The Senate

Community Affairs References Committee

Review of the Professional Services Review (PSR) Scheme

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43rd Parliament

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Senator the Hon Eric Abetz	LP, Tasmania
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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.

Recommendation 4

4.22 The committee recommends that the March 2011 changes be reviewed one year after their implementation and this should be carried out in consultation with all relevant medical professional bodies, and other key stakeholders such as the MDOs and consumer representative organisations. The findings of the review should be publicly available.

Recommendation 5

4.31 The Committee recommends that the government liaise further with stakeholders to ascertain the desirability for a legally qualified person to be involved in the PSR process.

Recommendation 6

4.46 The Committee recommends that the Commonwealth government review the legislation to allow the Determining Authority greater flexibility in its sanctions with regard to PBS items.

Recommendation 7

4.51 The committee recommends that the Commonwealth government review the PSR's enabling legislation, to ensure that the PSR can effectively pursue abuse of the MBS or PBS systems, regardless of the structure of employment of the person under review.

Chapter 1

Introduction

Referral of inquiry

1.1 On 6 July 2011, the Senate referred the following matter to the Community Affairs References Committee for inquiry and report:

> *A review of the Professional Services Review (PSR) Scheme provided for under the Health Insurance Act 1973 (the Act) which is responsible for reviewing and investigating the provision of Medicare or Pharmaceutical Benefits Scheme services by health professionals, with particular reference to:*
>
> *(a) the structure and composition of the PSR, including:*
>
> *(i) criteria for selection of the executive and constituent members encompassing their experience in administrative review proceedings,*
>
> *(ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise, and*
>
> *(iii) accountability of all parties under the Act;*
>
> *(b) current operating procedures and processes used to guide committees in reviewing cases;*
>
> *(c) procedures for investigating alleged breaches under the Act;*
>
> *(d) pathways available to practitioners or health professionals under review to respond to any alleged breach;*
>
> *(e) the appropriateness of the appeals process; and*
>
> *(f) any other related matter.*

1.2 The reporting date for the inquiry was originally set as 22 September 2011; this date was subsequently extended to 12 October 2011.

Conduct of inquiry

1.3 The inquiry was advertised in *The Australian* and on the internet. The committee also wrote directly to a number of organisations and individuals inviting submissions to the inquiry. The committee received submissions from 52 individuals and organisations. The committee held two public hearings, the first in Canberra on 22 September 2011 and the second in Canberra on 23 September 2011.

1.4 The committee thanks all those who contributed to the inquiry by making submissions, providing additional information or appearing before it to give evidence.

1.5 The committee also wishes to mention the contribution of those health and medical practitioners who, through sharing their experiences with the PSR Scheme, brought many of the issues discussed in this report to the fore.

Context for the PSR Scheme

1.6 The PSR Scheme:

> ...was introduced in 1994 to replace the previous Medical Services Committees of Inquiry (MSCI) scheme. A report by the Australian National Audit Office (ANAO) in 1992-93, entitled *Medifraud and excessive servicing: Health Insurance Commission* found that MSCIs were not operating satisfactorily and needed to be strengthened.[1]

1.7 The primary purpose of the PSR scheme is to:

> ...protect the integrity of the Commonwealth Medicare benefits and pharmaceutical benefits programs and, in doing so:
> (a) protect patients and the community in general from the risks associated with inappropriate practice; and
> (b) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.[2]

1.8 The scheme:

> ...provides for the examination of an individual health practitioner's conduct by a committee of peers to ascertain whether inappropriate practice under Medicare is involved and, if so, to provide for action to be taken.[3]

The current PSR Scheme

1.9 The PSR is made up of 3 separate elements: the Director, the committee of peers, and the Determining Authority. The Director's main role is to decide whether or not the case should proceed, and if so whether it is appropriate to enter into an agreement with the practitioner which may include repaying some or all of the Medicare benefits received. This agreement has to be ratified, or rejected by the Determining Authority. If the Director does not consider an agreement to be appropriate, or one cannot be reached, the Director will then refer the case to the committee of peers. This panel will then examine the case in detail with the

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1 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p. 9, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf (accessed on 28 September 2011).

2 *Health Insurance Act 1973*, s. 79A.

3 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p. 9, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf (accessed on 28 September 2011).

practitioner and report to the Determining Authority. If inappropriate practice has been found the Determining Authority will decide on appropriate sanctions.

1.10 The three stages in detail are as follows:

Review by the Director

Medicare Australia requests the Director of the PSR to undertake a review of the provision of services by a practitioner over a specified period.

The Director considers the Medicare Australia request and, if the Director forms the opinion that the person may have engaged in inappropriate practice, they undertake a review.

The Director examines the data received from Medicare Australia and may also direct the practitioner to produce complete and original patient records. The records are examined, the Director may meet with the practitioner, a report on the findings is made and any submission received from the practitioner is considered. After this, the Director must decide to:

- take no further action;
- offer the practitioner the opportunity to negotiate an Agreement under section 92 of the Act where the practitioner acknowledges inappropriate practice and agrees specific actions which may include repaying a part or all of the Medicare benefit that has been received; or
- refer the practitioner to a peer review Committee.

If the Director considers that the conduct of the practitioner needs further investigation, or the practitioner chooses not to enter a section 92 Agreement, a Committee of the practitioner's peers is established.[4]

Review by a Committee

Members are drawn from the Panel appointed by the Minister.

The Committee will consider whether the practitioner's clinical decisions were inappropriate for the patient, whether the services provided did not meet the requirements of the Medicare item descriptor and / or any PBS restrictions as well as assessing the adequacy of clinical records. The Committee will use clinical records and any other material provided by the practitioner. The Committee determines whether the practitioner's conduct in connection with the rendering or initiation of services would be acceptable to the general body of their peers.

If, after considering the information provided, the Committee forms a preliminary view that the practitioner may have engaged in inappropriate practice, a hearing will be held.

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4 Professional Services Review, *Your Guide to the PSR*, p. 14, available at: http://www.psr.gov.au/docs/publications/Your%20Guide%20to%20the%20PSR%20Process%2012July2011.pdf (accessed on 5 October 2011).

The hearing will provide the practitioner with the opportunity to present both oral and written evidence to support their case. After considering all the evidence, the Committee produces a Draft Report containing its findings. The practitioner is given a copy of this Report.

If the Committee finds that no inappropriate practice has occurred, the matter is closed.

If the Committee finds that inappropriate practice has occurred, the practitioner will be given time to make submissions on the Draft Report. The Committee will then consider the Practitioner's submissions and may or may not change their findings. The Committee will then issue a Final Report to the practitioner, and the Determining Authority.[5]

The Determining Authority

The Determining Authority is an independent body within the Professional Services Review which has two main functions:

decide whether to ratify section 92 Negotiated Agreements reached between the Director of PSR and a practitioner; and

determine what sanctions to apply whenever practitioners have been found to have engaged in inappropriate practice by a Committee.

When a Committee makes a finding of inappropriate practice against a practitioner, the Determining Authority will invite submissions from the practitioner on the sanctions it should impose. The Determining Authority will then draft a determination, including the sanctions it intends to impose.

The Determining Authority must impose one or more of the following sanctions:

- a reprimand;
- counselling;
- partial disqualification from claiming a Medicare benefit for no more than 3 years;
- full disqualification from claiming a Medicare benefit for no more than 3 years;
- an order for repayment of any Medicare benefits for services provided in the review period which have been found as being provided inappropriately; or
- a full disqualification from the PBS for no more than 3 years.

Practitioners are given an opportunity to make written submissions on the Draft Determination. The Determining Authority will consider this submission and then make a Final Determination. This Final Determination

5 Professional Services Review, *Your Guide to the PSR*, pp.14-15, available at: http://www.psr.gov.au/docs/publications/Your%20Guide%20to%20the%20PSR%20Process%2012July2011.pdf (accessed on 5 October 2011).

> contains the final decision of PSR and is the end of the PSR process unless the practitioner appeals to the Federal Court or Federal Magistrates Court.[6]

Major changes to the PSR Scheme

1999 Review of the PSR Scheme

1.11 The PSR Scheme was reviewed in 1999 following the 1998 Federal Court decision in the case of *Anthony Adams v Steven Yung & Anor [1998]* FCA 506 (15 May 1998). According to the review report the case:

> ...highlighted deficiencies in the legislation and in the operation of the Professional Services Review Scheme, and necessitated a comprehensive review of the Scheme. In the *Yung* case, the PSRC relied on the legislative definition of inappropriate practice being conduct unacceptable to the general body of the profession. Consequently, the PSRC inquiry focussed on the general pattern of conduct, not on the provision of excessive services to individual patients as required by the previous Medical Services Committees of Inquiry (MSCI) process.[7]

1.12 A review committee was consequently established which comprised the AMA, the Health Insurance Commission, DoHA and the Director of the PSR. The remit of the review was to:

> ...address the deficiencies identified by the Court and to clarify the legislative intention of the Scheme to focus on professional conduct.[8]

1.13 The Review Committee concluded that the PSR Scheme ethos of peer review be maintained and made 45 recommendations in its report that were:

> ...necessary to improve the administration of the PSR process to meet the needs for legal effectiveness, transparency and natural justice, and to ensure the peer review process is maintained.[9]

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6 Professional Services Review, *Your Guide to the PSR*, p. 15, available at: http://www.psr.gov.au/docs/publications/Your%20Guide%20to%20the%20PSR%20Process%2012July2011.pdf (accessed on 5 October 2011).

7 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p. 2, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf (accessed on 28 September 2011).

8 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p. 3, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf (accessed on 28 September 2011).

9 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p. 1, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf

1.14 The recommendations covered the following areas:

- the definition of inappropriate practice;
- processes to arrive at findings;
- determinations;
- expanding the agency;
- the Health Insurance Commission (HIC) and referral processes;
- the role and responsibilities of the Director of PSR;
- enhanced legal assistance and processes;
- referral of professional issues;
- the determining panel;
- revised time periods; and
- review rights.[10]

1.15 Recommendations of note included the publication of the names of practitioners who had been found to have practiced inappropriately, and the introduction of the 'deeming provision' that applies where a general practitioner provided 80 or more consultation services on 20 or more days in a 12 month period.[11]

1.16 In ensuring these recommendations were considered and actioned, the Review Committee recommended that the government review the new PSR arrangements within three years after coming into effect.[12]

2006 Review of the PSR Scheme

1.17 The 1999 review had prompted a number of legislative changes to the PSR enabling legislation. The recommendation to review these changes within 3 years was not implemented because the government felt that not enough case law had developed to properly assess whether the changes had had the desired effect. The 2006 report explains the government's decision:

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10 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p.p. 4-8, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf (accessed on 28 September 2011).

11 Department of Health and Ageing, *Review of the Professional Services Review Scheme – Report of the Steering Committee*, May 2007, p.p. 16-17, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed on 28 September 2011).

12 *The Report of the Review Committee of the Professional Services Review Scheme*, March 1999, p. 2, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report%20March%201999.pdf (accessed on 28 September 2011).

> ...the proposed review was delayed because there was insufficient case law to effectively evaluate the 1999 legislative amendments. When further refinements to the PSR Scheme were made in 2002 in response to the decision in the *Pradhan* case, the decision was made to postpone the review until such time as an adequate case law history could be developed to inform the process.[13]

1.18 The 2002 amendments were intended to clarify the object and operation of the Scheme and the amendments included:

- the inclusion of a new objects clause (s.79A of the HIA), emphasising the public protective aim of the Scheme;
- the replacement of the investigative referral process with a request from Medicare Australia that the DPSR examine Medicare services rendered or initiated by a practitioner for whom a Medicare benefit had been claimed during a period (s.86). This amendment meant that the DPSR or a PSR committee was able to examine patient records relating to any or all specified services rendered or initiated by the practitioner during a specified period, and was not restricted by Medicare Australia's reasons for the request; and
- enhanced procedural fairness opportunities at various stages of the Scheme's review process.[14]

1.19 When established the 2006 review committee comprised the AMA, Medicare Australia, DoHA and a representative from the PSR. The committee's remit was to examine:

> ...the impact of the recommendations of the 1999 Review and the impact of the 1999 and 2002 legislative changes on the operation of the PSR Scheme.[15]

1.20 The report on the review broadly confirmed the continued support for the PSR Scheme and the concept of peer review and found that:

> All of the 1999 Review recommendations have been implemented, except for recommendations 6, 10, 16, 40 and 44...(of which) recommendation 6

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13 Department of Health and Ageing, *Review of the Professional Services Review Scheme – Report of the Steering Committee*, May 2007, p. 8, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed on 5 October 2011).

14 Department of Health and Ageing, *Review of the Professional Services Review Scheme – Report of the Steering Committee*, May 2007, p. 14, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed on 5 October 2011).

15 Department of Health and Ageing, *Review of the Professional Services Review Scheme – Report of the Steering Committee*, May 2007, p. 4, available at: http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed on 5 October 2011).

> has been partially implemented...recommendation 44 ... has been implemented (through the 2006) Review.[16]

1.21 The report described the 1999 and 2002 amendments to the scheme had clarified:

> ...the protective nature of the scheme in protecting both Commonwealth revenue and patients from inappropriate practice. The amendments also reinforced the 'procedural fairness' requirements necessary in the process, based on a strong system of peer review. The Steering Committee considers that these were important changes to ensure procedural fairness and protect the rights of the person under review (PUR).[17]

Recent context

1.22 The PSR recently lost two cases in the Federal Courts. The first was the decision on 7 June 2011 to quash the decision of the PSR against Dr Peter Tisdall in 2009[18] with costs being awarded to Dr Tisdall. The court cited a lack of evidentiary support for the PSR Committee's conclusion in that case, though the PSR Director at the time, Dr Webber, noted that the finding ' does not go to the clinical behaviour' of the doctor in question.[19] The second case, *Kutlu v the Director of PSR*, [20] concerned the appointment of a number of PSR Deputy Director and Panel members going back to 2005. The Court decided on 28 July 2011 that the appointments were made in contravention of the Minister's obligation under sections 84(3), and 85(3) to consult with the Australian Medical Association (AMA) prior to the appointments. The court deemed invalid the committees to which one or more of those named were members, as well as the reports of those committees. The committee understands that this has led to the dropping of a large number of reviews of medical professionals that were on foot at the time of the decision.[21]

1.23 The committee wrote to the minister on 30 August 2011 asking how the government intended to respond to both cases. A reply was received on 12 September 2011 saying that the Commonwealth had applied for special leave to appeal the decision of Kutlu v Director of PSR but did not outline the grounds on which it will

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16 Department of Health and Ageing, *Review of the Professional Services Review Scheme – Report of the Steering Committee*, May 2007, p.p. 17-18, http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed on 5 October 2011).

17 Department of Health and Ageing, *Review of the Professional Services Review Scheme – Report of the Steering Committee*, May 2007, p. 19, accessed on 5 October 2011 via http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf

18 *Tisdall v Webber* [2011] FCAFC 76

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

20 *Kutlu v Director of Professional Services Review* [2011] FCAFC 94

21 Sean Parnell, 'Probe into medical watchdog', *The Australian*, 15 March 2011, p. 7.

do so. The Commonwealth has advised that it will not be appealing the decision of Tisdall v Webber.

1.24 The PSR submission states that on 27 October 2010 it requested that all current Panel Members and Deputy Directors of the PSR resign in response to 'potential issues with the 2009 appointment of Panel members and Deputy Directors'.[22]

1.25 In March 2011 new guidelines were agreed by the PSR and AMA for the appointment of Panel Members and Deputy Directors, however the recruitment process has not yet commenced. This means that currently the PSR does not have any Panel Members and Deputy Directors.

22 PSR, *Submission* 24, p. 16.

Chapter 2

Audit Procedures

Medicare Australia

2.1 Since the inception of the PSR it has received 767 referrals from Medicare Australia ("Medicare"). This represents a long term average of 45 per annum.[1] As of June 2011 there were 95 000 health practitioners providing services that attract a Medicare benefit.[2] The practitioners referred to PSR represent less than 0.1 of one per cent of all medical practitioners.[3] Outcomes from the PSR's work during 2004-05 to 2010-11 include:

- 70 matters in which decisions to take no further action were taken (21 per cent of matters);
- 166 Agreements in which a practitioner acknowledged inappropriate practice were negotiated and entered into (49 per cent of matters);
- 103 final determinations were made in which a practitioner was found to have engaged in inappropriate practice by a Committee of their peers (30 per cent of matters).[4]

2.2 The committee received a significant amount of evidence focussed on the audit procedures utilised by Medicare that identify practitioners with profiles significantly different from that of their peers. There was a particular focus on the role of statistics and the methodology employed to highlight anomalies.

2.3 The committee undertook an inquiry in March 2009 into Compliance Audits on Medicare Benefits and reflected in that report on some of the issues raised.

2.4 In response to the specific concerns raised throughout the current inquiry, on 26 September 2011 the committee sent written questions to the Department of Human Services (DHS), which is responsible for compliance activity relating to MBS and PBS including audits of services billed to Medicare.[5] The committee received a response on 5 October 2011.

2.5 The Medicare Practitioner Review Program is a five step process which uses a practitioner's practice profile to identify whether they are rendering services

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1 PSR, *Submission 24*, p.7.

2 Consumers Health Forum Australia (CHFA), *Proof Committee Hansard*, 23 September 2011, p. 38.

3 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 2.

4 *Submission 24*, p. 13.

5 Dept. of Health and Ageing (DoHA), *Proof Committee Hansard*, 23 September 2011, p. 60.

significantly differently to their peers. The Program literature explains how the practitioner's profile is established:

> The Profile is a suite of Medicare and PBS data which reflect the services rendered (provided by or on behalf of the practitioner) or initiated (eg requests for pathology or diagnostic imaging) under Medicare and PBS prescribing for that practitioner over a specified time frame.[6]
>
> The department uses sophisticated data mining techniques to analyse large amounts of information and derive statistically valid methods of identifying health practitioners with profiles or practices significantly different from their peers. These methods take into account potential differences in claiming patterns between health practitioners based on such factors as patient demographics and location. Data mining tools are customised for each health practitioners group; and these tools are currently used to review general practitioners and specialists.
>
> All profiling techniques rely on input from Medicare Medical Advisers (qualified medical practitioners with current practice experience). At all stages of analysis, Medicare Medical Advisers provide advice on the nature of the risk and conclusions drawn from the analysis.[7]

2.6 Much of the discussion in the public hearing and in written evidence discussed the representation of the profile statistics in terms of a bell or 'Gaussian' curve. The suggestion was that the further to the right of that curve a practitioner's profile lies, the more likely that inappropriate practice is occurring. Dr Ruse explained the assumptions used in the methodology:

> Medicare deals with a huge volume of statistics regarding doctor claims. Because of varying individual doctor work patterns the frequency distribution for each item is not the classical bell shaped curve. There is a long right tail. Some of those doctors might just have chosen to work very long hours (for standard consultation item outliers). Some might have a particular clientele of patients generating a lot more than the average number of specific investigations or treatments.
>
> However, as a doctor's position on the curve moves further right, it was assumed that the possibility of inappropriate categorisation, of consultation items, or inappropriate use of investigations or treatments, or inappropriate professional input, because of time constraints, (all potentially present anywhere in the curve) might be rising. I think that assumption, as a basis for further enquiry, but not a final judgement, was appropriate. The amount of sub standard professional practice that I have seen in my Committee

6 Practitioner Review Program, *Medicare Australia*, 12 August 2011, http://www.medicareaustralia.gov.au/provider/business/audits/prp.jsp#N10026 (accessed 7 October 2011).

7 Dept. of Human Services (DHS), answer to question on notice, 26 September 2011 (received 5 October 2011).

> work is, I am sure, much higher than that seen in more statistically "normal" practitioners.[8]

2.7 There were a number of suggestions that practitioners were identified purely on the use of statistics, and that this process included no context. In the public hearing Mr Watt from the Australian Doctors Union (ADU) specifically cited an example that implied that there was no profiling involved other than the use of basic statistics:

> ...a simple, logical profiling of practices would explain, from the outset, why a female doctor at a female clinic specialising in treating females is ordering so many pap smears, as opposed to simply saying, 'Wow—look how many she's ordering compared to the bloke who is up the road!'[9]

2.8 Dr Reece, Chairman of the ADU, also stated in his opening statement his analysis of the Medicare audit process:

> It is just a repeated line of, 'We notice that you are a statistical outlier, so you are different from your colleagues; therefore, we have got concerns.' When you ask them, 'What exactly is your concern?' they say, 'We're just letting you know that you're in this five or 10 per cent of people who do,' for instance, 'more long consultations than other doctors.' Then you might say back to them, 'How many would you like me to do? They say, 'No. That's not a problem. Just what your peers would find acceptable.'[10]

2.9 Dr Masters from the ADU also commented:

> I think Medicare are suggesting to us that they would be very happy if we had this bell curve and there was a straight line right down the middle. They do not seem to like anybody on the end of the bell curve and they seem to want to interrogate them.[11]

2.10 The response received through DHS described how Medicare assessed the information produced by its profiling techniques. Their process includes:

- identifying unusual patterns of item usage and item combinations;
- reviewing top claimants by a range of fields including demographic and claim or service types; and
- identifying and applying patterns learned from previous cases of non-compliance.[12]

2.11 Dr Cootes, Acting Director of the PSR rebutted suggestions that Medicare do not take a number of factors into account. He cited a submission from Medicare

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8 Dr Ruse, *Submission 11*, p. 3.

9 Australian Doctors' Union (ADU), *Proof Committee Hansard*, 23 September 2011, p. 7.

10 ADU, *Proof Committee Hansard*, 23 September 2011, p. 3.

11 ADU, *Proof Committee Hansard*, 23 September 2011, p. 3.

12 DHS, answer to question on notice, 26 September 2011 (received 5 October 2011).

to the Community Affairs Committee's inquiry in 2009 into Compliance Audits on Medicare Benefits:

> Medicare Australia uses sophisticated technology to compare factors including total benefits, services, patient demographics and prescribing of pharmaceuticals. The profiling system is adaptive and takes into account factors such as number of days worked and area of practice.[13]

2.12 That response from Medicare to the committee's inquiry goes on to say:

> There are four broad situations in which a provider's claims may be identified for audit. These are when:
>
> - a provider has used an item with a medium to high risk of non-compliance;
> - a provider's individual claiming statistics appear to be unusual or irregular;
> - a provider's claiming statistics are significantly different to their peers; or
> - a provider has been identified through 'tip-offs' and information received.
>
> In each of these situations, Medicare Australia recognises there are often many acceptable reasons for claiming behaviour. Medicare Australia's approach is not to assume an incorrect claim but to raise the concern with the provider and allow the provider the opportunity to explain their situation.[14]

2.13 The committee was concerned with the example used by the ADU that a women's health clinic would be subject to Medicare or PSR review for over-servicing in relation to pap smears. It requested that PSR review their records to discover if this was a genuine case. PSR responded:

> There are 18 pap-smear specific item numbers in the Medicare Benefits Schedule. A search of the PSR case management system returned no finding of a referral to PSR from Medicare Australia in relation to concerns around these Pap-smear items.
>
> PSR has no record of any of these items ever being reviewed by PSR for any practitioner.[15]

2.14 The committee also heard that the auditing methodology unjustly identified practitioners who were particularly innovative and busy. The Australasian Integrative Medicine Association discussed their concerns at the public hearing:

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13 PSR, *Proof Committee Hansard*, 23 September 2011, p. 49.

14 Medicare Australia, *Submission 16 to Community Affairs Committee Inquiry into Compliance Audits on Medicare Benefits*, April 2009, p. 14.

15 PSR, answer to question on notice, 23 September 2011, p. 5 (received 29 September).

> From AIMA's observation, the problem starts with Medicare auditing for the longer consultations, which subsequently leads to the PSR referral. GPs who see more patients with chronic diseases or multiple health problems, such as AIMA members, are more likely to use longer consultation item numbers. Using the longer consultation item numbers, such as items 36 and 44 that I mentioned, more than the general body of peers is an indicator for Medicare auditing, and it has been noted by the PSR director in annual reports that it can lead to referral to the PSR.[16]

2.15 With respect to AIMA's evidence on the extent of the auditing of their members, the committee is not persuaded that they are being unfairly targeted due to their practice profile. AIMA's evidence was that a small number of its members were audited. The number appeared to be in line with the average across all professions,[17] showing that AIMA members were not particularly likely to attract the attention of Medicare and the PSR.

2.16 The question of whether the auditing methodology is appropriate is more complex. The committee accepts the assumptions that premise the methodology, in that by focussing attention on the statistical outliers it is more likely to identify inappropriate practitioners. It notes the admission by Dr Webber and others[18] that 'a low-volume, inappropriately practicing doctor would probably not be identified using the Medicare auditing methodology',[19] however given the scale of the data administered by Medicare it concedes that there are going to be practitioners who slip through the net.[20] The committee accepts Medicare's contention that it is using advanced data mining and analysis. It encourages Medicare to continue to try and develop techniques that have the capacity to uncover inappropriate MBS item use and PBS prescribing practices other than those identified as statistical outliers using current methods.

Recommendation 1

2.17 The committee emphasises the importance of communicating the methodology utilised by Medicare Australia to the wider medical community. The committee recommends that Medicare Australia publish its current auditing methodology and any subsequent improvements to the methodology as they come on stream.

16 Australasian Integrative Medicine Association (AIMA), *Proof Committee Hansard*, 23 September 2011, p. 32.

17 AIMA, *Proof Committee Hansard*, 23 September 2011, pp. 33–34.

18 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 4*;* Dr Ruse's *Submission 11*, p. 3.

19 Sen Abetz, *Proof Committee Hansard*, 22 September 2011, p. 4.

20 Page 4 of the PSR submission shows that 319.1 million MBS services and 201.5 million PBS services were processed in 2010-11, PSR *Submission No 24*, p.4.

2.18 The committee is not convinced by the ADU's suggestion that sophisticated audit profiling does not take place. It notes that the use of unfounded allegations in relation to over-servicing of pap smears was unhelpful to the conduct of the inquiry.

Medicare Education and Advisory processes

2.19 The issue of whether practitioners have access to information, education and advice over the interpretation and application of MBS items arose during the inquiry.

2.20 There were suggestions made in evidence that some MBS items are difficult to interpret and therefore adhere to. Dr Masters from the ADU recounted a situation following the establishment of his multidisciplinary clinic:

> I was concerned to get the Medicare numbers right for this clinic. They are not straightforward. So I sent quite a lot of information to Medicare asking for help. I said: 'Are these odd numbers right? Is what I am going to charge right?' It took months to get a reply. I got a reply saying: 'We cannot give you an answer, Dr Masters. We suggest you contact the AMA and the college of GPs.' I contacted the AMA and the college of GPs—and I think I put this in my submission—and they said: 'We are not here to interpret the Medicare schedule. That should be done by Medicare.' Medicare will not do it. The PSR will not do it. The AMA will not do it. The college of GPs will not do it. And we get fined.[21]

2.21 MDA National also provided evidence regarding the interpretation of some MBS items:

> We believe that there should be greater consultation with the profession, including the relevant colleges, in developing MBS item descriptors and the associated explanatory notes. In developing MBS item descriptors and the associated notes, we feel that feedback should be actively sought from these groups and the PSR where problems are identified. We believe that improved processes should also be put in place to enable individual practitioners to obtain clarity about the use of specific MBS items.[22]

2.22 Mr Dahm from the ADU also discussed the MBS Item interpretation, and made an interesting point on how the Australian Tax Office issues rulings and interpretations for complex situations.

> ...many practice managers report an inconsistency in verbal advice provided to them by employees of Medicare with very little reference to any written rulings. Yet they stand accused for misunderstanding the said rules or interpretations that have not been published or circulated widely to practices and even their own Medicare advisers...
>
> The Australian Tax Office issue public rulings on a variety of tax matters, especially matters considered ambiguous and at a high risk of misinterpretation or perceived fraud. We find it unusual that given the

21 ADU, *Proof Committee Hansard*, 23 September 2011, pp 12-13.

22 MDA National, *Proof Committee Hansard*, 23 September 2011, p. 15.

> apparent high incidence of fraud in the medical profession that similar rulings and interpretations are not reported by Medicare and are not included on the Governments website or in various education programs.[23]

2.23 The committee was concerned that there may not be sufficient educative and advisory processes in place to provide practitioners with confidence in their interpretations of MBS Item Descriptors. It put the issue to AMA, DoHA and also to Medicare.

2.24 The AMA concurred that there was an issue around interpretation and outlined the steps they took on behalf on their members:

> We have made strong representations to Medicare and any doctor, any person who bills Medicare now, can ask for a written interpretation, which they can be expected to receive and hold. Once they have got that written interpretation, I would expect that they would be able to submit that as a piece of evidence if they were called into question. I am not sure of the timing of that, but that is the case now.[24]

2.25 DoHA were concerned by suggestions that people were not given appropriate information from either the Department of Health and Ageing, or Medicare. They advised that:

> There are a number of avenues that are available to practitioners to receive advice about the interpretation of Medicare Benefits Schedule (MBS) items. The Department of Human Services (DHS) maintains a dedicated Provider Enquiry line that provides advice to practitioners and practitioners can also call the Department.[25]

2.26 The response from DoHA is consistent with the information the committee received from Medicare in response to specific questions on this issue. Medicare said it provides information in the following manner:

> The Department of Human Services - Medicare program has available formalised education resources, which include a range of self paced eLearning programs available online 24 hours a day. These programs include:
>
> - Medicare and You – for new health professionals;
> - Medicare and You – MBS primary care items;
> - Medicare and You – for Dentists;
> - Medicare and You – treatment for skin lesions; and
> - Medicare and You – Chronic Disease Management for GPs.[26]

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23 Health and Life Pty Ltd, *Submission 4*, p. 11.

24 Australian Medical Association (AMA), *Hansard Committee Proof*, 23 September 2011, p. 28.

25 Dept. of Health and Ageing (DoHA), answer to question on notice, 23 September 2011, p. 1 (received 4 October 2011).

26 DHS, answer to question on notice, 26 September 2011 (received 5 October 2011).

2.27 It also outlined how it communicates information on particularly complex MBS items:

> Where the Department of Human Services – Medicare program is aware of ambiguity or difficulty in using an MBS item, it works with the Department of Health and Ageing to clarify the issue.
>
> Once the issue is clarified it is communicated to health professionals. This can be directly to an individual, through professional associations, newsletters, quick reference guides and fact sheets.

2.28 Importantly however Medicare does not provide advice on the appropriate clinical practice for specific MBS items:

> All clinical decisions are for the professional judgement of the medical practitioner.[27]

2.29 Dr Cootes, Acting Director of the PSR, advised the committee:

> Around that whole issue of the items and people complaining that they are not sure where to place an item or how to itemise a particular consultation, there is a need for a little bit of realism here. Doctors are professionals; they have certain responsibilities put on them. The AMA Code of Ethics implores them to be a little bit sensible in their use of the community's resources. The new code of conduct produced by the Medical Board of Australia makes the same point even more strongly. I do not know that you can ever codify these things. Just in the GP domain, I think the total number is 120 million. There are 120 million interactions between a GP and an Australian each year, and if anyone can codify those unambiguously into four brief descriptions then good luck to them. So it falls back on the professional responsibility of the GP, and the system in the main does work effectively.[28]

2.30 While the committee agrees that it is the practitioner's responsibility to make clinical judgements and decisions in relation to MBS items, we are of the view that as much advice and information as possible should be as accessible to the practitioners. The production of quick reference guides and factsheets are particularly useful and the committee commends Medicare on this initiative. The committee suggests that the department, in consultation with practitioner representative bodies keep a watching brief on the accessibility and currency of information sources.

27 DHS, answer to question on notice, 26 September 2011 (received 5 October 2011).

28 PSR, *Proof Committee Hansard*, 23 September 2011, p.58.

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);

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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:

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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.

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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.

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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.

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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]

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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.

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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.

Chapter 4

Operating procedures of the PSR

Natural Justice and Procedural Fairness

4.1 The principles of natural justice and procedural fairness were discussed at length in submissions. The suggestion that the PSR process did not provide these protections was at the heart of much of the criticism of the scheme. Criticism of the scheme focussed around the following questions:

(a) Do practitioners under review receive adequate information of the concerns of PSR and/or Medicare Australia and at what stage in the process?

(b) Does the practitioner under review have adequate opportunities to respond to the concerns raised in the PSR process and/or by Medicare Australia?

(c) Are practitioners under review afforded sufficient legal assistance?

(d) Is the appeals process fair and accessible?

4.2 The first of these issues was discussed in numerous submissions and during the public hearings. There were accusations that practitioners under review did not have any detailed knowledge of the concerns raised by PSR or Medicare, and therefore could not defend or explain their conduct in relation to those concerns. In the committee's view, if true this would certainly qualify as a denial of natural justice.

4.3 The AMA acknowledged in their submission that some doctors are claiming that natural justice was not always provided:

> In recent years, the PSR process has suffered from a perceived failure to afford natural justice to the Person Under Review (PUR). AMA members who have been reviewed by the PSR have complained that:
>
> (i) PURs could not prepare adequately for the Director's investigation because they were not informed about what services were being investigated and why;
>
> (ii) PURs were not given a clear explanation of the review process and their rights at the beginning of an investigation;
>
> (iii) PSR Committees were comprised of medical practitioners who have not practised for some time or who practised in a different specialty to the PUR;
>
> (iv) the initial meeting between the PUR and the Director was intimidating. Further, the AMA identified a lack of consistency in the procedures followed at these meetings.

(v) written decisions made by the Director or Committee did not appear to consider evidence the PUR had provided during the review, or explain how the evidence was considered, or why it was dismissed; and

(vi) written decisions did not actually explain the reasons for the decision of the Director or Committee.[1]

4.4 The Medical Defence Organisations, Avant and MDA National were critical in their appraisal of whether the PSR process in particular afforded natural justice to their clients.

4.5 Avant submitted that:

> There is an opportunity for reform to the PSR Scheme to overcome actual and perceived unfairness...Reform is desirable to improve the procedural fairness of PSR's process for the person under review and to protect the reputation of the PSR as a legitimate peer review scheme.[2]

4.6 MDA National submitted, both in their written submission and during the public hearing that:

> review meetings between the director and the practitioner under review often do not meet the requirements for procedural fairness in that practitioners are not provided with sufficient information to understand the case against them, nor are they provided with adequate opportunity to reply to such charges.[3]

4.7 The ADU criticised the lack of natural justice. Dr Reece claimed the PSR was:

> refusing to attach weight to any form of evidence on behalf of defendant doctors, [it] does not even make the charges at stake explicit until it is too late to mount any form of defence and does not allow doctors meaningful legal representation.[4]

4.8 Dr Masters, also from the ADU, targeted his criticisms towards both Medicare Australia and PSR for not providing enough information at the start of the process:

> It is very difficult if you disagree with anybody in the PSR process to actually state your case and have the ability to cross-examine them about what they actually want. I see the big problem here is at the very first step. When the audit starts from Medicare, there is no actual guide from Medicare that you have done anything wrong.[5]

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1 Australian Medical Association (AMA), *Submission 13*, pp 1-2.

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

3 MDA National, *Proof Committee Hansard*, 23 September 2011, p. 15.

4 Australian Doctors' Union (ADU), *Proof Committee Hansard*, 23 September 2011, p. 2.

5 Australian Doctors' Union (ADU), *Proof Committee Hansard*, 23 September 2011, p. 3.

4.9 Dr Caska of the ADU also commented on an issue raised by Avant in their submission[6] that PSR cases are prejudged:

> The doctor seems to be presumed guilty and knows there is no real or practical avenue for appeal or review.[7]

4.10 Dr Brazenor from the ADU contributed:

> ...there is never a stated process. They tell me that, if you are investigated by the tax office, first you get a frank statement of the concerns and, in the same envelope, you get an explanation of the due process. Neither of these things was accorded to any of my three colleagues until right at the end, when they said, 'Right, we've got you. Here are the concerns. Your interview with the director is next Tuesday'—and that is as close as they got to due process.[8]

4.11 The issue of practitioners being of the view that they had no choice but to enter into a negotiated agreement concerned the committee. Mr Watt from the ADU suggested that:

> ...it was a coercive process, with Dr Webber himself admitting, and again I am quoting: 'I informed them'—the person under review—'the process is long and very stressful.' How much free will have you got going into that? That is persuasive, intimidatory and threatening. You cannot voluntarily enter into an agreement if there is a threat hanging over your head.[9]

4.12 Dr Webber addressed the perception that there are a lack of options available to a practitioner under review, and went further to suggest that often it is the legal representative of the practitioner who requests a negotiated agreement:

> It is almost universal that submissions in the review process are constructed and sent by their legal representatives, with the doctor's input, and it is not uncommon for the concluding paragraph to request a section 92 agreement if I am not going to dismiss somebody. So, in fact, these section 92 agreements are asked for almost universally.[10]

4.13 Dr Webber continued that negotiated agreements are only entered into if, in his judgement, the inappropriate practice is minor in nature:

> ...it has been my practice to offer a 92 agreement only where there has been relatively minor inappropriate practice—certainly, inappropriate practice that has not put anybody at risk—and where the practitioner had insight into their behaviour and had demonstrated a change in behaviour...However, if

6 *Submission 10*, p. 10.

7 Australian Doctors' Union (ADU), *Proof Committee Hansard*, 23 September 2011, p. 3.

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

9 ADU, *Proof Committee Hansard*, 23 September 2011, p. 6.

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

> significant inappropriate practice has been found early on, then I would not entertain the idea of a 92 agreement with the practitioner at all.[11]

4.14 The committee accepts that the powers vested in the Director of the PSR under the Act are substantial. However the role of the Determining Authority in ratifying, or rejecting the section 92 Agreements, and its willingness to do so, albeit on a small number of occasions,[12] would suggest that sufficient checks and balances are in place to prevent any abuse of the Director's powers.

4.15 The PSR submission focussed on changes made to the process of the Scheme. It concentrates on the draft guidelines agreed with the AMA and DoHA, and it acknowledges that:

> The PSR process set out in Part VAA of the Act has the potential to be confusing to some practitioners who are referred to the Scheme.[13]

4.16 The PSR and Medicare have rebutted the concerns around the issues of whether the practitioner under review has been informed of the matters of concern, and also whether the practitioner has the opportunity to respond to any matters that may amount to inappropriate practice. Medicare submitted evidence in response to a request by the committee which states that:

> Health practitioners are informed of the specific concerns when first contacted by a Medicare Medical Adviser by telephone to arrange a time for an interview. The letter confirming the interview also lists the concerns and is accompanied by the health practitioner's claiming data.
>
> A Medicare Medical Adviser details the concerns at the interview with reference to the health practitioner's claiming profile. The interview allows the health practitioner the opportunity to clarify the concerns and provide information that may explain the concerns.[14]

4.17 The PSR response to Questions on Notice sets out the opportunities for the practitioner to respond to the concerns:

> A practitioner who goes through the full PSR process will have at least eight opportunities to make submissions and explain their practice in light of the concerns that have been identified. These are:
>
> - A written submission and interview process through Medicare Australia's practitioner review program
> - A verbal submission at the Director's review meeting
> - A written submission on the Director's findings contained in the s89C report

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

12 PSR, *Proof Committee Hansard*, 23 September 2011, p. 56.

13 PSR, *Submission 24*, p. 7.

14 Dept. of Human Services (DHS), answer to question on notice, 26 September 2011 (received 5 October 2011).

- Written submissions prior to the committee hearing
- Verbal and written submissions at the Committee hearing and written submissions following the hearing
- A written submission on the Committee's Draft Report
- A written submission on the Committee's Final Report
- A written submission on the Determining Authority's Draft Determination[15]

4.18 The PSR additional response to questions posed by the committee sets out the process through which feedback and reasons for decisions are communicated to the practitioner:

(a) Once the Director determines to undertake a review, a notice of this decision is sent to the practitioner. This letter contains a paragraph or list, under the heading "Decision to Undertake a Review" that details the concerns that may suggest that inappropriate practice may have occurred.

(b) The Director's Review meeting invitation outlines to the PUR that the purpose of the meeting is to discuss the reasons for the practitioner's referral to PSR and the findings of the Director's review of medical records. In changes introduced in 2011 this letter now also contains excerpts of the practitioner's clinical records, that the Director has reviewed and may demonstrate the nature of the concerns.

(c) Following the review meeting the practitioner receives an 89C Report which details the concerns that remain following the review of the medical records and the review meeting. These concerns are set out in relation to each specific MBS or PBS item and generally ranges from 2 to 5 pages in length. The 89C report specifically details the Director's preliminary findings and invites the practitioner to respond to these findings.

(d) If the matter is referred to a Committee, the Director must produce a section 93 report and provide it to the practitioner. This report details the reasons why the Director thinks the practitioner may have engaged in inappropriate practice. Under the heading "Discussion and Findings" the Director details the findings of concern that has resulted in the committee referral. These are further spelled out in a following section headed "Reasons for making the Referral" which contains a list of concerns that the Director is referring to the Committee.[16]

15 PSR, answer to question on notice, 23 September 2011, p. 5 (received 29 September 2011).

16 PSR, answer to question on notice, 23 September 2011, p. 4 (received 29 September 2011).

4.19 Given the PSR's admission that the process is long and very stressful[17] and the significant potential consequences for practitioners, it is not acceptable for any practitioner under review not be afforded the basic information that explains the process at the commencement of the review.

4.20 The committee accepts the AMA's appraisal that there have been concerns around the natural justice of the PSR procedures to date, while recognising that there is a legitimate argument to be had over whether these concerns were actual, or perceived. Nonetheless the overhaul of the procedures in the March 2011 guidelines implies a tacit admission that procedurally there was significant scope for improvement.

4.21 The committee is encouraged by the steps that have been taken by the PSR, DoHA and the AMA to address concerns around the information provided to the practitioner at all stages in the process, including broadening the explanations for decisions taken.

Recommendation 4

4.22 The committee recommends that the March 2011 changes be reviewed one year after their implementation and this should be carried out in consultation with all relevant medical professional bodies, and other key stakeholders such as the MDOs and consumer representative organisations. The findings of the review should be publicly available.

Legal representation

4.23 The committee heard from a number of witnesses concerned that the practitioner under review was disadvantaged by not having a legal representative to argue their case. Two MDOs pursued this argument in their written submissions and in the public hearing.

4.24 MDA National told the committee:

> They [practitioners] can be accompanied by a person who can have legal qualifications but they cannot make presentations or representations to the committee except on advice from that advisor. The lawyer cannot make submissions or representations. It would be our view that, in improving the power imbalance, as it were, and the need for more of the image that procedural fairness has been granted, perhaps there should be some consideration to formal legal representation being allowed in some circumstances.[18]

4.25 Avant argues that the situation where the practitioner under review is only accompanied by a lawyer and not represented:

17 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 2.

18 MDA National, *Proof Committee Hansard*, 23 September 2011, p. 21.

> ...creates very significant barriers to the PUR effectively adducing any evidence in their defense as the PUR is nervous, inexperienced and often fatigued by extended questioning which can continue for days...[19]

4.26 The committee notes ADU's statement that the process 'does not allow doctors meaningful legal representation'. However, the PSR's own guide states that 'We advise you to engage a medical defence organisation and /or lawyer to assist you through the PSR process'.[20] In evidence, the former PSR Director Dr Webber noted:

> Most of the people that are before the PSR are represented by their MDUs with legal advice. It is almost universal that submissions in the review process are constructed and sent by their legal representatives, with the doctor's input...[21]

4.27 Dr Cootes, the Acting Director of the PSR also refuted any implication that the practitioner under review did not have access to legal advice:

> ...practitioners appearing before PSR do have access to legal advice—PSR actually advises practitioners to obtain legal advice. Around 80 per cent of the correspondence that goes out of PSR to a practitioner under review is conducted through a legal adviser to the practitioner. At PSR committee hearings, practitioners are able to be accompanied by and advised by their legal adviser. So practitioners under review do have legal advice.[22]

4.28 Dr Ruse responded to the claims principally made by Avant and cited in paragraph 4.25 above, that procedures employed by the PSR during Committee hearings place the practitioner under review in an exposed or vulnerable position. He explained the conditions in the PSR Committee from the Panel's perspective:

> The suggestion, which has been made in several places, that the PUR is somehow intimidated by not being allowed sufficient breaks is just not true. We have secretarial staff, we have our own lawyers, we have three doctors who know that they are peer reviewing a fellow human being. We often suggest to a doctor that they might like a break and, if you want to get into the mechanics of the committee hearing later, certainly in my committees we call a break of about 10 minutes in every hour.[23]

4.29 The committee heard conflicting evidence whether the practitioner under review is disadvantaged by not having a lawyer representing them in the PSR committee stage and questions whether this would actually hinder the analysis of clinical practice that is the purpose of this stage. The committee reiterates the position that all submitters appear to support regarding the PSR process: that it is a

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19 Avant, *Submission 10*, p. 12.

20 Professional Services Review, *Your Guide to the PSR Process*, 12 July 2011, http://www.psr.gov.au/docs/publications/Your%20Guide%20to%20the%20PSR%20Process%2012July2011.pdf (accessed 6 October 2011), p. 25.

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

22 PSR, *Proof Committee Hansard*, 23 September 2011, p. 46.

23 PSR, *Proof Committee Hansard*, 23 September 2011, p. 48.

peer review scheme, not a court. As the Acting Director of PSR said: 'it is a professional review system where professionals are given the opportunity to explain their practice to a committee of peers'.[24] If lawyers were to take over and represent their clients, rather than simply advise them (as is currently the case), it would no longer be peer review. The committee did not receive evidence to support such a radical revision of the scheme.

4.30 The committee also heard evidence that the PSR Committee should be chaired by a legal officer. The Committee, whilst appreciating the concerns and calls for a legally qualified person to be involved in the process, remains ambivalent to the suggestion.

Recommendation 5

4.31 The Committee recommends that the government liaise further with stakeholders to ascertain the desirability for a legally qualified person to be involved in the PSR process.

The Appeals process and accountability of the PSR

4.32 Since the abolition of the PSR Tribunal and subsequent creation of the Determining Authority (DA) in 1999 practitioners can appeal against PSR decisions to the Federal Court by way of seeking a judicial review of decisions at any stage under the *Administrative Decisions (Judicial Review) Act 1977*. There is a wide range of reasons for which review can be sought:

> i. the decision was not authorised by the Health Insurance Act 1973
>
> ii. the decision involved an error of law
>
> iii. that a breach of the rules of procedural fairness/natural justice occurred
>
> iv. that the procedures required by law were not observed
>
> v. that irrelevant considerations were taken into account or there was a failure to take relevant considerations into account
>
> vi. that the exercise of power by the decision maker was so unreasonable that no reasonable person could have so exercised it.[25]

4.33 The PSR Tribunal was removed from the process following the Report of the Review Committee in 1999 in which it recommended:

> ...the removal of the PSR Tribunal from the process in recognition that review on the merits of the final determination is not appropriate in a scheme in which the key judgment is a professional judgment by the practitioner's peers about the practitioner's conduct. The right of review on points of law by the courts will, of course, be retained.[26]

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24 PSR, *Proof Committee Hansard*, 23 September 2011, p. 45.

25 PSR, *Submission 24*, pp 12–13.

26 PSR, *PSR Review Committee Report*, 1999, p. 2.

4.34 Avant were explicit in their desire for the reintroduction of a merits-based appeal process by commenting:

> Judicial review, though essential, is no substitute for relatively quick, cheap and fair merits review...
>
> If it is the merits of the matter rather than the fairness of the process which is truly at issue for the PUR it is advantageous to all parties to have the issue resolved by way of merits review rather than potentially more legally-convoluted judicial review proceedings.[27]

4.35 The committee is not persuaded by this argument for the same reasons that it does not consider it within the spirit of the peer review process to have a non-peer of the practitioner deciding on whether inappropriate practice has occurred. Moves in this direction can only be considered if there is a willingness to abandon peer review as the fundamental principal of the scheme. As noted earlier in this report, the committee did not receive evidence indicating that any major stakeholders would support such a shift.

4.36 The committee does note that there is ready recourse to the courts, which play a role in ensuring procedural fairness and ensuring the PSR complies with its legislation. Indeed, the extensive use of the courts since the scheme's inception illustrates that PSR decisions are routinely challenged in this way. Up to May 2007, there had been around 60 court cases involving the PSR scheme, several of which led to reviews and refinements of the PSR's procedures.[28] Between 2006 and 2011 there were 14 Federal Court appeals.[29] The committee also notes that the Scheme itself has been subject to continual review and the PSR submission points out that the Scheme and its enabling legislation has been amended on a number of occasions in response to either court cases or as a result of reviews of the process:

> The PSR Scheme has continued to evolve since its inception. Legislative amendments were made in 1997, 1999, 2002 and 2006 to strengthen and clarify the professional review process and address evidentiary difficulties. Comprehensive reviews conducted in 1999 and 2006 by Government and key stakeholders also made recommendations to refine the administration of the Scheme and improve its legal effectiveness and transparency.[30]

4.37 The High Court has on several occasions upheld the constitutional validity of the PSR scheme,[31] most recently in the case *Wong v Commonwealth of Australia;*

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27 Avant, *Submission 10*, p. 15.

28 Professional Services Review, *Review of the Professional Services Review Scheme, Report of the Steering Committee*, May 2007, http://www.psr.gov.au/docs/publications/PSR%20Review%20Report-Final%20July%202007.pdf (accessed 5 October 2011), pp. 30, 69–71.

29 PSR, *Submission 24*, p. 13.

30 *Submission 24*, p. 6.

31 Robin Bell, 'Protecting Medicare services: trials of a peer review scheme', *Journal of Law and Medicine*, vol. 13, 2005, p.40.

Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee.[32]

4.38 The committee is of the view that the structure of the PSR must provide sufficient checks and balances to prevent any single participant in the Scheme from exercising undue power. In the case of the role of Director, Dr Webber was asked specifically if too much power lay with that role. He replied:

> Any case that proceeds from a decision of the director—in other words, either a negotiated agreement or a decision to send someone to a committee—is overseen by other people. If I, as director, were to enter into an agreement with a practitioner, that agreement and all the documentation that supported it is ratified. It has to be ratified by the determining authority—a completely separate body. If I send someone to a committee, the committee obviously has oversight of that, which is then also reviewed by the determining authority. The only absolute discretion I have is to dismiss somebody.[33]

Sanctions available to the Determining Authority

4.39 The committee heard evidence from MDA National who said in their written submission:

> Some of the repayments of Medicare benefits claimed are substantial; for example, in 2008-09 one practitioner was required to make a repayment of $1,202,872.40 and in 2009-10 another practitioner was required to repay $473,203.05. MDA National further notes that some practitioners have only received a percentage of the Medicare benefits, indeed in some cases we understand only 20%, and yet the practitioner is required to repay 100% of the MBS benefits. To date, MDA National is not aware that the PSR has prosecuted a person who is an officer of a body corporate who causes a person to engage in inappropriate practice, despite its ability to do so under the Act.[34]

4.40 The committee was concerned by this allegation that a practitioner would be required to repay more than they actually received from Medicare and explored the issue with MDA National in its public hearing. Professor Rait explained:

> The specific situation I can think of is that, for example, in my own practice a proportion of my fees are diverted to the practice and retained by the practice group. In other words, in the event that someone has paid for a service and it goes to the practice, they may not actually personally receive all the proceeds of that because of their particular practice structure or the fact that they are employed by a practice organisation.[35]

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32 *Wong v Commonwealth of Australia; Selim v Lele, Tan and Rivett constituting the Professional Services Review Committee* No. 309 [2009] HCA 3 (2 February 2009)

33 Dr Webber, *Proof Committee Hansard,* 22 September 2011, pp 5-6.

34 MDA National, *Submission 5*, p. 4.

35 MDA National, *Proof Committee Hansard,* 23 September 2011, p 18.

4.41 The example provided describes internal financial arrangements of a medical practice. The committee is of the view that the onus lies with the medical practitioner to negotiate the financial ramifications of an adverse PSR finding within his or her practice, and this is not the responsibility of the Determining Authority. The committee received no other evidence suggesting that the Determining Authority had required payment beyond what the practitioner received from Medicare Australia.

4.42 The committee notes that a section 92 agreement reached with the Director of the PSR may include agreement to repay part or all of the Medicare benefits received in relation to Medicare benefits paid for practices which the person under review agrees were professionally inappropriate. It does not allow for the amount to be more than was originally paid. Section 106U of the Act places the same limitation on the Determining Authority.

4.43 The committee notes that if a doctor does not believe their practice was inappropriate, then they may reject a proposed section 92 agreement in favour of seeking the support of a committee of their peers regarding their practice. The Senate committee would expect that advisers from medical defence organisations would also be able to give an assessment, based on experience, of whether the doctor's practices would be likely to secure peer support. The committee agrees that where MBS items have been inappropriately used, it is appropriate that one option available to the Determining Authority be that the money be repaid.

Part VII authority

4.44 In his evidence the Chairman of the Determining Authority, Dr Nicolas Radford, requested that the committee explore the powers under Part VII of the Act to disqualify practitioners from the PBS:

> There is only one other thing I might say with regard to an item which the committee might feel it would like to address, and that is the matter of the part VII authority. At the moment, the matter of drug prescribing is only usually handled as part of the spectrum of inappropriate practice with regard to clinical services. If, say, we had a doctor who was prescribing vast amounts of opiates improperly, it is not open to us to disqualify that practitioner from prescribing certain drugs. We can only revoke the authority to prescribe all drugs as pharmaceutical benefits, and that is a very, very blunt and heavy instrument, so blunt that—I would have to research it, but I think it has been seldom if ever applied.

4.45 The committee agrees that this is a sanction that should be available to the Determining Authority, and concurs with the Chairman that Part VII should be reviewed to allow more flexibility in its application.

Recommendation 6

4.46 The Committee recommends that the Commonwealth government review the legislation to allow the Determining Authority greater flexibility in its sanctions with regard to PBS items.

The challenge of corporate medical practice

4.47 Dr Webber, the former head of the PSR, remarked on the role of corporate medical practice during his opening statement:

> As you know, there has been an explosion in medical knowledge and technology since Medibank was first introduced in 1973 and, of course, the business of medicine has been altered forever by the entry of corporatised medicine practising for a third party profit...
>
> As for the future, I can certainly see PSR—and this may be somewhat controversial—having an own-motion ability to investigate scams and unacceptable corporate behaviour, of which I have seen significant examples, to prevent an escalation of this sort of inappropriate clinical behaviour.[36]

4.48 His observations were followed up during evidence:

> Senator ABETZ: ... In your opening statement you referred to corporatised medicine and unacceptable corporate behaviour. Has the PSR prosecuted any person who is an officer of the body corporate?
>
> Dr Webber: Sadly, no, because the legislation makes it very difficult to do so. It talks about the ability to take action against an employer of a practitioner if that employer has directed the employee to practice inappropriately. However, it is silent about a contractor. Because many of the practitioners working in the corporatised medical field are working under contracts, the owner of the practice is not able to be followed up.[37]

4.49 The AMA's guide indicates that the 'overwhelming majority of Corporate contracts will define [a doctor's] status as that of independent contractor'.[38] The Kit advises doctors to:

> remain on your guard to ensure that your clinical independence is not compromised indirectly through influences on referral patterns, changes to throughput of patients or various financial inducements.[39]

4.50 The committee received no evidence from other organisations on this point. However, given that corporate medical practice is growing, and with independent contractors central to its workforce, Dr Webber's concern should not be overlooked. It would seem anomalous for the legislation to allow the PSR to act against an employer, but not a contracting corporation, even though the pressures each might be exerting on medical professionals could be similar in nature.

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36 Dr Webber, *Proof Committee Hansard*, 22 September 2011, pp. 2–3.

37 Dr Webber, *Proof Committee Hansard*, 22 September 2011, p. 4.

38 Australian Medical Association, *Corporatisation of General Practice: Decision Support Kit for Doctors*, August 2010, http://www.ama.com.au/node/5997 (accessed 6 October 2011), p. 22.

39 Australian Medical Association, *Corporatisation of General Practice: Decision Support Kit for Doctors*, August 2010, http://www.ama.com.au/node/5997 (accessed 6 October 2011), p. 28.

Recommendation 7

4.51 The committee recommends that the Commonwealth government review the PSR's enabling legislation, to ensure that the PSR can effectively pursue abuse of the MBS or PBS systems, regardless of the structure of employment of the person under review.

Senator Rachel Siewert
Chair

ADDITIONAL COMMENTS BY COALITION SENATORS

1.1 Coalition Senators acknowledge those of the medical profession who were sufficiently courageous to expose some of the limitations of the Professional Services Review process.

1.2 There is no doubt in the minds of the Coalition Senators that the processes were deficient and led to unjust outcomes. This in turn must detract from people joining or remaining in the medical profession at a time when there are very real shortages.

1.3 Whether some concerns were exaggerated or as elegantly advocated as they may have been is a matter for judgment. What is not a matter for judgement is the genuine deep concerns of many in the medical profession about the process and procedures.

1.4 But for the courageous advocacy by some and their willingness to litigate many of the deficiencies would not have been so widely exposed.

1.5 Coalition Senators believe the issue of the PSR is an issue in which partisan politics plays no role. Indeed we expressed our concerns and asked questions with a view to ventilating the issues to achieve a more acceptable, fairer, and efficient methodology for the oversight of taxpayer's money in an area where government is rightly concerned to protect the integrity of the Commonwealth Medicare benefits and pharmaceutical benefits programmes.

1.6 In March 2011 changes were made to the PSR and with them Coalition Senators trust a new confidence and acceptance. A review in 12 months time will allow for ongoing monitoring.

1.7 Coalition Senators urge the soon to be appointed personnel of the PSR to take a more consultative approach in the performance of their functions and ascertain methodologies whereby fairness to all can be transparently observed. This is especially important for those in the emerging areas of speciality. This will go a long way to restoring confidence by the profession in the operations of the PSR.

Senator the Hon Eric Abetz **Senator Chris Back**

Senator Judith Adams **Senator Bridget McKenzie**

APPENDIX 1

Submissions Received

1	Dr Nicolas Radford
2	Mr Bert Smith
3	Mr Malcolm Watt
4	Health and Life Pty Ltd
5	MDA National
6	Dr Timothy Flanagan
7	Dr. Paul Hanson
8	Dr Felicity Wivell
9	Australasian Podiatry Council
10	Avant Mutual Group Ltd
11	Dr Warwick Ruse
12	Dr Gerard Ingham
13	Australian Medical Association
14	Medical Indemnity Protection Society Limited
15	Consumers Health Forum of Australia
16	Department of Health and Ageing
17	Australian Dental Association
18	Rural Doctors Association of Australia
19	Australasian Integrative Medicine Association
20	Peter and Lydia Spitz
21	Mr Ian Nobel
22	Dr Chris McKenzie
23	Confidential
24	Professional Services Review Agency
25	Professor Robert Allen
26	Dr Scott Masters Supplementary Submission Supplementary Submission
27	Australasian College of Nutritional and Environmental Medicine (ACNEM) Inc
28	Confidential
29	Confidential
30	Confidential

31 Confidential

32 Confidential

33 Name Withheld

34 Name Withheld

35 Name Withheld

36 Fresh Start Recovery Programme

37 The Australian Association of Musculoskeletal Medicine

38 Dr Richard Waluk

39 Mr Alan Williamson

40 The Royal Australian College of General Practitioners

41 The Royal Australasian College of Physicians

42 Confidential

43 Assoc Professor Felicity Allen

44 Ms Ania Zamecznik

45 Dr Bruce Harris

46 Confidential

47 Australian College of Skin Cancer Medicine

48 Name Withheld

49 Name Withheld

50 Name Withheld

51 Dr Peter Buchanan

52 Kyabram and District Doctors Recruitment Action Group

Additional Information

Professional Services Review Agency

- Your Guide to the PSR Process

Professional Services Review Agency

- Guidelines for the Appointment of Medical Practitioners as Panel Members, Deputy Directors and Consultants to Professional Services Review Matters

Professional Services Review Agency

- Committee Handbook for PSR Panel Members and Deputy Directors

Answers to Questions on Notice

Professional Services Review

- Received 29 September 2011, updated 11 October 2011
- Received 18 October 2011

Australian Medical Association

- Received 23 September 2011
- Received 12 October 2011

Consumer Health Forum

- Received 29 September 2011
- Attachment to answers to Questions on Notice, received 29 September 2011

Department of Health and Ageing

- Received 4 October 2011

Department of Human Services

- Received 5 October 2011

Dr Warwick Ruse

- Received 10 October 2011

APPENDIX 2

WITNESSES WHO APPEARED BEFORE THE COMMITTEE AT PUBLIC HEARINGS

Friday, 22 September 2011
Parliament House, Canberra

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore (Deputy Chair)
Senator the Hon Eric Abetz
Senator Judith Adams
Senator Chris Back
Senator McKenzie

Witnesses

Former PSR Director

WEBBER, Dr Anthony David, Private capacity

Friday, 23 September 2011
Parliament House, Canberra

Committee Members in attendance

Senator Rachel Siewert (Chair)
Senator Claire Moore (Deputy Chair)
Senator the Hon Eric Abetz
Senator Judith Adams
Senator Chris Back
Senator McKenzie

Witnesses

Australian Doctors Union

BRAZENOR, Adjunct Professor Graeme Alexander, Private capacity
CASKA, Dr John Pius, Board Member
DAHM, Mr David, Representative
MASTERS, Dr Colin Scott, Member
REECE, Associate Professor Albert Stuart, Chairman
WATT, Mr Malcolm Ian, Paralegal Adviser

MDA National Insurance Pty Limited

BIRD, Dr Sara, Manager, Medico-legal and Advisory Services

RAIT, Associate Professor Julian, President

Medical Indemnity Protection Society Ltd (MIPS)

BROWNING, Dr Anthony Troy, Managing Director

Australian Medical Association

HAMBLETON, Dr Steve, President, Australian Medical Association
SULLIVAN, Mr Francis, Secretary-General, Australian Medical Association

Australasian Integrative Medicine Association

KOTSIRILOS, Dr Vicki, Founder and Past President

Consumers Health Forum of Australia

BENNETT, Ms Carol, Chief Executive Officer
WISE, Ms Anna, Senior Policy Manager

Professional Services Review (PSR) Scheme

COOTE, Dr William, Acting Director
RADFORD, Dr Nicolas, Chairman, Determining Authority
RUSE, Dr Warwick Henry, Former Deputy Director
TWYFORD, Mr Luke, Acting Executive Officer

Department of Health and Ageing

BARTLETT, Mr Richard, First Assistant Secretary, Medical Benefits Division
LEARMONTH, Mr David, Deputy Secretary
REID, Mr Chris, General Counsel
SHAKESPEARE, Ms Penny, Assistant Secretary