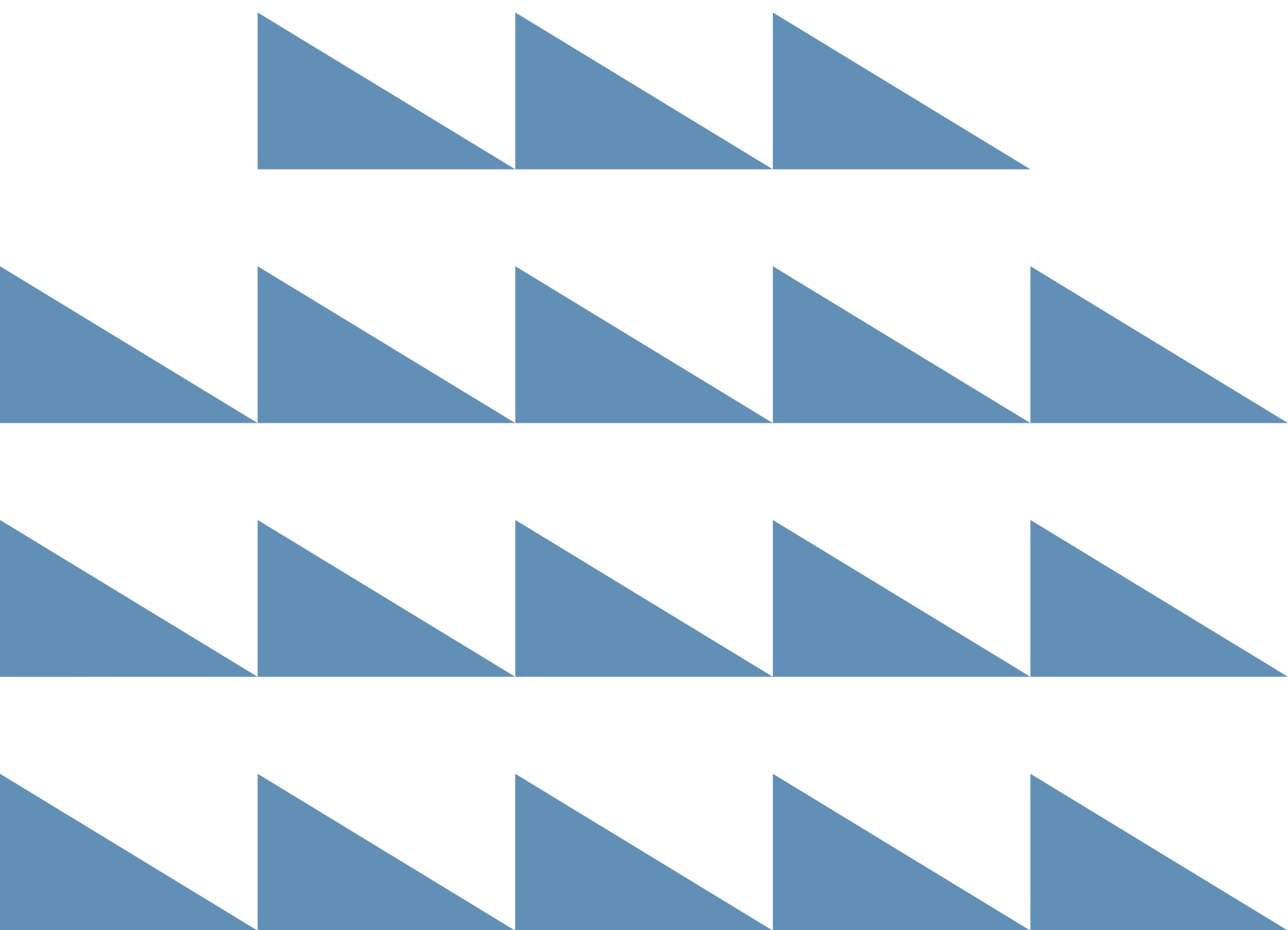


Corruption risks associated with the public health sector

October 2017



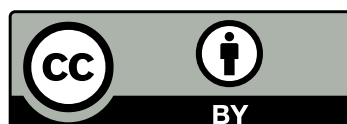
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1 Definitions

	Explanation
AHPRA	Australian Health Practitioner Regulation Agency
AV	Ambulance Victoria
DHHS/the Department	Department of Health and Human Services
HACC	Home and Community Care
HPV	Health Purchasing Victoria
NGO	Non-government organisations
PD	Protected disclosures or PDs (previously known as 'whistleblower' complaints) entitle the complainant to certain legal protections
RACS	Royal Australasian College of Surgeons
TAC	Transport Accident Commission
VAGO	Victorian Auditor-General's Office
VO	Victorian Ombudsman
VPS	Victorian Public Service
VPSC	Victorian Public Sector Commission

2 Overview

The Victorian public health sector has the largest budget and employs the most people of any sector operated by the Victorian government. More than \$15 billion of the state budget is spent on public health each year and the public health sector employs more than 106,000 people, almost one-third of the entire Victorian public sector.¹

The health sector faces unique corruption risks. Access to controlled drugs, complex employment agreements and billing structures, and multiple complaints systems present challenges specific to the health sector. The strong hierarchical culture within the medical profession may enable behaviours that drive or obscure corrupt conduct.² But many integrity issues facing the health sector are not unique; for example, procurement and conflicts of interest have been identified by IBAC as corruption risks affecting agencies across Victoria's public sector.

This report presents a snapshot of health sector complaints and cases that have arisen during IBAC's first four years of operation. It explores the corruption vulnerabilities associated with the health sector – both those specific to the health sector and those it shares with the broader public sector. Highlighting such issues helps the health sector to identify corruption risks, and take appropriate prevention and detection actions to address them.

2.1 Key findings

1. The size, diversity and nature of the public health system creates corruption risks and vulnerabilities that are specific to the health sector. These include the theft of controlled drugs, covering up of clinical malpractice, fraudulent billing practices and bullying within the medical profession, which can enable or obscure corrupt conduct.
2. The public health sector shares other significant corruption risks with the broader public sector. These include risks associated with procurement and contract management, funding vulnerabilities, employment practices, and thefts of cash and smaller physical assets.
3. Non-government organisations such as community health centres, which are government funded to deliver public health services, potentially represent a significant gap in IBAC's jurisdiction.
4. The size and complexity of the health sector, and the comparatively low number of notifications IBAC has received from health sector agencies, means IBAC's awareness of potential risks and vulnerabilities associated with the health sector is still developing.

¹ Department of Treasury and Finance, *Victorian Budget 2016/17*, page 213, budgetfiles201617.budget.vic.gov.au/2016-17+State+Budget+-+BP5+Statement+of+Finances.pdf; Victorian Public Sector Commission, *The State of the Victorian Public Sector 2015/16*.

² Hospital Safety and Quality Assurance Review Panel, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and improve quality of care*, October 2016.

2.2 Methodology

2.2.1 Scope

This report defines the Victorian public health sector as:³

- government-owned hospitals and health services, including large metropolitan health services that operate multiple hospitals, regional health services, small rural health services and specialist health services
- government-owned research, professional registration and health promotion bodies, and ancillary services such as dietitians, therapists, counsellors, psychologists, pharmacists, scientists and technicians
- the Department of Health and Human Services (the Department)⁴ and other associated statutory bodies connected with the delivery and oversight of health services.

2.2.2 Information sources

This report is based on:

- complaints and notifications received by IBAC
- IBAC and law enforcement intelligence
- consultation with and information provided by the Department
- consultation with and information provided by other integrity agencies: the Victorian Ombudsman and the Victorian Auditor-General's Office
- open source literature including research reports, media and other materials.

2.2.3 Terminology

For the purposes of this report, a 'case' is a complaint or notification addressing a particular subject, individual(s) or agency. That case may consist of multiple allegations. A case is not an IBAC investigation and references to cases do not mean a complaint or notification was investigated or substantiated by IBAC or another agency.

The report includes summaries of allegations received by IBAC as a means to illustrate some key points. IBAC notes there are limitations with the use of allegations including:

- allegations are unsubstantiated at the time of receipt
- allegations can be incomplete, lack detail, be from an anonymous source or may not individually name the subject of the allegation
- allegation data is not a comprehensive or reliable indicator of the prevalence of particular activities.

Despite these limitations, allegations can help identify trends or patterns and provide practical examples of identified trends.

³ This definition is consistent with that adopted by the Victorian Public Sector Commission. See VPSC State of the Public Sector Report, page 9, vpsc.vic.gov.au/wp-content/uploads/2016/12/SOPSIV-2015-16-Final-Web-version-ISSN2204-9096.pdf.

⁴ This report has not considered other portfolio responsibilities associated with the Department: human services, sport and recreation.

3 Context

3.1 Complaints and notifications received by IBAC

Cases and allegations received and assessed against the public health sector have remained stable for the past two years after peaking in 2014/15. The high number of cases in 2014/15 was driven primarily by the high volume of protected disclosure (PD) notifications received, which has decreased in successive years.

Between IBAC's commencement of full operations on 11 February 2013 and 30 June 2016, IBAC received five 'voluntary' (that is, non-PD related) notifications of suspected corrupt conduct from public health sector agencies pursuant to section 57(1) of the *Independent Broad-based Anti-corruption Commission Act 2011* (IBAC Act). Following changes to IBAC's legislation in 2016, it became mandatory from 1 December 2016 for heads of public sector bodies to notify IBAC of suspected corrupt conduct. Subsequently, in 2016/17 IBAC received nine notifications from the heads of public sector bodies pursuant to section 57(1) of the IBAC Act. The introduction of mandatory notifications is likely to lead to an increase in notifications in the future.

A factor that may have contributed to the lower than expected number of notifications received to date is the number of complaints bodies concerned with the health system. This may cause confusion about where to report complaints. This issue is further explored in section 5.2 of this report.

FIGURE 1: CASES, ALLEGATIONS AND PROTECTED DISCLOSURES RECEIVED BY IBAC ABOUT THE PUBLIC HEALTH SECTOR

	2012/13*	2013/14	2014/15	2015/16	2016/17
Cases	21	53	70	62	62
% change on previous year	-	↑ 152%	↑ 32%	↓ 11%	-
Allegations	27	107	199	137	141
Protected disclosure notifications	3	10	20	7	5

* From 11 February 2013 to 30 June 2013

3.2 Protected disclosure notifications

Protected disclosures (PDs), previously known as ‘whistleblower’ complaints, entitle the complainant to certain legal protections. Under section 21 of the *Protected Disclosure Act 2012* (PD Act) public bodies must notify IBAC of disclosures that they consider may be PDs. These notifications are recorded by IBAC as PD notifications but, like all notifications received by IBAC, are assessed to determine if they meet the required threshold for a PD complaint.

The decrease in cases and allegations since 2014/15 corresponded with a sharp decrease in PD notifications IBAC received from the public health sector over the past two years – from 20 in 2014/15 to seven in 2015/16, to five in 2016/17. Various factors may contribute to the lower number of PD notifications, including limitations within the PD Act, differences of legal opinion across notifying agencies around what qualifies for PD status, and limitations around the Department receiving PD notifications about non-Departmental employees.

3.3 Complaints about hospitals and health services

Hospitals and health services represent the largest component of the public health sector. They employ approximately 100,000 people, in contrast with the Department, which employs approximately 1500 people within its health function⁵ and Ambulance Victoria (AV), which employs approximately 4000. So it is not surprising that hospitals and health services have been the most commonly complained against subsector, accounting for 67 per cent of IBAC’s health sector cases in 2016/17. Cases connected to the Department accounted for 19 per cent of IBAC’s health sector cases over the same period.

IBAC’s major public sector investigations – Operations Fitzroy, Ord, Dunham and Lansdowne – are likely to have increased awareness of corruption and IBAC across the public sector. The release of IBAC’s special report on Operation Liverpool in March 2017 (addressing allegations of corrupt conduct at Bendigo Health) and Operation Tone (concerning allegations against AV paramedics) may further increase awareness of IBAC, particularly across Victoria’s health sector.

⁵ Note that these 1500 employees are those employed within the Department’s health function. Departmental employees working in the other portfolio responsibilities of human services, sport and recreation were not considered.

4 Corruption issues affecting the public health sector

4.1 Clinical malpractice

Cover-ups of clinical malpractice may amount to misconduct in public office, which constitutes corrupt conduct under the IBAC Act.⁶ Following a number of avoidable stillborn and newborn deaths at the Bacchus Marsh Hospital in 2013 and 2014, due in part to clinical errors, a series of inquiries, investigations and reviews were undertaken by the Coroner, the Department and an independent panel led by Dr Stephen Duckett.⁷ The independent panel produced a report in October 2016 (the Duckett Report), which made a number of findings in relation to clinical governance and malpractice. These included:

- the strongly hierarchical culture of the medical profession makes it difficult to own up to, document or highlight the mistakes of others (in particular superiors)
- the current fault-based approach to medical compensation in Victoria is a significant disincentive for owning up to, documenting or highlighting the mistakes of others
- the boards of Victorian hospitals and health services generally lack people with sufficient clinical skills and knowledge to provide adequate clinical governance.

The factors identified in the Duckett Report may contribute to environments where cover-ups of clinical malpractice could occur.

IBAC CASE EXAMPLE

A doctor made a complaint to IBAC alleging cover-ups of clinical malpractice by a senior doctor. The complainant alleged that foreign doctors who have attempted to speak up have been threatened with adverse recommendations to the Australian Health Practitioner Regulation Agency (AHPRA), potentially resulting in the cancellation of their registration to practice medicine in Australia and jeopardising their visa status. The allegations were dismissed by IBAC, but details of the complainant and the complaint were forwarded to AHPRA and DHHS.

This case example echoes the issues raised in the Duckett Report by highlighting a culture where complaints are stifled through threats of adverse consequences.

⁶ Note that the definition of misconduct in public office is not sufficiently broad to cover all matters of clinical malpractice and any IBAC investigation could not address broader matters pertaining to proper medical practice, but could address alleged cover-ups of malpractice.

⁷ Hospital Safety and Quality Assurance Review Panel, *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and improve quality of care*, October 2016.

4.2 Theft of controlled drugs

The theft of controlled drugs for personal use or to be sold for financial gain is a significant corruption risk within the public health sector. Intelligence reports by law enforcement agencies and alerts by health departments nationally suggest that the misuse of pharmaceutical prescription medications in the community is increasing, in particular opioid analgesics (such as fentanyl, morphine and oxycodone) and benzodiazepines (such as Valium and Xanax).⁸ The increased demand for these substances and the access health service staff have to these drugs creates a risk of corruption.

Recent investigations by IBAC, Victoria Police and other Australian integrity agencies highlight the issue of drug thefts within the public health sector. This includes a recent IBAC investigation involving alleged thefts and use of drugs of dependence by paramedics.

CASE STUDY – OPERATION TONE

IBAC's Operation Tone investigated allegations that AV paramedics engaged in the theft, trafficking and use of drugs of dependence, as well as misappropriation of AV equipment. IBAC identified:

- two paramedics were involved in the trafficking, use and possession of illicit drugs
- several paramedics were found to be using illicit drugs
- one serving paramedic stole and used AV drugs of dependence including fentanyl and morphine
- unauthorised cannulation (administration of saline solution via an intravenous needle) by AV paramedics, often involving misappropriation of AV equipment
- taking AV equipment for personal use was quite common.

During Operation Tone, one paramedic was dismissed and eight resigned under investigation. Six paramedics received formal warnings.

During a separate 2012 internal investigation, AV found that 344 vials of fentanyl across 38 ambulance locations had been tampered with and, in a number of instances, replaced with water. AV found that numerous patients had been given water instead of fentanyl, a significant breach of public trust and patient safety.⁹ As a result of this investigation, AV and its suppliers made changes to the packaging and disbursement of fentanyl, in addition to tightening accountability around its use.

⁸ Australian Institute of Health and Welfare, *National Drug Strategy Household Survey*, 2013 www.aihw.gov.au/alcohol-and-other-drugs/data-sources/ndshs-2013/ch6/; Australian Criminal Intelligence Commission, *Illicit Drug Data Report*, 2016. acic.govcms.gov.au/sites/g/files/net1491/f/2017/06/illicit_drug_data_report_2015-16_full_report.pdf.

⁹ Morris-Marr, L., 'Victorian ambulances change fentanyl system after Annika Beer's tragic death', *Herald Sun*, 24 November 2015. www.heraldsun.com.au/news/victorian-ambulances-change-fentanyl-system-after-annika-beers-tragic-death/news-story/4cda9141decba062aed49f60f1a5a50e.

WESTERN AUSTRALIAN CORRUPTION AND CRIME COMMISSION REVIEW 2010

In 2010 the Western Australian Corruption and Crime Commission reviewed the misconduct handling procedures in the state's public health sector.¹⁰ The review was based on more than 300 interviews with health sector employees, a staff survey of misconduct and an examination of hospital policies on controlled drug security and handling.

Drug-related misconduct was identified as a significant issue across public hospitals. The review found that workplace stress, a culture of entitlement among some staff and the ability to easily subvert drug security and dispensation requirements had contributed to the theft of controlled drugs.

The consequences of the theft of controlled drugs by clinical staff are potentially catastrophic. Since 2012/13, three Victorian paramedics have fatally overdosed on fentanyl they had stolen from ambulances or drug storage areas. Additionally, coronial findings from around Australia have highlighted the deaths of nurse practitioners from overdoses of fentanyl and morphine.

4.3 Fraudulent billing practices

Billing practices in relation to compensable patients (patients whose medical costs are billed to state insurance authorities) create opportunities for corrupt conduct. An investigation by the Victorian Ombudsman (VO) in 2009¹² found that the Transport Accident Commission (TAC) and Victorian Workcover Authority had been subject to fraudulent billing practices by medical practitioners. The investigation found both agencies had relied on the honesty of medical practitioners and trusted submitted bills without examining 'outlier' billing practices.

Suspect billing practices uncovered by the VO are similar to other forms of invoicing fraud identified by IBAC. For example, the VO found:

- Some surgeons were 'bill splitting' for complex surgeries that required multiple operations. Under the Medicare Benefits Schedule (MBS) surgeons are entitled to be paid on a sliding scale when performing multiple operations during a single surgery – that is, 100 per cent for operation A, 50 per cent for operation B and 25 per cent for every other operation performed. By submitting individual invoices for each procedure – 'bill splitting' – a surgeon could receive the full 100 per cent fee for each operation.
- Some medical practitioners were fraudulently billing TAC and WorkCover for mutually exclusive procedures, which due to their nature could not both have been performed. The VO reported that in a single financial year (2007/08), TAC and WorkCover paid medical practitioners more than \$9.5 million combined for mutually exclusive surgical procedures.

Following the VO's investigation, TAC and WorkCover committed to improving their internal systems to detect fraudulent billing practices. However, discipline decisions published on the AHPRA website indicate fraudulent billing remains an issue.

¹⁰ Western Australian Corruption and Crime Commission, 2010, *Misconduct handling procedures in the Western Australian public sector: WA Health*, www.ccc.wa.gov.au/sites/default/files/WA%20Health%20Misconduct%20Handling%20Procedures.pdf.

¹¹ For example, see www.courts.qld.gov.au/__data/assets/pdf_file/0015/431304/cif-howman-kl-20150727.pdf, www.coronerscourt.wa.gov.au/_files/Doherty_finding.pdf and www.coronerscourt.wa.gov.au/_files/Fisher_finding.pdf.

¹² Victorian Ombudsman, *An investigation into the Transport Accident Commission's and the Victorian WorkCover Authority's administrative processes for medical practitioner billing*, July 2009.

4.4 Procurement and contract management

Significant hospital capital works projects may be vulnerable to corruption due to pressure to deliver works within tight timeframes. In recent years the Victorian Government has committed to significant capital works projects in partnership with the private sector to construct new and upgrade existing public hospital facilities. IBAC's investigations across the public sector have demonstrated that, while adequate financial controls are usually in place for such projects, corrupt conduct can still occur where there is a failure to adhere to processes or a lack of oversight by those responsible for maintaining checks and balances.

CASE STUDY – OPERATION LIVERPOOL

IBAC's Operation Liverpool investigated allegations that a senior manager at Bendigo Health had engaged in a variety of corrupt activities including awarding contracts to friends without proper procurement processes, exploiting his position with contractors, stealing tools and building supplies, and using his position to obtain personal benefits.

The manager was responsible for a \$15 million construction budget as part of the \$630 million new Bendigo Hospital project. He was able to subvert financial controls due to a lack of oversight by his manager and by justifying his failure to follow established processes on the basis that the hospital redevelopment was governed primarily by the Department.

The manager was charged by IBAC with multiple offences including theft, obtaining property by deception and obtaining financial advantage by deception. He pleaded guilty and was convicted and fined in September 2016.

Similar examples have been identified interstate. The Western Australian Corruption and Crime Commission investigated a hospital construction manager in 2010 over allegations he had subverted financial controls by 'splitting' contracts so that they fell within his \$10,000 financial delegation and then awarding those contracts to an associate.¹³ The associate subcontracted work back to the hospital construction manager, who undertook the works through private companies he owned. The hospital construction manager was able to avoid detection because of his ability to deliver work on time and within budget.

¹³ Western Australian Corruption and Crime Commission, *Report on fraud and corruption in procurement in WA Health*, June 2014.

4.5 Conflicts of interest

Risks exist around the potential for medical practitioners and administrators to be influenced by private sector organisations when procuring medical supplies and equipment. The creation of Health Purchasing Victoria (HPV) in 2001 sought to address some of these risks by centralising procurement activities. In 2015/16, HPV held collective procurement contracts valued at \$777 million. HPV uses collective procurement contracts to seek to provide better value for money for high volume, commonly used goods and services. However, although the value of HPV's collective contracts is increasing, these contracts likely represent less than half of Victoria's public health sector spend on goods and services (estimated at \$1.6 billion in 2011).¹⁴

IBAC CASE EXAMPLE

A doctor at a large regional hospital alleged that a senior medical practitioner at the hospital had accepted a paid overseas trip for themselves and their family from a major pharmaceutical company in exchange for recommending the hospital use one of the company's drugs. The complainant alleged that the hospital subsequently became the biggest public hospital user of the drug in Australia. IBAC referred the complaint to the VO.

As the proportion of contracting that falls to HPV increases, conflicts of interest associated with procurement of medical supplies and equipment may decrease. However, certain categories of medical supplies and equipment are unlikely to fall under HPV's centralised procurement due to logistical practicalities, existing contracts between individual hospitals/health services and suppliers, and compliance exemptions. Contracts that remain the responsibility of hospitals and health services may create opportunities for private organisations to attempt to improperly influence procurement outcomes.

There are also potential conflicts of interest around medical practitioners' involvement with medical technology and pharmaceutical companies. For example, concerns have been raised regarding inducements allegedly offered by Johnson & Johnson to surgeons to encourage use of vaginal mesh products. Legal action is being pursued by numerous women who have suffered serious complications following the insertion of such products. As well as concerns around the provision of inducements, concerns have been raised that some surgeons operated on patients who may not have needed the mesh, and that Johnson & Johnson failed to investigate proper clinical trials.¹⁵

¹⁴ Victorian Auditor-General's Office, *Procurement practices in the health sector*, October 2011.

¹⁵ www.abc.net.au/news/2017-08-14/surgical-mesh-maker-used-fast-cars-to-market-device-doctors/8796838.

4.6 Employment practices

As with other areas of the public sector, nepotism and conflicts of interest in employment practices present significant corruption risks for the health sector. As the largest segment of the Victorian public sector, and one with a highly qualified and specialised workforce, the public health sector is likely to experience considerable 'recycling' of problematic employees.

IBAC has previously considered potential corruption risks arising from employees who are dismissed or resign under investigation from one public sector organisation, only to be re-employed at another.¹⁶ In order to prevent the recycling of problematic employees, IBAC recommends agencies adopt a risk-based approach to recruitment by seeking to understand the corruption and misconduct risks faced by their agency, and the specific risks associated with particular roles.

4.7 Thefts of cash and portable assets

Cash and other portable physical assets are attractive targets for corrupt employees. A recent audit conducted by another Australian integrity agency found that public health sector agencies in that state were reporting to police the thefts of lower value items (considered by individuals to have a lower risk of detection) without trying to address the factors that led to the thefts occurring.¹⁷

Opportunities to misappropriate cash or assets exist across the public health sector. Many hospitals and health services conduct cash-based fundraising activities or operate cash-based services such as cafeterias. VAGO noted that cash-based activities present a greater risk of misappropriation due to the difficulty of tracking cash transactions compared with electronic transactions.¹⁸

CASE STUDY – WESTERN AUSTRALIAN CORRUPTION AND CRIME COMMISSION INVESTIGATION

In 2010 the Corruption and Crime Commission investigated a report that a public hospital employee had been stealing cash from the hospital café where she worked. The investigation revealed the employee had been stealing money from the café for at least five and a half years. She was charged with multiple counts of theft, totalling \$187,000. The employee was convicted and received a suspended jail sentence.¹⁹

While cash presents an obvious risk, other portable assets are also at risk of misappropriation. IBAC's Operation Liverpool investigated and substantiated allegations that a senior Bendigo Health manager had stolen a variety of assets, including power tools and building materials. IBAC found that insufficient controls over high and low-value assets helped enable the manager's conduct.

As the above examples highlight, corrupt conduct involving the theft of cash or assets often involves only a single responsible individual, without the need for complex schemes or collusion with others. Employees involved have been able to exploit their familiarity with processes, lax management or lack of controls.

¹⁶ IBAC's materials on recruitment and employment available at: www.ibac.vic.gov.au/preventing-corruption/are-you-vulnerable-to-corruption/recruitment-and-employment.

¹⁷ Consultation with an interstate integrity agency, 21 November 2016.

¹⁸ Consultations with the Victorian Ombudsman's office and the Victorian Auditor-General's Office.

¹⁹ Corruption and Crime Commission (WA): *Report on the investigation of alleged public sector misconduct in relation to the activities of an employee of the Department of Health*, December 2010.

5 Drivers of corruption in the public health sector

5.1 Links between bullying and corrupt conduct

Bullying and harassment are significant and entrenched concerns within the public health sector. They have been identified as issues in the annual People Matters Survey conducted by the VPSC,²⁰ a 2016 audit conducted by VAGO,²¹ a Commonwealth Senate Committee report²² and a suite of work undertaken by an expert advisory group on behalf of the Royal Australasian College of Surgeons (RACS).²³ While bullying is not corrupt in and of itself, the reported high prevalence of it within the health sector may contribute to conditions where corruption is more likely to occur.

IBAC's Operation Dunham investigated alleged corruption at the Department of Education and Training. It identified a number of departmental officers whose bullying and seniority helped facilitate and obscure alleged corrupt conduct. Parallels exist with the public health sector, where senior medical practitioners may seek to use their authority, status and demand for their expertise to avoid accountability for their behaviour. Cultures of bullying within workplaces have a negative effect on morale and can create a climate of fear where employees are scared to speak up about their experiences for fear of reprisal.

Medical and nursing practitioners have reported concerns that some senior medical practitioners may not be held accountable for unethical behaviour.²⁴ Agencies charged with investigating and examining senior medical practitioners have also reported to IBAC that hospitals often push back against their inquiries.²⁵ Medical practitioners of high standing bring prestige to hospitals in addition to their expertise, and it has been suggested hospitals may be reluctant to hold these people to the same standards expected of other staff. If senior practitioners are routinely not held accountable, this has the potential to encourage or facilitate potentially corrupt behaviour.

Many health sector complaints received by IBAC contain elements of bullying and harassment in addition to, or as part of, alleged corruption. The work undertaken by RACS and the Department's launch of a strategy to address bullying and harassment within the health sector are positive steps to address the issue.²⁶ Progress to reduce the prevalence of bullying within the health sector may contribute to making the sector more corruption resistant.

²⁰ Victorian Public Sector Commission, *Data insights: Bullying in the Victorian public sector*, September 2016 vpvc.vic.gov.au/data-and-research/data-insights/data-insights-bullying-victorian-public-sector/.

²¹ Victorian Auditor-General's Office, *Bullying and harassment in the health sector*, March 2016.

²² Australian Senate Community Affairs Reference Committee, *Medical complaints process in Australia*, November 2016.

²³ Royal Australasian College of Surgeons, Expert Advisory Group, *Building respect, improving patient safety*, www.surgeons.org/about-respect/what-we-have-done/building-respect,-improving-patient-safety/expert-advisory-group/.

²⁴ Senate Community Affairs References Committee, *Medical complaints processes in Australia*, November 2016 www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report.

²⁵ Consultations with the Victorian Ombudsman's office and the Victorian Auditor-General's Office.

²⁶ Department of Health and Human Services, *Our pathway to change: eliminating bullying and harassment in healthcare*, April 2016.

5.2 The health complaints system

'Overcrowding' of the complaints and oversight system for the public health sector may result in corrupt conduct not being exposed or addressed. A recent Commonwealth Senate Committee report on health sector complaints handling found evidence of confusion among patients and medical practitioners about the roles of the various bodies capable of receiving, investigating and/or resolving complaints.²⁷

Historically in Victoria, complaints about the conduct of public health sector employees have been received and investigated by multiple bodies including:

- AHPRA and its respective professional boards
- Victoria Police
- the Department's internal integrity unit
- the human resources departments of hospitals and health services
- regulators and complaint-handling bodies such as the Drugs and Poisons Regulation unit of the Department, the Health Services Commissioner²⁸ and the Mental Health Complaints Commissioner.

In this crowded field, IBAC may be overlooked as an option for reporting serious misconduct or corrupt conduct.

Discipline sanctions against medical practitioners published on the AHPRA website detail many cases of 'professional misconduct'. If the practitioners involved were working at Victorian public hospitals and health services, some of the conduct described would likely amount to corrupt conduct as defined by the IBAC Act. The described conduct includes drug use and trafficking, theft, obtaining financial advantage by deception and sexual offences. IBAC has received few notifications from hospitals and health services detailing allegations similar to those published by AHPRA, although the introduction of mandatory notifications by public sector heads of suspected corruption from 1 December 2016 may increase reporting of these issues.

5.3 Individual employment agreements and private practice arrangements

To attract highly qualified specialist medical practitioners, many public hospitals offer practitioners the opportunity to practise privately using public hospital facilities such as outpatient clinics and consultation rooms, as well as hospital administrative resources. These private practice arrangements are negotiated between the individual medical practitioner and the hospital or health service. A 2008 VAGO audit found a lack of transparency around the value of allowing public resources to be used for the treatment of private patients in public health facilities.²⁹

The 2008 VAGO audit also raised concerns about medical practitioners treating and billing private patients when they were being paid to work in the public system. Recently published research has found many specialist medical practitioners spend less than 30 per cent of their clinical time treating public patients.³⁰ The research highlights a lack of clear direction about how much time doctors employed by public hospitals should be spending on private patients. This lack of clear direction makes it unlikely that such practices could be considered corrupt; however, it does represent a loophole in private practice arrangements that may be exploited.

²⁷ Australian Senate Community Affairs Reference Committee, *Medical complaints process in Australia*, November 2016.

²⁸ In February 2017 the Health Services Commissioner was replaced by the new Health Complaints Commissioner who has greater investigative powers. It is uncertain what, if any, impact the change will have on notifications or referrals to IBAC.

²⁹ Victorian Auditor-General's Office, *Private practice arrangements in health services*, October 2008.

³⁰ Freed, G., Turbitt, E., Allen, A., 'Public or private care: where do specialists spend their time?' in *Australian Health Review*, September 2016.

5.4 Funding vulnerabilities and data integrity

Non-government organisations (NGOs) – often largely funded by government – are used across the Victorian public sector to deliver public services. In consultations for this report, the Department raised concerns that there could be a lack of oversight of NGO employees who misuse funding provided by the Department to deliver public services. The Department views the misuse of funding by NGOs as a potentially significant corruption vulnerability.

Risks around funding NGOs and private organisations to deliver public services is an issue across the public sector. Consultations undertaken for this report suggested NGOs that provide public services may be at greater risk of improper or corrupt conduct due to their unfamiliarity with public sector values and principles. The New South Wales Independent Commission Against Corruption published a report in 2012 that highlighted a number of potential corruption risks and vulnerabilities, including:

- NGO clients fear reporting issues due to fear of being cut off from the services provided
- NGOs can be unwilling to report corrupt or fraudulent conduct by their own staff due to concerns over the potential impact on their relationship with the funding agency, and the flow-on effects of losing funding
- Some NGOs are fully or largely funded by government, creating risks around the renewal of funding agreements
- Some NGOs ‘double dip’ from government agencies, effectively receiving multiple sources of government funding to deliver the same services, without government being completely aware of how much it is paying for the delivery of these services.³¹

Following recent amendments to its legislation, VAGO has ‘follow the dollar’ powers allowing it to audit how public funds are used by NGOs. VAGO has flagged its intention to conduct performance audits of community health services (and other private organisations delivering public services) in 2017/18.³²

IBAC believes that funding provided to agencies by the Department (outside the National Health Reform Agreement) may be susceptible to corrupt manipulation.³³ Where data is used to justify funding, risks could emerge where appropriate scrutiny is not applied to the collection, storage and general integrity of the data. While IBAC has investigated one such incidence of this conduct, the full extent of this issue is not known.

IBAC CASE EXAMPLE

In 2015 IBAC investigated allegations regarding the misuse of funding provided by the Department to a council that provided services for the Home and Community Care (HACC) program.³⁴ The investigation found that an employee of the council falsified data on HACC activities by deliberately overstating the number of clients and services delivered by the council. As a result, the council received more than \$900,000 in additional unjustified funding.

IBAC found that the same employee obtained a benefit by using council funds (from the same HACC program budget) to purchase electrical goods and grocery gift cards for herself and members of her family. It is believed that the employee’s activities were not detected for more than 10 years, in part due to the employee’s perceived good performance in managing the HACC program budget.

The above case highlights the risks associated with the falsification of data to justify funding. In order to reduce the risk of such conduct occurring, agencies that provide or receive funding should apply appropriate data integrity checks.

³¹ NSW Independent Commission Against Corruption, *Funding NGO delivery of human services in New South Wales – Consultation Paper*, August 2012.

³² Victorian Auditor-General’s Office, Media release, *Program of audits that makes a difference in the community announced*, 8 June 2016.

³³ The Department has a unit dedicated to examining the data provided to justify NHR funding, making such data less vulnerable to manipulation.

³⁴ IBAC understands the HACC program transitioned to the Commonwealth on 1 July 2016 as part of the rollout of the National Disability Insurance Scheme.

6 Conclusions

The size, diversity and nature of Victoria's public health sector presents specific corruption risks including malpractice, theft of controlled drugs and fraudulent billing practices. Issues around procurement, conflicts of interest and employment practices – which are not unique to health – present considerable risks because of the size of the public health sector.

The Department has a range of corruption prevention policies and practices in place. These include audits, vetting of employees, and multiple oversight bodies. Notwithstanding these measures, investigations by IBAC and other agencies have highlighted corrupt behaviour within the health sector that was not prevented or identified by existing safeguards. Furthermore, prevention and detection strategies adopted by some areas of the sector could be applied more broadly in Victoria to help prevent corrupt conduct.

Considering how to best apply corruption prevention measures is an ongoing challenge for the health sector and the broader public sector. Ensuring such strategies are tailored to the different operating environments within the sector is crucial in ensuring they are both effective and proportionate.

The complexity of the sector and the limited number of complaints and notifications received by IBAC means that IBAC's understanding of the sector's corruption issues is still developing. The introduction of mandatory notifications may help address this and give the Department and IBAC greater visibility of key corruption issues affecting the sector.

