

# Review of the Accident Compensation Corporation Fraud Unit

July 2007

Report

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McCallum Petterson

MARTIN JENKINS

## Preface

This report has been prepared for ACC by Doug Martin and Chloe Anderson from Martin, Jenkins & Associates Limited (MartinJenkins) and Barry Jordan from PPB McCallum Petterson.

### MartinJenkins

MartinJenkins is a New Zealand based consulting firm providing strategic management support to clients in the public, private and not-for-profit sectors.

Our overriding goal is to build the management capability of the organisations we work with. We do this by providing strategic advice and practical support for implementation in the areas of:

- organisational design and strategy
- public policy and issues management
- evaluation and research
- financial and economic analysis
- human resource management.

MartinJenkins was established in 1993, and is privately owned and directed by Doug Martin, Kevin Jenkins and Michael Mills.

### PPB McCallum Petterson

PPB McCallum Petterson was asked to provide technical input for this review

For over 15 years PPB McCallum Petterson has been one of New Zealand's leading forensic accounting and IT forensic practices. The firm specialises in undertaking independent investigations of financial and electronic issues. They have a track record of undertaking investigation assignments for prominent legal practices and regulators, together with working for clients in both the public and private sectors.

PPB McCallum Petterson is part of the PPB Group, a group of independent partnerships and entities which has over 200 partners and staff working from offices in Auckland and Wellington as well as all of the major capitals in Australia.

Barry Jordan is a director and shareholder of PPB McCallum Petterson. He heads the firm's national forensic services practice and has been leading forensic accounting and fraud investigation assignments in New Zealand and in the UK for over 15 years. He is often engaged by legal advisors from Government departments and listed companies when an independent expert or investigator is required.

Barry is a Certified Fraud Examiner and has led many high profile complex investigations. He has provided expert evidence in Court and to international arbitrations on numerous occasions. Barry also regularly provides education and training in fraud investigation, financial management, insolvency and strategic business evaluations.

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# Introduction

## Terms of Reference

Martin, Jenkins & Associates Limited (MartinJenkins) were engaged by the Chief Executive, Accident Compensation Corporation (ACC) to conduct an independent review of the ACC Fraud Unit.

In undertaking the review, MartinJenkins were asked to consider the following aspects of the Fraud Unit and its operations:

- structure (including interfaces with other internal business units)
- reporting arrangements
- culture
- operating approach (including methodology, application of that methodology and mechanisms to share learnings) and
- capability and capacity.

MartinJenkins were also asked to take into account any cross-Government initiatives or innovations in this area and consider relevant best practice where appropriate.

## The Approach

The approach to the assignment consisted of the following stages:

- 1 Situation assessment:
  - Key staff were interviewed from within the Fraud Unit and from other areas within ACC that have interaction with the Fraud Unit. Most of the ACC's Executive Leadership Team was also interviewed.
  - Officials from NZ Police, the Ministry of Health and the Ministry of Social Development were interviewed to establish the scope for a cross-agency approach to fraud investigations and to compare and contrast different organisation design models for the investigative function.
  - External stakeholder groups that had a perspective on the Fraud Unit's operation were afforded an opportunity to make representations to the reviewers.
  - Key documents relating to the ACC Fraud Unit were reviewed including position descriptions and business plans.

A full list of interviewees is attached as Appendix 1.

- 2 Option Identification and Analysis
  - A draft set of evaluation criteria for evaluating the options for the positioning of the Fraud Unit within ACC were developed, along with a provisional set of options.
  - A draft set of evaluation criteria for evaluating the internal structure of the Fraud Unit were developed, along with a provisional set of options.
- 3 Identification of preferred option for the positioning of the Fraud Unit and internal structure
  - The options for positioning and internal structure were refined and evaluated leading to the identification of the preferred options.
- 4 Initiatives to improve the operating approach, culture, capability and capacity within the Unit were identified.
- 5 The findings and recommendations were incorporated in the final report.

## Report Structure

The report is structured as follows:

- **Part 1** describes the current structure, reporting arrangements, culture, operating approach, capacity and capability of the Fraud Unit and comments on cross-government initiatives
- **Part 2** summarises the key themes that emerged from the consultation process
- **Part 3** summarises the key issues that emerge from the analysis
- **Part 4** presents and evaluates the potential options for the positioning of the Fraud Unit within ACC
- **Part 5** assesses the Unit's internal structure
- **Part 6** assesses the consequential impacts of the preferred option for the positioning of the Fraud Unit on the Risk & Assurance Group
- **Part 7** describes initiatives to improve the operating approach, culture, capability and capacity of the Unit, and
- **Part 8** presents the recommendations resulting from the analysis.

## Part 1: Current Arrangements

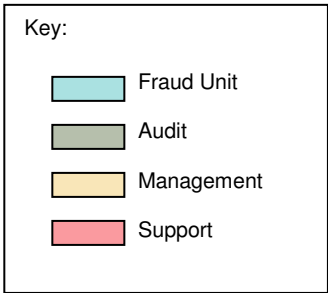
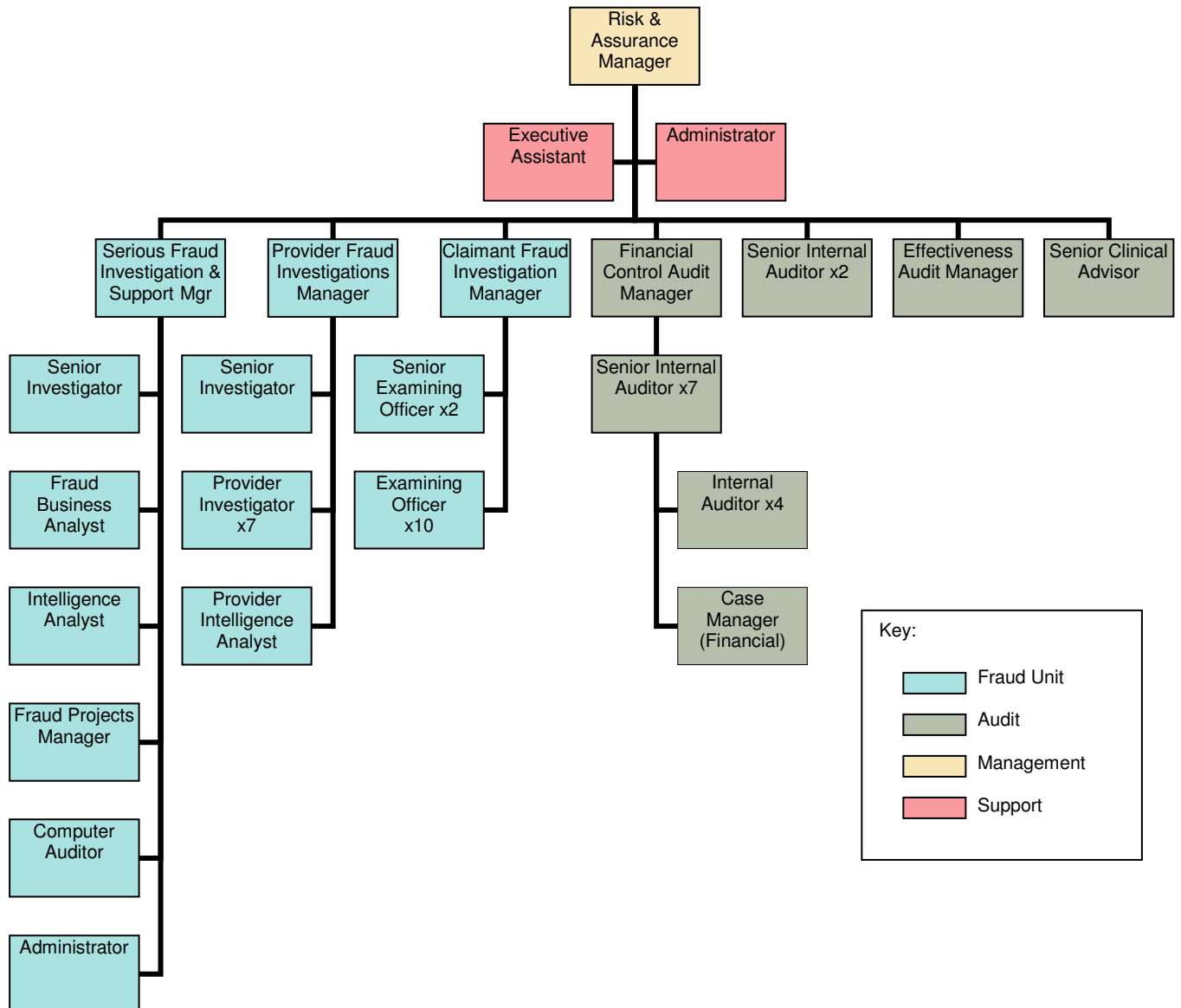
### Positioning of the Fraud Unit within ACC

- 1 Since its inception the Fraud Unit has been positioned within several different business units in ACC. The history of its structure and positioning within ACC is outlined in Appendix 2.
- 2 The Fraud Unit currently sits within the Risk & Assurance Group which also includes internal audit and external practice audit functions. There are 50 people in the Risk & Assurance Group, 30 of whom are in the Fraud Unit.
- 3 The Risk & Assurance Manager currently reports to the Director, CEO's Office. However, for the internal audit component of the role there is a direct reporting line to the Audit Committee. This direct line to the Audit Committee exists to ensure independence of the internal audit function.
- 4 When the Fraud Unit was placed within Risk & Assurance the Audit Committee's Terms of Reference were expanded to include fraud matters.
- 5 The Fraud Unit's placement within the Risk & Assurance Group was driven as much by issues of capacity as functional association. There is little interaction between the audit and fraud sides of the group. It is acknowledged that from time to time audit can assist fraud with identifying control opportunities and gaps, and some of the competencies possessed by audit staff are relevant to fraud prevention and detection.

### Structure of the Fraud Unit

- 6 The current structure was designed by Human Resources staff approximately three years ago and is outlined below:

Figure 1: Risk & Assurance Organisation Chart



## Role & Function of Fraud Unit

- 7 The role of the ACC Fraud Unit is to effectively manage the prevention, detection, investigation and prosecution of fraud in the ACC scheme in the areas of levy, provider, staff and claimant fraud.
- 8 This includes:
  - the development of fraud detection tools and frameworks



- managing contracts and relationships with Private Investigators
- managing contracts and relationships with Crown Solicitors and Prosecutors
- developing relationships with other agencies including the Combined Law Agency Group (CLAG)
- developing and implementing fraud control and awareness programmes throughout ACC and more widely
- working across the organisation to ensure that control processes and systems minimise the opportunities for fraud and to maximise management's ability to exercise effective control.

9 Some \$5.24 million is spent annually on the activities of the Fraud Unit, made up as follows:

**Table 1: Fraud Unit Expenditure**

Item	Budget
Salaries & Wages	\$2,049,009
Investigation Fees Provider:	\$1,893,540
Investigation Fees Claimant:	\$151,824
Total Operating Expenses:	\$5,238,768

Provided by ACC Finance Group

10 Excluding staff fraud, some \$4.4 billion of annual revenue received by ACC is potentially subject to the fraud investigative function, broken down as follows:

**Table 2: Revenue in each area of potential fraud**

Area	Revenue
Levy	\$2.6bn
Provider	\$1bn
Claimant	\$800m

From Risk & Assurance Manager Position Description

11 The Fraud Unit is split into three teams: Claimant Fraud, Provider Fraud, and Serious Fraud & Investigation Support.

12 The Claimant and Provider Fraud Teams operate relatively independently of each other. Both teams rely on the Serious Fraud & Investigation Support Team for data

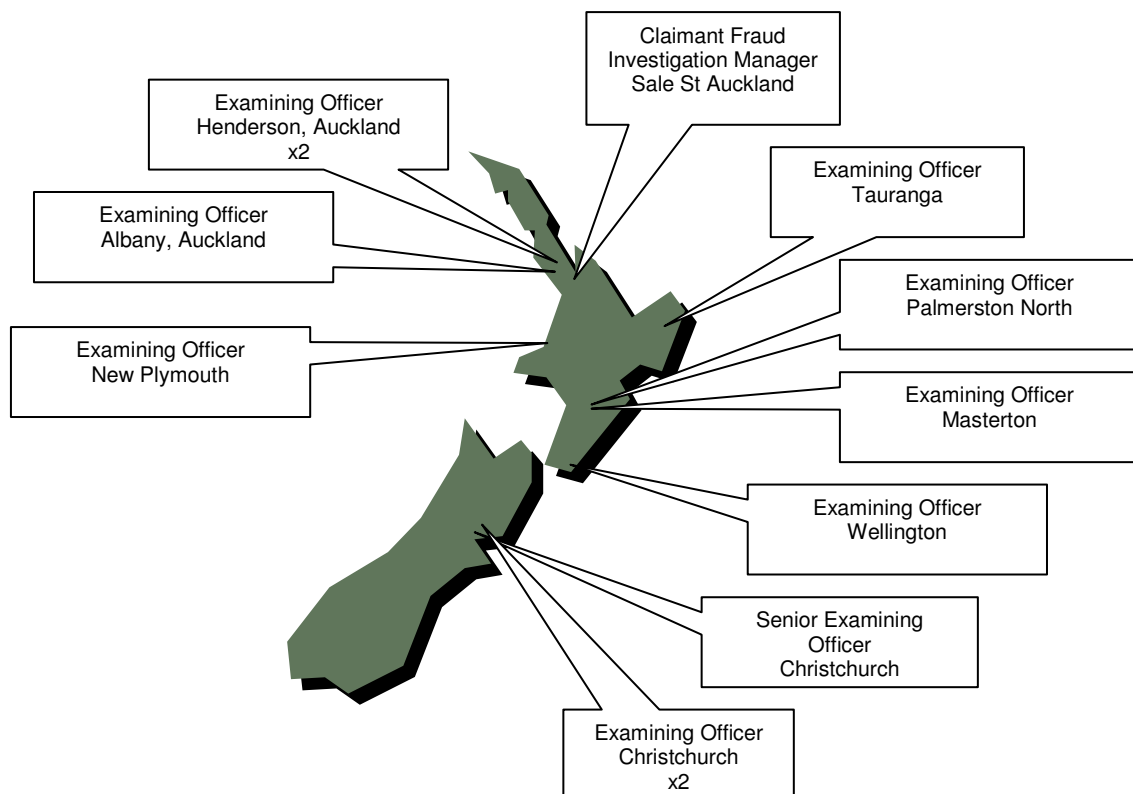
analysis and assist that team with special projects. The function and structure of each of the teams are described below.

- 13 The Risk & Assurance Manager is responsible for leading the three teams in the Fraud Unit along with the internal audit and external practice audit functions.

### Claimant Fraud

- 14 The Claimant Fraud Team manages and coordinates activities concerned with the prevention, detection, investigation and prosecution of fraud by claimants.
- 15 The Claimant Fraud Team is comprised of one national manager, two Senior Examining Officers and ten Examining Officers.
- 16 All Claimant Fraud staff report through to the Claimant Fraud Investigation Manager. However, for day-to-day advice and support each Senior Examining Officer has five Examining Officers allocated to them.
- 17 The team is scattered throughout the country including some 'inherited' locations as follows:

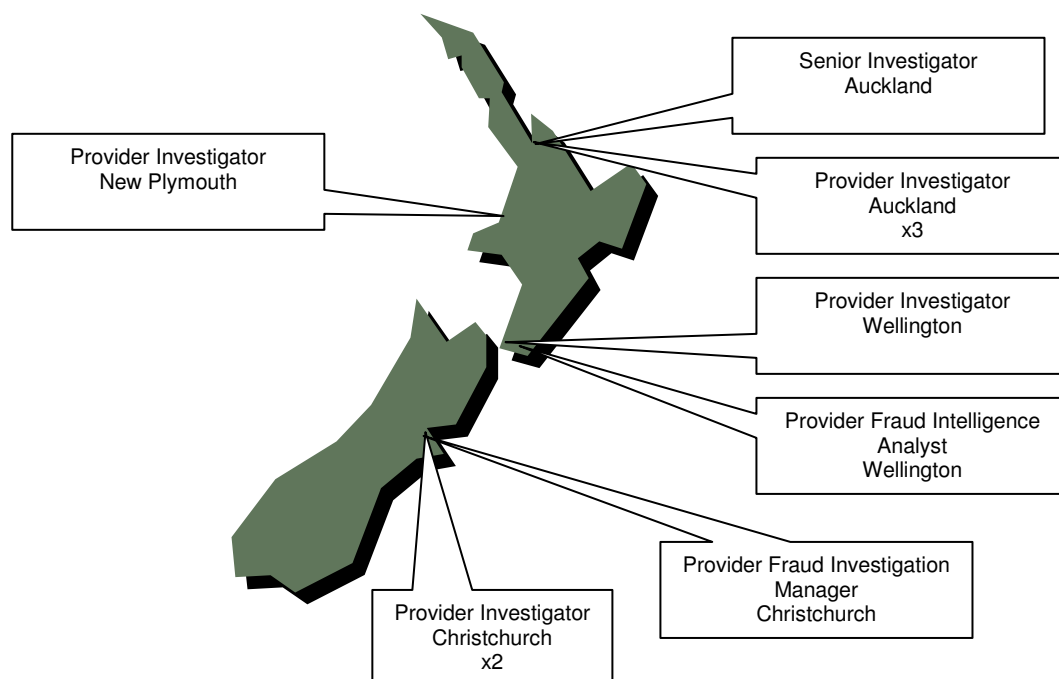
**Figure 2: Claimant Fraud Team Location**



## Provider Fraud

- 18 The Provider Fraud Team manages and coordinates activities concerned with the prevention, detection, investigation and prosecution of fraud by providers.
- 19 The Provider Fraud Team is comprised of one national manager, one Senior Investigator, seven Provider Investigators and one Provider Intelligence Analyst.
- 20 The team is located throughout the country as follows:

**Figure 3: Provider Fraud Team Location**



## Serious Fraud and Investigation Support

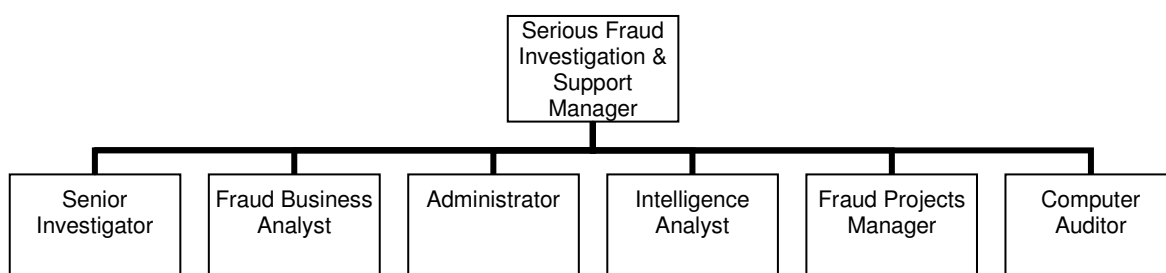
- 21 The Serious Fraud & Investigation Support Team manages and coordinates a variety of fraud-related functions. The team is managed by the Serious Fraud & Investigation Support Manager and is comprised of five specialists and one administrative support role.
- 22 The key areas of focus for this team are:
- managing the support function of the Fraud Unit (including carrying out all reporting for the Unit)

- managing the detection function of the Fraud Unit (including managing fraud systems and databases, analysing corporate databases, and developing and implementing appropriate CAATS and profiling tools)
- coordinating fraud activities across the Unit (including managing the Hotline and resourcing long outstanding investigations within the Unit)
- managing fraud projects (which may draw on the expertise of members of the Provider Fraud and Claimant Fraud Teams)
- managing serious fraud investigations
- managing staff fraud investigations
- managing levy fraud investigations (although this area is often not investigated as it is considered time-consuming).

23 Essentially the Serious Fraud & Investigation Support Team is responsible for all fraud-related activities that do not logically sit within the claimant and provider teams.

24 The group is located in Wellington and is structured as follows:

**Figure 4: Serious Fraud & Investigation Support Group Structure**



## Interfaces with other internal business units

25 The extent of interfaces with other internal business units varies significantly between the three fraud teams:

### Claimant Fraud

26 The nature of claimant fraud means that the Claimant Fraud Team is reliant on regular communication with Case Managers. When a Case Manager has reason to suspect a claimant has the capacity to move off the scheme but has failed to report this, they will notify the Claimant Fraud Team.

27 The majority of referrals to the Claimant Fraud Team are from Case Managers. Other referrals arise from the hotline or from other claimants or providers.

- 28 The Claimant Fraud Investigation Manager has also recently developed a process for formally communicating with Case, Area and Branch managers regarding the team's activities in their areas and with their claimants. This has been well received and resulted in positive feedback.

## Provider Fraud

- 29 The functions of Provider Fraud are part of a continuum of activities related to providers as follows:
- **Primary Care** – responsible for developing service specifications and initiating and maintaining provider contracts (including conducting contract compliance audits) (*Rehabilitation Service Development - Operations*)
  - **Procurement** – responsible for developing contracts based on service specifications (*Finance*)
  - **Provider Relationship Management** – responsible for building relationships with providers and assisting them to 'ACC' (*Capability Development – Operations*)
  - **Provider Monitoring** – responsible for monitoring providers and identifying atypical behaviour (including educating providers) (*Capability Development – Operations*)
  - **Practice Audit** – responsible for auditing clinical notes against contract requirements and making recommendations for business process improvement (*Risk & Assurance*)
  - **Provider Fraud** – responsible for detecting, investigating and resolving fraud by providers (*Risk & Assurance*)
- 30 As noted in italics, the various stages of the continuum are managed by several business units with the bulk sitting within the Operations Group.
- 31 Provider Fraud provides Provider Relationship Management with a monthly list of providers it is investigating and notifies the group of upcoming investigations 1-2 months in advance. Provider Relationship Management then stays away from those providers until the investigation is complete, and provides information on unusual activities by the providers to the Provider Fraud team. Provider Relationship Management also follows up investigations with education and training for providers where appropriate.
- 32 Contact with other internal business units appears to be relatively ad hoc and more likely to occur where Provider Fraud is co-located with these groups. There is little interface with the Primary Care, Procurement and Practice Audit functions.

- 33 The Provider Fraud Team does not appear to be well understood by other business units, particularly regarding the range of remedies they have available and use, the methods they use to assess whether or not fraud exists, and their investigation processes.

## Serious Fraud & Investigation Support

- 34 Because of its focus on data analysis the Serious Fraud & Investigation Support team has a close link to the data warehousing function within the Information Management business unit. There is otherwise little interface between this team and other internal business units.

## Culture

- 35 ACC is in the process of developing a new culture for the organisation. The new culture requires staff to be more innovative and responsive to the needs of claimants, and to build strong and collaborative relationships with providers and other key stakeholders. An important objective in this regard is to build the public's confidence in ACC as a responsive social insurance organisation and as a consequence improve the standing of ACC in the eye of the public. In terms of its internal functioning, the new culture requires a breakdown of the 'silo' mentality and the development of collaborative approaches throughout ACC.
- 36 This new culture represents a significant departure from the previous one, which was characterised by a strong focus on control and audit, stemming to a large extent from irregularities at the highest level of management of ACC in the early to mid 1990's. The focus on control and audit was an important part of restoring the integrity of ACC. However, it required a high degree of central control which stifled innovation and bred a culture of cynicism throughout ACC, which ultimately impacted adversely on relationships with claimants and providers. It also encouraged the development of a 'silo' mentality, that constrained the effective internal operation of ACC.
- 37 Whilst the new culture is being driven in other parts of ACC, it is acknowledged that very little has been done to promulgate it within the Fraud Unit. The detached nature of the Fraud Unit and the activities it performs has led to the development of a Fraud Unit subculture which is misaligned with the rest of the organisation. The recent initiatives by the Manager of the Claimant Fraud team to strengthen connections with Area and Branch Managers are however a step in the right direction. A culture of separation between the Provider Fraud and Claimant Fraud teams has also been described.

## Operating Approach

- 38 The ACC's new culture requires a reconsideration of the approach to fraud investigations at both the strategic and operational levels. At the strategic level, an organisation-wide view needs to be developed on the appropriate balance between a preventative, education-based approach to fraud and a harder-line deterrent and prosecution-focused approach. The current emphasis is clearly on detection, investigation and prosecution. There is very little focus on educating the wider community with the objective of preventing fraud occurring in the first place.
- 39 Currently, each team adopts its own approach to fraud with varying levels of inclusion of other business units. The Fraud Unit is the sole decision-maker regarding prosecutions with no input from the Operations Group, although the Unit's decision to prosecute can be overridden by the Chief Executive. The Fraud Unit operates in line with Prosecution Guidelines developed by the Crown Law Office.
- 40 At the operational level, ACC's responsive social insurance role means that there is a point at which ACC investigations should differ from regular criminal investigations. This may involve determining whether a situation is a case of poor compliance, overpayment, or something premeditated with intent to defraud. This point is currently unclear and is a source of tension between the Fraud Unit and other business units.
- 41 The current operational approach of the two units is described in general terms below.

## Claimant Fraud

- 42 Claimant fraud investigations are overseen by the Claimant Fraud Team with a large component of field investigation work being carried out by private investigators. The majority of referrals come from Case Managers and the remainder via the hotline, other claimants and providers.
- 43 There are mixed views over whether or not case managers are kept sufficiently apprised of investigation processes, and whether they are able to provide sufficient information about claimants. This appears to vary between locations and individuals. Claimant advocacy groups in particular cite instances of a lack of communication between the Case Manager and Examining Officer, particularly where the referral is received via the hotline or from another claimant or provider. In these circumstances, the Examining Officer may not be in full possession of the facts held by the Case Manager, the nature of which may have averted the need for an investigation and the attendant stress and possible reputational damage for the claimant.

- 44 The current investigative approach involves a number steps and processes. At the lowest level, the Examining Officer, following an initial investigation and analysis of data, might simply suggest more intensive case management. Alternatively, the claimant might be sent a form reminding him or her to advise ACC if they have returned to work or if their situation is changed. This often resolves the matter. If it does not, then a private investigator is engaged to undertake initial surveillance. Some 10 hours of surveillance activity is commonly arranged. If there is no evidence of fraud, or the claim is of low value, then the investigation ceases. However, a follow up of the claimant's activity will occur further down the track.
- 45 If a prima facie case of fraud exists then a full investigation is undertaken involving requests for a statutory declaration, requests for an interview (invariably undertaken by the private investigator), and requests for a warrant for search and seizure of document. The decision to prosecute follows a review of the evidence collected in accordance with Crown Law's prosecution guidelines. If there is sufficient evidence to mount a prosecution, then the claimant may be afforded the opportunity settle the matter out of court.
- 46 Both claimant advocate groups and some Examining Officers and Case Managers within ACC regard some aspects of the current investigative process as rigid, overly formal, and overbearing. They see a softer approach as more in keeping with a responsive social insurance organisation such as ACC.

## Provider Fraud

- 47 Provider fraud investigations are managed and conducted by the team with limited use of private investigators.
- 48 Over time the catalyst for investigation has shifted from Operations Group referrals to self-initiated data analysis. Currently the team has a target of 50% self-detection. Other channels providing information to the team include:
- other business units (including Provider Monitoring, Provider Relationship Management and Rehabilitation Service Development)
  - other providers
  - hotline and other informants, and
  - claimants.
- 49 The Provider Fraud Investigation Manager is the initial screener of all information and will determine whether or not the information is sufficient to commence an investigation.



- 50 Provider Fraud Investigators are responsible for planning and conducting investigations. There are three 'stop points' in the investigation process where matters can be referred to other parts of the business. The Provider Fraud Investigation Manager and Senior Investigator share responsibilities for approving progression beyond certain parts of the investigation process.
- 51 The performance measures of the Provider Fraud Team are fiscally focused with a target savings of \$11m per annum. This savings calculation includes the actual fraud detected and an estimate of the prospective fraud that has been stopped as a result of the detection.
- 52 Cost effectiveness is a significant focus for investigations with a target \$50 return on each \$1 spent on Private Investigator and Crown Solicitor fees.
- 53 The team is also tasked with a 100% success rate for prosecutions. As a result only cases which are likely to result in prosecution are pursued to that end. Other remedies available include:
- formal warnings
  - debt recovery
  - application of penalties
  - future billing restriction
  - provision of advice
  - reporting of risk, and
  - complaints to professional bodies.
- 54 Provider Fraud also works to increase fraud awareness through conducting presentations, meeting with appropriate business groups, publicising outcomes, reporting risks and increasing referrals. The team also conducts its own projects relating to provider fraud.
- 55 The provider side of ACC has been described as unnecessarily convoluted with numerous silos. Being at the tail end of the 'continuum', the Provider Fraud Team both contributes to and is affected by this lack of communication between business units. The current lack of formal handover between groups is viewed as ineffective.
- 56 A more detailed description of the Provider Fraud Team's operating approach is outlined in Appendix 3.

## Serious Fraud & Investigation Support

- 57 The Serious Fraud & Investigation Support Team is comprised of specialists with differing expertise and conducts a variety of services for the Unit and the wider organisation including reporting for the Fraud Unit, managing Official Information Act requests, undertaking data analysis, managing serious fraud investigations and conducting projects for the Unit.
- 58 The majority of work completed by this team comes from managers and senior investigators within the provider fraud and claimant fraud groups. The team also completes regular checks for internal fraud. There is currently no definition of “serious fraud” but it tends to include high cost claimant fraud and lengthy investigations.
- 59 The current operating approach of the Serious Fraud & Investigation Support Team appears to be well received by the business. However, there is an acknowledged potential for increased intelligence capability within the team.
- 60 Although the team is responsible for detecting and investigating levy (premium) fraud, this is viewed as resource-intensive and hard to prove and is therefore not a primary focus.

## Mechanisms to share learnings

- 61 There are few formal mechanisms for sharing learnings between fraud teams and other business units. Some sharing occurs in fairly limited and ad hoc pockets and appears to be driven by co-location of work groups.

## Benchmarking of Operating Approach

- 62 Commercial insurance companies, while different from the public sector responsive social insurance nature of ACC, have similar functions in terms of providing compensation to individuals, and an imperative to substantiate the nature of the claims to ensure they are appropriate.
- 63 Claim investigations by commercial insurance companies are referred to as ‘investigations’ and the term ‘fraud investigation’ is rarely used.
- 64 Claims assessors examine the factual basis of the claim, the medical issues, the circumstances of the claim, and if applicable any financial issues. Insurance companies typically have expertise in the medical, claims and financial areas. However, they often engage specialists as follows:

- While commercial insurance companies often have in-house medical specialists they may on occasion call in an independent specialist for a second opinion;
- Loss adjustors are engaged to assess business interruption and material damage;
- Private Investigators are used to observe the activities of a claimant;
- Forensic accountants are used to assess financial information, and determining technical aspects such as how the claimant's income is structured and the impact of disability.

65 It is worth noting that the potential outcomes if fraudulent activity is detected are different from the options ACC has available. That is, the insurance company may elect to decline a claim, or in the most severe instance they may cancel the claimant's insurance policy. Commercial insurance companies have a primary focus on shareholders and reinsurers, whereas ACC has an obligation to take account of the public interest which can lead to prosecution.

## Capability & Capacity

- 66 The capability and capacity of the Fraud Unit are fragmented within the three existing teams. The vastly different approaches to claimant and provider fraud have until recently meant that very different skills, experience and competencies were accumulated in each team.
- 67 While there is general acknowledgement that investigative skills are essential, there is a view that people skills are becoming increasingly important for the Unit.

## Claimant Fraud

- 68 The Claimant Fraud Team includes one Manager, two Senior Examining Officers and ten Examining Officers.
- 69 The Manager of the Claimant Fraud Team is a qualified lawyer with prosecutions experience and an investigative background. The team has an artificial division of expertise, namely a group of former police officers with investigative experience and former case managers with a strong knowledge of the business. It is perceived that these two distinct types of team members have different operating approaches.
- 70 Recent recruitment activities have focused on the acquisition of additional investigative skills within the Claimant Fraud Team. Despite the shared skill and competency bases with the Provider Fraud Team there is no sharing of personnel or joint investigations.

## Provider Fraud

- 71 The Provider Fraud Team includes one Manager, one Senior Investigator, six Provider Investigators and one Provider Intelligence Analyst. The Provider Fraud Team is largely comprised of former police officers and private investigators.
- 72 As mentioned, while there are shared skills and competencies with the Claimant Fraud Team there is no sharing of personnel or joint investigations between the teams. There appears to be a perception that provider fraud investigations are more complex and require a greater level of skill than for claimant fraud.

## Serious Fraud & Investigation Support

- 73 The Serious Fraud & Investigation Support Team is comprised of specialists with expertise in functions including data mining, intelligence analysis, serious fraud and staff fraud investigation and fraud project management.
- 74 It is acknowledged that the current Fraud Business Analyst is highly skilled in data mining and profiling and there is no current succession plan in place.
- 75 There is also an acknowledged opportunity to increase the intelligence capability of the unit through increased resourcing. This would enable the team to carry out more comprehensive data mining and profiling activities and potentially other functions for ACC such as computer auditing.

## Cross Government Initiatives

- 76 There are numerous counter-fraud and enforcement agencies across Government working within individual organisations. The ACC Fraud Unit has developed and maintains strong relationships with several such organisations including the Ministry of Health (Provider Fraud), the Ministry of Social Development (Claimant Fraud), the Inland Revenue Department and Australian workers compensation organisations.
- 77 New Zealand Police is currently investigating opportunities for greater alignment in Government agencies involved in criminal investigations. This review will consider whether investigative processes within individual organisations are sufficiently aligned to achieve wider community benefits and public good.
- 78 The Ministry of Health is currently reviewing its counter-fraud practices in view of a recent NHS counter-fraud project.
- 79 These concurrent initiatives are likely to recommend increased information sharing between organisations involved in fraud detection and investigation. In the short-to

medium term there are no obvious plans for consolidation of counter-fraud units within the Sector.

- 80 For the ACC Fraud Unit this means that the Unit will need to continue building on its existing relationships and building new linkages as opportunities arise.

## Part 2: Key Themes Arising from Consultation

This section sets out the key themes that emerged during the one-on-one consultation with stakeholders (Appendix 1).

### Internal Structure

**The current structure recognises the distinct natures of provider and claimant fraud investigations but does not assist shared learning between the teams.**

- Provider and claimant fraud investigations are acknowledged as being distinct activities. However, there is arguably a shared skill set between the two teams, and the current separation has not encouraged shared learnings.
- There is a general lack of communication between the provider and claimant fraud teams which may be leading to lost opportunities.

### Interfaces with internal business units differ by Fraud team

- The Claimant Fraud Team has frequent contact with case management staff as this is where the majority of its referrals originate. Recent initiatives by the new Claimant Fraud Investigation Manager have resulted in increased interfaces and formal reporting systems between Claimant Fraud and Operations Group staff.
- In the past there were Fraud Liaison Officers in each branch; however, as the incumbents left they were not replaced. It is unclear why this occurred. However it appears to have contributed to the opaqueness of the Unit.
- The Provider Fraud Team is generally perceived as operating separately from the rest of the organisation. While there are pockets of information sharing this appears to primarily exist where groups are co-located.
- Communication with other business units appears to be relatively ad hoc and has led to some frustration especially from the Operations Group.
- There are reports of the Fraud Unit ignoring advice from internal specialists from other business units, even in situations where they were able to provide legitimate explanations for provider or claimant conduct.

### The current location of fraud staff is fragmented and not driven by business need

- Members of the Fraud Unit are located throughout the country and managed remotely depending on their team (with the exception of the Serious Fraud & Investigation Support Team which is located solely in Wellington).

- The locations of team members do not appear to correlate with where the fraud work is located. While provider and claimant fraud investigations can both be managed remotely this fragmentation does not assist national oversight or strategic alignment of the Unit
- As a result two distinct subcultures have emerged in the Unit that are misaligned with the rest of ACC

## Reporting Arrangements

### **The independence of the internal audit function has artificially extended to the Fraud Unit.**

- The Fraud Unit is located within the Risk & Assurance Group which also includes internal audit and external practice audit functions. The Risk & Assurance Manager reports through to the Director, CE's Office with a direct reporting line to the Audit Committee on internal audit matters.
- The independence of the internal audit function appears to have artificially extended to the activities of the Fraud Unit. There is resistance in sharing information on fraud investigations with senior management and the operational arm of the business. This has led to dissatisfaction and concerns from other business units.
- The Fraud Unit has been placed within the Risk & Assurance Group for convenience rather than being driven by business need. There is an apparent need to separate investigation activities from the internal audit function. The Fraud Unit is generally viewed as an operational function which may better fit within the service delivery arm of the business.

## Culture

### **The Fraud Unit operates a distinct culture from the rest of the organisation.**

- The Fraud Unit is generally seen as detached from the rest of the organisation. Its approach is perceived by other business units as being somewhat secretive and non-transparent.
- There is a perception that some staff have transported a culture into the Unit which is not aligned with the philosophy of a responsive social insurance organisation.
- The name "Fraud Unit" is perceived as predetermining the outcome of an investigation as identifying fraudulent activity when there could be many other explanations and outcomes.
- There is not a clear organisational view of fraud prevention, detection and investigation strategy and in the absence of that different views have emerged within different business units. This has caused conflict and tensions between the Fraud Unit and other business groups.

## Operating Approach

**The Fraud Unit generally follows appropriate investigative processes however there are concerns over the application of those processes.**

- There are concerns over the approach to investigations particularly by the Provider Fraud Team. There have been several incidents which have been directed at providers and operational staff that have caused concern. There is a perception that the Provider Fraud Team's mode of operation is at odds with the greater business direction of the organisation.
- Recent high profile cases have placed scrutiny on the Claimant Fraud Team's approach however these appear to have been isolated incidents which are being appropriately managed.
- Reports suggest that some private investigators and employees within the Claimant Fraud Team are not behaving in line with ACC's desired mode of operation. For example, there is concern that some pockets of the Unit may be accessing information ACC may not be supposed to be privy to.
- There are no obvious concerns relating to the operating approach of the Serious Fraud & Investigation Support Team.
- The triggers for claimant fraud investigations are perceived by some as being inconsistent. For example, a number of full investigations appear to have been triggered by malicious calls to the hotline by a claimant's estranged partner or family member.
- There are concerns that investigators are often not sufficiently aware of the claimant's injury and rehabilitation plan. For example, claimants have been investigated for carrying out volunteer work or household chores despite these being specifically agreed and documented by their case manager as part of their rehabilitation plan.
- Concerns have been raised over the disclosure of personal information regarding claimants during investigations, and the inability of claimants to access their own information.
- The parameters of some investigations are somewhat unclear. For example, if prima facie evidence is not found after an initial period of surveillance, the investigation should be discontinued. It appears that in some cases this has not occurred and some investigations have been continued for an unwarranted period of time.
- There is concern over investigations continuing for long periods despite no evidence being found. For example, one investigation has continued for 10 years and many have gone on for 2-3 years. There are also reports of repeat investigations with the most regular being 4 investigations on one claimant in 12 years.
- There are reports of an over-bearing and unduly aggressive approach to some claimant investigations, which is not well aligned with a responsive social insurance organisation such as ACC.



- Reports also indicate that some surveillance techniques are inappropriate and less than discreet.
- Methods for obtaining further information for some investigations appear to be unprofessional. Examples include chasing neighbours and approaching members of the community on the basis and telling these individuals that the claimant is committing fraud against ACC.
- There are also numerous concerns over procedural aspects of investigations, including execution of search warrants and short timeframes for statutory declarations.
- It has been alleged that some investigation methods used have exacerbated stress-related conditions for claimants as well as impacting on their personal lives and standing in the community, even when no evidence of fraud has been found.
- There is a general lack of closure when cases come to an end. Claimants receive a letter saying the investigation has been closed, but this often comes in the form of a warning letter advising them not to do 'it' again. It appears that claimants are not always told what they were meant to have done wrong.

**There are pockets of intelligence throughout the organisation and no one point within the organisation that makes the decision to investigate potential fraud.**

- The Fraud Unit operates its own database as does Provider Monitoring and Provider Relationship Management. Each database looks at information through a different lens yet each may be used as the starting point for a fraud investigation.
- Provider Fraud investigations may be commenced by the team itself with no clinical input, or upon referrals from other parts of the business.
- There could be an opportunity to have a 'screening' function where an individual or group with clinical expertise can determine whether or not there is cause for investigation at which time the case can be handed to the Provider Fraud Team for action.

**There is a general lack of understanding by other business units of what the Fraud Unit does and how it operates**

- The Fraud Unit is perceived to operate in a non-transparent way and only limited information is passed on to other business areas. This has led to a lack of understanding of the role and function of the Fraud Unit and how it goes about investigating fraud.
- There is some scepticism over the model used to estimate actual savings by the Fraud Unit as its calculations are estimates based on retrospective and future fraud by the claimant or provider.
- There is general frustration around the lack of communication regarding investigations, particularly around the withdrawal of prosecutions.

### **There is no clear organisational mandate or approach towards fraud prevention, detection, investigation and resolution.**

- The Fraud Unit has been located in several business units since its inception. As a result there is no senior manager actively 'behind' the Unit providing strategic direction and support.
- The absence of a mandate has led to differing views on how fraud should be approached by the organisation and in particular the Fraud Unit. This has caused ongoing tension between business units.
- There are some concerns that placing the Unit elsewhere in the organisation with the current lack of direction may result in interference and conflicting objectives.

## **Capability and Capacity**

### **The current capability of the Fraud Unit has influenced the culture and there is an absence of clinical expertise within the Unit.**

- There are mixed views over the current skill mix within the Fraud Unit.
- There is a perception, particularly from the operational business units, that the presence of former police officers and private investigators within the Provider Fraud Team has impacted negatively on the group's interaction with the rest of the business.
- There are concerns that a n approach is taken to investigations with a focus on prosecution. This does not sit comfortably with the responsive social insurance focus of the rest of the organisation and does not take into account organisational objectives and other considerations.
- There is a perceived lack of clinical expertise within the Provider Fraud Team. This has resulted in certain actions being taken which may not otherwise have occurred.

## Part 3: Summary of Key Issues

- 81 The investigative function is undoubtedly important to assuring the integrity of the ACC's payments system. However, the overriding conclusion is that the Fraud Unit as it currently operates is not well aligned with the new direction that has been adopted for the ACC. The new direction can be characterised as one that encourages innovation, is responsive to the needs of claimants, providers and other stakeholders, seeks to build and maintain collaborative relationships with the ACC's stakeholders, and promotes seamless teamwork within ACC. It positions ACC as an important responsive social insurance organisation.
- 82 The new direction is underpinned by a structure that is built around the key statutory functions of ACC, appropriately supported by policy and corporate capability, and which is therefore based on a high degree of functional association.
- 83 This lack of alignment between the Fraud Unit and the wider organisation is evident across most of the dimensions covered in the reviews terms of reference:
- the Fraud Unit's positioning within the Risk & Assurance Group was driven more by issues of managerial capacity than strong functional association. In practice, there is little interaction between the Fraud Unit and audit, although it is acknowledged that some of the competencies possessed by the internal auditors are of relevance to fraud detection. The inclusion of an essentially operational function within the Risk & Assurance Group also creates potential conflicts, given the Groups 'whole of organisation' responsibility to assure the Chief Executive and the Board about the robustness of ACC's internal systems and controls
  - the Fraud Unit is not particularly well connected in a systematic way to the wider organisation. The connections that do occur are generally the minimum required for the Fraud Unit to undertake its investigative activities, or arise in an ad hoc way through co-location. It tends to operate under a 'cloak of secrecy'. The recent moves by the Claimant Fraud Manager to strengthen connections with Area and Branch management are however a step in the right direction
  - the Fraud Unit has developed its own subculture that is not in step with the new culture being inculcated throughout ACC. Within the unit itself, different cultures are evident both between the provider fraud and claimant fraud teams, and within those each team. Noticeably missing is a culture of collaboration, either internally within the unit, or with the wider organisation
  - the Fraud Unit's subculture is reflected in its operating approach, both at the strategic and operational levels. At the strategic level, the emphasis is very much on the detection, investigation and prosecution rather than prevention. However, this reflects in part the fact that ACC has not reviewed its strategic approach to

fraud as a result of the organisation's new direction. At the operational level, the approach to investigations is seen to be rigid, overly formal and over-bearing, and sits uneasily with a responsive social insurance organisation. Decision-making at critical stages of the investigative process needs to involve key staff outside of the unit including, on occasions, the relevant senior managers

- the Fraud Unit generally has adequate capacity to perform its investigative functions, but its capability could be enhanced through the engagement of staff with a wider skill/experience mix. These include staff skilled in communicating with the wider community on the prevention of fraud, and staff with substantial knowledge of the operations of ACC (which is currently evident in the claimant team). The unit also needs to access clinical input, particularly at the front end of the investigation process. Finally, there is a need for a person with all-round competencies in investigation techniques and processes to undertake training, particularly of new staff, to peer review the investigative work being undertaken to ensure that it complies with agreed standards and processes, and to provide an overview of the Unit's operations to other parts of the organisation.

- 84 These conclusions are not surprising given that the moves to inculcate the new culture and direction throughout other parts of ACC have not occurred, to any great extent, with the Fraud Unit.
- 85 The following parts of the report identify options for addressing the key issues arising from the analysis.

## Part 4: The Positioning of the Fraud Unit within ACC

- 86 As noted earlier, the positioning of the Fraud Unit within ACC has clearly been problematic, given the history of its frequent relocation between the business groups. This has contributed to the unit being somewhat disconnected from the wider organisation.
- 87 A variety of different approaches are evident for the location of a fraud unit or its equivalent within an organisation. In some organisations, the unit is co-located with the audit function, as it is with ACC. Under this model, the audit and fraud functions may stand alone as a separate group, or be part of finance. In others, the Fraud Unit is part of the main service delivery arm, or is located in a separate service line (MSD).
- 88 A distinction is often drawn organisationally between internal or staff fraud (often co-located with audit) and external fraud (which can be more aligned with service delivery). It is noteworthy, in this regard, that MSD is in the process of relocating the function of staff fraud from its corporate risk and assurance group to the specialist service that deals with benefit (external) fraud (Integrity Services), the principal driver being the need to provide the government and the public with assurance about the integrity of the system as a whole. Nonetheless it is coherent from an organisation design perspective to continue to position staff fraud with internal audit, reflecting the latter's focus on internal controls.
- 89 The optimum model might well therefore be organisation-specific, depending on the organisation's overall purpose and strategic direction and the contribution that fraud prevention, detection and investigation makes to this.

### The Options

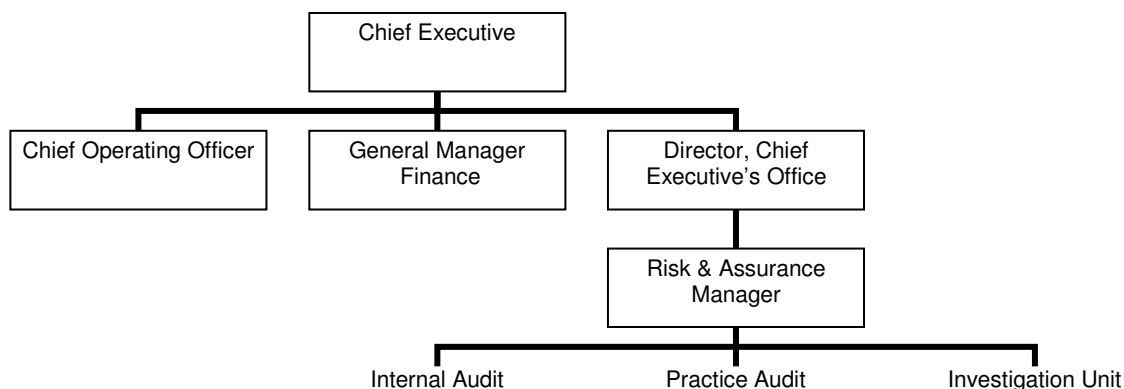
- 90 Consistent with the above, four broad options have been identified for the positioning of the Fraud Unit within ACC:
- Option 1, the unit remains within the Risk & Assurance Group (status quo);
  - Option 2, the unit becomes part of the Operations Group;
  - Option 3, the unit becomes part of the Finance Group;
  - Option 4, the unit reports directly to the Director, CEO's Office.
- 91 In all of the options, the Fraud Unit is renamed the Investigation Unit, consistent with the oft-made comment that the current nomenclature in itself involves a presupposition of fraud.

- 92 As noted above, staff fraud could either be located with internal audit in the Risk and Assurance Group or be associated with claimant and provider fraud. The scope of Options 2, 3 and 4 could therefore include the investigation of internal or staff fraud, or be limited to the investigation of provider and claimant fraud.
- 93 The options are briefly described below.

### Option 1: The Investigation Unit remains within the Risk & Assurance Group

- 94 Under this option the Investigation Unit would continue to be part of the Risk & Assurance Group and the Unit's Managers would report to the Risk & Assurance Manager. The diagrammatic representation of the option is as follows:

**Figure 5: Investigation Unit remaining within the Risk & Assurance Group**



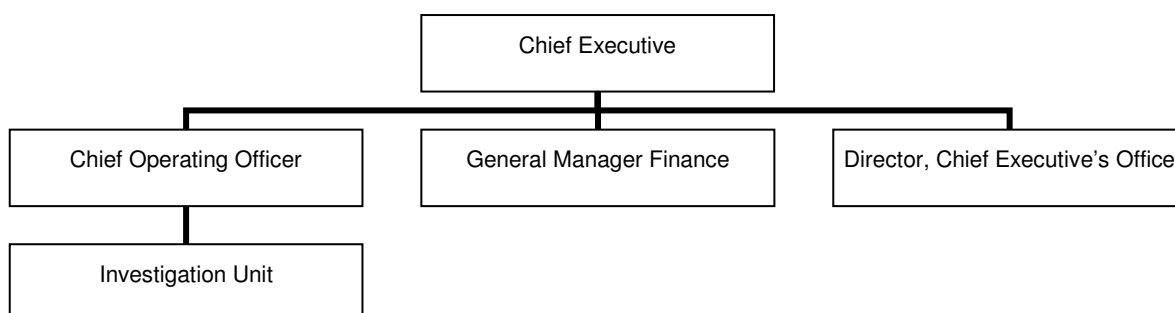
- 95 As noted previously, the original rationale for locating the unit within the Risk & Assurance Group relied more on managerial capacity rather than strong functional association. Having said that, the co-location of audit and investigative functions is not uncommon, particularly the internal audit and staff investigative functions.
- 96 This option has the advantage of maintaining a measure of stability in reporting relationships, the importance of which should not be underestimated given the numerous changes to reporting arrangements that have occurred in recent years. There is also potential leverage to be gained from a greater degree of interaction between auditors and examining officers in the detection of possible fraud, particularly but not exclusively internal fraud.
- 97 The principal drawback with this option relates to the potential conflict in co-locating audit and investigative functions, given the organisation-wide responsibility that the Risk & Assurance Group has for assuring the Board and Chief Executive of the

robustness of the ACC's systems and controls, including the systems and controls developed by the Investigation Unit.

## Option 2: The Investigation Unit becomes part of the Operations Group

98 Under this option the Investigation Unit would report through to the Chief Operating Officer as follows:

**Figure 6: Investigation Unit becoming part of the Operations Group**



99 The principal rationale for this option is that the Investigation Unit's function can be seen as part of the service delivery continuum and therefore closely linked with activities of the Operations Group. The vast majority of the interactions that the Investigation Unit has are with different parts of the Operations Group, and the positioning of the Unit within the Group would facilitate improved communications.

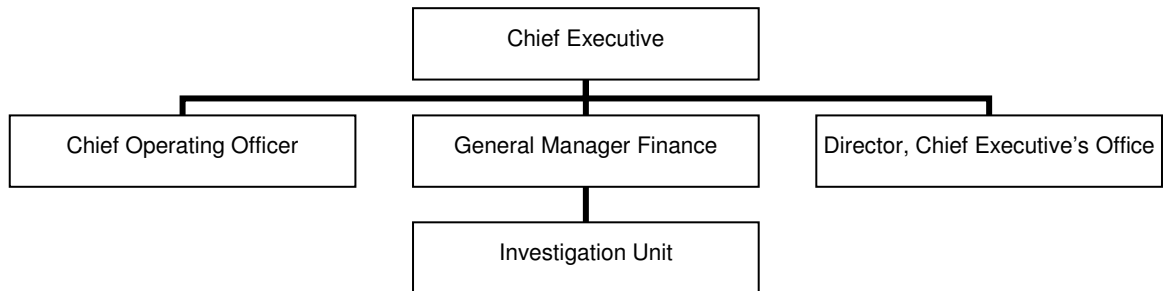
100 The principal drawback with this option is that, arguably, a degree of separation is warranted between the investigative and service delivery functions, related in part to the different incentives that drive those functions. This would be mitigated to some extent by the Unit reporting directly to the COO.

101 In addition, the Chief Operating Officer's role is already significant in scope with a broad span of control. Issues of the capacity of the COO to manage an additional function would need to be seriously weighed up.

## Option 3: The Investigation Unit becomes part of the Finance Group

102 Under this option the Investigation Unit would report through to the General Manager Finance as follows:

**Figure 7: Investigation Unit becoming part of the Finance Group**



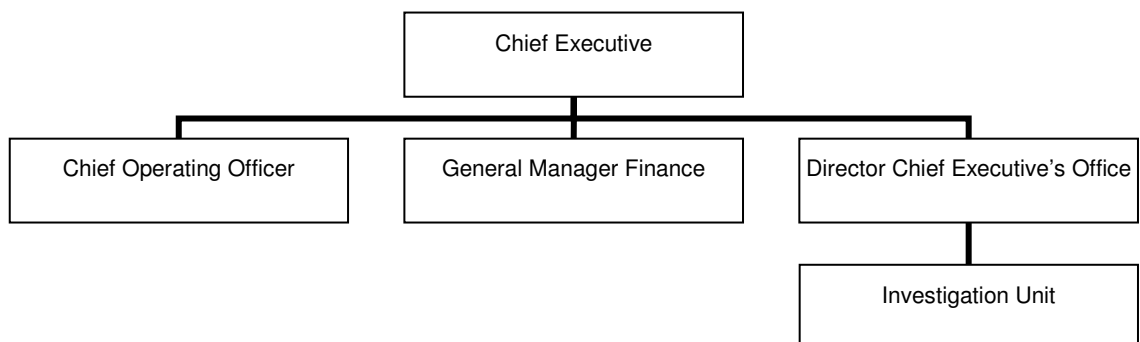
103 This option would be more in the nature of a transitional arrangement, should cross-agency initiatives emerge for the management of the investigative function. The principal role of the General Manager Finance would be to prepare the unit for migration out of ACC, whether to another existing government agency or to a standalone agency that undertakes investigations on behalf of multiple agencies. As noted previously, this possibility is not on the immediate horizon. The GM Finance would have the capability to manage this transition without compromising the delivery of other finance functions.

104 The reason why this is not an enduring option is that there is a relatively weak functional association between the Finance Group and the Investigation Unit. The only potential link is in regard to procurement contracts for providers, the negotiation of which is the responsibility of Finance.

**Option 4: The Investigation Unit reports directly to the Director: Chief Executive’s Office**

105 Under this option the Investigation Unit would report directly through to the Director: Chief Executive’s Office as follows:

**Figure 8: Investigation Unit reporting directly to the Director: CE's Office**



106 The rationale behind this option would be to establish a triangle of accountability within ACC with the aim of ensuring that the government and the wider public have confidence in the integrity in the accident compensation system. Thus:



- the Investigation Unit would be responsible for establishing systems and controls for the prevention, detection and investigation of fraud
- the Operations Group would be responsible for the administration of those systems and for monitoring claimants and providers and making referrals to the Investigation Unit as appropriate
- the Risk & Assurance Group would be responsible for providing independent advice to the Chief Executive and Board on the adequacy of the systems and controls established by the Investigation Unit.

107 The efficacy of this option depends on whether emphasis is given to a clear separation of accountabilities and responsibilities in ensuring the integrity of the ACC payments system (which would lend weight to this option), or on achieving closer integration between the investigative function and service delivery (which would lend weight to Option 2).

## Evaluation of the Options

108 The four options specified above were evaluated against a standard set of criteria. The criteria developed for the purposes of the evaluation are:

- supports the realisation of the strategic direction and SOI
- supports the efficient and effective operation of ACC in assuring the integrity of the payments system;
- provides clear roles and accountabilities with appropriate spans of control
- promotes seamless teamwork with other areas in ACC
- supports an approach to investigation that is appropriate to a responsive social insurance organisation and enhances stakeholder confidence
- enables shared learnings and constructive interfaces with other areas of ACC
- supports ACC's desired culture
- supports the provision of independent advice on investigative systems and controls

The results of the evaluation are presented in tabular form below.

**Table 3: Reporting Arrangements Evaluation Criteria**

<b>Evaluation Criteria</b>	<b>Option 1: The Investigation Unit remains part of the Risk &amp; Assurance Group</b>	<b>Option 2: The Investigation Unit becomes part of the Operations Group</b>	<b>Option 3: The Investigation Unit becomes part of the Finance Group</b>	<b>Option 4: The Investigation Unit reports directly to the Director, Chief Executive's Office</b>
Supports the realisation of the strategic direction and SOI	<ul style="list-style-type: none"> <li>Conflict in co-locating the investigative function and the organisation-wide audit function. Relatively weak functional association</li> </ul>	<ul style="list-style-type: none"> <li>Supports integrated service delivery</li> <li>Strong functional association, although a higher degree of separation may be warranted given the different incentives that apply to the investigative and core service delivery functions</li> </ul>	<ul style="list-style-type: none"> <li>Weak functional association</li> </ul>	<ul style="list-style-type: none"> <li>Provides for a clear separation of responsibilities for assuring the integrity of the ACC payments system</li> <li>Less well integrated with service delivery</li> </ul>
Supports the efficient and effective operation of ACC	<ul style="list-style-type: none"> <li>Provides stability in reporting arrangements for a group that has been relocated numerous times in recent years</li> <li>Some scope for leverage between investigative and audit functions</li> <li>Disconnected from service delivery arm</li> </ul>	<ul style="list-style-type: none"> <li>Opportunity created to better align the investigative function with service delivery, with attendant gains in efficiency and effectiveness</li> </ul>	<ul style="list-style-type: none"> <li>As noted above, weak functional association and disconnected from service delivery</li> </ul>	<ul style="list-style-type: none"> <li>Provides clear accountabilities for assuring the integrity of the ACC's payments system</li> <li>Disconnected from service delivery</li> </ul>

<b>Evaluation Criteria</b>	<b>Option 1: The Investigation Unit remains part of the Risk &amp; Assurance Group</b>	<b>Option 2: The Investigation Unit becomes part of the Operations Group</b>	<b>Option 3: The Investigation Unit becomes part of the Finance Group</b>	<b>Option 4: The Investigation Unit reports directly to the Director, Chief Executive's Office</b>
Provides clear roles and accountabilities with appropriate spans of control	<ul style="list-style-type: none"> <li>• Mixed accountabilities, given the potential conflicts in co-locating the investigative and audit function</li> <li>• Span of control is manageable</li> </ul>	<ul style="list-style-type: none"> <li>• The investigative and service delivery functions involve slightly different incentives, which can potentially result in blurred accountability in either direction</li> <li>• Span of control manageable but still wide and serious issues around managerial capacity</li> </ul>	<ul style="list-style-type: none"> <li>• Mixed accountabilities given the potential conflicts in co-locating the investigative and finance functions, particularly in regard to internal investigations</li> <li>• Span of control manageable;</li> </ul>	<ul style="list-style-type: none"> <li>• Creates clear roles and accountabilities between the Investigative unit, audit, and service delivery for assuring the integrity of the ACC's payments system</li> <li>• Span of control manageable</li> </ul>
Promotes seamless teamwork with other areas within ACC	<ul style="list-style-type: none"> <li>• Degree of structural separation from the rest of ACC and co-location with audit, which must have a measure of independence, creates real barriers to seamless teamwork.</li> </ul>	<ul style="list-style-type: none"> <li>• Would remove any structural barriers to increased teamwork with other service delivery groups</li> </ul>	<ul style="list-style-type: none"> <li>• Degree of structural separation from the rest of ACC would create barriers to seamless teamwork</li> </ul>	<ul style="list-style-type: none"> <li>• The Director, CEO's Office, has a strong organisation-wide focus on performance and business improvement which would incentivise the identification and effective management of the junction points between the Investigative Unit and other parts of ACC</li> </ul>

<b>Evaluation Criteria</b>	<b>Option 1: The Investigation Unit remains part of the Risk &amp; Assurance Group</b>	<b>Option 2: The Investigation Unit becomes part of the Operations Group</b>	<b>Option 3: The Investigation Unit becomes part of the Finance Group</b>	<b>Option 4: The Investigation Unit reports directly to the Director, Chief Executive's Office</b>
Supports an approach to investigation that is appropriate to a responsive social insurance organisation and enhances stakeholder confidence	<ul style="list-style-type: none"> <li>The degree of structural separation and co-location with audit mitigates against this</li> </ul>	<ul style="list-style-type: none"> <li>Would encourage an investigative approach that had regard to other service delivery objectives, without necessarily compromising the integrity of the investigation</li> </ul>	<ul style="list-style-type: none"> <li>The degree of structural separation mitigates against this</li> </ul>	<ul style="list-style-type: none"> <li>The organisation wide focus on performance and business improvement would encourage an investigative approach that is appropriate to ACC</li> </ul>
Enables shared learnings and constructive interfaces with other areas of ACC	<ul style="list-style-type: none"> <li>The degree of structural separation mitigates against this</li> </ul>	<ul style="list-style-type: none"> <li>Would facilitate shared learnings and constructive interfaces with the Operations Group and emphasise its role on the provider and/or claimant service delivery continuum</li> </ul>	<ul style="list-style-type: none"> <li>The degree of structural separation mitigates against this</li> </ul>	<ul style="list-style-type: none"> <li>As with the above, the strong organisation-wide focus on performance and business improvement would facilitate shared learnings and constructive interfaces with other areas of ACC</li> </ul>
Supports ACC's desired culture	<ul style="list-style-type: none"> <li>The degree of structural separation may lead to the continuance/development of misaligned subcultures</li> </ul>	<ul style="list-style-type: none"> <li>More likely to facilitate shared culture</li> </ul>	<ul style="list-style-type: none"> <li>The degree of structural separation may lead to the continuance / development of a misaligned subculture</li> </ul>	<ul style="list-style-type: none"> <li>The Director of the CEO's Office is strongly incentivised to encourage a shared culture</li> </ul>
Supports the provision of independent advice on investigative systems and controls	<ul style="list-style-type: none"> <li>Conflict arising from the co-location of the audit and investigative functions mitigates against this</li> </ul>	<ul style="list-style-type: none"> <li>There is a risk that the independence of advice from the Investigation Unit is compromised by wider service delivery objectives</li> </ul>	<ul style="list-style-type: none"> <li>Conflict arising from the collocation of the investigative and finance functions may mitigate against this</li> </ul>	<ul style="list-style-type: none"> <li>Clear separation of roles and accountability enhances the provision of independent advice on investigative systems and controls</li> </ul>

109 In terms of the degree of alignment with the evaluation criteria, the outcome of the evaluation is summarised as follows:

**Table 4: Summary of Evaluation**

Criteria	Option 1	Option 2	Option 3	Option 4
Supports the realisation of the strategic direction and SOI	Weak	Medium/Strong	Weak	Medium/Strong
Supports the effective and efficient operation of ACC	Medium	Medium/Strong	Weak	Medium/Strong
Provides clear roles and accountabilities with appropriate spans of control	Weak	Medium	Weak	Strong
Promotes seamless teamwork with other areas of ACC	Weak	Strong	Weak	Medium/Strong
Supports an approach to investigation that is appropriate to a responsive social insurance organisation	Weak	Strong	Weak	Strong
Enables shared learning and constructive interfaces with other parts of ACC	Weak	Strong	Weak	Strong
Supports ACC's desired culture	Medium	Strong	Medium	Strong
Supports the provision of independent advice on investigative systems and controls	Weak	Medium	Medium	Strong

110 Based on the analysis, Options 2 and 4 emerged as the clearly preferred options. The election between the two options essentially depends on where ACC chooses to place the emphasis. If the investigative function is seen as part of the continuum of service delivery, then placement within the Operations Group is the preferred option. On the other hand, if the Board and Chief Executive place emphasis on a clear separation of roles and accountabilities for assuring the integrity of the ACC's payments system, the Investigation Unit should arguably report directly to the Director of the CEO's office.

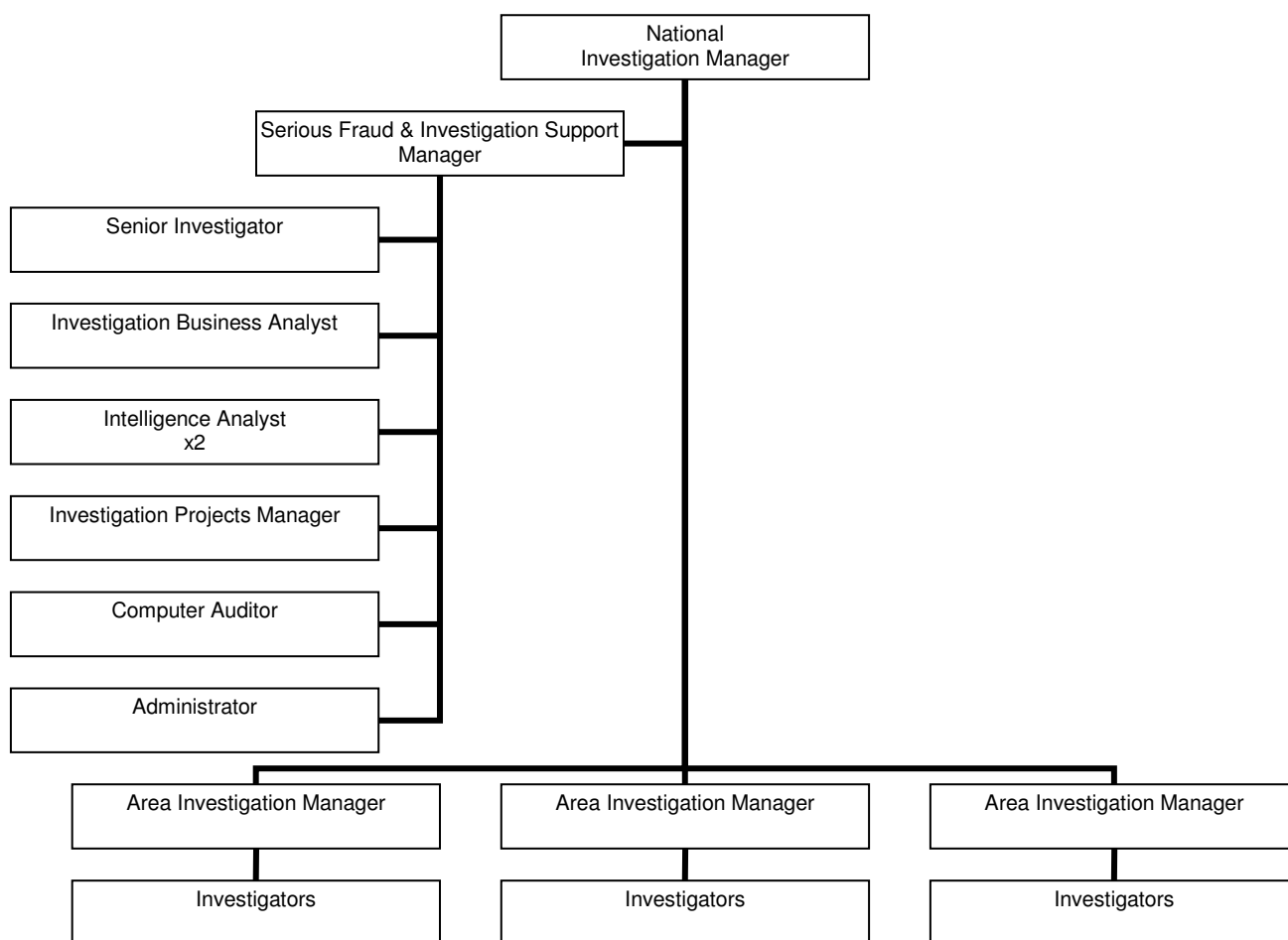
- 111 On balance, the reviewers favour the Investigation Unit becoming part of the Operations Group, at least for the next three years. The Unit has had a history of operating in a relatively autonomous manner, somewhat disconnected from the wider organisation. Positioning the Unit within the Operations Group would send a strong message that the Unit needs to become more connected with the other parts of ACC, principally the Operations Group. Once the necessary behaviours have bedded in, then consideration could be given to moving to the more sophisticated model being applied at MSD.
- 112 The reviewers also favour, on balance, staff fraud continuing to be located within the Risk and Assurance Group, given the strong potential synergy that exists between that function and internal audit.

## Part 5: The Internal Structure of the Investigation Unit

- 113 As noted previously, the current structure of the Investigation (Fraud) Unit is split into three teams: the Provider Fraud Team, the Claimant Fraud Team, and the Serious Investigation and Support Team. The rationale for separating claimant and provider fraud relied on the different nature of the investigations required. The Claimant Fraud Team makes extensive use of private investigators for surveillance and other investigative activities, whereas the Provider Fraud Team largely undertakes its own investigations which, it argues, are more complex.
- 114 During the course of the consultation, it became evident that there is very little interaction between the claimant and provider fraud teams. This meant that any links between the claimant and provider might possibly be missed. In addition, the benefits arising from an exchange of learnings / experiences between the two teams were not being realised. It also constrains the opportunities for the professional development of staff.
- 115 There are strong reasons for bringing together the claimant and provider fraud teams under a single, specialist manager, a National Investigation Manager. That manager should ideally be based in Wellington, to strengthen the linkages between the activities of the Investigation Unit and senior managers within ACC, particularly at the strategic level.
- 116 Beyond that, the teams should ideally be organised by ACC Area, as it is at this level that the control framework for the Operations Group is applied. Each Area Team would be headed by an Investigation Manager, who would be responsible for building and maintaining strong working relationship with the Area Manager and working closely with the Area Manager at crucial decision points in the investigation process. The current positions of Claimant Fraud Manager and Provider Fraud Manager would be disestablished, were the proposed new structure adopted.
- 117 The Provider Fraud Intelligence Analyst position should be placed within the Serious Fraud & Investigation Support branch of the Unit working closely alongside the other Analysts in the group.
- 118 A screening function should also be defined within the Investigation Unit, which would be responsible for assessing or 'triaging' whether or not information received is sufficient to commence an investigation. This function could be either an individual or a small group with clinical expertise and an understanding of both ACC and investigative processes.

- 119 The future recruitment strategy for the Investigation Unit should centre on acquiring individuals with the necessary skill sets and competencies to carry out both claimant and provider investigations. In turn this would provide richer career development experiences for the team.
- 120 The proposed structure is illustrated diagrammatically below.

**Figure 9: Proposed Internal Structure**



## Evaluating the Proposed New Structure

- 121 The current structure and the proposed new structure were evaluated against a standard set of criteria. The criteria were:
  - supports an efficient, effective and appropriate operating approach to fraud prevention, detection, investigation and prosecution



- provides clear roles and accountabilities
- supports the production of high-quality work within the Fraud Unit by providing appropriate leadership, capability and capacity
- promotes seamless teamwork within the Fraud Unit
- supports a professional approach to investigation and thereby enhances stakeholder confidence
- enables shared learnings and constructive interfaces within the Fraud Unit
- supports ACC's desired culture

122 The results of the evaluation of options are set out below. The proposed new structure has a much stronger alignment across all of the evaluation criteria.

**Table 5: Internal Structure evaluation criteria**

<b>Evaluation Criteria</b>	<b>Option 1: Retaining the existing structure of the Fraud Unit (separate claimant and provider investigation teams)</b>	<b>Option 2: Combining the claimant and provider investigative functions into one team</b>
Supports an efficient, effective and appropriate operating approach to fraud prevention, detection, investigation and prosecution	Weak alignment <ul style="list-style-type: none"> <li>• will retain the currently fragmented intelligence function which does not leverage opportunities for increased efficiency and effectiveness</li> <li>• professional leadership of the Unit is fragmented and different operating approaches apply</li> </ul>	Strong alignment <ul style="list-style-type: none"> <li>• enables shared learnings resulting from provider and claimant investigations</li> <li>• increases efficiency through the use of common templates and processes where appropriate</li> <li>• increases effectiveness and efficiency of the Unit's intelligence function</li> <li>• provides consistent professional leadership</li> </ul>
Provides clear roles and accountabilities	Medium alignment <ul style="list-style-type: none"> <li>• professional leadership of the Unit is fragmented - no one person is accountable for the development of professional standards and frameworks</li> </ul>	Strong alignment <ul style="list-style-type: none"> <li>• Clearly assigns accountability for the professional performance of the Unit to the National Manager</li> </ul>
Supports the production of high-quality work within the Fraud Unit by providing appropriate leadership, capability and capacity	Weak alignment <ul style="list-style-type: none"> <li>• maintains fairly limited opportunities for development within the Unit</li> <li>• does not place the individual teams' operating approaches under increased scrutiny from within the Unit</li> </ul>	Medium to strong alignment <ul style="list-style-type: none"> <li>• will assist with providing a shared strategic direction for the Unit rather than its individual parts</li> <li>• will provide increased opportunity for development and knowledge base within the Unit</li> <li>• will increase the opportunity for peer review</li> </ul>

Evaluation Criteria	Option 1: Retaining the existing structure of the Fraud Unit (separate claimant and provider investigation teams)	Option 2: Combining the claimant and provider investigative functions into one team
Promotes seamless teamwork within the Fraud Unit	Weak alignment <ul style="list-style-type: none"> <li>retains separation between the provider and claimant fraud teams and does not encourage teamwork</li> </ul>	Medium to strong alignment <ul style="list-style-type: none"> <li>will encourage increased communication and teamwork between provider and claimant fraud investigators</li> </ul>
Supports a professional approach to investigation and thereby enhances stakeholder confidence	Weak alignment <ul style="list-style-type: none"> <li>responsibility for professional standards of investigation fragmented</li> </ul>	Medium to strong alignment <ul style="list-style-type: none"> <li>allows for the development of a consistent set of professional standards and processes for the Unit through the National Investigation Manager;</li> <li>will provide increased opportunity for peer review</li> </ul>
Supports shared learnings and constructive interfaces within the Fraud Unit	Weak alignment <ul style="list-style-type: none"> <li>does not provide an impetus for shared learnings and constructive interfaces</li> <li>maintaining the status quo in terms of structure may encourage the maintenance of status quo in terms of separate practices and few interfaces between the teams</li> </ul>	Medium to strong alignment <ul style="list-style-type: none"> <li>will provide increased opportunity for shared learnings across the Unit</li> </ul>
Supports ACC's desired culture	Weak alignment <ul style="list-style-type: none"> <li>may send a message that the current subcultures within the Unit are appropriate</li> </ul>	Medium to strong alignment <ul style="list-style-type: none"> <li>will discourage the retention and formation of subcultures between provider fraud and claimant fraud</li> </ul>

## Part 6: Consequential Impacts on the Risk & Assurance Group

- 123 The Risk & Assurance Group will be considerably smaller (reducing from 50 to 20 positions) as a consequence of relocating the Fraud Unit into another part of the organisation. Remaining within Risk & Assurance will be the internal audit and external practice audit functions, overseen by the Risk & Assurance Manager.
- 124 It is envisaged that this reduction in team size will provide the Risk & Assurance Manager with the opportunity to take on a more strategic role focused on operational business risk across the organisation, in addition to core internal audit work.
- 125 Whilst not part of the brief, the reviewers note the extensive use of external accountancy firms to undertake the internal audit programme. The difficulty with this approach is that the opportunity to use internal audit as one of the drivers of business improvement can be lost, since this requires the internal auditors to have an intimate and ongoing understanding of the business. The opportunity therefore exists for the ACC to build its own internal audit capacity and capability and hence make a greater contribution to business improvement than has been possible to date.
- 126 The reviewers also believe that the Risk & Assurance Manager should report directly to the Chief Executive and Audit Committee on substantive matters of operational business risk and audit. However, for resourcing and planning purposes, the Risk & Assurance Manager should report to the General Manager Finance. Whilst not part of the Executive Leadership Team on an ongoing basis, there is no reason why the Risk & Assurance Manager should not be part of the Executive Leadership Team's strategic planning processes - indeed there will be considerable value in this.

## Part 7: Operating Approach, Culture and Capability and Capacity

### Operating Approach

- 127 As noted earlier, the new culture and strategic direction for ACC requires a reassessment of the operating approach to investigations, at both the strategic and operational levels.
- 128 At the strategic level, the ACC needs to define the balance between fraud prevention, detection, investigation and prosecution, appropriate to a responsive social insurance organisation. At the present time, relatively little attention is being paid to fraud prevention. This is appropriately a matter for the Executive Leadership Team, working in concert with the National Investigation Manager.
- 129 At the operational level, the view both inside and outside ACC is that its approach to investigation is overly formal, rigid and overbearing. It needs to be recognised that, on the claimant side, the person being investigated might well have significant and genuine issues of capacity to deal with. On the provider side, the ACC is actively seeking to develop constructive and collaborative relationships with providers, which could well be threatened by misplaced investigations. For these reason alone, the Investigation Unit needs to be much better connected with the operational side of ACC.
- 130 In terms of process, the key issue is the decision-making process at key points in the investigation, that is, the decision to commence an investigation; the decision to escalate an investigation; and the decision to prosecute. A common approach in other organisation is to have a triage team with the appropriate skills and knowledge to make these calls.
- 131 Within the ACC setting, such a group could be convened in each area by the Area Investigation Manager, and comprise the Area Manager (or that persons nominee), a person with the appropriate clinical skills (which might vary depending on the nature of the investigation), a senior Provider Relationship Manager (for provider investigations), and a senior case manager (for claimant investigations). The National Investigation Manager might also connect with the group's deliberations, particularly for significant cases, for the purpose of ensuring consistency in approach between the areas.

- 132 This group would meet regularly (possibly weekly) and consider information received about both claimants and providers from the relevant staff. It would have a monitoring and decision-making role, but would not become involved in the details of the investigation itself.
- 133 If the group determined there were grounds to investigate a particular claimant or provider, the Unit would be directed to commence an initial investigation and report back within a set timeframe (eg 7 days). At that time, the group would consider the information gained to date, and determine whether or not there were grounds to escalate the investigation, with the attendant use of legal powers of investigation. If so, the investigation would be directed to continue and become a 'project', subject to normal reporting requirements back to the group. At the conclusion of this stage of the investigation, the group would review the evidence and determine whether grounds existed for a prosecution.
- 134 A process such as this would ensure that all relevant factors are accorded due weight at different points in the investigation process.
- 135 As noted earlier, one particular issue that emerged in the course of the consultation concerned the operation of the hotline. It would seem that there have been instances, on the claimant side, of investigations being commenced by the Examining Officer as a result of information received from a member of the public without first consulting with the Case Manager. On at least one occasion, the claimant concerned was participating in a rehabilitation scheme arranged by ACC itself. The process outlined above will address this issue, although it would be good practice in this instance for the Examining Officer to consult with the Case Manager prior to any consideration by the triage group. In some cases, this might mean that the allegation is not referred through to the group for consideration.

## Culture

- 136 As noted previously, the Fraud Unit has its own subculture that is not well aligned with the ACC's culture. Different cultures are also evident both between and within the different teams. This is fundamentally a leadership issue, which will be addressed by a repositioning of the Investigation Unit within ACC and the proposed new National Investigation Manager.

## Capability and Capacity

- 137 As noted earlier, combining the provider and claimant fraud teams provides career development opportunities for staff. The scope of investigation work is broadened so that staff can engage in both types of investigation. It is noted that there is variance in the experience, skills and competencies possessed by different team

members – this could be addressed through a career development exercise to determine what attributes are required to successfully investigate provider fraud and claimant fraud.

138 A process such as this may involve a capability model which progressively ‘signs off’ staff as competent to perform both types of investigation. Future recruitment activity would focus on hiring people with the attributes required to successfully investigate.

139 The current capacity of the Investigation Unit is generally considered appropriate, with the potential addition of two new roles, namely:

- a Training and Development Adviser position. This position would be responsible for ensuring national consistency of investigation processes, which would involve regular area visits and liaison with investigation staff. The role would also be responsible for building relationships with internal business units, encouraging two-way communication with the Investigation Unit through activities such as presentations and feedback sessions.
- potentially adding an additional data mining and profiling position within the Serious Fraud & Investigation Support Team. The purpose behind increasing the resource in this team is the specialist nature of skills required in this area, as well as the significant potential for additional intelligence capability within the Unit.

## Part 8: Recommendations

It is recommended that you:

- 1 agree to develop an organisation-wide strategy on claimant and provider investigations, which strikes an appropriate balance between a preventative, education-based approach to fraud and a harder-line deterrent and prosecution-focused approach, having regard to the fact that ACC is a responsive social insurance organisation
- 2 agree to recommend to the Board that the Audit Committee's terms of reference be modified to remove the investigation of fraud , thereby treating fraud on the same basis as other operational business risks being monitored by the Audit Committee
- 3 agree to rename the 'Fraud Unit' the 'Investigation Unit'
- 4 agree to relocate responsibility for the claimant and provider investigative functions of the Unit , including the functions undertaken by the Serious Fraud and Investigation Team (with the exception of staff investigations) to the Operations Group
- 5 agree to retain responsibility for the function of the investigation of staff fraud with the Risk and Assurance Group
- 6 agree to combine responsibility for claimant and provider investigation functions into one team under a new position of National Investigation Manager
- 7 agree that the National Investigation Manager position be located in Wellington;
- 8 agree to base the internal structure of the Investigation Unit on ACC Areas, and establish Area Investigations Manager positions in each ACC Area, and co-locate the respective management positions and investigation teams with Area Office staff
- 9 agree to establish 'screening' groups in each Area comprising the Area Manager (or that persons nominee), the Area Investigation Manager (Convenor), a clinician, a senior Provider Relationship Manager (for provider investigations), a Senior Case Manager (for claimant investigations) for the purpose of ensuring that all relevant factors are properly considered at key decision-making points in the investigation process
- 10 agree to augment the capability of the Investigation Unit with a new Training and Development Adviser position, a prime purpose of which is to ensure national consistency in investigative processes and standards, and with an additional data mining and profiling position
- 11 agree to develop an appropriate career development model for the Investigation Unit to ensure that staff acquire the necessary competencies for the broader roles within the Unit.

## **Appendix 1: Interviewees**

Interviewee names have been removed from the public version of this report.



## Appendix 2: History of Fraud Unit Structure & Reporting Arrangements

- 1 In 1994, ACC established its own internal audit function. Until then, the function was outsourced and run by KPMG. A Chief Internal Auditor was appointed to implement an internal audit system that would support ACC to achieve its business goals.
- 2 A person was then appointed to establish a Fraud Unit within ACC. Examining Officers and a Doctor were also appointed to identify and investigate fraud. The Unit sat within the Executive Service group, worked closely with the Operations Group and was primarily claimant-focused.
- 3 The Fraud and Audit groups were co-located but managed separately. The audit processes were recognised as being robust but were perceived as being applied somewhat punitively.
- 4 The area then underwent some personnel changes. The Fraud Unit reported to Finance and then Policy groups for short periods of time. At that stage the Unit had a flat structure of 25-26 staff with a manager overseeing the function.
- 5 In 2001, a new manager was appointed to manage the audit function. At that time, the Audit function reported through to the Company Secretariat, but there was also an open line to the Chief Executive and the Audit Committee.
- 6 In 2003, the Fraud Unit was placed into the Risk & Assurance Group for convenience rather than functional needs. The manager was seen to have the capacity to manage a greater scope of work and there was an acknowledged similarity between audit and fraud processes.
- 7 At that time, the Fraud Unit was undertaking three studies, known as quest exercises, to detect the level of fraud risk in different areas. The areas of focus were claimants, GPs, and chiropractors/physiotherapists. The studies concluded that there was sufficient indication of fraud risk by these groups to warrant a restructure of the Unit.
- 8 Provider Fraud was deemed to be under-resourced and an additional 4-5 staff were required. Staff numbers in the other areas of the Fraud Unit and Audit Unit were deemed sufficient. The conditions of the restructure meant that the Risk & Assurance Manager had to retain all current staff and could recruit the additional 4-5 employees.
- 9 Human Resources designed the resulting structure of the Fraud Unit.

## Appendix 3: Provider Fraud Team Operating Approach

- Provider Fraud receives information via one or more of the following sources:
  - self-detection through data analysis or other method
  - other business units (including Provider Monitoring, Provider Relationship Management and Rehabilitation Service Development)
  - other providers
  - hotline and other informants, or
  - claimants.
- The Provider Fraud Investigation Manager conducts an initial assessment of the information to determine whether or not it raises genuine fraud concerns.
- If there are no fraud concerns the matter is referred to another area of the business.
- If fraud concerns are raised, the case is allocated to a Provider Fraud Investigator who will commence assessment of the file. The Investigator will go through a process of analysing data, planning the approach and commencing the investigation. During the investigation they may also call on Private Investigators and/or the Provider Intelligence Analyst where considered appropriate.
- If the Provider Fraud Investigator determines there is no fraud the matter is referred to another area of the business.
- If evidence of fraud is obtained, the Provider Fraud Investigator will plan a further investigation. Again, they may call on assistance from a Private Investigator and/or the Provider Intelligence Analyst as appropriate. The Provider Fraud Investigator then prepares a report for the Provider Fraud Manager or Senior Investigator outlining the findings.
- If the Provider Fraud Manager or Senior Investigator determines there is insufficient evidence of fraud the matter is referred to another part of the business.
- If there is sufficient evidence of fraud, the Provider Fraud Investigator will then proceed towards:
- Civil or criminal prosecution (which requires the approval of the Provider Fraud Manager and a Prosecution Panel and involves consultation with the Crown)

- Complaint to a Professional Body (which involves input from a Competency Review Panel and Professional Body before going to hearing)
- Other action (which involves the Provider Fraud Manager and/or Senior Investigator and often involves interacting directly with the provider.
- At the conclusion of the process exhibits are returned, the database is updated, savings are reported, and informants, witnesses and branches are advised. The file goes to the Provider Fraud Manager or Senior Investigator for quality assurance and is then archived.

**Table 6: Provider Fraud KPIs**

Provider Fraud KPIs
<ul style="list-style-type: none"> <li>• Detect, investigate, prosecute, apply appropriate sanctions and recover losses</li> <li>• Apply the highest professional standards and ensure the provisions of necessary specialist skills</li> <li>• Increase risk awareness within relevant business groups by educations and creating an anti-fraud environment</li> <li>• Accurately measure and report fraud and investigation outcomes</li> <li>• Effectively use resources for maximum outcomes</li> <li>• Create a strong deterrent effect</li> </ul>

Provider Fraud Action Plan 2007-2008

Developed by Provider Fraud Investigation Manager