Chapter 3

General Principles of the PSR

Peer review and selection of PSR Committees

3.1 Peer review is the guiding principle of the PSR process. The concept of peer review as the most appropriate vehicle for a regulatory framework to protect the integrity of the MBS and PBS programs has been universally supported in the submissions that discussed this issue. The issue that has been debated in the evidence is whether peer review is truly demonstrated in the PSR process.

3.2 The issue is pivotal to the committee's inquiry because the central tenets of the PSR model are that the provision of services by a medical practitioner should be reviewed by the peers of that practitioner; and that the conduct of a practitioner should be compared with that of others in similar circumstances. The importance of peer review is summed up in the Royal College of Australian Physician's (RCAP) submission:

> the provision of services...involves professional medical judgement and may relate to the specific circumstances of the health practitioner's profession and practice. It is thus important that the decision about whether the practice is appropriate is made by professional peers with adequate understanding of the practice and profession of the practitioner under review.[1]

3.3 Part VAA of the Act broadly establishes the appointment process and terms and conditions of the Director, Deputy Directors, Panel Members and the members of the Determining Authority.[2] However there are no detailed guidelines in the legislation setting out the selection criteria for any of the PSR roles, although more criteria are provided for the selection of members of the Determining Authority.[3]

3.4 The committee notes that the new guidelines agreed between the AMA and PSR in March 2011 appear to address some of submitters' concerns about peer review and selection processes. The new guidelines clearly stipulate the criteria for appointment for both PSR Panel members and Deputy Directors. These are:

> *Qualifications of Panel members*
>
> In order to be appointed to the Panel, a provider must:
>
> (a) be a currently registered provider within the meaning of the Act;
> (b) be currently practicing (at least on a part time basis);

---

1 RCAP, *Submission 41*, p. 3.

2 *Health Insurance Act 1973 (Cth)*, Part VAA, Divisions 2 and 6.

3 *Health Insurance Act 1973 (Cth)*, Part VAA, Subdivision D.

(c) have sufficient experience in, and knowledge of, current medical practice in his or her specialty as to be able to represent their body of peers, usually demonstrated by at least 15 years FTE practice experience;
(d) be both willing and available to sit in Committee hearings and make proper enquiries into the appropriateness of practice of one of their peers;
(e) be willing to participate in training that will enable them to participate in the legal orientated processes associated with sitting on a Committee;
(f) be recognised as a suitable member of their profession and specialty to represent their peers on a Committee;
(g) be willing to sign a declaration of interest document prior to their name being submitted to the Minister; and
(h) be willing to enter a deed of confidentiality in relation to the information they will obtain as Panel and Committee members.

Qualifications of Deputy Directors

In order to be appointed as a Deputy Director, a provider must:

(a) be a currently registered provider within the meaning of the Act;
(b) be currently practicing (at least on a part time basis);
(c) be a current Panel member appointed by the Minister under Section 84 of the Act, or able to be so appointed prior to appointment as a Deputy Director;
(d) have sufficient experience in, and knowledge of, current medical practice in his or her specialty as to be able to represent their body of peers, usually demonstrated by at least 15 years experience;
(e) have experience in the PSR Committee process, usually demonstrated by having previously served as a Committee member on more than 2 Committees;
(f) have demonstrated ability to manage the conduct of a PSR hearing;
(g) be both willing and available to be the chairperson of the Committee and make proper enquiries into the appropriateness of practice of one of their peers;
(h) have demonstrated ability to participate and control the legal orientated processes associated with chairing a Committee;
(i) be recognised as an appropriate member of their profession and sub-specialty to represent their peers on a Committee;
(j) enter a deed of confidentiality in relation to the information they will obtain as a Deputy-Director, Panel and Committee member.[4]

3.5 The committee received extensive submissions on this subject, and much of the discussion in the public hearings was devoted to this issue. Several submitters argued that peer review is not demonstrated by the PSR scheme because those subject to the scheme are not judged by their true peers. Some of the proponents of this view are medical practitioners who have been through the PSR scheme and believe that the Panel members and Deputy Directors on the PSR Committees did not hold sufficient expertise to ascertain whether their conduct constituted inappropriate practice in their

4 PSR, *Submission 24*, pp 16-17.

specific circumstances. Others holding this view included the Australasian College of Nutritional and Environmental Medicine (ACNEM), the Australasian Integrative Medicine Association (AIMA), the Australian Association of Musculoskeletal Medicine, and the Australian College of Skin Cancer Medicine, all of which are peak bodies of medical practitioners not recognised by the PSR, Medicare or Medical Boards as being sub-specialties of General Practice.[5]

3.6 The Act currently provides for the appointment of the two Panel members to be members of the same profession or specialty as the practitioner under review. The professions recognised under section 81 of the Act are:

(a) medicine
(b) dentistry
(c) optometry
(ca) midwifery
(cb) the practice of a nurse practitioner
(d) chiropractic
(e) physiotherapy
(f) podiatry
(g) osteopathy.

Recognition of Medical Specialties

3.7 The PSR takes its lead from Medicare Australia in its recognition of medical specialties. Medicare Australia only recognises[6] those specialties listed in Schedule 4 of the Health Insurance Regulations 1975.[7] These are:

Sport and Exercise Medicine
General Medicine
General Paediatrics
Cardiology
Clinical Genetics
Clinical Pharmacology
Community Child Health
Endocrinology
Gastroenterology and Hepatology
Geriatric Medicine
Haematology

5 Australasian College of Nutritional and Environmental Medicine (ACNEM), *Submission 27*, p. 2.

6 Medicare Australia - *Information sheet for recognition as a Specialist or Consultant Physician*, available at: http://www.medicareaustralia.gov.au/provider/pubs/medicare-forms/files/ma_3126_app_for_recognition_as_specialist_or_consultant_physician_011106.pdf, (accessed on 5 October 2011).

7 *Health Insurance Regulations 1975*, Schedule 4, available at: http://www.austlii.edu.au/au/legis/cth/consol_reg/hir1975273/sch4.html, (accessed on 5 October 2011).

Immunology and Allergy
Infectious Diseases
Intensive Care Medicine
Medical Oncology
Neonatal/Perinatal Medicine
Nephrology
Neurology
Nuclear Medicine
Paediatric Emergency Medicine
Palliative Medicine Respiratory and Sleep Medicine
Rheumatology
Palliative Medicine
Addiction Medicine
Sexual Health Medicine
Occupational and Environmental Medicine
Rehabilitation Medicine
Public Health Medicine
Anaesthesia
Pain Medicine

3.8 Dr Webber in his evidence to the Committee during the public hearing on 22 September 2011 said that the PSR complied with the legislation in the staffing of the PSR committees:

> In forming a committee, PSR has to follow the legislation, and the legislation requires peers to be appointed to a committee. The peer is defined by the practicing group, as defined by Medicare. So we have always followed the legislation. We have also tried as much as possible to fit particular expertise with a particular doctor. There are always going to be people who do not think we get that right. In my view we have got that as right as is possible to do so.[8]

3.9 In his written submission Dr Webber details cases that have fallen into the specialist, or sub-specialist category over recent years:

- Over the last three years, ten practitioners (18.8% of those referred to a Committee) have claimed to be practising in a special interest or sub-speciality area.
- In four of these cases the Director recognised the sub-specialities of the medical profession and consequently appointed Panel members to the peer review Committee who were also specialists in relation to those sub-specialities.
- In the six other instances the practitioners claimed they were practising:

  i. phlebology
  ii. hormone replacement therapy and myofascial medicine
  iii. nutritional and environmental medicine

8 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 5.

iv. non-malignant pain therapy, laser therapy and complementary medicine
v. fatigue management
vi. thyroid and hormonal medicine.

- In these instances the Director did not consider the claimed specialities were sub-specialties of general practice and appointed Panel members to the Professional Services Review Committees who were general practitioners.
- This decision aligns with advice received by the Professional Services Review Advisory Committee from the Royal Australian College of General Practitioners in April 2011 that only a specific interest group with Chapter status should be recognised for the purposes of peer review (that is, a Fellow of the Chapter should be peer reviewed from other Fellows of the Chapter).[9]

3.10 A number of submitters voiced their concerns over the criteria used by the PSR for selecting Panel members based on their profession or specialty. The Australasian Integrative Medicine Association (AIMA) claimed in their submission that there was a lack of true peer representation on the PSR Panel:

> by not consulting with AIMA...to appoint appropriate peer representation on the PSR panel, denies the right of our members to have true and appropriate peers to fairly assess their clinical work.[10]

3.11 The Medical Indemnity Protection Society (MIPS) made the suggestion that PSR panel members should hold appropriate contemporary 'craft specific' practice for the practitioner under review. They argued for instance that recent changes made by the Australian Health Practitioners Regulation Agency (AHPRA) to increase 'the range of recognised "specialist" practitioners' reflects an 'ongoing trend of super/sub specialisation'.[11]

3.12 Another Medical Defence Organisation (MDO), MDA National provided an example of a case:

> where a plastic surgeon was involved in the review of a GP who was performing skin cancer work, and another where a dual specialty qualified practitioner did not have a similarly qualified peer on the PSR Committee.[12]

3.13 The Australian Association of Musculoskeletal Medicine submission claimed that:

> adverse findings of inappropriate practice made against musculoskeletal practitioners represent an ignorance of the world-wide body of evidence in

9 *Submission 24*, p. 18.

10 Australasian Integrative Medicine Association (AIMA), *Submission 19*, p. 4.

11 Medical Indemnity Protection Society (MIPS), *Submission 14*, p. 5.

12 MDA National, *Submission* 5, p. 2.

> musculoskeletal and pain medicine and that using members [of PSRCs], who are true peers for the review of practice by musculoskeletal medicine would substantially minimize these curious findings.[13]

3.14 The ADU were also dismissive of the possibility of single doctors or even groupings of doctors being recognised for the purposes of peer review:

> ...there is no obvious pathway for individuals or groups of doctors to move up to chapter status. Indeed, this seems to be impossible in an environment of heavy PSR policing.[14]

3.15 The Australian College of Skin Cancer Medicine concurred:

> Medicare and PSR do not recognize any subspecialties within General Practice...comparing a profile of a full time skin cancer doctor with a full time general practitioner is a denial of natural justice. This practice also extends to the selection of peers. PSR does not recognize and as a result does not provide a doctor under review with equivalent peers.[15]

3.16 In response to the committee's request for further information on PSR's practice with regard to the representation of medical specialties on Panels, the PSR commented:

> It is important the Committee appreciates that recognition of emerging medical specialties is not the role of the PSR. This is a role for the Australian Medical Council (AMC). The AMC website states: "In 2002 in response to an invitation from the Commonwealth Minister for Health and Ageing, the AMC took on the responsibility for advising the Minister on which disciplines of medical practice should be recognised as medical specialties". In assessing submissions for recognition as a specialty the AMC assesses matters such as the "standards of the specialist education, training programs and continuing professional development programs available for the medical specialty".[16]

3.17 The PSR's submission cites advice it received from the Royal Australian College of General Practitioners (RACGP) in April 2001 that stated:

> ...only a specific interest group with Chapter status should be recognised for the purposes of peer review (that is, a Fellow of the Chapter should be peer reviewed from other Fellows of the Chapter).[17]

3.18 The PSR submission also referred to the March 2011 guidelines which stipulate that the Director will seek to appoint members from the Panel who are members:

---

13 Australian Association of Musculoskeletal Medicine, *Submission 37*, p. 9.

14 ADU, *Proof Committee Hansard*, 23 September 2011, p. 2.

15 Australian College of Skin Cancer Medicine, *Submission 47*, p. 3.

16 PSR, answer to question on notice, 23 September 2011, p. 1 (received 29 September 2011).

17 RACGP, *Submission 24*, p. 18.

> ...of the same special interest or sub-specialty area as the person under review when that special interest or sub-specialty area is recognised by the relevant professional organisation.[18]

3.19 The committee notes that while the Act is the starting point for recognising specialty areas, the PSR has committed itself to recognising sub-specialties, provided that these have first been recognised by the professional bodies. It is clear that the onus is on the professions to determine who should be recognised as each practitioner's community of peers.

3.20 The recognition of specialties was queried in the public hearing. The question was raised of how the PSR could have representatives of all the specialities appointed as Panel members given that on 1 January 2010 there were only 92 Panel members. The PSR responded:

> There are comings and goings from the panel as appointments expire and new people are appointed. The guidelines recently agreed with the Australian Medical Association have included a special category or a special process for what we call 'just in time' appointments. If the director does receive a referral from a unique specialty or one of those 83 [medical specialists] that we have not seen before then a 'just in time' appointment to the panel would be undertaken... And can I just add that there is only really on average 13 to 15 committees established each year. That is the other quantum to take into account.[19]

3.21 The PSR further expanded on this answer in a response to a question on notice concerning the use of 'just in time' appointments:

> Since 2000/2001 PSR has requested the Minister to appoint the following practitioners through a 'just in time' appointment process:
>
> - 4 Radiologists (9 Jul 2010)
> - 1 Dermatologist (23 Oct 2009)
> - 1 Geriatrician (20 Jul 2009)
> - 2 Psychoanalysts (20 Jul 2009)
> - 1 Sports Physician (3 Mar 2009)
> - 1 Sports Physician (25 Nov 2008)
> - 3 ENT surgeons (14 Oct 2008)
> - 1 Sports Physician (14 Oct 2008)
> - 3 Ophthalmologists (13 Aug 2008)
> - 1 Anaesthetist (3 Mar 2008)
> - 1 Chest Physician (3 Mar 2008)
> - 1 Dermatologist (25 Sep 2007)
> - 2 Psychiatrists (5 Sep 2005)
> - 4 Physiotherapists (5 Sep 2005)
> - 1 Chiropractor (5 Sep 2005)

18 *Submission 24*, p. 18.

19 PSR, *Proof Committee Hansard*, 23 September 2011, p. 54.

- 3 ENT surgeons (14 Oct 2002)
- 1 Colorectal surgeon (14 Oct 2002)
- 1 Urological surgeon (14 Oct 2002)
- 1 Paediatric Physician (14 Oct 2002)
- 8 Surgeons and 7 Physicians (1 Oct 2001)[20]

3.22 Dr Ruse in his submission framed the issue as a question of whether Panel members can recognise good or bad practice, even if they do not practice in an identical way. He says:

> The very existence of the PSR implies awareness that good professional practice takes many forms, but so does inappropriate professional practice. Both can be recognized by peers, even if the sample of reviewing peers does not embrace in its own practice a particular mode of what is still recognized as good. That is one of the underpinnings of any form of peer review or conduct tribunal. Good practice is a smorgasbord at which no one can eat everything. Bad practice however is not allowed on the table as an option for any one.[21]

3.23 The committee notes that the PSR's use of recognised specialties helps to ensure that doctors are assessed by their peers. The committee also notes the concerns of the representative organisations of medical practitioners that are not recognised specialties, however it does not believe that it is the role of the PSR to decide what constitutes a specialty. Furthermore it did not receive evidence showing that the path to recognition is unclear or overly complicated for those practitioners wishing to pursue formal recognition. The committee supports the efforts of the AMA and the PSR in developing guidelines which will further broaden the pool of potential Panel members for service on PSR Committees.

Selection criteria other than medical specialty

3.24 Numerous contributors commented that the doctors appointed to PSR committees are not necessarily peers of those practitioners under review, for reasons other than medical specialty.

3.25 The AMA reported that members who had been reviewed by the PSR had complained that 'PSR Committees were comprised of medical practitioners who have not practised for some time'.[22] However Dr Webber, past Director of the PSR, stated that Panel members 'are required to be in practice'.[23] The March 2011 guidelines confirm this position. The committee sees no reason that Panel members should be required to be in full-time practice, and the guidelines support the inclusion of part-time members.

---

20 PSR, answer to question on notice, 23 September 2011, p.2 (received 29 September 2011).

21 Dr Ruse, *Submission 11*, p. 6.

22 AMA, *Submission 13*, p. 2.

23 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 3.

3.26 Mr Alan Williamson, the lawyer who represented Dr Peter Tisdall against the PSR, stated that the PSR appointed doctors who:

> ...may not have had experience in practicing in similar circumstances to those in which the doctor [under review] practiced.[24]

3.27 In emphasising the importance of using suitable peers MDA National told the committee:

> I think the director really needs to consider the use of commissioned reports from independent experts that practice in the area, whether it be rural medicine or nurse practitioner type activities and so on. If someone does come up for review, and particularly looking at prospective changes in the health system, we would encourage the PSR to be more anxious to use independent experts that have demonstrated competence in the field in which the practitioner under investigation practices in.[25]

3.28 The Rural Doctors Association of Australia (RDAA) believe that any PSR committee:

> ...appointed to review and investigate the provision of services by a rural doctor should include panel members who have substantial experience in rural medicine and/or who are currently practising rural medicine.[26]

3.29 The committee notes that Rural and Remote Medicine was not recognised as a medical specialty following a decision by the Minister for Health and Ageing in 2005.[27] However it recognises that General Practice in a rural area holds particular challenges. The committee requested that the PSR provide information on the experience of panel members in relation to rural medicine in recent years. The PSR replied that:

> The last 60 practitioners referred to PSR involved 43 practicing in capital cities, 14 practicing in regional areas, and 3 practicing in rural areas...of the 92 Panel members available to serve on Committees as at January 1 2010 there are 72 located in city/metropolitan areas, 15 in regional areas and 5 in rural areas.[28]

3.30 While the committee has not seen evidence that would indicate that doctors practicing in a rural area are significantly disadvantaged by the selection process for PSR Committee members, it would like to see the new guidelines strengthened to ensure that any unique demographic factors are taken into account when selecting Committee members.

---

24 Mr Alan Williamson, *Submission 39,* p. 7.

25 MDA National, *Proof Committee Hansard,* 23 September 2011, p. 17.

26 Rural Doctors Association of Australia, *Submission 18,* p. 1.

27 Australian Medical Council, *Accreditations and Registration,* available at: http://www.amc.org.au/index.php/ar/rms/publications/71-rural (accessed on 5 October 2011).

28 PSR, answer to question on notice, 23 September 2011, p. 6 (received 29 September 2011).

Suggested improvements

3.31 The ADU suggested improvements to the process:

> ...we feel it is just not inclusive. It is just the AMA and the PSR at the moment. We would say, 'Sure, keep the AMA but what about the ADU, what about the RACGP, what about the Integrative Medicine Association, what about the rural doctors and what about all of the other people who put those submissions in?' They are all representative groups and they all need to be heard.[29]

3.32 The suggestion that the PSR Committee could be replaced by a panel of 12 medical jurists was put to the committee. The ADU proposed that:

> You could go back to a jury system. You could pick 12 doctors who are in full-time practice and adjust it the way you want. It could be a bit like a jury system, where you would pull them out. The jury system has served us well. You could do that by having 12 people plucked from the front-lines.[30]

3.33 The Royal Australasian College of Physicians (RACP) submission said that there were:

> ...opportunities to enhance the openness and transparency of statutory appointments to the PSR Scheme, including clarification of the process for the selection and reappointment to these positions, suggesting that all eligible health practitioners are given the opportunity to participate in the scheme as either a Panel member or a Deputy Director.[31]

3.34 The AMA indicated that a number of its issues are being addressed through the March 2011 guidelines:

> The Guidelines include provisions that ensure (in respect of reviews of medical practitioners):
>
> - the medical practitioners selected by the Director PSR as Panel members and Deputy Directors are currently practising and appropriately qualified and experienced to conduct peer review of medical practitioners;
> - the diversity of medical practice is appropriately reflected on the Panel;
> - regard is had to the gender balance, cultural diversity and geographic spread of the Panel;
> - a biennial recruitment round for the Panel will be undertaken which includes an open call for applications in appropriate public forums; and

29 ADU *Proof Committee Hansard,* 23 September 2011, p. 13.

30 ADU *Proof Committee Hansard,* 23 September 2011, p. 14.

31 RACP, *Submission 41*, p. 2.

- Consultants are appropriately qualified and experienced to provide advice on the practice of medical practitioners.[32]

3.35 Another issue discussed at the committee's hearing was whether patients should be involved at any stage of the process. The committee was informed that patients may be contacted during audit procedures carried out by private medical insurers to ascertain details about the treatment they received. The committee also heard evidence from the ADU that suggested issues could be resolved by contacting the patients involved in disputed practice:

> Senators are right to identify that patients are a major resource of information and evidence. The big question in our game is: was it 20 minutes or not? Once the patient's mind is refreshed on what happened and what the conversation was, they can tell you that.[33]

3.36 The committee understands in some circumstances facts might be able to be verified if a patient was asked for their recall of the procedure. However there is a real danger that consulting a patient could prejudice their relationship with their practitioner. The timing of patient involvement also raises a number of issues. The committee of peers is likely to be the most appropriate place where patient testimony would be considered as it is at this stage that a practitioner's conduct is considered in detail. Given that this stage is relatively far along in a process that could take a number of years from when Medicare's auditing procedures first flag a matter of concern, the reliability of patients' recall and how much weight it would carry could raise difficulties.

3.37 In the committee's view this would only be appropriate in relatively simple cases where a verification of basic factual data would resolve an issue. The committee does not believe that a case which relies only on questions such as the length of consultations is likely to get very far in either the Medicare or PSR processes. Given the difficult issues that arise in the involvement of patients in a practitioner peer review process, the committee would advise extreme caution in responding to any suggestion that patient consultation should become part of the process.

3.38 The committee believes that a number of improvements raised by submitters are included in the March 2011 guidelines. There was not widespread support for a jury approach, or patient involvement which would also create significant logistical problems. However, other improvements included in the March 2011 guidelines are pertinent to the issues above, and this is discussed further in the next chapter, in which the committee also recommends a future review and assessment of the effect of the new guidelines.

---

32 AMA, *Submission 13*, p. 2.

33 ADU, *Proof Committee Hansard*, 23 September 2011, p. 12.

Training and Performance of PSR Panel Members

3.39 The Committee received evidence from a number of stakeholders on the appropriateness of the selection procedures of the PSR, and whether Committee members and chairs were suitably trained.

3.40 The Avant submission provided proposals for reform, particularly around the constitution of PSR Committees and the procedures employed by those committees.[34] One of the key points Avant made was that PSR committees should be chaired by a legally qualified chair independent of the PSR Director. This proposal was supported by the ADU.[35] They reasoned that PSRCs are required to administer a legal test in deciding whether the conduct of the practitioner under review amounts to inappropriate conduct under section 82 of the Act. They claim that:

> ...the proper application of that test has proved difficult for many PSRCs because they lack the legal skills and experience to properly interpret and apply the test.[36]

3.41 MDA National, another of the MDOs that provided a submission to the inquiry concurred with Avant's view saying that:

> Consideration should also be given to having the PSR Committees chaired by a legally qualified person with experience in administrative review proceedings.[37]

3.42 Health and Life, an accounting, taxation and consultancy firm specialising in the provision of services to the healthcare industry added that 'the criteria are too broad and do not demand medical skill or expertise of panel members'.[38]

3.43 Dr Ruse provided a written submission to the inquiry as well as appearing before the committee at its public hearing on 23 September 2011. In his written submission he commented on the criteria for selecting panel members and deputy directors for the PSRCs by saying 'that their experience in administrative review proceedings is probably limited, on their appointment'.[39] However he continued:

> ...this is well recognised by the PSR, and actively corrected before any one gets on a Committee. I have had multiple courses in the legal underpinnings of the scheme and, much more important, how natural justice should be applied in peer review. In my time we were privileged to be instructed by George and Felicity Hempel, George a retired judge at the time and Felicity now on the bench in Victoria.[40]

---

34 Avant, *Submission 10,* p. 4.

35 ADU, *Proof Committee Hansard,* 23 September 2011, p. 4.

36 Avant, *Submission 10,* p. 13.

37 MDA National, *Submission 5,* p. 2.

38 Health and Life Pty Ltd, *Submission 4,* p. 7.

39 Dr Ruse, *Submission 11,* p. 4.

40 *Submission 11,* p. 4.

3.44 Another former PSR Panel member, Dr Gerard Ingham concurred with Dr Ruse with regard to the training required for his role:

> I, like other PSR panel members, received training prior to serving on a committee. The importance of bringing an open mind to each committee and ensuring a fair process for the person under review was emphasised in this training. This has been my experience on the panel.[41]

3.45 The committee notes the strong support from across the spectrum of submitters of the concept of peer review as the guiding principle of the PSR Scheme, while recognising that there are different opinions on the detail of what constitutes good peer review. It is not persuaded that the chairpersons of PSR Committees require formal legal qualification to consider if inappropriate clinical practice has occurred. In the committee's view arguments that the Committees are not comprised of true peers, so therefore do not provide natural justice, are best addressed by improving the pool of potential Panel members and strengthening the requirements to have peers on each panel rather than with having a legally trained chairperson. There is further discussion on the issue of legal representation in the following chapter.

3.46 The committee is concerned at the complexity and consistency of the various lists of professions and specialities. Witnesses made reference at various stages to lists maintained by the Medical Board of Australia, the Australian Medical Council, the Australian Health Practitioner Regulation Agency, the regulations to the Health Insurance Act, and Part VAA of the Health Insurance Act. In addition, some organisations, such as the RACGP, maintain their own sub-groupings, that go by various names.

3.47 Furthermore, the committee found that information presented by different bodies in different media was not always current. During the course of its inquiry, the committee had cause to seek information from the websites of various organisations. This revealed web pages that presented information that was inaccurate and up to two years out of date. These sites included those of the PSR and the Australian Medical Council.

3.48 Major stakeholders, including individual medical professionals who may come into contact with the PSR scheme, will, like the rest of the population, use agency websites as a key source of information. These sites need to be kept updated.

AHPRA and the PSR

3.49 The committee heard evidence regarding the role of AHPRA as the potential regulator of all clinical medical practice which could include the use of MBS items. MIPS proposed that functions currently undertaken by PSR should be moved to AHPRA:

41 Dr G Ingham, *Submission 12*, p. 1.

> ...inappropriate practice, if it is a concern that should be addressed and considered for the benefit of the community, we believe that the body best able to do so is the Australian Health Practitioners Regulation Agency, AHPRA. That is their role: to protect the public from inappropriate practice. So, at the moment we have an unusual hybrid of an inappropriate practice that is really about appropriateness of billing for a service that is provided.[42]

3.50 This view was disputed by the Consumers Health Forum who gave evidence that suggested there was no confusion in their membership between the roles of the PSR and AHPRA:

> They are fairly distinct in that one is looking at appropriate practice and the application of the government's guidelines around the use of MBS and PBS and the other is looking specifically at clinical practice. So our understanding is that the PSR looks at overall practice and how it is applied to the funding mechanism that is used, whereas clinical practice and specific and appropriate practice is more the focus of AHPRA. It certainly has not been raised by our members as a specific concern.[43]

3.51 The committee put the question of whether AHPRA has been considered as the appropriate place for clinical assessment of a practitioner in relation to Medicare benefits to DoHA, who responded:

> A lot of what is done [at PSR] is about ensuring the integrity of the MBS and that system, whereas AHPRA and the medical boards are there to ensure people are considered appropriate to continue practising. It is a different level of requirement and they are fulfilling very different roles.[44]

3.52 The committee is satisfied that the agencies have clear and distinct roles in the regulation of the medical profession.

Recommendation 2

3.53 The committee recommends that agencies involved in health policy and regulation review their online information policies and procedures to ensure that changes in important information, regulations and policies affecting stakeholders are regularly updated on agency web pages.

Recommendation 3

3.54 The committee recommends that there be a simplification of the ways in which official lists of professions, specialties and sub-specialties are constructed. It recommends that, at a minimum, all bodies that use lists with a statutory basis be required to publish only the current version of such a list.

---

42 MIPS, *Proof Committee Hansard,* 23 September 2011, p. 20.

43 Consumer Health Forum Australia, *Proof Committee Hansard,* 23 September 2011, p. 44.

44 DoHA, *Proof Committee Hansard,* 23 September 2011, p. 65.