often share resources and use hospital resources and accommodation. Examples of these bodies include the Women and Infants Research Foundation and the Western Australian Institute of Medical Research.

Many research activities also involve employees from the University of Western Australia Medical School who are involved in undertaking research and teaching activities at each of the hospitals. These staff can also receive other research grants, generally competitive grants, which are managed through the University.

Moneys received by the hospitals for research purposes from external sources are normally subject to funding agreements that restrict the use of the moneys for that purpose, and are therefore, usually held in SPAs and accounted for separately from the other moneys belonging to the hospital. Depending on the size of the research project, funds may be deposited in an SPA created specifically for that project or mixed with the funds for other projects in hospital department research SPAs.

Hospitals do not have complete and up-to-date records of all research being undertaken and therefore, it is difficult to establish the extent and value of their research activities. However, it is estimated that research revenues and expenditures transacted through SPAs totalled around $10 million and $9 million respectively for the year ended December 31, 2001.

This audit reviewed a sample of 34 research grants and trials at the four hospitals primarily to determine if expenditures were in accordance with the research agreements or conditions of the funding. A range of issues covering the approval and financial management processes were identified which hospitals need to address to improve the coordination and management of research activities.

Managing Research

At the time of the audit, none of the hospitals had formal policies or processes in place for coordinating or managing research undertaken by hospital staff and/or undertaken within the hospital. However, a number of initiatives have commenced to improve the management of research activities including:

- KEMH/PMH establishing a research committee that has issued guidelines and procedures for the operation of research activities. Responsibilities of this committee include reviewing and monitoring budgets and financial transactions for research activities.
- SCGH appointing a Director of Medical Research Development whose responsibilities include coordinating and streamlining the management of research related activities.

These initiatives should assist in improving the management of research activities and all hospitals should develop policies and processes to address the following issues identified during this audit.

Research Agreements

Research funded by competitive grants and commercial organisations are normally undertaken to achieve set objectives and/or outcomes. In these circumstances, it is prudent for both the hospitals and the external funding organisations to enter into agreements that establish the rights and obligations of both parties. Typically, a financial agreement is entered into to accept the funding and includes matters such as acquittal requirements and timing of payments. For clinical trials, an indemnity agreement limiting the liability of the hospital from any claims arising from the trial is also entered into.

Common issues identified in relation to these agreements included:

- Agreements were usually drafted by the external funding body and entered into without being legally vetted by the hospital. This exposed the hospitals to unnecessary risks. For example, some agreements were governed by the laws of other states or countries, which could be costly if the government had to contest litigation in another jurisdiction. In other instances, long-term research agreements involving payments to the hospitals in foreign currencies were not assessed for the risk of currency fluctuations.

- Agreements were often signed by the investigator (or doctor) undertaking the research or trial rather than an officer authorised to act on behalf of the hospital. This could potentially invalidate the agreements and adversely affect the hospitals' ability to enforce its rights.
- Five clinical trials involving the use of drugs or applications on patients did not have indemnity agreements, while financial agreements could not be located for two trials.

Research Funding and Financial Management

For research grants received from external bodies, a budget is required to be prepared as part of the application process. However, there was no clear or consistent basis used for deriving budget costings. As an example, the costs of using hospital staff had been factored in some cases while other projects only budgeted for new or additional costs associated with undertaking the research.

For commercial research trials, only one of the 21 trials reviewed had prepared a budget or business case to estimate the financial return (or profit/loss) from undertaking the trial. Only direct labour and other costs were recorded against the revenue received for these trials

It is acknowledged that some external funding bodies restrict the level of funding provided. However, the lack of proper budgeting means that hospitals are not able to demonstrate whether a particular research activity is feasible and whether the level of funding being sought is sufficient to minimise the impact on hospital resources that have been committed or provided for other purposes. These impacts can be greater because:

- There is currently no requirement to identify and charge any overheads against these research activities and the issue of whether these costs should be recovered against the grant or fees received has not been considered. This has the potential to generate surpluses if funds provided by external bodies have included a component for overheads. These surpluses are not normally returned to the hospital operating fund and remain in SPAs for use by SPA account holders.
- There are no systems in place to regularly report on individual research projects and establish whether they are in surplus or deficit. Quantifying surpluses or deficits is made more difficult because research funds are sometimes mixed with other moneys.
- Unspent balances in research SPAs are often used to fund other research projects or expenditures unrelated to any particular research project without having first established the extent of surpluses available.
- There are no hospital policies to deal with the issue of surpluses and the uses to which those surpluses can be applied and therefore, hospitals are not able to effectively demonstrate whether funds have been used in an acceptable manner.

Recommendations

The accountable authority/hospitals should develop policies covering the management of research activities and implement procedures to ensure:

- all research agreements are vetted and signed by officers authorised or delegated to act on behalf of the hospital;
- budgets are prepared and approved for all research activities on a consistent basis before any agreements are signed. These budgets should include the identification of overheads where considered appropriate;
- research projects are reviewed and monitored against budgets;
- research activities are properly demarcated from other SPAs and departmental moneys to allow for monitoring and review of these activities; and
- that the use of surpluses arising from research activities are approved by the hospital.

Privatised Clinics

- *Action has been taken to resolve the operation of privatised clinics at KEMH/PMH although other matters are still being investigated by Commonwealth authorities.*
- *Arrangements whereby private services are provided at SCGH are still being clarified and need to encompass all similar practices operating at that hospital and more generally across the public health sector.*

One of the significant issues raised from the internal audits undertaken at KEMH/PMH involved the operation of what has commonly been called privatised clinics. These clinics generally operate from hospital premises and/or use hospital resources. Patients are bulkbilled against Medicare, with those funds being deposited into a SPA which is used to meet expenses, such as salary and other costs involved in running the clinic.

The internal audit findings identified instances where occasions of care to public patients had been bulkbilled by hospital employed clinicians with the approval of hospital administration. Legal opinion was received that bulkbilling public patients was likely to be in breach of the *(Commonwealth) Health Insurance Act 1973* and the Medicare principles adopted by the State. This requires that eligible people must be given the choice to receive public hospital services free of charge as public patients (and consequently patients elected to be treated as public patients cannot be bulkbilled).

As a result of these findings, the MHSB formally notified the Health Insurance Commission in December 2000 of these matters. The Commission is still finalising its investigations into bulkbilling practices.

The Hospital also stopped bulkbilling arrangements for two clinics in November 2001 until these issues were resolved. The operation of one of the clinics (Cleft Lip and Palate Orthodontic Clinic) has now been approved, while other arrangements have been put in place for the Diabetes Clinic that does not involve bulkbilling by the Hospital.

The Hospital is also seeking clarification on the operation of the other clinic (Sleep Clinic) and in the meantime has stopped the placing of Medicare funds into the Hospital's SPA. This Clinic is considered to be fully privatised as the medical practitioner concerned operates the clinic when not employed by the Hospital.

The Operation of Privatised Clinics at KEMH/PMH

Since the late 1980s, a number of States have developed arrangements under which outpatients are treated as privately referred non-inpatients and billed against Medicare. It has been reported that one hospital in New South Wales treats around 80 per cent of its patients as private referred non-inpatients. These clinics operate at arms length from the hospital and generally have the following features:

- patients must be referred to named hospital specialists working within outpatient clinics and exercising rights of private practice;
- a commercially based fee is charged for the use of hospital facilities in treating these patients; and
- the revenue (after payment of fees for the use of facilities and other clinic costs) is retained by the clinician.

At KEMH/PMH up to 15 privatised clinics were established in the early 1990s to provide additional or expanded services not able to be funded through the hospital's budget. These clinics were also seen as a means of raising additional revenue or making net savings to the cost of the hospital system.

However, there were some differences in how these clinics operated compared with the features outlined above. These included the Medicare revenue being 'donated' to the hospital rather than retained by the clinicians, while there was also no clear separation between the employment of the doctor and their role in operating the clinic.

In the mid 1990s, two issues arose which raised concerns about the operations of these clinics at KEMH/PMH:

- in late 1994, the Commonwealth expressed concerns about 'cost shifting' from the States to the Commonwealth for public outpatient services. Legal advice to the Hospital from the Crown Solicitor's Office and the Legal Section of the Department of Health around this time also raised concerns about the arrangements in place at KEMH/PMH; and
- in mid 1995, advice was received from the Australian Taxation Office indicating that it was likely the doctors would be liable for taxation on the income generated by the clinic.

These issues resulted in many doctors withdrawing from operating privatised clinics and by 1997 only a small number of clinics were still operating. The budget of the Hospital was also amended to allow these bulkbilling arrangements to cease, however the operations of the Diabetes and Orthodontic Clinics continued. In early 1996, the Commissioner of Health also initiated action on these concerns and wrote to the teaching hospitals to:

- *"(a) to ascertain what is happening at the public hospitals in connection with these matters; and*
- *(b) armed with that information, to develop strategies for dealing with current arrangements and guidelines for the lawful establishment of Trusts and private clinics in the future".*

The Department of Health is unable to locate any responses to this request or what further action was taken beyond making these initial queries.

Between 1995 and 1998, KEMH/PMH continued to investigate and develop alternative models for the operation of privatised models, however these arrangements were not finalised or agreed.

Arrangements at Other Hospitals

SCGH operate a number of clinics or have other arrangements in place which involves Medicare revenue being placed in SPAs. This involves six 'clinics' or services operating under similar arrangements.

SCGH has been discussing the billing arrangements utilised at the Hospital with the Health Insurance Commission to clarify whether these processes comply with the *Health Insurance Act 1973*. In addition, the doctors operating one clinic stopped bulkbilling in November 2001 pending further clarification on this issue. It was also noted that differing arrangements are in place covering the billing process and collection of fees for the various clinics.

Two other clinics (one established as an incorporated body and the other as a private company) also operate from SCGH and pay a lease for the use of hospital facilities. These clinics operate their own financial systems. One of these clinics also stopped bulkbilling non-insured outpatients from November 2001 until these bulkbilling issues are clarified.

No similar arrangements were identified at RPH and FHHS which related to the operation of such clinics. However, FHHS advised that issues had been raised whereby private doctors had been bulkbilling from hospital premises provided at no cost and this issue is currently being reviewed. More recently, it has been noted the Well Women's Clinic operated by the Peel and Rockingham/Kwinana Health Service has been closed following a review by the Health Insurance Commission.

Recent Developments

The above history and status of current arrangements portrays an uncoordinated and fragmented approach to establishing clinics and resolving concerns in relation to the operation of these clinics by the Department of Health and hospitals operating such clinics.

In 2001, the Department of Health, with the support of the Government, commenced developing a model based on the approach followed in another State for the introduction of privatised clinics. This model was to be introduced following Health Insurance Commission, Crown Solicitor's Office and Government approval. Details of the financial processes to be followed for these clinics were also included in this model. However, this initiative has been suspended until the Health Insurance Commission investigation at KEMH/PMH has been concluded.

Recommendations

The Department of Health should coordinate and monitor the review of existing arrangements as well as establishment of any new clinics based on the proposed model if this initiative is finalised.

All hospitals should:

- review existing arrangements whereby private services are provided and obtain advice to ensure these arrangements are in accordance with the *Health Insurance Act 1973* and Medicare principles. Financial arrangements covering the billing processes, fees collection and revenue distribution should also be reviewed to ensure adequate controls are in place;
- only establish new clinics in accordance with the model developed by the Department of Health if this initiative is finalised and approved; and
- ensure clinics which are currently operating, or are established in the future, prepare a business case which includes full costing for the use of hospital facilities.

Relationships With External Bodies

- *Many organisations are associated with the hospitals that involve the use of hospital resources. However, agreements setting out the objectives and parameters have generally not been entered into between these organisations and the hospitals.*

Each of the hospitals are affiliated or associated with a range of organisations or groups that often share resources, use hospital staff, are accommodated in hospital premises or are provided with accounting services by the hospital. Some of these 'affiliations' impact on the use of funds in SPAs. These organisations:

- involve the hospitals in research activities - examples of these bodies include the Women and Infants Research Foundation at KEMH/PMH and the Western Australian Institute for Medical Research which involves a collaborative arrangement between SCGH, RPH and the Institute for coordinating research;
- undertake fund raising activities or receive donations and bequests that are used for the benefit of the hospitals in areas such as funding research or purchasing equipment. Examples of these bodies include the PMH Foundation; and
- provide support services to patients or extensions to the services provided by hospitals – these include groups, such as Friends of RPH, the Voluntary Transport of RPH (Inc) and the Multiple Births Association at KEMH/PMH.

Agreements with Associated Bodies

The specific arrangements for each of the organisations associated with the hospitals were not reviewed by Audit. However, it was noted that the provision of accommodation, outgoings and other resources by the hospital to these organisations (usually at no cost or a nominal fee) was not subject to formal agreements or agreements had existed in the past but had since lapsed.

In the absence of formalised arrangements or agreements that set out the objectives, rules and parameters of the relationship with external bodies, the hospitals are exposed to a range of risks, including:

- hospital resources being provided without appropriate recompense or resources being diverted from other hospital activities;
- key decisions or activities may be undertaken without the knowledge of hospital management;
- relationships may not be operating as expected or providing the expected benefits to the hospital; and
- the hospital being exposed to further liabilities and obligations.

The lack of formal agreements also raises additional risks and complexities in a number of areas as outlined in the examples below:

- RPH has divested the infrastructure used for its research activities to RPH Medical Research Foundation Inc. However, whilst the Foundation is subject to the control of the hospital, it is not subject to the FAAA and therefore, the Foundation is not accountable to the Minister or Parliament for its operations; and
- KEMH/PMH has divested its fund-raising activities to PMH Foundation Inc but does not control the operations of the Foundation.

KEMH/PMH has recently approached the Crown Solicitor's Office to establish the most appropriate form of agreements to be entered into with the various organisations attached to that Hospital.

Agreement with the University of Western Australia

As teaching hospitals, the hospitals also have close relationships with the University of Western Australia (UWA) Medical School. The *University Medical School, Teaching Hospitals Act 1955* allows for an agreement to be entered into with the UWA Senate in relation to a range of matters, including the provision of hospital facilities and any other matter relating to the carrying on of research and teaching functions.

No formal agreement has been put in place either by the individual hospitals or the MHSB. As previously detailed, a number of issues were identified during this audit relating to the ownership and use of hospital SPAs by UWA staff and transfers between hospital and UWA accounts, which need to be clarified. These and other issues, such as access to hospital resources by UWA staff, should be formalised as allowed for under this Act.

Recommendations

The accountable authority/hospitals should:

- identify and review the arrangements in place with external bodies attached to the hospital and obtain legal advice on the most appropriate form of agreement to be entered into with these bodies. These agreements should address the rights and obligations of all parties as well as covering relevant legal and administrative arrangements; and
- enter into an agreement with the UWA Senate in accordance with the provisions of the *University Medical School, Teaching Hospitals Act 1955*.

Appendix 1: The Establishment of these Accounts and the Application of the FAAA

The basis for establishing these accounts, as well as the common use of the term hospital trust accounts, resulted in previous reviews raising issues about the authority for establishing these accounts and the associated accounting and governance frameworks in place.

As previously outlined, the term hospital 'trust accounts' has been commonly used when referring to these accounts. This has been a cause of confusion outside the public health sector and has also contributed to some misunderstandings about the nature of these accounts within individual hospitals.

This appendix outlines the background for hospitals using the FAAA as the basis for establishing these accounts, why the provisions used do not apply to most accounts and the accounting treatment and disclosure made in the annual financial statements for these accounts.

The Application of the FAAA

The use of the term 'trust accounts' has predominately occurred as three of the hospitals consider most of these accounts are established under the authority of the FAAA. This view has not been held by SCGH who has referred to these accounts as special purpose accounts since the mid 1990s.

The FAAA contains a number of provisions regarding trust moneys and how agencies such as hospitals should account for these moneys. Under section 36, private moneys must be credited to the Trust Fund[13] or held in a bank account opened and maintained in accordance with section 21 of the FAAA. Private moneys are defined under the FAAA as moneys, negotiable instruments or securities of any kind collected, received or held by the State or a statutory authority for or on behalf of a person other than the State or a statutory authority.

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

The hospitals prepared and obtained approval from the then Treasury Department in 1989 (RPH and SCGH) and 1997 (KEMH/PMH and FHHS) for trust statements governing the operation of these accounts[14]. Action to prepare revised statements in the name of the Metropolitan Health Services Board commenced in 1998 but was not finalised.

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

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

13 The term, Trust Fund, refers to the account maintained by the Treasurer under section 5 of the FAAA.

14 Some of the accounts are set up to manage capital projects or for other activities that have not been included in these trust statements.

Why Were the Provisions of the FAAA Used?

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

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

- The reference to private moneys in section 36 of the FAAA is not defined but has been interpreted as referring to moneys which a statutory authority is holding on behalf of another party. In this regard, the trust statements are not intended nor does it purport to establish the conditions for a trust relationship in relation to moneys held in an affected account. Rather, it is a mechanism intended to enhance accountability by the formal documentation of the key elements of the affected account.
- The strict legal interpretation as to whether donations, grants and bequests would constitute trust moneys in the strict legal sense or are special purpose funds with a condition attached is a complex area which in some instances can only be resolved by recourse to legal advice.
- The use of the terms Trust Fund and trust account were continued from the *Audit Act 1904*. It has been recognised that reference to the term 'trust' in relation to the Trust Fund and trust accounts may inadvertently give the impression that all affected accounts hold trust moneys and a review has recommended that this terminology be amended in the FAAA to remove the possibility of any misunderstanding as to the purpose of such trust accounts.

Financial Reporting Requirements for 'True Trusts' and Special Purpose Moneys

There are different financial reporting requirements for SPA moneys and 'true trust' moneys and this issue was reviewed and resolved when accrual reporting was being introduced in the early 1990s. Transactions relating to SPAs (ie moneys controlled by the hospitals) are consolidated in the financial statements along with operating revenues and expenses. Transactions relating to 'true trusts' are only shown in a note to the statements.

The reporting of these SPAs and 'true trusts' was fully implemented for the financial year ended June 30, 1995.

Appendix 2: Guidance on the Identification and Classification of Special Purpose Funds

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

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

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

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

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

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

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

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

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

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

Trust Accounts

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

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

Restricted Moneys

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

Tied Moneys (Internal Restriction)

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

Further Information

For further information on the matters covered above, refer to Statement of Accounting Concepts 4 and Treasurer's Instructions 1102 and 1103. The following table is provided as a guide only and is not meant to be prescriptive. Each source of revenue should still be assessed individually.

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

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

Source: OAG

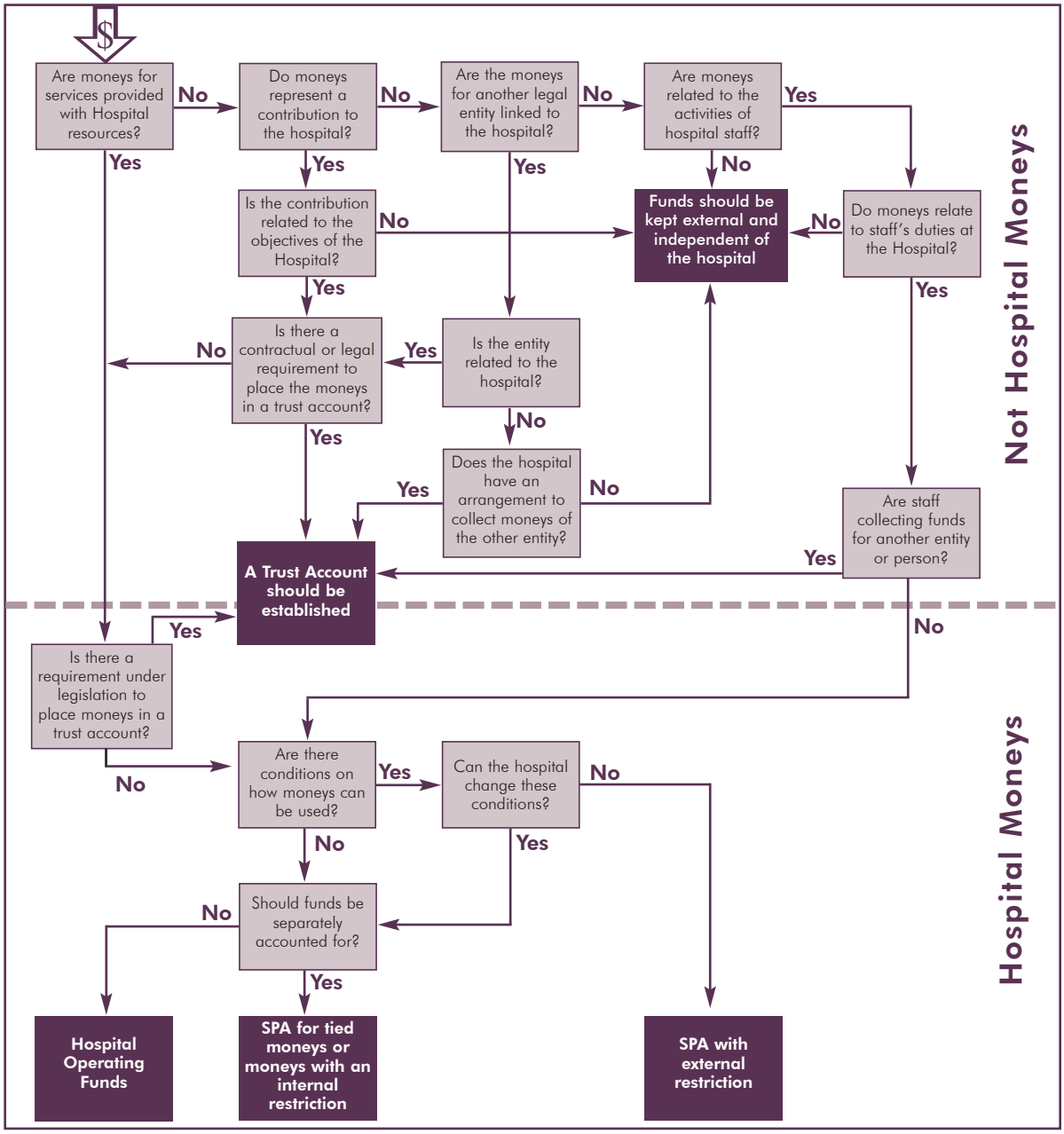

Figure 3: Classification of hospital receipts.

Source: OAG

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

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