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**SENATE STANDING COMMITTEE ON
COMMUNITY AFFAIRS
Wednesday, 6 May 2009**

Members: Senator Moore (*Chair*), Senator Siewert (*Deputy Chair*), Senators Adams, Bilyk, Boyce, Carol Brown, Furner and Humphries

Participating members: Senators Abetz, Back, Barnett, Bernardi, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Siewert, Stephens, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Bilyk, Boyce, Furner, Humphries, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

Any Government proposal to implement the Government's announced 2008-09 Budget measure to increase compliance audits on Medicare benefits by increasing the audit powers to Medicare Australia to access the patient records supporting Medicare billing and to apply sanctions on providers.

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Committee met at 8.59 am**CORDWELL, Ms Lauren Heather, Representative, Royal Australian College of General Practitioners****FLEGG, Dr Karen, Representative, Royal Australian College of General Practitioners**

CHAIR (Senator Moore)—This committee is commencing its inquiry into the compliance audits on Medicare benefits. I welcome representatives from the Royal Australian College of General Practitioners. You have information on parliamentary privilege and the protection of witnesses, and you can get more if you require. We have your submission. Thank you very much. I invite you to make an opening statement before we go to questions.

Dr Flegg—The RACGP thanks the Senate Standing Committee on Community Affairs for the opportunity to contribute to these discussions today. The Royal Australian College of General Practitioners is the specialty medical college for general practice in Australia. We are responsible for defining the discipline of general practice. Our concerns basically amount to standards, quality and competency issues.

From my memory, the RACGP first developed standards for general practices in about 1993-94. We have had nearly 30 years experience at running a fellowship exam. When doctors succeed at the fellowship exam they are awarded a fellowship of the college and they are eligible for vocational registration as a specialist GP. We also run a quality assurance and continuing professional development program, which enables GPs to demonstrate their commitment to the maintenance of professional standards. We have about 20,000 members, and about 4,000 also participate in that QA and CPD program. So, in a nutshell, we support GPs in providing excellence in patient care.

The RACGP support efforts to ensure that Medicare funding is distributed appropriately; however, we are opposed to the proposed legislation as we have concerns over proposals to enhance the auditing of the Medicare benefits scheme. Our major concerns are that the proposed powers are far too broad, there is no detail on the specifics of what information will be required for Medicare Australia audits and there are insufficient safeguards for medical practitioners' legal rights and insufficient safeguards for patients' privacy. There will be significantly increased levels of red tape for medical practitioners. As a medical practitioner I can say that the purpose of medical records is not to document compliance with Medicare Australia's requirements; medical records are an inappropriate tool for this purpose.

The RACGP believes the focus should be on education around appropriate billing practices, whilst sanctions, such as fines, should be reserved for repeat offenders. The effect of the draft bill will be to compromise the very important relationship between a medical practitioner and their patient. The main cause of this fragmentation will be that the proposals may require medical practitioners to breach the privacy of their patients by requiring the submission of detailed patient records to Commonwealth bureaucracy. There are no clear guidelines on how much detail will be required.

The *RACGP standards for general practices* sets the standards for the provision of high-quality general practice care for the Australian community. We have a few copies of those here,

which if you like we can leave for you. The standards address the role and details of a patient health record. The proposed legislation will compensate the ability of GPs like me to adhere to a number of current RACGP standards, including those relating to patient health records, confidentiality and privacy of health information, information security and the transfer of patient health information.

The RACGP believes there are possible harmful consequences of this proposed legislation which include deterring patients from discussing intimate health concerns with their doctors. Personally, I think the most vulnerable patients will be the most afflicted: people like mental health patients, adolescents and, as a doctor in an Indigenous health centre, I would add Indigenous patients who are very concerned about the government accessing their private information. Medical practitioners who do take patient confidentiality very seriously may be forced to compromise this commitment to privacy, and patients will lose confidence in the privacy and protection of their medical records. This will erode the doctor-patient relationship and impact upon the capacity of a GP to offer comprehensive, holistic and patient-centred care.

Basically, the RACGP has concerns with the draft bill in three key areas. One, an increase in the number of compliance audits will add additional red tape burdens to doctors. Two, a requirement that practitioners produce evidence to verify their Medicare claiming when audited is breaching patient confidentiality. Three, we are concerned about the imposition of financial penalties on doctors with no allowances for the difficulties to comply with the requirements, especially with regard to gaining patient consent to release the records.

In summary, the proposed legislation really compromises the doctor-patient relationship. I just imagine what I would not tell my doctor, and I would challenge you to imagine what you might not tell yours. Those who are most needy are most likely to not attend if they feel confidentiality may be compromised. The end result may be worse health outcomes and a potential increase in adverse events. Thank you.

CHAIR—Thank you, Dr Flegg. Ms Cordwell, do you want to add anything at this stage?

Ms Cordwell—No.

Senator SIEWERT—I apologise that I have not read your submission because we were only just given it, so I will ask you questions around what you have just said and issues raised in other submissions I have read. Firstly, do you not support this proposal at all or with modifications?

Dr Flegg—We think there are better ways to spend the money. We support scrutiny on how Medicare money is spent. We support more equitable distribution of that money. However, we have quite significant concerns, as you have heard, about the way it is phrased at this point in time. We think there are certainly better ways to spend that money and better ways to improve the way doctors claim under Medicare.

Senator SIEWERT—From what I understand of the legislation, the government are saying that they are spending some money to save some money overall. I am playing devil's advocate here, purely exploring the issues. My take on this is that the department will argue when we see them this afternoon that we are spending some money to make some money, but if we do not make that money we cannot spend any money. My question to you, firstly, is: spend what money

if they are not doing this? The government are suggesting they are doing this in order to tighten up on any misspending of money. So, secondly, how would you suggest that the government does that? And, thirdly, is it your position that it is a minor problem so we should not be worried about it? Is that the underlying issue?

Dr Flegg—No. I think you are planning to spend something like \$77 million to hopefully recoup \$140 million—that order of numbers. One of the thoughts we have had is that it would not take much of a blow-out on the \$77 million to recoup very little at all. We feel that incorrect claiming or mistakes in claiming could be better addressed by investing in the education of general practitioners specifically in the area of billing practices, particularly of new GPs who may be confused by the schedule.

I think confusion by the schedule is another important point to make. The MBS is complex and amazingly confusing. Medicare itself gives conflicting advice at times about how to bill properly. Even excellent doctors with really good intentions can make mistakes. The college thinks that the MBS needs revision with a view to simplification and that that money would be better spent on an activity such as that, plus education. We believe the end result would be the same.

Senator SIEWERT—So you are saying you would spend that money doing that and you would save money anyway, so that is how you would pay for the education and for simplifying the process. Is that the essence of the argument?

Dr Flegg—We presume the savings that are projected to be made by the proposed legislation or by what we would suggest are savings on people billing inaccurately or making mistakes during their billing.

Senator SIEWERT—I was presuming that it is not only that but that there are issues around fraud as well. That is certainly my understanding from implications of the legislation. I may be wrong. What you are suggesting would indeed fix where there are genuine mistakes—which I do not doubt there are, because everybody says it is complex et cetera—but I understand there are also issues around fraud, and that also needs to be dealt with. What you are suggesting does not really deal with that area.

Dr Flegg—We are not suggesting scrapping the level of audits that are currently happening. There is still that option. The other avenue that is in the system already that is more acceptable to doctors is the Professional Services Review, which is run by doctors. So there are other avenues already in the system. The MBS is so complicated and so confusing that I do not think we really know what run-off it would have if that were simplified and reviewed.

Senator SIEWERT—Have you had discussions with the department around that simplification? It seems to me very obvious—and, again, a lot of submissions talk about wanting to simplify the system. Have you had discussions with the government around simplification?

Ms Cordwell—I can comment on some simplification that happened in December last year and January of this year, where the minister announced a review of the MBS, which was particularly looking at reducing red tape and boosting prevention. The college worked quite confidently with our members and we also put in a submission to the Department of Health and

Ageing. That review aimed to simplify aspects of the MBS but it was really, in our mind, only a small percentage of some of the current issues. So the MBS review looked at health assessments, the level Cs and Ds of attendance items, out-of-surgery hours, after-hours and chronic disease management. Those things are a very small percentage of the MBS items. So, whilst there has been some effort by the department to make some changes to the MBS in those areas, we feel that there is significant reform that needs to take place in order to simplify the process and to ensure that all consumers and patients in Australia can access good, appropriate, timely, evidence based health care.

Senator SIEWERT—I have a series of questions around some amendments that have been suggested through some of the submissions. I am wondering whether, if those amendments were made, you would still think that there are concerns with the system. The Public Interest Advocacy Centre suggests issues around de-identifying patient information and a two-step process where you first look at whether you need to access clinical records and then tell patients that their records are going to be accessed. Have you looked at those sorts of issues at all or do you just think we should not be going down that line?

Dr Flegg—On a personal level I think we should not be going down that line. There are a number of issues on accessing records. One is patient consent, and we are really very concerned about that. I guess we cannot think of any way that that can be done that will not destroy and impinge on the patient-doctor relationship and the patient's trust in their doctor. If you do consent prospectively on every consultation, that really is a bit of a nightmare. If you do it retrospectively and go back looking to get patients to consent to release information from a certain day's practice, we feel it is quite unfair that the doctor is going to be financially penalised if the patients do not say that they will release their records. So I guess we are not sure how that consent can be obtained to release any information to anyone. If the doctor were to de-identify the information, I am not sure how it would actually satisfy what Medicare are asking for—justification of what was in the consult. And I guess it is more red tape for the doctors. We feel that if Medicare went and asked for the consent that might take some of the pressure off the doctor and remove some of the destructive influence on that doctor-patient relationship. We have tried to think about that. Lauren, did you want to add to that?

Ms Cordwell—I want to highlight that in our submission we actually put forward three questions around this issue of consent, because we think it is a particular issue. Under the proposed legislation, we ask:

- Will a general practitioner be required to contact a patient to obtain their consent to release the patient's records?
- Will Medicare Australia accept evidence that a patient did not want their records released?

We have some concerns there. Further:

- Will adequate time be given to medical practitioners to cull unnecessary or irrelevant information from patients' records before submission to the audit?

Senator SIEWERT—They are all issues that we can refer to the department.

Senator FURNER—Can I ask what your preference is in obtaining the consent?

Dr Flegg—I would have to say that I think our preference, from discussions that I have had, would be that Medicare could be the ones forced to obtain patient consent, and that would relieve the doctor from being fined if the patients refused.

Ms Cordwell—On the basis of that we are very concerned about fragmenting the doctor-patient relationship. What would happen if a doctor were required to call a patient to say, ‘I need to release your records; Medicare is undertaking an audit’? The patient is very likely to say, ‘Okay, if you have to do it this time, but I am not going to come back to your practice, because I do not want the government being able to look into my medical records.’

Senator FURNER—Of course that would only occur if there is a reasonable concern, as expressed in the proposed legislation.

Dr Flegg—One of the difficulties about the doctor-patient relationship—and it is a very private thing for all of us, obviously. Everybody in this room is highly educated and well able to articulate their wants and desires, but there are some patients who are much more disadvantaged than us. I think those patients are less able to understand what this consent may mean and more likely to confuse what the doctor is actually being subject to interrogation for. Patients often do not distinguish between an audit for overbilling purposes on Medicare versus bad practice or malpractice in terms of clinical incompetence. I really fear that a lot of the patients will not see the difference and will not understand the difference, even if we try to explain it to them. I work in a situation locally here in the ACT with disadvantaged patients and I feel that getting consent out of those patients with them knowing what they are consenting to is going to be quite difficult, if that should ever happen.

Ms Cordwell—Can I make a final comment on that. In our submission on the last page, we wonder about the implications, given the \$2,500 proposed fine which is included in the legislation.

CHAIR—It is not the fine; it is the threshold.

Ms Cordwell—Yes, the threshold.

CHAIR—Just so we get the figures right.

Ms Cordwell—Okay. We have specific concerns that relate to requiring a general practitioner to pay \$2,500 if they refuse to release a patient’s medical record as well as requiring a general practitioner to pay \$2,500 if they are unable to obtain a patient’s consent.

CHAIR—So you are actually talking about any amount rather than \$2,500?

Ms Cordwell—Yes.

CHAIR—The threshold questions are fine and we will take them up with the department, but it is important to be accurate about the amount. In the examples provided in the government’s paper I do not think any of the fines were looking at that kind of level, but it is important to know them.

Senator BOYCE—I would like to go back, Dr Flegg, to your comments regarding the complexity of the current MBS schedule. Could you flesh that out a bit and give us a bit more detail as to the examples of its complexity?

Dr Flegg—There are probably a lot of examples. From a practitioner perspective it seems to be quite frequent over the last couple of years that extra item numbers have been added for doing things that are not just consultations from nought to five minutes or from six to 20 minutes or for more than 20 minutes, for example. There are item numbers for doing care plans for chronic disease, team care arrangements, mental health care plans. We were discussing an example this week where a practice can claim a SIP payment, which is basically a practice incentive payment, if they look retrospectively at their diabetic patients and observe that they have done a certain amount of the suggested screening and monitoring tests and things like that, so if they have all had a blood test to check their levels—

Senator BOYCE—So that is almost a payment for administration.

Dr Flegg—Yes, except that there is discussion about whether that payment can be claimed on the same day as a GP does a care plan for diabetes or a team care arrangement for a patient with diabetes. The Medicare schedule seems to say that it cannot, yet one of my colleagues has been to an education session where the Medicare person seemed to be saying: ‘Yes, you can; one looks backwards, and it’s admin—it’s a practice payment. The other one is about you doing a plan with the individual patient.’ So there are a lot of things like that. I think that some GPs probably understand the schedule quite well, but there would be many of us who do not understand the fine points. We probably are not claiming everything we could be claiming, but, in saying that, I am sure that that is also how mistakes are made.

Senator BOYCE—Okay. That leads me to two other points. I have an article here from a local GP journal suggesting that many GPs do not bill or COD, ‘even if it fits the criteria, for fear of being investigated, and this trend would skew the Medicare statistics’. Would the college like to comment on that?

Dr Flegg—I think that is probably true. There is a fear that, if you do more long consultations than the average GP, someone is going to come and investigate you. I personally timed my consultations for one session once, just to see what happened, and every consultation fell between 18 and 22 minutes. That is probably not average; it is probably longer than average—but some of those would be level B and some of those would be level C. However many are level C, I know it is more than average but ultimately I know that I did spend the time and that they satisfied the requirements, so I do bill it. But I am sure there are others who think, ‘No; I’ve already done a few long consults today and, yes, I shouldn’t really have that many.’ I know of practitioners who, for example, may have an interest in cardiology, and sometimes it is hard to access cardiologists—I should say ‘in rural areas’ but it also happens here in the ACT—so they may do a lot of ECGs. I have heard of people being audited for doing more than the average number of ECGs, but they were actually someone with a special interest in cardiology who takes referrals from their GP colleagues. It can be difficult, yes.

Senator BOYCE—Can you explain to us why a GP might be concerned about being audited for taking what they perceive to be a professional attitude.

Dr Flegg—For me, it creates concern and anxiety that they might say, ‘You’ve done something wrong,’ even if you feel you have not. It creates an enormous amount of red tape, if you like, so it is going to take up time, probably yours and certainly staff’s. So some people find it an extremely anxiety-provoking event.

Senator BOYCE—So there is the administrative burden of having to prove you were doing what you said you were—

Dr Flegg—There is an administrative burden for the doctor and the practice and the patient—

Senator BOYCE—and there is also concern—

Dr Flegg—Yes, and doctor anxiety. Certainly, when doctors are subject to complaints, sued or audited, their anxiety levels go up. We already have a higher rate of depression, suicide and things like that. We do not really need extra complicating factors like that.

Senator BOYCE—Medicare, in their submission, talk about the fact that they do quite a lot of face-to-face and other educative practices. They say, about the previous financial year:

We have provided face to face education to more than 2200 new medical practitioners ...

You mentioned a bit of confusion that had come up out of one of those sessions. What is the college’s view of the education offered by Medicare to GPs under the current system?

Ms Cordwell—Can we take that on notice and provide a response?

Senator BOYCE—Yes. I am just interested because we have Medicare’s comments on how they go about trying to ensure there are not inaccurate claims and I would like to hear the profession’s view on that topic.

Dr Flegg—I am involved in the local training program for doctors to become GPs, and the registrars regard the Medicare online modules as really very useful. There are a number of them and they are quite helpful, and the registrars find it a very positive experience and quite educative to do those modules online. So I would compliment Medicare on what they have got online. I have not actually been to one of their face-to-face sessions. It was another college member who had been to one.

Senator BOYCE—There is also a comment in the Medicare submission pointing out that a number of the item numbers disclose the type of disease or problem that people might have and that this information is already quite available to them. Would you care to comment on that?

Dr Flegg—Termination of pregnancy, for example—

Senator BOYCE—That is right.

Dr Flegg—or insertion of an intrauterine device or a diabetes care plan.

Senator BOYCE—Yes.

Dr Flegg—The chronic disease care plans do not actually specify ‘disease’, so I could do a chronic disease care plan for you and they would not know whether your chronic disease was diabetes or something else. Obviously if I did a mental healthcare plan they would have an idea that there is a mental health problem but not what it is. The mental health one is interesting because we do have concerns that, if that sort of information is not safeguarded for the patient from, for example, insurance companies, some of them may have their ability to get personal life insurance or disability insurance jeopardised. Yes, you can tell from the item numbers some times and, just like we have heard reports of doctors not charging for the longer consultations, we have also heard reports of doctors not actually charging for an item because it is identifiable.

Senator BOYCE—Can you tell us a little bit more about that?

Dr Flegg—A doctor will have a long consultation and will not charge for something like a mental healthcare plan because it is identifiable from the item number.

Senator FURNER—On page 3 of your submission you indicate particular examples of the review process. That is generally conducted by experienced doctors through the PSR. You view, I take it, is that it should be reviewed by experienced general practitioners only. Are you aware of whether or not there is a case for what is conducted by public health insurers or do public health insurers use trained administrative staff to review clinical notes under their order processes?

Dr Flegg—Sorry, I am not quite clear what the question is. I think the answer is, ‘No, I am not aware.’

Senator FURNER—You are not aware?

Dr Flegg—No, but these public health insurers are doing—

Senator FURNER—I understand that they do an audit process as well. Under their process I am just wondering whether your position on this would be that they use trained administrative staff to conduct that audit process.

Dr Flegg—I am not aware.

Senator FURNER—You also ask whether a GP will be required to contact a patient. This is going back to the issue of your preference. You did not necessarily identify a preference on how that consent should be achieved. I would like to thrash out some more examples of what you consider appropriate to deliver that consent other than the examples that you provided.

Dr Flegg—We found it very difficult to come up with any idea on how that consent could be attained that would not be potentially damaging to the patient-doctor relationship. Some people may say, ‘Obtain consent retrospectively on every consultation.’ That presents logistical dilemmas and it present a whole new system that does not exist in medical practice at the moment in this country. Retrospectively obtaining consent would not be easy. In my practice I would have trouble locating some patients retrospectively to obtain consent for release of information. We really just cannot think of a way that can be obtained by the doctor without damaging the relationship.

Senator FURNER—It would not be every patient though; it would be only those caught up in the audit process, wouldn't it?

Dr Flegg—That would be a number of patients though, wouldn't it?

Senator FURNER—It could be.

Dr Flegg—For a certain period or with certain item numbers. I think the other thing about that which I need to go back to is even if the patients do give you consent to give their record to Medicare, some patients, like me, would want to give consent for only a part of that record to go. I would not want Medicare having my home address or home phone number. I probably would not give it to my doctor if I knew there was a chance—

Senator FURNER—Medicare would have their home address.

Dr Flegg—They may or may not have your home address.

Senator FURNER—My understanding is they do. That is the way they returned their cheques and what not to you.

Dr Flegg—It currently goes to my post office box. There is a whole raft of other quite personal information that GPs collect from patients: information about your social history, your alcohol history, smoking, what your family situation is like—a whole raft of personal stuff. I think there would be hesitation on the part of the GP and the patient to have that recorded if they knew there was a chance that a Medicare bureaucrat may access that information. Even if the patients gave consent for the whole lot to be handed over, the question is how useful will that be.

The other thing I have said is that, as a medical practitioner, I do not write my records to demonstrate compliance with Medicare's billing. I write my records as a legal record of the consultation so that other doctors may know what I am doing with a patient. They are designed to be read by other doctors. Abbreviations, acronyms, things like that which are acceptable within the profession are all okay within a record, but they are certainly not a tool that I would see as appropriate for Medicare billing justification.

Senator FURNER—You suggest in your submission that the proposal will give Medicare Australia the right to access all information recorded by doctors on individual patient records. The Medicare submission indicates that the practitioner will have discretion over what information they provide and that they are only required to provide information necessary to substantiate the claim. How does this impact on the college's view on the proposal?

Dr Flegg—We felt that it is not clear at this point; there are no clear guidelines on how much detail will be required at all.

Senator HUMPHRIES—I want to clarify something you have already said: it is not part of the current proposal for the consent of patients to be sought or obtained before access to these records is sought under an audit process?

Dr Flegg—That it is not part of that?

Senator HUMPHRIES—The consent of patients is not required under the current proposals before an audit is undertaken on their medical records. Is that your understanding?

Dr Flegg—Yes.

Senator HUMPHRIES—Thanks. Some of the discussion might have led us to believe that there was some explanation of consent—

Dr Flegg—If it is not required, that is a difficulty of total breach of confidentiality by the medical practitioner in handing that over. If it is required, I have probably talked enough about how that is difficult from our perspective as well.

Senator HUMPHRIES—Yes, of course.

Ms Cordwell—The college has a handbook for the management of health information in private medical practice, and we have included some of the key comments in our submission. If I could, I want to briefly highlight one of them, which is around patient consent. It says:

Medical practitioners should respect the right of patients to determine how their personal information is used or disclosed, and should ensure that patients are provided with sufficient information to enable them to fully exercise this right.

It goes on:

The consent of the patient should be the guiding principle for medical practitioners when obtaining personal health information from their patients, using that information, or disclosing the information to other people.

Senator HUMPHRIES—That is right, but the point is that consent is not an issue in this legislation because it does not require patient consent before those records are accessed, does it?

Dr Flegg—No, but that will create another issue for GPs in divulging that information without consent.

Senator HUMPHRIES—That is right. One of the points made by Medicare Australia in their submission is that the present system of auditing relies on voluntary cooperation. They say that across a range of audits in 2006-07 the non-response rate ranged from four per cent to 70 per cent. The average non-response rate for compliance audits for Medicare services during this period is around 20 per cent. When a practitioner does not respond or refuses to cooperate with an audit request Medicare Australia does not currently have the authority to require the production of the relevant information. They simply do not take any further action in those circumstances. That figure is rather alarmingly high. Is there a case for saying that where a practitioner refuses to cooperate or fails to respond to a voluntary audit you ought to have the power to examine the records?

Dr Flegg—I would not want to suggest that.

Senator HUMPHRIES—How do we then deal with that non-response rate? I would not suggest that all these people are frauds, but it could be that if there is a tolerance of nonresponse then that might be a cover for fraud within Medicare.

Dr Flegg—It may be. I would not want to suggest that they should be subject to compulsory audits when refusing. This legislation goes further than that. It has far broader effects than the current legislation, though. We just question the cost-effectiveness and the cost benefit of this legislation in terms of what you can recoup versus what you are going to have to spend to recoup it, and the flow-on costs that really are not measurable if there are fluent cost in terms of doctor-patient relationships, subsequent health outcomes and adverse events.

Senator HUMPHRIES—I will just put a couple of questions on notice, if that is all right. You say on the first page of your submission:

- The lack of clear safeguards against the possibility of patient information becoming available to health insurance companies could jeopardise patients' rights to obtain medical insurance.

I would like you to flesh out what you mean by that, please, if you could.

Dr Flegg—I can give you an example of how that would flesh out. A history of depression recorded in your medical record significantly adversely affects your chance of getting life insurance or sickness/accident/disability type insurance if you are trying to get it. So there will be situations where GPs will write 'depressed mood' on a medical record rather than 'depression' because at some future time should a patient be getting a letter from the doctor to an insurance company about their history that changes the inferences.

Senator HUMPHRIES—The department would say in response to that that the companies do not get access to these records. It is only departmental officials that do as part of the audit process.

Dr Flegg—One would hope that is the case.

Senator HUMPHRIES— So that issue should not arise. I suppose you would say that you cannot guarantee the information—

CHAIR—Can I just butt in there. Why would you think it would not be the case, Dr Flegg, in terms of the process that has been happening in the past and is spelt out? Why would you think that anything that is given to Medicare officials for audit purposes would translate from them to anybody else? What gives you that concern?

Dr Flegg—I think the college people who have really looked at the legislation felt that there were inadequate safeguards documented in the legislation.

CHAIR—And you have read the privacy statement that is attached to it that came out last week?

Ms Cordwell—No, I have not.

CHAIR—I take the point that the privacy impact statement came out last week and that is later, but there is quite a detailed privacy impact statement. I am sorry to jump in, Senator, but it is a core issue. People would infer that somehow information would be spread. I am just wanting to see what was the basis of that statement, because the Medicare statement and the privacy impact statement talk very clearly about concerns for privacy—absolute concerns for privacy. If

you do have genuine concerns about that, it is good to state them rather than just stating, 'It could happen.' It is quite a significant issue, and I am sorry to labour the point, but it is core to the whole issue of the trust and the professionalism of any kind of audit system. So if you have a specific concern about the lack of privacy and the lack of security we would very much like to hear it—that would be great—rather than just a nebulous, 'It could happen.' I do not want to be difficult, but I think it is a very important point.

Dr Flegg—Thanks, Senator Moore. It would seem our submission predated that statement.

CHAIR—I do apologise again for the tight time frames that we are all operating in. If the college—and I know you have done a lot of work with care—would have a look at the privacy impact statement, which is on the net, and then, if you have subsequent concerns, which you may well have, get back to us urgently, that would help the committee, I think.

Dr Flegg—Okay, thank you.

CHAIR—It is attached to the department's submission, which we have got, so you could take it in hard copy, but I know you like to look at it with your process with the emails. I am sorry, Senator Humphries. I just thought that was important.

Senator HUMPHRIES—The other question I want you to take on notice is: what do you think the college would say we should do about this problem of non compliance with voluntary audits?

Dr Flegg—We can take that on notice.

Senator HUMPHRIES—There are billions of dollars spent on Medicare every year. There is a public interest in making sure it is being accounted for. If one in five doctors is saying, 'Go away; we're not going to talk to you about how we're spending or how we're accounting for the money,' then there's a pretty significant problem. What can we do, instead of disclosing the records, to get those high levels of compliance?

Dr Flegg—We can take that on notice. I can see what your concern is: the good guys are actually submitting to the audits and the potential bad guys are the ones who are refusing them.

Senator HUMPHRIES—Yes.

Dr Flegg—I can see where you are coming from.

Senator HUMPHRIES—There are also a few disorganised, sloppy and just chaotic practices that probably do not submit either, but that might be a cover for some people who are being fraudulent.

Senator FURNER—When you take that on notice, can you also include whether what the college's position is concerns the cost-benefit or privacy.

Dr Flegg—There are both concerns. Privacy is a big issue for us, because as individuals out there working, we find that the doctor-patient relationship is really the cornerstone of what we

do. Even if there is less that patients are happy to tell me then that would erode the relationships and may erode what I can do for them. That privacy is a major issue for us individuals on the ground out there. The cost-benefit stuff is really a more overarching organisational type issue.

CHAIR—Thank you. I do apologise for the shortness of time. I know that the college has worked very closely with the department on many things to do with health policy. I take it that you are prepared to continue working on this process, in particular on the whole issue of Medicare?

Dr Flegg—Yes. Could I leave you a few copies of our practice standards?

CHAIR—Certainly, we will get those.

Dr Flegg—There is a little cheat sheet there about what the college is about, for anyone who does not know.

CHAIR—Thank you very much.

Dr Flegg—Thank you for having us today.

CHAIR—My pleasure.

[9.42 am]

ROWLINGS, Mr William (Bill), Chief Executive Officer, Civil Liberties Australia Inc.

ACTING CHAIR—I welcome the representative from Civil Liberties Australia. I understand you have already had information on parliamentary privilege and the protection of witnesses and evidence.

Mr Rowlings—I have appeared before a committee before so I am aware of it.

ACTING CHAIR—Okay, thank you. I would like to invite you to make a short opening statement and then there will be lots of questions from the committee members.

Mr Rowlings—Thank you very much, Senator Moore. I will keep my opening statement brief. The first issue, which is not really a civil liberties issue, is the cost. If you accept the figures—basically, they date from 18 months ago so they may well need refiguring in that the financial world has changed in the past 18 months—and then say that they are out by about one third the \$147 million savings becomes about \$100 million savings. If, on the other hand, the \$70-odd million cost becomes \$93 million, because it is out by one third as well, then the margin for whether or not this is going to save money becomes extraordinarily fine. The history of claims by government departments in budget documents is notorious for over claiming on savings and for underestimating on costs.

So I think it would be very wise for the committee to consider asking Medicare to produce a new set of costings. That is just their basic costings. And there appears to be no allowance whatsoever made for the costs to doctors and their staff to effectively implement this program for Medicare. Most of the grunt work of sourcing documents and so on has to be done in the doctor's surgery. If you add that to the figures that are allegedly correct you will find that this project may well cost Australia money, which would be a very silly thing to do.

On the other hand, nobody can say accurately what doctors' costs will be. I know Medicare should be able to estimate. My estimate would be that two to four hours a week will be added to doctors' time—two hours in more detailed taking of records and two hours in chasing up documents, particularly if they are identified as being 'of concern'. We mention in our submission that 'of concern' is an extraordinarily low standard. I think the legislation needs changing in that respect.

The privacy issue is of course most important. People's health records are their most valued and most private asset. To tamper with that and to propose a system where people's records are going to be accessed and Medicare does not want to tell them is just outrageous.

I would also like to say that the Medicare privacy statement being late is an insult to the stakeholders who put submissions in and to the Senate committee. If the Medicare privacy statement could not be produced until all the submissions were in, and after the closing date, that shows exactly how much value they put on privacy. If you think about it, the privacy statement

could have been written months ago—it certainly could have been written when the legislation was drafted—yet it has been insultingly withheld until after everybody else has had a say.

The next thing I would like to comment on is that this legislation is part of a series of legislation that is of general concern to Civil Liberties Australia. Governments are targeting special groups of people. It started, notoriously, with unionists, with the ABCC legislation of the previous government. That legislation is still in place, so unionists have special clauses and restrictions on what they can do, with penalties and so on. We have bikies legislation, endorsed by the federal government and to be mirrored around Australia—in two states already. And now we have doctors, where there will be a special penalty regime brought in only against doctors. It is not planned that it will operate against any other professional group or trade union group, yet there will be a penalty regime brought in so a mistake by a doctor will involve a cost penalty as well as the other penalties to reputation and so on. If there is to be a penalty regime, it would be a fair go if the Senate demanded that an equal penalty regime applied to Medicare. If Medicare makes mistakes, if it identifies something of concern and that turns out to be totally wrong and it puts doctors and their staff through hoops, and then finds ultimately that it has made an error, a penalty regime should apply in that case if it applies to doctors.

Overall, though, this appears to be a proposal that puts down doctors. It assumes they are all guilty to start with and then works from there. It gives increasing power to Medicare bureaucrats over clinical decisions of doctors. The examples given by Medicare in their explanatory material prove quite conclusively that they will be in clinical decisions involving the doctors. Thank you.

Senator SIEWERT—Can you explain a little bit further to us whether you see that this legislation could be amended, to deliver what I think you have acknowledged as an issue. Or do you think we should just scrap it and start again?

Mr Rowlings—It needs to be scrapped and started again. It needs a new proposal from Medicare to come back. In the first instance it needs a financial proposal. Medicare needs to prove to this committee that its financial basis is accurate, because if the financial basis is not accurate—as I seriously worry—this will cost Australian money. In two or three or five years time we will find that this ‘project’, as they described it, has actually cost the nation money as well as doctors’ time, patient confidence, privacy issues and all the other incidental things. On the raw basis of money, given the government’s track record and given, particularly, Medicare’s track record of very poor delivery on promised savings, this will cost Australia money. So the legislation needs redrafting, but it only needs redrafting if Medicare can prove, based on their track record, that the claims they make are accurate and that they can deliver. I suggest that the Senate might decide to ask Medicare for a rundown of the past 15 years of claims savings on various projects and what has actually been achieved. I would be very confident that if that evidence is produced the committee will not go ahead with it.

Senator SIEWERT—Just say the financial angle of it is addressed. What sort of approach do you think should be taken to this issue, then?

Mr Rowlings—The approach that should be taken to this issue is to ignore the fact that Medicare wants to grab power and take over a part of the compliance area that has always been the responsibility of the Professional Services Review area. It is basically a grab for power by Medicare into someone else’s domain. What should happen is that the PSR should be increased.

If this is necessary—and it may well be necessary where there is more compliance auditing, as there are many more doctors—then the PSR should be the agency that is getting more staff and more funding to do the job that the PSR is set up to do using doctors to look at clinical information and not public servants.

Senator SIEWERT—I understand the argument between looking at pure compliance and then professional issues around the PSR. I am trying to understand whether or not people believe there is a genuine need for this legislation and, if there is, how we can address the concerns that have been raised. Not all the issues that are being raised are PSR issues, as I understand it. I accept the fact that you increase, if needed, resources to the PSR. But if we are dealing with issues of not just mistakes—I can understand the issues around mistakes—but fraud, some of that is not necessarily for the PSR. How do you suggest we deal with those issues?

Mr Rowlings—If it involves fraud, it is a PSR issue. That is exactly what PSR is set up to do. It is why a separate statutory authority was established and exactly how it operates. This is Medicare trying to take over PSR's work. It is not the other way around. PSR is set up to do exactly what this proposes Medicare will do.

Senator BOYCE—I was wanting to just ask you a couple of questions around your section of your submission talking about lowering the bar. You are suggesting here that you think the definition of 'a concern' needs to be strengthened. Could you go into some more detail as to why you think that should happen.

Mr Rowlings—You and I have a child. The child is out late after dark, eight o'clock, and is supposed to be home at six. If I had a concern for that child, I would not do anything. But if I had a suspicion that that child had met danger I would really jump in and do whatever possible I could do. 'Reasonable concern' is just a very, very light concern issue. It is not enough to justify the hoops that this legislation will put doctors and their staff through and the damage to the confidence and relationships that it will involve.

'Reasonable concern' is not defined anywhere that I can find, in the legislation or in the explanatory material. I do not know what reasonable concern is, but I do know that it is far, far less than reasonable suspicion. We need in the legislation to have a definition of what reasonable concern is, and I would suggest very strongly that reasonable concern is not strong enough as the bar to have somebody trigger the enormous imposts on doctors, their staff, patients and their privacy rights.

Senator BOYCE—You have suggested here that it should require 'a suspicious pattern of behaviour extending beyond three months'. Could you explain why you chose that definition particularly?

Mr Rowlings—It was chosen rather arbitrarily. It might be three weeks, but it would depend on the number of incidents more than the time, and that would depend on the type of practice that the doctor had. But all of this material is available to Medicare through its computer monitoring system and its intelligence gathering abilities through its IT. So it needs to have a pattern—not just one mistake or maybe two mistakes but a pattern of behaviour that appears to make it look as if there is either some error involved or some fraud involved. As we say in our

submission, if it is an error then it can be corrected by education; if it is fraud, it should go to the PSR.

Senator BOYCE—My other questions are related to the area where you talk about ‘creeping compulsion’. I am a little at a loss to understand what you perceive to be Medicare’s motives in establishing this scheme, if it were not simply to create better compliance.

Mr Rowlings—The scheme is designed for Medicare to take over a significant part of the compliance system that has always been operated by PSR. Medicare have long wanted to take over the PSR. Medicare wants to have more of that business. That is exactly what this is about. In terms of compliance, what this does is forces a doctor to self-incriminate. He or she must provide documents which could be used in a court of law and would certainly be used in a court of law if fraud is involved. We have not in the past in Australia had a legal system where we forced people to self-incriminate. However, that is creeping into legislation—outside of Medicare, in other areas—and it is a worry to civil liberties people, because one of the bases of our rule of law in Australia is these safeguards that have always been in the common law and part of the legal system.

Senator BOYCE—Could we go back to your earlier statement there, where you said that Medicare has always wanted to take over the compliance area. Could you give me some evidence for this?

Mr Rowlings—I worked at Medicare for nearly three years.

Senator BOYCE—You did work with them?

Mr Rowlings—Yes.

Senator BOYCE—When was that?

Mr Rowlings—About five or six years ago.

CHAIR—And you have documentation from that period that says that Medicare wanted to take over that work?

Mr Rowlings—I do not have documentation from that period, no, but I was in the public relations section and then in the IT planning section, helping to get the IT strategy ready for the next five to 10 years at that time. But it is just part of the normal argy-bargy between government departments and agencies, where they each want more of the other’s business. If they think it is attractive, they should have it. It is quite common. There is an equal tension between Medicare and the department of health.

Senator BOYCE—I think there is perhaps a difference between that simple impulse to growth that all institutions established by human beings seem to have and—

CHAIR—A strategy.

Senator BOYCE—what you are suggesting, which is a developed plan and strategy, long term, to take over Professional Services.

Mr Rowlings—That is my interpretation of this legislation and the explanatory material. Other people might have different interpretations, but to me, knowing the agency, knowing its background, knowing its wishes and reading the material put in front of me, it is fairly obvious that that is what it is.

CHAIR—Senator Furner, we do not have much time, but do you have any questions you want to ask this witness or put on notice?

Senator FURNER—I will put them on notice, given there are a few of them. Mr Rowlings, we have heard from you your belief that Medicare is trying to take over the role of PSR. Can you indicate where you believe that PSR will lose those powers? Secondly, in CLA's submission on, I think, page 13, you mention 'raw "policing" powers'. Can you point us to any comparable powers that either state police or Federal Police have, such as search and seizure.

Mr Rowlings—That 'policing' is not meant in the sense of Australian Federal Police; it is meant in terms of supervising. Is that your question?

Senator FURNER—You refer to 'raw "policing" powers' in your submission.

Mr Rowlings—Yes.

Senator FURNER—I am asking you to point out what comparable powers either state or Federal Police have, such as search and seizure. That is on notice.

Mr Rowlings—The term 'policing' is not meant to mean police powers. In that context it means supervisory, monitoring compliance powers—the power to police the whole regime around that. That is how that is meant. It does not relate to the police.

Senator FURNER—Righto.

Mr Rowlings—To answer the question that I think you are asking, gradually these compliance audits would take over the role that PSR is doing. So asking Medicare to explain what would be left for PSR to do would be the other side of the question you are asking me. Let us say that these compliance orders come in and they work perfectly. What is then left for PSR to do? I think that is a question that you might consider asking Medicare, because if this works perfectly—

Senator FURNER—I was asking you whether or not you believed PSR would lose those powers. Next, you indicate on page 13 of your submission:

... a doctor's practice can be effectively 'raided' for total production of documentation ...

Can you point to from where in the exposure draft you have inferred that power exists. Lastly, how did you calculate the proposal's hours per week impact on doctors, as indicated in your introduction?

Mr Rowlings—In terms of the ‘raided’ issue, the ultimate basis for this is that, if the doctor does not provide documentation, at some stage Medicare compliance people will go into the doctor’s surgery and look through all the documents held there. That is why we use the term ‘raided’. If you have a look at the addendum, we give an example of how that operates under current compliance audits, as given to us by a doctor. That is what that is about. As for the hours per week impact, it is total guesswork. I do not know. But it is a reasonable estimate, given that I have read the documents, as you have. Other people may have different estimates. Certainly, the doctor representative groups should be able to provide more accurate estimates than I can provide.

Senator FURNER—You made the inference.

CHAIR—Mr Rowlings, what we will do is send you these questions. We need to report very quickly on this piece of legislation, so if we can get the answers back quickly. If you care to give some more comments, we would welcome those, because this is an important area, and I know you have a deep interest in this area and I know you have taken time on it. So we will get to you any questions that senators have put on notice this afternoon as quickly as possible. We have to end here, sir, because we are being evacuated as part of an emergency exercise. So thank you for your evidence and your time.

Mr Rowlings—Thank you. Goodbye.

Proceedings suspended from 10.04 am to 10.36 am

STOKES, Mr David, Senior Manager Professional Practice, Australian Psychological Society

TOMASIC, Dr Maria, Honorary Secretary, The Royal Australian and New Zealand College of Psychiatrists

CHAIR—We welcome Dr Tomasic from the Royal Australian and New Zealand College of Psychiatrists and Mr Stokes from the Australian Psychological Society. I know you have both been here before, so you understand parliamentary privilege and the protection of witnesses. We have received submissions from both of your organisations. I know you will both want to make an opening statement, so we will hear those and then go to questions. We had this session scheduled until 11.30 am, just so you know the time frame in which we are operating.

Dr Tomasic—Thank you for the opportunity to speak to some of the points. As you say, you have the submission from the college, and I would like to reiterate some of the major points in that submission. Some of you will also know that I am speaking as the honorary secretary but also informed by my work, which is in private practice psychotherapy. I also do remote Indigenous work and forensic work. So I think that gives me a broad view of some of the topics.

The college supports the appropriate use of audits. I would like to say that first off. We think they are necessary, we agree they are necessary and there is no problem with the idea of increasing the audits. However, it is the type of information that a service provider needs to produce that we have issue with. We believe that it should not compromise patient confidentiality. This is a factor for all doctors—and also other services, but I will concentrate on the profession—but it is particularly a consideration for psychiatry. The college offers to work with the department and Medicare to ensure that the compliance framework is well informed about the scope of psychiatric practice—for example, subspecialties such as long-term intensive psychotherapy, which is very different to a general practice in private psychiatry. Similarly, the college would like to work with government with regard to what is expected in terms of record keeping in psychiatry.

The college has a very good working relationship with consumer and carer groups and in fact we have members represented on several college committees. I know that they share the same concerns about patient confidentiality. I believe you also have a submission from Janne McMahon from the Private Mental Health Consumer Carer Network.

We consider that there are significant risks when a third party accesses very private and sensitive information that is disclosed in a psychiatric setting. I would like to stress the importance of the context of the psychiatrist-patient relationship and its difference from some other areas of medicine. The relationship itself is actually pivotal to the therapeutic effect. A stigma is still associated with mental illness and with seeking psychiatric help. The relationship relies on the development of a safe and trusting environment, and that trust can take a great deal of time to develop; it can take years to develop. The information that is disclosed to a psychiatrist involves very delicate and private information, often secrets that have not been disclosed to anybody else. Most of you will know that many patients that we see have past experiences of significant abuse, neglect and attachment difficulties, so they have problems with

trust. Trust takes a long time to develop and, once it is developed, that is the only time that they feel safe to disclose their past experiences and other things—things that might not be encountered in other areas of medicine.

People will often disclose fantasies and dreams—things that are very private. They also often disclose information about third parties, which is also very delicate and private information. I think that most patients would be horrified at the thought of someone else knowing any of this information—that even includes another doctor. Often, they are not happy for their general practitioner to know parts of the information that they disclose to a psychiatrist, and when writing to the doctor you would have to omit some information—let alone a Medicare officer or someone else seeing that information. Breaches of confidentiality have very serious consequences: for a start, it can be extremely traumatising to the patient; it can damage and even end the therapeutic relationship, even though it is not something that the psychiatrist has done, because there is no longer that safety and trust; and in the worst case scenario it can produce a suicidal response in certain types of patients.

The other concern that we have in the proposed compliance order initiative, with the possibility that excerpts or whole files can be accessed by a third party, is that it will affect all psychiatrist-patient relationships because patients cannot trust the confidentiality of the situation anymore. Although Medicare has concerns that notifying patients may compromise the provider's privacy and cause anxiety in the patient, the college would say that the patient has a right to know that their file is being accessed. To not do so, from the psychiatrist's point of view, is being dishonest to the patient and betraying them, and that is not an appropriate thing to do. They have a right to know.

I would like to reinforce some of our recommendations. There should be broad consultation with consumer carer mental health organisations, and they should have an ongoing role in monitoring the process, as well as an opportunity to advise on any breaches regarding confidentiality. There should be appropriate precautions put in place to limit the release of sensitive information. There should be guidelines developed on how to inform patients of a psychiatrist when records are being accessed, and there need to be appropriate checks put in place to ensure that that information is managed appropriately and securely.

I would like to make two other comments: one is in relation to the targeting activity. It is essential that the college is consulted on what is deemed as anomalous practice, because our past experience is that Medicare officers do not fully understand psychiatric practices and the various types of practice, and have sometimes identified as anomalous practices which are actually working within the scope of their type of practice; for example, long-term intensive therapy.

CHAIR—Doctor, you just gave a quick example but I think we would all like to know if you could give a little more information on that issue—as something that could be seen as deserving of more investigation from the department from your experience as a psychiatrist. Mr Stokes, even though your experience with Medicare is a little shorter with the psychologists, you might provide information about whether there is a specific practice that you know of that could be misunderstood. It would be good to get something concrete. I am sorry to jump in but I thought I would pick up on that quickly.

Dr Tomasic—That is all right. You probably know that the majority of psychiatrists would have a general practice where they see some people intermittently, some people only once and some people more frequently than that, perhaps monthly. There are people who do more intensive psychotherapy. That might be weekly or twice weekly. The extreme of that is the people who do analysis. They may see people three or four times a week, and that is all they do. They would have additional training. Psychiatrists who are analysts would do another six years of analytic training. They are a tertiary referral. Most of those referrals would come from psychiatrists. They would be people who may have had various other treatments previously that did not work, so they end up in that situation. It is a very small percentage of what psychiatrists do, but those psychiatrists would only do that and they are often picked up as anomalous because of the frequency with which they see patients and the limited number of patients that they have.

CHAIR—They are not different Medicare numbers?

Dr Tomasic—They may use the 319, but not everyone qualifies for the 319. Those people now have patients who personally pay for a substantial amount of their care.

CHAIR—So they do not come under 319?

Dr Tomasic—If they cannot come under 319.

CHAIR—That could cause some confusion.

Dr Tomasic—Because of the frequency and because those psychiatrists would be doing that as their primary practice. That is their subspecialty. They are not going to be doing the other types of assessments.

My last point is on record making. The initiative states that records should be sufficiently comprehensive to communicate the details of the service provided. It is not clearly spelt out what that means. We would like clear guidelines developed, again across the scope of psychiatric practice. I will give an example related to the previous example. When patients are seen on an irregular basis or on a one-off basis, a mental state examination is a vital aspect of the notes that are taken. When someone is being seen for long-term psychotherapy there is not a mental state examination done each time. If that sort of requirement were placed there, it would be inappropriate because these are people a psychiatrist would be seeing on a frequent basis. There is not going to be a change from week to week. They would not always document a mental state examination, nor is that appropriate. That might be one of the things that would be targeted. We believe there needs to be very clear guidelines and they need to take into account different kinds of practice.

They are the major points I wanted to reinforce. Thank you again for the opportunity.

CHAIR—Mr Stokes, do you have some comments to make?

Mr Stokes—Yes. I thank the Senate for conducting this inquiry because it is something we wanted to contribute to as a process and have not had the opportunity. This is a great opportunity; thank you. The society has asked me to stress that we obviously agree with the notion of the increase in the number of audits. We see that as an appropriate response to the fact

that there is an increased number of providers, to which psychologists have been contributors. We agree that the provider should be made to comply with the request for compliance audit. We have no difficulty with that, because we have for a long time agreed with the general principle of accountability for the public moneys and for the creation of trustworthy services. We have no difficulty with that.

I want to stress that the society has ensured in a number of ways that psychologists are compliant with the Medicare process. We have gone to considerable lengths to support our members in providing high-quality services through resources on our web site, particularly for members, and setting standard processes they should follow in regard to Medicare. We have no difficulty with those concepts. Certainly the society has engaged with other societies, like the RANZCP, in the national practice standards for the mental health workforce. That is another project to which we are committed.

But I would just like to reiterate very briefly our concerns about the access to clinical records and the unique nature of the mental health patient's file as distinct from the records of a physician or even a GP. The content of that file makes it quite unique, and the whole therapeutic relationship is dependent on that sense of confidentiality for the client. You cannot even engage some clients until you have made those issues clear and stable and you have gained the confidence and trust of the client. So to in any way unsettle that process is counterproductive in terms of therapeutic interventions. Certainly, as Maria suggested, there is very special content on that file that is very personal, but it also may involve third parties. That sort of stuff does not occur in general medical situations. That is one of the unique features of such records that make them special and different and in need of protection and a particular type of treatment.

I would like to suggest that there be a distinction made in all this documentation—and it is not clear; in fact, it is quite fuzzy on some points—between administrative file information in a clinical practice and the clinical file information. With administrative file information, I am talking about things like appointment diaries, electronic diaries, tax invoices and other administrative records of service. We are comfortable with that being available for an audit. The clinical file information—that is, clinical notes, clinical assessments, clinical reports—is the area about which we have concern. I just want to make that distinction. If, administratively, we could make that distinction in terms of Medicare processes, we would have a much clearer basis for negotiations and agreement.

The society have no difficulty with this once standards and details are set about the sorts of processes that Medicare wants to follow. We are happy to encourage, if not cajole, in fact, members into structuring their administrative records to meet those expectations and requirements. That is not be an issue for us. But we cannot, in light of our code of ethics and interpretation of the Privacy Act, allow access to the clinical file information. That is just an absolute no-no from our perspective. So they are the sorts of issues that we struggle with in terms of this process.

The other issue I wanted to raise was the fact that the clinical file information is such that it is only relevant where there are questions about the appropriateness or the quality of service that was provided, and that is the domain of the Professional Services Review, not this Medicare compliance audit. So my feeling is that not only should a distinction be made between those two processes or aspects of file information but also it should be made clear what and where goes to

which arm of the Medicare process. And, since there is a Professional Services Review, or a PSR, as it is commonly known, that is the appropriate place for a peer review of the appropriateness and validity of treatment. That all belongs there, and therefore that is the only group that should have access to the clinical file. If the compliance audit makes clear what it actually wants to see in the administrative process of the practice then we will be able to access those aspects of the file.

I wanted to comment on the privacy impact statement which was subsequently released by Medicare, because we have had a look at that. Can I?

CHAIR—Yes, absolutely. We are so pleased that you saw it.

Mr Stokes—First of all, I have to regret that it was not released prior to our submission or we would have done our best to comment on it, but if I can just make a few points about it. One regret is that the APS were not consulted by Medicare with regard to this document which we would love to have been—and if there is still an opportunity for that to occur we would appreciate that opportunity.

Once again, though, just as we did with the exposure draft, we felt that there is not clear information in this privacy impact assessment. There is a blurring of administrative and clinical file content. That distinction, I think, needs to be picked up and made. There is almost a conflict in both documents about the stand on these issues. In one breath they want to have access to the clinical record on occasions, and then they raise all sorts of concerns about the complications that that produces for them. My simple reaction would be to say that, if we could make a clear distinction, once again, between the two content areas of the file, then the processes that they enunciate could be much clearer, and they should be. They very clearly say that their access to the clinical record is not necessary or required if the compliance with the administrative information is intact. They are the sorts of things that we would want to insist upon, because it then protects our clients.

This is not about the psychologist's file; it is about the patient's confidentiality that we are focused on here. Psychologists are used to sharing their files with courts where there is a subpoena and a chance to protect yourself from the misuse of the file. You can often ask the Master of the Court to assess whether all of the file needs to be accessed and black out or blank out those areas that are not relevant to the court case. There is no such assurance in the privacy impact statement from Medicare. So we are very uncomfortable with what seems to me a fairly muddled approach to the process as yet, and we hope that it might be clarified in due course.

As a last point, a number of our members and members of our society expressed concern regarding the compliance responsibility implications in both documents. There are concerns that the provider carries the responsibility, it would seem, for Medicare errors, and I will give you a classic example. A practitioner I am aware of received her statement of payments made to her over a period of time and found that a couple of dates were incorrect. When she checked the records she found that the information she had sent to Medicare was different and that there was an error. That sort of error could well be the basis for a compliance audit criticism and if she had not checked carefully that matching of information she could have been held to have received funds for which she did not provide a service. Yet she would have been held responsible for that

error. That seems to me to be a shade unfair and she could even have received a penalty, and it was an error of Medicare not an error of the practitioner.

CHAIR—I am sorry to jump in, Mr Stokes, but if there was an error and there was an audit that came out of that, wouldn't that expose the error? I think that your level of argument is that there was an error—and of course there are always errors in administrative systems; I do not think that we could ever guarantee otherwise. Your practitioner, very rightly, and her office staff found the error and identified it. But the only way there would have been further action would have been if there had been an audit, and it would have exposed that there had been an error. There is no automatic penalty. I think that it is important to acknowledge that this system does not automatically find people guilty; it is an investigative system. In terms of the level of argument, I accept the fact of a practitioner actually getting information from organisation like Medicare and saying, 'We found these things and we just want to check them out.' That is the process and that would have exposed the error. Your practitioner would not have been immediately punished because of the error.

Mr Stokes—I am reassured by what you say, but it is not the way that the documentation seems to convey its message, and I would like that clarified.

CHAIR—We will certainly take it up with the department. I just want to make sure that it is sequential and there is no concept that people are automatically punished.

Mr Stokes—Thank you, and I am reassured by that. As I say, when we read the documents we were not reassured, so it would be good if it were clarified.

CHAIR—Maybe we need to have more communication.

Mr Stokes—Absolutely.

CHAIR—I do apologise. I do not normally interrupt but I just needed to make sure of the facts. Is that the end of your statement?

Mr Stokes—It is the end of my speech, thank you.

Senator HUMPHRIES—The college has raised in its submission, Dr Tomasic, the issue of a breach of confidentiality being very traumatising and devastating for a patient. As you say, it could even provoke a suicidal response. The suggestion has been made in other submissions that if this process is to go ahead then it should be accompanied by proper notification to the patient that the records are going to be accessed for the purposes of an audit. Under the present proposal, of course, there is no notification and the records can be accessed without the patient even knowing about it.

Which do you think is the lesser of the two evils there? I imagine there would be great uncertainty and concern felt by patients knowing that their records are being accessed for an audit—in some cases at least. Is it better for them not to know and therefore not to risk that kind of adverse reaction or is the right to know that the records are being accessed more fundamental and the risk of harm being done in those circumstances overridden by that need for them to know what is going on?

Dr Tomasic—It is a real dilemma because it is a lose-lose situation, isn't it? We believe that, because maintaining trust and not betraying your patient are pivotal parts of the treatment of the therapeutic relationship, to do that would be to actually do those things. Therefore they do need to be informed. You risk damage; but there would be more damage done if they were to find out afterwards having not been informed because that would be an outright betrayal and that would have a greater risk of harm. So I think they do have a right to know but it needs to be done in a very careful way. It certainly needs to involve the therapist doing that and not just a letter from an agency saying, 'Your notes are about to be looked at.'

Senator HUMPHRIES—The psychological society's submission makes a recommendation that all references to access to clinical information as part of the compliance audit process should be removed from the bill whereas I think there is a difference in the college's submission. It recommends that appropriate precautions be put in place to limit the release of sensitive confidential information. Perhaps there is not a contradiction. Are you suggesting from the college's point of view that it should be possible to access the information?

Dr Tomasic—We do not think that clinical information should be accessed, but if it is going to be accessed then it needs to be dealt with in a very careful way. So we are covering both possible outcomes.

Senator HUMPHRIES—Do you think what is in the exposure draft of the bill already adequately protects people against exposure of information in that way?

Dr Tomasic—No, I do not think it does. The college certainly does not think it does.

Mr Stokes—I would add that I do not think there is a good defence in any of the documentation as to why that clinical information needs to be accessed. That is why I think it would be helpful to make a clear distinction between what is administrative information and what is clinical information.

Senator HUMPHRIES—At the heart of this issue is the question of mistake or fraud with respect to the making of claims under Medicare. No-one has been able to quite quantify what the extent of that problem might be. Do you have any information you could provide the committee about your sense in which there is a fringe—I presume it is only a fringe—in your respective professions of people who might be deliberately fiddling the system and the extent of the issue that we need to confront here?

Dr Tomasic—I do not think I can comment on that. It is bound to happen. It happens in all professions but I cannot comment on what the extent of that is. I think it is a tiny minority who do. More frequently, the people I know spend more time with patients than they are actually claiming for—and that would be the majority. So I think it is a tiny minority. It is bound to exist. I cannot estimate how many that involves.

Senator HUMPHRIES—Lastly, would you see in these arrangements a significant administrative burden being placed on the shoulders of psychiatrists and psychologists in administering the extra levels of compliance and dealing with the audit responsibilities that the legislation foreshadows?

Mr Stokes—It would be, I guess, where an audit is requested because it does mean having to go back to information—for instance, even if it was a diary it would be necessary to blank out those entries that were not relevant to the audit, because usually it is focused on a number of particular services and therefore a particular set of patients. So there would be administrative processes but I think it is a reasonable price to pay and that society feels the audit process is a way of putting a check in and instituting an accountability. Although we recognise that it will be an imposition on some, it is a reasonable price to pay.

Senator HUMPHRIES—So the audit is okay but the disclosure of private medical records as part of that process is not okay.

Mr Stokes—Yes, that is not okay. I do not know quite where they will go in those circumstances because they are instances where the access to a clinical record would be absolutely opposed, if you like, in terms of the practice of a psychologist; and what they would do under those circumstances I do not understand entirely. It is one of those things that we feel is just not comprehended by Medicare if it thinks that this is okay to dabble with. It just is not, and we have serious concerns.

Senator FURNER—Can you just let us know what the process is now in regard to the PSR coming in and reviewing a patient's records. Does a practitioner notify that particular patient that the PSR is coming in to review their records?

Mr Stokes—I am sorry, but because we are new at Medicare we are not aware that any psychologists have been subjected to that process. We have read the documentation so we are familiar with the fact that it exists but the details of the process I cannot comment on.

Dr Tomasic—My understanding is that they do not have access to the clinical records but they would have access to the sorts of administrative information that David spoke about.

Senator FURNER—But in that circumstance do you notify that patient that those records are being examined by the PSR?

Dr Tomasic—I cannot provide statistics of how many people would and how many would not. I know that some do notify their patients that this is occurring, but I am sure that many do not.

Mr Stokes—We would recommend to the member that they should notify the patient under that sort of informed consent process but it would be up to the individual practitioner as to what they did.

Senator FURNER—Your submissions say that Medicare Australia will be able to access all information recorded by doctors for individual patients, including information which identifies patients, their attendance and the services which were rendered. But is it not the case that Medicare already has the capacity to identify a patient, where they attended and the services that were rendered through the billing information process?

Mr Stokes—Yes, that is true and we have a difficulty with that because not only is that just a matter of public record in the sense that Medicare has it but also it is legitimate information for

an audit. So that is not the issue and that is why I think this clear distinction should be made between what we have described as administrative information and clinical information. It is that distinction that we want to see instituted or placed into the discussion if not the legislation.

Senator FURNER—But the PSR deals with issues associated with inappropriate practices not administrative issues—is that not the case?

Mr Stokes—Yes, and I would have expected—because this is not familiar territory for me—that that would be a peer review of the file in some circumstances.

Senator HUMPHRIES—So is being done by practitioners looking over other practitioners' work rather than bureaucrats doing it.

Mr Stokes—Yes, that is my understanding.

Senator FURNER—You also go on in your submission to indicate that this could also include a full patient record where Medicare determines it necessary. What sort of Medicare items do psychiatrists use that you think might require the disclosure of full records rather than just extracts or redacted versions?

Dr Tomasic—The plan is to be able to access records. So the potential is there. Obviously Medicare would not always do that or would not always choose to do that but the potential is that they would require the full records to be available.

Mr Stokes—And no indication of how they will limit that or what provisos they will allow you to express or institute. The full record is the full record. In practice, that means a manila folder or an electronic file which gives everything about the patient—their assessment, their ongoing sessions, their personal information and records of conversations and details that were necessary for the therapeutic process.

CHAIR—I am just a little concerned because, in my reading—and I certainly have no professional expertise either working in Medicare or working in your professions—in the questions and answers there it says the Medicare process would be to contact the doctor or the doctor's practice and seek information about a particular line item. Then it is up to the practitioner or the medical administrator to determine what information needs to be provided back to Medicare. I do not see anything in the documentation, as I read it, that there is any intent through this stream to have access to the full files. The onus of what would be necessary to provide proof of a use of an item was clearly left to the professional understanding of the practitioner. I am interested to hear from both of you—and I am sorry for jumping in on your questioning, Senator Furner—from a psychiatrist's and a psychologist's point of view, the kinds of information that you would believe you would have to provide from a file—all the details you have given us, the sensitivities and all those things which we respect deeply. To follow up on whether a person was referred for a test, which is one of the Medicare items, what kinds of personal information would you need to provide? The information I have in front of me—and I am very keen to just get this really clear—is that this line of audit is an administrative audit. The professional side is for the other side. It is spelt out in the document that anything to do with clinical practice or appropriateness of treatment is not included in this audit. It is up to the professional group to do that, as you have quite rightly said.

Concerns about access to files seems to be the major issue for both of you. Can you give us a particular example through this process, which would be looking at which item number was used and the veracity of the use of that item number, of what kinds of details from a personal file you believe you would need to show? That is what I think we are trying to trawl down to. With a full understanding of the need for privacy concerns, as has been spelt out in the privacy statement, and the kinds of sensitivities that you have spelt out and the need for confidence and all that stuff, what notes would you have to provide giving private information? That is what I am wanting to find out. Can you give me a practical example from a treating perspective. If Medicare comes along and says, 'There have been a large number of usages of this number and we want to check out what processes have gone on and what has been the cause of the use of this particular process,' what would you then need to take from your personal and professional records in that interaction?

Dr Tomasic—I am happy to start. First of all, I would like to repeat what was stated earlier. The privacy impact assessment has only just come out. We received that late last week, so we have not had a chance at all to review it fully or to comment on it. We would appreciate the ability to do that.

CHAIR—Sure.

Dr Tomasic—Our understanding of the reading is that potentially it might be necessary to provide all information recorded to Medicare.

CHAIR—Can you point me to where—

Dr Tomasic—I do not—

CHAIR—I have not found that from my reading but we could be misinterpreting it.

Dr Tomasic—This could include the full patient record. I think psychiatric practice might be different to that of some other doctors in that regard. It is seldom going to involve referral for tests because that is not done very often and it is only done at the beginning of the initial assessment. I guess the easiest example to pick is the more intensive therapy. Say that somebody is being seen frequently—

CHAIR—Like the 319?

Dr Tomasic—Perhaps not the 319 because they are required to have criteria, but perhaps someone who is doing psychotherapy, using the 50-minute session—the 306—but is doing that frequently. How does one prove that it is appropriate to be using that frequently with one patient? The only information that you could use to do that would be their clinical information, because it is not dependent on the diagnosis. It is dependent on a diagnosis plus their childhood history, plus their relationship history, the things that have happened to them, things that are continuing to happen and how they think. Only someone's clinical history could provide that information, so our fear is that that is what would be required in those situations.

CHAIR—We need to find out from the department, and I would expect certainly that your college would be asking the department directly so we have something really specific to follow

up. For the psychiatrists, it would be the use of the 306, which is the longer session that you have. The series of sessions are billed differently, so if there were a feeling that that particular item was the stimulus for the audit, if that particular item were under investigation, you would want to know exactly what kind of information would be required. Is that right?

Dr Tomasic—That is not the only one, though. That is just an easy example to give, but I think it could include all. We clearly believed, as did the psychologists, that the reading is that it could potentially include all clinical information. I am not quite sure, apart from the administrative details such as timing and frequency, which we would expect Medicare to ask about if it were doing an audit, what other information is going to prove that it is being used appropriately.

Senator HUMPHRIES—Could I just step in and clarify. When you say ‘clinical information’, do you anticipate that that means showing somebody the actual clinical notes that the psychiatrist has made in the course of their consultation?

Mr Stokes—It certainly would be a possibility if ‘clinical information’ is not clarified. That is what is lacking here. What is really meant by ‘clinical information’? If Medicare is saying that, if in the process we discover that a diagnosis was made because of the implication of the referral or something, and that is all it is meaning, then that is reasonable because it is part of the administrative procedure. But, from the point of view of a psychologist, there are no referrals made to others because there are no services accessible by psychologists. There is already a limitation on sessions, so overservicing is unlikely to be a major issue. But, if there were a concern that somebody was doing 18 sessions on a regular basis and Medicare wanted to know why, the information that I assume they would want to know is: when did these happen and were they genuine sessions? So the diary would be the source. But then we ask: why do you need to have this rider saying ‘but we may need to access clinical information’ unless you are doing an appropriateness check, which is the domain of the PSR? So I think it is terminology. I am prepared to assume that what is being said here is a general statement which covers a whole range of activities which are perhaps being seen more sensitively by the mental health services, who may not in actual fact be the focus of that particular terminology. But, while that terminology exists and the possibility exists, we have to protect our clients from that process.

CHAIR—I think it is because this process is to apply to a whole range of medical professions.

Mr Stokes—That is exactly what I meant.

CHAIR—Each group may well have their particular questions, because it does not just apply to psychologists, psychiatrists or orthopaedic surgeons.

Mr Stokes—I am sure it does not.

Dr Tomasic—That is right.

CHAIR—It is the whole Medicare system.

Senator SIEWERT—But the point is that you could include something in the legislation, surely, or a legislative instrument even, that dealt with separate professions as required, if necessary.

Mr Stokes—I guess from our point of view that is why we thought, ‘Wouldn’t it be nice if we actually separated out the types of information you are talking about,’ because once you say clinical information—

CHAIR—That is where the red lights come on.

Mr Stokes—Radars go out. We say: ‘What do you mean? You are not going to actually access the file?’ There are powers given to the CEO of Medicare to do so if necessary. We say: ‘Why? What are you going to get from the file that you cannot get from our diaries?’ That is the practical question. From a psychologist’s point of view, since it is only going to be a question of whether treatments were actually provided on the date specified, then certainly administrative information like a diary is all you need to access. If in the process you have identified a patient and a service was provided—Medicare already has that information anyway—we have got no problem. But if clinical information means accessing the file of a clinical nature then we are in real trouble.

Senator HUMPHRIES—There is no way of de-identifying the patient’s information in that process, is there?

Mr Stokes—Absolutely not, not without a lot of work to go through and change everything and so forth. Anyway, if it is the file they want they already know who the patient is, so what can you de-identify? So I think it is a question of communicating clearly what is actually meant by some of these terms. You are quite right: they have tried to be written for a range of circumstances and it has just created anxiety in some areas that were probably unjustified but that needed to be clarified.

Senator FURNER—I guess that is why the discretion is left to the practitioner to decide what sort of information should be provided.

Mr Stokes—I am not comfortable that that is the case, because the powers are given to the CEO of Medicare to order such things as he or she feels are required. That seems to override any practitioner sensitivity. Once again, I think it is a question of getting the process clear and setting the limits on that process that will make us feel more able to cooperate with it. Because we want to, in principle. We just cannot let the client’s information be exposed to something that we were not expecting, which is what we are not clear about.

Dr Tomasic—It is certainly the college’s view that currently there is some discretion about what information is provided, but our reading is that this actually limits that and that it can be required.

CHAIR—I think there is an expectation that there is going to be communication. The request is made: ‘We are wanting to seek out information on this item,’ and the practitioner responds about what they are prepared to provide or not provide and it gets into a discussion. The current situation, as you both agree, is that some practitioners have just refused to communicate, and that

is the rationale that has been put in this statement as to why there needs to be a more focussed process. Senator Furner, I apologise for jumping in there. Do you have any other questions?

Senator FURNER—Not at this stage, thanks.

Senator SIEWERT—Again, if you have answered this question, just tell me to go and look at the *Hansard*. A number of people from the medical profession have said they absolutely do not want this legislation. I get the impression from both of your organisations and your evidence that you are not saying, ‘Do not have the legislation’; you are saying that you have got concerns and you are asking for those concerns to be fixed.

Mr Stokes—Absolutely; that is our position.

Dr Tomasic—And we do not want the legislation as it stands. But we certainly understand the need for audits and have no problem with that in itself.

Senator SIEWERT—Both your submissions have made constructive recommendations and suggestions for amendments. That is why I am asking. You were making what I thought were constructive suggestions—different people may have different opinions—whereas other submissions are saying, ‘We just do not support this legislation.’ I wanted to clarify your position. The other questions I had have been asked.

Senator BOYCE—Mr Stokes, I would just like to follow on from what you said earlier about perhaps using a diary entry to check the frequency of a claim or something like that. Surely then the next step for Medicare would be to confirm with that patient that they did attend those sessions, for instance, which brings us back to the whole question of a patient being aware that this is happening and so forth.

The College of General Practitioners suggested that, if this were going to happen, it should be Medicare approaching patients to ask for permission for their records to be accessed, rather than approaching the individual practitioner, because in the college’s view that would help to isolate the practitioner-patient relationship from this other area and would perhaps also help patients to understand that not every inquiry was suggestive of potential malpractice, that there were other things that Medicare could be caring about. Could you—after that very long question—tell me your views on those points?

Mr Stokes—Thank you, I would like to add to what was said about that. In a sense, I feel comfortable with the Royal College of GPs’ position too in saying that the access should be to the patient, but as long as the practitioner is warned that this is going to happen because there may be some backwash. From the psychologists’ point of view, what we would want to be very clear was that what was said in the letter was clearly what was being accessed and that the clinical file was not being accessed, so that the patient’s confidential information was protected by this process and that merely what was being accessed was the question of a record of services and to whom. That we have no difficulty with, and want to occur, because it is good practice. What we want to assure the patient is that there is nothing of their confidential record being approached. That is why the whole question of health information and clinical information, which does occur throughout these documents, needs to be determined and clarified and that distinction made; then we are comfortable.

Dr Tomasic—I would like to reinforce that. There is a very big difference between the patient simply aware of an audit, where that is an audit of the psychiatrist, not of the patient, not of their information at all, and a situation where access to clinical notes was a possibility of that process, which would have to be handled very differently.

Senator BOYCE—Do you think it would affect your business, though—which was a suggestion that was perhaps being made by the GPs—if patients were told you were being audited? Might they consider going elsewhere?

Dr Tomasic—I think that depends on the relationship that you have with that patient. I think if you have developed a good strong therapeutic relationship it will not result in that. It would be discussed in; it would probably take a whole session. You would just talk about the fact that this is a process and that it is about you and your practice, not about them. You would deal with those things, so it would not necessarily result in that. But I think it is different for a psychiatrist because often they have developed that kind of relationship and so things get talked about, rather than simply acted on. For other doctors, I think sometimes that would be the situation.

Senator BOYCE—Mr Stokes, your submission raises the matter of Medicare making administrative errors, which is not something that is actually covered in the Medicare report. Could the two of you give us an indication of the level of concern you have about that area and also talk a bit about your comment that providers could end up being made liable for Medicare's errors.

Mr Stokes—I gave you a real example of the practitioner whose records did not comply with what the Medicare record was. Clearly, because she checked her records and what she had sent to Medicare, she knew that the error was Medicare's. Once again, there could be a question of who was responsible; I am satisfied by the response to that. But I have another instance in the back of my mind where a client received benefits for the services provided but was nonetheless, not because of her mistake but because of the Medicare mistake, not entitled to those rebates. I do not know whether you know the process for psychologists but there must be the reception of a GP referral item before a psychologist's rebates can be paid to the patient. In this instance, without the practitioner knowing, Medicare had paid these benefits even though there had not been a GP item referral received, and then Medicare sought to recover those. That seemed to me like an error of Medicare, not an error of the practitioner, and so that seemed to me unfair. It became a real battle royal, which has not been resolved yet.

That, to me, is not a fault of the practitioner, who, in good faith, has sent off the claims on behalf of the client and has been paid for them. The reason they had been paid was that there was an oversight by somebody of the fact that the GP item had not been received et cetera. That to me is the same sort of thing: the practitioner is being asked to bear the responsibility for that, regardless of who was at fault. I think it needs to be said somewhere that if Medicare is in no way at fault then the practitioner has to bear that responsibility.

Senator BOYCE—What would the view of the society be regarding the level of administrative error made by Medicare?

Mr Stokes—With all new items, you expect a teething period. I think that it is pretty good; there is currently a low level of errors. But it is certainly disruptive to practitioners when they

have to find \$4,000 or \$5,000 to pay back some six months down the track. They are the sorts of things that have occurred but very rarely and, by and large, I have every confidence that this process works. But when there is an error, let's at least be fair about who takes responsibility for that error.

Dr Tomasic—It has not been raised as a significant issue for psychiatrists. Our greatest concern is the inappropriate targeting of anomalous practice. That would be more of an issue for psychiatrists.

Senator BOYCE—As you have already pointed out, there is really no way of knowing whether a practice is anomalous without looking at clinical records and that brings us into—

Dr Tomasic—It is possible to develop guidelines on that but, if the department and Medicare worked with the college, we would certainly be able to help develop guidelines because there are different kinds of practitioners and they have different practices. They should be compared against each other, not against the broader group.

Mr Stokes—I would have thought anomalous practice was, once again, the domain of the PSR anyway rather than the Medicare audit compliance.

Dr Tomasic—No. It becomes a question of overservicing.

Mr Stokes—But if you wanted to push that through, yes.

Senator BOYCE—To try and understand what constitutes overservicing you really need to look at the patient, don't you?

Mr Stokes—You do.

CHAIR—Dr Tomasic, if you have a chance to look at that privacy impact statement and you wish to put more comments in, we are due to report at the end of next week so it is a tight time frame. I know, Mr Stokes, you found some issues you particularly wanted to raise from that, so there is that possibility. Thank you so much for your time. I have one question to clarify and will ask other witnesses as well. When the records are used for PSR investigation—I know that Dr Tomasic and Mr Stokes would not at this stage have any record of this and I know that psychiatrists have been subject to that—are you aware of the records process there?

Dr Tomasic—Not clearly enough to be confident to explain it.

CHAIR—All right. I just want to be clear in terms of people's understanding of the process. Our next witness is from the Public Interest Advocacy Centre, via teleconference.

[11.33 am]

DODD, Mr Peter, Solicitor, Public Interest Advocacy Centre

Evidence was taken via teleconference—

Mr Dodd—PIAC is a non-profit organisation that works on public interest issues, including legal strategies, and has involvement with law reform. The PIAC submission sets out PIAC's previous work in health and privacy issues. PIAC does welcome the opportunity to make this submission. Our submission is mainly focused on the draft bill that has been circulated. PIAC does recognise that the draft bill does raise two potentially competing public interest principles. The first is that there is a public interest for Australian consumers in the maintenance and integrity of Australia's universal healthcare scheme, Medicare. On the other hand, there is a distinct public interest in the confidentiality of communications within the doctor-patient relationship that is recorded in the medical records of patients. PIAC strongly believes in that principle—that medical records are totally confidential—and, therefore, medical records should be provided with the same stringent protection as other sensitive information and privacy principles and privacy laws.

Having said that, PIAC did make some comments in its submission about the terms of reference of the inquiry. I will not go through all of those, but it is important to highlight some of them. PIAC was of the very strong view that if any information could be identified during the process then it should be. It was very clear in its submission that there should be a stepped review process. In other words, sensitive information should not be accessed unless there is no alternative to that course and that should be a decision that is made by senior officers of Medicare. Having said all that, PIAC concludes that the bill, together with the privacy safeguards already in place for Medicare, appropriately balances in the public interest in the integrity of Medicare and the public interest in the maintenance of patient confidentiality and privacy of health records. PIAC have had the opportunity to look at the privacy impact statement and PIAC think that the recommendations there are positive ones and could be implemented.

Finally, PIAC was concerned about the nature of the public debate about this issue. Our submission says that it has been misdirected and often verged on the hysterical, and that we are probably more concerned about privacy issues that might arise from greater corporatisation of medicine in Australia than arise from this legislation. Thank you.

Senator SIEWERT—Thank you for your submission. You raised a large number of really interesting points. I want to ask you a couple of questions and ask you to explain a few things in your submission a bit further as well, if that is okay.

Mr Dodd—Certainly.

Senator SIEWERT—I want to come back to this issue about the multi-step process around decision making about the collection of clinical information.

Mr Dodd—Yes.

Senator SIEWERT—But one point I did want to ask you about—and I will probably jump around the submission a bit—is seeking consent. I appreciate the argument that you make about not seeking consent but rather informing patients that their records are being accessed. The point that has been raised in some of the other submissions is that you impinge on medical practitioners' rights because you are going to a patient and informing a patient that their records are potentially being accessed so that then informs the patient that the clinician is being audited. The point raised in a number of other submissions is that that is not fair either. Do you have a response to that?

Mr Dodd—Yes. I think there is a general principle that if personal information in the form of health records is accessed, then that person should, in a general sense, be informed. That is a general principle and I think that should be adhered to unless there are particular reasons to divert from that. The privacy audit does mention that and gives reasons why that might be problematic. I think that could be in some ways countered by the way that that information is given to health consumers. I think it could be made clear in that notification that there is no finding against a particular practitioner concerned. And there should be a thorough explanation as to why the information is being accessed. But, nevertheless, there is that general principle that if someone is going to access your personal information, you have a right to know about it.

Senator SIEWERT—And that, basically, is the overriding principle—that is, the patient has the right to know if their records are being accessed.

Mr Dodd—That is correct. You could take that further and say that they have a right to say yes or no, but PIAC recognises in this situation that giving the consumer that veto would probably undermine the scheme totally and is not practical. But those general principles still apply.

Senator SIEWERT—You touched on this issue in a number of places in your submission, and you made the point in your oral evidence, that you thought there had been an overreaction to this legislation. You make the point on page 5:

PIAC sees nothing in the draft Bill or Explanatory Memorandum that suggests existing practices, as outlined above, will be overturned, and finds no evidence to suggest that the drastic outcomes predicted by the AMA would occur unless there are other significant changes in the future to existing Australian law and practice not found in the Bill in question.

There has been a number of submissions that point out very strong concerns about the breaching of confidentiality in the giving of clinical information. We have just had psychiatrists talking to us about their concerns. To me, these seem to be very genuine concerns. It is not just about them saying, 'We don't want you to audit our records'; they are very concerned, particularly psychologists, about access to clinical data. They have suggested that the wording is more clearly defined about what 'access to clinical records' means—whether it is the administrative or the clinical records—and I must admit that I am concerned about this issue of access to clinical records. I accept the point you make in your submission that, yes, confidentiality is paramount, but there are circumstances where these records are accessed anyway. I am not quite sure that they are the same circumstances that we are talking about here.

Mr Dodd—Certainly in New South Wales, the Health Care Complaints Commission and the medical board have power to access medical records following a complaint. I know that is a little

bit different, but nevertheless there is some analogy in those procedures. PIAC was probably reacting in some ways to statements by the AMA, which was suggesting that records would be available to all and sundry. The AMA referred to court records being available, and our submission tried to indicate that that probably is not going to happen given the existing practices in the courts where patients are clearly de-identified in those circumstances.

Senator SIEWERT—In your submission you talk about your concerns, particularly in large medical centres and in aged care facilities, and you give some examples. Do you have evidence that supports these issues? Where can we access the data that particularly picks out those two?

Mr Dodd—You are talking about the fact that patients are told to go to one particular diagnostic service or another?

Senator SIEWERT—Yes.

Mr Dodd—I think that is just anecdotal evidence. I am not sure whether there has been any study of that, but I have certainly heard of cases where people have been told that they must go to this particular diagnostic service.

Senator SIEWERT—And in aged care facilities? The issues around overservicing?

Mr Dodd—I think that that is a general concern. The practice is, as you know, that GPs quite often attend aged-care facilities and see lots of patients. For how long they see them is a bit problematic. I am not suggesting that there is always fraud or always misconduct, but it certainly lends itself to overservicing at some level.

Senator HUMPHRIES—I must say I was a little bit concerned about your submission. You say at the outset:

PIAC submits that the principle that patient medical records are totally confidential and that medical records should be provided with the same stringent protection as other sensitive information ... is a fundamental one.

You then go on to say that access by bureaucrats under this audit process should be able to proceed. You suggest some protection for the records through de-identification once they reach court proceedings but not before that point. You say that a patient should be notified of their records being accessed but the audit should not proceed if they cannot be, for some reason, reached or notified. And you say that they should not have the right to refuse consent to having their records audited. With great respect, it really seems to me as if there is not much left of the principle that you state here that patient medical records are totally confidential, if all of those concessions are made.

Mr Dodd—Every right that we have as citizens is to some extent subject to other rights. We have emphasised that there is a right of Australian consumers to have access to Medicare, and that the maintenance of Medicare does depend on the integrity of the practitioners and the financial viability of the scheme. So that is an important right, and that is something that we recognise. We also recognise the right to confidentiality that people have at all points of the process, not just in the courts system. Rights always have to be balanced in these and other circumstances. I do not think I agree with you, with all respect, that this will greatly threaten a

right of confidentiality or privacy. I think, as we pointed out in the submission, the law surrounding subpoenas would probably more greatly threaten that right than this legislation.

Senator HUMPHRIES—All of the other witnesses we have had today have argued that the access to the private records is a bridge too far in one form or another. You go to some lengths to identify the issue of making sure that the records, when used in a court, should be de-identified. But isn't the real problem with this legislation that it allows access to people's records at a much earlier stage in proceedings through the audit process? These are not medical practitioners reviewing the processes used by other practitioners; these are bureaucrats checking the records to see whether what is on the claim form by the doctor matches up with what is on the clinical records. Wouldn't it be extremely corrosive of the patient-doctor relationship to have strangers poring over the medical records? Isn't that really a fundamental blow to that principle that you state, that patient medical records are totally confidential?

Mr Dodd—I do not see it as corrosive of the doctor-patient relationship. It is an exception to that question of confidentiality. There are other exceptions. There are exceptions, as I said, in terms of subpoenas. There are exceptions in terms of investigations by the police. There are exceptions in relation to complaints made to health care complaints commissions and organisations like the medical board. These rights are not absolute. PIAC are very clear that we think that the integrity of the Medicare system is very important. I think that the arguments that have been put up in support of the legislation are valid in the sense that there does seem to be some need to increase the level of audits. The public would expect that.

Senator HUMPHRIES—We have a different view about what the public would expect. If people knew their records were being checked by bureaucrats and confidential information on those was available to people, I think that they would be horrified. But we have our own assessments to make about what the public might think about that.

Mr Dodd—I think it is a very good recommendation that is made. The privacy impacts assessment says that the public should be informed about the fact that their records may be used. The records can potentially be subpoenaed today; they can potentially be obtained by the police in the course of their investigation; and they can be obtained, as I said, by health care complaints commissions and by registration boards.

Senator HUMPHRIES—These are all in circumstances where some actual evidence has emerged of a problem and reasonably the records need to be examined in order to deal with a live issue which is actually there. I think people would expect some access to records in those circumstances, however reluctantly. But surely people will have concerns with simply looking at the records as part of a bureaucratic exercise in auditing. Won't that be exacerbated by the existence of notification? You get a note saying, 'Your doctor's records are being audited and we intend to examine your personal medical files in order to see whether your doctor has been claiming appropriately against Medicare.' Won't that send a shiver down a lot of people's spines and cause them some concern?

Mr Dodd—As I said to the committee earlier, and as the submission says, these are two conflicting public interest principles. There is a public interest principle in the confidentiality of Medicare records but there is also a public interest in the integrity of the Medicare system. People are concerned that doctors are basically, to use the vernacular, ripping off Medicare.

There is concern in the public about that and we cannot ignore it. I am not suggesting that the majority of doctors want or intend to rip off Medicare, but I think that it is true, on anecdotal evidence, that not all doctors are honest. It is very competitive out there and there are a lot of temptations for doctors to not necessarily abuse the system but to cut corners. There has to be a public interest in that as well. Those two public interest principles have to be balanced. I am not suggesting that it is a good thing that people's records are accessed, perhaps without them knowing, but it is also not a good thing if the costs of Medicare increase for consumers. And it is not a good thing if the Medicare system is ripped off. I have worked in the health complaints system and I do know that people are concerned when Medicare is abused.

Senator HUMPHRIES—My last question is this: the doctors who appeared before us today have said quite strongly that they feel that the disclosure of records would be corrosive of the doctor-patient relationship. That is their professional opinion. You have said that that is not the case. Can you offer some evidence to suggest that people would not in fact feel less comfortable disclosing matters to their doctor knowing that they can be disclosed to bureaucrats under a review?

Mr Dodd—I agree that that is a concern, and that is why the legislation and policy should have all the safeguards possible. But I think that those issues have been addressed in the Privacy Impact Statement. Generally speaking, it seems that the Privacy Commissioner has come up with the same conclusions that PIAC has, that on balance, with appropriate safeguards, the legislative model generally protects consumers. I am not sure what you mean when you say it is corrosive to the doctor-patient relationship. I think the doctor-patient relationship is a little bit different to a question of confidentiality.

Senator HUMPHRIES—Confidentiality is part of that relationship. You can disclose to your doctor that you have a mental illness or a venereal disease or HIV or whatever it might be and know that it is just between you and your doctor and not going to be shared with some bureaucrat from a department.

Mr Dodd—You used the word bureaucrat. Presumably, the people that are involved are aware and trained about privacy. I think that is part of the Privacy Impact Statement. I am not sure that the people that you call bureaucrats are any less reliable than other people who have access to medical information and I am not sure whether every doctor in Australia respects privacy at all times. There are complaints to health care complaints commissions and medical boards et cetera about doctors breaching confidentiality.

Senator HUMPHRIES—Are you suggesting that, because some doctors breach confidentiality, we are generally entitled to forget about confidentiality when it comes to accessing records?

Mr Dodd—No.

Senator HUMPHRIES—What does that have to do with the issue of records generally being made confidential and retained as confidential?

Mr Dodd—I am saying that it is a difficult issue. You have referred to bureaucrats dealing with the information. I am not sure why bureaucrats could be any less or more trusted than anybody else. That is the only point I make.

Senator HUMPHRIES—Thank you.

Senator FURNER—Mr Dodd, in relation to records access I do not know whether you have had an opportunity to read the Australian Health Insurance Association's submission which indicates they have access to records as part of their audit process. This appears to be comparable with what is being proposed. I also understand that that submission has been supported in that part by the Consumer Health Forum. I take it that it is consistent with most insurance firms that they have access to types of information where there may be inappropriate or fraudulent claims so they can identify those types of issues. Once again, can I take you to your position on that type of access to records, please.

Mr Dodd—I have not read that submission. I think we would be a little bit more concerned about that sort of access than the access that is proposed here. I think that that is one of the points that our paper makes, that the protections that you find in the Health Insurance Act, the protections that are now suggested by the audit, are far stronger than the protections you find in other areas, certainly in the private sector where there are opportunities for access. That is one of the areas. I have not read their submission and I do not think I can comment any further on that, and I am not suggesting that there are not legitimate purposes for health insurance organisations to have access to medical records, but I would be far more concerned about that—unless again there were safeguards in place—than I am about the current legislation.

Senator FURNER—In your submission you referred to safeguards associated with the proposal. In fact, you indicated they provide a higher level of protection to the privacy and confidentiality of personal health information held by Medicare Australia than the protection afforded similar information held by the private sector. I guess that is going back to the statements that you have just made. I am wondering whether you can provide some examples to the committee of the latter, please.

Mr Dodd—I think it is not so much a question of examples. I think the reality is that everyone is subject to the privacy legislation—the federal privacy act. What the Health Insurance Act and the provisions in this recommendation provide are extra safeguards. PIAC welcomes those. PIAC actually suggested additional safeguards in its submission. But in the private sector you have the privacy act and nothing else. If you look at section 130 of the Health Insurance Act you will see that it provides pretty stringent penalties for people unlawfully disclosing information. Those penalties generally cannot be imposed on people in the private sector.

Senator FURNER—Would you suggest therefore that the proposal may help improve the handling of personal health information anyway?

Mr Dodd—Absolutely. I think the sorts of provisions that are suggested in the privacy audit and that are already in the legislation should also be applied to the private sector. Contrary to what has been suggested, we are strongly of the view that confidentiality and privacy should remain paramount. That should be reflected in those sorts of safeguards. But we also recognise that sometimes, in the public interest, records can and should be accessed.

Senator FURNER—Does the centre have any views on obtaining patient consent at the time of a claim as per private health insurance?

Mr Dodd—I think that is covered by the submission. We recognise that giving the patient effectively a veto over whether the information is used is not practical. There is a danger that doctors could pressure their patients not to consent. Take the scenario of a patient in a regional centre. There are a lot of regional centres in New South Wales which have just one doctor. If the doctor is subjected to an audit, patients are going to be very reluctant in that situation to consent, even if there is not pressure put on that patient by the doctor. So we just do not think that having the absolute consent of the patient in the legislation is practical. It is a good principle to have. I do not think there is any doubt that, as a general principle, there should be a requirement for a patient to give consent for their information to be accessed by other sources, but we do recognise that there are competing public interests here and that the public interest in conducting the audits have to be taken into account.

Senator BOYCE—You mentioned under section 3 the idea of de-identifying information. Can you explain to us exactly what you mean when you say ‘de-identify’? What would it involve doing?

Mr Dodd—I think that if a patient can be de-identified at any point then they should be de-identified as a matter of course. In my experience in the court system I have had some experience in disciplinary tribunals for doctors, nurses et cetera. In that court situation, people are referred to as AB or AD. They are not referred to by their full name if they are patients and not a party to the proceedings. I think that should take place as a matter of course at any time, even when they are being dealt with by—and I will use Senator Humphries’ term—bureaucrats. I think it is just a safeguard. But, on the other hand, we would recognise that there are times when the need for patients’ names and identities to be identified would be an essential part of the process. I think those situations are referred to in the privacy impact assessment.

Senator BOYCE—So the practitioner would be the one who would, in your view, be doing the de-identifying?

Mr Dodd—Not necessarily. I have got to say that I think that we recognise that de-identifying patients is probably not going to be possible in many of the cases, and it may be possible at one stage of the process and not possible at another stage in the process. It is certainly not going to be possible—

Senator BOYCE—It also has the potential to be a very lengthy and time-consuming exercise, doesn’t it, for whoever is going to be responsible for doing the de-identifying?

Mr Dodd—I am not sure if I agree with that. Clearly, if you are marrying up patient records with other records then you need the name of the person. But if the information goes on a file then the identification of the person is not necessary at all—and, if there are further records made, someone could be referred to as patient A or patient B or whatever. I cannot see why you would need to identify people in documents produced in records after that. These are all minor safeguards. You might suggest that they add to the cost of the process, and that might be true, but they also reduce the potential for that sort of information to be inappropriately disclosed.

Senator BOYCE—I am trying to think of what sorts of files you have in mind. Practitioners have spoken about perhaps simple diaries and other non-identifying administrative files, but then the only other files are the clinical notes of the practitioner which would identify the patient very clearly, I would have thought.

Mr Dodd—Not necessarily. Someone's clinical notes may not refer to someone by name.

Senator BOYCE—You do not think they would have a name on them?

Mr Dodd—They would have a name on the front. I quite often have access to clinical notes; they do not have the name of the person identified on every page. You could de-identify a document like that.

Senator BOYCE—And you do not think potentially identifying information would be in those notes?

Mr Dodd—Yes, of course that is the case. Nevertheless, I am just trying to talk about reducing the possibility of that information being disclosed to the wrong person; I am not saying it would eliminate it.

Senator BOYCE—Nevertheless, if you were to go about trying to de-identify clinical records, for instance, someone would need to read through the entire record, would they not, to ensure that that had happened?

Mr Dodd—Yes, that could be done; yes, I agree. You might say that would be unnecessary and costly, but it could be done.

Senator BOYCE—It could be done, but it could be very time consuming, could it not?

Mr Dodd—As a legal practitioner I have had to do that time-consuming process as part of presenting evidence in relation to a prosecution of a matter in disciplinary proceedings, and it is a time-consuming process, but it can be done.

Senator BOYCE—Nevertheless, we are talking about circumstances which are extremely different, are they not, from those regarding a prosecution? We are talking about inadvertent potential errors.

Mr Dodd—Absolutely, and that is why—

Senator BOYCE—So to require the same amount of time to be devoted to something like that seems unusual.

Mr Dodd—Yes. Our submission says:

... if any personal information can be de-identified without undermining the integrity of the audit process ... then it should be de-identified.

It is again a question of balance. This is a balancing process and we accept that.

Senator BOYCE—Thank you.

CHAIR—Thank you very much, Mr Dodd. If there are any further comments you wish to make, if something comes to mind, please let us know by getting in contact with the committee.

Mr Dodd—Yes, thank you very much. Thank you for your time.

Proceedings suspended from 12.10 pm to 1.37 pm

CLARKE, Dr Roger, Chair, Australian Privacy Foundation**FERNANDO, Dr Juanita, Chair, Health Subcommittee, Australian Privacy Foundation**

CHAIR—Before we hear from the Australian Privacy Foundation, I want to put on record that, after discussion, the committee believe that we need to seek an extension of our reporting date, which we have agreed to be 10 June. The reason for the extension is that the privacy impact statement, which is so important to this whole discussion, was late in being able to be seen by many of the witnesses and, as we saw this morning, very few had been able to get across it. We will be contacting the witnesses we had this morning and confirming that, because we had asked them for further comment, and we will also be mentioning it to our witnesses this afternoon. I want it clearly on the record that the reporting date for this particular piece of legislation will now be 10 June and so further comments can be put forward to us, as well as answers to questions on notice, in the next couple of weeks.

I now welcome Dr Clarke and Dr Fernando from the Australian Privacy Foundation. Had you been able to have a look at the privacy impact statement?

Dr Clarke—We have received the privacy impact assessment report. We have not had an opportunity to evaluate it yet.

CHAIR—Given the organisation you represent, it is most important that you have a chance to look at that. Information on parliamentary privilege and the protection of witnesses and evidence is available to you. We have your submission, thank you very much. I now invite either or both of you to make some opening statements and then we will go to questions. Your evidence is scheduled until 2.15; we will see how we go with the time.

Dr Clarke—Thank you very much. The Australian Privacy Foundation is a longstanding advocacy organisation for the public interest in privacy. It was formed in 1987. We have made a great many submissions to a great many organisations, many to Senate committees. I have been its chair for the last three years. I am a longstanding board member. My background is in information technology in the broad. I am an e-business consultant in the daytime, most daytimes. My colleague Dr Juanita Fernando, who is chair of the health subcommittee, also has an information systems and business systems background but her doctorate is in health information systems and, in particular, in the security and privacy aspects of them. So between us we bring quite a lot of expertise to bear on the subject matter, despite the fact that it is a voluntary organisation.

There have been several iterations that we have gone through since last September with the agency, with little success, and now a submission to you and the invitation to provide a further one now that we have a PIA report to look at. It seemed appropriate that we briefly summarise our positions on the process that has been undertaken, the product that is before the Senate and what the APF believes the appropriate steps are from here.

A couple of points about the process are that the bill and the explanatory memorandum provide no evidence to us that any of the submissions made to the agency in relation to the

initiative's privacy impact have been reflected. The second point is that the PIA was conducted behind closed doors, so the agency was not in a position to assimilate the messages that the representatives of patients' interests have been trying to provide. The agency had indicated certainly to me quite some months ago that it would not be releasing the PIA report, but it has now done so, to our surprise—but of course it has done so in such a way that we cannot reflect it, either in our submission to you or in what we are saying to you today. As far as we can see, the PIA was performed without the assistance of anyone with appropriate expertise in the area, and the reason this is evident is that there are far better balanced design features and amelioration measures available than have been provided in this bill. The aims could be achieved without the substantial privacy breaches that are currently inherent in the bill. So the process is one aspect.

As to the product, firstly and fundamentally, the bill would create powers to expropriate sensitive patient data. It is quite a substantial set of provisions in there, with substantial powers. Second, the exercise of those powers could be justified merely by, to express it in short form, reasonable concern that there may have been an overpayment. That is far from sufficient for such serious breaches. The third point is that the bill would overturn the existing privacy protections. It is specific in subsection 8. Fourthly, the bill fails to specify appropriate security safeguards for the data, either in transit or in storage, despite claims in the information sheet that there would be such safeguards specified. Fifthly, the individuals who would access the data need not be medically qualified. That undermines their capacity to understand the data and it certainly undermines their ethical obligations in relation to patient privacy, which are quite critical parts of the privacy protective framework.

The sixth point—of, I promise, only nine—is that there is no requirement that the patient be notified of the expropriation of their sensitive personal data. Seventh, there is no requirement to minimise the privacy intrusiveness of the actions taken using the power. So the power is granted but without any forms of constraints on the manner in which it is exercised. As examples of that, there is no requirement that the data required by the agency be de-identified at any stage; copies of the data can be made, which will multiply the risk factor; and there is no preclusion of the production of identified patient data in court, and that, of course, would then result in that data escaping into the public sphere. All of those are simply omitted. Finally, if the bill were passed in its present form, it would erode public confidence in the privacy of patient data. If that occurs, patients are going to suppress information—that is a natural behaviour on their part—and indeed providers would fail to record information where they felt that it was too sensitive and too much at risk.

What we put, therefore, as our conclusion, firstly, is that passage of the bill would result in an adverse impact on the quality of care. So it is not just a privacy issue; it is also a quality issue. As to the next steps, the APF submits that the Senate committee should find that the bill in its current form fails to reflect serious privacy concerns and fails to propose a balanced solution. We further submit that the bill should be withdrawn and, if it is not withdrawn, then it should be rejected and it should be resubmitted only once it has been significantly amended to reflect the serious privacy concerns it gives rise to and to implement appropriately balanced measures.

CHAIR—Dr Fernando, do you want to add anything at this stage?

Dr Fernando—No, that is fine.

CHAIR—Senator Siewert.

Senator SIEWERT—I want to go to your last comment first, Dr Clarke, about amending the bill. Could you take us through some of the amendments that could be made to the bill that you think would make it acceptable. Your first comment was that you do not disagree with measures to ensure that the funds are appropriately spent. So I suppose my first question is: do you think there is a need to tighten up current procedures? I will ask that first, because my other questions go on from there.

Dr Clarke—If I can cut through to it, the bill as it stands is not a suitable basis for amendment.

Senator SIEWERT—I appreciate that. So you are saying: ‘Start again. Don’t amend it; start again.’

Dr Clarke—It does not reflect sufficient consideration by the agency of what the conflicting factors and conflicting interests and values are. If the agency steps back, looks at the various factors and then comes forward with a design that will achieve each of the aims, then it will have a very different shape to the one it currently has. Currently, it basically gives carte blanche power to the CEO. It does not submit the CEO to constraints, neither justification constraints at the outset nor control measures once data has been collected, and each of those is an absolute necessity for data of this kind. So it really has been misconceived and it needs to be started again. That is why we have gone to this fairly unusual position of saying we just do not think this is a salvageable bill; it should not be in the Senate.

Senator SIEWERT—Okay. Where would you start, if you were redesigning the bill?

Dr Clarke—We would start with the requirement statement, because we are systems people, and then we would end up with a bill at the end of the process. The requirement statement would lay out a series of things—we have put the framework for that in our papers—saying what the requirements are from a privacy perspective. They would then be lined up against the requirements from a procedural perspective in order to achieve audit. One of the biggest stumbling blocks is this major problem of access by people without appropriate qualifications to clinical data. Clinical data is extraordinarily easy to misinterpret. I have a wife and a daughter in the medical profession and I have conversations with them, and my ability to misread and misinterpret and misconstrue written medical information is extraordinary—

Senator SIEWERT—If you can read it!

Dr Clarke—So for us that is an absolutely crucial issue that is not addressed here. There is an existing professional review scheme in place which involves appropriately qualified people looking at documents when there are sufficient grounds for them to do so. This is quite different.

Senator SIEWERT—I will take a step back. When the two doctor groups were presenting to us this morning, the psychologists and the Australian College of Practitioners, we talked about wording and meaning, and they were questioning the meaning of ‘clinical records’. So my question is: do you think you need to access clinical records? And perhaps ‘clinical records’ is

being defined in a very broad way; if it were just the administration side of things, what would your comments be?

Dr Clarke—Some of the difficult examples that were put forward in the information sheet are related to item 2517, ‘requires a completed range of checks’. Understanding what one is looking at in a doctor’s records—in this case we are talking about a doctor, I believe—and understanding that this therefore implies that those tests were or were not ordered presumably requires some insight which I do not have. I would be very likely to misconstrue those records and I am more representative of the kind of bureaucrat who, under this scheme, would be looking at those documents. So, from a systems analysis viewpoint, the sheer effectiveness of the control mechanism of the audit process is not facilitated. It is not going to work.

CHAIR—Dr Clarke, I do not understand your point. The example was about checking that the test had been done. It was not looking at the clinical veracity of the test; it was not looking at any of the professional practice; it was purely looking at whether the test had been done. That is what they are seeking. So I do not understand your point about needing to have a professional background to check whether a test had been done. I perfectly understand if you are looking at whether a test was justified or whether there was an appropriate professional reason to do it, but that is a clinical issue which is not part of this audit. It was clearly a ‘was it done’ question. That is what I took it to be. On that point, I am not clear about what your objection is. I am sorry, Senator Siewert; I just wanted to clarify it straightaway.

Dr Clarke—My concern is the scope of the misunderstanding by the person looking at that document.

CHAIR—Whether a test had been done or not?

Dr Clarke—Yes. When I have looked at the only documents I am familiar with, which are for blood tests performed on me, I have had to ask questions. And I have some knowledge in this area, with a daughter who performs these sorts of tests as a nurse. I have looked at the document and had to scratch my head as to how the nurse who was filling in the form understood that those ticks there would actually achieve the seven things that we discussed. It requires more than lay knowledge in a lot of these circumstances.

CHAIR—About whether or not a test had been done.

Dr Clarke—My example may not have been a good one.

CHAIR—Dr Fernando, were you wanting to add something?

Dr Fernando—The only thing I would add is that quite often when a patient is undergoing some testing regime we are not looking at a single test; we are looking at a range of tests. So auditing whether or not a test had actually been done might tell you whether one test had been done but it would not tell you the range of tests that had been done.

CHAIR—But would it actually match up with the number that was claimed? The point is that this audit process is looking at, ‘You have claimed test 1234. Test 1234 allows you to have this and this and this. Has this patient had this and this and this?’ Not, ‘Why?’ not, ‘By whom?’ not,

‘What was the purpose?’ That is the audit. So I am just wanting to clarify. I am not questioning whether or not someone needs to understand. I am just wanting to know what is the level of professional medical process which you are stating in your evidence you would need to know whether test 1234 had been done.

Dr Fernando—It depends upon the Medicare Benefits Schedule, and I am not as familiar with it as, obviously, MBS is. But it depends on what is contained in item 1234. For example, a patient might have had item 1234 and 155. MBS might ask about 1234. Only a clinician would know that 155 went with that test. In other words, generally speaking, tests are not in isolation. They are generally paired to other forms of diagnosis. For that reason, I think that a clinician should be involved.

CHAIR—Sure. I just wanted to make the process really clear. Sorry, Senator Siewert.

Senator SIEWERT—That is okay, because it is really important that we laypeople understand all this as well. The argument I take is that any look at any clinical data should be done by the PSR.

Dr Clarke—When there are sufficient grounds for access as part of an audit process then the individual who inspects the record should be a person with appropriate medical qualifications. It used to be easy to say, ‘It should be a doctor.’ Even that was not quite right, because it may need to be a doctor with a particular specialisation. But increasingly now we are talking physiotherapists, we are talking about specialisations. So, yes, for both reasons: the effectiveness of communication reasons and avoidance of misinterpretation and clearly from a privacy perspective, because the privacy constraints on qualified medical practitioners of all kinds is far greater and far more satisfactory from a privacy viewpoint than the secrecy/confidentiality constraints on public servants.

Senator SIEWERT—You make a number of points in your submission around data. For example, audit data should not be stored in a single database and things like that. That is why I went to that question in the beginning of whether you think this bill should be amended or whether we should start again. All these points, I therefore presume, given your answer previously, are what should be taken into consideration in a new bill.

Dr Fernando—Yes.

Senator SIEWERT—Is that a correct interpretation of your position?

Dr Clarke—Yes. The depth to which a bill should go in specifying the solutions is of course an open question. What we are saying is that there is currently not even a framework for it, and this is of sufficient significance that there should be some level of specificity in a bill like this.

Senator SIEWERT—In other words, in the bill you build in the protection to guarantee that people’s privacy will not be violated.

Dr Fernando—Yes.

Senator SIEWERT—I may be going into too much technicality, but what you are saying is that some of these data issues could then be done as a legislative instrument, so you would not necessarily include that in the legislation. You include the protections.

Dr Clarke—Indeed. There is general support, when there is a suitable framework in the legislation, for greater detail to be in regulations.

Senator SIEWERT—In your submission you said that you have made two previous submissions: to Medicare and to the department. Have you been involved in any consultations with the department over either this bill or prior to the bill being developed?

Dr Fernando—Yes. I cannot remember the exact dates so I will have to go through it.

Senator SIEWERT—I do not need to know the dates.

Dr Fernando—I had a meeting with various officials from MBS. That was in November. That was a face to face meeting in Melbourne at Monash University, where I work. I have had two further meetings that I would call phone meetings with Colin Bridge and—actually, I think they were both with Colin Bridge. One was fairly recent—the last one was in March and I will check my records for the date of the first one—

Senator SIEWERT—Where I am going with this is that you have talked to them but from your submissions I understand that you have not had the response that you think is—

Dr Clarke—Correct. Can we make it that there are two legs to it. The first one is that the consultation that was taking place was based on two and a half pages of text and no more, and that text changed slightly during the course of those discussions. The evidence that we have in the bill shows two things: that the things that were submitted were ignored and, secondly, that the things that are in the bill do not reflect the information sheet; there is inconsistency between the two.

Senator SIEWERT—And you make that point in your submission.

Dr Clarke—So such consultation as has occurred has been of the very low grade variety and totally unsatisfactory from our perspective. Indeed, we understand that Medicare were also dissatisfied, because they wrote down different notes from the meeting from those Dr Fernando wrote down from one of those meetings.

Dr Fernando—In fact, one of the opening statements Colin made was that Rose was very surprised at our submission, given our meeting in December. That was the opening of our conversation. So clearly there is some ambiguity there.

Senator SIEWERT—Maybe it is just not agreement. Consultation and agreement are two different things.

Dr Clarke—I agree.

Senator BOYCE—Dr Clarke, you mentioned early in your statement the design features and amelioration measures that in your view needed to be applied to this legislation to make it acceptable. Have we covered those design features and amelioration measures, as you put it in your evidence to date? Is there any other important issue that you would like to put into the system?

Dr Clarke—We have given examples. We have not been comprehensive. As a declaration of interest: I am a consultant and I probably do 20 per cent of my consultancy in these kinds of areas and I can write chapters on a range of these things in appropriate circumstances. The role that we play as the APF is, of course, to draw attention to policy issues and to indicate directions rather than trying to do free consultancy because we will not make a living if we do it that way. So what we have drawn to attention in this one-page document, a copy of which, with your permission, I would be pleased to provide as a supplementary, is to highlight a couple of the key words and then to give a couple of examples of the sorts of safeguards and balancing measures that could be achieved.

Senator BOYCE—Dr Fernando, I presume that within the sort of systems that you normally work with, e-health would be one of the areas?

Dr Fernando—It is, yes.

Senator BOYCE—Are there any lessons from the sorts of privacy issues that are being considered in terms of an e-health system that we could be applying here?

Dr Fernando—Are you talking about any changes you can implement or are you talking about—

Senator BOYCE—You were talking about the storage, the dissemination and the protection of information. These are all issues that are going to be—

Dr Fernando—Yes, that is right.

Senator BOYCE—Further issues within the entire health system. Are there lessons there?

Dr Fernando—We come back to this idea of a single database. You only need one person to make an error. I am not even talking about a technical error or a black hat with some kind of evil or malicious intent. We are talking about an error. Just a simple human error can bring a single database down. In fact, there are lots of media releases internationally that indicate the fact that does happen. There are errors that occur. With people, errors happen.

Senator BOYCE—That is right.

Dr Clarke—If I could just add to that, we have made a succession of submissions on electronic health related matters over the last few years. Dr Fernando has joined the board only in the last 12 months and she has been responsible for a huge flurry of work since then. We have gone closest to codifying what we think should be done in the context of NETHA submissions in the past, which have been by and large ignored, and we are hopeful that we will find the resources, meaning enough of Dr Fernando's time, to revise, revisit and codify into a small

document a set of principles that would address this and a great many other issues. This was not the primary target area; there are a great many other initiatives around Australia at the moment at federal and state level which are much fuller electronics health record proposals which have major problems. So we are endeavouring to do that but we cannot currently table that. I am sorry.

Senator BOYCE—That is fine. I would be interested to see that when you do have it. That would be very good. You have also noted in section 4 of your material that research suggests that many staff tend not to be adequately trained to handle secure information. Could you just flesh out that comment a little bit more?

Dr Fernando—Sure. Basically, if you look at research that is coming out from the States, the UK and my own research and you talk to clinicians and you ask them about what training they receive in terms of information privacy and security, the responses are really rather alarming. A minority of clinicians say that they have not been trained at all, but of those that have been trained what they say is that the training generally occurs several weeks prior to when a new electronic system is being rolled in, so it has no relevance. They do not know what they are being trained to do or what they are being trained to use. They do not know what the problems are. There is no relevance to their practice concerns and there is no relevance to their everyday clinical concerns. The sorts of examples they are giving are: ‘Today, if I have to send an email on a patient to someone, how do I comply with the law?’ I think probably the worst thing for everyone in hospitals in terms of updating people and providing training on privacy and security is that they actually attach amendments to the legislation to their salary slips and clinicians are expected to read those amendments in their own time and incorporate them into their practice. No-one actually checks to see that this legislation is actually being incorporated at the ground floor, the critical level, the patient care level.

Senator BOYCE—Are you talking about clinicians specifically here?

Dr Fernando—Yes.

Senator BOYCE—What about administrative staff? I read that comment to be more directed at the sorts of Medicare staff who might be looking at data.

Dr Fernando—I could not make an educated comment about that. I do not really know if there is a lot of research about it. I know that there is a lot of stuff coming out of the UK about the fact that the NHS is not training its staff properly to work with their electronic health system. In fact, that has been the basis of lot of the data breaches that we have been hearing about internationally. But I cannot actually point to any particular direction.

Senator BOYCE—The sort of evidence that we have been getting to date suggests that if this legislation were to go through in its current format we might get as an unintended consequence a change in the way notes are taken and kept. Do you think that could be a problem, Dr Fernando? Would you like to comment?

Dr Fernando—I have spoken to Rose Ross from Medicare about this as well. I work in the medical faculty at a university. A lot of the people who work in the medical faculty are practising clinicians as well as researchers, so they are practitioner-researchers. My understanding is that

they tend to keep parallel records. They keep one formal record and another informal record. It is really easy to read into that informal record keeping that there is some kind of evil intent or wrongdoing.

Senator BOYCE—It is like keeping two sets of books, with one for the taxman type of thing.

Dr Fernando—That is right. But that may not necessarily be the case. Again, quite often patients come and talk to clinicians and say, ‘Look, I’d rather you didn’t put this in my record. Can you put that in my record, because I’ll be really embarrassed if that comes out. I don’t want that to come out. I don’t want my mother to know. I don’t want my father to know. I don’t want my wife to know’—whatever. So very often the reason for two sets of records is not necessarily any wrongdoing. It is simply to protect the patient’s privacy.

Senator BOYCE—And that exists now, you say?

Dr Fernando—Yes.

Senator BOYCE—And is perhaps much expanded?

Dr Fernando—I believe so.

Senator BOYCE—So it is current practice?

Dr Fernando—Yes, I believe so. But again keep in mind that this is from my own straw polls. I just ask people things. As I go around, I will put questions to various clinicians in my environment.

Senator BOYCE—What about the point that Medicare has put that a lot of the numbers in the schedule would tell you what someone has anyway, whether they are a diabetic, whether they are pregnant—whatever?

Dr Fernando—Yes.

Senator BOYCE—So there is already quite a lot of personal information encapsulated, so to speak, just in that number. What is wrong with more of that sort of information being available?

Dr Fernando—I think it goes back to what I was talking about earlier—that is, patients will actually say, ‘Look, either don’t put this down or put this down on another number, because I don’t want someone to know.’ So on the one level Medicare is right. People do understand what 213 means. But I am saying that, if patients have to take a piece of paper with 213 on it to their local Medicare branch to get a refund, they do not want 213; they want 354 because 354 is less embarrassing for them than 213. That is what I am trying to say. Does that make sense?

Senator BOYCE—Yes, it makes sense. It does not make administration easy, but it makes sense.

Dr Clarke—One other point is that the big proportion of items are the short, medium and long consultations. So while what you say is quite true, that there are quite a number of

condition specific items on the schedule, a big volume of them are not condition specific. So we have a lot of concern—and have had since 1983—about the extent to which there is disclosure of patient data just in item numbers. It is not a flood. The flood is in this person went to the doctor.

Dr Fernando—I have an article from the press, so there is no research, about people using personal health records. A commercial brand of personal health record was drawing data from something like a Medicare organisation and, because there were not the right item numbers and the item number did not match the patient's illness, administrators were putting the next closest number. Using the next closest number had really dire consequences for the patient who read about themselves on this personal health record and read about all these dire illnesses that they had no idea that they had contracted and, in fact, and had not contracted. It was simply that there was an umbrella term, an umbrella number. I am happy to forward that article.

Senator BOYCE—Did that occur in Australia, Dr Fernando?

Dr Fernando—No, I think it occurred in the States. That was last week.

Senator BOYCE—Thank you.

Senator FURNER—What sort of proposals would you consider would help bring down the non-response rate of 20 per cent to your satisfaction?

Dr Clarke—Sorry, which non-response rate are we talking about?

Senator FURNER—The 20 per cent.

Dr Clarke—Nonresponse of what to what?

Senator FURNER—The nonresponse of the auditing—of those that do not voluntarily offer those sorts of auditing responses.

Dr Clarke—With respect, that is something that I could be asked as a consultant but I do not believe I can be asked it as a privacy advocate. It is up to Medicare and its supporting consultants to build the case and to show the need. Let us be clear: we are not disputing that there is a need for controls on overpayments that are accidental, overpayments through little white lies and of course overpayments through outright fraud. Not for a moment are we opposing that motivation; what we are saying is that this is not being gone about in the right way.

Senator FURNER—In your submission you indicate that the committee should ensure that patient consent is necessary for access to any clinical details unless the authorities possess reasonable grounds for believing that fraud is committed. Does that suggest that the foundation supports the provision of the information if consent is provided?

Dr Clarke—Consent is always obviously fully informed and freely given et cetera. Yes, proper consent is always the basis. The Australian Privacy Foundation has no role to tell people how they should go about protecting their privacy or how they should value it. Our role is to

draw out information about privacy risks and about ways to ameliorate privacy risks not to tell people how to value things.

Senator FURNER—If the doctor voluntarily provides the information based on their professional judgement—that is, he or she accepts that being provided as appropriate—then are there adequate safeguards in place within Medicare Australia?

Dr Clarke—Firstly, it appears that there has been a moderate amount of this going on. Our view on that is that it would appear that Medicare has been procuring disclosure of sensitive patient data in contexts that are purely administrative contexts. If that were the case, which is not before this committee, we would be very concerned about that too. Whether there are sufficient grounds is a crucial test here. A vague suspicion based on some unclear audit sampling that maybe there has been an overpayment or two here does not appear to us to be sufficient grounds for breaching patient privacy. If we go to the other end of the spectrum—reasonable grounds for suspicion of fraud—then the game changes. The next question is: who is it who is going to see these documents. We have gone through that point already. The greater the protections that exist—and in particular the protection of professional expectations and ethical obligations—the stronger the privacy protection there is and the less concern there is from a privacy viewpoint. But when you move it to a general public servant with an administrative interest and without clinical knowledge looking at that material then the concerns go up again.

Senator FURNER—I think you indicated earlier that you have not had an opportunity to look at the PIA yet, have you?

Dr Fernando—No.

Senator FURNER—It might allay some of the concerns you have in that particular area.

Dr Clarke—I have to say that I have serious doubts based on flicking through the pages, but we will of course evaluate the PIA and see whether it is consistent with either the bill or the information sheet.

CHAIR—As an ex public servant, the process around the criminal charges and the dismissal provisions for breaching privacy as a federal public servant seems to me to be a very high bar. On three occasions in your evidence you have dismissed that as somehow some kind of low level of awareness of and adherence to privacy principles. Do you have any evidence about a low punitive process or a low awareness process within the Australian public service on privacy issues? Dr Fernando talked about medical practitioners and their concern, and that is something that is very serious about their understanding of the process; but, as you mentioned three times in your evidence your concerns about a bureaucrat or public servant and their low levels of responsibility, I am keen to know whether you have any evidence that we can learn from in the Australian public service to show where there is a lack of very strong support for privacy—and there are very strong penalties if any public servant is found to have breached that—because that seems to be the basis of your concern in some ways. This is apart from your concern about clinical evidence; this is specifically on the issue of privacy.

Dr Clarke—It is one of a basket of points.

CHAIR—Yes, but I was a public servant and I am very concerned about the integrity of the public sector—and issues around privacy and dismissal. It is a case of criminal charges and a criminal record if you are found to have actually released information that is part of your job. Is there something in that with which you are not satisfied?

Dr Clarke—Yes, very much so.

CHAIR—I would like to know, because you have said it three times—four times.

Dr Clarke—The provisions do exist and the provisions exist in many agencies and they are differently framed in many different agencies. Some agencies would appear to have essentially never had any form of prosecution and would appear to have had very little in the way of disciplinary procedures to the extent that we can tell. Until relatively recent times there were not many agencies that had made much impact at all in the use of those provisions. In recent times we have seen the opposite occurring—we have seen it in Centrelink, in state governments, we have seen it in police forces around the nation and in the ATO. We have indeed seen prosecutions. That is good news and bad news. It is good news in the sense that: a) the provisions exist and can be enforced and b) they have been. But on the other hand it means that it is not a terribly effective deterrent because there are still people doing it and there are still prosecutions each year coming through Centrelink and the ATO. So the effectiveness is insufficient.

I did not intend to suggest, and my apologies if I did, that it is totally ineffectual. That was not my intention. What I was talking about was a higher standard. The public believes much more in people who have committed their lives to various kinds of medical support than they do in people who have committed their lives to being public servants. That is a simple fact of people's preferences and beliefs. So, no, we do not believe that the public service provisions have got the same strength as professional obligations.

CHAIR—We will get a comment from the Public Service Commissioner and the privacy ombudsperson on that issue because it is a threshold issue in terms of the understanding in the privacy process.

Senator FURNER—Obviously you are not satisfied with the proposal. Are you willing to put something forward as an alternative?

Dr Clarke—If I were a consultant being paid to do this sort of thing, of course. This is a voluntary organisation that is responding to an initiative by a government agency. We have drawn attention to a set of deficiencies in here and inconsistencies between documents provided, which shows that no attention has been paid to the privacy issues. We have made some suggestions about the general frame for safeguards and we have provided several examples of the sorts of things that should be done. There is ample information and ample expertise in the consultancy sphere in Australia to provide Medicare Australia with the information they need. Clearly, I can no longer tout for that kind of work. I would have no difficulty in finding appropriate balancing mechanisms and amelioration measures. Other colleagues and competitors of mine in the market space could do the same thing.

Senator FURNER—Obviously, you have shown an interest in the proposal so no doubt you should be in a position to provide at least one single practical example that might need to be considered.

Dr Clarke—Our submissions already provide multiples of them. We would be delighted to do so but at this time of day I suspect that the chair would not be pleased that we went into details.

CHAIR—We would be very keen to get some more feedback, though that is on the basis of suggestion rather than absolute decision.

Senator HUMPHRIES—A witness earlier today suggested that when medical records are accessed for the purposes of a prosecution of a practitioner for defrauding Medicare or when there is a requirement for some other kind of investigation the principle that the privacy of records must be sacrosanct is breached anyway and therefore this measure to allow for random audits of patient's records is really just an extension of that same principle and should not concern us. What is your response to that argument?

Dr Clarke—We completely disagree with the proposition. Serious crime, and the investigation and prosecution of it, clearly justifies much more in the way of compromise of other interests than administrative overservicing. It is quite extreme of the agency to be suggesting that all forms of infringement and all forms of suspicions about even accidental overservicing are sufficient to justify substantial invasions of privacy in relation to sensitive data. From a privacy viewpoint it is an untenable position to adopt in our view. It is not reflecting the values the Australia population places on privacy.

Senator HUMPHRIES—Are there any parallels you can think of for this sort of intrusion into confidential record keeping that might be relied on as a precedent for this kind of legislation.

Dr Clarke—We would be concerned about any precedents we could find. Nothing comes to mind. And note that we have talked in our submission about the fact that there are no controls on the justification up-front—the CEO determines or the CEO suspects and therefore a document or an excerpt therefrom can be demanded by the CEO. There is no justification requirement along the lines of: 'This is a sufficiently serious matter and the particular data being demanded is sufficiently minor in its sensitivity that, therefore, the balance is reasonable'. There is no such requirement anywhere in the act.

If you want suggestions about how a replacement bill might be framed, they are some of the sorts of things that would have to go in it. There is just not a sense of proportionality in here at all.

Senator FURNER—There are submissions from the Australian Health Insurance Association indicating that they are going to have an issue with the access to records as part of their audit process. I take it that you have not had an opportunity to study their submissions, but what is your view on the private health insurance organisations having access to records?

Dr Clarke—I am filled with alarm at one level but I may be misunderstanding what their proposition is. I am afraid I am not familiar with their submission so I do not know what they were actually seeking. Are you saying that they were seeking—

Senator FURNER—Are you aware that they have access to records for the case of completion of the processes in insurance companies?

Dr Clarke—I am not aware of the processes that are involved—no.

Senator FURNER—Do you have an issue with that?

Dr Clarke—That would depend. Clearly there are needs for control mechanisms for private sector and public sector insurance—that is a given. It is the manner in which those control mechanisms are designed and the extent to which they take into account, or fail to, the privacy of the patients. But I regret that I am ignorant about the process and about their submission.

Senator FURNER—So you do not have a fundamental issue with the accessing of records but it depends on what depth they go to.

Dr Clarke—That is right. To be clear, once again there is an existing professional review scheme in the Medicare environment and that one involves sufficient cause and it involves medical professionals being the ones who check the information that is being provided. That is much closer to a balance. That is one we have never got ourselves involved with because we look at it and we think ‘Well, it looks like things have been weighed up, different interests have been balanced against one another and I think we have got other things to do.’ If it is designed in that manner, as we would hope, then we would not be focusing attention on that. If on the other hand they had access of the kind that is being sought by Medicare Australia we would be very concerned. We simply do not know, I am sorry.

CHAIR—We have an extended date, as you know, so when you have a chance have a look at the privacy statement. If you could give us some feedback on what you think about that and whether there are any follow-up suggestions that we could take through.

Dr Clarke—I am afraid I should have been able to pick how long a deferral to 10 June represented and therefore guess that we might get about that long to—

CHAIR—No, we have to table on 10 June so we would like some response within a week.

Dr Fernando—It extends to the weekend.

CHAIR—By 29 May, which is longer.

Dr Clarke—That makes it a little easier.

CHAIR—To the secretariat by 29 May in the same way as the previous ones.

Dr Clarke—Thank you. We can do that.

[2.24 pm]

EDMONDS-WILSON, Mrs Ellen, Chief Executive Officer, Medical Indemnity Industry Association of Australia

CHAIR—Welcome. Information on parliamentary privilege and the protection of witnesses and evidence has been provided. We have your submission. Would you like to make an opening statement?

Mrs Edmonds-Wilson—Thank you for providing the MIIAA with the opportunity to speak further to our submission to the Senate Community Affairs Committee inquiry into compliance audits on Medicare benefits. By way of background the MIIAA is the peak body for medical indemnity insurers and therefore our submission limits its discussion to those areas of the exposure draft that will have an impact on the 70 per cent of insured doctors represented by our members.

The MIIAA acknowledges the need for accountability mechanisms and controls within Medicare Australia and supports a program of appropriately directed and soundly based compliance auditing and education. What is proposed, however, meets neither of these two criteria. What is proposed will create additional uncertainty for the medical profession and further diminish the capacity of practitioners to devote their time and energy to patient care.

The current proposals are: 1) lacking in natural justice, 2) do not provide for external review of the decisions made, 3) place medical decision making in the hands of those who are not medically trained, and 4) will result in some patients not providing full information to their doctors and possibly jeopardising their health for fear of what Medicare Australia may do with their patient file information. Furthermore, the MIIAA believes that powerful incentives already exist to prevent intentional or opportunistic overbilling of Medicare benefits.

Of most concern to the MIIAA is that Medicare Australia is not required to give reasons for its findings. The MIIAA believes that, where it is proposed to find that material produced by doctors pursuant to a notice to produce does not substantiate the amount billed to Medicare, the opportunity must be given to the practitioner who will be affected to show cause why the findings should not be made. A debt should only be recoverable under section 129AC(1) after the practitioner has been given the opportunity to show cause. The notice to show cause should state the reasons for the finding and provide a time frame for a response so that the person affected can correct any alleged noncompliance or provide further materials to address any alleged deficiency in the material previously provided. This is consistent with the principles of natural justice.

In the same vein, when a decision is made by Medicare Australia that a notice to produce has not been complied with or the material produced by the doctor is assessed as not properly substantiating the amount paid, the MIIAA believes that the opportunity should be provided for an external merits review. The current proposal has no external review mechanism for decisions made by Medicare Australia in relation to these matters.

The MIIAA is of the opinion that the Administrative Appeals Tribunal is the most appropriate forum in which an appeal should be heard and that review by the AAT should be by way of a hearing de novo, or a new hearing, as of right on application by the recipient of the notice to produce or by the person by or on who's behalf the service was rendered. It is not appropriate that there is no mechanism by which to appeal to a third party on a decision of Medicare Australia. The Medicare Australia decision should be stayed until the AAT has confirmed, carried or set aside the original decision.

In addition, the exposure draft has no provision for noncompliance with the notice to produce as a consequence of the practitioner's failure to receive a notice. This is unfair.

The MIIAA asserts that administrative staff at Medicare Australia, no matter what their training, are not qualified to interpret the sensitive health information that will be provided to them in these instances. It is not true to say that the assessments required are purely matters of fact and require no clinical assessment. If the committee wishes, I am happy to provide examples of instances where an issue may appear administrative on the surface but in fact requires medical expertise and knowledge if it is to be appropriately addressed. It is disrespectful to the patient and the doctor for judgments to be made by someone who lacks the necessary qualifications and experience to interpret the information.

Patients need to feel that when they see their doctor their private medical information will remain confidential. Whilst the patient may reasonably expect that another medical practitioner could review their file, they would not expect that their private health information would be provided to a clerk at Medicare. This will mean that some patients may choose not to fully disclose or to provide incorrect information to their doctor. It is the perception of the patient as to how the Commonwealth would use that information which affects the patient's willingness to be open and truthful. Failure to provide appropriate and relevant information to doctors could have serious adverse outcomes for patients.

We also believe that those mechanisms which exist, such as the professional services review, include rights of review and procedural fairness, which the current proposals do not. The existing mechanisms provide that a patient's medical records are examined by appropriately trained peers of the practitioner under review, not by administrative clerks. There is no evidence of widespread misuse of Medicare by the profession, with the present mechanisms resulting in repayment of incorrectly claimed benefits, reprimands and disqualification from Medicare. Our experience is that doctors are fearful of the existing mechanisms and act very carefully in their billing practices to ensure compliance.

It is telling that in 2007-2008 only 50 practitioners were referred for review to the Professional Services Review Scheme by Medicare Australia and in 2006-2007 only 27 practitioners were referred. Between July 2008 and December 2008, Medicare Australia referred only one medical practitioner to the Commonwealth Director of Public Prosecutions for criminal prosecution for fraud. During this period, the CDPP successfully finalised prosecution of only three medical practitioners. There was a recent analysis of Medicare billing by GPs involving over 100,000 consultations and 2,811 GPs, and it concluded that their use of level B and level C descriptors was appropriate and in accordance with the complex descriptors.

I am happy to answer any questions the committee members may have regarding the MIIAA position.

CHAIR—Thanks you very much.

Senator BOYCE—The previous witnesses, the Privacy Foundation, suggested in evidence that a number of clinicians would currently already hold two sets of notes for some patients. They are not suggesting that there is any Machiavellian reason for this but that often patients would ask that material not be recorded in such a way that anybody else might see it or that it would become available. There are even suggestions that patients might ask clinicians to use a different Medicare number to that which would be used for any sort of schedule item that might identify what was considered to be an embarrassing procedure or an embarrassing diagnosis. Is this true, to your knowledge?

Mrs Edmonds-Wilson—I have no knowledge of that. I would have to consult with my members on it, but certainly from my experience I am not aware of that. I can take that on notice and ask and come back to you.

Senator BOYCE—Yes. What led on from that was whether, in the view of your organisation, the way that notes are kept might be affected by this legislation if it were to be adopted in its current format.

Mrs Edmonds-Wilson—The medical indemnity insurers would generally require that detailed notes be kept by a doctor in any case, so any suggestion that there would be a reduction would be of concern to them. I would need to seek advice on that. They would be concerned about anything that would result in a reduction in detail in notes. They just simply would not do that.

Senator BOYCE—I was not actually suggesting a reduction; I was suggesting a change which might be more oriented to meeting the requirements of Medicare than perhaps some other clinician trying to look at the notes.

Mrs Edmonds-Wilson—I think the view of the insurers was that the patients would just not provide the information.

Senator BOYCE—What is that based on?

Mrs Edmonds-Wilson—Simple fear that providing information that may cause some embarrassment or difficulty—

Senator BOYCE—But you have evidence that that has happened in other situations?

Mrs Edmonds-Wilson—The view was perhaps more anecdotal, but there was a perception that if people were aware that it would go to Medicare there would be a certain proportion of patients who would not provide full information.

Senator BOYCE—Yes. I am not sure if I understood you correctly. You offered, during your opening remarks, to talk about some examples, and I am assuming that that was in relation to

why it would need a clinician to assess a compliance audit rather than a clerk. Is that what you were saying?

Mrs Edmonds-Wilson—That is right, yes.

Senator BOYCE—Would you like to expand on that, please.

Mrs Edmonds-Wilson—Sure. For example, level C consultation services, which are item 36 long consultations, represent about 12 per cent of services rendered by an average GP. The item descriptor for that service with the MBS currently says:

Professional attendance involving taking a detailed history, an examination of multiple systems, arranging any necessary investigations and implementing a management plan in relation to one or more problems, and lasting at least 20 minutes ...

The explanatory material that was sent out with the exposure draft states that the compliance audit will involve an assessment by administrative staff as to whether the service provided met the requirements of the Medicare item and that, obviously, it does not involve an issue of fact. But for things like: ‘What is a detailed history of a head injury or depression?’ how do you determine whether it is a detailed history or not? You need to have medical knowledge for that. When is it an examination of multiple systems? We have also received reports that during the current practice nurse audit Medicare clerks have informed some doctors that they are unable to bill for consultations provided in conjunction with certain practice nurse items.

Senator BOYCE—Is this just a misunderstanding?

Mrs Edmonds-Wilson—The clerks are advising our GP members that they should not and do not need to consult in conjunction with a practice nurse when a patient is having a nurse immunisation, which is item 10993, and for wound care, which is item 10996. But wound care and immunisation may, in some instances, require both a nurse and a doctor. It is a medical decision, not a clerical decision, about whether the decision and assessment were appropriate. There will be times when both a doctor and a nurse are required, and the doctors are being told that it is not approved and that it should only be a nurse. And the decision is being made by Medicare that it is an administrative issue, when in fact there are good sound medical reasons for the doctor being involved.

Senator BOYCE—So that is about how the claim is initially made or correctly made rather than about any compliance audit of the material?

Mrs Edmonds-Wilson—This is the audit of practice nurse compliance. Also, a clinical assessment is required to determine whether a certain amount of time has been spent with a patient unless there is a computerised record of that consultation start and finish time.

Senator BOYCE—I notice time is getting on, but there is one question I particularly want to ask you. What implications, if any, are there for medical indemnity insurance in this legislation if it were to be accepted in its current format?

Mrs Edmonds-Wilson—At the moment Medicare claims represent, for one of our insurers, MDA National, about 1.4 per cent of the cases that they are working on.

Senator BOYCE—I am sorry, could you say that again.

Mrs Edmonds-Wilson—Medicare matters comprise approximately 1.4 per cent of the files of one of our members, MDA National, at the moment. Of these files, 75 per cent have been opened in 2009. That is a huge increase in the workload and—

Senator BOYCE—So there has been a massive increase in the number of practitioners with cases related to Medicare through their insurance?

Mrs Edmonds-Wilson—That is right. That means a higher workload, which means an increased incidence of potential claims and work, and there is a potential flow-on to premiums.

Senator BOYCE—Yes. Could you characterise this increase in any way?

Mrs Edmonds-Wilson—I could not give you a figure, no, because it would depend on the volume as well as the quantum, in the end.

Senator BOYCE—But is there any specific area that is causing this increase? For example, is it all related to cardiac or whatever?

Mrs Edmonds-Wilson—No, I do not know that information.

CHAIR—Could we find that out?

Senator BOYCE—Would you be able to take that on notice? Could you please characterise in some way for us why this particular increase has happened and if it relates to any particular Medicare items.

Mrs Edmonds-Wilson—I can certainly do that and come back to you.

Senator SIEWERT—A lot of people are very critical of this legislation, with many people believing the legislation should be withdrawn and started again. I am looking at your submission, and you make some very sensible suggestions. Is your suggestion basically that the legislation will be okay to proceed if it is amended or would you rather see it withdrawn and started again?

Mrs Edmonds-Wilson—Our fundamental view is that there are already mechanisms which work to ensure that there is not wholesale abuse of Medicare billing and we do not believe that it is necessary. The Professional Services Review and the other ones that are listed in our submission, we believe, are strong deterrents that already exist. Our view is that we probably do not need it, but if it were to go ahead then it would need some amendment to include issues of procedural fairness.

Senator SIEWERT—You say the current legislation is a strong deterrent, but I understand Medicare Australia's argument is that this bill is going to save a significant amount of money. It is going to cost quite a bit to put the new process in place but it is then going to save even more. The implication from that is that there are not sufficient deterrents there as it is.

Mrs Edmonds-Wilson—The evidence we have from the cases our members deal with, the Professional Services Review reports and the publications that are released on Medicare fraud is that, at the moment, there appears to be a fairly low level of fraud. That is at the upper end, obviously, and this legislation appears to be focused on lower level and lower cost difficulties.

Senator SIEWERT—There are also a number of submissions that are saying that you have already got the PSR process in place and that what essentially this legislation is about is giving more power to Medicare and, in effect, subverting the Professional Services Review process. Is that your take on the legislation?

Mrs Edmonds-Wilson—I do not think we would say that it was subverting it; I think it is at a different level to the PSR. It is not looking at higher level, deliberate criminal abuse of Medicare, which is what the PSR is clearly looking at.

Senator SIEWERT—What a lot of both our witnesses and submissions are saying is that anything to do with clinical records needs to go to the PSR, that this legislation essentially requires production of the clinical records and therefore it is essentially undermining the role of the PSR because the assessments of clinical records will not be going to the PSR; they will be going straight to Medicare.

Mrs Edmonds-Wilson—We would agree. That is our perception of it, yes.

Senator FURNER—In regard to your comment about strong deterrents, I guess that draws a question about the current situation with a 20 per cent nondisclosure or nonresponse to the current audits. How do you explain that figure of 20 per cent if we do have strong deterrents in this system?

Mrs Edmonds-Wilson—I am not in a position to be able to explain that.

Senator FURNER—So you have no explanation of why it is at 20 per cent?

Mrs Edmonds-Wilson—There are a number of issues such as the sheer amount of paperwork that doctors have to deal with, but I cannot personally comment on why 20 per cent do not bother responding. I do not know. I can seek advice on that if the insurers have any idea, but I do not know.

Senator FURNER—In your submission you indicate that the proposal will introduce further complexity in expanding the administrative demands. Would you be able to clarify for the committee which aspects of the proposal you believe will create greater complexity and in what way?

Mrs Edmonds-Wilson—Obviously there will be correspondence that comes from Medicare Australia which requires the provision of information from patient files. There are obviously administrative costs within the practice in doing that and there is complexity in getting that into the format that Medicare wants. There are the issues around yet another investigation process. Quite frankly, getting anything from the Professional Services Review generally puts the fear of God into any doctor. They are going to panic, ring their insurers and seek advice. They are going

to be concerned about what they have to do. It adds a layer of concern, fear, just sheer paperwork and compliance costs.

Senator FURNER—What is your understanding of how the proposed audits might differ in terms of complexity from those currently conducted by private health insurers?

Mrs Edmonds-Wilson—I do not know about the private health insurance investigations. That is not part of my role. I can seek the advice of the insurers on that.

Senator HUMPHRIES—Just following up that last question from Senator Furner, are there any circumstances in which you or your members seek to examine the medical records of medical practitioners or other health professionals?

Mrs Edmonds-Wilson—When a doctor receives a claim from a patient they would generally provide a copy of the relevant materials to their medical indemnity insurer to assess the case.

Senator HUMPHRIES—What is the relevant material? Is it a copy of the clinical notes?

Mrs Edmonds-Wilson—It would depend on the case. They could potentially provide a copy of the clinical notes.

Senator HUMPHRIES—Do you know if they provide those notes with the permission of the patient?

Mrs Edmonds-Wilson—They would have to have the patient's permission, yes.

Senator HUMPHRIES—I assume that your constituent members investigate fraud from time to time against their own policies.

Mrs Edmonds-Wilson—As in people who have not declared the claims history and things like that?

Senator HUMPHRIES—Those who have made claims that you suspect are fraudulent or you have information that subsequently comes forward that the claims might have been fraudulent or possibly in error.

Mrs Edmonds-Wilson—Yes, I would presume so.

Senator HUMPHRIES—Can you tell us anything about the way in which they conduct those investigations? Do they have the power to refuse to make payments until the medical practitioner concerned produces evidence for what they have claimed or something of that sort?

Mrs Edmonds-Wilson—Individual policies would have exclusions for particular areas of fraud or if there was criminal activity involved. It is a policy dependent issue but, generally speaking, if they found there was a criminal act involved there is a compulsion to report.

Senator HUMPHRIES—Report to whom? Report to the police?

Mrs Edmonds-Wilson—They normally have exclusions for things like if the doctor is drunk, under the influence of drugs and those sorts of things. The policy would not cover them under those instances. It would depend on the policy cover. They would certainly work to a certain point with the doctor on the claim even if there was fraud involved.

CHAIR—Thank you very much. We have announced that we have extended the reporting date for this inquiry until 10 June because of the lateness of the privacy statement. If there is anything you wish to add, particularly regarding the privacy statement, could you be in contact with the committee by the end of the month. Thank you so much for your evidence.

Mrs Edmonds-Wilson—Thank you.

[2.49 pm]

CAPOLINGUA, Dr Rosanna, President, Australian Medical Association

SULLIVAN, Mr Francis, Secretary General, Australian Medical Association

CHAIR—I welcome witnesses from the Australian Medical Association, Dr Rosanna Capolingua and Mr Francis Sullivan. You both know about information on parliamentary privilege and the protection of witnesses. We have your submission, thank you very much. I would now ask either or both of you to make an opening statement and then we will go into questions.

Dr Capolingua—Firstly, I think that we need to start by sincerely thanking this committee for establishing this very important inquiry and for taking our evidence today. I would particularly like to register our gratitude to Senator Ludwig for opening this to examination by the Senate and for making the draft legislation available prior to its introduction to parliament.

Please let me assure you that these measures are highly deserving of your scrutiny and concern. If passed, this legislation will have a dark and fundamental impact on the health of this nation, and it will deliver very little in return at a great cost. This goes to the threshold issue of patient privacy. The bold intention of this legislation is made plain in your terms of reference, and despite continued efforts to disguise the implications, this legislation aims to specifically empower administrative officers to gain access to confidential patient medical records. And this is the crucial point here. If the legislation did not specifically seek these powers, I doubt that any of us would even be here today; there would not be a problem.

Under these powers, the requirements which compel doctors to release these records compel us to breach our oath and the trust of our patients, and the consequences of this are detailed in the submission. And we believe that these are dire consequences. Once patients know that the privacy of their consultation with the doctor cannot be guaranteed, we fear they will withhold highly personal information and this will stop them from receiving the care that they need. But the authors of the legislation seek to disguise its intention to view the patient notes, including labelling AMA objections as hysterical and insisting that the information required is only administrative. Well, if that is the case then the simple solution is to remove from the legislation the provision to compel doctors under the requirements to provide records containing clinical details of patients. Do that, and we could all go home.

The authors also suggest that the legislation is designed to protect doctors who elect to hand over details from patient records to satisfy Medicare inquiries. Again, I think this is a disguise and diversion. Today doctors have a degree of discretion in what we can reasonably release from our patient records to meet Medicare needs, or other needs as you have referred to. The legislation replaces discretion with compulsion in this case. It means that patients will know that no part of their discussion with the doctor can legally be protected from access by an administrative officer.

Medicare desires this legislation because they claim that doctors hide behind the confidentiality of patient records to avoid scrutiny by auditors. They believe that doctors are doing wrong. They do not actually wish to protect the doctors or make legalities clear; they need access to the clinical information. And we ask: why? We have repeatedly asked for the evidence as to why this is necessary and, as you will likely find in your own inquiries, there really is no evidence forthcoming because we strongly suspect there is none. The legislation seeks to strip patients of their privacy on a whim.

I would respectfully ask this committee to quiz the authors of the legislation on the underlying assumptions of the numbers in the budget measure. You will quickly discover that this is all based pretty much on speculation. The only certainty is that it will cost \$76.9 million. The projected savings of \$147.2 million over four years are, by their own admission, a best guess. This effectively sells patient privacy for a guesstimate net gain of \$17.6 million a year—about 0.13 per cent of the Medicare budget or about 80c per Australian per year. The legislation sells the privacy of Australians for about 80c. It makes privacy look pretty cheap.

The real net gain is likely to be far less. The total cost of each audit is \$9,600 and each must recoup on average \$18,400 to achieve this level of savings. We are now being flooded with calls from members complaining not just about the heavy-handed approach they feel of Medicare auditors but about the frustrating futility of the process. One doctor reported an excruciating 10-hour audit that recovered the princely sum of \$78.05, a far call from the \$18,400 that is required to make this a viable budgetary measure.

So like that audit, we believe that this process is really a fishing expedition. It is a huge expensive net being dragged through the profession but, more importantly, through the intimate details of our patients, in the hopes that it will dredge up some mistakes and, fingers crossed perhaps, a few real areas of concern. All this, when government already openly admits that the biggest hurdle to compliance is red tape, and helping doctors to understand and comply with an increasingly complex system will deliver far greater, long-term benefits than sacrificing the privacy of all Australians to catch a handful of doctors and a few honest mistakes.

The profession has no time for those doctors who deliberately and inappropriately use the MBS, and the present system is well-equipped to deal with them. Where the gravity of the situation demands, patient records can be subpoenaed by courts and through the professional services review process. The proposed legislation demands no such gravity. Administrative staff will be able to compel access on a whim to material that has been previously afforded enormous respect and protection by our system.

I would like to report that this assault on patient privacy is unprecedented, but in fact it is not. The bureaucracy tried for similar powers in 1993 and fortunately that bill was afforded the same scrutiny that this bill is receiving here today. Following a Senate inquiry back then, the government of the time not only removed the relevant clauses from the proposed bill but actively legislated to preserve the sanctity of the health records of all Australians. Doctors and patients are hoping that the parliament can once again protect them from a bureaucracy that is eager to sell their privacy for powers that are as extraordinary as they are unnecessary.

Very soon, I am sure, the officials will be in here claiming very furtively that they do not understand all the fuss and that all they really want, they will say, is access to patient information

relevant to their reasonable concerns about the proper use of an item number. However much they attempt to characterise this as harmless administrative activity the reality is that they are asking parliament to give administrative officers the power to read deeply personal, sensitive and previously protected information about the health of any Australian. They will also say that it is up to the doctor as to what information is provided. But in fact, Medicare will have a general power to require practitioners to provide verifying documents during a clients' audit and the practical effect of this is that the only documents that can do this will be the details in the patient record. Thank you. I would be happy to take your questions.

CHAIR—Mr Sullivan, do you want to add anything at this stage?

Mr Sullivan—No, I am fine, thank you.

Senator SIEWERT—Perhaps I will start where you just left off, Dr Capolingua, and my question is not arguing in support of access to patient records. Where do you suggest we go with verifying claims if we cannot access extensive clinical records? I have listened to all the discussion this morning and I understand the concern around access to clinical records. So what do we do if we are not going to do that?

Dr Capolingua—There is access to the clinical records through the existing processes. Where there is a high degree of concern there is access through court subpoena and through PSR. Where there is auditing for compliance around the use of item numbers based on a reasonable concern we would be very happy to work with Medicare and have offered to work with them to find other ways of accessing what is required to verify an audit process without having to go to the clinical notes. At the moment there has been no other definition provided by Medicare as to how we can fulfil the requirement to meet the audit except having to go to the clinical notes.

Senator SIEWERT—We had a discussion with the psychiatrist this morning concerning the understanding of clinical records and whether it just meant the administrative side of clinical records, and I am aware that it would probably take further work. But if there was a halfway house where there could be something else filled in that deals with the numbers issue—and we have had quite lengthy discussions about why people do not want numbers necessarily recorded against a particular procedure or condition—so you do not get access to all clinical records, something that could be verified through another piece of paper or process, would that be better?

Dr Capolingua—That is exactly what we have also put to the Senator. We would be very happy to work on an alternative solution. We have to protect the privacy of the patient record, otherwise we jeopardise the patient's ability to feel confident in their conversations with a doctor and that may indeed compromise the level of care that they get. We must look at other ways, where we have not got a huge amount of evidence, of saying that this is going to turn up a lot of low-level fraud, if that is what you want to call it.

Fraud, of course, is a high-level thing and should be dealt with through the courts or through the PSR as inappropriate practice. But if there are other ways that we can satisfy the requirements without having to hand over the powers to Medicare administrative investigators to look at the patient record, and in order to answer the audit requirements the doctor does not feel compelled to have to open the record, then we would be happy to work on that. There are many situations with reference to item numbers, as I am sure you have heard before where under this

particular framework the only way you can prove you have spent this amount of time with a patient or you have billed the right item because of the degree of history taking and examination that is required or if you have written up a mental health plan where you have identified the formulation of someone's mental health issues and the diagnosis, is to reveal the patient notes, and we cannot let that happen to Australians.

Senator SIEWERT—When you have said that you have offered to have those discussions, how has the department responded?

Dr Capolingua—With the response that there are many doctors that do not comply—four to 70 per cent, but 20 per cent is a common figure—and why shouldn't Medicare have the right to be able to do this to make doctors comply in order to make the taxpayers' money accountable. That is as far as we get as a response. We believe in the accountability of taxpayers' money. We do not support inappropriate use of Medicare or the MBS because that is destructive to patients and doctors. Let us work out a way to do this that does not provide these powers to Medicare.

Senator SIEWERT—I think you did hear me ask the previous witness the question around undermining the PSR. A lot of the submissions argue that this in fact is giving power to Medicare that has always resided with the PSR. Is that your opinion as well?

Dr Capolingua—The PSR has a separate role looking at inappropriate practice. I would not use the term 'undermining' the PSR. This is a whole other provision of power to Medicare administrative officers around the patient record. That is a separate issue again. I think that the PSR role should continue as is. Perhaps it may do more work over time. It certainly has been very successful. We have seen the PSR report recently in identifying those serious cases and we fully support that work. This is something else that means a lot more to patients, I think.

Senator SIEWERT—I appreciate that. The argument in some submissions then is that if you are accessing any clinical records it should be done through that process not through—

Dr Capolingua—It may be that the interpretation of clinical records when they are accessed. In the PSR it is only done by medical practitioners, the point being that for someone who has not got that training or skill—even though I understand that the specially trained Medicare compliance auditors will be administrative staff with additional training in the use and storage of sensitive information—that does not assist them in interpreting clinical notes in order to understand that an extensive or detailed history has been taken, that multiple systems have been examined, and the time frame it would take to do that. Only appropriately trained clinicians such as those in the PSR would understand that. So it is almost too big an ask for a Medicare compliance auditor to be able to analyse clinical records let alone the threshold issue that they are viewing patients' personal records—

Senator SIEWERT—I appreciate that, yes.

Dr Capolingua—to analyse a medical record and make a determination. On that example around the current auditing that is occurring, particularly around the use of nurse item numbers, for or on behalf of, for routine immunisations and for wound care, I know a number of doctors who have been audited because they have had a consultation with a patient which is a level B or C—appropriately so, depending on the clinical content—and a nurse item. The query has been:

why did you need a consultation? Particularly at the moment, with the flu season—not H1N1 but the normal flu vaccine—we provide flu vaccines free. The government does that for patients over the age of 65 and we recommend immunisation for many other patients.

Opportunistically, rather than making them have another appointment to come and see us for a flu vaccine, if they are coming in for other reasons—a routine review of their hypertensive medication, their diabetes or whatever—we will do it then. There is a consultation in that and we say to them: ‘While you are here, the flu vaccines are in. Will you have yours today?’ They go to the nurse so we can see the next patient and they have their flu vaccine. A level B is charged as well as a nurse item, and we are being audited—very thoroughly and rigorously, mind you—and have to provide evidence of the reason for doing that. There is good, clinical, sound reason for doing that, but sometimes you can only prove that by reading the patient notes, and there might be other things in that level B or level C that are not just a blood pressure check or a script. There can be very intimate personal details.

CHAIR—On that point, and I thought it was a really good example, you said that you were being audited. If Medicare contacted the surgery, either the doctor or the administrative person who does it—I know it can be either—and asked that question and got the answer, what happens then?

Dr Capolingua—You would hope that was enough, wouldn’t you?

CHAIR—Yes. I think it is really important that that kind of stuff is put on record, because it has been talked about a bit. You gave a really good, specific example where there were two items claimed and Medicare then questioned why there were two items claimed for the one patient on the same day. They ask and the response goes back. What happens then?

Dr Capolingua—What happens is that there is a ‘reasonable concern’ that is activated, so you might see a doctor who has a number of these consultations over a period of time that look like a blip on the graph. So it is not a matter of a phone call or whatever; it is a letter. We have been made aware of letters with a 60-page list of consultations—pages like this with lists of Medicare numbers and patient details for the doctor to go through. They have to check back in their notes and verify that is what occurred, that the appropriate clinical item was charged and then, for instance, the nurse for or on behalf of. So that verification is not a simple answer over the phone: ‘Yes, that’s what happened.’ Now, under this legislation, with Medicare administrative officers having this power, that is not enough evidence. That is again taking the doctor’s word. To provide real evidence, you would have to hand over the clinical notes which showed what occurred in the consultation where that item was charged with the nurse item, and that is the patient’s personal private record.

CHAIR—Is it absolutely certain you would have to hand over the clinical notes? We have to get beyond the general, into the actual detail. So your understanding is that they would have to hand over the clinical notes?

Dr Capolingua—For instance, for a time based consultation, B or C, with a nurse item or without a nurse item—I will quote the explanatory material:

... if a practitioner provides a service for which a Medicare benefit is paid in respect of a Medicare item that ...

- requires a certain amount of time to be spent—

then the evidence of this time requirement has to be met. The appointment book does not reflect that. I ran—I should not confess—90 minutes late on Monday. My patients may have been booked in every 15 minutes or so, with a ‘do not book’ every hour, because that is the way I run my practice, but I had some issues with some patients that took a lot longer than the allocated time. If you looked at my appointment book, you would never believe it. So the appointment book does not provide that.

CHAIR—The appointment book does not say A, B or C.

Dr Capolingua—The only thing that will show that I did a level D with two or three patients that day is reading what I have written about the patient consultations. So I would have to provide that evidence in order to justify or substantiate the use of that particular item number being billed.

CHAIR—So a statement from you or the person who was providing it for you, depending on how your surgery operates, stating that you actually saw the patient for significant issues and it took longer would not suffice?

Dr Capolingua—Under this new legislation, no.

Senator SIEWERT—Which is where we come back to using another process where you make notes on another piece of paper. I appreciate it takes time, but it would say, ‘This patient was seen for this, this and this.’

Dr Capolingua—There is a gap. There is not an answer to that question because if Medicare could give us details that something else would suffice then we would not have to hand over the patient record. Under what we can see here, the only way to verify that or the other sorts of things we have described is for someone to look at the clinical notes. If they do not want to look at the clinical notes and we do not want to hand them over, why are we sitting here trying to change legislation to empower Medicare to look at clinical notes? We do not need it.

CHAIR—We will ask Medicare directly for you. I thought it was important to pull it right down to a specific example rather than generalities.

Dr Capolingua—I appreciate that.

Senator BILYK—Can I just follow up on that. Obviously you are aware of the private health insurance access, so what impact does access by private health insurance auditors to clinical records have on the patient-provider confidence? Why would patients be any more worried about Medicare Australia seeing things than they are about private health insurers?

Dr Capolingua—Private health insurers’ access is with patient consent, is it not, to start off with? It is also specifically—

Senator BILYK—Yes, and so what would stop that happening—

Dr Capolingua—Patient consent is not here, and it is interesting that the privacy impact statement makes comments that, if patients did know about it, it would undermine the therapeutic relationship, and then at the same time that this is not going to undermine—

Senator BILYK—Would the AMA support that process if it were to be changed to say ‘with patient consent’? Would the AMA support that?

Dr Capolingua—The AMA is saying that we do not need this power to be handed over to Medicare administrative offices.

Senator BILYK—But would you support it if it were changed?

Dr Capolingua—It would still undermine the therapeutic relationship and the patient confidence. Our goal here is to make sure that our patients are not frightened to tell us the things they need to tell us so that we can care for them appropriately.

Senator BILYK—I am still a bit confused here about why it is all right to tell private health insurers.

Dr Capolingua—Because it is with patient consent. It is also specific—

Senator BILYK—So the question is, therefore: would the AMA support it if it were with patient consent?

Dr Capolingua—For the private health insurers there are specific bits of information that would be accessed, not this opening of the patient file, the way it is here, with all the intimate details. I do not want to tell you stories—you can imagine the sorts of things that patients do need to share with their doctors, and sometimes it is only their doctors that they can tell these things to. So it is a completely different entity. The private health insurers will only pay the benefit once Medicare Australia has paid their benefit. So in fact, if we cover off the Medicare Australia issue, then the private health insurance issue is not over the top of that.

Other people have put to me that patient information is provided for workers compensation or other insurance issues—life insurance et cetera. Again, that is around a specific issue and with patient consent. This is, remember, just a ‘reasonable concern’ around a Medicare audit, and what we are sacrificing here is the threshold issue of the privacy of the patient record. Everyone’s record in Australia will be opened under these powers. It is not necessary to achieve the end goal.

Senator BILYK—Can you just clarify for me, because I am not a doctor and I do not work in Medicare, so I am trying to get this completely straight in my own head. Aren’t you therefore arguing for different treatment for public spending and for private health spending? You are saying it is all right to open it up to private health insurers.

Mr Sullivan—If I could answer that. You are using a precedent that was established by another government at another time, not the AMA. The AMA’s position on this is very clear.

Senator BILYK—Where is your argument on that now, though?

CHAIR—Senator, could you just let the witness finish?

Senator BILYK—Sorry.

Mr Sullivan—If you are asking for the AMA's position, the AMA's position is consistent in both cases. Where the funder seeks to justify for audit purposes the allocation of an item, we are very open to discuss how that can happen, how the information can be provided—but we are making it very clear that we are not going to break down the protection of the personal patient record to satisfy what we believe is an activity at a very low level. The personal patient record has a high status of protection at law. It is only ever changed in that status when you are dealing with a grave issue. We are seeing here a proposed bill which is going to enable at the minor level of activity at Medicare Australia—at the administrative end, which is the first part of the hierarchy of activity—powers that are not even granted to the chief executive of Medicare Australia when they are doing investigative work. That is the crux of the issue here.

Dr Capolingua—And private health insurers actually do not get access to the patient's clinical records, the actual notes—they do not read the patient notes, which is what the doctor is required to give over in order to fulfil the audit.

Senator BILYK—That is clarified for me.

Senator SIEWERT—For the record, what do they get access to?

Dr Capolingua—They get access to what would have been billed. If you had coronary artery bypass surgery, that item would appear, I guess. So those sorts of details; not the clinical issues around a mental health issue or a domestic violence issue or abuse issues of other kinds—all of the nature of things that can be presented to you in a practice.

Mr Sullivan—Senator, I think your questions are helpful for us because in our submission we make it very clear there is a difference between technical details and personal information, and I think the words are important. So I think your question about how can you capture information as opposed to devolving the history of a patient's treatment is very important.

Senator FURNER—I take it, then, there are no circumstances where extracts or entire clinical records are disclosed.

Dr Capolingua—Occasionally when there is a claim on disability insurance the insurers will try and get that from us. They get the patients to sign a consent, and the patients I am sure do not understand exactly what they are consenting to. We go to great lengths to block out parts of the record that are not related to the disability claim. So we even fight at that level. It takes a lot of effort by doctors to produce a record that protects a patient's personal and private information, because a disability claim or a sickness claim may be about as particular, narrow issue for a patient and the patient record will hold a whole array of other information.

Senator BILYK—Your submission talked about Medicare having the power to view, copy and keep extracts. I could not find where you got that information from. Can you direct me to that.

Dr Capolingua—It is 129AAD(7) of the proposed amendment. It says:

The power under this section to require a document, extract or copy to be produced includes the power to require the production of a document, extract or copy containing health information ... about an individual.

So it actually states that.

Senator BILYK—Okay, but it also makes it clear that the material collected would be destroyed.

Dr Capolingua—That is afterwards. The threshold issue is that a Medicare compliance auditor, who is an administrative staff member with additional training, will actually read your patient notes. That is the threshold issue for us.

Senator BILYK—Which does lead me to a lot of other questions, but I am happy to move on as long as I can come back to that.

Senator HUMPHRIES—Could I just summarise the evidence you have given on that score. You are saying that at the present time you do not disclose to private health insurance companies—

Senator FURNER—No, they did not say that.

Senator HUMPHRIES—I will clarify what I am asking. Doctors do not disclose the medical records of their patients to private health insurance companies as part of the claims process for services that you render.

Dr Capolingua—Correct.

Senator HUMPHRIES—Thank you. What you said about the importance of respecting the privacy of the doctor-patient relationship carries a lot of weight. What also concerns me, though, is what Medicare have described as the high rate of noncompliance with the voluntary audits, ranging up to a 70 per cent non-response rate in certain circumstances. You talked before about working through these issues if the department would sit down with you and try to find a way through them.

Given that doctors are meant to be the primary custodians and protectors of the patient records—they have the records in their possession and they are meant to protect them—would it be appropriate to say, as a compromise, that you do not disclose the records in a random audit unless the doctor has refused to provide relevant information from his or her records as part of a voluntary audit process? That is, where they do not or will not satisfy the auditors—as seems to be the case in one in five voluntary audits at the moment—but they have complied with their obligations, then their records should be accessible. That then would leave in the doctor's hands entirely the question of whether those records were being accessed or not.

Dr Capolingua—That is sort of what is being put—that it is up to the doctor to decide what information they should provide to respond to the audit at the moment, but the legislation proposed will require the doctor to produce the document in order to ascertain whether the item

is correct. So your suggestion—if I may reiterate—is that there is an issue with 20 per cent or four to 70 per cent non-compliance. We do not approve of non-compliance but I have to say to you that sometimes they are very big, and 60 pages of patient consultations that you have to go through is very time consuming, demanding and takes you away from caring for patients while you are doing that. So maybe in some cases the doctors are just thinking, ‘I haven’t done anything wrong and therefore it’s too much effort; I’m not going to comply.’

But if doctors do not comply the issues are: how do we make them engage and how do we make them comply? That is something that we would need to look at, perhaps. We would need to answer the question, which is part of that: what other ways are there of providing the information that is necessary—ways that are not onerous but provide the information that is necessary to answer the Medicare audit without going to the patient notes first. If we can solve that nexus then perhaps we do not even need to go to the next step. If there is an issue of such significant concern that Medicare needs to audit a doctor then perhaps it is at a level where it goes to the PSR anyway and the patient notes are part of the PSR process. So the nexus is: what can we do to encourage compliance, firstly with the utilisation of Medicare—and that means understanding the 5,700 items and making sure the doctors use them appropriately, that there is no misinterpretation, that the book is on the desk as well as being online and in a disk version. We need all of the above so that we have good transparency, good education, and good innate compliance for the protection of Medicare and doctors.

Without a huge amount of evidence that these fishing exercises are required because a \$76 return, or whatever it was, for 10 hours worth of audit shows that there is not necessarily a huge amount of inappropriate use of Medicare. So the next step is to work through ways that we can encourage and increase compliance. We certainly do not condone lack of compliance—I was a bit startled to see those figures—but it is a daunting prospect when you receive those letters or that communication from Medicare.

Senator HUMPHRIES—Sure.

Mr Sullivan—I was just going to add to the president’s comments that we would ask the committee to critique the assumptions of this activity. It has been very difficult to get any hard evidence that justifies (1) the increase in the audit activity, and (2) the estimates on the savings. The point here is that it would be a far more productive exercise to look at an education program than to look at a program based on guesstimates. More importantly, medical practices keep their information in a certain way, and because Medicare Australia now have a different agenda they now have a problem with the information. If Medicare Australia have a different agenda they should be looking at new ways of asking for information and supporting how the information can be given without making red tape a further issue and, as you have heard, without making doctors spend time justifying, when nothing is wrong, instead of seeing patients. These are fundamental questions that we hope the committee can ask Medicare Australia.

Senator HUMPHRIES—It is my impression that the 20 per cent who are not complying or are not responding to the voluntary audits are overwhelmingly doctors who are very pressed for time and are working very hard. The Medicare paperwork is the last thing they want to do at the end of a long day. It would concern me if a certain amount of rejection of that process was also disguising a small amount of fraud. I would be very interested to see what the AMA can propose

as an alternative to this what you might describe as a sort of sledgehammer approach to the issue of fraud.

Dr Capolingua—We should remember that the increased number of audits have already started—they started on 1 January—without the powers that are in this around privacy. So without giving up the right to privacy of the patient record the audits are happening. An increased number of audits are happening and the doctors are responding. It would be interesting to review the statistics. The effect of that increased activity is already occurring without having to hand over the patient records. Again we have to ask whether this part of the legislation is necessary at all—this right to privacy being handed over. Let us deal with the issues without compromising that.

Senator HUMPHRIES—You have said that it is a fundamental right to have the privacy of that relationship and those records protected. The Public Interest Advocacy Centre argued earlier today that, if the records can be opened up by courts using subpoenas or by the PSR process, then it is really only a small step further to have them examined by an audit. What is your response to that argument?

Dr Capolingua—If there is fraud and the courts or the PSR are involved, they are high-level concerns. The patient record is viewed in a different light for the purposes of dealing with those issues. This is auditing for reasonable concerns, for as we describe, the Bs and Cs and the use of the nurse item number. To compromise the privacy of the patient record for that is something we could not support.

Medicare Australia's *National Compliance Program 2008-09* shows the compliance model. It shows the issue when you are dealing with criminal behaviour. Certainly the patient notes are subpoenaed and under court protection. It covers the PSR looking at inappropriate practice. When you are talking about clerical or administrative errors that might occur on occasion or a change in the billing pattern due to patient need—responding to flu vaccines or whatever—I would argue it is inappropriate to have the power to view the patient records. There are good systems in place to deal with those cases where the patient notes do need to be explored for high-level grave concerns.

Senator BILYK—So you are saying that private health insurers only get access when there are grave concerns?

Dr Capolingua—No, we are talking about Medicare auditing here. Private health insurance audits just check the items that are claimed against whatever it is being provided.

Senator BILYK—But they get access to some.

Dr Capolingua—They get billing item numbers; they do not get clinical notes. I am talking about when someone has come in and told me some very intimate and personal details about their lives. That is what is in there. Private health insurers do not go there. Certainly it is appropriate for Medicare audits to occur and patient notes to be looked at if there are high-level or grave concerns.

Senator BILYK—So you are telling me that the only reason my private health insurer would access any of my information would be to get item numbers.

Dr Capolingua—Private health insurers never look at your private and personal records. It does not happen.

Senator BILYK—They just get the item numbers, which can tell them a whole lot of things anyway. I have worked in the medical area. It can give you a vague idea of what the issue is.

Dr Capolingua—It does not tell you that you have come into the practice extremely anxious and concerned, that you are having difficulties in your marriage or that you believe your husband is having an affair.

Senator BILYK—But you would have a long consultation then, wouldn't you?

Dr Capolingua—The private health insurer would see that you have had a mastectomy, a hysterectomy, coronary artery bypass surgery—

Senator BILYK—Or a long consultation.

Dr Capolingua—No, because private health insurance is not involved in providing any rebate to patients in the general practice, primary care or specialist setting in the private sector. That is Medicare.

Senator BILYK—Okay. I have a question about that but I will hold that for now.

Senator HUMPHRIES—Let's assume that the system was redesigned so that patient consent had to be sought for the records to be accessed. What do you imagine would be the typical reaction of patients receiving a letter from Medicare saying, 'We're going to audit your doctor's records and we want to examine your records to see whether the doctor is complying with Medicare orders'? Do you think everyone would be sanguine or would problems and issues arise from people's reaction to that sort of request?

Dr Capolingua—If this proposal goes through it means that everyone in Australia's file will be opened without any redress.

Senator HUMPHRIES—That is right.

Dr Capolingua—Are you saying we would need to get specific consent if, due to reasonable concern, there was an audit? Are we asking for consent or are we just telling patients that it is going to be done? I need to clarify that with you. What are we suggesting—are we going to ask their consent?

Senator HUMPHRIES—I am asking: if the arrangement was changed to say that you have to have a reasonable suspicion and then write to the patient to get their consent to open up their records, what would that do to the patient-doctor relationship? What would happen if they saw that sort of letter in their letterbox?

Dr Capolingua—If you were in those shoes and you got a letter saying that a Medicare compliance auditor, who is an administrative staff member with additional training, was going to read your patient record, how would you feel about that? You would be devastated.

Senator BILYK—I would not have an issue. They are looking after taxpayers' money.

Dr Capolingua—Many people have different things in their records and there are different levels of sensitivity about what people feel is very personal and private. When we do a health assessment we might ask about incontinence or constipation. For some people, whether or not they have incontinence is a very personal and private issue and they would be mortified to know that someone else was reading about that. A man might have had a huge night on the town and had unprotected sex, including anal sex, and gone into the doctor for an STI check the next day. There are variations in sensitivity. In patient records there might be issues around mental health, coping with things at work or concerns about children. If someone got a letter saying that a Medicare officer was going to be reading their notes—understanding the sorts of things that patients have in their notes—it could drive them to suicide, in fact, when you think about it.

Senator HUMPHRIES—It is also possible that some patients could think: 'My records aren't safe with this particular doctor because he's being investigated. I'd better move to another doctor.'

Dr Capolingua—The next issue is indeed that you could discredit the doctor and damage the trust that the patient has in that doctor, even though the doctor probably has not done anything wrong at all—there is no evidence to say that all these doctors have committed fraud; they are just under scrutiny at the moment. You could destroy that trust.

Senator BILYK—That would depend on how the letter was worded.

Senator HUMPHRIES—Yes, but it would also depend on how you read it. If someone had things on their doctor's record which were sensitive, they would perhaps react very differently to how you and I, Senator Bilyk—who have nothing but the usual boring things—would react.

Senator BILYK—You do not know that about me, Gary; I might have lots of personal information—

CHAIR—Is that your last question, Senator Humphries?

Senator HUMPHRIES—Yes, it is.

Mr Sullivan—The only other interesting aspect to that is that there are some people—and two of the senators said it here just then—that say it would not worry them if their personal information was viewed, but the AMA is concerned for people who would be concerned. This is not about your own personal reaction to a bill; it is about legislation for a community and the protection of people's privacy. It is broader than just personal whim about how it goes.

Senator BILYK—What evidence have you actually got that people are concerned about it? One of the other submissions I read—I think it was the Consumers' Health Forum—was in

favour. I certainly have not received anything from the AMA in my mail asking if I would be happy or anything. I am just wondering if you can validate those concerns for me.

Dr Capolingua—Already, because this debate is out in the public arena to a degree, I have had many patients come in and say to me that they would be devastated if their personal records—

Senator BILYK—But is there any validatable evidence? Have you done surveys?

Dr Capolingua—Let me tell you that patients come into a doctor's surgery on the basis that the conversation that is had and the information that is imparted, the discussions that are engaged in, are confidential and private, and—

Senator BILYK—I have worked in the medical area; I understand that. I am asking about whether you have done any statistical analysis of whether patients are really concerned about it, because we have had evidence to the contrary.

Dr Capolingua—We are actually putting something on our website today asking doctors in Australia to put a petition on their front desk in order for patients to express their concerns. So we are going out there gathering it. We have had plenty of phone calls from doctors, and certainly from patients directly, expressing their concerns, but we are going to go out there and ask them to say that they have an issue with the fact that their patient record will be opened.

Senator BILYK—What is the time line for that petition? When will it all be collated?

Dr Capolingua—It is going up on the website today. I guess we will need to have it collated before the end of this inquiry, which I believe has been extended because of the privacy impact statement.

Senator FURNER—Will you also petition those 20 per cent that are non-compliant to make sure they are compliant?

Senator BOYCE—It is not 20 per cent of members, Senator Furner.

Senator BILYK—Twenty per cent of the population.

Dr Capolingua—We have always supported compliance with Medicare auditing.

Mr Sullivan—May I add, in response to your question, that that might go more to what is already on public record about that. In the Federal Court, for example, last year, Justice Reeves said:

... medical records in general, let alone those dealing with a person's sexual health or activities, are generally among the most personal about an individual.

Also the federal Privacy Commissioner made it clear that:

... health information ... medical records ... are sensitive information, which is generally afforded a higher level of protection than other forms of personal information.

Both those comments are based on how individuals appreciate their personal information. As the president said, we are going out now to formally, if you like, survey. We have a full-time officer that looks at how the Medicare Benefits Schedule is applied, and we get practices calling us every day—at least 10 calls a day to our own office, let alone the state offices—from a practice manager or whatever trying to clarify the use of a particular item, but we also get the general public ringing us. Since this legislation has been mooted, we have had many calls to our office—because sometimes people get confused about who to get the information from. You, Senator, being a politician, will know it will not take very long to get a barometer in the community.

Senator BILYK—Yes, I am just surprised nobody has actually talked to my office at all.

Mr Sullivan—I think one of the points here—and it is worth saying again—is about the fundamental assumptions of evidence and what this bill is based on. So far no-one in the government or in the department has put in place any evidence to justify increases in audits or the supposed savings. If we could start with that evidence and get that clear, by that time we will have ours.

Senator FURNER—What sort of wording will you be putting in this petition that you are putting on the counter in doctors' surgeries?

Mr Sullivan—We will show the Senate the finalised petition when it is complete.

Dr Capolingua—We were working on that today. I was working on it before I came here today because we believe that we need to hear from the public how they feel about it as well.

CHAIR—The public who are coming to your surgery.

Dr Capolingua—Yes, the patients, where the records are.

Senator FURNER—I want to go back to this issue about consent and access to information through private health cover. I have seen documentation myself from organisations where they actually provide that consent. It is a standard consent acknowledgement on most forms, not only in private health cover but also in other forms of cover where people making application to join consent to provide information to whatever relevant authority. I will read you the one I have before me: 'I agree to assist the insurance company, provide all information relevant to this claim, authorise the doctors, practitioners or other relevant authorities to provide access to any records relevant to this ailment or injury to the insurance company including date, type of services and relevant clinical information, and consent to the release of all relevant information to a medical referee as determined necessarily by the insurance company for the purpose of assessment of this claim.' So there is already in existence—

Dr Capolingua—Yes, that is about a claim.

Senator FURNER—Let me finish, please. There are already applications in existence providing the consent for practitioners to supply that information to private health organisations.

Your members, no doubt, would be providing them information on the basis of that consent already indicated and signed by that particular person.

Dr Capolingua—That is with relevance to a particular claim: illness, disability or injury. It is one issue specifically. The patient has consented to provide for me to provide the information around that for the purpose of the benefit to be paid or the insurance cover or whatever. We are not talking about that here. We are talking about opening the patient record—which has in it the most intimate details about the issues that are affecting you in life with regards to your physical health, your mental health and wellbeing, your social structure, your family et cetera. I do not want to waste the committee's time but I could give you examples of the sort of information that patients provide. That is completely separate to what you are describing there, which is specifically about a claim or an injury or a benefit or an insurance. It is a separate issue.

Senator HUMPHRIES—And where consent is given.

Dr Capolingua—Thank you, yes—and where consent is given.

Senator BILYK—Can I put some questions on notice?

CHAIR—You can, but we will get back to you once we have finished Senator Boyce's questions.

Senator BOYCE—I have just a couple of questions. We had evidence given this morning that, in the opinion of one organisation, the funds being devoted to this would be better spent in simplifying the entire MBS system. You have touched on this. I was wondering if you would like to expand on that—briefly.

Dr Capolingua—Yes, very briefly. As I said, we have been arguing very strongly about simplification of the 5,700 item numbers but, even in general practice specifically, about the number of item numbers and their requirements to fulfil the criteria of the item number for the particular thing—the mental health plan or the health assessment or whatever. We have argued that we need to try to work out solutions as far as simplification of the MBS is concerned so that doctors will find it easier to comply, there will be less opportunity for there to be mistakes made and there will be greater clarity around the use of the Medicare rebate. If this money is not allocated there, we should find other money to do that with.

Senator BOYCE—My other question is related. Medicare, in the information they have provided, have pointed out with some pride that they run a fairly extensive education program: online and face-to-face type programs. Could you give me the AMA's assessment of how good they are and what else might happen with the current Medicare education program?

Dr Capolingua—I understand that they provide an online educative familiarisation tool. Certainly, new graduates with a provider number who enter the system and who would need to access Medicare are encouraged to participate in that, and international medical graduates who have come from different systems are encouraged to participate in it. In our own newsletters or whatever, we certainly provide Medicare information—if Medicare give us information to distribute we will do that. Medicare provide a bulletin on a regular basis where they put a lot of their information and we encourage doctors to read that.

As we have described the situation, it is about busy doctors having the time to make sure that they stay up to date. And it is not just the doctors. The practice staff at the front desk often assist in making the determination as to which Medicare item is allocated to the consultation. Doctors are encouraged, in fact, to direct them—I go to my desk every time and tell them exactly what they need to bill so that the responsibility is mine and hopefully no mistakes are made—but practice staff will often, in a busy practice, pick up some of that role.

We were very concerned when what we call the yellow book—the printed text—disappeared without real notice from our desks, and that instead a disk was given or information had to be accessed online. For practice staff to be going to and loading a computer during a billing with patients waiting at the front desk is time consuming, and losing that book has made an impact on, perhaps, that fine tuning of making sure you choose—

Senator BOYCE—On time management.

Dr Capolingua—Yes. And there are a lot of practices who need to have the book because they are not completely electronic. I believe now you can apply for and purchase it, but it did disappear quite rapidly. So those sorts of things just add to the frustration and the difficulties and really we need to make compliance easier.

Senator BOYCE—Thank you.

Senator SIEWERT—In its submission, Medicare said—and I do not know whether you have had a chance to read it—that 10 per cent of providers already voluntarily give their confidential patient records that are subject to this legislation to Medicare Australia. Is that the case as you understand it?

Dr Capolingua—I understand that is the case, and much of that occurs, basically, under duress—as a result of the scrutiny, fear and anxiety that the doctors have around the Medicare audit. I think we would all agree that that is not really a good reason for the doctors to respond in that manner. I had an e-mail from a practice manager whose practice is being audited at the moment. He said that the doctors have said to him: just put the Medicare officer in a room, give them access to all the records and let them do the work because we do not have time. The fact that doctors are, in their exasperation and despair in trying to comply with the process of the audit, expressing the relinquishment of the confidentiality of the patient note to that level shows you why 10 per cent of doctors are handing over that information now. I think it would be far better to provide the information in another manner.

Mr Sullivan—Yes, clarify the info.

Senator SIEWERT—So 10 per cent of doctors are already handing over all the clinical records?

Dr Capolingua—I do not know the details of what they are handing over. It probably is not—I hope—all of the clinical records. They probably do not realise the implications of doing that and, as I said, they are acting under duress.

Mr Sullivan—It is a very good question because it goes to the heart of what we are saying—that the patient record needs to be protected. We would prefer an arrangement whereby Medicare can get its audit requirements satisfied and the patient record can be protected. There needs to be a more creative solution to this than what appears to be on the table. Then you would not have a situation where some doctors are handing over aspects of the record out of fear or duress.

CHAIR—I just want to jump in there. I think it is very important in this argument not to generalise too much and to try to come down to the details. You have made a statement that all the doctors who provide the information are under fear and duress whereas I think it would be fair to say that it is just some who would. The statement that you have both made—

Dr Capolingua—We do not understand all the reasons around that issue? Correct.

CHAIR—I just think that doctors—

Mr Sullivan—And we are taking those comments that were raised and the stats in good faith, because we do not know either.

Dr Capolingua—I will be following those up with Medicare.

CHAIR—You said that all of those doctors are under fear and duress but I think it would be possibly some of—

Dr Capolingua—Some of them may be, yes. It may be one of the reasons.

Senator SIEWERT—This is probably better addressed to Medicare and I will follow it up with them, but I thought that under the present system the clinical records that are handed over go to the PSR. It appears that that is obviously not happening.

Dr Capolingua—No, that is right. In that 10 per cent that we are trying to tease out, it is not a PSR process the doctors are handing over. They may not understand what their duties and responsibilities are in answering that audit. Certainly in the PSR the clinical notes may be viewed by doctors.

Senator SIEWERT—Yes, I understand that, and that is why it was going to be part of my original question. But then you said, ‘No, they are handing them over already when they are auditing them.’

Mr Sullivan—Just for the record, the AMA’s view is that, concerning that particular issue, it does not follow that that precedent therefore makes it a principle you can build on.

Senator SIEWERT—I am not necessarily arguing that. I also heard Senator Bilyk asking this question. What was going through my head was: have you had complaints about that? The other issue is one that Senator Moore just touched on, and it is to do with fear. I suppose the issue is that there is a lot of money involved here and it is standard practice to audit. So when I hear you talk about fear it does not sit quite right. When you are getting the amount of money—and, as I understand it, it is \$160, 000 to \$200,000—the average community member out there will say,

‘We do expect that to be audited. There must be some form of audit. We all have audits. The tax department audits us.’

Dr Capolingua—Agreed.

Senator SIEWERT—So I suppose it does not sit quite right.

Dr Capolingua—I think perhaps it is anxiety. In general, apart from a few that you read about in the PSR or the ones that are in the courts, doctors are really trying to do their best and use the Medicare rebates appropriately for their patients. But there is a general anxiety about being approached about an audit. I have seen it happen in my practice with one of my colleagues who is extremely diligent and in fact draws my attention to things that occur in my practice and wants me to sort them out because she is concerned about doing things correctly. She came under some scrutiny and that caused her great anxiety. There was absolutely no problem with any of her practices. In fact, she was probably practising in an exceptional manner. So there is an anxiety and a fear, because doctors generally intend to do what is right. However, they also should come under appropriate scrutiny because the dollars need to be accounted for, and there are processes to do that.

Senator SIEWERT—Just fixing up the privacy aspect of this legislation—and I am totally getting the argument about privacy—is not going to get over somebody’s anxiety about being audited, though, is it?

Dr Capolingua—We need to have other processes in place to ensure that doctors feel that they can competently use the item numbers. Perhaps if there is simplification, there is good education and all of the other issues, then you do not even question yourself when the time comes.

Senator BILYK—I am a bit confused. You are telling us that about 10 per cent of doctors are already handing over things. I did not quite get the answer about whether there had been any complaints by patients.

Dr Capolingua—I would suggest that patients do not know about it. There is no consent around that.

Senator BILYK—What are the complaints from the doctors?

Dr Capolingua—The issue is the work involved in meeting the requirements of the audit and that in some instances they are feeling that they have to hand over the patient notes in order to satisfy the questions that are being asked of them.

Senator BILYK—So they are being forced to hand over things. Is that what you are telling me?

Dr Capolingua—They feel a compulsion on themselves.

Senator BILYK—They feel a compulsion, but that does not actually clarify whether they are being forced to hand over the notes.

Mr Sullivan—It really goes to the first question you asked, which was: at the end of the day, what is it that is going to justify Medicare's audit requirement? In the cases the President is speaking about, how far do we go? How much information do you need? We are saying that there is nothing in the current bill that makes clear what will be required, how much information will be required and when that information is deemed technical as opposed to personal. It is all the same issue.

Senator BILYK—So if there were moves afoot to clarify the criteria, would that help?

Dr Capolingua—If it protected the patient records, certainly.

Senator BILYK—As I said, I have worked in the medical area. I have dealt with confidentiality at a very high level. I would think that, for the doctors I have worked for, there would be things in the records that could be extracted that would give a bit of information but not necessarily the whole gamut. I am wondering how the AMA would feel if that were part of the process.

Dr Capolingua—We need to work on what information can be obtained that protects the privacy of the patient record. It has been put to us that to justify a long consultation you could probably black out all the sensitive bits so you could see that lots of words had been written and then blacked out, and that might be evidence that there was a lot of time required in that consultation. To me, that does not really achieve a great deal. There need to be other mechanisms that are not also extremely arduous on the doctor. If you had 60 pages of consultations you would then have to black out bits and forward a pruned medical record to someone to examine. Having blacked out the bits may not actually satisfy the requirements of the audit. They would need to see the content to verify that in fact a detailed history was taken and that multiple systems were examined. You would have to read the words. So, yes, we need to protect that and find another way of doing it.

Senator BILYK—An item number usually tells you a base level.

Dr Capolingua—Yes.

Senator BILYK—It does not say that they were there for a cold or because they had a quick consultation about conjunctivitis just to do a comparison, but it does tell you that it was a quick visit.

Dr Capolingua—Sure. We do not have a problem with that.

Senator BILYK—So item numbers do tell you vaguely what it is about, don't they? But in some situations—

Dr Capolingua—They reflect time or complexity or whether you have had a mental health plan or a health assessment done. There are various items. We have that information and we do not have a problem with that. That is fine.

Senator BILYK—Good. That has clarified that for me.

Dr Capolingua—Remember that the Bs and Cs, for instance, make up 30 per cent of Medicare claims. A large bulk of this would be in that area, and at the moment, with the current proposal, the only way to justify that is to read the patient record.

Senator BILYK—I want to go back to the issue that 20 per cent of practitioners do not respond to audits. Where do you stand in regard to that? Do you have any ideas about how that might be changed?

Dr Capolingua—We absolutely support practitioners complying with audits, not evading or not responding to them, and we need to work out what the barriers are to their compliance. One is, perhaps, that they are busy and that the compliance would take a considerable amount of their time, as we have described. There is an innate anxiety in doctors when they are approached with regard to an audit, and that may make them reluctant to start off with. We need to help them, give them the tools to assist their compliance. The other part of assisting compliance is to streamline the Medicare rebate system and reduce the number of item numbers, provide comprehensive explanatory notes about how it is used and continue the education—things that we have already reiterated this afternoon.

Senator BILYK—I am surprised you keep talking about this anxiety. I have worked not only in the medical profession but in the childcare area and a number of other areas where there are audits all the time on how you actually deliver your job, not only on what you are doing to receive government funding for the parents to receive government assistance. It surprises me a bit.

Dr Capolingua—Most people get anxious that they will get a tax audit even though they have complied with every—

Senator BILYK—I know, but that is no reason not—

Dr Capolingua—I think it is an innate human—

Senator BILYK—It is. It is part of life and it is necessary to life but it is no reason not to account for public money.

Dr Capolingua—It is not an excuse not to comply. I agree with you.

Senator BILYK—I do not see that as—

Dr Capolingua—I would rather resolve the reason for the anxiety. I agree.

CHAIR—Thank you very much. I am sure there will be more things you wish to add. We are very keen to see the wording of the petition in terms of how the situation is presented. As you know, with the extended date there will be the opportunity to give more information. There may well be questions on notice from members of the committee, and if there are we will get them to you as quickly as possible.

Mr Sullivan—Yes, we are happy to take them.

Dr Capolingua—And the Privacy Impact Assessment will provide commentary on that. I have looked at it initially, and it certainly goes to the management of the information once it has been handed over. Our threshold issue is, again, the fact that the patient information is being opened up in the first instance.

CHAIR—Absolutely. Thank you.

Proceedings suspended from 3.59 pm to 4.09 pm

KINGDON, Mr Tony, First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing

LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing

ROBERTSON, Ms Samantha, Assistant Secretary, Medicare Benefits Branch, Medical Benefits Division, Department of Health and Ageing

BRIDGE, Mr Colin, General Manager, Program Review Division, Medicare Australia

GODWIN, Ms Philippa, Acting Chief Executive Officer, Medicare Australia

JACKSON, Mr Mark, Acting Deputy Chief Executive Officer, Medicare Australia

CHAIR—I welcome officers from Medicare Australia and the Department of Health and Ageing. You all have information on parliamentary privilege and the protection of witnesses. As departmental officers and senators know there should not be questions about opinions on matters of policy though there can be questions about explanations of policy or factual questions. We have received the submissions from both departments and also the attached privacy impact statement. I invite you to make a short opening statement, whoever is doing that for the departments, and we will then go to questions.

You may be aware that we have now extended the reporting date for the committee until 10 June. That was principally because of the late arrival of the privacy impact statement and the fact that many of the witnesses had not had the chance to look at that before giving evidence. We have negotiated that extension so there will be time.

I anticipate that members of the department have been listening to the proceedings that we have been going through today, and you have seen the submissions. I would really welcome it if you could cover in your opening statement any key issues that have been picked up. I know that you have been following it very closely so if there are particular issues you would like to address and get on the record straight away then please give it a go early in the process.

Mr Learmonth—There are three measures in this increased MBS compliance audit initiative: there is an increase in the number of audits from around 500 to 2,500 a year, there is the requirement for the production of evidence in support of claims that are subject to the audit and there is an administrative sanctions regime. To put this in a bit of context, in the last 10 years expenditure on the MBS has more than doubled. It is now more than \$13 billion a year and growing at more than \$1 billion a year. In the last 10 years the number of providers has gone up by over 80 per cent. There are now over 81,000 individual providers billing Medicare. The number of services that they bill has grown by nearly 40 per cent in the last 10 years. There are now 280 million services each year which are billed to Medicare. This is a very large program with very high volumes of transactions.

In that context there are three risks to that program and that large level of expenditure. There is fraud—and that is reasonably dealt with at the moment under the existing provisions

administered by Medicare Australia. There is inappropriate professional practice—and I will draw that distinction very clearly—which is administered by the Professional Services Review as part of the health portfolio not part of the Human Services portfolio. That is about professional practice and about clinical judgements. Have these pathology tests been ordered reasonably in light of the patient's presentation and their clinical state? Has the appropriate level of clinical care and input gone into this particular care plan given the circumstances of the patient? It is about professional judgements.

The third area of risk, and one of the biggest ones given the volume, is the risk of incorrect payments. This is not about professional service or professional and clinical judgement; this is about claims made incorrectly against the administrative rules on the Medicare benefits schedule and its items. There is a very high volume—as I said, 280 million services per annum—and small differences or small impacts in respect of individual items inappropriately claimed can add up to substantial imposts on the public purse. That particular risk is being addressed in two ways through this initiative. One is the administrative sanctions. That will give us the regime to provide some proportionality to the response. At the moment we have Professional Services Review, which is one issue, or we have fraud—we really have no active deterrent or disincentive to inappropriate claiming. Administrative sanctions are widely used and they are consistent with the recommendations of the Australian Law Reform Commission for these sorts of high-volume transactional systems. The second is the power to require health practitioners to produce evidence to support their claims. There is currently no obligation to do so—some comply and some do not. On average about 20 per cent do not, and that figure is higher in relation to some audits. It is a significant weakness in our capacity to protect public money. I guess it seems somewhat unusual that any funding or benefits program, particularly one of \$13 billion a year, enables people to choose whether or not they are audited.

These measures have been subject to significant discussion and consultation with a range of stakeholders and there are mixed views, as you expect given that we are balancing competing issues in this measure. There is though a fair bit of mythology that has grown up about it and we welcome the opportunity to set some of that straight in this hearing today. This is not about a fishing expedition, just as it is not about bureaucrats poring over whole files of patients at their leisure; this is a very targeted measure designed to require providers to produce documents which evidence the claims that they have already made. It is very narrowly constrained. It is specifically targeted to specific items where a reasonable concern has already been formed in the mind of the CEO of Medicare Australia.

What is being sought is evidence of compliance with those administrative requirements of the MBS schedule—things such as preconditions, time, tests and so on that are requirements in order to claim a particular item. It is open of course to the practitioner to censor or black out the elements that are not relevant and to choose what may be produced in order to comply with the request. Clinical records may not be the appropriate source—indeed they will not be in some circumstances—it may be things such as appointment books. So it is a very targeted and constrained exercise. It is not about clinical assessment. As I said, this is not the role of the PSR. We are not looking at making professional judgements or clinical judgements; this is about administrative requirements for claiming payments. Finally, there are strict safeguards on the use of the data as to who can access it, how information can be accessed, what purpose it can be used for and how it must be disposed of.

Ms Godwin—I do not have any further comments to make at this point.

CHAIR—I would suggest that we go through this topic by topic because there are some clear topics. I will give every senator a chance to speak. I call on Senator Siewert to start and to get a topic to begin questioning so that we are not going backwards and forwards. Senator Siewert, where would you like to start?

Senator SIEWERT—I have a question around the number of audits and the results of the increase of the audits first. Then I would like to go straight to the heart of the matter—which is the confidentiality of patient records.

CHAIR—Is that also about justifying the budget and so on?

Senator SIEWERT—Yes, we could do that.

CHAIR—Okay, we will get the justification in the first segment.

Senator SIEWERT—As I understand it you have already started the process of increasing the number of audits. Other witnesses have asked the question: what have been the results of those increased audits? I suppose it is five months since this started. Is there increasing evidence of a number of incorrect claims?

Mr Bridge—It is a bit too early to tell. With those audits we have had to recruit staff. We have bought them in and have been training them. At this stage we have a range of audits which we are undertaking. We do not have all the final results for those in at this point in time. It is fair to say that prima facie there are mixed results, which is normal, across the audits but we do not have hard and fast details at this stage.

Senator SIEWERT—What do you mean by mixed results?

Mr Bridge—Different items tend to attract different levels of compliance so what we find is that, depending on the item we are looking at, there might be high levels of compliance in a particular item or low levels of compliance in a particular item. As we are doing these audits we are seeing some of that. But it is very early at this stage to be able to get specifics.

The other thing we have is that in terms of the conclusion of an audit after the conduct of an audit we wait for a period of time to see what is happening with the claiming patterns and behaviour of the provider to see what shift has been made, and we do need to allow some time for that. So is a bit hard to say precisely at this stage.

Senator SIEWERT—That leads me to a question around the issue that Mr Learmonth touched on. I did not write down the exact words but he said, if I understand his comment correctly, there are particular areas that seem to have more noncompliance than others in terms of audits. He said there were interesting results. He talked about ‘some audits’ which I presume meant audits of particular numbers.

Mr Learmonth—Yes, there were some. As I understand it, and Medicare Australia will have the details, there are some different kinds of audits. The average figure which has been quoted,

which is the proportion of providers who choose not to comply and not to provide records, is 20 per cent. That figure varies across different sorts of audits, and Mr Bridge might have—

Mr Bridge—I think the reference is not so much to what we have been doing in the last few months but over the period of time we have been monitoring and auditing in the Medicare space. Audit outcomes can range dramatically. We have identified items with compliance as high as 90-plus per cent and items we have identified with compliance down to 64-65 per cent. It is very different across the range of issues and items that we are dealing with.

CHAIR—We asked one of the previous witnesses the same questions about what the areas were at the end of the spectrum—and I just forget which witness we asked—the ones with low compliance. Is it a particular area that creates that? I think that it is really important to know that so that we do not generalise too much.

Mr Bridge—It is actually hard to suggest that there is an explicit type of pattern in terms of those items. They do move over time due to the dynamic of the health system. The particular one I was thinking of when I mentioned that 36 per cent of people are not compliant was an audit we undertook in the 2008 financial year in relation to chronic disease management plans. One we looked at for the levels of compliance was an item in relation to what is called ‘open procedures’ and there was about 90 per cent compliance in that one. So it is very difficult to draw patterns in that sense.

Ms Godwin—If I can just clarify, and I apologise for interrupting: I think we do need to also note that when Mr Learmonth was talking about compliance he was talking about the response to our request for information to substantiate the claim. Once we have got that response, these results relate to those people who have responded to our request for substantiation. So there is another body of practitioners out there who may not have responded to our request for substantiation.

CHAIR—I lost a step there—can you just run—

Ms Godwin—It is a complex issue. There are two issues for us here. Firstly, at the moment, because we do not have any formal powers to require substantiation, if we identify a matter of concern and we go to the practitioner and explain to them that we have this concern and that we would like them to substantiate the claims, there is a segment of the provider population that does not respond to that.

CHAIR—I think that my question was about that. So if you ask 200 practitioners that you have identified a particular item that you are following up on—and I was wanting to know, because of the kind of data we have been talking about—how many people just ignore that request?

Mr Learmonth—On average, 40 would ignore it and refuse to supply substantiation—a fifth.

Ms Godwin—That is the 20 per cent.

Senator SIEWERT—So there is a group against item numbers for that?

Mr Learmonth—No, Senator. There are two different phenomena—we are all getting a little confused.

CHAIR—You need a whiteboard!

Mr Learmonth—Medicare Australia forms the view that with a particular provider there is a risk of inappropriate claiming. They go to the provider and they say, ‘We think that there is a problem. Can you please substantiate.’ On average, one-fifth of providers will say, ‘No, we are not going to comply. Go away.’

Senator BOYCE—Do you know why?

Mr Learmonth—I will come back to that, Senator. The second phenomenon is: if they say yes and then we audit, there are different rates of compliance with the rules of individual items and they go item by item.

Senator SIEWERT—But you do not then pick individual items and then go and see across providers how they are complying with that particular item, do you?

Mr Bridge—We may do.

Senator SIEWERT—You do that as well, okay.

Ms Godwin—The concern may be either a particular provider or a particular type of service—

Senator SIEWERT—That is what I thought.

Ms Godwin—and either of those could give rise to concerns. Senator, your question about why don’t they comply—

Senator BOYCE—I just wondered whether you have had feedback in any way or a survey of why not?

Mr Bridge—We get lots of feedback, Senator! I think it is fair to say that, again, it is a very mixed bag. There are some people who quote the time and the impact; some say they are doing business for the government and so are not interested in doing so. But in fact the majority do not give us a reason—they just do not respond; they refuse to respond to a contact.

CHAIR—And there is currently nothing you can do?

Ms Godwin—No.

CHAIR—On the general issue, Senator Furner?

Senator FURNER—Firstly, congratulations on winning the Australian Privacy Award 2008.

CHAIR—That may well be another topic, Senator Furner!

Senator FURNER—Going to the threshold issue of a trigger for doing the audits that we are currently discussing, one witness indicated that you will be raiding practitioners' offices on one person's view of having a 'reasonable concern'. Firstly, I am wondering what your response would be to that sort of statement. Secondly, how does a 'reasonable concern' relate to the current trigger in terms of concern to conduct an audit?

Ms Godwin—I will ask my colleagues to talk in more detail in a moment about the concept of reasonable concern, but of course I must address the concept of us 'raiding' practitioners' offices. That does not happen—and won't happen. If we have formed a concern, however we have formed it, our practice is to draw that to the practitioner's attention and then to seek, on a voluntary basis, to address that concern. The measure before us would give us an additional power such that, if during that process of voluntary engagement there has still not been adequate substantiation—and that is effectively what we are talking about: a substantiation power—then the proposed legislation would enable us to issue a notice asking for documents that go to substantiation. If the practitioner refuses to supply those documents, there is no further power in the legislation that enables us to go in and seize documents. That is not the intention of the legislation. There is no power for us to go in and seize documents in those circumstances. So the concept of us 'raiding' practitioners is really very inconsistent with both our current practice and the proposals in the legislation.

I will ask my colleague Mr Bridge to address the issue of what forms a 'reasonable concern'. We do have quite sophisticated data mining and data analysis processes in Medicare Australia that underpin our identification of potential areas of risk.

Mr Bridge—Firstly, I will distinguish this from our powers in relation to criminal matters. We have an existing set of powers under the Medicare act to take action where we come to a view that a crime has been or is being committed. In those circumstances we do have a provision where, through the seeking of a warrant, we can actually search and seize, but it is in a very limited set of circumstances. There has to be quite clear indication that there is a crime actually being committed or that has been committed. We have to go to a magistrate to do that.

In terms of being able to work out what a concern is, as Ms Godwin said, we undertake a fairly broad range of activities, and we engage quite extensively with the health profession to help us to understand what is happening in the profession at any particular point in time, to identify what we would think might be the high areas of risk or concern. As to the actual tools we have, we do quite an extensive review of the claiming data we get, as Mr Learmonth mentioned—with some nearly 300 million transactions, there is a lot of data. We have quite sophisticated artificial intelligence tools and profiling tools to identify patterns, trends and areas that may be of concern that might trigger an issue that we would look at.

We also focus on what is happening with new items. We always want to make sure that the profession understands the new item. There is bedding time, so we watch those. We receive tip-offs, in fact. We have a fraud tip-off line and we get several thousand calls a year from members of the public and providers with a range of different information. We look at a range of environmental factors. We look at the nature of the claims that we get. Some items might lend

themselves more to incorrect itemisation than others, so we look at the nature of the item and try to assess the risk.

We also then look quite explicitly at the claiming and billing profile of all providers. We look at how a particular provider is tracking by comparison with a relevant group of their peers. Should there be unexplained differences, that may trigger concern for us and we would seek to get some explanation in relation to those.

Senator FURNER—When you say ‘relevant group’, are they practitioners or specialists in particular fields of medicine?

Mr Bridge—That is right. Clearly there would be no point comparing, for example, a down town GP practice with a regional or remote practice—that would just be silly. We look to do comparisons with a relevant group: the peers of that particular practitioner, whether geographically or in the specialist area.

Senator FURNER—When you talk about powers, are you referring to the powers that the AMA talked about? The AMA indicated in their submissions that Medicare Australia will have the power to view, copy and keep extracts of patient medical records.

Mr Bridge—If you put it that way, the power would be to request a provider to substantiate. What we would actually see is what they choose to provide. We do not have a power to go to a practice, demand access and peruse things. We would see what they provided us with. We would have the power to ask them to provide us with information.

Senator FURNER—That is what is being proposed.

Senator HUMPHRIES—I do not understand how that is consistent with clause 129AAD(7). This is where the CEO gives notice to a doctor that they require production of certain documents. It says:

The power under this section to require a document, extract or copy to be produced includes the power to require the production of a document ... about an individual.

Doesn't that include the power to obtain the original patient record and copies?

Ms Robertson—One of the reasons that we have not specified some of these requirements under the act is that we have been listening to the views of stakeholders and working out how they can comply, given the documents that they keep within their practices and given how those documents are kept. We have tried to make it as easy as possible for practitioners to be able to comply. What we have said is, ‘What we want you to do is provide us with information to substantiate that service.’ We hope that it would then be a matter of an iterative discussion between the auditor and the practitioner as to how that information would be produced, whether there is a copy a produced—

Senator HUMPHRIES—Yes. We have got through that bit. But let us say that that process has failed and the document that you are looking for to substantiate the claim has not been provided.

Ms Robertson—Yes.

Senator HUMPHRIES—At that point, does the CEO have the power to order that the document be obtained and copied?

Ms Robertson—No.

Mr Bridge—No.

Senator HUMPHRIES—How does that work? What does clause 129AAD(7) mean, then?

Mr Bridge—If a provider refuses to provide the relevant substantiation, that stops the matter.

Senator HUMPHRIES—I understand that.

Mr Bridge—It makes the claim disallowable, so there is no further step.

Senator HUMPHRIES—I have got that bit. What if they don't, though? That is the bit that we are looking for here.

Mr Bridge—I am sorry.

Senator HUMPHRIES—Supposing that they do not do that. We understand the bit about them being able to be asked. But what if they are asked and they refuse or just do not respond? We have the first bit, but what happens in the next bit when they do not comply with the request? What power do you have to look at the documents involuntarily?

Ms Robertson—None.

Mr Bridge—None.

Mr Learmonth—There is no power. The consequence of them refusing to provide the document in relation to the direction is that the benefit is no longer payable.

Senator HUMPHRIES—Sorry, I still do not understand. I am trying to read this section. Clause 1 of this proposed section is about where the CEO has a concern about whether an amount that has been paid under Medicare might not have been appropriately paid. Clause (2) says that, if the CEO believes on reasonable grounds that the person has possession of the documents, they may give written notice to the person to produce those documents. Notice may be given in respect of a professional service rendered up to two years previously. Fine—there is a time limit on it. Clause (4) says: 'The CEO may require the person to produce to the CEO any document or extract that is relevant for the purpose set out in subsection (2).' Clause (5) is an exclusionary clause, so forget about that. Clause (6) describes the contents of the notice, but clause (7) says:

The power under this section to require a document, extract or copy to be produced—

this is the document that the CEO has asked of the professional based on a suspected failure to properly account for the services that they have billed for—

includes the power to require the production of a document ... about an individual.

Doesn't that read to you like a person having to produce a document that the person concerned is not willing to provide?

Mr Bridge—What happens is that, if a person refuses to comply with those requests, it triggers a new provision, which is 129AC(1)(1A), which deals with failure to produce a document. That comes into play immediately at that point. We do not have any power to continue to pursue the line to seek the documents. Clause 129AC(1)(1A) comes into place and the claim gets disallowed.

Ms Godwin—Once the claim is then disallowed, it is a debt to the Commonwealth because we have paid it and now we have determined that it should not have been paid because of the failure to substantiate.

Senator SIEWERT—They get a penalty too, don't they?

Ms Godwin—It works in the same way as the other penalty power. So if the amount payable does not reach the \$2,500 threshold it is merely the repayment of the amount that was paid. If it is over the \$2,500 threshold, it attracts the penalty.

Mr Learmonth—In summary, to be very clear, there is no power to ultimately compel documents at all. Ultimately, the provider may refuse and the consequences of refusal are that the benefits become no longer payable. They are recoverable, and if they exceed the threshold an administrative sanction may also apply. But there is no power to compel documents.

Senator SIEWERT—Isn't that semantics? The power to compel is the fact that, if they do not hand over confidential patient records, they are penalised by not being able to claim?

Ms Godwin—I do not think it is just semantics. It goes to this question of whether the proposal is that we would then be able to go in and, in effect, take the documents.

Senator SIEWERT—I understand the point about not being able to go in. I acknowledge that, but the point is that if clinicians, practitioners or providers feel very strongly about not handing over confidential records—which, very plainly, a lot of them do—the penalty they pay is that they cannot claim for the provision of the service that you are questioning.

Ms Robertson—The benefit would have already been paid in that case.

Senator SIEWERT—But they then have to pay it back.

Ms Robertson—That is exactly right.

Senator SIEWERT—It amounts to the same thing. Sorry, but again that is semantics. It amounts to the same thing. A debt is then raised against them and, if it is over \$2,500, if it is for a series of—

Mr Learmonth—This is just a different way of approaching the core question of the reasonableness of what we are doing in terms of accessing information. At the end of the day, there could be any number of reasons why a provider may choose not to comply, and that is their choice. The question comes down to: is that reasonable in the context of what it is we are asking for, why we are asking for it and how we are dealing with it and protecting it?

Senator SIEWERT—And I acknowledge that, if there is an incorrect claim and it does turn out that there is some fraud involved or purposeful misquoting of numbers—

Mr Learmonth—Inappropriate claiming.

Senator SIEWERT—Inappropriate claiming, yes. That is a point, and obviously action should be taken. But a lot of concern is being raised about confidentiality of records. The issue that has been raised with us is: can you come up with another way of providing the detail without providing those confidential records?

CHAIR—We are now moving on to—

Senator SIEWERT—We are now moving on, sorry—we are overlapping.

CHAIR—Are there any other questions about the threshold issue of the power and the threshold issue of the justification for the legislation? It has been raised by many witnesses that we should check the figures.

Senator SIEWERT—I do want to go to the figures as well.

CHAIR—I think the confidentiality issue is so big that we should stick with the general issues first.

Senator BILYK—Can I just ask whether you have consulted with people about this whole issue of confidentiality. If so, who?

Ms Robertson—Extensively.

Mr Learmonth—The consultation has been very, very extensive.

Senator BILYK—I asked the AMA for any sort of evidential issues, not just hearsay, so can you just explain to us—

CHAIR—It is obvious that the committee wishes to move on to confidentiality issues! I am not going to hold up the process.

Senator BILYK—It is all linked.

CHAIR—We will move to the question of consultation on the issue, then we can go back to general issues about the confidentiality of patient records.

Mr Learmonth—Would it help if we just put on notice for you what our consultation process was and who we talked to?

CHAIR—That would be fine. It was all in the submission. Going to confidentiality, Senator Siewert?

Senator SIEWERT—I started on the issue in terms of whether you have looked at any other form of being able to provide information, other than gaining access to individual confidential records.

Mr Learmonth—At the end of the day a number of MBS items are constructed such as to require certain things to be done or certain preconditions. That is all we are looking for in terms of substantiation—and nothing more in terms of the broader clinical circumstances or history of the patient. In many ways what we are asking for is only what the provider has already told us about the patient. So, for example, if item 2517 has been claimed by a provider, we know from that item that the patient has diabetes and they have done a BMI, a height and weight, and a blood pressure test on them. Those are the requirements for that item. So we know what the diagnosis is for that patient and we know what procedures have been done. Those are all the things that we would be looking for to substantiate that item—nothing else.

Senator SIEWERT—But how then does a provider prove that, without giving you access to confidential records?

Mr Learmonth—The provider could provide a copy or an extract of their record, with evidence that those things had been done represented and everything else blacked out.

Senator SIEWERT—I think you were in the room when the AMA were going through saying a provider may have to do that for 60 patients—

Mr Learmonth—That is a question about whether there should be an audit program or not. It seems to me that, in terms of workload, there are two ways you can have an audit program. One is to ask for everything—the tax office can do that—or you can be very targeted. We have a very sophisticated way of saying, ‘Here we think is significant risk; here are some particular items that we think are a concern’—and we will narrow and limit our scope of attention to those particular items and thus minimise the footprint, if you like, or the impact on the provider. It seems to me that this is a very targeted, narrowed and specified way of conducting an audit that is intrinsically minimising of the workload, as opposed to the tax office approach—‘Give us your records for X financial year and we will spend some days with them.’ This is very targeted. So the question is really about whether there ought to be an audit program or not, and if there is going to be an audit program there does have to be some minimal assessment of whether or not the administrative requirements of an MBS item have been complied with. It seems to me that this is really crunched down to the absolute minimum of what is required to substantiate a payment, in a targeted way.

Senator HUMPHRIES—Can you describe the sorts of circumstances in which for the purposes of substantiation you would want to see the full clinical record.

Mr Learmonth—I personally could not think of one, but—

Mr Bridge—In fact, I was going to say the same thing: I cannot actually imagine a circumstance where we would require the full clinical record.

Mr Learmonth—We just could not ask for it under this—

Mr Bridge—Yes, I was about to say—

Mr Learmonth—We could not ask for it. If you look at the act, the requirement is to produce a request in respect of a document that specifies substantiation in relation to individual specified MBS items on specified days. You could not construe a wealth of information around that; all you could construe as relevant to that is the specific evidence that attests that the necessary preconditions for claiming that MBS item have been met.

Senator BOYCE—But nevertheless it could require quite a lot of administrative work on the part of the clinician or someone in that practice to provide that information to you in such a way that it only related to that event.

Mr Learmonth—If you are going to have any audit program, whoever is being audited must give you something. The alternative is to say: ‘Here’s my filing cabinet. Go for it.’

Senator BOYCE—That was not the question I asked though.

Mr Learmonth—No, I understand that.

Senator BOYCE—There could be a considerable amount of time and effort required to extract the information you want, couldn’t there?

Mr Learmonth—Firstly, it is very targeted and narrow. As I was saying before to Senator Siewert, this is not a broad based thing. It is quite specific in terms of the items, the dates and so on that are requested. It is quite narrow in its focus. Mr Bridge might even put some more context around this in terms of the likelihood of being audited in the scheme of things.

Secondly, as Ms Robertson was saying earlier, in response to the profession and their desires we have not wanted to be too specific in what they provide but have allowed them the judgement and the flexibility to produce a document that is appropriate. They will do that having regard to what systems they wish to use—whether it is paper, electronic or whatever it might be; however it is stored—in order to minimise their workload. They will be able to choose how they comply in order to substantiate the claim that has been made. I think in all those circumstances it is very targeted and specific and it gives them the capacity to respond in an appropriate way. I think those things together, if you are going to have an audit program at all, will minimise the impact and the workload on the provider.

Mr Bridge—Any form of audit is an impost on the party that is being audited in any regime. We set ourselves the task of ensuring it has as low an impact as it possibly could. We do that through a number of things. We consult with the industry. We try to be as transparent as we possibly can. We publish each year a document called the *National compliance program*. We put out in the public arena for practitioners the areas that we are seeking to focus on in a particular year and the types of issues we are encountering. It is all very clear. We give them quite a clear understanding of what they can expect.

We want to be out there. We have undertaken audits in the past where we have had quite a bit of feedback about what we have been doing. We have adjusted the style of the audit to reflect that. We recognise that it has an impact, but at the end of the day some level of impact is part of the cost of being part of the system. We do go to great lengths.

In terms of the level of audit that Mr Learmonth was referring to, prior to the introduction of this increased activity Medicare Australia was auditing in the order of 0.7 per cent of medical providers. That effectively meant that 99.3 per cent of providers were not getting audited. It meant that if you were dealing with it sequentially there is a one-in-over-100-year chance of being subject to audit. Even with the increase ,now about 94 per cent of doctors are still not going to be subject to an audit. The odds have come down. It is only once in 25 years now.

Senator BOYCE—But surely that is because you have identified that their behaviours would not warrant it.

Mr Bridge—Correct.

Mr Learmonth—That is partly because they know there is an audit program there.

Mr Bridge—An audit program serves a number of purposes. One significant element of that is to act as a deterrent in relation to behaviour. It does influence broad behaviour. It also feeds potentially policy advice and helps us to understand the areas we need to focus on to improve our support for medical practitioners. Another interesting statistic in that sense is that currently there is a far greater chance that a provider would be engaged with our compliance activities through our help and support activities. Somewhere in the order of 30 per cent of providers currently would have contact with us through our support programs as opposed to through our audit programs. We are very keen to make sure this is a balanced, low-impact proposition.

Senator BOYCE—That sounds good.

Senator FURNER—I would not be too alarmed about the scrutiny of privacy, particularly from the opposition. They had an issue when it came to the Fair Work Bill with union officials having access. Moving on, the AMA indicated in their evidence that doctors do not have to provide extracts or entire clinical records to private health insurers. I am wondering whether you could explain their requirements when it comes to auditing their people with regards to health insurance issues? Do they have access to clinical records? Do administrative clerks handle those audits or is it always a medical professional?

CHAIR—Is that something that you can answer?

Mr Learmonth—We will take a punt on it to the extent that we can, but the main experts for PHI are not with us today, I am sorry.

Ms Robertson—In the submission that has been put in by the Health Insurance Association, I note that they have made mention of the fact that when their customers make claims they actually sign a declaration that would provide some sort of consent to their records being accessed. My understanding is that they have accessed records and do access records in the administration of private health insurance, particularly with regard to pre-existing ailments or conditions, for which there are longer waiting periods. In terms of who accesses the information, I would also stress that under existing legislation, in the Health Insurance Act, there is some clinical information provided that is not required to be provided to a medical practitioner, and that is in relation to specialist referrals, and diagnostic imaging and pathology information. When the Professional Services Review goes out and obtains clinical information now, it is not required that it only be looked at by a medical practitioner.

Senator FURNER—So patients actually consent on the application to provide that ability for—

Ms Robertson—Under private health insurance, my understanding is yes, but in relation to other programs, particularly the PSR, no.

Senator FURNER—Okay. Thanks.

Senator BILYK—This new system has been working for a few months now; is that right?

Mr Learmonth—Only the increased number of audits, not the new powers. They are still under the existing powers.

Senator BILYK—What happens if a practitioner has got a complaint about an audit, like the way it is proceeding? Have there been any complaints or an increase in complaints? I have got no idea what the numbers might be.

Mr Bridge—Usually I get a phone call. There has been some increase in the level of complaints, which I think is natural: when you increase the numbers, you are going to increase the number of complaints. At this stage I would not suggest that it is out of hand, and the complaints have been more along the lines of the approach we may have taken—the particular type of audit rather than about the auditors themselves. Historically, we get a range of different issues raised with us and actually some compliments, come to think of it, as well. One that we have encountered is that, having undertaken an audit of a practice, it has provided greater clarity and understanding in that particular practice. So we do get that as well. So we have seen a slight increase in complaints, but they are in particular areas, and we are seeking to address the issues that have been raised in those complaints.

Senator BILYK—Just to clarify, will you only be doing an audit, though, where there are some grounds for concern, or is this just a spot-check type audit where your name might just get pulled out of the computer?

Mr Bridge—No. At the moment, our program—and we have worked very hard on this over recent years—is 100 per cent risk based. So we go through extensive work to target particular areas of concern. We simply do not have the resources or capability to be randomly chasing rabbits down burrows, if you like. It is a very targeted program looking at areas where there might be particular issues of concern and, as mentioned earlier, whether they relate to a particular item or series of items, a particular provider or indeed a patient—or whatever the case may be across the whole breadth of our program.

Senator BILYK—Thanks.

Senator BOYCE—I have just two questions that sort of flow on from the questions Senator Bilyk just asked. The Medical Indemnity Insurance Association earlier commented that there had been a large percentage increase—not numbers but percentage—in Medicare related claims to the organisation MDA in the past six months or so. They have undertaken to have a look at why that might be so. But I was wondering whether you might be aware if that is related to your audit activity.

Mr Bridge—I am not aware of it other than the fact that I heard the same comment made. I would certainly be happy to talk to them to see if there is a connection, because as I said earlier we are very focused on trying to make our audits low impact, so if that is happening we would be very happy to hear why.

Senator BOYCE—The other question I had was in relation to reasonable concern. We have had a number of witnesses suggest that they are concerned that there is no definition of reasonable concern and they have made some suggestions about patterns of behaviour or patterns over a particular period or something like that that should be included.

Ms Robertson—Can I draw your attention to section 129AAD(1) in the draft legislation. We have put a note in there about the types of things that would cause reasonable concern. That is one of the reasons that has been put in there. I know there was a suggestion earlier today about a reasonable suspicion. We have deliberately stayed away from reasonable suspicion because that is used very much in connection with criminal activity, which is not what this is about. So the reasonable concern would be in relation to benefits or payments in relation to professional services rendered by individual practitioners. A situation that might arise is where you might have a practitioner that would be doing high volumes of services outside their area of specialty, for example. You might have professional services rendered by particular kinds of practitioners. Once again, the rendering of services in relation to specific items, groups of items and that sort of thing is where we have a concern about growth.

Senator BOYCE—Presumably that was a deliberate decision to put it into the notes rather than to actually have it as a definition in the legislation. Why was that?

Ms Robertson—I think it is very hard for us to be able to define what is a reasonable concern. The reasonable concern is actually going to be very different depending on the type of audit that is undertaken. Your reasonable concern, for example, in relation to a new policy, might be where you have got excessive growth in services over and beyond what was ever envisaged as part of designing that program. In relation to a particular item, for example, all of a sudden you might notice that there has been a very large spike in the use of this particular item. It might be on the

item itself or it could be simply a result of a different specialty group all of a sudden claiming this item. Those are the sorts of things that will trigger audits. It really does differ issue to issue.

Senator BOYCE—So change in activity or claiming patterns could not be put into a definition. Can you see that the profession has a reasonable concern that, right now, reasonable concern can be defined any way you want to define it without them having any input or say?

Ms Robertson—I understand the issues that have been raised by people who have given evidence here today and it was one thing that we did talk about quite extensively in the drafting of the legislation. The definition ‘reasonable concern’ is not defined anywhere else in the Health Insurance Act. It is something that is particular to these provisions. Once again, in designing the legislation, we have to be very careful that we have got that element of flexibility whilst at the same time providing some very clear parameters around this. The more you get into defining what is a reasonable concern, the more you might lock things down to have unintended consequences and a concern that is quite genuine but outside the definition.

Mr Learmonth—I note also that the act requires the notice from the CEO to the practitioner to actually spell out what their concern is in relation to the document, so it will be quite specific.

Senator BOYCE—But there is still no avenue for the practitioner to say, ‘No, that is not a reasonable concern under the law,’ is there?

Mr Learmonth—That is the whole purpose of the audit—to verify the provider’s claim that it is indeed reasonable.

Mr Bridge—At the beginning of the year we put out our program, so we have given very early indications of the areas where we have got concerns.

Senator BOYCE—This year’s reasonable concerns?

Mr Bridge—This year’s reasonable concerns—very much so, public. Maybe I could give you a couple of examples of that, at an item kind of level. There is a particular set of items dealing with heart checks.

Mr Learmonth—There have been ads on the radio.

Mr Bridge—Yes, you often hear the ads on the radio. We were monitoring at an item level. The level of claiming against those particular items across all age groups in the community—including under-18-year-olds—grew dramatically. I will have to confirm the figures, but it went from about \$500,000 a year to \$10 million in one 12-month period. I would suggest that is a reasonable concern.

Senator BOYCE—One of the submitters makes the point that in fact that was a legal activity under the current framework and was really a policy issue rather than a Medicare compliance issue.

Mr Learmonth—But the risk was not that the volume itself was an issue. It might be ‘reasonable demand’ generated. It was more that it was prudent to see whether or not all of those

items were in fact being claimed correctly and what they were held out to be, as part of the claim.

Senator BILYK—Could you actually define what is not a reasonable concern, if you cannot define what might be a reasonable concern? I know it probably sounds a bit back to front, but is there a possibility of that?

Mr Bridge—Things that are in normal claiming ranges would be unlikely to attract our attention, but I am not sure how you would actually spell that out without creating—

Senator BILYK—Perhaps you could think about that and see if that would help alleviate the problems.

Mr Learmonth—I think the challenge is that the MBS does evolve and change; the kinds of items that you find on the schedule change and their requirements change, and thus the things that might give you concern change. So if you go back a little ways, for example, you would not have found care plans on the schedule. They have a bunch of quite specific requirements and they are subject to some compliance risk, as Mr Bridge said earlier. The sorts of things that might give you cause for concern in relation to those might be very different than in relation to others. So the concern is how you actually have some flexibility to allow the evolution of the MBS and the items on it and thus what might give you concern from time to time.

Ms Godwin—Could I also add to something that Senator Boyce raised? It is not our proposition, in terms of the use of these powers, that we would go immediately to the issuing of a formal notice. The overall approach that we generally take and we propose to take in relation to audits on an ongoing basis, even should we have this power, is that the first thing that you do is let a practitioner know that you have got a concern. We would not do that by way of a formal notice in the first instance. We would, as we do now, either write to them or call them and let them know that we were worried about a particular thing, and that would give us the opportunity to talk through with the provider what the concern was and what sort of substantiation might be appropriate.

Senator BOYCE—Can I just stop you there and ask you: if the responses are, ‘Oh heavens, I didn’t realise I was claiming that under the wrong number,’ or ‘Isn’t that the way I should have done it?’ what happens next?

Mr Bridge—That would be a good response if there was actually an incorrect claim—

Senator BOYCE—I presume that sometimes you do get that.

Ms Godwin—It does happen.

Senator BOYCE— The response ‘I didn’t know I was doing that the wrong way’?

Ms Godwin—Yes.

Mr Bridge—What we would do there is look to quantify the level of those errors with the doctor. We would not necessarily have to go to any formal records at that point in time. We

would calculate the amount outstanding, we would give them the opportunity to review that to make sure they are satisfied that we have got it right and then we would issue them a notice for them to repay.

Senator BOYCE—Okay.

Senator SIEWERT—I want to go back to the area of compliance and the comment that you made in your submission on page 17 at point 67:

... 10 percent of providers already give to Medicare Australia voluntarily the confidential patient material that is the subject of this legislation ...

I raised this issue with the AMA. The extent of the confidential information that is provided—is it whole records? Because what the AMA suggested happens is that people—and I know a number of you were in the room when they were talking about it—are fearful and concerned about the fact that they are being audited and just say: ‘Okay. Here are the records; you go and look at them.’ Is that in fact what happens?

CHAIR—Under duress.

Senator SIEWERT—Is that what happens? What are the circumstances in which they can gain access to this 10 per cent? I realise that it is 10 per cent of the people being audited and not 10 per cent of the entire group of providers. Or is it along the lines of what Mr Learmonth was saying earlier, that there is only a certain amount of information that is provided or that would be asked for?

Mr Bridge—There is certainly a limit in terms of the information we ask for. We do tend on occasion to get a varied level of response and we have had people provide us with information that we did not ask for. To some extent that comes from the lack of any clarity or framework at this point in time as to what they can and cannot provide. I think it is fair to say that the medical profession is like any sector of the community and you are always going to get a varied interpretation and response in relation to that. Some people take great care; some just send us in stuff. We seek very quickly to get to the information we need and to get the records that we do not want back to the people. It is very much a mixed bag, and I think it comes from a lack of understanding of what are the limits and what is the framework in relation to what can be provided and what cannot be provided.

Senator SIEWERT—That goes back to concerns pointed out in a number of submissions, by both providers and other people worried about privacy, that it is not clear from the legislation what level of information is provided and that, out of fear or concern, medical practitioners perhaps give more than is required. I appreciate that you do not mean that that should be provided, but the fact is that patients can still feel insecure about their confidential records, which they think should be private, being handed over—whether that was your intent or not.

Ms Godwin—Sure. I think that goes to a couple of things we have already talked about. First of all, as I have mentioned, our continuing practice will be to raise the concern with the doctor and talk about what sorts of information might go to substantiation. While we expect that there are some items that would require access to the patient record, there are also items that do not,

and that would give us the opportunity to talk to the doctor about the fact that it would not be necessary to go to that level to substantiate this type of claim. Secondly, if we do then have to go to a formal notice, it will set out what the concern is and what it is we are seeking to substantiate.

The other thing that we do acknowledge is that, surrounding this, there will need to be further provider information, education and consultation with the industry about various types of audits. We would want in that process to emphasise that it is not our requirement, under any circumstances that we can think of, to receive a whole patient record; that what we are very much looking for is the excerpt that can go to the substantiation of the particular item about which we are concerned. As the legislation sets out, we actually have to specify what item, what date, what patient, so it should enable the practitioner to be quite precise about what they are required to give us in that instance, and not the whole patient record. In fact, if they give us the whole patient record, our practice in the past has been either to send it straight back or to destroy that part of the record that we do not need.

Ms Robertson—A lot of this information is also contained in the privacy principles as well as in the privacy impact assessment. I know that some of the witnesses here today have spent some time talking about the lack of information in the bill around protections given to information, particularly private information, health information. One of the reasons that that is the case is that it is already covered elsewhere by existing government legislation and principles.

Senator FURNER—Can you advise who was involved in the formation of the privacy impact assessment? There were some concerns expressed.

Ms Robertson—There was Medicare Australia and there was us, the Department of Health and Ageing, and as well as the Office of the Privacy Commissioner. Certainly one of the issues with finalising the privacy impact assessment for release has been making sure that we take into account a lot of the issues that have been raised by the Privacy Commissioner.

In terms of consultations, obviously there have been lots of consultations with stakeholders as part of the process. One of the things that we have been at particular pains to talk very openly with people about is whether or not patient consent should be provided. Obviously, you would have seen today that there is a very mixed reaction out there with regard to consent, not just with the witnesses but also with the submissions. In fact, we have a letter here from the Consumers Health Forum, which says that they understand that privacy will not be compromised under the proposal to extend the current arrangements to require health professionals to provide documents to verify compliance with the Medicare billing processes, that they believe that consumers are fully aware of the need to ensure a sustainable health system that has checks and balances in place, that they believe that it is entirely in the public interest for the new MBS compliance procedures to be implemented and that they support the measure.

There is a lot of scaremongering out there about what sort of information will be provided to Medicare Australia. But a lot of the information that is contained in a patient record now will never be required for Medicare audit processes. We go through the items in the MBS, there are certain things that we can ask for and they are stipulated in there. There are certain things that are not relevant to the Medicare audit and which they will not want to look at. In terms of balancing those interests, one of the reasons that the bill has been constructed in the way that it

has is that we do not want to alarm people unnecessarily. That was advice that we obtained through the Consumers Health Forum.

Senator HUMPHRIES—Is it possible for a practitioner to provide evidence other than from the patient's medical record to satisfy Medicare that a particular service has been provided? I am trying to conceptualise how this will work in practice and whether by a process of creeping accretion we will get to the stage where it is standard to supply several pages from a record to demonstrate irrefutably that a certain service has been provided.

Ms Robertson—It would depend on the issue that is being audited. I can probably give you a couple of examples. One is where we say, 'You need to have a referral from your GP for this particular item to be claimed.' All Medicare Australia would want to see in that case is that there is a dated referral from the patient's GP in that regard. There would be other instances where the question could be, 'Did you have a blood test?' It does not matter what the result was; we just want to see that there is evidence for that there. It really depends on the issue.

CHAIR—One of the examples that the AMA and other people put forward was the extended appointment. There is a difference in the Medicare item number depending on the time that it takes to have an appointment. That was an example that was used. If you were looking at the longer appointment Medicare item, how would a practitioner justify that, particularly when we heard that the diary would not be sufficient—we looked immediately at whether diaries could be used—because the diary shows when the appointments were but not their length? If someone had an extended appointment with a client and you were checking that, how would they justify that?

Ms Robertson—That is the difficulty with the time based items. The simple fact of the matter is that if there is not a record of it then you cannot substantiate it. That may not be the sort of thing that would be appropriate for this type of audit.

CHAIR—It came up consistently in evidence, so there seems to be a view among the practitioners that it is something that could be audited.

Ms Robertson—There has been a lot of discussion around the primary care items, particularly—level Cs and level Ds.

Mr Learmonth—This is separate to the audit question.

Ms Robertson—That is exactly right. But I also happened to look after other matters relating to the schedule as well, so I am quite intimately involved with that. We have been going through a process of consultation with practitioners around simplifying that part of the schedule as well to do away with some of that concern.

CHAIR—Is that the kind of issue you are looking at, Senator Humphries—having to justify and how you would do it?

Senator HUMPHRIES—I can see what you are saying at one end of the spectrum, but I am looking at the other end, where effectively what is on the medical record is what you are looking for to substantiate that the service has been provided. Just suppose that Medicare wants to

ascertain whether a patient really is being treated for a particular illness. There is no referral and there is no other evidence of a circumstantial kind that might prove that the service has been provided. If the doctor submits an extract from a record—a photocopy with sheets on either side—saying, ‘Treated this patient for venereal disease on such and such a data’—

Ms Robertson—There would be no item for that.

Senator HUMPHRIES—I am giving an example.

Ms Robertson—I know. I understand what you are saying.

Senator HUMPHRIES—Some condition that is referred to that is claimable—forget what it is; let us make something up.

Ms Robertson—I can give you an example, if you like. There are items in the schedule about the treatment of diabetes. I think Mr Learmonth has raised this issue before. In that particular case, the thing that you would be looking for in claiming that item is: does the patient have diabetes? So is there an extract? You talked about it being blanked either side. All you would want to see is something that says, ‘Patient has diabetes.’

Senator HUMPHRIES—How do you know it relates to the patient that you are auditing?

Ms Robertson—Hopefully, there would be a name at the top of that record. There would have to be something that would link that patient to that record.

Mr Learmonth—The request would relate to a named item for a named patient on a specified date. So if you get back a record which says the patient name which corresponds and says that the patient has diabetes, that is all you are looking for.

CHAIR—Are there any other questions in this area? We should move on to general questions.

Senator HUMPHRIES—Can I clarify? You are saying that there are no circumstances where you would require the production of a full medical record except where the doctor concerned wishes to obtain payment. You are saying to them, ‘If you want the payment for that service, you have to produce a medical record that satisfies us that in these circumstances there is an entitlement.’

Mr Learmonth—There are a couple of things mixed up in the there. The doctor can choose what they provide. In terms of what we require, again, the act is not framed in such a way as to ask for a patient’s medical records. The act is framed in such a way as to require documents to support and substantiate the claiming of specified items on specified dates for specified patients. As Ms Godwin said, we will be working with the profession to ensure they understand that. It will be specified in the document. The reasons for concern will be set out in the document. The practitioner will have a clear guide as to what we will be looking for in order to substantiate a claim—that is, specified items, specified dates and specified causes for concern.

Senator HUMPHRIES—On the point about informing the profession, the College of General Practitioners, the AMA and other specialist groups have come before us today with apparently a

complete misunderstanding of what this is all about. So at best it could be said that the process of consultation you have engaged in so far has not been terribly effective in educating them about what exactly you are talking about.

Mr Learmonth—I would probably separate consultation from advocacy.

Senator HUMPHRIES—Okay. So you are suggesting that they choose not to understand.

Mr Learmonth—All the material has been out there in the public domain. We have had a number of meetings with all of the stakeholders. I am not sure there is anything we are telling you today that we have not actually told them in our consultations.

Senator BOYCE—I think their response to that would be that they have not noticed much difference to your material after the consultations.

Ms Robertson—It is interesting. I did notice that someone said today that there was an inconsistency between our information sheets and what was in the legislation. That was actually quite deliberate because we took into account what people were saying through stakeholder consultation when we went and drafted the legislation.

Senator BOYCE—Could you give us some examples of that?

Ms Robertson—Yes. One of the issues that was raised in stakeholder consultation was: what do you do if the information or the patient record does not belong to the practitioner?

Mr Learmonth—Corporate practices and so on.

Ms Robertson—Yes, that sort of thing. That is one of the reasons why in the draft legislation now there is the ability to go to a person who has control of those records.

Mr Learmonth—Third party access.

Ms Robertson—Concerning other issues that were raised in the consultation—and I have already said this—specifically we were asking whether we have a patient notification provision in there or not. The balance of the consultation was that the detriment would outweigh having that in there. I would also note only two of the people I personally met with in that stakeholder consultation were here giving evidence today.

Senator BOYCE—But not the organisations.

Ms Robertson—The organisations were here.

Senator BOYCE—Surely more than two organisations who appeared today provided feedback.

Ms Robertson—We have definitely consulted with the organisations. But of the people we have been consulting with within the organisations only two were here today to give evidence.

Senator BOYCE—One hopes information flows around organisations as well as it does around departments, Ms Robertson.

Ms Robertson—I would hope so, yes, but I am beginning to wonder about that, because the messages that we are getting back seem to be a little bit different depending on who you talk to.

CHAIR—Are there any further questions?

Senator HUMPHRIES—The Civil Liberties Australia submission says that Medicare has an abysmal record of making financial claims as to potential savings that prove illusory. Is that a fair criticism?

CHAIR—And I think the submission recommended that we ask Medicare about their history, Senator Humphries.

Senator HUMPHRIES—That is what I am doing now.

CHAIR—I know.

Senator HUMPHRIES—Is that true? Is it a fair comment? If we went back and tracked how the savings you have predicated in budget submissions have panned out, would we find that you are pretty accurate or that you are pretty inaccurate?

Ms Godwin—I honestly have no idea what basis they would have for making that statement. The costs and the savings in the measure are not just the costs and savings that we have asserted. There is a process in government for having those checked and agreed with the department of finance, and that is what goes into the documents. The costs figure is what we have been budgeted for.

Mr Learmonth—I can assure you that their disposition is to try to bring them down, not magnify them.. It is hard work getting them acceptable.

Ms Godwin—The costs figure is what is in the budget, and that is what we will have to live within. With respect to the savings figure, as I say, both the methodology and the figures have been reviewed and substantiated in the process we have to go through with DOFD. We think they are robust, and it is not just our assertion. There is some substance to those figures. I cannot comment about other circumstances that the submission is referring to. I am not sure what particular things he would be referring to. I am really at a loss to comment.

Senator HUMPHRIES—I have asked them to explain what they mean in a question on notice, so presumably—

Mr Bridge—I think it is worth recognising that this is actually the first compliance measure in about 10 years for Medicare space. So I am not sure what the previous—

Senator SIEWERT—You mean new compliance measure, don't you?

Mr Bridge—New compliance measure, yes. There were previous measures in that period of time in relation to the Pharmaceutical Benefits Scheme about six or seven years ago. There was the same kind of proposition. Fairly robust costings were undertaken and agreed with the department of finance and the department of health. A methodology was agreed in terms of calculating the savings. Those savings were reported on to government. They have been delivered.

Senator HUMPHRIES—Okay. That is all I wanted to ask.

Senator SIEWERT—I want to go back to the issue of notifying patients. I do not know if you have read or seen PIAC's submission. I presume you have read it, but there is a lot, so I do not take anything for granted. They are suggesting, rather than a consent process, a notification process. Had you considered that?

Mr Learmonth—It is a complex issue, Senator. There is no requirement for consent or notification under the privacy principles or otherwise. It was certainly one that we did consider and certainly one that we consulted on. There were mixed views.

Senator SIEWERT—On the notification specifically versus the consent?

Mr Learmonth—On whether or not there should be either. There is a great commonality to the issues that pertain to both, to the extent that the balance of view came down that it would be better not to do either on the basis that to do so really gives rise to some significant risks insofar as there is a potential privacy impact on the patient in that their family might discover they have been to a medical practitioner for something which they did not wish to be discovered. There was a concern on the part of a significant part of the medical profession that notification or consent would raise the level of anxiety in their patients unnecessarily, that it would undermine the trust, the clinical bond and the relationship between doctor and patient and that it would cause unnecessary concern.

Senator SIEWERT—Thank you.

Mr Learmonth—Sorry—if I could continue. As I said, there are different views. There is nothing that precludes individual practitioners from providing some general notification that this might happen—like putting a sign up. We are obviously happy to continue working with any elements of the profession—with the Office of the Privacy Commissioner, Medicare Australia and so on—to facilitate that if that is their wish. That would be by way of supporting the profession in making their choice. But, as far as the legislation goes, the balance of concern seemed to be that there would be more risk in doing so than not.

Senator FURNER—The AMA indicated that the process would be better dealt with in an educational way than just a compliance way. What is your response in that respect?

Mr Learmonth—They are absolutely right in that education support is critical. An enormous investment goes into that on the part of Medicare Australia. I think Mr Bridge provided some context on the relative levels of contact between Medicare Australia and individual practitioners on a support education basis versus an audit basis. The question is: is education enough? There will always be people who for one reason or another—whether it be carelessness or otherwise—

do claim inappropriately. At the end of the day, if there is no deterrent or if there is nothing at all to make them think carefully as their pencil hovers or their finger hovers above the keyboard on claiming a particular item, that is going to be a risk to an extremely large program.

Mr Bridge—If I could I add to that. It is always a question of balance. It is quite clear that at the moment the balance of our activities is weighted towards education and support. We try to engage quite extensively across a range of activities. We provide online learning tools. Indeed, we are seeking to go into universities and provide education at that level. We do face-to-work with providers. We provide quick-reference guides. We provide all sorts of material. We try to provide it in the most usable format for providers to access. That will continue to be a main element of our compliance program. We aim to be balanced. The weight is in the education. It is far better from a compliance perspective if we are able to put people in a position where they can voluntarily comply. At the end of the day, we cannot audit everybody so we by far want to put the general population in that place.

Ms Godwin—Notwithstanding that very significant education effort and notwithstanding the limitations to our current powers, we continue to find cases of incorrect claiming in some instances of many thousands and thousands of dollars. Our only option, when we find it, is to seek recovery. We do not find it everywhere because we cannot check often; we cannot substantiate all the claims. We have had that discussion before. Some people do not pay back for whatever reason. The overpayments are sometimes very large. If education were the key to it, you would expect that our very significant efforts now would be having an impact. At one end of the spectrum, there is still significant incorrect claiming.

CHAIR—So they are not all \$79?

Ms Godwin—They are not all \$79, unfortunately.

Senator FURNER—I have just one last question. The AMA indicated in closing they were going to petition their members. Why would they go to that sort of trouble? What sorts of issues are you aware of they have with the proposed legislation?

Mr Learmonth—We could go through all the issues of privacy access and workload. I would be hard pressed to think of any sector that would volunteer to be audited.

Senator BOYCE—I have just one question, following on from the questions earlier. Not only the AMA but also a number of other witnesses suggested that perhaps some more effort should be put into simplifying the MBS and the number of items within the MBS. What is the department or Medicare doing in that area?

Mr Learmonth—They are quite right, Senator. There are a couple of things, and Mr Kingdon and Ms Robertson will talk more about it. One of the minister's undertakings was an MBS review, which looks at simplification of some of the items in particular, and that is under way.

Senator BOYCE—So there is a review under way.

Mr Learmonth—Yes.

Senator BOYCE—Is that with a finish date?

Mr Learmonth—Shortly. Secondly—and Ms Robertson might talk about this—we do have a very substantial engagement with the profession, and the AMA takes the lead in it in developing any new item that goes onto the MBS. We have a beast called the Medicare Benefits Consultative Committee, which is essentially between the department, Medicare Australia and the AMA, that goes to the detail of new items to go on the schedule. It goes to the descriptors and what those administrative hoops are that have to be jumped through to be claimed—indeed what would be subject to this audit. So it is very much in the joint remit of the organisations to ensure that the items are going forward appropriately. As to some of the items that exist that they have some concern with, I think rightly, the minister has already put in place a process to deal with those.

Mr Bridge—At the same time we are still trying to provide greater clarity in relation to the current state. As I mentioned, we have a range of educational products such as reference guides and we are continuing to increase the energy we put into that and introduce some more products. Recently we introduced a product which we call an administrative practice statement, which is a Medicare Australia interpretation of item numbers, to try to give to providers quite explicit clarity about what can and cannot be done.

Senator BOYCE—Item by item?

Mr Bridge—On a range of items. There are a lot of items, so we are picking the items that we have had complaints or concerns about or issues with.

Senator BOYCE—The most asked about items.

Mr Bridge—We are also publishing, on our website, overall claiming profiles for items, particularly the key items, so that practitioners can see where their practice might sit against the general population. So we are constantly trying to give them some sense of where they are and some sense of how to interpret the issues.

Senator BOYCE—Is the review that is currently being undertaken systemic?

Ms Robertson—It is with regard to the primary care items within the Medicare Benefits Schedule and what it covers.

Senator BOYCE—What is your stated purpose in the review?

Ms Robertson—To simplify the schedule and do away with red tape. It is affecting not only the items but also the explanatory material that goes along with the items.

Mr Learmonth—It is questions like level B, level C or level D consults—

Senator BOYCE—I am sorry, I am not understanding.

Mr Learmonth—I am sorry, Senator. It is questions like the issues raised in relation to level B, C and D consultations. That goes to the heart of what the review is covering.

Ms Robertson—Yes, so it is going to be covering those items, the health assessment items, chronic disease management items, out-of-surgery items, after-hours items and GP case-conferencing items. We are whittling it down quite dramatically, in consultation with the profession.

Mr Kingdon—That is reducing the number of items.

Senator BOYCE—Do we have a target there?

Ms Robertson—As much as possible.

Senator BOYCE—Good.

Ms Robertson—It means I have to read and be across less, as well.

CHAIR—I have two questions. One can go on notice. That is looking at the indemnity issues that were raised in detail in their evidence on the issue of the process of appeal. I would like to get the department's view on that. The other, which is dear to my heart, is the ongoing issue of the quality of the bureaucrats who would be dealing with this process. It came out consistently in evidence—about knowledge, awareness of privacy issues, credibility on privacy issues. There was also one direct statement from one of the witnesses about bureaucrats, of which I was one. I will not verbal him, but it was in terms of people accepting a doctor on issues of privacy much more easily than they would accept a bureaucrat. I ask you to have a look at that evidence. I know that there are issues in the Australian Public Service about privacy and the penalties involved with breach of privacy. I know Medicare won the award last year, but can I put on notice for you to give me some detail about the training, the awareness, the penalties and the process within the Australian Public Service about the integrity of the system. I know that is there, but it would be really good to have that itemised.

Mr Learmonth—We will provide you with a complete profile on the legislative framework that we are subject to. There are specific provisions in the Health Insurance Act, the Privacy Act and the Public Service Act. I note for the record that we are all subject to these, regardless of our respective professions. We will provide that to you on notice, Senator.

Ms Godwin—And we will certainly be happy to give you information that includes training materials and so forth.

CHAIR—That will be very useful in terms of the importance.

Ms Godwin—I would like to make just a couple of very quick comments. We actually have both a core level of training and additional training for people in the Program Review Division. So we do not just rely on our standard privacy training in the program review division; we actually have another level. The other point to make, and we will include this in a bit more detail in some written material, is that we do employ medical advisers. They do work in the Program Review Division. They do provide advice to auditors and audit teams. If an auditor believes that they have received material that they do need assistance in interpreting then that goes to a medical adviser. Part of the costings for the measure included additional medical advisers and we have been conducting a recruitment process. That does not mean that individual audits will

be conducted by medical practitioners, but we recognised as part of this overall measure that we would require additional medical advisers and we are seeking to source them now.

CHAIR—It would be very useful to have that detail. You have seen the evidence and heard it today.

Mr Bridge—An additional point to pick up on there is that the audit staff are constantly doing this. Through that engagement on a regular basis they are actually quite familiar with the procedures, the processes and the item numbers so we are not talking about a casual observer. They are not coming from the same base that somebody who does not know anything about the MBS or the medical process might be. So they actually have quite a degree of familiarity with the processes and what they are trying to do there.

CHAIR—That would be useful. Mr Learmonth, I know you will give the framework in which the public service operates but I am particularly interested in the penalty or punitive levels that people are subject to if they are found to have breached this process.

Mr Learmonth—We will set them out in all their terrifying detail.

CHAIR—Thank you. Thank you very much to the witnesses from the Department of Health and Ageing and from Medicare. As you know we have extended the reporting time so there probably will be further questions on notice from senators as we absorb these processes. If there is anything that you believe we should have then please get in contact.

Ms Robertson—I think you have everything we have now

Committee adjourned at 5.36 pm