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SUBMISSION

REVIEW OF THE PROFESSIONAL SERVICES REVIEW (PSR) SCHEME

Executive Summary:

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- **The structure and composition of the PSR**
- **Current operating procedures and processes**
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Preamble

Throughout the world medical profession is unquestionably the most regulated of all professions.

Medical practitioners throughout their academic teaching are imbibed with the sense of unique responsibility and accountability for their actions and role in the society.

All doctors without exception readily accept the need for regulatory measures in regards to their profession as well as the need for constant scrutiny and evaluation of their working practices in the name of public safety.

In Australia doctors are regulated, accredited, educated and reviewed by a plethora of governmental and professional organizations such as AHPRA, remnants of Medical Boards, Departments of Health & Community Services with its Drug & Poison Control Units, Infectious Diseases and Public Health reporting agencies, Health Complaints Commissioner, Coroners, Registers of Births, Deaths & Marriages, Accreditation Committees, Divisions of General Practice, Environment Authorities, CME entities, Specialist Colleges, Craft and Vocational licensing authorities as well as the police and local government.

In this situation the need for yet another doctor policing governmental body must be considered against the background of existing regulatory bodies in the context of public benefits and costs.

It is obvious that Health Commission which operates Medicare prefers to have its own doctors policing body than to have to rely on the other regulatory bodies. However this desire must not be assessed as impartial. Since Medicare is in essence a publicly funded health insurance organization and medical practitioners are service providers there is an enormous, sometimes not fully realized, potential for the doctor to be trapped between opposite forces of the insurer and the insured, where the insured demands the best service and the insurer tries to limit expenditure. The situation can be compared to the car insurance industry where the repairer is constantly pressurized by the client to provide "the best possible" fix and by the insurer to provide "modestly priced 'reasonable'" fix.

The evidence shows that Medicare, being a government supported monopolist, has been already pursuing expenditure limiting policies. One of the best examples of it is the fact that over the years Medicare benefits did not keep pace with inflation. Obviously this policy if pursued relentlessly will eventually lead to increased co-payments, which work much like excess payments in the car insurance industry.

Medicare is in unique position to exert fiscal pressure on the doctors and already does it by sluggish indexation of Medicare benefits, introduction of "hopefully cheaper than doctors" nurse practitioners, operation of the Authority & Special Benefit pharmaceutical scheme as well as constant surveillance, detection and fixing of fiscal policy threats,

where Medicare/PSR audits are enforcement instruments of the cost limiting fiscal policy. For full, in depth analysis of this proposition (and remedy considerations) I refer to the attached position paper called "Hipocritical not Hippocratic".

Considering that Medicare claims a mandate of acting in the public interest, the relative dearth of the patient representation, their engagement and involvement in all its fiscal determinations, decisions and policies is of deep concern and should draw widespread criticism. The same can be said about current doctor policing, where the patients input is deliberately and unfairly excluded. The situation is akin to not allowing a car owner to have any say about how his car should be fixed so all repairs are decided behind his back between the car mechanic and the car insurer.

The structure and composition of the PSR

Current composition of the PSR includes only medical practitioners with most of them being recruited from the upper ranks of the Australian Medical Association (AMA). The process of recruitment allows the AMA full key control over the appointments.

Considering that the AMA currently represents less than one third of the practicing medical practitioners its key role in dispensing handsomely paid appointments to PSR must be viewed as unjustified and unrepresentative of the medical profession. The capacity of AMA apparatchiks to represent the "peer" view of the majority of practicing doctors is questionable and one would strongly advocate Divisions of General Practice or local GPs representative voting system as a much better and more "peer" representative alternatives. These representatives should not be funded by the government but rather seen as completely independent, free of any influence, voluntary unpaid positions akin to the positions of Jury members, Justices of Peace or Bail Officers. It should be the prestige not money attracting doctors to these positions.

In order to balance the conflicting interests and views of the government, medical profession and patient groups there must be a balanced representation of these groups on the PSR. The role of the patient groups must be especially recognized and supported, considering that it is the patients not government or doctors who are representing and defining the public interest.

Current operating procedures and processes

Current behaviour of Medicare/PSR investigators, with judicially confirmed procedural unfairness (cf. Tisdall's case), bureaucratic malfeasance and systematic disregard for the law (cf. PSR inappropriate appointments' case) must be stopped. For further in depth information about the current experiences of the audit (and proposed remedies) please refer to the attached doctor account called "I still do not know why".

Medicare statistical targeting must be calibrated against the practice demographics and specialization. Current practice of comparing referral patterns of an urban medical

practitioner with those of his rural colleague must be ceased and replaced by comparing comparable.

“Fishing expeditions” and “fault finding missions” must stop with the immediate effect. Escalating the audit in order to find implicating evidence at all cost must not be allowed.

Medicare descriptors must be reviewed, made non-ambiguous and their meaning must be communicated to all doctors. Introduction of time only (not content) based consultation charging may simplify audits enormously.

The current belief that it is more acceptable when a medical record is being perused by an unknown doctor than by an unknown official is baseless from the patient’s point of view and must not be used as an excuse for an unauthorized access to the medical records of the patients.

Medical records must never be seized in the course of audit without written consent of the concerned patient unless both the doctor and the patient are criminally implicated, but even then subject to a judicial warrant. The request for the medical record must be viewed as a last resort and the option of provision of audit information (as opposed to the provision of private medical information) directly by the patient, aided by his or her own medical records, must be allowed and preferred.

The natural justice and procedural fairness must be specifically guaranteed in the law and delivered. The auditor must refer to the actual evidence, not general statistical concerns when charging the practitioner and must allow all evidence (as opposed to the current PSR practice of evidence restricting) to be considered and taken into account. The early involvement of the patients (inviting their input, regarding the content of consultations or process of doctor/patient decision making) must be enshrined in the law and actively promoted.

PSR officials must not be above the law. They should be externally audited and held answerable for any unjust decisions.

Pathways available to practitioners

Practitioner must be provided with a clearly defined charge, based of factual evidence Independent, external testimonies of medical authorities and medical literature reviews and references must be allowed and considered in the course of Medicare/PSR audit. Special provisions must be in place that innovative, progressive and patient benefiting approaches are recognized, accommodated and supported.

Practitioner under review must always have the right to the merit based judicial review of the audit with the usual appeal provisions.

In the first instance support, counseling and education should be available to medical practitioners who albeit honest, simply erred in their interpretation or application of the

Medicate descriptors. Repayment of the Medicare benefits must only apply in reference to the evident, factually proven trespasses and the amount of remedial repayment must be based on the facts not on general statistics. The punishment must be reserved for cases of proven fraudulent and deliberately criminal behaviour.

Punishments in the form of partial disqualification from provision of longer consultations under Medicare must be discouraged as they punish the sick and financially disadvantaged patient more than the doctor.

Respectfully yours,

Dr Richard Waluk