



COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

## SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

### **Professional Services Review Scheme**

(Public)

THURSDAY, 22 SEPTEMBER 2011

CANBERRA

#### **CONDITIONS OF DISTRIBUTION**

This is an uncorrected proof of evidence taken before the committee.  
It is made available under the condition that it is recognised as such.

BY AUTHORITY OF THE SENATE

**[PROOF COPY]**

THIS TRANSCRIPT HAS BEEN PREPARED BY AN EXTERNAL PROVIDER  
TO EXPEDITE DELIVERY, THIS TRANSCRIPT HAS NOT BEEN SUBEDITED

## **INTERNET**

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

The internet address is:

**<http://www.aph.gov.au/hansard>**

To search the parliamentary database, go to:

**<http://parlinfo.aph.gov.au>**

**SENATE**  
**COMMUNITY AFFAIRS REFERENCES COMMITTEE**  
**Thursday, 22 September 2011**

**Senators in attendance:** Senators Abetz, Adams, Back, McKenzie, Moore and Siewert

**Terms of reference for the inquiry:**

To inquire into and report on:

A review of the Professional Services Review (PSR) Scheme provided for under the Health Insurance Act 1973 (the Act) which is responsible for reviewing and investigating the provision of Medicare or Pharmaceutical Benefits Scheme services by health professionals, with particular reference to:

- (a) the structure and composition of the PSR, including:
  - (i) criteria for selection of the executive and constituent members encompassing their experience in administrative review proceedings,
  - (ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise, and
  - (iii) accountability of all parties under the Act;
- (b) current operating procedures and processes used to guide committees in reviewing cases;
- (c) procedures for investigating alleged breaches under the Act;
- (d) pathways available to practitioners or health professionals under review to respond to any alleged breach;
- (e) the appropriateness of the appeals process; and
- (f) any other related matter.

**WITNESSES**

**WEBBER, Dr Anthony David, Private capacity ..... 2**

**Committee met at 16:33**

**CHAIR (Senator Siewert):** I declare open this public hearing and welcome everyone who is present today. The Senate Community Affairs References Committee is inquiring into the Professional Services Review scheme. Today is the committee's first public hearing in this inquiry. The committee reminds all witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. The committee asks that witnesses avoid making adverse comments against other parties and warns that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and witnesses may also ask that evidence be taken in camera, at which point we go over to another process.

**WEBBER, Dr Anthony David, Private capacity****[16:34]***Evidence was taken via teleconference—*

**CHAIR:** Welcome. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

**Dr Webber:** It has.

**CHAIR:** Dr Webber, we have your submission before us, numbered 24. I invite you to make an opening statement and then the senators present will ask you some questions.

**Dr Webber:** Thank you, senators, for affording me this opportunity to address you this afternoon. I would like to make a very brief opening statement in general terms and I am happy to answer your questions. As you know, there has been an explosion in medical knowledge and technology since Medibank was first introduced in 1973 and, of course, the business of medicine has been altered forever by the entry of corporatised medicine practising for a third party profit. The Medical Benefits Scheme and the Pharmaceutical Benefits Scheme have essentially not changed in basic form and still operate on the honour system. There is probably no other area of Commonwealth expenditure which allows recipients of taxpayers' funds to determine their level of remuneration. The Medical Benefits Scheme has accreted many new items over its existence, many in response to clinical needs. However, these archaeological layers have come to resemble a fridge covered with sticky notes. The MBS has a very complicated document for clinicians to get right and also it is very difficult to audit it and to ensure that patients are receiving quality care and the taxpayer is not funding inappropriate practice.

Medicare itself administers over half a billion transactions every year and, unfortunately, it has a fairly limited ability to track inappropriate practice. It would be my understanding that it is relatively understaffed and has difficulty attracting medical staff in particular and this has resulted in, unfortunately, many areas of fairly blatant inappropriate use of the MBS which has continued for many years. I have certainly, as my time as director, come across many examples where this has happened. That is not a criticism of Medicare; it is the way that the audit process is structured and it does leave quite a few deficiencies, in my view.

The practitioners referred to PSR represent a very special group of practitioners: less than 0.1 of one per cent of all medical practitioners. They have been screened by Medicare Australia, given an opportunity to change their practice over a six-to-12-month period by Medicare and only those who have not changed their behaviour significantly are sent to PSR for a detailed examination of their behaviour. This generally represents about only 10 per cent of the people that Medicare has initially screened. The outstanding characteristic of the more than 350 practitioners I have reviewed as director is a remarkable lack of insight. These practitioners lack insight into the standard of medical care they have been rendering and also display a lack of insight as to how their conduct may be viewed by their colleagues. Despite this, I have been able to dismiss 20 per cent of those practitioners sent to me as their clinical behaviour, when examined, has been appropriate. Eighty per cent, however, have had a case to answer and in 35 per cent, on average, the behaviour is so egregious they are required to be reviewed by a committee of their peers who will forensically examine their clinical practice.

There have been complaints aired recently that the PSR committee process is stressful. Well, it is. At the first meeting with a practitioner I inform them that the process is long and very stressful. Any investigative process into personal or professional behaviour is personally very challenging and practitioners certainly find it so. However, I do believe the committee process is a fair one. Committees strive to give the benefit of the doubt to the practitioner where possible and the practitioner has many opportunities to put his or her side of the case throughout the whole PSR process and yet the inability of several practitioners to appreciate that they have been treated fairly is, I think, a reflection of their lack of insight generally.

The other criticism often voiced is that PSR is designed and run to claw back Medicare funds as its sole aim. Now, I reject that assertion completely. I have always taken the view that, if the clinical behaviour is appropriate and in the best interests of the patient, the dollars will look after themselves, and it is a perspective that all committees I have established have followed: concentrate on the medicine and do not be concerned with the recovery of money. Financial recovery is the role of the Determining Authority.

PSR has an important role to play in dealing fairly and transparently with those practitioners referred by Medicare Australia. It also has an important role in educating practitioners in general about the areas of practice where others have not met acceptable standards. PSR has always been willing to work with the AMA and other representative bodies to improve how the process operates. That has always been a part of the scheme, and

significant improvements have been put in place, certainly over the time that I have been director. As for the future, I can certainly see PSR—and this may be somewhat controversial—having an own-motion ability to investigate scams and unacceptable corporate behaviour, of which I have seen significant examples, to prevent an escalation of this sort of inappropriate clinical behaviour. Thank you. That is all I want to say initially.

**CHAIR:** Thank you. I will ask Senator Back if he wants to start with some questions.

**Senator BACK:** Thanks, Dr Webber. You may recall that, in estimates, I asked you a number of questions regarding the membership of the panels. Could you just remind the committee whether, in the case of a doctor being the person under review, members of the panel reviewing that doctor work part-time or full-time or are retired? I think you said to me at the time that you did not use part-time doctors. Is that the case? Or do you use some part-time doctors?

**Dr Webber:** There are some doctors who do practice part-time. In general, the criterion would be not so much part time or full time but active practice. People are required to be in active practice. Many of the doctors that serve on panels, on committees, are fairly senior and have a lot of experience and often perform other functions—sitting on medical boards, college boards et cetera—so they have restricted their practice to a part-time situation because they wished to diversify their interests. But, certainly, people are selected for a committee on the basis that they are in active practice and have an understanding of how practices run in Australia.

**Senator BACK:** Without wanting to know names of doctors, would it be possible for you to take on notice, if you still have access to those who could provide the information, to give us some understanding of the remuneration that panel members would get if they were actively involved over a 12-month period? I do not expect you to answer that now—if you could take that on notice. Could you also tell me: with a panel constituted to examine one person under review, is it likely that, for example, two members of the same practice or indeed a couple who may be married or in a relationship could both be members of a panel for the same person under review?

**Dr Webber:** Just to clarify the first point, my having retired and now being back in private practice, I think it would be best to ask Dr Coote tomorrow for that information that you require on notice, Senator, because I do not have access to that.

**Senator BACK:** Sure.

**Dr Webber:** In general terms, the answer would be no, because generally people come from individual practices. To my recollection, there is only one practice which has two members of the panel in the same practice—that is to my recollection—and that is in Tasmania.

**Senator BACK:** That is the one in Launceston, is it?

**Dr Webber:** That is right, yes.

**Senator BACK:** In your submission I think you refer more than once to committee members being reappointed dependent on their performance. Could you tell me what that means? What is their 'performance'? Is it based on the number of scalps that they achieve, or is it based on their capacity and willingness to participate in panels? What is that 'performance'?

**Dr Webber:** Essentially—

**CHAIR:** Senator Back, could you rephrase your question, please?

**Senator BACK:** Certainly. Could you explain to us your comment in the submission about members being reappointed dependent on their 'performance'? Could you explain it to us what you mean by their 'performance'?

**Dr Webber:** There are a couple of criteria. If their performance in a committee is not seen to be fair to the practitioner—if people are asking inappropriate questions or clearly have displayed an inability to act fairly—then that would preclude them from further use for a panel. It does not happen very often, but it has happened.

Another criterion would be if a particular doctor was too busy to devote enough time to the process and was tardy in getting back documentation and so forth. If someone was prepared to work well with the committee in general, was not displaying bias, asked appropriate questions, was being cooperative and was not making the practitioner feel any more stressed than they otherwise would be, then they would be asked to serve again. But people who do not meet those criteria I would not use again.

**Senator BACK:** In your submission you have made the observation that doctors under review can call witnesses to give evidence. Just going back to the answers I thought you gave during estimates, it is my understanding—or perhaps you can correct me—that it is not until after the issuing of a draft report some months after the hearing is concluded that the doctor is actually aware of why he or she was being called before a panel. If

I am correct in that assumption, I just wonder how a doctor would know the sorts of witnesses that they might call to give evidence on their behalf if indeed it is not known until sometime afterwards what the matter was.

**Dr Webber:** The doctor would be fairly well aware of the issues in general to be discussed following a preliminary meeting with me. There would also be, in the referral document, an indication of the sorts of issues that I was concerned about to refer that person. Also, when the committee met for the first time with the practitioner, they would be talking about the issues that were to be discussed. So I suppose the issues in general would be known fairly well upfront. As for the findings, they probably would not be known except during the course of a hearing. But a practitioner would certainly be able to present evidence or have expert witnesses present or giving evidence at any time in that process.

**Senator BACK:** I think the claims has been made that PSR committee members are experts and that outside expertise can be called in. Could you explain to me how often outside experts would be called in to assist panels in terms of their expertise to then assess a person under review?

**Dr Webber:** Generally, not very often; and the reason for that is that common things occur commonly, and the sorts of issues that generally are investigated for most doctors are the standard sorts of consultation items and so forth that do not require any particular expertise. However, if a practitioner was involved in, say, plastic surgery, and other general practitioners on the panel did not have that expertise, a plastic surgeon might be called in. If there was some other particular area of expertise and the committee felt that they did not have the required level of expertise themselves, it would certainly be at the discretion of the committee to get a consultant to give them an opinion. Also, in discussing the case at the formation of a committee, I have sometimes included a specialist practitioner to sit on the committee and be part of the committee. Sometimes they are part of the committee; more often they are used as a consultant.

**Senator ADAMS:** I would like to continue in that vein. Looking at your definition of practitioners, if you had a midwife or a nurse practitioner, would you have somebody on the committee with nursing expertise or would they be assessed by medical people?

**Dr Webber:** If the person were a nurse practitioner, the committee would have a chair plus two nurse practitioners. If they were a podiatrist, it would have two podiatrists. Each individual specialty being examined is always examined by its peers.

**Senator ADAMS:** I just wanted to clarify that. I was a little bit worried. My second question is on your submission, where a chart shows a number of years and the number of practitioners referred to the PSR. In 2008-09 there was a huge rise—you had 136 practitioners referred. I was just wondering what happened then. It then went to 39 practitioners over 2009-10 and 56 in 2010-11. Have you any idea why that was such a large jump?

**Dr Webber:** Yes, and it does not reflect an increase in inappropriate practice. If you looked at the figures for the two years prior to that big jump, they were quite low—in fact, they were down to seven practitioners in a year. The reason for that is that we rely exclusively on Medicare for our referrals and Medicare had changed its practice and introduced a two-step review practice. That resulted in our work drying up almost completely over an 18-month period or so. That was clearly a problem, so Medicare's practices and the way it went about things were altered. The large number of practitioners basically represents a catch-up by Medicare. If you average out the number of practitioners over the last six to seven years, it hovers around the 50 mark. So it is an aberration.

**Senator ADAMS:** I was just wondering why it dropped from 136 down to 39 the following year.

**Dr Webber:** Between about 40 and 60 would be our working average per annum.

**Senator ABETZ:** I will try to keep my questions brief, and could you keep your answers brief. In your opening statement you referred to corporatised medicine and unacceptable corporate behaviour. Has the PSR prosecuted any person who is an officer of the body corporate?

**Dr Webber:** Sadly, no, because the legislation makes it very difficult to do so. It talks about the ability to take action against an employer of a practitioner if that employer has directed the employee to practice inappropriately. However, it is silent about a contractor. Because many of the practitioners working in the corporatised medical field are working under contracts, the owner of the practice is not able to be followed up.

**Senator ABETZ:** The answer was no. Is it correct to say that, given the methodologies you use, a low-volume, inappropriately practicing doctor would probably not be identified using the Medicare auditing methodology?

**Dr Webber:** That is correct.

**Senator ABETZ:** What about doctors who are innovative in their medical practice and are at the forefront? They as a matter of course must therefore be thrown up as a result of the auditing methodology. Is that correct?

**Dr Webber:** That is correct, or possibly so. But they tend to be sorted out fairly quickly. If they have been practising inappropriately and they have just been caught by the methodology, that can be sorted out quite quickly and easily.

**Senator ABETZ:** We do have cases where an associate professor, without mentioning names, has the specialist support of two cardiologists but was still determined to have been practising inappropriately by GPs who were not specialists in the field. If a doctor is in the innovative space, how on earth can you get a PSR panel that is also in that innovative space?

**Dr Webber:** The person being reviewed has to meet two criteria. The first one is that they are practising within the rules of the MBS and PBS. It is fairly straightforward to work out whether people have fulfilled the item descriptor. The second criteria is whether their behaviour would be seen as appropriate. While no-one wants to burn Galileo at the stake it is my belief that committees have quite a large experience and expertise and, if there is doubt about a particular innovative procedure or so forth, they have the ability to source information to judge it correctly or not.

**Senator ABETZ:** In relation to that which you told us about 'appropriate peers, genuine peers' reviewing, why is it that the AMA, AIMA, MIPS, MDA National and the ADU all raise doubts in their submissions to us? It seems that every organisation does not support that which you are asserting in relation to peer review involving genuine peers, or that external expert opinion provided by the person under the review is not taken into account, or that there is no right of reply et cetera. It seems that all the medical organisations are basically of a similar view and yet you are asserting an alternative view. Are you able to offer us an explanation for that?

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

**Senator ABETZ:** I indicate that a number of the submissions, and I think the AMA submission—I hope I don't do them a disservice—basically say there is no real problem with the legislation—it is more the administration and the personal conduct of these review committees that is causing a problem—and that natural justice does not apply et cetera. It is more in the administration of the PSR rather than the legislation under which you operate. What would you say to that?

**Dr Webber:** I would reject that. The administration of PSR and the committees, I think, always strive to give the benefit of the doubt where that is possible. Regarding the sorts of behaviours by practitioners in these special interest groups, the ones that come to PSR are really quite at the extreme end. It is not minor behaviour by any means. It is quite clear, I would think, to any objective observer that their behaviour is inappropriate.

**Senator ABETZ:** Case does not make you reflect on that answer?

**Dr Webber:** I missed that, sorry.

**Senator ABETZ:** The Tisdale case does not make you reflect on that answer?

**Dr Webber:** No, it does not. I believe that the committees have always strived to get it right for practitioners.

**Senator ABETZ:** If I may, didn't the court find a lack of evidentiary support for the PSR committee's conclusion in that case?

**Dr Webber:** This is the Tisdale case?

**Senator ABETZ:** I beg your pardon?

**Dr Webber:** Tisdale. Is that the case you refer to?

**Senator ABETZ:** That is the one.

**Dr Webber:** That was a completely separate issue and not to do with clinical practice. That was due to a breach of the 80-20 rule. You are right. That is the case's finding but it does not go to the clinical behaviour.

**Senator ABETZ:** I will not argue the law.

**Senator McKENZIE:** Dr Webber, as the past director, now no longer, do you think there is too much power vested in the director of the PSR's role, especially given the three stages in the process for reviewing a case? The first stage is obviously that the director makes a decision as to whether it proceeds or not. Do you think that is too much power in the hands of one person?

**Dr Webber:** That is a difficult question for me to answer, Senator. Any case that proceeds from a decision of the director—in other words, either a negotiated agreement or a decision to send someone to a committee—is

overseen by other people. If I, as director, were to enter into an agreement with a practitioner, that agreement and all the documentation that supported it is ratified. It has to be ratified by the determining authority—a completely separate body. If I send someone to a committee, the committee obviously has oversight of that, which is then also reviewed by the determining authority. The only absolute discretion I have is to dismiss somebody.

**Senator McKENZIE:** On page 51, the decision on whether to refer a case in either place seemed to sit with the director. I must have misread that.

**Dr Webber:** That is right. It does. The decision to do that does sit with the director, yes.

**Senator McKENZIE:** That would suggest that the role itself has some decision-making process on where the practitioner ends up. That is fine. One final question: in your opinion, given the feedback thus far, do you think the PSR retains the confidence of the medical profession?

**Dr Webber:** I think overall it probably does. I think this process, the Senate process, is a good way of airing the washing. I do not have any problem with that, because I think it is a fair process and the people that I speak to are supportive of it.

**Senator McKENZIE:** Thank you.

**Senator MOORE:** Doctor, the PSR has been in place for how long?

**Dr Webber:** Since 1994.

**Senator MOORE:** Have there been any changes in the way it operates in that period, between 1994 and now?

**Dr Webber:** Yes, there have been quite a number of different legislative changes over that time. The ability to enter into a negotiated agreement was not in the original legislation, nor was the independent determining authority in the original legislation. They have been improvements in the scheme over the years.

**Senator MOORE:** Has that been reviewed in that period?

**Dr Webber:** Yes. There was a significant review of PSR in 2007.

**Senator MOORE:** In terms of the processes, have there been significant changes to the way peer review operates?

**Dr Webber:** Not since about 2004. There are some changes being considered by the department to go before parliament but they have not done that as yet.

**Senator MOORE:** The peer process has been operating in much the same way since 2004—that is your position?

**Dr Webber:** Yes. The committee process has been operating all the time, but there have been significant changes subsequent to that.

**Senator MOORE:** I would imagine you have had a look at some of the evidence we have received?

**Dr Webber:** I have.

**Senator MOORE:** As you have heard from other people from the panel, a lot of people have put in criticism. Was there any of this criticism that you were unaware of before this particular inquiry started?

**Dr Webber:** No.

**Senator MOORE:** So, as to the people who are putting in the evidence, are these cases that you are aware of?

**Dr Webber:** They are individual cases and individuals that I am aware of, yes.

**Senator MOORE:** The organisation the Australian Doctors Union—had you heard of them? Had they been in contact with the PSR when you were director?

**Dr Webber:** No, they have never been in contact with me.

**Senator MOORE:** I am sorry; I missed the beginning of that.

**Dr Webber:** They have never been in contact with me directly.

**Senator MOORE:** And there had been no communication between that organisation and you in your role as the director?

**Dr Webber:** Not at all, no.

**Senator MOORE:** As to the process with the AMA: there has always been a close association with the AMA; had the kinds of issues raised by the AMA in their significant submission been raised with you previously?

**Dr Webber:** Yes, we have been talking about those and many other issues since the PSR was instituted.

**Senator MOORE:** And the process between your position and the AMA was a regular kind of discussion?

**Dr Webber:** Yes it was.

**Senator MOORE:** Thank you.

**CHAIR:** Can I just clarify—

*Member of the audience interjecting—*

**CHAIR:** I am sorry, we cannot take evidence from the floor. Dr Webber, can I just follow up on a question that Senator Moore asked in terms of contact from the Australian Doctors Union. Have you had contact with members of the doctors union?

**Dr Webber:** No. I do not know who they are or who they represent.

**CHAIR:** There are some doctors who are appearing tomorrow, so you might want to have a look at that list and see if you have had contact from any of those doctors.

**Dr Webber:** Some of those doctors have been through the PSR process, but that would have been my only contact.

**CHAIR:** Thank you; I just wanted to clarify that.

**Senator ABETZ:** In fairness, I think the Australian Doctors Union was set up specifically because of the concerns with PSR and matters arising. We can ask them tomorrow about that.

**CHAIR:** Yes, obviously. Are there more questions? We have seven more minutes.

**Senator BACK:** I will just ask a couple. I think, Dr Webber, that when you were kind enough to appear at estimates you told us that people fell into one of three categories: firstly, having met with you, there was no further action; or, secondly, you were able to reach with them a negotiated settlement; and then, thirdly, there were those who went on to review. Can you tell us again: in a negotiated settlement, I guess by its very nature, they were resolved to your satisfaction; what proportion of people who went on to the final, review process panel subsequently were actually found to have acted incorrectly, and what proportion were found by the panels to have no case to answer?

**Dr Webber:** I cannot tell you off the top of my head the numbers of committees, but I think there was, in my time as director, one committee where the committee found no inappropriate practice. Indeed, before I was director I was also a panel member, and at one of the committees that I sat on the person was found not to have practised inappropriately. But the practitioners referred to committees have been through a very significant screening program, and I would think that—well, as it has proved—most of them have a significant case to answer. I think that is why there are very few who come out with no inappropriate practice being found.

**Senator BACK:** Is one of the options available to you to refer these people back to a medical board—is that the case? If that is the case, is that because the panel would not feel able to undertake the review? Would that be the reason why you would refer them back to a medical board?

**Dr Webber:** No, it is a separate process. At any stage of the review process of the committee or indeed the Determining Authority, if there is a suggestion or evidence that there has been danger to the health or life of a patient or if there has been significant unprofessional behaviour, we have a legislative obligation to refer that person to a medical board, and that is a separate process. The PSR process continues, as well as, potentially, the person being referred to a medical board.

**Senator BACK:** This is my final question, then. Can you tell us in what proportion of cases, if ever, the PSR process has found disciplinary cause where the medical board in fact did not—in other words, the medical board may have perceived that they did not act inappropriately. Has that happened?

**Dr Webber:** Yes, it has, but it is comparing apples with oranges. As an example, a practitioner may have been found by a PSR committee to have practised inappropriately in relation to, for instance, prescribing narcotics. Whereas that behaviour would certainly be referred to a medical board because it is significantly unprofessional, there have been occasions where the medical board undertook rehabilitation of the doctor and did not find a need to take any disciplinary action. But it is a different process.

**Senator BACK:** Thank you.

**Senator ABETZ:** Dr Webber, in relation to negotiated agreements under section 92, can you indicate whether you have ever had feedback that a lot of these so-called negotiated settlements were simply commercial decisions by practitioners to cop it sweet to avoid the legal costs and time away from practice et cetera. As I understand it, the widespread view is that if you take on the PSR they will go for you, so it is a lot better to plead guilty, to use that term, even in circumstances where the overwhelming majority feel aggrieved by this and it is seen more as

go-away money that you pay to get rid of the problem. Has that view ever been expressed to you; and do you think it has any validity?

**Dr Webber:** It has certainly been expressed in the medical media. No, I do not think it has much validity. Most of the people that are before the PSR are represented by their MDUs with legal advice. It is almost universal that submissions in the review process are constructed and sent by their legal representatives, with the doctor's input, and it is not uncommon for the concluding paragraph to request a section 92 agreement if I am not going to dismiss somebody. So, in fact, these section 92 agreements are asked for almost universally. However, it has been my practice to offer a 92 agreement only where there has been relatively minor inappropriate practice—certainly, inappropriate practice that has not put anybody at risk—and where the practitioner had insight into their behaviour and had demonstrated a change in behaviour. Under those circumstances, a negotiated agreement is an appropriate course to take. It gets people back to practice quickly; they can get on with their lives. However, if significant inappropriate practice has been found early on, then I would not entertain the idea of a 92 agreement with the practitioner at all.

**Senator ABETZ:** You told us that people could be represented by their legal adviser. Isn't it rather that they can be accompanied by their legal adviser, as opposed to actually being represented by their legal adviser at these hearings?

**Dr Webber:** It is not a legal process. It is not the same as a court process, because the committee focuses on the clinical relevance of their behaviour. The legal person with the doctor being reviewed is certainly able to comment on points of law or procedure, or procedural fairness, but because they are not medical practitioners they do not have the ability to talk to the problem at hand.

**Senator ABETZ:** Though they are 'accompanied', not represented—in fact, that is the terminology you use on page 10, in the very last line of your submission.

**Dr Webber:** That is right, yes.

**CHAIR:** Dr Webber, they are all the questions we have for you. Thank you very much for appearing tonight because you could not appear tomorrow; we appreciate it. Thank you.

**Dr Webber:** Thanks very much, Senator.

**Committee adjourned at 17:15**



COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

## SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

### **Professional Services Review Scheme**

(Public)

FRIDAY, 23 SEPTEMBER 2011

CANBERRA

**CONDITIONS OF DISTRIBUTION**

This is an uncorrected proof of evidence taken before the committee.  
It is made available under the condition that it is recognised as such.

BY AUTHORITY OF THE SENATE

**[PROOF COPY]**

THIS TRANSCRIPT HAS BEEN PREPARED BY AN EXTERNAL PROVIDER  
TO EXPEDITE DELIVERY, THIS TRANSCRIPT HAS NOT BEEN SUBEDITED

## **INTERNET**

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

The internet address is:

**<http://www.aph.gov.au/hansard>**

To search the parliamentary database, go to:

**<http://parlinfo.aph.gov.au>**

**SENATE**  
**COMMUNITY AFFAIRS REFERENCES COMMITTEE**  
**Friday, 23 September 2011**

**Senators in attendance:** Senators Abetz, Adams, Back, McKenzie, Moore and Siewert,

**Terms of reference for the inquiry:**

To inquire into and report on:

A review of the Professional Services Review (PSR) Scheme provided for under the Health Insurance Act 1973 (the Act) which is responsible for reviewing and investigating the provision of Medicare or Pharmaceutical Benefits Scheme services by health professionals, with particular reference to:

- (a) the structure and composition of the PSR, including:
  - (i) criteria for selection of the executive and constituent members encompassing their experience in administrative review proceedings,
  - (ii) the role of specialist health professionals in assisting in cases where members lack relevant specialist expertise, and
  - (iii) accountability of all parties under the Act;
- (b) current operating procedures and processes used to guide committees in reviewing cases;
- (c) procedures for investigating alleged breaches under the Act;
- (d) pathways available to practitioners or health professionals under review to respond to any alleged breach;
- (e) the appropriateness of the appeals process; and
- (f) any other related matter.

## WITNESSES

<b>BARTLETT, Mr Richard, First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing .....</b>	<b>60</b>
<b>BENNETT, Ms Carol, Chief Executive Officer, Consumers Health Forum of Australia.....</b>	<b>38</b>
<b>BIRD, Dr Sara, Manager, Medico-legal and Advisory Services, MDA National.....</b>	<b>15</b>
<b>BRAZENOR, Adjunct Professor Graeme Alexander, Private capacity .....</b>	<b>1</b>
<b>BROWNING, Dr Anthony Troy, Managing Director, Medical Indemnity Protection Society Ltd, and EO, MIPS Insurance.....</b>	<b>15</b>
<b>CASKA, Dr John Pius, Board Member, Australian Doctors Union .....</b>	<b>1</b>
<b>COOTE, Dr William, Acting Director, Professional Services Review .....</b>	<b>45</b>
<b>DAHM, Mr David, Representative, Australian Doctors Union .....</b>	<b>1</b>
<b>HAMBLETON, Dr Steve, President, Australian Medical Association .....</b>	<b>22</b>
<b>KOTSIRILOS, Dr Vicki, Founder and Past President, Australasian Integrative Medicine Association.....</b>	<b>31</b>
<b>LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing.....</b>	<b>60</b>
<b>MASTERS, Dr Colin Scott, Member, Australian Doctors Union .....</b>	<b>1</b>
<b>RADFORD, Dr Nicolas, Chairman, Determining Authority .....</b>	<b>45</b>
<b>RAIT, Associate Professor Julian, President, MDA National.....</b>	<b>15</b>
<b>REECE, Associate Professor Albert Stuart, Chairman, Australian Doctors Union.....</b>	<b>1</b>
<b>REID, Mr Chris, General Counsel, Department of Health and Ageing .....</b>	<b>60</b>
<b>RUSE, Dr Warwick Henry, Former Deputy Director, Professional Services Review .....</b>	<b>45</b>
<b>SHAKESPEARE, Ms Penny, Assistant Secretary, Benefits Branch, Department of Health and Ageing .....</b>	<b>60</b>
<b>SULLIVAN, Mr Francis, Secretary-General, Australian Medical Association .....</b>	<b>22</b>
<b>TWYFORD, Mr Luke, Acting Executive Officer, Professional Services Review .....</b>	<b>45</b>
<b>WATT, Mr Malcolm Ian, Paralegal Adviser, Australian Doctors Union .....</b>	<b>1</b>
<b>WISE, Ms Anna, Senior Policy Manager, Consumers Health Forum of Australia.....</b>	<b>38</b>

**BRAZENOR, Adjunct Professor Graeme Alexander, Private capacity**

**CASKA, Dr John Pius, Board Member, Australian Doctors Union**

**DAHM, Mr David, Representative, Australian Doctors Union**

**MASTERS, Dr Colin Scott, Member, Australian Doctors Union**

**REECE, Associate Professor Albert Stuart, Chairman, Australian Doctors Union**

**WATT, Mr Malcolm Ian, Paralegal Adviser, Australian Doctors Union**

**Committee met at 09:02**

**CHAIR (Senator Siewert):** I welcome representatives of the Australian Doctors Union. I understand information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. If anybody has not seen it, the secretariat can provide further advice. Do you have any comments to make on the capacity in which you appear?

**Prof. Brazenor:** I am a special counsellor for the ADU.

**CHAIR:** The committee has before it the ADU's submission, which is No. 42. The committee also has other submissions by representatives of the ADU who have submitted in their own or their organisation's name. As the principal ADU submission is confidential, please exercise caution when giving evidence to ensure that it is directed to the terms of reference. Please note that the committee is not empowered to examine individual cases or to provide individuals with assistance with grievances.

I invite each of you to make a short opening statement of a maximum of five minutes, as agreed, and at the conclusion of your remarks I will invite committee members to ask you questions, as is the normal process. What we intend to do is give you a little 'ding' after four minutes. You will appreciate that we will have to be very careful with time management. I do not know if we can do what we do in the Senate, which is just turn off the microphone. I presume you have organised the order in which you want to speak, so please commence.

**Prof. Reece:** The Australian Doctors Union is a nascent union which has come together to support each other through the nightmare experience of PSR's incompetence, lies, intimidation and bullying. In addition to doctors damaged by—

**CHAIR:** Hang on please. That is making accusations and it is not the way that we take evidence. If you could please refrain from using that sort of language, that would be appreciated.

**Prof. Reece:** In addition to doctors damaged by PSR, its affiliates include some of the leading specialists in the country, lawyers, paralegals, psychologists, professors and many incensed patients. We are here today on a pro bono basis, at our own cost, out of our grave concern for the future of medical practice in this country.

PSR legislation sets in stone the great Australian pastime of the tall poppy syndrome. However, when this enforced mediocrity is given legislative teeth and whole-of-profession policing powers it has moved from being benign to overtly malignant. The evidences of this malignancy are numerous and include: an unknown number of doctors dead of suicide or stress; lowered bulk-billing rate; the closing of women's health clinics; the marginalising of our women; the closing of Indigenous health clinics; people leaving rural towns due to lack of medical help; many doctors planning to leave medicine early or not to pursue a career in general practice; many doctors losing their marriages, families and children; a scheme which is numbers driven and therefore, in its effect, demonstrably discriminatory on the grounds of both sex and race; three doctors removed from inner-city Brisbane, creating an artificial shortage requiring the establishment of a GP super clinic at Annerley; many excellent doctors damaged by the scheme, including: Dr George O'Neil of naltrexone implant and detox fame; Dr Scott Masters, past president of the Australian Association of Musculoskeletal Medicine; the nation's leading melanoma diagnostician, as described in the skin cancer college submission; Dr John Quayle, Vice President of the Rural Doctors Association; and Associate Professor Stuart Reece, one of the foremost detox doctors in the nation and a world authority on the long-term effects of opiate addiction. It has also utilised committees deliberately appointed in contravention of federal legislation. In short, it is a federal health department which, through negative practices, has been shown to be waging a very successful war against general practice in this country.

PSR admit to having audited the top 1.5 per cent of the profession and found them routinely guilty. In Bell's document they skite about ignoring all evidence provided by the doctors before them, as confirmed in the fourth

Tisdall decision and the second imminent Kutlu Federal Court case loss, scoff at evident unfairness and refuse to acknowledge the wholesale carnage they have created, particularly amongst the cream of the profession.

Why is there no cry for an urgent apology to the medical profession for the outrageous joint parliamentary committee 445 audit report 203 of 1982, which has formed the basis of the oft repeated assertion that seven per cent of doctors are rorters, based on the top half of the services for patient care and a handful of unfounded health department presuppositions?

The Australian Constitution is understood to guarantee due process and natural justice to all its citizens, even refugees and non-Australians. What then is the constitutional compliance of an act whose administration has boasted about refusing to attach weight to any form of evidence on behalf of defendant doctors, does not even make the charges at stake explicit until it is too late to mount any form of defence and does not allow doctors meaningful legal representation. Does the committee suppose that the past director would delight in being tried himself under such rules, as indeed he should be tried?

Since the HIC Act is only allowed to order repayments rather than fines, how is paying back the whole of long or prolonged consultation fees lawful? Ditto for radiology and pathology fees which were never even paid to GPs in the first place. How are the past director's discussions of penalty with numerous ADU doctors before he had even received their evidence even vaguely lawful, let alone constitutional?

Why, after 30 years of Medicare, are some item numbers ambiguous or routinely perversely interpreted by PSR? Why is an authoritative interpretation of difficult item number descriptors not readily available? Why are Medicare statistics applied so unintelligently? Why is nothing done about the lack of a formal audit branch of the medical profession, independent of government and providers? Why is medical based merit review by way of an appeal to AAT not available in this act as it is in others? Why is both double and triple jeopardy for GPs and double and triple dipping for hospital specialists encouraged? Why is the overt fraud of the supposed independence of the determining authority perpetuated when, according to its annual reports and Dr Radford's submission, its chairman has been involved in MSCI or PSR for 34 years, it is housed in PSR offices, reports to the PSR director, attends team-building exercises with PSR and its pecuniary success is presumably tied to the salary package bonuses of the PSR director?

Whilst the scheme outlined by PSR/AMA in its memorandum of understanding for determining medical subspecialties is a clear improvement in what has pertained, there is no obvious pathway for individuals or groups of doctors to move up to chapter status. Indeed, this seems to be impossible in an environment of heavy PSR policing. The ADU insists therefore that the act must acknowledge the centrality of the scientific evidence base of modern medical practice, independent from and at times in opposition to common populist medical peer opinion which may not be so well informed. This is the root and source of the exceedingly dangerous misdefinition of medical practice enshrined in the present form of the HIC Act. Due to the limited representation of the profession, particularly general practice, by the AMA, it is important that wider professional consultation occur with other colleges and professional bodies.

The Australian Doctors Union is keen to support and engage with the Senate committee and government in the ongoing process of developing an open audit process with professional integrity and competence. For now, we support the Avant proposal, including a legal chairman, one doctor appointed by the audit system, one appointed by the doctor under review and a lay person, after the medical tribunal model operating in each state. We are asking the committee to inquire into and publish the director's bonus arrangements, PSR' and Medicare's apparent abuses in their 15-year litigation of Dr Tisdall, intimidation against Dr Peter Buchanan's referral base, and Medicare's failure to assist Dr George O'Neil.

We wish now to remind the committee of the PSR report 507—our appendix M5—showing the deliberate misstatements of fact, incompetence and misdescriptions—

**CHAIR:** Sorry, Dr Reece, that is five minutes.

**Prof. Reece:** May I hand up some documents?

**CHAIR:** You may hand up some documents. We would need to look at them before we could accept them as tabled documents.

**Prof. Reece:** Yes.

**Dr Masters:** I have been a medical practitioner since 1984. I became a fellow of the college of general practitioners in the early nineties. I did my diploma in obstetrics in 1989. I did a fellowship with the Australian Association of Musculoskeletal Medicine in 2000 and a diploma in musculoskeletal medicine in 1999. I have a certificate in sports medicine and a certificate in manual medicine, and I am a member of the AMA. I am also a senior clinical lecturer with the University of Queensland and I have been a senior clinical lecturer with Griffith

University. At our practice we train nurses, medical students and general practitioners. We are an accredited practice with APGAL.

I suppose my point is that I am involved in medicine, I have been engaged in medicine for more than half my life and I feel very passionate about what is happening at the moment. I feel it has the capacity to really undermine the medical profession and the future of the medical profession, and that is why I am here today. My first point is that it has become apparent to me and certainly to the people I mix with that the whole Medicare audit system, the PSR system, has become dysfunctional. It seems to have become dysfunctional over, say, the last five years or so. This seems to have correlated with an increase in the auditing of the medical profession.

No-one here is against auditing of the medical profession. We think it is a very good idea, but it seems to have become very unbalanced such that there is no capacity for people who are audited or who are put up to the Professional Services Review to have their case heard in a natural justice situation. It is very difficult if you disagree with anybody in the PSR process to actually state your case and have the ability to cross-examine them about what they actually want.

I see the big problem here is at the very first step. When the audit starts from Medicare, there is no actual guide from Medicare that you have done anything wrong. It is just a repeated line of, 'We notice that you are a statistical outlier, so you are different from your colleagues; therefore, we have got concerns.' When you ask them, 'What exactly is your concern?' they say, 'We're just letting you know that you're in this five or 10 per cent of people who do,' for instance, 'more long consultations than other doctors.' Then you might say back to them, 'How many would you like me to do?' They say, 'No. That's not a problem. Just what your peers would find acceptable.'

I have never had complaint from my peers, and all the people whom I have spoken to who have been through this process have not actually had complaints from their peers. The only complaint they have had is from Medicare. So there lies the problem: what is a peer; how do we access our peers; how do Medicare relate to peers? As you can probably see from what I have outlined before, I am actively involved with peers every day, and I have never had a complaint about my practice, except that I am a statistical anomaly. I think Medicare are suggesting to us that they would be very happy if we had this bell curve and there was a straight line right down the middle. They do not seem to like anybody on the end of the bell curve and they seem to want to interrogate them. Probably our main concern is that. And then there is the actual process itself. So we are putting forward that we need something more like an administrative tribunal to look at these cases.

**CHAIR:** Thank you.

**Dr Masters:** I have one more minute. Is that five or four?

**CHAIR:** That was four, sorry. You have got one more minute.

**Dr Masters:** So we are proposing that something like the Queensland administrative tribunal would be a good way to go for people who think they need a hearing about what has happened. Obviously, at the moment, it seems that it is mainly the AMA who are talking to the PSR about how they should go forward. There has been quite a lot of talk over the last year between the two bodies, and I think that represents a sign from the AMA that they are not happy. The current survey they had on their website shows that nearly 90 per cent of their doctors think the auditing process is heavy-handed—and that is from the AMA members. The survey that was done through Aussie docs and the *Medical Observer*, which was handed into the committee under my submission, said about the same figure—90 per cent of doctors are unhappy with the PSR process.

**CHAIR:** That's your time. Thank you.

**Dr Caska:** I am a GP of 41 years standing in a non-metropolitan practice. Firstly, I wish to sincerely thank the Senate for agreeing to this all-important hearing on the operations of the PSR. It is having a very negative effect on the healthcare delivery in our nation. The ADU was formed, as you have heard, for one reason only: there is no organisation that truly assists, advises, oversees or councils doctors who become involved with the PSR process. This process, even according to the past director, is difficult, expensive, time consuming and very traumatic. The trigger for doctors to be referred to the PSR and its processes, as you have heard, is purely from statistics supplied by Medicare. These generally select the busier, higher performing doctors. I know that no underperforming doctor has come to the attention of the PSR.

The overwhelming view of doctors is that the process is inequitable, heavy handed, intimidatory, traumatic, stressful and loaded against the doctor as legal support is only allowed during the various interviews while the issues in contention are mostly clinical. The view of a particular director seems to totally prevail. The doctor seems to be presumed guilty and knows there is no real or practical avenue for appeal or review. According to the PSR's last annual report, the average resolution time for a matter referred to a committee is 670 days, with almost all being found guilty. It is little wonder that so far very few doctors have elected to go to a committee and have

simply made whatever payments and mandatory recantations are required to end the matter. We are told that if we do this then there will be no further action. If we proceed to a committee, it is intimated that it will be long and traumatic, as I said before. Also, at the end of that our names will be published and of course that has a bad effect on doctors.

In all of this process the doctor stands alone without any medical support or advice because that is precluded. Beside the heavy penalties extracted, mostly for interpretation problems with descriptors, the personal stress and distress is enormous and inhuman. A recent statement by a committee member stated that 15 out of 16 records to his knowledge in fact did not comply completely with the current descriptors. It certainly would make rich pickings and a guaranteed result if these were investigated.

Repeated interviews, reports and reviews of their medical notes over 670 days on average while trying to run a busy practice would certainly create enormous stress on anybody. To my knowledge there is no-one else in society that has to put up with this sort of inquisition. This comes from the PSR's reports. Remember that it is mostly the busier, high-performing doctors who are investigated and the committee's seem to take time to rake through everything.

The personal toll on doctors and their families can only be described as a torture and has led to nearly every doctor being seriously and psychologically traumatised, often leading to tragic family break-ups. This is too high a price. I have totally lost faith in the AMA. I have been a member since graduation and received no support. I was sorry to find that many of the AMA elected executive in fact populate the ranks of the PSR committees rather than overseeing the process.

Our opinion is that cosmetics are not enough and that the legislation and regulations should be thoroughly reviewed utilising a far wider group of advisers than the current primary dependence on the AMA. The ADU intends to assist the government with advice if asked, but the prime objective is to assist and support doctors in this very difficult and traumatic process.

**Prof. Brazenor:** I appreciate the opportunity to present. I am here as a disinterested party. I am a neurosurgeon and I am here because over the past eight years I have watched the treatment of three of my general practice colleagues by the PSR. At first I was incredulous; I could not believe there were no charges and no appeals. But I have entered a state of chronic outrage, which is why I am here. The PSR process over those eight years has been pretty much the same. There are never any stated charges; there are concerns. They send a couple of suits and they look at your practice and seem to be mollified and go away. Then, two months later, it all comes back again. They request records with no financial help to the doctor for labour incurred in culling 200 records. The records go away for two or three months and then they come back with a whole new set of concerns. It goes on and on and on. Two of the three colleagues were persecuted over more than two years and I became very worried about their mental state. More to the point, after they had finally been released, bruised from their encounter, they each told me that they do not practice medicine now the way they used to. They are so worried about looking over their shoulders at what they order that their relationship with their patients has been permanently warped by this experience.

There are three things wrong with the process. Firstly, there is never a stated process. They tell me that, if you are investigated by the tax office, first you get a frank statement of the concerns and, in the same envelope, you get an explanation of the due process. Neither of these things was accorded to any of my three colleagues until right at the end, when they said, 'Right, we've got you. Here are the concerns. Your interview with the director is next Tuesday'—and that is as close as they got to due process. That nebulous not knowing where you stand after a year and a half grinds you down and, I think, could conceivably lead to suicide.

The second problem with the PSR process is that the judgments are all subjective. I went to an interview as an observer with one of my colleagues when he was interviewed by the director and one of the things he was accused of was ordering too many CT scans of the cervical spine. I happen to be President of the Spine Society of Australia, so I sat there mute, agreeing with my colleague and disagreeing with the director, and was absolutely flabbergasted when, three weeks later, the director's determination was issued along with a \$47,000 fine.

The third thing wrong with the process is that there is no real peer review. This is not peer review. The reason people do not seek an appeal against the director's determination is that the PSR committee is not a true peer review committee. I do not know where they get those doctors from, but they have an almost 100 per cent incidence of simply rubber-stamping the director's determination. I was at my colleague's shoulder when his lawyers said, 'Don't expect any help from the AMA and do not appeal because it is a waste of time and your money, and then your name gets published into the bargain.'

In summary, the PSR process could learn a lot from the tax office. There has to be genuine peer review because none of the three doctors of my acquaintance, I think, did anything wrong at all. They were simply taking good care of their patients. One of them was arraigned for too many vitamin D estimations, and yet she showed that 90 per cent of the patients showed low vitamin D levels. Where is the justice in that? Last but not least: people arraigned by whatever process we replace the PSR with must surely be accorded the same rights as those who are accused of criminal charges.

**Mr Dahm:** Thank you, honourable Senators, for the opportunity to appear today. The key area that I am focusing on is: does the PSR have the legal authority to engage in these activities and is this area being overregulated? I am the CEO and founder of Health and Life, which is a national taxation, accounting and practice management advisory firm. We have been operating for 20 years all over Australia and we have serviced over 1,200 clients both in the public hospital sector and in general and specialist practice. I am a registered tax agent. Prior to establishing my own practice I was an auditor for KPMG. I have also served on the national board of the Australian Association of Practice Managers, which represents about 1,600 members who are practice managers, owners and workers in hospital units throughout Australia, and I am the current chair of their certified practice manager program, which deals with a number of these issues. I also have been appointed and have done work for the national primary care collaboratives as a national financial analyst looking at sustainability of general practice, and I have worked as an Australian general practice accreditation surveyor for 10 years. I do not condone inappropriate practice and I have no conflicts of interest here, other than that I am interested. Back in 1997 when we surveyed patients in a practice, the overwhelming demand was for a women's clinic. In due course, what happened was that the female doctor got a telephone call from Medicare—it only took one telephone call—and that did change and curb the type of practice services that were offered at that clinic. This comment has come back from time to time over the years, so even a telephone call does create the same sort of outcome.

Order anxiety is gagging the profession. I have experienced, to some degree, elements of fishing expeditions, entrapment, poor Medicare systems and poor education given to providers and practice managers, and also inappropriate comments from Medicare in terms of the rights and duties of a practice manager in terms of handing over information. Basically the system implicitly gags doctors from speaking out and it interferes with their clinical practice. This means that there is less freedom of choice for patients for services where needs are not met, and this stifles innovation.

Of concern is the legal status of healthcare providers in Australia, when we look at the fact that the new national healthcare regulation rules and also the Medicare rules are denying natural justice. Section 1852 of the regulations states that natural justice should be observed; however the evidence rule does not need to be followed. So you can be prosecuted without evidence. The other aspect is that the right to self-incrimination has been waived if you are billing on Medicare. So I do have concerns and would like that looked into. The status that healthcare providers have in this country—and they risk losing their registration, which is their entire livelihood—seems to be quite onerous. We see that bikie gangs and illegal immigrants actually have more rights when you follow the recent High Court rulings. At the moment, the free market system and concurrent consumer laws give a fair degree of protection in addition to the laws that currently exist.

What is my concern? There is going to be an intergenerational workforce and succession planning crisis. We are involved with a lot of planning of healthcare practices in rural and metropolitan areas, because there is no practice certainty. Private investment into healthcare facilities and services is of concern. In 2009 there was research done, which was printed in the *Medical Journal of Australia*, stating that 85 per cent of generation Y GPs are considering quitting practice, and for 50 per cent the reason is Medicare, GP superclinics and bureaucracy. So this does have an overall effect in terms of the morale of the profession.

A leading High Court case is *General Practitioners Society v Commonwealth* in 1980. It states that the Australian Constitution does not explicitly or implicitly give the government the power to interfere with the doctor-patient relationship. The Health Insurance Act was recently amended and it states at section 129AAD(10):

In forming a reasonable concern for the purposes of subsection (1), the CEO is not to take into account the clinical relevance of a particular professional service.

How do you deem an appropriate practice when these sorts of requirements are basically disempowering the agency and yet there can still be a finding of inappropriate practice? I am not sure how this new legislation is going to work in practice.

There are some other issues that I will allude to later, but the concern that I have is, what right does the PSR have to say how many CT scans you can and cannot order? Also, the AMA and the college denied that they have any role in Medicare interpretation. The other issue is that PSR is not an independent body. It is actually funded 100 per cent, when you look at their annual report, by the government. The appointments are made by the

minister, policy and regulation are set by the minister; it is not truly independent. It is just another government arm.

**CHAIR:** Sorry, that is time.

**Mr Watt:** Thank you for permitting John Citizen to come in and speak to you. I am not in the medical fraternity. I have no possibility of financial gain as a result of being here. I am just here because I can see that there need to be some massive changes. I have heard about the system for a number of years, and given my policing background I have been absolutely astounded that the practices are permitted in Australia. They should not be, and that is why I am here. I am not here for any financial gain. I am not a paid representative; I am just here to explain how the public are likely to see these issues. I have concerns about the content of some of the submissions received by this inquiry. My concerns centre on the accuracy and validity of certain assertions. Written details of these concerns will be tendered this morning. My experience in criminal law, which very often attracts complaints about a perceived lack of natural justice, have provided me with extensive knowledge of safeguards which must be included in an investigative process. The PSR system has no such safeguards, and submissions alleging independence of the determining authority are questionable at best.

Independence implies a complete separation of powers, roles and relationships between staff. Given the director of the PSR is the immediate manager of the chair of the determining authority, there is no meaningful independence. The director appoints the chair of the DA, so there is a fundamental relationship between the two. If the chair of the DA is not performing to what the director expects or requires, he is not going to have a job at the end of the renewal period.

As was briefly touched on yesterday, the director has certain powers conferred upon them under the act. Those powers are extraordinary, given the damage that can occur from the improper administration of them. And those powers dictate the entire process from start to finish—none of this three-step rubbish. Dr Webber confirmed he made the initial decision. He also had an initial meeting in which he decided if he would offer a negotiated agreement—they were his words. Alternatively, he referred persons under review to hearings because, as he said yesterday, their behaviour had been determined by him, and him alone, as so bad it had to proceed to hearing. Why go to hearing? He had already made that determination; he expressly said that in the words that will appear in the transcript.

Speaking of the negotiated agreement, perhaps the committee could review the submissions before it to see if anyone agreed that the process was a negotiation. Instead, it was a coercive process, with Dr Webber himself admitting, and again I am quoting: 'I informed them'—the person under review—'the process is long and very stressful.' How much free will have you got going into that? That is persuasive, intimidatory and threatening. You cannot voluntarily enter into an agreement if there is a threat hanging over your head.

In Queensland law, as a police officer, if I suspect someone is guilty of an offence I can go up to them and ask them if they will voluntarily accompany me to the police station. I cannot say, 'If you decline that invitation I am going to arrest you on suspicion,' because then their independent thought process has been impaired and they are acting under threat or duress. Such is the process of the PSR: persuasiveness, intimidation and threatening. And that is why I am here.

Our ageing population needs more doctors, yet the PSR are causing doctors to leave the profession. And that is why we are all here. Thank you.

**CHAIR:** Thank you. We will go to questions.

**Senator ABETZ:** First of all, how many members does the ADU have?

**Dr Masters:** Two hundred.

**Senator ABETZ:** Is it correct, in the experience that is before us, that if there is a question of overservicing or a time allocation put in the doctor's notes but there are not sufficient clinical notes to suggest that it was, say, a 15-minute slot, does the PSR then actually go to the patient concerned and say, 'When you visited Dr Bloggs he only wrote three lines but did he actually spend 15 minutes with you?' Or do they determine the length of time by the length of the clinical notes?

**Dr Masters:** Purely from the notes.

**Senator ABETZ:** Time is very short, so thank you for that brief answer; that is very helpful. I think it was you, Dr Masters, who said that the PSR was dysfunctional. I assume we are all agreed that some auditing needs to occur. Therefore, the question is: do you have a blueprint as to how that ought be undertaken?

It seems quite clear from the array of expertise in front of us—we have a professor, an associate professor and, I am sorry, Dr Masters, I have forgotten all your details—that there seem to be people at the cutting edge and in the

innovative area, if I might describe it as such, of medical practice. In those circumstances, to get a peer body to judge that would be most difficult and I am wondering whether you seek to offer any comments.

**Dr Masters:** There are lots of different ways that that could go. What we are proposing, rather than us just putting up a blueprint, is that at the moment we feel it is just not inclusive. It is just the AMA and the PSR at the moment. We would say, 'Sure, keep the AMA but what about the ADU, what about the RACGP, what about the Integrative Medicine Association, what about the rural doctors and what about all of the other people who put those submissions in?' They are all representative groups and they all need to be heard. If you look at the submissions, we are all saying fairly similar things. I am sure we will be able to come up with a solution that everybody will agree on. I can see a real win-win here where Medicare would be happy—there are so many ways they could reduce the money they are spending on this—the doctors would be happy and the patients would be happy.

There is a great possibility for a win-win for everyone here. There are simple things. As Graeme said, you just need to get confidence back that it is peer review. At the moment, I do not think anyone has any confidence that we are being judged by our peers. That would be the honing point: how to get the peers. You could go back to a jury system. You could pick 12 doctors who are in full-time practice and adjust it the way you want. It could be a bit like a jury system, where you would pull them out. The jury system has served us well. You could do that by having 12 people plucked from the front-lines. As long as you also had the right through something like the QCAT to appeal if you were unhappy, just something as simple as that would get confidence back.

**Senator ABETZ:** It does concern me. I think I raised one example with Dr Webber yesterday, but to have the example that the professor gave us with his knowledge and expertise et cetera in matters spinal, if I recall correctly, and then to have a body of GPs determine that that which a professor and other experts think is good practice is not good practice would, in my profession, be like a bunch of suburban lawyers of which I was one trying to sit in judgment on whether a QC specialising in taxation matters did the right thing by his client.

**Prof. Brazenor:** Except that what the peer committee would be doing is working out whether this person was ordering a ridiculous number of CT scans from the point of view of practising GPs. They know by and large—there is a gut feeling—when somebody should have a CT based on their age and their risk and all sorts of things. So, to answer your first question, we can either try and establish a fair dinkum peer review system, in which I think GPs should be called up just like jurists, or go back to allowing a legal process such as the tax department conducts. But then you have to have definitions of what you need to claim a level D consultation and what you need to justify a CT of cervical spine. We could write rules for all of those things—it would be terribly proscriptive—but I cannot really tell you which would be the better way to go. The peer review system keeps it all subjective, and that is why they have to be through peers; they are not the moment. You can either go that way or simply lock everything down in tightly-worded definitions. They have tried to do that with surgical item numbers and to some extent they have been successful, but it still remains a bit subjective.

**Mr Dahm:** I would like to make a comment. In the accounting industry how it works is that you have something like 150,000 accountants, so you have some major competing bodies: the Institute of Chartered Accountants, CPA Australia and a few others in between. The taxation board engages the entire profession and they put their representatives forward on that particular basis. Each of these associations, in terms of getting recognition with the taxation board, have to fulfil accreditation requirements and they have to have codes of ethics and standards that those individual associations must ensure that their members are actually following. So there is more self-regulation involved and there are proactive monthly meetings and discussions moving forward. So there are workable models and we have international accounting standards. These things are actually achievable. That probably would be a good starting point, and I guess if things got more serious then they could escalate into that more legal environment. I think we could push for more self-regulation; peers reviewing each other is a much more immediate process. Naming and shaming amongst your own peers, and having that sort of thing amongst your own to be in control of, would put the pressure on. The 'It's either self-regulate or we will regulate,' type of message is what the accounting fraternity got in the eighties when we had all the collapses, and I think the same message needs to come out again so that there is some ownership taken by the professions, to move forward, and there is an encouragement as well.

**Mr Watt:** On your question as to what improvements can be made to the current system as it is: a simple, logical profiling of practices would explain, from the outset, why a female doctor at a female clinic specialising in treating females is ordering so many pap smears, as opposed to simply saying, 'Wow—look how many she's ordering compared to the bloke who is up the road!' Practice profiling would explain a lot of the discrepancies right from the outset.

I think the problem is also more underlying than that. Looking through Dr Ruse's submission, the whole structure, as it has been set up, was based on one assumption that was made back in 1994:

However, as a doctor's position on the curve moves further right, it was assumed that the possibility of inappropriate categorisation, of consultation items, or inappropriate use of investigations or treatments, or inappropriate professional input, because of time constraints ... might be rising.

So there was an assumption—not based on any fact, not based on any research, not based on anything. It was an assumption that was made by a group of unnamed people. There is no reference to any expert advice to give that assumption any credibility. Furthermore, he goes on to say:

Dredging the right hand end of the curve will always find some but not all of the targets. It was merely hoped, on quite sensible grounds, that the detection rate out there would be higher than in the middle. You had to start somewhere.

Those words indicate, to me, desperation. That is not the basis for establishing a process that cost this much money to the government and is impacting our doctors as badly as it is.

**Senator ABETZ:** It does seem to me that it is—if you can use the term—the hard-working, busy doctors, especially the innovative ones, who seem to be falling into the clutches of the PSR, whereas if you were a part-time doctor playing golf three days a week and not really providing good medical service you would never show up on the Medicare audit because you would be on the left-hand side of the bell curve—and therefore bad luck to those patients and to those people who are in that medical practice.

**Mr Watt:** And that was Dr Webber's evidence yesterday.

**Senator ABETZ:** Yes. I was astounded that he acknowledged that; I appreciated it. But I think that that, of itself, shows the real difficulty with the current methodology. I dare say I have had my fair share, Chair.

**CHAIR:** Yes, you have, but I think Dr Caska wants to make a comment.

**Dr Caska:** Just to comment on that, one of the big problems with this is that, at the beginning of the process, they do define some areas of concern in fairly vague and various ways. I think at the beginning that should be sorted out a lot better and the doctor given better information. As we go along, and when the records are taken down to Canberra to be forensically examined, I presume, by other Medicare staff, a report comes on and, in a lot of cases, the actual final—can we call them—charges are completely different from the original matters of concern. When you look at the information that comes out of the PSR's own annual report, with annual average resolution times of an amazing 670 days, surely that cannot be just from the half-dozen or whatever it is that they are auditing. It would make one think at least that somebody is trawling through everything until they find something, and if about 15 out of 16 records are not complete, you are bound to find something if you are going to look at whether every i is dotted and every t is crossed. We won't go into it; we all know, I think, what sort of tension and anxiety that is, because nobody is perfect to that degree, particularly the busier GPs. They do not really have time to have these perfect notes. While I do not want to say we suffer, general practice is a damned hard game. You have constant interruptions and things and yet we are supposed to have this relatively picture-perfect record. In fact, if I saw a doctor with that I would wonder did he get his secretary to write them out, because by and large that just does not in practical terms exist. The bar is put that high that if we all start is a seven foot jump then anybody virtually who is called to do that will fail. There is, in my view, no other reason why such a hugely protracted process is there. It is tortuous. Fortunately, I have never been through it, but some people have and it is absolutely dreadful.

**Mr Dahm:** We got tax agent registration. They sent one person to us and sat down with my staff and said, 'Listen, this is how you use your tax agent certificate.' We got straight education that way. With medical records, I notice the government has actually endorsed the issue, so I am moving to the next point about medical records. Under the government's approved new e-health scheme, if you are a politician or a high-profile celebrity you can mask the record by using discrete coding and fake names. If we were in front of Tony Webber and we were doing that, bang, you would be basically hit with a PSR.

**Senator MOORE:** Chair, Mr Dahm, there is a particular clause in that process which does not only apply to celebrities or to politicians. There certainly is a way of doing it, but I think it would be more useful if you gave us the whole content of that phrase or something else.

**Mr Dahm:** It was just to illustrate the point that—people, STD clinics et cetera—there is a need to be discreet, so this demand to look at these medical records and they look picture perfect might not be practical in the real world.

**CHAIR:** Thank you, and I will note that we did look at some of those issues in one of our previous inquiries into changes to that act.

**Senator ADAMS:** Dr Caska, I would like to continue with the start of the process. When this first starts and someone is first identified, how qualified other people who work at Medicare to start the process?

**Dr Caska:** Medicare have got counsellors or advisers that come and visit the doctor—

**Senator ADAMS:** No, even before that, when the doctor is identified. There is obviously coding and everything else and this flag goes up. Go to the CT scans, which is pretty easy—X number of CT scans. So the flag is up, the warning is there—what is this person up to? I want to know how qualified is that particular coder? How does it start? We have gone through other inquiries and found that the actual start of a process has been flawed. The ramifications as it goes further forward has created chaos. I really do want to know what qualifications the Medicare people have.

**Dr Caska:** I don't have a clue, because the first notice we have is a written notice from the Medicare counsellor. That is the first notice we have. It does not tell us any more than that.

**CHAIR:** Senator Adams, I think it is one of the issues that we can pick up the department this afternoon. We can go through with them the process.

**Senator ADAMS:** That is fine.

**CHAIR:** It is better to ask the people of actually run the process.

**Senator ADAMS:** The doctor was talking about the start of the process before and I thought we could probably go deeper, but that is fine.

**CHAIR:** I promise we will come to it with the department.

**Senator ADAMS:** I am from a rural area so rural GPs are pretty important, and, having nursing background, I am fully aware of how pressured they are, especially with a solo GP. In the area that I come from there is a three-week waiting list and the GPs are just rushed off their feet. They are on 24-hour call—the whole thing. They really are trying to cope with communities that are far too large for just one person. But, once again, how do we get enough GPs out into the bush. It is a difficult issue. Those GPs are really in a situation where they are going to create problems and get one of those red flags coming up somewhere along the line. If they have 607 days and they are living out in the middle of nowhere, trying to do their best by the community, and are dragged away to the city or wherever to meet up with this committee, you are penalising not only the GP but really the other people who live in that community. It is just not easy to get a locum in. If it is a rural GP who has been pulled up before, firstly, the director and then wherever it goes to from there, does the director have the expertise to understand the practical ramifications of how that person actually works on the ground?

**Prof. Reece:** No. That is absolutely correct. This is the headline from Kyabram, where Dr Peter Tisdall, the chap who died, worked. The article starts off: 'It could have been the funeral procession of a monarch.' I did want to hand these up and I forgot, so if you would—

**Senator MOORE:** Chair, we have already had that in the submission, so unless you wish to have it up behind the committee I am wondering why we need that as well as the one in the submission.

**Prof. Reece:** It is totally up to the committee.

**CHAIR:** We do have it, thank you.

**Mr Watt:** To get back to your question, Senator, from Dr Webber's evidence yesterday there was no implication whatsoever, and certainly no content, to say that the rural aspects or considerations are taken into account. Dr Webber stipulated his criteria for assessing whether or not he would offer a so-called negotiated agreement. None of that had any bearing on the location of the doctor's practice. So, to answer your question, from Dr Webber's evidence yesterday there does not appear to be any consideration given for the rural doctor nor the community.

What you said was absolutely spot on: not just is it punishing the doctor; it is punishing the community. Residents of Kyabram, as you are well aware, have made their submissions and they have clearly stated that they cannot get in to see another doctor. The pressures on rural doctors are enormous. The workload is there. If only the PSR would take the time to profile that practice, to assess the community, to consider the issues—be they location, gender, ethnicity or whatever—and consider all the circumstances. You have raised an excellent issue specific to rural areas, but it is also a lot more widespread.

**CHAIR:** Surely you are not suggesting that rural practices should be exempt from any auditing process?

**Mr Watt:** Absolutely not.

**CHAIR:** So what would you suggest? The question was specifically on rural doctors. I know you have put other suggestions on the table, but what would you specifically suggest for rural practices?

**Mr Watt:** In assessing whether or not the doctor was justified in exceeding the 80-20 rule, for example, have a look at what the cases were. Was there a particular outbreak, perhaps a whooping cough outbreak, in the district? If document after document, each medical record, shows that there was a need to see that patient on that day then surely that has to be a reasonable explanation, as opposed to saying simply: 'Eighty on this side, 20 on this side—guilty.' External issues have to be taken into account.

**Prof. Reece:** This is very frustrating for us. The act actually provides that the PSR process can take external advice at whatever process—at the director process, at the PSR. To our knowledge, there are no cases where they have taken external advice on this issue, whether it be a rural issue or any other issue.

The other thing that is very frustrating relates to what you were asking about earlier—how the process starts. If you read that document, 1982, it says that every doctor is compared with a peer group, starting with doctors who are seeing about 10 patients a week. We have been reliably told that in England, a bigger country than ours and with more doctors, rural doctors are compared with rural doctors, urban doctors with urban. If you have a lot of old folk, you are compared with doctors who see a lot of old folk. If you have a women's clinic then you are compared with other people who see women. Medicare obviously have a national database; they have been doing this for 20 years. I think there is no excuse for these outrageous comparisons. For example, if I am trying to control a heroin epidemic in South-East Queensland, what does comparing me with a person who is working an hour or two a week prove?

**Mr Watt:** It comes back to the issue of being a true peer. Does the simple fact that two people have done a similar university course, that they have both done their medical degree—and quite often with one of those people it is going to have been many decades previously—mean that they are actually true peers? One did a medical degree in the fifties, one did one in the eighties or nineties. Are they on the same page, or has medicine evolved in that time? The simple overlapping of a qualification, in my submission, does not equate to being a true peer.

**Senator ADAMS:** Mr Dahm, you mentioned GP super clinics. Would you like to expand on that, please—just the problem?

**CHAIR:** And its link to the PSR.

**Mr Dahm:** I was just quoting a research report that said that 85 per cent of gen Y GPs are considering quitting general practice. The question that was asked was what the main obstacle was for that, and the research paper said that it was—and it was sort of lumped together as one question—because of GP super clinics, Medicare and red tape. 50 per cent of respondents ticked the box and said that those were the reasons. So I was just quoting from that piece of research.

**Senator ADAMS:** Has your organisation looked at the Medicare Locals and how that is going to work and how you see that, because—just to give you an example—I come from Western Australia, and the latest Medicare local that has just been approved is covering nearly five health service districts that used to exist and is going to stretch the GPs that are there, out working in the rural area, even further. Have you looked at anyway that there could be perceived overservicing or anything like this? These people are going to be really stretched out with what they are expected to do.

**Mr Dahm:** I think that, if you are concerned about overservicing, I will throw this idea up: at the moment what I am concerned about is that there is no patient engagement, and even having a small gap in the safety net that exists will make people check their docket to scrutinise what services have been offered, so there will be more of a discussion happening at the time of the consult. That is a real market mechanism, and I am always quite forward about increasing the rebate simply because it forces that situation to occur. It is only when people start spending their own money that they start taking notice of the issue—it is like a speeding ticket.

My concern is that there are a lot of lifestyle issues—obesity and the like—and it seems to be that the taxpayer is the one that is going to fund all that, but that there are a lot of things that we could do without being too sophisticated. One of them would be allowing the free market to exist and making people more health-aspirational. The money that was saved could then go to those people who were genuinely in need.

So I believe that the environment and the culture we live in is what we need to change. It should not be that providers have to do everything; the patient should have to meet halfway so that there is common ownership. I have seen the Medicare Locals thing—it is the Divisions of General Practice being reorganised into more of a federal type of body—and it is creating more centralisation. But healthcare works on decentralisation and allowing the doctor and patient to have direct engagement.

**CHAIR:** We will move on because I think we are straying a little bit from the terms of reference and we have limited time. I am trying to really focus us.

**Senator BACK:** The rural question has, I think, been asked and responded to. Dr Masters, in your document you have proposed solutions. In No. 7 the observation is made that 'the charges against a doctor are not formulated formally until the draft findings of the committee are published'. You go on to talk about the incapacity then to be able to bring further expertise to the committee.

Could you explain that process? My understanding was that, under the legislation, the director has to present to the doctor under review the information that has come to him from Medicare and pass that on in its entirety. How is it then that the doctor under review does not have knowledge of the charges against him or her until the draft findings of the committee are published? Can you explain that to the committee?

**Dr Masters:** How it starts is that you get a letter from Medicare saying, for instance, 'We've noticed that your level Cs are in the top five per cent.' Then they come out to your practice and you have the opportunity to speak to them for about two hours about what that might be. Generally what happens then is they will say, 'Okay, we're just going to watch your practice now for the next 12 months.' They do not normally make an assessment about whether you are right or wrong; they just say 'we're watching you'. They come back in 12 months time and they might say, 'We've noticed that you're not doing any level Cs; you're only doing level Bs now—case closed,' or they might say, 'You're still doing level Cs; we'll have to look at this a bit further.' They will generally then ask for the records, so the records go off, around 100, to Medicare. That is when the director has a look at the records. Then they will come back to you saying, 'We'd like you to have a meeting with the director,' and the director may say, for instance, 'I've been having a look through your records, and I'm also worried about the level of such and such, and such and such,' maybe five or six things. At that meeting, you have your discussion, and then you get a letter about a month after that saying whether or not your discussion with the director was fruitful. That is when you may be offered the opportunity to have a negotiated agreement.

In a lot of the cases I have discussed with people, what happens is that they will look at the records and it will come back to, 'Yes, it looks pretty good, but I'm not happy with the detail of your medical records.' This is a fairly common occurrence lately. They will say something like, 'Fifty per cent of your long consultations did not have adequate documentation.' Now, if any of you can find out what 'adequate documentation' is, I will take my hat off to you, because I have been looking for the last two years and I cannot get an answer. The director will not give to me. Medicare will not give it to me. The college has guidelines, but guidelines can be taken number of ways.

**Senator BACK:** I do not think you have yet got to the point, and we are short on time. I still do not know how it is. Really, to me, you are almost saying that the doctor does know what the charges are. I just wondered if you could briefly explain—

**Dr Masters:** The director and you will have a discussion about what the concerns are; it is not charges but concerns. Then you get a letter back saying, 'We'll negotiate an agreement.' If you do not like that, then you can go to the committee. There is no actual charge when you go to the committee. The committee then do their own review and they will often have other concerns that are different from the director's. So you only find out when you go to the committee if there are other concerns and if they agree with the director or not. Often they will disagree with the director, saying, 'No, your care plans are good; your long consultations are good,' but then they might say, 'But, hang on; what's going on with your pathology ordering?' So you start again.

**CHAIR:** Professor Reece, you wanted to make a comment, and then we are going to have to move on.

**Prof. Reece:** This is an important thing and thank you for raising it. If they say to you, 'Your level Cs are a problem,' what can you say about that? I see a lot of drug addicts and I talk to them, and that is what I say. But you cannot talk about a situation until you know a name and date and there is a patient file in front of you. Do you see what I mean? At that point, you have evidence. They say, 'There's a service; we don't think it's adequate.' At that point, you know what the charge is. That is the thing. Then the question becomes, 'Was it adequate or not?' That is why we are saying that the charges are not formalised in a way that we can defend ourselves against them. They need to be specific—date, time, patient; there is the record—but you are not told that until the draft report is issued. That is the problem.

**Senator BACK:** Thank you.

**Senator ABETZ:** I have a quick follow-up on that: the patient is never part of the inquiry?

**Prof. Reece:** Correct.

**Senator ABETZ:** Thank you.

**Senator McKENZIE:** I have two questions. The ADU represent 200 doctors, we have heard this morning, and the AMA represent the medical profession more widely, and you both agree, I am assuming, that you provide a similar style of representative advocacy for medical practitioners. I just wanted to—

*Member of the audience interjecting—*

**CHAIR:** I told you yesterday that you cannot speak from the audience. Please continue, Senator McKenzie.

**Senator McKENZIE:** I am just wondering if you can flesh out whether I am misguided in that comment.

**Mr Watt:** The AMA website reveals that they claim to offer a very wide scope of services, representations and so forth, whereas the ADU is more specifically concerned with supporting other GPs going through the PSR system. The issue of the advertising and the claims made on the AMA website versus what they do when they are sitting on the panels is a matter that has been referred to the ACCC. They are claiming that they are going to protect financial, personal and professional interests, yet when the PSR is willing to write a cheque they sit on the panel. The doctor who got the \$47,000 fine probably does not really think he had his professional, personal or financial interests protected too well if there was an AMA member on that panel.

**Senator McKENZIE:** The ADU is not solely about representing doctors going through PSR process. Your representative role is wider than that, isn't it?

**Prof. Reece:** The ADU is brand new. This is the first issue we have become involved with. We are on a growth curve. The AMA is a mature organisation. It has been around for a long time and is going to be around for a long time yet. So we are different organisations in different growth or maturity stages.

**Senator McKENZIE:** My second question goes to something Senator Back's question touched on. It is about the patient role as evidence in the process. Is there a point in the process, perhaps the day that you sit down and have the conversation with the director, when you can take along some patient evidence? Or is there some other point in the process when you can do that?

**Prof. Reece:** No there is not. That is the whole point. We cannot defend ourselves because we are not told what the charges are until the process is over. The only case I know of where a doctor actually got to defend himself was the case of Dr Tisdall, who had to take it to the Federal Court so that he would get an opportunity to present his defence case. After he presented it they disregarded his evidence.

**Senator McKENZIE:** So it is because you do not know the case, not that you cannot?

**Prof. Reece:** Yes, there is no opportunity. It works in reverse. You are told the charges at the end in the way that I described, not at the beginning. So you can never present a case. All you can do is present submissions and they are at liberty to disregard them, which is what they do. Senators are right to identify that patients are a major resource of information and evidence. The big question in our game is: was it 20 minutes or not? Once the patient's mind is refreshed on what happened and what the conversation was, they can tell you that.

**Senator MOORE:** I have just got a couple of questions. There are many things that can be talked about. In terms of the survey that you referred to, Dr Masters, I notice that it has got about 177 respondents.

**Dr Masters:** The final was about 212.

**Senator MOORE:** That is the survey that you mentioned in your evidence?

**Dr Masters:** Yes.

**Senator MOORE:** Were the people who actually responded all members of the ADU?

**Dr Masters:** No. That was before the ADU. That was done through a group of doctors called Aussie Docs, which is like a network on email.

**Senator MOORE:** We have got confidential things that I cannot refer to, but you mentioned in your evidence the numbers that gave answers. Can you tell us that?

**Dr Masters:** Yes, I think the final number was 212.

**Senator MOORE:** That was just on a website. I have had a look at the AMA website and they have got some good to and fro going there in terms of the process. The issue that I want to get to though is something that I think a few of the submissions talked about—getting guidance and information. One of the submissions talked about having the same form of support as you get in the taxation office—I think it was yours, Mr Dahm—so that a standard is available and people can self-assess on issues that are causing questions, like long-term consultations and care plans. I am really interested in getting some more information on that.

**Dr Masters:** I will give you an example of how it works at the moment. We have set up a clinic that is specifically looking at people with chronic spinal pain.

**Senator MOORE:** I know your clinic.

**Dr Masters:** It is a multidisciplinary clinic. I had already been to the director because I was concerned to get the Medicare numbers right for this clinic. They are not straightforward. So I sent quite a lot of information to

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

**Senator MOORE:** So it is that gap in understanding.

**Dr Masters:** It is uninterpretable. The NBS is uninterpretable by their own staff. If you ring them up you will get five different answers. This is the problem. It needs to be simplified. That is one of the first steps. Most of the issues that end up in front of the PSR are not about people trying to rip off Medicare; it is just about interpreting the schedule.

**Mr Dahm:** Can I make a comment. Medicare did introduce what is called the APS system, which is administrative policy statements. I think that was around—I will have to double-check that—October 2010. It is similar to a tax ruling. I have been looking at that and seeing that, okay, all the things that are mentioned in the annual report are the big risks. If they are big risks, surely they should be publishing all these great ideas to reduce the risk. That is what the tax office does and that is how the ruling process works. When you have a look at it, they are raising half these things in the annual report and then, when you go and look at these rulings, you see that they do not even raise a lot of those key issues. If they do raise those key issues—and I do not think they actually do—it is very broad and they do not go to the clinical side of things. Again, how you have to manage your documents is in a very broad form. It does not get into the duck's guts of the issue. That is the problem—the detail is not in there.

**Mr Watt:** It is effectively having a travel regulation that says you are not to drive at an inappropriate speed. When you go and ask the police officer what the speed limit is, the officer says, 'I don't have to tell you.' 'How are you going to record my speed?' 'I don't have to tell you.' 'How am I able to double-check what my speed is?' 'I don't have to tell you.' 'Does the speed limit change at a certain location?' 'I don't have to tell you.'

**Senator MOORE:** In terms of the process of information—and we came across this in a few of the confidential submissions as well as the open submissions—there is confusion within the practitioner network. We will ask the AMA and also the department the same question. There has been a recent review of the NBS process—which involved consultation with the AMA and other groups, not the doctors union—about where it is going. That is what I am looking at: the knowledge and guidance given to the practitioners to work within the system.

**Mr Watt:** Education is definitely one of the main issues that is being sought and also a wider spread of the consultation process, not necessarily just with us.

**Senator MOORE:** Can you put any information on record about issues of interaction between the Australian Doctors Union and the AMA and also responses you may have had from the AMA about the concerns you have raised?

**Prof. Reece:** I am happy to talk to that. The PSR is the AMA. It is the upper echelons of the AMA. The two are sort of 'photocopiable' now. The AMA have been talking to government for a long time—

**Senator MOORE:** Dr Reece, we are running out of time and it is a statement that you have made in various submissions. I want to know what formal interactions there have been between the ADU and the AMA about the work that you have done and the concerns that you have had.

**Prof. Reece:** I have had a number of meetings both with Dr Hambleton and the Queensland President of the AMA to raise these subjects. That is why we are here today, making our own representation.

**Mr Watt:** In the absence of this inquiry, very little if any progress has actually been made for many, many years. Many submissions from PSR aspirants and formal panellists say that the process is fine; it does not need changing. Yet there has been a massive scramble this year to produce new brochures and to suddenly information share, to talk about consultation and to develop advisory groups which are still made up of the same people who have been providing the input to the unit the whole time anyway.

**Dr Masters:** We would say that it was probably the ADU members who got the AMA rolling the ball with the whole PSR issue. That is how the 39 cases were stopped. So we got the ball rolling with the AMA, and it was quite productive. To put it very quickly, we feel like the AMA has now sort of hit the wall with the issue. We believe it needs to go a bit further but the AMA has sort of stopped.

**Senator MOORE:** Thank you.

**Senator BOYCE:** You may not be able to answer this, but somebody commented that there has been an increase in auditing over the last five years. Could you flesh out what the trigger for that might have been, in your opinion?

**Dr Masters:** It happened about 2007 or 2008. The government announced there would be increased auditing. So was the health Department.

**Mr Watt:** I think Dr Webber said yesterday it was just a modification of the parameters of the search. They just cast the net a little bit wider is effectively what he was saying. No people here from the ADU have a problem with auditing. Not only have each and every one of them expressed a need for accountability but also they have said accountability has to be on their behalf but also on the body auditing them. That is what the ADU is pushing for.

**CHAIR:** We are close to time, so I ask that the answer to the next question be very short, please, because it is going to be the last one.

**Senator BACK:** Professor Brazenor, again in terms of the recommendations in point 9, the statement has been made and I wonder if you could respond to it. There is no time to quote it, but the question of the specialist and the GP. Can you explain briefly why it is that the practice of a GP, if acceptable to a specialist, cannot be acceptable to a panel of peers of GPs?

**Prof. Brazenor:** I think the opinion of the specialist would be acceptable to a panel of true peers.

**Senator BACK:** It should be.

**Prof. Brazenor:** Yes, absolutely.

**Senator BACK:** And is it at the moment?

**Prof. Brazenor:** There is not one in the PSR. If there were a panel of true peers, yes, I do not think we would have any problem with that at all.

**Senator BACK:** That would enhance the whole process, in your terms.

**Prof. Brazenor:** Absolutely.

**Prof. Reece:** Can I amend briefly an answer that was just given? You asked about interaction between the ADU and the AMA. The AMA was running with this ball about 12 months before we got involved. We did not precipitate the AMA, they were doing it. But what happened was that it accelerated the pace of change and bringing on this inquiry has helped enormously. I just needed to tweak that answer a little.

**CHAIR:** Thank you. I would like to note that you have seen the difficulty we have had with asking questions around the confidentiality of the submission. Thank you again.

**BIRD, Dr Sara, Manager, Medico-legal and Advisory Services, MDA National**

**BROWNING, Dr Anthony Troy, Managing Director, Medical Indemnity Protection Society Ltd, and CEO, MIPS Insurance**

**RAIT, Associate Professor Julian, President, MDA National**

[10:19]

**CHAIR:** Welcome. Would you like to add anything about the capacity in which you appear?

**Dr Browning:** I am chief executive officer of MIPS Insurance, which is the captive insurer.

**CHAIR:** The committee has before it your organisations' submissions, which it has numbered 5 and 14. I remind all witnesses that evidence should address the terms of reference of the committee and that misleading the committee can be regarded as a contempt of parliament. We ask that witnesses avoid making adverse comment against other parties and warn that such reflections may prompt the committee to suspend proceedings. The committee may decide to go in camera at any stage and also witnesses may ask to go in camera at any stage. I invite one of you to make an opening statement.

**Mr Rait:** I think, by agreement, I will start. Thank you very much for the opportunity to give evidence to the committee in relation to this inquiry into the review of the Professional Services Review scheme. As a medical defence organisation, MDA National has advised and assisted a number of our medical practitioner members in relation to their involvement in the PSR scheme and our comments today are based on this experience. You will note that in its submission MDA National has highlighted a number of concerns about the operation of the PSR scheme. In particular, we stress the need for the PSR scheme to be transparent and timely and adhere to the rules of procedural fairness.

MDA National support a peer review process in determining if appropriate practices occur, but we believe this must involve appropriate peers who apply a reasonable standard with respect to their assessment of the clinical relevance and adequacy of the services provided by the practitioner. In this regard, we welcome the PSR agency submission, which refers to the newly developed guidelines for the appointment of medical practitioner panel members and deputy directors to guide the future appointment processes. We also note the development of guidelines in relation to the appointment and use of consultants, of which we also approve. MDA National submits that the PSR process could be further strengthened by the increased use of independent medical experts to provide reports and/or give evidence before the director or a PSR committee.

MDA National noted in its submission that review meetings between the director and the practitioner under review often do not meet the requirements for procedural fairness in that practitioners are not provided with sufficient information to understand the case against them, nor are they provided with adequate opportunity to reply to such charges. Again we note that the meeting invitation that will now be sent to practitioner under review will include more detailed information on the director's preliminary views following review of the practitioner's clinical records. Obviously MDA National welcomes this change and believes it is quite a positive move.

It has been MDA National's invariable experience that medical practitioners who are involved in PSR committee hearings, however, find them very difficult, onerous, lengthy and quite stressful experiences regardless of the outcome that may follow. While we welcome the development of the PSR's *Your guide to the PSR process* and the published committee handbook for PSR panel members and deputy directors, we believe the PSR committee process could be strengthened by the chairperson having legal qualifications and the practitioner under review being entitled to legal representation.

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

Finally, MDA National understands and accepts the importance of protecting the integrity of the MBS and PBS schemes. However, it is essential that the community and health practitioners have confidence in these processes. We believe a more collaborative and consultative approach with the profession will result in an improved process which will still ensure that the Commonwealth and the community will be protected from the risks associated with inappropriate practice by health practitioners. We are happy to answer any questions in relation to our submission and any other issues of interest to the committee.

**Dr Browning:** Thank you, senators, for the opportunity to be able to participate in this hearing. It is very important for our members, as you have heard. It is a very stressful event in the lives of many doctors and I hope that there will be some positive outcomes from this process.

In summary, the broad-brush approach is about transparency and objectivity, fairness and natural justice, timeliness and efficiency and accountability of stakeholders. Looking through the submissions, I think that is a theme that keeps coming through—in different shades and volumes, but they are common factors.

We have also proposed that one of the areas of concern is in relation to this whole issue of finding of inappropriate practice—and I will speak a little later about that peer selection process. However, inappropriate practice, if it is a concern that should be addressed and considered for the benefit of the community, we believe that the body best able to do so is the Australian Health Practitioners Regulation Agency, AHPRA. That is their role: to protect the public from inappropriate practice. So, at the moment we have an unusual hybrid of an inappropriate practice that is really about appropriateness of billing for a service that is provided.

We are also very concerned about a developing tension between what many might believe is gold standard care and an interpretation that is of a lesser standard. In our submission we provide a simple example of the untoward consequences of modifying clinical practice through outcomes. Medical practitioners, fortunately for the community, are risk-averse individuals—they like to control risk, they like to control their environments. And one of the most distressing features of the PSR process is the uncertainty: not knowing the rules, not knowing how to either avoid an uncomfortable situation or indeed respond. Again, in our experience it is rare, during the PSR processes, for independent reports to be seen to be given much weight. That is quite devastating. It undermines legitimacy in the process; it certainly undermines the objectivity and is insulting, I would suggest, to those experts who have provided opinion.

I guess the major problem that we see is the use of non-current and non-craft-specific practitioners to provide that peer input. Medicine is very complex. It is becoming more complex. There are lots of super- and sub-specialisation—and that is good for the community, it is good for patients that there are practitioners who develop depth of skills and understanding in particular disease systems. That, unfortunately, will have flow-on effects onto the type of practice that they prescribe. So a practitioner who has developed skills in counselling of patients will have a different profile, different lengths of consultations. Those who are involved in skin cancer clinics will have a very different profile again. It does not mean that it is bad, it does not mean that it is wrong—in fact, it should be to the benefit of the community—but it does not fit comfortably with the current process.

Again, the best way that we can see for a proper representative peer process is a good old-fashioned jury process—that is, that the specialist-craft group, while you may have the reluctant, but who are willing to do their duty because it is good for the community, being called up, being tapped on the shoulder in order to participate. They would need to rely on a very skilled secretariat and administrative backup to make sure that the rules and structures are followed. However, I think that is the only way that you will get truly competent, and accepted by all stakeholders, peer committee panel advice. So I think there is a great opportunity to widen the net to involve all the various colleges, the special interest groups and craft groups into providing peers for that process. Of course, the most important thing of all is the transparency and accountability—so that, whatever the process is, it is audited without fear or favour; as doctors are audited, so should the process be, so that everybody can have comfort that rules are being followed, that there is natural justice and process and that there is there is clarity.

We have heard this morning, coming back to the simple things, about asking about the definition of an item number in a procedure. It should not be too much to ask. It has terrible consequences if medical practitioners get it wrong. Thank you very much.

**CHAIR:** Dr Bird, did you want to make any comment?

**Dr Bird:** No, thank you.

**CHAIR:** Senator Adams, you look like you're dying to ask a question!

**Senator ADAMS:** Thank you. My first question is: you are only dealing with medical indemnity; you do not deal with any of the other allied health people or anyone in that respect?

**Prof. Rait:** We indemnify dentists as well, so we are involved with them with respect to this matter through Dental Protection Ltd, which is a subsidiary.

**Dr Browning:** We also have dental practitioners, dental hygienists, prosthetists—those other types of practitioners.

**Senator ADAMS:** I did ask a question yesterday—I don't know whether you were listening to our witness Dr Webber—about nurse practitioners and also midwives. Of course, it is a fairly new area for them to have the

privilege of being able to use Medicare numbers. But it did worry me, to the extent to which the peer review went. This is the reason I asked about rural doctors earlier: because it is fine to have a director that has perhaps not practiced recently, and the pressure on our doctors in rural areas, especially at the moment, is very great. With the change in the health reforms—I will come back to the Medicare Locals—this is concerning me because, with the longer consultations, and the chronic care and management plans, GPs are going to have to spend time doing this. As the rural communities age, there is a terrific lot of older people now living in rural communities; therefore, the GPs' practices are changing. Clinic work is completely different, but I am just looking at the run-of-the-mill, with the Medicare Locals trying to get the primary care right. Can you comment on where you see that going? If we are going to have more problems with the lengthy consultations—that is probably a better way to put it.

**Dr Bird:** You are absolutely right that there are significant changes being undertaken in a general practice setting. Both of our organisations have made comments about the complexity of the MBS item descriptors, particularly those chronic disease management items that you have referred to. They are very important initiatives, to provide care within the community involving allied health professionals in the care of patients with chronic illnesses. But those item numbers in particular have drawn attention at the PSR, in my view largely because of the difficulty in demonstrating the documentation of that process. So there are significant pressures being put back on GPs in terms of even using those item numbers.

**Senator ADAMS:** Right. I will come back to my question, which really is: are the people—perhaps the director, and then the committee—aware of the change in the practice and how this all works? That really is the practical side of it. I believe, just from reading the evidence and the submissions, that there are GPs here who have been very unfairly—well, not targeted, because I guess the flags come up when they have done too many lengthy consultations. But we then have to look at the question of what does the community expect, and the changing nature of the practice. Going through the list, I am pretty aware of the people from WA, and I know that they have really had nothing to do with rural practices at all; they are city GPs, who are very good at what they do, but as to getting into the new way of doing things, as far as these care plans go: no.

**Prof. Rait:** Senator, I think you raise a very important point. Recently I was in the Kimberley, in the north-west of Western Australia, talking to our members up there. It was quite clear that there was a bit of difficulty in understanding the complexity of the practice, particularly as they are dealing with a largely Indigenous base of patients who do not really fit the normal pattern of care that you would see in the city. It gets back to what Dr Browning said: if people are to be assessed, they have to be assessed by genuine peers who understand the nuance of that.

You also make a very good point that, if there are allied health professionals such as nurses, midwives and so on moving into the Medicare system, it is essential that they be judged by their peers as well, otherwise they will be held to a standard that is unreasonable or inappropriate for their practice. So I go back to Dr Browning's point that, really, the setting of an appropriate standard requires genuine peers of the practitioners under evaluation. I think the director really needs to consider the use of commissioned reports from independent experts that practice in the area, whether it be rural medicine or nurse practitioner type activities and so on. If someone does come up for review, and particularly looking at prospective changes in the health system, we would encourage the PSR to be more anxious to use independent experts that have demonstrated competence in the field in which the practitioner under investigation practices in.

**Senator ADAMS:** I note that you represent dentists as well. What happens there? If a dental practitioner has been flagged and has come up for review by the director, does the director have any expertise in dental work, dental surgery or dental Medicare numbers?

**Prof. Rait:** I will defer to Dr Bird because I have had little to do with dentists.

**Dr Bird:** As far as I am aware, there have not been any referrals through to the director. Dr Browning might be able to correct me there.

**Prof. Rait:** I would like to pick up on one point that we made in our submission and that Dr Browning raised. There is difficulty with the item descriptors for some dental services. As I understand it, dentists get engaged with the Medicare system in respect of chronic care—that is, patients with chronic illness and disease. It is there again that the item descriptors are imprecise and could cause confusion, and we could have dentists being regarded as conducting inappropriate practice because of their lack of understanding of what the descriptor means. It gets back to more work needing to be done, particularly with the dentists too, to improve the accuracy and the clarity of the item descriptors.

**Senator BACK:** Professor Rait, in reference to repayments of Medicare benefits, in your submission you made the observation that there are cases where the clinician may have got only 20 per cent of the benefit and in fact they have to repay 100 per cent. You quote a case of somebody who repaid \$1.2 million and another who repaid \$473,000. If a person did not collect the sum, I am at a loss to understand why and how they pay it back?

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

**Senator BACK:** Can I then ask whether, if regrettably you were a person under review and it was determined that you had a repayment to make, the practice group compensate you for the proportion?

**Prof. Rait:** Not necessarily, and under the act I do not believe that it is necessarily the case, particularly if I am not an employee of that practice. If I am an associate of the practice, the act does not have the power to require my practice group to repay the proportion of the fee derived.

**Senator BACK:** I just want to go to another issue—that is, the process by which a doctor or other allied health professional is identified in the first place. It seems to be purely on a bell curve. If you find yourself too far out to the right, you are in trouble. It has been put to this committee that the concept of practice profiling, as is practiced by the Australian Taxation Office in every other industry that I am familiar with, would be a more fair process. Even having regard to this right-hand side of the bell curve, a practice profile of similar types of practices in similar geographic areas dealing with similar types of patients could actually identify it so you could say, 'Yes, whilst it appears to be out there, it is the fact that there was an epidemic, the doctor is very busy, they are very popular and therefore that is the explanation,' before it triggers this long process that we are hearing about.

**Prof. Rait:** Very much so. Three examples spring to mind. One is the example I gave of an Aboriginal health practice or one that is involved in that area. Another would be one that is involved in the management of drug addicts and detoxification. The other would be skin cancer clinics. These are not profiled appropriately under the current arrangements and I would concur that elsewhere in government there appears to be a more scientific approach to the analysis of outliers. So I would concur with your suggestion that it does seem that a different approach is warranted. I might defer to Dr Bird and Dr Browning to see what they feel about that too.

**Dr Browning:** I think that would be very helpful. Currently it seems as though there is a lot of time and energy wasted on a very lengthy process and a lot of angst created along the way. So, yes, profiling would be very useful. An even greater use for that would be to make sure that it is transparent and objective and to allow doctors to look at their profiles, put in the parameters and actually have a look at what Medicare might be considering, so they can look at that profile and say: 'I seem to be towards one end. Is there a reason for that?'

**Senator BACK:** As a supplement to that, can I ask: are you aware of doctors who, realising that they might be finding themselves in a risky situation, are actually changing their practices—in other words, not taking patients or not taking patients who might be requiring longer consultations, getting out of some areas to actually get themselves a bit to the left of the bell curve if they perceive they are getting somewhere close to a limit? Are we seeing that?

**Dr Bird:** Yes.

**Senator BACK:** Can you be a bit more expansive than the word 'yes'? Can you give us examples without breaking confidentiality?

**Dr Bird:** In the Medicare Australia process, as you are probably aware, doctors are visited by a medical adviser and their profile is sent out. It has certainly been our experience that a lot of members will reduce the number of level-36 consultations they are performing if that has come to the attention of Medicare Australia and still conduct a long consultation but bill it as a shorter level consultation. We have certainly seen practitioners who have been working specifically in the area of skin cancer clinics, have come to the attention of Medicare Australia and have ultimately elected to change their practice profile to deal with that.

**Senator BACK:** Dr Browning, you mentioned the Australian Health Practitioner Regulation Agency. This goes to the question of natural justice. In my own case as a veterinarian I remember way back in the 1970s having a dispute with the Australian Veterinary Association, which caused me to cancel my membership. As it happened I had no further dealings with them, but I have no doubt that had I ever had further dealings with them they would have been adverse as a result of that very public spat. I am just asking you to expand on your view of the Australian Health Practitioner Regulation Agency being the body delegated or devolved from Medicare to actually undertake this whole process.

**Dr Browning:** Just for clarification, it was not to undertake the entire process but only that part of the process where there may be a concern about inappropriate practice. In my mind, there seems to be a lack of clarity between the two parts of the PSR process. One is about inappropriate practice and there is another about protecting the public purse. There seems to be a lack of clarity between those. If there are issues—and it is important to ensure that the public is safe—then AHPRA is the body responsible for ensuring public safety. If, however, we are just talking about billing descriptors and not about conduct a practice that is dangerous to patients but rather billing irregularities or clerical issues then that could be the single focus of Medicare's reviews. I think that would take a lot of angst out of the situation. As was mentioned this morning, there is this threat of double and triple jeopardy and it was said this morning that practitioners often elect not to go any further because of the potential problems.

**Senator McKENZIE:** We have all heard of the bell curve, do you think the legislation unfairly targets GPs above other health and medical practitioners? If so, why?

**Prof. Rait:** The statistics speak for themselves, that it seems as though general practitioners attract an unreasonable degree as scrutiny. Speaking as a specialist, the reason for that is that they work with descriptors that are much more complicated than specialists are used to. In our own case, the descriptors have not changed very much over time. I certainly see that there is increasing complexity of the MBS with respect to all the services and items that are provided by general practitioners. I see that complexity is why there is a greater focus of attention upon them. It seems to me that they are unfairly targeted because of the greater complexity in the area in which they work. So it is easier to find errors.

**Senator ABETZ:** Page 6 of the MIPS submission states:

We believe that engaging those no longer involved in contemporary practice is unlikely to safely meet the requirements of the legislation ...

That is referring to the PSR committees. Is that an assertion or an experience that your members have come across?

**Dr Browning:** It is an assertion based purely on the wording of the legislation. It is about a general body and it has the flavour of peers. From those who are currently empanelled or part of the pool that has drawn upon, it seems that a true general body of like may not consider them as peers.

**Senator ABETZ:** Yes. It has been asserted and it is one of the common themes through the submissions that panels do not necessarily reflect genuine peer review or that they are part-timers, semiretired or retired et cetera, whereas I am not sure that that is necessarily considered by the PSR. It is interesting that those who actually represent the doctors would indicate that and that seems to be a common theme. The MDA submission indicated the costs of going through the PSR process and gave an example that the transcript alone was \$14½ thousand for one case. Are you able to provide us with examples of how much it has cost somebody to go through the system?

**Prof. Rait:** Sara, you have probably looked at that carefully.

**Dr Bird:** In terms of costs to our organisation in assisting a member through a PSR committee, which as you know often runs for up to six days now, we would generally have spent a lot of time with that doctor before the committee hearing in preparing them for what is quite an arduous process and then incur the costs on behalf of our member in having a solicitor attend with them as well. By way of an example, yesterday I was looking at a case that had gone to a PSR committee and the costs on the file were about \$50,000.

**Senator ABETZ:** I understand Senator Back has canvassed this but there are then situations where the doctor potentially is required to pay back the full 100 per cent, albeit they may have only been the beneficiary of about 20 per cent of the fee. That is also correct?

**Dr Bird:** Yes, that is correct.

**Senator ABETZ:** I have read both submissions and I think they are both very good. I have no further questions.

**Senator MOORE:** I have two questions. One is to do with the issue around referrals to APRA, as opposed to the PSR. The PSR is very clear regarding the two things they are supposed to look at. We need a little more information on that with your submission, Dr Browning; also in terms of cross reference. We have had some submissions that talk about cases that have gone to the PSR and then been referred on to the medical board because of particular issues. Where do you think the division is in terms of referral by whom to APRA and referral by whom to the PSR?

**Dr Browning:** Anyone, really, can make a complaint or lodge a notification to APRA. Their role is to protect the public from potential inappropriate practice that could be of danger to the public. That is what they do; that is where their skill set is. It is about protecting the public and about danger to the public. It is not necessarily about interpreting item numbers and what may or may not be appropriate descriptors. In our submission we really looked at what is currently in place—and that was put in place before APRA; APRA is a recent organisation, since 30 June last year. Is it really necessary anymore for the process to be in fact double jeopardy, to be looking at inappropriate practice as part of PSR, whatever that may mean, but also to run the jeopardy of referral to APRA? Certainly if there was any concern it should be the other way around—APRA first. If we are just talking about money then look at processes to look at the money.

**Senator MOORE:** I am still unsure as to whether behaviour or practice becomes clear to a PSR review, which is audited through Medicare and Medicare puts it through, whether it is not the appropriate way then to refer to APRA as opposed—the way I read your submission is that you are very much saying that anything to do with clinical practice should be the view of APRA as opposed to PSR, and I see that. We will be asking PSR, the AMA and the department about that. I do not necessarily see it as a double jeopardy. It could well be the Medicare pattern that alerted the process that then would be referred to an APRA referral. Do you see that as a possibility?

**Dr Browning:** Yes. Also a lot of practitioners involved in the preliminary stages will enter into agreement rather than run the risk of going to committee, because they are concerned that it may keep opening up and of the subsequent fallout.

**Senator MOORE:** I am not sure which way that is arguing, doctor.

**Dr Browning:** I am not arguing one way or the other. I am just saying this is what happens in real life examples.

**Senator MOORE:** If someone is actually under scrutiny, sure, I see that point.

**Dr Browning:** Someone who is under scrutiny may really want to dig in and may wish to enter into an agreement because of the potential risk of going further.

**Dr Browning:** It is not a specific case.

**Senator MOORE:** It is a what if.

**Dr Browning:** No, it is an amalgam of advice that had been provided to members and also to a member of our staff.

**Senator MOORE:** It is quite worrying. You were very careful in your submission not to say this was a case and I wanted to know. I cannot understand a paragraph, I am sorry, I probably cannot understand lots of paragraphs but the one I have highlighted is on page 4 of your submission. It says:

A consequence arising from not being perceived to provide balance and fairness ...

I know you are trying to make a point there and I am not able to get it. What are you saying there?

**Dr Browning:** I am saying that because there is a fairly widespread view that the process is flawed and biased that even those at the most florid and flagrant end of some might use emotive terms like 'rotting' or 'inappropriate billing' may be given significant benefit of doubt by colleagues and peers because of the very nature of the process.

**Senator MOORE:** I read that and then I was taken by other evidence we have received even this morning that as soon as you hit the PSR process you are guilty. You are actually making another argument. I think people take the extremes when they are putting forward an argument but we have had people who feel very strongly that the process automatically condemns people and you are saying, as is written in the PSR, people are supposed to have this openness and so on but people whose practice is not what we would like could escape penalty because they are given too much leeway.

**Dr Browning:** Just for clarification it is not 'escape penalty' but rather that within their community of peers they are given a benefit of doubt.

**Senator MOORE:** I have got you. That is where the confusion was. You are saying that if you go before the PSR and are given a hard time, even if you really should have got a hard time, other doctors may say, 'Poor so-and-so.'

**Dr Browning:** I think from many doctor's perspective you would not wish it on your worst enemy.

**Senator MOORE:** I get your point. Thank you very much.

**Senator ADAMS:** I have a point of clarification. With the person under review first up they are not entitled to have a formal legal representative there. Can you go with them as an advisor or not?

**Prof. Rait:** They can be accompanied by a person who can have legal qualification but they cannot make presentations or representations to the committee except on advice from that advisor. The lawyer cannot make submissions or representations. It would be our view that, in improving the power imbalance, as it were, and the need for more of the image that procedural fairness has been granted, perhaps there should be some consideration to formal legal representation being allowed in some circumstances. Furthermore as we have suggested in our submission there should be someone with legal training preferably the chair to make sure that principles of administrative law are more carefully followed.

**Senator ADAMS:** That moves me on to the membership of the PSR committees. I am concerned about the different health professionals now coming in under Medicare. Do you believe that it should be thrown open to people with skills in all the other areas as well? Also is there a place for consumers within that particular committee structure?

**Prof. Rait:** There is always the place for consumers in this sort of matter. Obviously they are the key to all this and as patients and users of the health system they have a voice as well. I would not have any hesitation about that. It goes back to our submission however that in having panel members it is important that their skills are appropriately matched to the person under consideration whether they be a doctor, a dentist or an allied health professional. Furthermore I think that there should be some mechanism by which there is transition, that there is a turnover over time. For example in my organisation I am only appointed for three years and then I am subject to re-election. I think that we have processes in our own organisation to make sure there is renewal so that new thinking, in particular in the case of panels, and knowledge about the new types of practice and new ideas can be fertilised into the group. I would endorse the views of some of the other submissions that there needs to be a mechanism whereby there is some rotation of the panel members and also the use of more genuine peers who are appropriate to the person that is under investigation.

**Senator ADAMS:** Thank you.

**CHAIR:** Thank you very much for your evidence. I do not think we gave you any homework.

**Proceedings suspended from 11:00 to 11:17**

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

**CHAIR:** I welcome representatives from the Australian Medical Association. I know you both know how to do this, but I have got to check that you know about parliamentary privilege and the protection of witnesses and evidence. We have your submission; it is No. 13. In a minute I will invite you to make an opening statement and then ask you some questions. Before I do, we have been making this statement to all witnesses: the committee remind witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comment against other parties and warn that such reflections may prompt the committee to suspend proceedings. As you know, the committee may decide to take evidence in camera at any stage and witnesses at any stage may ask to go in camera. I invite one or both of you to make an opening statement and then we will ask you some questions.

**Dr Hambleton:** Thank you for the opportunity to appear before you today. The AMA is a strong supporter of the role of the PSR scheme in protecting the integrity of the Medicare and pharmaceutical benefits programs. These programs provide Australians with affordable access to medical care and medicines. Coupled with high-quality medical care, they are critical to the health outcomes of Australians. For these reasons it is important to the medical profession that there are sound audit and peer review arrangements to ensure benefits are paid appropriately. It might be useful for the committee if I explain why peer review is fundamental to the medical profession's support of the PSR scheme. As you are aware, under the health insurance legislation, patients will receive a Medicare rebate for a medical service if that service meets the MBS item description and is clinically relevant to the treatment of the patient. Every day medical practitioners in Australia make decisions about which MBS items to assign to the services they provide. They do not have to write the item numbers on the accounts, but they do. This means that the patients receive their Medicare rebate more quickly and that we do not need an army of Medicare clerks to work out which rebate is payable.

Medical practitioners assign hundreds of millions of Medicare items to their services each year. This activity exposes medical practitioners to audits and peer review. If my billing pattern is different from my peers, I can expect a letter or phone call from Medicare. In an audit situation Medicare will decide whether my billing is correct or incorrect, based on administrative facts. Audits do not go to the issue of clinical relevance of my service. The clinical relevance of a service only comes into play if I am referred to the PSR for inappropriate practice. The legislation is clear that a clinically relevant service is one that is generally accepted by the medical profession as being appropriate for the treatment of the patient. Only medical practitioners can make these decisions, based on the medical facts. This is why peer review is so important to the PSR process. There is no simple or even complex test that can be applied to the medical facts for a non-medically trained person to make the decision about inappropriate practice. Just as every patient has their own individual set of circumstances that make their condition unique, there is no paint-by-numbers approach that a non-medically trained person could use to determine that a service was clinically relevant.

For this reason, the principal of peer review is fundamental to the medical profession's support of, and trust in, the Professional Services Review. There is no doubt that the PSR agency and some of its actions have come under fire in recent times. But, from the AMA perspective, the scheme itself is not broken. It does not need to be and should not be replaced by a process that substitutes peer medical review with legal review. There are administrative and operational problems. The AMA has been working with the Department of Health and Ageing and the PSR to improve procedural fairness. We are happy that documents such as *Your guide to the PSR Process* have been written at our instigation and published. These types of documents add transparency to the process. People who are being reviewed will know what is coming. They can use the document to be confident that their matter is being handled properly. PSR agency staff have to follow that documented process too. As set out in our submission, there is more of this type of work already in progress. We are confident that these changes will stand the PSR review process in good stead. I am happy to take questions.

**Senator ABETZ:** I thank the AMA for its submission. On the first page of your submission, under the heading 'Issues identified by the AMA', you tell us that 'in recent years the PSR process has suffered from a perceived failure to afford natural justice'. Would you agree with me that it is more than just a perceived failure, that we in fact do have genuine examples of failure of natural justice and that it goes beyond just a perception and that we have poor people who do not understand properly? That is often what is read into the word 'perceived': people do not understand, therefore they think there is a breach of natural justice. From the reading of many cases and the submissions it seems to me to be a lot stronger that there is actually breach of natural justice in many of the stages of the PSR.

**Dr Hambleton:** Certainly there have been some court cases which have concluded that the processes were not followed appropriately. The AMA is of the view that processes should be followed and that if they are followed properly the process would be fair. We support the process.

**Senator ABETZ:** But you have, I think, agreed that people have not been able to prepare adequately for the director's investigation? That would also be a breach of natural justice, wouldn't it?

**Dr Hambleton:** It is very difficult to talk about individual cases but we absolutely want to make sure that people are given the opportunity to prepare themselves appropriately. In my opening statement I referred to an explanation of that process so that people know what to expect, can prepare themselves appropriately and are informed about how the process takes place. We are very pleased that that process is taking place.

**Senator ABETZ:** With great respect, on page 1 you said:

PURs were not given a clear explanation of the review process ...

I am not talking about individual cases. I am referring to your own submission, which would suggest that natural justice has been breached and that there has been a failure. I am just wondering why the AMA is trying to soften it by saying that there was a perceived failure to afford natural justice when your submission goes on to document actual cases of breaches of natural justice.

**Mr Sullivan:** If I could add to our submission, what we are attempting to say is that the PSR process does have a process of natural justice instilled in it. What the president was saying was that there have clearly been cases where maybe procedures were not carried out correctly. Some people would then argue that natural justice was not carried out correctly. That would be their perception. We did not want to make a judgment one way or the other, but what we did want to say was that in particular cases we can see that some of the procedures could be strengthened in order for a person to feel that they were getting natural justice. Whether we are all just playing with interpretation is more to the point.

**Senator ABETZ:** Let us hope so, because I think there are many examples which would point to a failure of natural justice. If I can go to page 3 of your submission, under the heading 'Composition of PSR committees' we are told:

The AMA identified two aspects of PSR Committees that needed to be addressed ...

The fact that these two issues need to be addressed would indicate to me—and I just want to clarify that the AMA is concerned—that, for example, the PSR panel does not necessarily comprise currently-practising medical practitioners of sufficient and appropriate experience and standing.

**Dr Hambleton:** This is part of the feedback that we received, and we need to make sure of the opposite. We are not implying it did not happen; we are actually implying this must happen. This must be something going forward that is demonstrable.

**Senator ABETZ:** You are saying it needs to be addressed. The fact that it needs to be addressed would suggest that it has not been happening. If it had been happening, one assumes it does not need to be addressed. Is that correct?

**Mr Sullivan:** What we were saying in our submission is probably a little bit broader than that. I think it is not as simply put. The issues about the panels, the committees and the like were raised with the AMA over time. We raised those with the department and the PSR. In a sense what we are saying is it needs to make sure that they are appropriately and adequately panelled and that the appropriate competencies of doctors are on those committees and panels.

**Senator ABETZ:** Which is your second dot point, so you have saved me on that. The fact that you say that it needs to be addressed—if it were all running hunky dory, nice and smoothly, why would you be saying that it needs to be addressed?

**Mr Sullivan:** I do not think we have ever said in recent times that things were running hunky dory and smoothly, and that is why our language says 'needs to be addressed'.

**Senator ABETZ:** Yes. Because we had evidence yesterday suggesting to us that at all times the same speciality was there and that the panels were comprised appropriately, but I gleaned from the AMA submission that you are not necessarily satisfied that that is the case in all circumstances.

**Dr Hambleton:** In fact, if the rules are followed then the person under review does have the opportunity to object to an individual on a panel, and that needs to be made absolutely clear as well. That is not the change in the legislation—that is in the legislation—so we do need to make sure these things are clear to the person under review so they can actually make sure that the panel that is before them has their confidence and certainly has the confidence of the wider profession.

**Mr Sullivan:** We are saying that there were questions that we put.

**Senator ABETZ:** On page 5 your concluding paragraph tells us:

The AMA has been working with the Department of Health and Ageing.

Since when?

**Mr Sullivan:** Well over 12 months.

**Senator ABETZ:** This scheme has been operating for a long time now—

**Mr Sullivan:** Sorry; well over 12 months in the most recent period.

**Senator ABETZ:** So the scheme has been running for a long time; you are now working with the department on reviewing things, and you also tell us that the process is well underway. Would it be fair to say that your interaction with the department has been as a result of doctor agitation that the PSR was not working, it was failing and that there were real, genuine problems with the system?

**Mr Sullivan:** I do not believe it is as narrow as that, no.

**Senator ABETZ:** So the AMA woke up one morning and decided to start talking, 12 months ago, with the department, to see if they could do something about the system? What motivated this new round of discussions that started about 12 months ago?

**Mr Sullivan:** The AMA has regular meetings with the director. The director would always come and see the president and secretary-general on an ongoing basis, for all the years that the program has been running. Secondly, the AMA does constitute with the department an oversight committee. That oversight committee was reconvened around 12 months ago. I cannot give you the date off the top of my head—and I hope it is 12, not 11. The point is that we also had some concerns around aspects of the release of the annual report and the communication strategies with regard to that. Of course there have been calls into our offices from various doctors concerned about processes and therefore it is a natural thing for the AMA to raise these in the appropriate forum.

**Senator ABETZ:** The final sentence in that final paragraph talks about, 'restore the confidence of the medical profession in the PSR.' That would suggest that at one stage there was confidence by the medical profession in the PSR, that there is now no longer confidence and that you want to restore it. What led to the breakdown of confidence by the medical profession in the PSR?

**Dr Hambleton:** There are a number of things. The first thing to say is that when the PSR was set up there was great confidence in the process. In fact, when people were selected to be on panels they took that as a badge of honour, that they were seen as senior members of the profession, thought of highly by their peers and could possibly sit on these panels. And certainly I would probably disagree with the extent of the loss of confidence, but there was less confidence in the PSR.

**Senator ABETZ:** What brought that about?

**Dr Hambleton:** A number of things, including the way the PSR findings and reports have been publicly reported. There are a number of things that were occurring in small members of the profession that the public would have been forgiven for thinking were right across the profession. We were concerned about the way the profession was being portrayed in the public.

**Senator ABETZ:** What about the process of the PSR?

**Dr Hambleton:** Certainly individual feedback to the AMA from individuals was confirming that the process needed to be clarified to make sure that the confidence that those individuals and the wider profession could be maintained. I think that is what has led to—

**Senator ABETZ:** To serve on a PSR panel, do you have to be a member of the AMA?

**Dr Hambleton:** No, you do not.

**Senator ABETZ:** To your knowledge, how many members of the PSR panels were not members of the AMA?

**Dr Hambleton:** Part of the process for those people who are appointed to the panels is that the AMA needs to be consulted. But in fact our advice does not have to be taken. The minister can appoint. We are not informed about who is appointed and how many are appointed. We are not informed about who is appointed to a panel. Our advice is meant to be sought, and clearly was not, but we do not have a veto right over panel members, and therefore we do not know who is on the panel or how many members of the AMA there are on the panel.

**Senator ABETZ:** In your verbal submission—I think I took the note correctly; if I did not, please correct me—you suggested that we should not be replacing peer review with legal review or something of that nature.

Can I suggest to you that you can in fact have the best of both worlds by having peer review but also having the rule of law with natural justice applying as well. I wonder whether you would rule out the possibility, as had been suggested by our previous witnesses, of having somebody who has some understanding of natural justice, such as the chair of the panel, to ensure that natural justice does apply but still having peers determining the medical evidence.

**Dr Hambleton:** I absolutely agree that natural justice must apply. The role of the panel is actually to make a clinical decision that is acceptable to the wider body of the peers. They certainly need to be trained in those aspects of natural justice and need to be advised in that way. The AMA believes that is the appropriate way to ensure natural justice occurs. Those panel members need to be well trained and supported.

**Senator ABETZ:** Do you accept that the bell curve, if we can call it that, of medical practice is that you would have on the very extreme right-hand side of that bell curve those doctors who might be in innovative areas in cutting edge medical practice, where it would be difficult to empanel a group of peers and of course would immediately alert the statistical Medicare auditing process, because they are specialising in a new area and so the chances are it does not show up in many other practitioners' profile?

**Dr Hambleton:** There are new and innovative areas of medicine occurring all the time. We need to encourage that. Our problem is that we have a Medicare Benefits Schedule that is limited. There are many services that medical practitioners offer where there is no Medicare rebate and it would not be appropriate to indicate that there was. Certainly, if there is an innovative practice that requires a Medicare rebate, there is a process that the government has put in place to get one and that is the Medical Services Advisory Committee. They will be asking for research; they will be asking for cost-effective information. The role of the PSR is to see whether the service that was provided was appropriate for the item number that was listed and clinically appropriate. That does not stop someone from doing something outside of that process.

**Senator ABETZ:** Do you ever see innovative methodologies, such as a women's clinic where not surprisingly one would imagine the number of pap smears, for example, might be substantially higher than in other practices or somebody who wants to specialise or has a heart for dealing with drug addicts and therefore has a profile of longer consultations of 20 minutes or more? Having been a lawyer and dealing with people who have been on drugs, often they sit in your office in a blubbing mess for 15 minutes. Are the doctors' clinical notes supposed to say, 'Crying, crying a bit more, further crying, more crying?' The clinical note from a 20 minute consultation might be relatively brief. The notes I actually took on occasions with people sitting in my office for half an hour would not necessarily indicate that they had been sitting there for half an hour. Do you understand that those sort of profiles get thrown up by the auditing and then when you look at the clinical notes it would not necessarily indicate a 20-minute consultation?

**Dr Hambleton:** Absolutely. I think this is the great advantage of having senior members of the profession on the committee so that an individual can actually discuss the way they practise with them. I am certain in that circumstance they would get a fair hearing and an appropriate outcome.

**Senator ABETZ:** I will leave it at that.

**Senator ADAMS:** I would like to continue on about committee members or people who have been approved to sit on the committees. You said you do not have a list of these people. I find that very strange. The AMA would have had to have approved the applicants to be suitable candidates to be chosen on a peer review committee. I have seen a list of these people, so I find it very, very strange that you do not have a list.

**Dr Hambleton:** We certainly do not have a list. We are asked for advice. We are asked to consult with the profession which we do. We then send our advice back to the minister through the PSR. It is the minister's decision. We are not informed who is chosen, who is on the panel or who is chosen for individual committees. That is not our role; that is the role of the minister and the PSR. We do not have a list.

**Senator ADAMS:** You do not have a list of nominees who could be chosen for those committees?

**Dr Hambleton:** We certainly have a list of nominees. We do not know whether they are chosen.

**Senator ADAMS:** That is really what I was getting at. I do not know the question that Senator Abetz asked about that but you did not reply. We have that clarified then. You have a list of suitable nominees who could be chosen for the committee panel?

**Dr Hambleton:** That is not quite right. The PSR puts names forward to the AMA. We look at those names and we consult with the profession and we provide advice going back. We do not generate the names. They are generated by the director. They come to the AMA for the advice. The advice may be taken or may not be taken.

**Senator ABETZ:** But you know who is on the panel.

**Dr Hambleton:** No.

**Senator ADAMS:** You do not get what I am after. I really want to know whether you have a list of people who have been approved by you who are suitable to be chosen to sit on a panel?

**Mr Sullivan:** We have not taken a process like that inside the AMA where we have actively compiled a list of doctors whom we believe would be good to be on panels. I think that is what you are asking. The answer to that is no, we do not do it that way.

**CHAIR:** I think what everybody is asking about are the names that you subsequently provide to the minister. Presumably you keep that list?

**Mr Sullivan:** Yes, we have the correspondence with the names on it.

**Dr Hambleton:** We have no way of knowing whether they are actually chosen or not.

**Senator ADAMS:** No, that is not the point. It is the list of people who are suitable. My next question regards a rural GP who may have been flagged and has come up for review. How is that person going to be treated the way they should be with people really understanding the practise of a very busy, isolated, solo doctor in a rural area? This is what I want to get to the bottom of. To give that person the right support on that committee, they really should have people who understand what the health reforms are doing at the moment because things are changing so much—and I have brought up Medicare locals before because that really concerns me. There is chronic disease and a lot of elderly people still out in the bush, waiting lists are a mile long and there are all sorts of issues for rural doctors. I would like your comments on that because I have seen a list of potential people who could sit on those committees. I can assure you that for Western Australia, where I come from, the people on the list from Western Australia are certainly not people who practice in the bush.

**Dr Hambleton:** We would certainly expect the director to have sufficient members on the panel who would cover the sorts of cases that are coming before the panel. The individual person under review, if they had a look at their panel, has the opportunity to object to the members on that panel.

**Senator ADAMS:** I realise that. I am more concerned about the expertise. As I asked Dr Webber yesterday: as Medicare is being expanded—and I know that nurse practitioners and the AMA are probably not a very good example—how are nurse practitioners and midwives, probably the latest group to have the privilege of having Medicare item numbers, going to be treated? Is the AMA going to say, 'Yes, we can give you this person or that person'?

**Dr Hambleton:** In fact, the AMA will not be consulted about any other professions. The AMA will only be consulted about the medical profession.

**Senator ADAMS:** What about rural doctors? Where will they go? Will they be consulted or would you be consulted?

**Dr Hambleton:** When a name is put forward to us, we will consult with the colleges about whether the individual name is a person of sufficient seniority that we can approve that going back to the minister. Clearly there need to be sufficient members on the panel to cover the breadth of the medical profession that is being reviewed. There are mechanisms within the panels, if they do not believe they have the expertise, to actually call in an expert to assist them, as can the person under review. We certainly want to make sure the right people are on there because that is what builds confidence in the profession.

**Senator MOORE:** One of the core things was the process the AMA uses to consult with the medical profession. If we can have that clarified, it might be easier for us to know what questions to throw at you. When you are consulted by PSR, because they go to you as the first point, what process does the AMA use then to take into account the different needs for GPs?

**Mr Sullivan:** As the president was saying, we get a letter from the director. The director will have some names on the letter asking us for our view. We then would consult with the relevant college that the person probably is in. It does not matter whether they are an AMA member or not. That is an important point. We do not say, 'We will not have Dr Sullivan because he is not an AMA member.'

**Senator MOORE:** The list you get from the PSR director would say 'Claire Moore' with my speciality?

**Mr Sullivan:** Right.

**Senator MOORE:** Then you go to the appropriate college. Is that right?

**Mr Sullivan:** Yes.

**Senator MOORE:** They would give you that much information and you would then go forward with it.

**Mr Sullivan:** We go forward with that and then we send our correspondence in to the minister. After that, it is over to that process.

**Senator ABETZ:** I have a supplementary on this point. To your knowledge, has anyone whom the AMA has questioned been appointed to a PSR panel?

**Dr Hambleton:** We would have no way of knowing that. In fact, our advice to the minister is our advice. The minister is free to ignore or take that advice.

**Senator ABETZ:** Of course. It is big profession but I would have thought in general terms you would know whether or not your advice has been taken. You would have some idea as to which doctors are serving on these panels. How many are there?

**Senator MOORE:** Dr Hambleton, in the PSR submission from earlier this year it states: 'On 1 January 2010 there were 92 panel members available to serve on committees. From the appointed panel members the minister appoints deputy directors. On 1 January 2010 there were 23 deputy directors.' Is there a public list of the 92 panel members in January 2010?

**Dr Hambleton:** No. We are not privy to that list. We are not privy to who is on the panels.

**Senator MOORE:** So that question should go to the PSR or the department.

**Mr Sullivan:** We have had a quick bit of informal advice from behind, which tells me the answer to all your questions, and no we do not have any knowledge of that.

**Senator BACK:** Gentlemen, in terms of the question on your website, 'Do you think the Medicare audit process has become too heavy handed?' on 8 September the answer was 88 per cent or 300 yes, and 12 per cent or 42 no. Can you tell us what the updated percentage figure was for a more recent date than 8 September?

**Mr Sullivan:** We will take it on notice and see if we can get it for you.

**Senator BACK:** Thank you. What action, if any, would the AMA take based on what would appear to be a very heavy affirmative vote from that poll?

**Dr Hambleton:** We do interact with Medicare quite a bit as well. We respect the right of the government to audit a very expensive service. We do want to make sure that Medicare audits, which are outside of the PSR process, are conducted in appropriate way. We will continue to engage with Medicare to make sure that process is carried out in that way. In particular, the sorts of things we have said to the PSR on clarity about exactly what they are doing and how they doing it is the feedback we are giving to Medicare: why are you here? What are you looking at? What particular aspect of the billing is the problem?

That should be clearly stated to the doctor who is under audit. At the moment the way Medicare does it is by looking at people who fall outside of their peers, and there may well be very reasonable explanations for that. But they need to be clear to the person—not under review at that point—who is being audited about what they are actually looking at, what their exact concerns are. That is the sort of feedback we give to Medicare.

**Senator BACK:** You made the observation earlier that the panels have the capacity to bring in expert advice. Do you know how many times that has happened?

**Dr Hambleton:** I have got no information.

**Senator BACK:** Also, in terms of panel membership, you were saying that it does not involve yourselves, so it is from the minister, the department or Medicare. Who actually initiates the process for panel membership?

**Dr Hambleton:** My understanding is the PSR director will write to us with a list of names of panel individuals.

**Senator BACK:** In his evidence—at least in his submission—he made reference to members being reappointed dependent on their performance. That performance would be measured by whom: the director, the AMA, the minister, the department?

**Dr Hambleton:** We have no role in the reappointment; we only have the role when the names are submitted to us. We do not look at their performance. We cannot do that.

**CHAIR:** Just to clarify: do you only get the names—I know you may not be able to answer this—the first time they are appointed or are you aware of whether you get the names the second time?

**Dr Hambleton:** My understanding is that whenever anyone is appointed, needs to be appointed or reappointed, we are informed and we then go through the same process.

**CHAIR:** Where somebody has been reappointed and you have gone out to consult, have you ever had feedback that people have not been happy because of their past involvement with the panel?

**Dr Hambleton:** We may have to take that on notice. I think the answer is no.

**Mr Sullivan:** I think it is no.

**CHAIR:** If you could.

**Mr Sullivan:** We can check for you but I think it will be no.

**Senator BACK:** Going to the issue of AMA representing its members, we have been told that if a doctor is questioned in terms of length of time of a consultation et cetera they cannot actually bring a patient along with them to appear before the panel to verify or validate—is that correct—a patient is not allowed to appear?

**Dr Hambleton:** I think that is not the case. I do not think a patient can appear.

**Senator BACK:** Another point that was made to use and I wish to seek your advice on is that a doctor in advance of the fear that they might find themselves on the right-hand side of the bell curve, goes along to the AMA and says, 'What are the conditions under which I have to operate to make sure I don't incur anybody's wrath?' The answer from the AMA is: 'We can't tell you. You must go to other parties.' In fact these people have gone to Medicare. They have gone to other agencies and on each occasion have been told, 'No, we can't tell you that information.' In a sense, is that not really setting somebody up to fail? 'We won't tell you what the ground rules are but if you break them we're going to ping you.' Could you comment on that as the president of your association?

**Dr Hambleton:** Absolutely. We have made strong representations to Medicare and any doctor, any person who bills Medicare now, can ask for a written interpretation, which they can be expected to receive and hold. Once they have got that written interpretation, I would expect that they would be able to submit that as a piece of evidence if they were called into question. I am not sure of the timing of that, but that is the case now. We can come back to you with when that changed.

**Senator BACK:** If you could, thank you.

**Senator MOORE:** Doctor, from your understanding, what is the status of that advice?

**Dr Hambleton:** That is not binding but we are talking about a committee of your peers, which would make a judgment that was acceptable to the wider body of the profession. I would suspect that a wider body of the profession would be guided strongly by a piece of written advice coming from Medicare.

**Senator BACK:** I have one other question: obviously, if someone goes to the person under the review process and they are, as they almost invariably are, penalised, their name is then publicised. A hypothetical question: in the event that person was a specialist—they have been named, the community knows—a GP acting in a risk-averse way might feel very inclined then not to refer their patients onto that specialist for fear of being targeted themselves at some time. Can you tell me as the president of the profession: if a specialist came to you seeking the AMA's assistance in that process, what action would you take or what action could that specialist hypothetically take?

**Dr Hambleton:** I am getting a bit lost in the question but certainly if a member came to the AMA asking for advice about how the process worked we would provide them with the information about what to expect and how the process is supposed to be run and the likely outcomes of that process. We would be very happy to provide information.

**Senator BACK:** Perhaps I should ask PSR later or the department..

**Senator McKENZIE:** I have some quick ones. I am wondering if the AMA has any suggestions about an alternative method of identifying those doctors, through the audit process rather than using statistical outlines. Is there another way of identifying or auditing, rather than using 'let's look at the outlines'?

**Dr Hambleton:** We have actually made strong representations to Medicare to say that the great majority of individuals are doing absolutely the right thing and so, whichever way the process is run, we cannot be expecting doctors who are doing the right thing to be producing enormous amounts of information. So we do want to see the process as a targeted process. Medicare has chosen to target that in a certain way, but we would much rather see it targeted rather than being across the board in some other way, because the great majority of people—in fact, the vast majority—are doing the right thing all the time.

**Senator McKENZIE:** Would you like to briefly comment, from the AMA's perspective, on the educative processes involved at both the development of and the design of item number descriptors and then how you communicate them to your members and the role that your organisation plays in that.

**Dr Hambleton:** The process has recently changed. It has gone from a Medicare Benefits Consultative Committee, or MMBC, process which the AMA chaired to a different process, which is the Medicare Services Advisory Committee, or MSAC, and which is more complicated and is more comprehensive. When a new service is introduced or developed under the Medicare Services Advisory Committee process, there needs to be a significant amount of information offered—research, cost-effectiveness as to what it might replace—to prove that it is worth spending public money on. For lesser items the Medicare Benefits Consultative Committee process gave an opportunity to refine wording, to change elements and to rewrite it and perhaps improve the interpretation of those items. So it seems we have a more complex procedure now than we had before. We do need to make sure that everyone—the public and the doctors—using the Medicare system are clear on what it means. We have had some concerns about item number interpretation and I think the committee has already referred to that.

**Senator McKENZIE:** Yes, we have. Finally, I refer to the guidelines that were approved on 16 March 2011 for the appointment of panel members. I am wondering how widely circulated they were. The AMA and the PSR agreed on those guidelines, so what sort of consultative process did the AMA go through before they were agreed to?

**Mr Sullivan:** We had our own committee assisting us in that process. That means our own committee would be made up of our own select members. It was literally like a working party that was working with the PSR administration to devise the guidelines and then they would disseminate that information through their processes. This is picking up the whole tenor of the questions in a sense. The AMA has a medical fees book. We get calls every day from practices wanting to be clear about particular items that they should ascribe to a particular procedure and the like. We do not have anybody in our offices that is a medical practitioner per se, so we are always very loath to try and give medical advice but we do try to assist, at the administrative level, practices as to how they will ascribe an item number. The key to this whole issue is that the auditing process starts a long way before PSR kicks in and the engagement of medical practices with Medicare Australia is done sometimes well down the track, where there is clarification about some items and you never hear anything again or a practice is asked to provide pages and pages of billing information and everything is clarified. As Dr Hambleton said, in the majority of cases everything is fine. The next stage is where there might be a question about some billing behaviour. Again, once that is examined—and this is with Medicare Australia—it is fine. If, after that, there is a process to do with clinical judgment and a series of clinical judgments, that is when something like PSR kicks in. It is important to realise that there are grades of auditing. In a sense the grades of auditing also deal with the risk management process and so on. At the AMA we try desperately to say to all doctors, as Senator Abetz said about his own profession, that it is really good to keep the notes. We encourage people to keep good notes. We went through some legislation in the last two years about Medicare auditing and I think it was quite clear that the AMA supports the process but wants patient records protected, and that when patient records are looked at that they are looked at by doctors only. That sort of thing.

**CHAIR:** We are going to have to wind it up.

**Mr Sullivan:** There is a whole ethos around this which we embrace positively and I think it is important that the committee at least has that on the record.

**Senator MOORE:** I have a few questions and might actually put some on notice. One of the things I am interested in is that there has been considerable discussion around the issue of the 80/20 rule and the inference that only hard-working doctors are picked up by the PSR process. I know that the AMA has been in discussions with the government about that over a long period. I would like to get some more information about that and I do not think we have time to have that in discussion, because it is quite complex. There are clearly some inferences that hard work can be confused with malpractice, so I would like to have some comment on that.

There was evidence given to us this morning about concerns that the clinical nature of complaints should be going through the APRA process as opposed to the PSR. I am interested in that and it is probably another answer that will take some time. I am aware that in some evidence—and, I think, in the PSR submission—we have heard that at times when doctors are going through the PSR process things become clear which are then referred to medical boards. I would think that role of the medical boards is now taken over by APRA, so I would have thought that if something of the nature of clinical practice came up through the PSR process it would probably be a natural referral. I would like some comment from the AMA.

**Dr Hambleton:** We can take that on notice.

**CHAIR:** I am happy if he would make some comment now.

**Senator MOORE:** We have time? Sure.

**Dr Hambleton:** The inappropriate practice for MBS purposes has a specific legislative background. That is really to do with billing on items, and that sort of thing, whereas the APRA referrals are really looking at appropriate professional conduct as against the good medical practice code. They are two different things: one is looking at the administrative issue in relation to Medicare and the other is actually good medical practice code. I will clarify that in a written submission.

**Senator MOORE:** I would like to get a little bit on that because we have had it spelled out to us numerous times what the two roles of the PSR are, and the first one is to protect patients and community in general from the risks associated with inappropriate practice.

**Dr Hambleton:** Sometimes when the PSR process takes place there is a view that APRA should be informed, but the primary role of that process is in relation to Medicare billing. We can fill that out a little bit with a submission.

**Senator MOORE:** That would be great.

**CHAIR:** That would be appreciated, thanks.

**Senator MOORE:** You gave some information about the advice around what is in a Medicare item, and we will take that up with the department and also with PSR, but I think that is really critical. I note on your website that there is a running process around the whole area of auditing and PSR. The kinds of issues that are coming up with that—and there is a range of things that doctors have written in about—are they being fed back to the department?

**Dr Hambleton:** Yes, we do have regular contact with the department and we certainly want to make sure that they get feedback—both the PSR directly and the department.

**Senator MOORE:** Thankyou very much.

**CHAIR:** Thank you. You have some homework—several pieces of homework.

**Mr Sullivan:** We always get homework.

**CHAIR:** Would next Thursday be achievable?

**Mr Sullivan:** That would be fine, yes.

**CHAIR:** Thank you very much.

**KOTSIRILOS, Dr Vicki, Founder and Past President, Australasian Integrative Medicine Association**

[12:08]

*Evidence was taken by teleconference—*

**CHAIR:** Welcome. I understand, Dr Kotsirilos, that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

**Dr Kotsirilos:** Yes.

**CHAIR:** Do you have anything to say about the capacity in which you appear?

**Dr Kotsirilos:** I am a practising GP working about three days per week. I speak today on behalf of the members of the Australasian Integrative Medicine Association, also known as AIMA, and for our president, Professor Kerryn Phelps, who is currently overseas and could not be here today.

**CHAIR:** Thank you. We have your submission; it is submission 19. Very shortly I will invite you to make a brief opening statement, at the end of which we will ask you some questions. Before that, though, I would like to remind you as a witness that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comments against other parties and we warn that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and, equally, witnesses may also ask that evidence be taken in camera. I invite you to make an opening statement.

**Dr Kotsirilos:** Briefly, I will just give you some background about AIMA. It was formed in 1992 as an independent, not-for-profit organisation of doctors, mostly GPs, seeking to provide whole person medical care by integrating evidence based complementary medicine into mainstream practice. AIMA encourages our doctors to practise from a holistic approach, with an emphasis on prevention through patient education and lifestyle to treat diseases, such as the importance of exercise, sleep management, dietary changes, sunshine, stress management, and using evidence based non-drug therapies such as acupuncture, musculoskeletal therapy, counselling, hypnosis and nutritional medicine where necessary. This approach requires a doctor to spend longer consultations.

According to a national survey of Australian GPs by the National Prescribing Service in 2009, there is a rising number of Australian GPs—estimated at 30 per cent—who describe themselves as practising integrative medicine and some forms of complementary medicines. The survey also indicated that the majority of doctors—over 80 per cent—were interested in this area. This survey indicates that a large proportion of our GP peers are integrating complementary medicine into their clinical practice, but the degree of integration and type of complementary medicine vary from one GP to another.

AIMA has grown to be a leading voice for integrative medical practitioners—the majority of whom are GPs—and has forged relationships with key organisations such as the Royal Australian College of GP, the AMA and other professional organisations. We are recognised as a special interest group by the RACGP and by the Victorian AMA. AIMA seeks to ensure that both practitioners and consumers have access to the best available knowledge about the scientific evidence, the benefits and risks of these modalities to care for our patient.

The Senate inquiry is welcomed by AIMA, as it is relevant to a number of our members who have been audited by Medicare, with subsequent referral to the PSR, particularly for the use of long and prolonged consultations—namely, for a doctor who has vocationally registered items 36 and 44 above the general body of peers—as our members see more patients with chronic diseases and multiple diseases. I personally have spoken to most of these doctors. In some cases they have been referred for ordering excessive pathology tests, such as vitamin D, iron, other nutritional tests and celiac screening or radiology testing when they do musculoskeletal medicine—above the general body of peers. Also, the main complaint from our members is a lack of representation of peers to assess them in Medicare auditing and on the PSR panels.

We do not support the inappropriate use of these Medicare items or fraudulent behaviour of GPs. We also acknowledge and greatly value the continued efforts of Medicare and the PSR to provide a safeguard for the public and patients against inappropriate medical practice in Australia. AIMA, myself and Kerryn Phelps have met with Dr Tony Webber on several occasions and have found him very helpful. Our submission is not a personal attack on Dr Webber. We do value his contribution and help over the years. In a letter in 2007 Dr Webber did acknowledge that the RACGP and AMA were regarded as the peer reference group of bodies for general practitioners who practise in the areas of integrative medicine and complementary medicine.

We have also recently met with senior members of Medicare to try to address these issues at the auditing stage to prevent problems with our members, particularly for auditing of long and prolonged consultations and doing testing like vitamin D testing. However, even up till recently our members have continued to be audited and in

some cases subsequently referred to the PSR. Consequently, AIMA has submitted the report to the inquiry, as these issues are relevant to our members.

From AIMA's observation, the problem starts with Medicare auditing for the longer consultations, which subsequently leads to the PSR referral. GPs who see more patients with chronic diseases or multiple health problems, such as AIMA members, are more likely to use longer consultation item numbers. Using the longer consultation item numbers, such as items 36 and 44 that I mentioned, more than the general body of peers is an indicator for Medicare auditing, and it has been noted by the PSR director in annual reports that it can lead to referral to the PSR. AIMA believes this is fundamentally unfair. Why are doctors not being audited for doing more six-minute medicine, which is much more costly to Medicare? Also, what is the evidence suggesting that GPs who do more six- to 10-minute medicine provide better quality of care than GPs who do 30- to 60-minute medicine?

So GPs are being audited for doing longer consultations. It becomes a disincentive to do more longer consultations, and it is not surprising that this has caused a drop in the number of long consultations by GPs. However, the evidence suggests there are benefits of long consultations in improving clinical outcomes. There is evidence that longer consultations are often preferred by patients and that they help manage chronic diseases, improve therapeutic relationships, handle psychosocial problems better, provide time to educate patients on lifestyle and prevention, and reduce the likelihood of generating a prescription.

AIMA and I are well aware that some doctors are using item 23 in place of 36 and 44 because of a fear of being audited and referred to the PSR. We encourage our members to write thorough notes, but sometimes it can be difficult to take a full history, do a physical examination and be typing at the same time, so the length of a consultation is not always reflected in the length of the notes taken. Management often includes counselling, and while we are counselling we would like to look at our patients, and it can be difficult to do this at the same time as writing on a keyboard and looking at a computer screen to see exactly what we write. There is no evidence that suggests that doctors doing quicker consultations of six to 10 minutes can fulfil even item 23. In other words, even in shorter consultations it can be difficult to write a thorough history and physical examination. So it is not surprising to find that, whilst doctors who do longer consultations go to great effort to write good notes, sometimes those notes may not reflect the time that they have spent with the patient.

Also, Medicare auditing and referral to the PSR is a significant life stress for doctors and creates a lot of stress for GPs. AIMA members who have been through Medicare auditing and referral to the PSR have experienced extreme anxiety and stress as a result of the process, whatever the outcome has been. An MJA article in 2010 highlighted that audit anxiety is one of the major reasons for a drop in level C and D consultations, in preference to shorter level A and B consults. AIMA supports the Royal Australian College of GPs submission to the Senate inquiry, which proposes that:

The focus of audits should therefore be shifted to the Professional Review Program, focussing on education and quality improvement, rather than compliance and discipline.

They go on to say:

Prevention, education, and guidance are always better than compliance, fines, sanctions, discipline, and unnecessary red-tape.

This works well with, for example, AHPRA, the performance pathway, and should be considered with the PSR.

It is our experience that GPs who subspecialise in certain fields such as counselling, hypnosis, acupuncture, musculoskeletal medicine or nutritional medicine are often targets for Medicare auditing and in some cases referral to the PSR due to the reasons that I have outlined—that they do more longer consultations and they are different to most GPs. To statistically compare an individual GP who is a specialist in a particular area of general practice with the wider general practice population is inappropriate, as the statistical method is inherently unfair to the GP. Yet it is not uncommon for us to see medical specialists move into subspecialty areas. For example, I know a lot of gynaecologists who are doing purely gynaecological ultrasounds and nothing else in their practice. Like medical specialists, GPs may develop an interest in a particular field during their working life and should also be valued as contributing to the overall healthcare system. Often these GPs are sought out by patients with chronic, complex problems who have seen many doctors and are looking for non-drug approaches to their health care. The Medicare and PSR need to acknowledge the growing number of GPs who, like medical specialists, are specialising in particular fields and they too constitute part of the peer body of GPs, and they need to be adequately represented by their peers during the Medicare auditing and also on the PSR panel.

The PSR panel and representation on the PSR seem to be a major complaint from our members. It is not uncommon that they complain that they are not having true peers when audited by Medicare and on the PSR panel. By not consulting with AIMA or the relevant GP specialty colleges—such as the musculoskeletal

association for doctors with an interest in musculoskeletal medicine or the Australian College of Nutritional and Environmental Medicine for doctors with an interest in nutritional and environmental medicine—or for the AMA to not appoint appropriate peer representation for Medicare auditing and on the PSR panel denies the right of our members to have true and appropriate peers to fairly assess their clinical work.

We are finding that there is a growing body of scientific evidence for some of these areas, including acupuncture, musculoskeletal medicine, nutritional medicine and even some areas of herbal medicine. If the PSR panellists are not familiar with the scientific evidence in these areas then how are they to fairly understand the work of the GP, working and specialising in these fields? On many occasions some of our members will take textbooks and references to hearings because, as they have explained to me, they were not adequately considered as part of the decision-making by the panellists.

AIMA supports the Australian Medical Association submission for the PSR inquiry whereby the composition of the PSR committee should be formed by:

... practising medical practitioners of sufficient and appropriate experience and standing; and

- Committees formed must include Panel members from the same specialty as the—  
person under review. The submission further states:

- the diversity of medical practice is appropriately reflected on the Panel;

Finally, on the role of pathology testing with chronic diseases: because we are seeing more patients with chronic diseases and multiple health problems, some of our members are doing more higher pathology testing and radiology testing than their general body of peers—for example, vitamin D and coeliac screening. Coeliac disease is often undiagnosed in the community and nutritional testing such as vitamin D testing is now supported by a growing body of research, particularly in high-risk group areas such as dark skinned people, elderly in institutions, those who avoid the sun and people who live in high-risk areas, especially in the lower latitudes of Australia. Vitamin D testing is also supported by leading experts in the field as vitamin D plays an important role in the prevention of diseases such as multiple sclerosis and osteoporosis and with falls in the elderly. Deficiency is a risk factor for developing a number of other diseases, yet our doctors are audited for using these tests and are referred to the PSR where they have had to pay back moneys to the PSR.

The main factors—high long consultations, prolonged consultations, nutritional testing and radiology testing—seem to be the main triggers for the initial Medicare auditing and subsequent auditing to the PSR. Thankyou.

**Senator McKENZIE:** Your submission at point 1 suggests that doctors are charging against Medicare item No. 23 in place of item Nos 36 or 44, and you go into a long description about the benefits of the longer consultation in order to avoid being audited by Medicare. What evidence do you have of that?

**Dr Kotsirilos:** Most of our members I have spoken to have actually told us that they are now using item 23 because they do not want to create a signal that will lead to the auditing.

**Senator McKENZIE:** So your members have directly made representations?

**Dr Kotsirilos:** Yes, correct, and directly to me.

**Senator McKENZIE:** Some of the concerns you raise about the type of practice of your members and its holistic nature and the requirements are quite specific to the type of practice and approach that your doctors take towards their work.

**Dr Kotsirilos:** Yes.

**Senator McKENZIE:** New guidelines are being developed and a document is currently being drafted by the PSR, in consultation with the AMA. One suggestion we have had from other submitters is that that document will have regard to the speciality of the person under review, as well as their gender, cultural background and mode of practice. Will that allay some of your concerns?

**Dr Kotsirilos:** Yes, it will. We fully support the statement and approach by the AMA, and I think that would be particularly useful. If the AMA could consult AIMA and other relevant groups where doctors have developed a subspecialty area in these areas so that they have a true peer on the PSR panel.

**Senator McKENZIE:** Finally, how many members of AIMA have been audited by Medicare?

**Dr Kotsirilos:** I do not have the current number, but it averages several numbers per year. Quite often, I am one of the first people that they approach. They usually come to AIMA and the phone calls are usually referred to me, to talk to me about what they need to do and that sort of thing. Maybe every two or three months I get a phone call. Only a month ago, one of our AIMA board members was audited for long consultations and vitamin D testing.

**Senator McKENZIE:** What about going through the more rigorous PSR process?

**Dr Kotsirilos:** Not all of them are referred. Some of them are audited and then six months down the track are told, 'Yes, that's fine.' Often, it is because they start to cut down on item 36, they start to cut down on the pathology testing. Because of the change in their statistics, usually it is dropped. It is when they do not change their statistics and their profile that they are then considered for referral to the PSR. Their first line is usually a meeting.

**Senator McKENZIE:** Over the last 12 months how many members of AIMA have been referred to that further process?

**Dr Kotsirilos:** To the PSR? I only know of one. One out of three or four have actually been referred. I must say at this point that I am not saying that we support anybody who does not fulfil the item numbers appropriately. When we talk to our members we encourage them to write good notes to try to fulfil the item numbers and to take on a more holistic approach with patient education, lifestyle approaches and to sort out the more evidence based low-risk type therapies.

**Senator McKENZIE:** Thank you.

**Senator ABETZ:** How many members do AIMA have?

**Dr Kotsirilos:** We have over 360 members. We have had up to 500, but it all depends on our administrative officer following up, computer services and all that sort of stuff.

**Senator ABETZ:** So if one per cent of GPs were audited, you should have 3.6 audits per year?

**Dr Kotsirilos:** I am not certain of that. I would not know. Just from the National Prescribing Service data that I talked about, I was actually involved in that research. We did a random sample of Australian GPs as a whole and found that up to 30 per cent of GPs were integrating some form of complementary medicine into their practice. We are talking about a large number as a whole. In terms of actively recruiting members, we are a voluntary organisation and it is very much based on our voluntary work.

**Senator ABETZ:** Thank you. The organisation was formed in 1992.

**Dr Kotsirilos:** Yes.

**Senator ABETZ:** When did the PSR become an issue for your organisation?

**Dr Kotsirilos:** It actually was an issue even in 1992 and in the late 1990s. However, at that time, Dr John Holmes was involved. What was very good about the year 2000 was that I was invited on the PSR panel, on which I served from 2001 to 2005, to try to address the issue of having a representative on the panel. I had done some private work with Dr John Holmes for a case, before it got referred to the panel where I helped him make a decision for one of our doctor members. It has been going on for quite some time. In fact, I was the founder of AIMA, in 1992. One reason why I started AIMA was to form a peak body to help representation for these situations and also, as a stakeholder, to talk to the Royal Australian College of GPs and the AMA to help GPs in this area.

**Senator ABETZ:** So, despite your organisation being formed in 1992 for those purposes, you and your organisation are still of the view that you are at a higher risk of being audited by Medicare?

**Dr Kotsirilos:** Yes, that is totally correct.

**Senator ABETZ:** You indicated to us that you work three days a week. Have you ever been audited?

**Dr Kotsirilos:** Yes, I have. In 2005 I was audited for long consultations. I work as a GP three days a week. Obviously, it was a very stressful period for me. Six months down the track, I received a letter saying that they were satisfied with my long consultations. I actually decided not to minimise or reduce my time with patients. I decided that I would continue spending half an hour, or whatever time was needed. So it is not definite; it varies from one patient to another. I did not drop it.

Interestingly, in 2007, I became the winner of the AGPAL General Practice Excellence Award because of my more holistic approach. So even good GPs who are trying to do their best, by taking on a more holistic approach, become targets of a Medicare audit, with a possible subsequent referral to the PSR.

**Senator ABETZ:** Are you the exception to the rule, because I thought you indicated in your verbal submission that those who had been audited, if they changed their profile of charging, were usually not referred? To me, it seems the process is—I do not want to use the word 'bullying'—intimidatory, that you are audited and then if you start changing your practice—

**Dr Kotsirilos:** Not everybody changes their practice. Some doctors do that. I actually encourage doctors not to change their practice but to continue doing longer consultations, because it offers a lot of clinical benefits for our

patients. I truly believe it is a good approach to take in general practice. Not everybody does. In my case, I actually continued with long consultations. However, I am low with pathology testing and extremely low with prescribing as well.

**Senator ABETZ:** Would you see your practice of medicine as being somewhat innovative?

**Dr Kotsirilos:** I see my practice as being a gold standard general practice. We have four GPs here. We see casuals, we see patients from all walks of life and those with all sorts of diseases, including chronic diseases. I think that spending time with patients not only creates patient satisfaction but also helps with clinical outcomes and helps them to improve. Virtually everybody who improves their lifestyle through stress management, relaxation, counselling, talking, improving their sleep, getting enough sunshine and exercise, and changing their diet, no matter what disease they have, will improve. I have been doing this for 20 years and that is the great benefit of working in this sort of practice. I am fully committed to a holistic approach.

**Senator ABETZ:** If I may interrupt, would you agree that the way that you and your practice practise medicine is not necessarily run-of-the-mill general practice?

**Dr Kotsirilos:** Absolutely. Where we are different is the fact that we spend more time with patients.

**Senator ABETZ:** And, as a result, you are more likely to end up on the right-hand side of the bell curve.

**Dr Kotsirilos:** Correct, and this is why we are here today.

**Senator ABETZ:** Yes, whereas general practitioners who do not seem to take the degree of care and interest that you seem to do—

**Dr Kotsirilos:** Oh, no; they do.

**Senator ABETZ:** and, let us say, only operate two or three days a week, would fall on the left-hand side of the bell curve with the number of consultations, and they would therefore never fall under the Medicare orbit.

**Dr Kotsirilos:** The Medicare radar. Yes, that is correct. I would like to just rephrase some of the things you said, because you commented that it was not the top quality care. That is not true. GPs who spend less time do provide better quality care. What I was referring to earlier is that when doctors spend just over five minutes—much shorter consultations—it may be very appropriate, to just provide a prescription where necessary. But the thing is that, if you were to audit them, they might not necessarily be providing better notes, history taking, physical examination et cetera. The studies show that people with chronic diseases do benefit with longer consultations. According to the Royal Australian College of GPs, this is what they are trying to teach younger doctors as well. There are many doctors who spend up to 20 minutes and they provide excellent quality of care.

**Senator BACK:** I appreciate your time and your submission. Can you tell us how many of your members are now on PSR panels, to your knowledge—or would you not have that information?

**Dr Kotsirilos:** I would not have the information, but within the last six months there were a couple who were to proceed with the PSR panel, but they were dropped due to what happened with lack of representation and AMA involvement in choice of peers on the panel.

**Senator BACK:** AMA involvement in choice? Could you explain that.

**Dr Kotsirilos:** This is not something that I am totally familiar with. This is our members saying that their cases were dropped because of what had happened in the last six months with, as I understand it, Dr Tony Webber and the PSR not consulting with the AMA to have appropriate peers on the panel.

**CHAIR:** Could I just clarify. Your first answer could have been misinterpreted to suggest that, because of AMA's involvement, they got dropped. What you are saying is that, because of the process, it occurred with AMA not being consulted.

**Dr Kotsirilos:** That is exactly what I meant. Thanks for rephrasing it.

**CHAIR:** Thank you. It is important to clarify.

**Senator BACK:** You mentioned that you were a panellist yourself from 2001 to 2005, and I think you said that it was in 2005 that you yourself were the subject of a review. Were you still a panellist at that stage?

**Dr Kotsirilos:** No. I had actually retired. The reason why I retired was that the panels that I had to sit through had nothing to do with integrative medicine or complementary medicine; they were to do with doctors seeing over 80 patients a day. They were doctors who were prescribing too much pethidine and drugs of addiction. So it was not really relevant to my practice. So in 2005 I actually gave a letter of resignation. It was at that point that Dr John Holmes came and met me down in Melbourne and he also gave me a private case to deal with, which was successful. It eventuated as being successful. It was shortly after that that I then received a letter for my long consultations.

**Senator BACK:** You mention the field of complementary medicine, which is, as I understand it, not universally accepted within the profession. In your time as a panellist, I imagine that you must have been sitting in judgment of some of your peers who also engaged in complementary medicine. Would that be the case?

**Dr Kotsirilos:** No, what I am saying is that we never talked about complementary medicine, because none of the cases I saw was to do with complementary medicine.

**Senator BACK:** I thought you said you resigned because—

**Dr Kotsirilos:** I did not receive any—

**Senator BACK:** You did not receive any.

**Dr Kotsirilos:** Correct.

**Senator BACK:** My question really is: even in conversations with peers, do you have a sense of whether other panel members look favourably upon those of you who do engage in complementary medicine and medical activities as well, or do you think that in a sense it is a level playing field in that area?

**Dr Kotsirilos:** I can only say that, based on our members' experience with peer panellists, they felt that they were not well understood and that the panel did not understand the field they were working in. For example, we have members who proceeded with the PSR panel and were doing muscular-skeletal medicine, and they said that they felt that the panellists did not understand the area they were practising in and that there was no true representation there. There are other doctors as well. Doctors who practise in nutritional medicine have commented that none of the panellists understood the area of medicine they practised in.

**Senator BACK:** Can you tell me: what proportion of your members would actually be rural and regional doctors?

**Dr Kotsirilos:** I am sorry; I would not be able to comment on that without the statistics in front of me.

**Senator BACK:** Okay. Thank you.

**Senator ADAMS:** I am a little concerned about the auditing of GPs and the number who have changed from item Nos 36 and 44 and doing 23s. Would you consider, with the knowledge you have through your members, that patient care is being compromised through this change of practice?

**Dr Kotsirilos:** I do believe that. I think it is like going backwards. The other thing I want to emphasise is that it actually costs Medicare a lot less if doctors see only one or two patients per hour.

**Senator ADAMS:** Yes, I am fully aware of that. I am just worried about patient care because this is about patients. That is your job.

**Dr Kotsirilos:** Yes, exactly. I totally agree with you there.

**Senator ADAMS:** I would like to move to the new health reform and the focus now on primary care and the Medicare locals. Coming back to those item numbers, I have a concern about looking at chronic care management and the number of the allied health team you would be bringing in to help you with that care plan. How are your people going to deal with this? The way I look at it is that it is going to become a problem.

**Dr Kotsirilos:** It is something that I have not thought about clearly, and I do not have the material in front of me to give you a clear response. But anything that involves proper care plans for management of chronic diseases and working with allied health provides a benefit to our patients and helps our patients. Is that what you are asking?

**Senator ADAMS:** This is a new focus of healthcare. It is very good, because it is patient focused. But if you have your members cutting their consultations down because of the threat that they are going to be flagged and end up having a review, somewhere along the line we have got to get this fixed up, because this is going to be the future of healthcare for people.

**Dr Kotsirilos:** Exactly. One of the solutions—and this is where we have spoken with senior members of Medicare who have been really helpful—is that as long as there is no fraud consider reducing the auditing of doctors when they are doing long and prolonged consultations and to consider it more so for doctors who are doing very quick medicines, six-minute medicine. That might be a possible solution, where it does the reverse and actually encourages doctors to spend more time with their patient, which is what we want, and therefore taking the fear down. I remember when I spoke with Dr Tony Webber he said that what is most important is to go back to Medicare and talk to them about this as well. So I agree with you totally. We need to take the fear and anxiety away so that we do not get a drop in items 36 and 44; in fact, if anything, we need to encourage that. There are certain situations where you need to spend only six minutes per patient. But when you are doing only six minutes and up to 10 minutes I think you need to be questioning that, and particularly if your practice consists of chronic

disease patients, because it is almost impossible to see them fairly quickly. I think it needs to start at the core level of consideration, whether that be altering the computer and having less emphasis on detecting doctors who are spending more time with patients.

**Senator ADAMS:** Thank you.

**Senator MOORE:** You talked earlier in your evidence that there should be a more educative development process. I believe that the educative development process works side by side with the other one; what are your comments on that? You were saying 'either/or', but I am saying 'both'.

**Dr Kotsirilos:** That would be reasonable as well. As I mentioned earlier, there are situations where there may be good justification to refer the doctor to the PSR panel and they do need assessment. It might be that you need both in those situations.

**CHAIR:** Dr **Dr Kotsirilos:** I personally receive about three or four phone calls per year, and the most recent was only a month ago.

**CHAIR:** And one of those audited has gone to the PSR panel?

**Dr Kotsirilos:** Yes, and that case was recently dropped.

**CHAIR:** I am not sure whether we gave you any follow-up work.

**Senator McKENZIE:** Yes. There was a question about the number of members practising out of urban areas, and we would like to put that question to you on notice.

**Dr Kotsirilos:** Could you repeat that, please?

**CHAIR:** You took on notice to find out the number of members you have who are practising in rural areas.

**Dr Kotsirilos:** Do you want us to do that and provide you with something via email?

**CHAIR:** That would be perfect, and if you could do it by next Thursday it would be much appreciated.

**Dr Kotsirilos:** That will be no trouble at all. Are we talking about GPs, or about all medical practitioners?

**CHAIR:** Medical practitioners who are your members.

**Dr Kotsirilos:** Do you want rural versus urban?

**CHAIR:** Yes. Thank you very much for your time today.

**Dr Kotsirilos:** Thank you. I very much appreciate what you are doing.

**Proceedings suspended from 12:48 to 13:32**

**BENNETT, Ms Carol, Chief Executive Officer, Consumers Health Forum of Australia**

**WISE, Ms Anna, Senior Policy Manager, Consumers Health Forum of Australia**

**CHAIR:** I welcome representatives of the Consumers Health Forum of Australia. I know you have done this lots of times before but I have to ask. I understand the information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

**Ms Bennett:** Yes.

**CHAIR:** The committee has before it your submission, which we have numbered 15. I remind witnesses that evidence should address the terms of reference of the committee and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comments against other parties and warn that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage and likewise witnesses may also ask that evidence be taken in camera at any stage. Having said that I invite one or both of you to make an opening statement.

**Ms Bennett:** We appreciate the opportunity to be here this afternoon. I would like to start by drawing on some key statistics. At 30 June 2011 there were almost 95,000 health practitioners providing services that attract a Medicare rebate. Since 2004-05 there have been 324 requests from Medicare to the Professional Services Review agency to review a health practitioner's practice. Of these there was no further action in 70 cases. In real terms this means that there has been some action taken on cases regarding inappropriate health practitioner behaviour in less than on average 50 cases per year. That is less than one a week from 95,000 providers. We are not suggesting that a significant percentage of health practitioners do the wrong thing but with 95,000 health practitioners delivering Medicare services the complaint and follow-up action rates seem to us to be very low and they do not demonstrate a pattern of doctor persecution as some media reports would imply. CHF members value the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme as pillars of the Australian health system. They provide affordable access to services provided by a range of health professionals and essential medications. For most health consumers, the MBS and the PBS are fundamental to maintaining health and quality of life. This is why the PSR scheme is so important. As taxpayers and funders of the health system, consumers recognise that there must be checks and balances in place to ensure that services are being delivered appropriately and in line with the requirements that are set out by government. Inappropriate use of taxpayer funded services is detrimental to consumers. The vast majority of health professionals are doing the right thing and delivering taxpayer funded services appropriately, but there must be measures in place to address misuse of the system by a small minority of practitioners.

CHF and its members are therefore supportive of the Professional Services Review Scheme. The key to the success of the PSR system is deterrence. The penalties applied to doctors who are found to be doing the wrong thing should, we hope, encourage others to review their practice and make necessary adjustments. If this deterrence effect is to be successful, the system must be well known and well implemented. The penalties must be meaningful and the penalties must be enforced. While a review of the PSR is not unwelcome to consumers, we would be concerned if the outcomes of a review result in changes to the PSR system that leave it so restricted that it cannot undertake investigations or apply penalties in cases of inappropriate practice. This will reduce the PSR's deterrence affect and prevent it from achieving its goals of protecting patients and the community from the risks that are associated with inappropriate practice. It will also fail to protect the Commonwealth from having to meet the cost of services provided through inappropriate practice.

Privacy is a case in point. As I mentioned earlier, there have been 324 requests for review from Medicare to the PSR since 2004-05, of which 254 proceeded to investigation by the PSR director and therefore would have required provision of patient records in order to review patterns of clinical practice. A number of submissions have raised privacy concerns about the provision of these records. CHF considers that a balanced view is required so that patient privacy is not used as a furphy to distract from the underlying issue of inappropriate clinical practice. When patient records are provided to the PSR, the information accessed is used for specific purposes only and there are rigorous requirements in place about who can access the information and the standards which they must adhere to. CHF's view is that appropriate privacy protections are in place to ensure that clinical records are used in line with the legislation. Given these safeguards, we cannot allow privacy to become a roadblock in efforts to protect the community from inappropriate practices and billing.

Health consumers and the community at large are major stakeholders, if not key stakeholder, in the PSR Scheme. With this in mind, CHF calls for greater consumer involvement in the PSR system. While we recognise that one of the strengths of the PSR is its peer review mechanism, we would argue that there are other ways in which consumer input into the PSR process and decision making can and should be sought. One mechanism for

ongoing consumer involvement would be consumer involvement in the PSR advisory committee, currently made up of representatives of the Department of Health and Ageing, the Australian Medical Association and the PSR. Other mechanisms for consumer engagement can and should be developed as consumers are major stakeholders of the PSR both as beneficiaries from the MBS and PBS and as taxpayers.

In conclusion, CHF supports the PSR scheme. While we consider that a review is timely, we would be concerned at the introduction of any changes that will stymie the efforts of the PSR to protect the community from inappropriate practice and deter poor practice in the future. Consumers must be at the table in any reviews or reforms of the PSR system. PSR is not just about health professionals; consumers have skin in this game. The health system exists to serve the needs of health consumers. The role of health consumers must not be discounted in the PSR process.

**Senator BACK:** Thank you for your submission. It appears that the main trigger at the moment for a doctor to be called upon to explain their actions is that they find themselves out to the right-hand side of a bell curve. Evidence that has been given to us suggests that the people most likely to find themselves out there are those who are innovative, hard workers and popular. Do you think that is a reasonable process or mechanism by which to actually identify those doctors who are going to be the subject of some further investigation? I ask you that question, of course, from the viewpoint of yourselves representing consumers.

**Ms Bennett:** The statistics really speak for themselves. When you consider the fact that, on average, less than 50 cases a year are actually investigated by the PSR, you would have to say that those cases must represent the extreme end of practice and therefore the extreme end of either overservicing or some kind of practice which suggests that the requirements as set out by the government in relation to the use of the Medicare or PBS schemes is not being adhered to. I think that is probably not likely to be the case. These are outliers, and we are concerned about the outliers because they represent a risk to the community and they represent a risk to the sustainability of the system and the appropriate use of the system.

**Senator BACK:** If, as evidence earlier today confirmed, the risk of a doctor finding themselves out at this right-hand end causes them to change their practice activities, perhaps to cease from a consumer's point of view, do you think that is advantageous? We have heard in the case of women's health where they actually downgraded or ceased that particular service or they reduced the number of hours that they actually practised and this would have effect particularly in rural communities where in the event that a doctor in a country town decided, 'I'm getting somewhere near this end so therefore I will practice only four days a week.'

**Ms Bennett:** Certainly consumers are disadvantaged when that occurs, but I would also argue—in fact probably more so—that they are more disadvantaged if they are the recipients of care that may be inappropriate. We are talking about the extreme end here, the outliers. For consumers that is perhaps more of a risk than the reduction of access to services, although that is clearly an issue as well. But inappropriate practice needs to be dealt with regardless of the circumstances around that, and we would expect that that would be dealt with.

**Senator BACK:** A submission this morning was put to us, as indeed the Australian Taxation Office would do with any other business in Australia, that there is the capacity, one would think, to be able to engage in what is called 'practice profiling'. In other words, even if a doctor is identified out of that top 1.5, a practice profile of that practice compared with similar practices, do you think that would be advantageous to the whole system so that immediately you would think—with databases and the capacity to be able to analyse data quickly—the procedures and practices of that doctor would actually become evident quite quickly, that indeed they really are overservicing rather than just being innovative, good or hardworking? Would you support a notion of that type?

**Ms Bennett:** Yes, I would imagine it would be administratively and financially quite an expense—

**Senator BACK:** It is exactly what the Australian tax office does now. I will give you a very quick example. If it is a milk bar or a delicatessen, one of the key indicators is bread rolls, so they will simply line up all the businesses of that type, they will see how many bread rolls a week or a day that business buys. In my own profession, in the veterinary profession, they use small animal tranquilizer as an indicator of the likely profitability, et cetera, of a practice. If there is very high use of acetyl promazine but apparently very low turnover, it is a trigger. That is the sort of thing I am speaking about.

**Ms Bennett:** Anything that provides good, transparent, accountable information—preferably information that is accessible by the community—we always believe is a good thing, and it certainly would indicate where a practice fell outside appropriate guidelines.

**Senator BACK:** Two other very quick points. Patients are not allowed to appear. If a doctor is under review before a panel and there is a claim that the person is overstating the time that they spend with patients, patients are

not allowed to appear with the doctor to validate or verify. Do you support that from a consumer's point of view? Is there any reason that a patient's evidence is unacceptable to a panel?

**Ms Bennett:** I guess it is a peer review scheme. It is based on looking at the parameters of appropriate practice. I am not sure whether on specific cases where a consumer is involved and there is some sort of claim of inappropriate practice that they would necessarily bring an added advantage to the process. It may but I am not particularly convinced of that.

**Ms Wise:** The other thing I would add there is that it is not necessarily about whether a longer consultation for example was delivered. It is also about whether it was clinically appropriate to deliver a longer consultation. That is my understanding.

**Senator BACK:** Again that would be a very good question to ask a patient though, would it not? Absolutely finally, from evidence that has been presented and obviously in the wider community it has been stated to us that surveys—and I cannot produce them—of gen Y doctors are indicating up to 85 per cent are intending to leave the profession and of those 50 per cent are giving as their reason red tape, fear of litigation, fear of being caught up in the sort of processes and procedures. I do not think a question specifically went to 'Do you fear being the subject of an adverse decision?' Would that concern you as consumers that such a high proportion of young doctors are intending to leave the profession?

**Ms Bennett:** Yes, but I would not link that necessarily to the PSR scheme. Certainly doctors are smart; they can see the stats for themselves; the stats do not represent a great risk to those who are providing appropriate practice. There is a broader issue obviously around commitment to the profession for other reasons.

**Senator ABETZ:** How many members do you have?

**Ms Bennett:** We have 250 members which represent a whole range of groups and organisations; around one million if you take into account those member organisations' memberships.

**Senator ABETZ:** Could you on notice provide us with a list of those please?

**Ms Bennett:** Absolutely.

**Senator ABETZ:** I assume that is your funding source?

**Ms Bennett:** It is partly our funding source. We also receive funding from government and we receive funding from particular contracted services to produce particular projects.

**Senator ABETZ:** You say you are a consumer organisation. Senator Back has already partially covered an area I was going to ask questions about—that is, consumers, or patients being allowed to give evidence to the PSR. I have heard your response to that. How does that match with your opening submission suggesting that your body and consumers should in fact be represented on PSR? You believe it is important for consumers who are not intimately involved with the process to be represented but those who actually have genuine skin in the game by being the patient of a doctor under investigation should not be part of it.

**Ms Bennett:** What we are talking about here is being involved in the PSR scheme at a broader level and providing some sort of oversight, some input, some level of involvement as regards the guidelines around how that scheme operates and the value of the scheme to consumers generally I think is quite important.

**Senator ABETZ:** You indicated that it was a peer review in answer to Senator Back. If it is going to be a peer review, should it not be the doctors that determine that and possibly the odd lawyer for natural justice. What would a consumer actually add to that?

**Ms Bennett:** We are not opposed to there being consumers on all of the particular panels at all layers of the scheme but our concern is about the broader scheme and its implications for the community. We would certainly want to be involved at that very high level. It is a peer review scheme. You could argue that a consumer should be sitting on every single panel. I think that would be administratively and financially burdensome. It may well bring another layer of accountability or it may well provide another check and balance to the process. We do not oppose that but I do not think it is essential that you have consumers involved at that level of detail. We are concerned about the overall process and the representation of the community.

**Senator ABETZ:** I would agree with you. I just found it astounding that you would not necessarily want consumers being able to give evidence on cases that intimately involved them. Let us move on. As representatives of health consumers does it concern you that their health care is being prejudiced by the fact that many medical practitioners—according to the evidence being given to us—are in fact curtailing their consultations and not providing the care they would normally provide because they fear being the subject of an audit?

**Ms Bennett:** I am not sure about that evidence, and we have not looked at the specific surveys that you are referring to, but again I think it comes back to the statistics—that very few of these cases actually ever arrive at

the investigation point. So it is surprising to me that doctors would be curtailing their practice—on the basis of those statistics—because they might be brought up against the PSR. There is no indication of that if you look at those statistics. But clearly there are surveys indicating otherwise.

**Senator ABETZ:** With great respect, there is a lot of evidence from the organisations that have submitted to us that doctors are changing their practice habits to ensure that they do not find their way into the right-hand side of the bell curve. I would also have thought that as a consumer organisation you would have been very supportive of practices that are innovative—for example, women's practices, which not surprisingly would have more pap smears done than ordinary general practices, but that throws them out onto the right-hand side of the bell curve for certain matters. We also heard from AIMA this morning, Professor Phelps's organisation, that the way they deliver medical practice tends to get them under the auspices of an audit as well and as a result people change their practice habits. I would have thought it was in the interests of consumers that we actually encourage innovative medical practice rather than have these practices which try to push everybody back into the centre.

**Ms Bennett:** Certainly, we would hope that providers deliver to consumers the best possible range of options. If that is the case, if this scheme genuinely does provide that kind of deterrence around the kinds of services that are delivered and there is good evidence of that, then I guess this review will find that that is something that needs to be adjusted. We want consumers to have good access but we also believe that this scheme does provide a check and balance that is also beneficial to consumers and that, where practice is very much outside the norm, that would be dealt with; but, for the vast majority of cases, that is not the case.

**Senator ABETZ:** What do you mean, with great respect, by 'practice outside the norm'? If I specialise in looking after women, chances are my practice will be outside the norm in relation to the number of pap smears done. If as a GP I specialise in chronic diseases, I will be outside the norm in relation to the length of appointments. If I specialise in a holistic approach, as AIMA does, chances are I will be outside of the norm in relation to consultations and, we were told, vitamin D prescriptions or something like that. So all those get thrown out and they become subject to audit, which puts a lot of people through a lot of strain, stress and expense. As a result, they shift their practice back to the norm, and I would not have thought that was of benefit to the Australian health consumer.

**Ms Bennett:** Australian health consumers deserve, as you say, access to a range of services and, where there is a need for a specialty practice, that should certainly be available to people without undue penalty. But I guess the specifics do not—

**Senator ABETZ:** Yes, but the system you seem to be defending does exactly all those things. According to the evidence from all the people who work in this space, from the AMA to the Doctors Union, to AIMA, to MIPS and to MDA National, that is what is occurring. One final question: surely as a consumer organisation you would believe that natural justice is something that should be afforded to everybody in society, including doctors?

**Ms Bennett:** Yes.

**Senator ABETZ:** And are you aware of the host of evidence suggesting that, under the PSR mechanisms, medical practitioners are denied natural justice?

**Ms Bennett:** I suppose the legislation as it currently stands provides the parameters around the legal representation that is afforded to those who find themselves up for investigation.

**Senator ABETZ:** We know that, but do you support that?

**Ms Bennett:** We do not have a particular view on that. We are not here representing the doctor groups; we are here representing the consumers, who need to know that appropriate practice is applied to them when they are visiting a practitioner.

**Senator ABETZ:** Yes, and I would have thought Medicare spitting out audits only on the right-hand side of the bell curve, which is the uncontradicted evidence, would not necessarily agitate consumer interest as much as those that are on the left-hand side of the bell curve that never come up for Medicare auditing, who may be practising quite inappropriately but, because they do not bill or charge much, never come into the scheme of an audit. So I would just invite the consumer organisation to take a broader look at their members' benefits.

**Senator MOORE:** I have a point of order in terms of the process: that was not a direct question to the consumers. They were not given a chance to put their whole process, and we are looking at a particular issue in this inquiry. So I think, Senator, you went over the line.

**Senator ABETZ:** Thank you for your opinion, Senator Moore; that is very interesting. But I would like the witnesses to respond rather than Senator Moore.

**CHAIR:** Could you take that one on notice in terms of having a look at the evidence we have received and at the question that I think Senator Abetz was getting to.

**Ms Wise:** I would like to note that there were several submissions which commented about concerns about natural justice but also several which said that there were elements to protect natural justice within the system. So there are views on both sides, I suppose depending on which side of the system you have been sitting on. We have read through the submissions and observed both viewpoints.

**Senator ABETZ:** The PSR has a point of view.

**Ms Bennett:** Yes.

**CHAIR:** We are running out of time.

**Senator McKENZIE:** I have two questions. As you have stated, your organisation is concerned that consumers get access to appropriate health care, and you are also trying to balance that against the tension of them not only being healthcare consumers but also paying for the services through their taxes. I am just wondering about the issue with the audit process looking at those practitioners as statistical outliers. For a range of reasons, some quite appropriately are outliers—from a consumer's perspective, I guess, and appropriateness of practice. Do you think there might be from your perspective another way of selecting practitioners for audit other than the outliers to ensure that those within the 80th percentile who are not practising appropriately but are not necessarily outliers can actually be brought through the PSR process?

**Ms Bennett:** The process is premised around the way that the Medicare and PBS work at the moment. I guess there is the basis of the Medicare system itself, the fee-for-service model and the way that six-minute medicine works, perhaps—excuse these figures—because you are talking about other elements of practice and specialisation that will obviously provide for some of those practitioners to be in the higher end of the statistics—sorry, in the lower end. They are in the extreme end—the outlier end. So I guess there are different ways of looking at how you could set up the system that would ensure that you could accommodate some of those other practices and services that would otherwise end up as outliers within this system.

**Senator McKENZIE:** I am wondering whether you have any ideas about other ways to do it—that is all.

**Ms Bennett:** I guess that really goes to the heart of what you define as being appropriate medical practice and at what point that falls outside what is considered to be the norm. Certainly there are other ways of doing it. You can put more emphasis on prevention and on specialised skills and so on, but our system and the way the PSR works is premised on the way that the Medicare system works currently.

**Senator McKENZIE:** So it will just leave it at the status quo. I want to know the amount of consultation CHF has had. Earlier today we heard some guidelines have been developed around the setting up of the PSR panel, and there are ongoing discussions around another document. Regarding this, what involvement has your organisation had in that?

**Ms Bennett:** We have had very limited involvement and, in fact, that has been of concern for us, because we do feel that consumers very much benefit from having this kind of a scheme in place. We believe that there does need to be more consultation, particularly at that high-end level where you are looking at how the scheme works, what guidelines it operates on and how effective it is and so forth. We would very much welcome more involvement in this scheme because we believe consumers are beneficiaries and key stakeholders in this scheme, as are health professionals.

**Senator McKENZIE:** Thank you.

**Senator ADAMS:** In your opening presentation, just at the end, you said that you were afraid of changes that may be made. Could you just give us an idea about what those changes might be, please?

**Ms Bennett:** We would be concerned if there were to be an overemphasis on the issues that have been raised in some of the submissions around privacy protections, for instance, and other measures that have been raised, particularly by those who have found themselves at the investigation end of the PSR system. Basically, this system needs to provide a balance and the balance is having the capacity to investigate cases, while still ensuring that there are measures in place—for example, if you are talking about privacy, that there are privacy protections and legislation that protect consumers' interests. So it is about striking the balance. Our concern would be if the balance erred too much in the direction of extreme privacy controls, that would then stymie the PSR's capacity to investigate, not on the basis of appropriate practice but on the basis of privacy being used as a way of hamstringing the scheme so it cannot work effectively. That would be a concern.

**Senator ADAMS:** That is the only one?

**Ms Bennett:** That is one of the concerns. There are a number of others that have been raised in the submission process. We want to see the scheme enabled to operate but at the same time still producing a good outcome.

**Senator ADAMS:** I would like to move on and ask you about the new health reform and the role of Medicare Locals and patients with chronic disease. It seems the Medicare audits are of the longer consultations. The current focus and the future focus for health is actually on primary care, and that involves a multidisciplinary team to work with the GP. These longer consultations are the ones that are being audited. Senator Abetz was stating that a number of GPs have been flagged because they have gone too far with their consultations. They are now using item 36 and item 44, instead of item 23, which is of much less concern. I wonder whether this committee should be recommending that, once again, there should be a focus on the longer consultations because of the new health reforms. Could you comment on that. I know you have been doing some work with Medicare Locals because I get your magazines and I have been reading them with interest. Could you just look at that scenario, perhaps looking at the rural areas where we do have a lot of older people staying in communities with a solo practice doctor.

**Ms Bennett:** It is a good point. When you are focusing more on primary health care and health prevention services you are perhaps looking at longer term consultations. I think there is a bigger issue about how we define Medicare and whether our current fee-for-service model does operate as effectively as it could. That certainly is a discussion we are engaged in. We believe consumers have a right to access good services that are not necessarily based on a fee-for-service throughput model. We believe that does not always best serve the needs of consumers. I think there certainly needs to be some consideration about some of those models and whether they work effectively. That should always be the subject of review and reconsideration.

**Senator ADAMS:** Would you be able to raise that with your people and look at it a bit further?

**Ms Bennett:** Yes, absolutely.

**Senator ADAMS:** Have any of your members been asked to go onto one of the peer review committees?

**Ms Bennett:** No-one I am aware of.

**Senator MOORE:** On your website you list all of the organisations that are part of your process, and also your process of having consumer fora to talk about things that are important to consumers. Have you ever had a question raised by consumers about their concerns, fears or knowledge of the PSR?

**Ms Bennett:** We have consulted with consumers about the PSR. Consumers are not necessarily aware of the PSR and how it operates.

**Senator MOORE:** No, that is an issue in itself.

**Ms Bennett:** It is not something that is out there in the public arena. I agree with you; it is an issue in itself. But those who are aware, and they tend to be health consumers who are high-end users of the system and have knowledge of how it works, say that they would like to ensure that the legislation properly reflects adequate protections for consumers. To some extent that does embrace privacy, but it is about ensuring that there are appropriate controls in place. We have not had any particular instances raised with us in which that has not occurred.

**Senator MOORE:** So, through that extraordinary list of organisations that are part of your network, to the best of your knowledge there have not been consumers coming up and saying, 'We have been damaged by this. We are scared about being damaged'?

**Ms Bennett:** No.

**Senator MOORE:** Your organisation may wish to have some discussion about the whole auditing process and the link. It could well be something that will be useful.

**Ms Bennett:** Yes.

**Senator MOORE:** In the PSR document, which was quite extensive, there is a reference to the makeup of the Determining Authority. It says that one of the people on the Determining Authority is 'a member who is not a practitioner—that is, a member of the public'. I will be asking the PSR about how that has worked. When you said there are areas you would like to be more involved in, is that the kind of area you would like to have some discussions about with the organisation?

**Ms Bennett:** Yes, we would welcome that.

**Senator MOORE:** And just for our records you also mentioned that the advisory group is another area.

**Ms Bennett:** Yes, and the advisory group, and the overarching policy and guideline-setting process.

**CHAIR:** Earlier, Senator Moore raised a point of order. I jumped to the chase rather than explaining the reasoning behind it. This inquiry is essentially about the PSR, but the terms of reference say 'any other related

matter'. The initial auditing process is obviously part of this process as it is coming up repeatedly. I thought that Senator Abetz's question about the auditing process was fair enough—I think he was probably asking it very robustly. But I do think it is a relevant question, because it is intimately associated with the following process of the PSR, which is why I have been allowing those questions on auditing. I think your opinion on whether there is another way of auditing, which we have asked other witnesses, would be very helpful to the committee, because it has come up repeatedly.

That leads me to my question. You commented on the number of requests that have been made over the past five years, of which 50 have then gone on for a further process. Have you looked at what those cases involved? Have you had access to that sort of information?

**Ms Bennett:** No, we have not.

**Ms Wise:** We have seen some of what is available publicly on the PSR's website and in their annual reporting, but we have not had a chance to review that in detail.

**CHAIR:** Do you think they are appropriate indicators that should be used for identifying those that should be reviewed? This ties in with the earlier question.

**Ms Bennett:** It would be valuable to have information about the sorts of cases and to have that delineated more specifically.

**CHAIR:** We have had several witnesses bring up the issue of the interaction or the overlap between AHPRA and PSR. Have any of your members raised that with you and have you looked into those issues? Do you think there are areas of overlap there?

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

**CHAIR:** So you are comfortable with the way it works—

**Ms Bennett:** Yes.

**CHAIR:** without making assumptions about the PSR process and whatever comes out of it—if there are any comments or any findings from that review. But processes should continue the way they are at the moment. I am not asking you to qualify anything about the PSR process but, assuming everyone is happy with it, the two processes can continue?

**Ms Bennett:** We note that some of the cases that are brought before PSR are referred to AHPRA, but not so much the other direction, in that AHPRA is able to refer to the PSR. I think there is perhaps some substance to calls for some better communication and links between the two organisations in their distinct roles.

**CHAIR:** Thank you very much. If you could get us answers to the questions that you took on notice by around next Thursday, that would be appreciated.

**COOTE, Dr William, Acting Director, Professional Services Review**

**RADFORD, Dr Nicolas, Chairman, Determining Authority**

**RUSE, Dr Warwick Henry, Former Deputy Director, Professional Services Review**

**TWYFORD, Mr Luke, Acting Executive Officer, Professional Services Review**

[14:14]

**CHAIR:** I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you.

**CHAIR:** Thank you. We have your submissions. They are numbered 24, 1 and 11. I remind witnesses that evidence should address the terms of reference and that misleading the committee may constitute a contempt. We ask that witnesses avoid making adverse comment against other parties and that such reflections may prompt the committee to suspend proceedings. The committee may decide to take evidence in camera at any stage; likewise, witnesses may also ask to have evidence taken in camera.

A transcript of some of this morning's evidence has been provided to you, the reason being that it makes comments about the PSR. I invite you to respond now or to respond in writing if you would rather consider it. I now invite you to make an opening statement.

**Dr Coote:** I will make a brief opening statement. Dr Ruse will then make a brief statement focusing on his experience as a committee chair. Then Dr Radford in his more independent role as chair of the determining authority will also make a brief statement.

Thank you for this opportunity to appear before the committee. From my personal point of view as someone who has just been appointed as acting director of the PSR, in one sense this committee is a very useful process for airing a lot of issues around the system. Starting from the very basics, Medicare and the PBS amount now to \$25 billion a year in programs. Medicare is an open-ended, fee-for-service system. It is inevitable with such a program that there must be some process for assessing suspected inappropriate behaviour. I will make five brief points.

The first is that PSR receives referrals from Medicare, and Medicare refers practitioners to PSR when it has concerns that the practitioner may be practising inappropriately. I am not here to explain how Medicare go about their business, but I think there may have been a little misunderstanding this morning about Medicare's processes, and I am sure that they are much more sophisticated than has been implied. As I say, I am not here to go into or explain those in detail, but we did find a section of a submission to this committee in 2009 when you were looking at the new audit process. It reads:

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

So I think that it is more complicated than may have been implied in some of the submissions you heard this morning.

The second issue is that, again stating the obvious, PSR is a peer review process, and this peer review is at the very core of the PSR system. The system provides practitioners with an opportunity to discuss with a committee of peers those aspects of their practice which led to the referral. I am not a lawyer, but it is unfortunate to hear terms such as 'charges', 'convicted' and 'crimes' and things—it is a professional review system where professionals are given the opportunity to explain their practice to a committee of peers. Medicine is a very rapidly changing field, and the demand for medical services in the population grows and grows. Sitting listening to the evidence this morning, I reflected on that point that there are processes in Australia outside of PSR for assessing claims for new specialties. People can go to the Australian Medical Council, have their continuing education activities assessed and be recognised as a college, as it were—the new Medical Board of Australia recognises 83 distinct medical specialties. It is a very rapidly evolving field. But some of the groups who have spoken today—and I am in no way reflecting on what they do; they offer extremely valuable services—do not have that formal recognition. I am just making the technical point that it makes PSR's job a little bit complex.

**Senator ABETZ:** That was 83—

**Dr Coote:** Yes, 83 specialties. The final point I will make on that is that there are processes established whereby groups can liaise with the federal health department in regard to the Medicare schedule and have items developed that reflect their style of practice. So I am simply making the point that it is not PSR's role primarily to make determinations on what is and what is not a specialty. Having said that, obviously PSR does have some flexibility in the construction of a panel and in its ability to engage consultants.

The third point overall is that, during the Medicare PSR process, a practitioner has eight opportunities to make submissions and explain their practice, and those are listed in our submission. Briefly, they are interviewed by Medicare; the PSR director meets with them; they make written submissions on the PSR 89C report—the 89C refers to the act; they can make written submissions prior to a committee hearing; they appear before a committee and can make verbal and written submissions at the committee hearing; they are allowed to make written submissions on a committee's draft report; they are able to make submissions on the committee's final report that goes to the determining authority; and they are able to make submissions on the determining authority's draft determinations. So the practitioners under review have these multiple opportunities to comment as the process proceeds.

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

The final point—and this was pointed out briefly this morning—is that, under the act, a committee may refer a practitioner to the Medical Board if the committee has concerns that the practitioner may be practising in ways that constitute, as the act says, a significant 'threat to the life or health of any person'. A review of the PSR records shows that around 15 per cent of completed cases lead to identification of concerns requiring referral to a medical board.

I conclude by saying that I think that everybody involved with PSR realises that it is a challenging role. The legislation is set up in such a way that it inevitably is balancing a whole lot of factors. While I am the acting director, one of the things that we will be trying to do is to look at the processes and see if they can be improved. We realise that it inevitably must be a stressful process because in a sense it is challenging not just a practitioners economic status but also, potentially, their public reputation. So it is inevitably a stressful process, and we are aware of that.

**Dr Ruse:** Thanks for allowing me to appear. I make clear that I am appearing in a private capacity as one of Dr Hambleton's original badge-of-honour men. I will happily speak to my original submission 11, which I hope you have had a chance to read, and answer questions. Like everyone else, I have had a chance to read the other submissions that have appeared online and are still available. I have also been following with interest the online debates on these matters on the medical websites. I would therefore like to take this opportunity to flag to the inquiry a few new points which I think are important.

Half a score and seven years ago, this parliament brought forth in legislation an innovative peer review mechanism in the form of the PSR. It is yours and it is the consumers'; it is not mine. It is has had several major reviews. I am sure you have all read Robin Bell's scholarly legal paper written in 2005 on how legal misperception of the intentions of parliament at that time have required multiple legal challenges to be heard, principles to be established and, occasionally, legislation to be changed. All the major institutional bodies continue to support peer review as the basis of the PSR. The MIPS and AMA submissions—Senator Abetz commented on them—commented on perceptions within the profession; the RACGP's submission states 'facts' that might better be described as perceptions which it has received from its members; and the websites I have been on are awash with perceptions. I think it is important that these perceptions be briefly identified and flagged for you, because I believe that some of them are erroneous.

The first popular misconception is that at the committee level doctors are being judged somehow purely on solely on their place in what is a very skewed distribution. This is a technical point and I am not a statistician, but we are not dealing with the bell curve, which is the Gaussian curve; we are dealing with a very skewed distribution. They are not judged in that distribution, which can be of services, total services per patient, prescriptions or dollars in rebates.. The Avant submission states as a fact—or perception—that almost all its members who have appeared before the committees believed that their case was prejudged. As one of the judges, I am disturbed about that. It suggests that there has been a formal debriefing process by Avant, a database and statistical analysis. If that is true, I would encourage you to seek it out; otherwise, it is just an unsubstantiated allegation.

More importantly from my perspective, both arms of this non-bell-shaped-curve misperception are just not true. At the committee level we engage, as Dr Coote just said, in peer review of individual services which have been randomly selected by completely different—and, we are told, unbiased—statistical methods. The doctor explains to his peers on the committee, as called for in the legislation, what his conduct was in providing that service—the conduct is what he did. A peer review judgment is then passed in each case on whether or not the

conduct is thought to be inappropriate. What has not been heard cannot be prejudged. If there are peer judgments of inappropriate behaviour—and let us say that is a raw score of 10 out of 25 services—it is then corrected downwards in the doctor's favour, through the miracle of statistics, by another legislative statistical procedure, and it is only if the corrected inappropriate judgment score is greater than 10 per cent that the determining authority may take it into account in getting back pro rata rebates. But I point out that the raw score of inappropriate individual services, depending on the size of the total number of services provided in that group in the year, has to be seven out of 25 or eight out of 25 before it is called 10 per cent—which is two and a bit.

The second marketplace misperception, in my opinion, is that the panel members themselves—the committees—are driven purely to recover Medicare's dollars. This has never been institutional policy that I have been informed of or made to follow. It has never been the express purpose of any of my committee members or me, and I point out that, having found inappropriate practice if it exists, we have no say in setting the recovery amounts; that is the job of my learned friend on my right. The joint skin colleges submission, which is open, on page 3 in point 6 states:

... there is alarming evidence demonstrating that PSR staff obtain performance bonus commensurate with the number of doctors who enter into a Negotiated Settlement.

This is aimed purely at Dr Webber, and it is under parliamentary privilege. I am told that it is just not so, and I would ask that you press the authors of that for the evidence before you consider it at all.

The third misperception is that the PSR committee level is overly scrupulous in some way about medical records. I have covered this at some length in my original submission. The RACGP fourth edition guidelines for accreditation are quite specific on what they believe the record should contain to be accredited, and they actually expand on the Medicare requirement, which has been extant since 1999, for adequate and contemporaneous records. The RACGP spells out quite clearly that the record must contain the name, the date, the patients presenting a complaint, relevant clinical findings and then—quite separately—a diagnosis and then, separately again, a management plan including medication. A record which consists of, say, three days of bronchitis Amoxil is just not acceptable even from a super doctor on a very busy day—and we do not judge by the gold standard or by the Silver standard but by the lead standard. It is only when records fall below what would be considered the lead standard that we consider them in themselves to be inappropriate. The fourth misperception, we have heard before, is that charges must be laid and known before a committee hearing. The concept of peer review retains the support of almost all the institutional submissions you have received. It is disappointing to see Avant, the single biggest medical insurer, complaining that the nature of the case against the doctor under review is not known. That is the point of this peer review process—we are allowed to look and see what their conduct was in delivering services to consumers, who believe they are above the lead standard.

In the matter of the transfer to APRA, if I may use a small analogy: we all break the speed limit at times; we know that it is set statistically; we accept it. There is a concept of dangerous driving, which hopefully we do not do, and it often does not lead to misadventure. Medical boards—old or now under APRA—deal with 'dangerous driving' that has led to people being killed. There is no way, in my opinion, that APRA want to plough through all the stuff we see on the odd chance that they may catch a bit of dangerous driving.

The RACGP, once again, in spite of supporting peer review also recommends that allegations regarding breaches of the act be clearly set out. I think I have covered in my submission that we are not looking at statutory crimes under an act; we are permitted by an act of this parliament to engage in peer review.

Fifth: some minor annoyances—and then, you will be pleased to hear, I am finished. The Avant submission feels that inappropriate practice is in some way a legal test and therefore should only be applied by a legally qualified chair. All doctors recognise, and welcome, legal tests like the McNaughton test for mental unsoundness as a defence and they welcome the expert application of such legal tests by judges. But this is different. Parliament—yourselves, your predecessors—made a law that inappropriate conduct is a test to be judged by medical peers. To call it a legal test, somehow needing a legal technician, is to my mind erroneous.

It is disappointing after 17 years that the medical defence organisations in some way object to that part of the process which involves lengthy and repetitive questioning and that invites comment from the PUR for further information about the conduct of each service—this is there in writing. That is what we are charged to do, and there is a reason. Because of the possibility that, if more than 10 per cent of services in a large group are found to be inappropriate, there may be recovery of money, each item we are looking at is carrying a statistical weight of probably tens of thousands of dollars. I am surprised that the medical defence organisations do not want each of those 25 statistical weight-bearing points explored in great detail.

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

You will be pleased to hear I am finished. I would welcome questions.

**CHAIR:** Dr Radford.

**Dr Radford:** Thank you for giving me the opportunity to speak here. I have been associated with the Professional Services Review in its various incarnations, and with its predecessors, since the 1970s, when the problem of what was then called 'overservicing' came to light in a report of the parliament and produced a scheme of Medical Services Committees of Inquiry, under the auspices of the then Department of Health, to inquire into matters of overservicing.

This scheme has evolved ever since. I have been a member of an MSCI and chairman of an MSCI, and then, when the PSR was established, I became a deputy director of the Professional Services Review for Victoria. Later I was made a member of the Professional Services Review Tribunal, about which I would be pleased to answer questions later, because it may go to one of the submissions made by Avant. Then, when the determining officer was replaced by the determining authority on the basis of the minister's review committee of the Professional Services Review scheme of 1999—which I am sure you have—the Professional Services Review Tribunal was abolished. I became chairman of the determining authority and have been chairman of the determining authority ever since.

I know that the system, the parliament, the AMA and the profession in general have gone through a very long learning curve in this, with the help of the courts, which have pointed out what parliament really meant by the legislation it has made and what could be done to improve and to act according to law in respect of how practitioners under review, or PURs, are treated by the whole system. The result of that has been a system where, as Dr Ruse said, there are multiple steps in which a doctor is afforded the greatest possible opportunity to state his or her case with the help of suitable advisers. The doctor is enabled to have legal advice, to call evidence and witnesses et cetera.

That is all in the past from the point of view of my present duties. I am now the chairman of the determining authority, which includes me because the act says the chairperson has to be a medical practitioner. Then there is another medical practitioner or a member of the group to which the practitioner whose report comes before us belongs—it might be a chiropractor or an optometrist, for instance. Then there is one non-medical member who is appointed by the minister. They are appointed not by PSR but by the minister. I am appointed by the minister and the other two members are appointed by the minister. We have certain powers under the legislation. There are two main areas. We ratify or reject agreements that the director has come to with regard to section 92 agreements, which are agreements under the legislation where a practitioner has admitted inappropriate practice and has come to an agreement with the director, almost always with advice, to be reprimanded or counselled, to repay some benefits or to accept a period of disqualification.

The other main part of our work is that we receive reports of the committee. We are given the report of the committee and the background of it—in other words, the Medicare referral to the director. We have to then determine what sanctions we might apply given the very strictly limited powers that we have. It must be emphasised here that we are not a judicial body. I am not judicially appointed. If we were to try to do anything which would be construed by the courts as being a judicial act, we would be acting totally improperly and our findings would be struck down. We are charged with making a determination which has to contain one of several things: a reprimand, counselling, repayment of benefits, a period of disqualification and/or a disqualification from what is called the part VII authority, which is the authority given to a medical practitioner to prescribe medications under the Pharmaceutical Benefits Scheme. Like the directors, we also have our education system. We have our own legal advisers, who are appointed as separate legal advisers from the legal advisers to the PSR, and we have had education sessions. Our lawyers are always pointing out to us and helping us in applying the proper legal principles—although not making our decisions for us—which we must follow in determining the sanctions we apply and, in particular, deciding the cases on their merits.

The committee has to report to us on whether there was inappropriate action with regard to medical benefits and then identify those benefits which they feel were inappropriate. That might give us a number of dollars, but that is not what we might apply. We take into account the submissions which the practitioner might give to us—and practically always does, but sometimes does not. These submissions may go to many things other than what is in the report. They may contain submissions about the practitioner's age and cultural background, their general

mode of practice, their health, their financial situation, their family situation—101 things. Sometimes they can be very helpful for us in deciding what sanctions we should apply. Sometimes that may result in a major reduction in the amount that we ask to be repaid.

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

**CHAIR:** Thank you very much.

**Senator MOORE:** If I raise issues, other people may want to jump in, too, because I think we have similar questions. I think, Mr Twyford, this will come to you. How detailed are the records of PSR? We have had a number of claims made about the impact of PSR processes and the kinds of practitioners that have been affected. Do your records indicate what the issues were and what the outcome was?

**Mr Twyford:** We have a case management system that records the key dates and timings, and the identity of the practitioner under review. We also run a records management system that would contain the draft and final reports and the draft and final determinations in each matter.

**Senator MOORE:** So how public are they? Are those kinds of records protected by privacy?

**Mr Twyford:** Absolutely.

**Senator MOORE:** I ask because we have heard a number of claims, and I am just wanting to know how we verify some of the claims. There were things such as: the system focuses on rural, hardworking, popular and innovative doctors. Dr Ruse, I wish I totally understood your evidence. I am going to read it again. We looked at the graph thing there, and I would like to have a look at that because there has been a lot of discussion about the bell curve and allegations about the bell curve. I really have to read that. What I am trying to find out are a couple of specific things. We had, as has been mentioned a couple of times, women's health clinics being closed down because women practitioners were closed down by the PSR for having done too many pap smears. That has been put on the public record a number of times. I would like to know whether there is any way we can find out whether that is true or not. So I am putting that to your organisation to see if there is any way by which we can find out whether there have been, as a result of the PSR process, specific investigations into women's health, women's practitioners and their services being closed down.

**Dr Coote:** We will respond to that in writing.

**Senator MOORE:** That would be fine. I understand that.

**Dr Coote:** I can say that the whole issue of the different things is right outside of any issue to do with PSR. The issue of women having a different pattern of practice from that of male GPs is for part of a general discussion in the general practice world. It has been part of the discussion for years. There are any number of studies and statistical reports available demonstrating—

**Senator MOORE:** But I am particularly interested, Dr Coote, in the issue that, as a result of the PSR process, we have lost services because—as the allegation was— of overservicing.

**Dr Coote:** Overservicing in relation to?

**Senator MOORE:** Pap smears. There has been a specific allegation and I would like to follow up on it.

**Dr Coote:** We will search the records and get back to you.

**Senator MOORE:** That would be useful.

**CHAIR:** If I may clarify that a little bit, my understanding of it is that it is overservicing because there is not profiling done. You have heard the discussions about the profiling and that, as I am using the terminology that the witnesses are using, they pop out at the top end of the bell curve. That is why they pop out.

**Dr Coote:** I am going to repeat the sentence I read out earlier—and, as I said, I am not here to talk about Medicare's processes—from that previous submission to the committee in 2009. The sentence I read out was:

Medicare Australia uses sophisticated technology to compare factors including total benefits, services, patient demographics and prescribing of pharmaceuticals.

I am sure their systems do take account of—

**Senator MOORE:** We will be asking Medicare about their processes. I think that when claims are made we need to follow them up.

**Dr Radford:** I know that Dr Coote has said that he is going to research the matter, but I cannot recall one case in which my authority has applied any sanctions with regard to gynaecological services at all. The next thing is, I think, the idea about profiling. From the documents that are sent to my committee for reports and for section 92 agreements there is so much data applied to so many different parameters that, in fact, there is a profile and there are the bread rolls that are in there. Say you see a practitioner who says that they deal with complex chronic diseases and then their profile says that they have practically no referrals to specialist surgeons or specialist oncologists or specialist physicians or specialist psychiatrists. It might be considered that there is something odd there, given that they say they are dealing with serious conditions but actually they may not be. That is the kind of thing that it is right and proper for a committee to then inquire into.

**Senator MOORE:** Thank you, Dr Radford, and so if someone could look into that. Unsurprisingly, that was one that jumped out. There are lots of other issues but I had to follow up on that one.

**CHAIR:** Dr Ruse, you had your hand up.

**Dr Ruse:** Yes. It is about another unsubstantiated perception in this debate. From my experience of process, it is extremely unlikely that a practitioner in a recognised women's health clinic or practice—and I am not talking about someone with an interest within a practice—would not be able to convince the Medicare adviser that 'this is where I am'—and they do go out and visit them and walk through the door that says, 'Special Women's Health Clinic'. It is unlikely it would not be able to be picked up by the directors, all of whom are doctors who are aware that special areas of interest can generate peculiar profiles. And if they got to any committee and were able to show all and everything else—and the reason I do say this is that you mentioned Pap smears and they are the bread rolls of this practice—I firmly believe it would be found, if it were a matter of Pap smears, that they had no case to answer.

**Senator MOORE:** I am just wanting to check it out.

**Dr Ruse:** I understand. The other thing is the 80/20 rule. It has received a fair bit of going over in the submissions and the evidence. I have asked the AMA to give me some information on it. I know that you do not determine the rule, that Medicare does the profiling and sends it to you, but, from the PSR perspective, how is the concept of the 80/20 handled?

**Dr Coote:** In what respect?

**Senator MOORE:** In terms of it being reviewed under the PSR process. I know that there is the guideline about 80/20 over so many days in a year as being something to raise awareness of but we have had some evidence that it has caused great stress, particularly to hardworking doctors, who are caught out in this process.

**Dr Coote:** Mr Twyford might like to say something but, historically, that so-called deeming provision was not part of the PSR scheme when it was originally set up in 1994. It was introduced after the 1999 review and it is a requirement in the regulations that flow from the act. There was, at the time it was introduced, a defence of exceptional circumstances, and I think if you go back to that committee report, that was to deal with epidemics or a situation where they may have been two doctors in a town and one left.

**Mr Twyford:** That was essentially what I was going to say. It is set out in the regulations that 80 professional attendances on 20 or more days within a calendar year is deemed to constitute inappropriate practice. That is a very different type of case to what the PSR normally sees. Looking back over time—and I could get you an exact figure—

**Senator MOORE:** That would lovely.

**Mr Twyford:** something like only five 80/20 matters in the last five years—

**Senator MOORE:** Only five?

**Mr Twyford:** have been referred to the PSR. In that situation the committee is required to accept or not accept the practitioner's proposition that there were exceptional circumstances so, again, it is a reversal of the onus in terms of how the committee functions.

**Senator MOORE:** So, are such circumstances as an epidemic in the community or a shortage of doctors in a rural area the kinds of things that constitute exceptional circumstances for the doctor to put forward?

**Mr Twyford:** Yes. The regulations state it as being an unusual occurrence, which would be an epidemic type of situation or an absence of other medical services for patients of the person under review during the relevant period. The point I was going to make was that when the provision was introduced it was done with the agreement and acceptance of the Royal Australian College of General Practitioners and the AMA's own Council

of General Practice. They endorsed the concept of the 80/20 rule. In fact, when there was a review in 2005 there was debate around changing it to a 70/30 ruling but that was not picked up.

**Dr Ruse:** It is one of the speed limit things. Coming back to the exceptional circumstances, some doctors do believe that they are very busy, very effective and cannot change this, and they ask to be excised from the experience of everybody else. I am sure there are very good pilots who believe they could fly 20 hours a day, but after due consideration by their professional organisation and health experts it has been decreed that they shall only fly whatever hours it is before a break of so many hours. Obviously, if they are flying to evacuate Australians from Egypt or something, an exception might be made, and I think it was that sort of thinking that went into setting the exceptions. My son had to break the speed limit to take his wife who was in labour to Melbourne recently, but we would not encourage him to make a habit of it. It really was a speed limit sort of thing. It is accepted that there will be busy days. The 80 is the number of services and the 20 is how many days in a year we would accept it as part of any busy practice. It is only when the individual practitioner has had 80-plus, 20-plus that questions start to be raised.

**Senator MOORE:** Doctor Ruse, you actually mentioned in your statement that people raise issues and put perceptions. One of the things that have come out—and it has come out about a whole range of issues and I am sure the other senators will want to be involved in this—is about you, Dr Radford, Dr Coote and Mr Twyford going through the process as it is set out. The allegation from the people who have come to us is that it does not matter what the rules are; the way they have been implemented has actually led to poor practice and a sense of bullying and fear amongst the doctors. On that particular point, there is a view that it did not matter whether they could bring witnesses, have evidence or provide statements—no-one cared and the end result was going to be that they would be found guilty. That is what the evidence has said. I am seeking from you, as the people in the PSR and working in the area, what can be done to respond to people who have that view. We have had evidence of surveys of doctors. We have had concerns that have come through from groups, and I would think that would be a fair assessment of the process and would like to hear your response to that.

**Dr Ruse:** Firstly, as to the surveys, there is quite a science to surveys. Self-reported surveys such as 'Do you feel hard done by?' will undoubtedly get the numerator but the question is the denominator. It is interesting that even in the 209 or 212 persons in Dr Masters's survey they did not have 100 per cent who felt hard done by. Some of them had what I would consider a positive opinion about the PSR. These perceptions worry me. As I said, I consider myself a badge-of-honour man. I do lie awake at night during individual hearings, agonising over these things. I do not have a heart of stone. But once these perceptions have been raised, to be put to bed once, I think someone has to pay the money for a proper scientific survey which goes out and asks everybody—not just those who feel hard done by—firstly, 'Are you aware of the PSR process? Were you part of it?' There probably could be two surveys: one for the however many hundreds who have been through the PSR process and one for those who have not.

Since everyone is allowed to strap their own wounds, I have had one PSR person come and shake me by the hand at the end of it. I am not saying that he was grovelling, but he appreciated the way we did it. I had a second person who did not bring legal counsel and on the first day he asked permission to turn on his recorder so he could have his own transcript. On the second day I said, 'Do you want to turn your recorder on, Doctor?' and he said, 'No, after the first day I am quite happy that it is fair.' These are only anecdotes too. Obviously I believe I have never bullied anybody. In fact, if anything, our legal people say, 'You are bending over backwards.' It is perception against perception; misperception against misperception.

**CHAIR:** Dr Coote or Mr Twyford, do you want to add to the comments that Dr Ruse just made?

**Dr Coote:** I would like to. Just in a more general sense, I was pleased when I turned up at PSR a few weeks ago and found that a lot of effort has gone in over the last year, particularly driven by the advisory committee comprising the department, Medicare, PSR and the AMA—and I think Mr Sullivan may have mentioned this this morning—to better explain the process. There has been a resource guide published, which I think was attached to our submission but we can provide hard copies of if you like. There have been changes agreed with the previous director, which I will certainly follow, to make the initial meeting with the person under review less confronting in the way the proposal for the meeting goes out. There is further work in train. There is work on finalising guidelines on selecting members to a specific committee to give the director some guidance in selecting from the panel for a particular committee. There is further work which should be finished in the next couple of months. There are further guidelines in regard to the director meeting with persons under review. There are a whole lot of things happening to try and improve the process in response to what are obviously a lot of genuine concerns that people are expressing.

**Senator ABETZ:** Dr Coote, that is heart warming to hear, because it seemed, up until that stage of the submission, that everything was hunky-dory, and I was going to traverse with you all the changes that seem to be happening, like the documentation we have been given. There seems to have been a lot of movement in the last 12 months—would that be fair?

**Dr Coote:** Most of that work that I detailed has all happened in the last 12 months; that is right.

**Senator ABETZ:** And how long has PSR been going for?

**Dr Coote:** Since 1994.

**Senator ABETZ:** Yes, since 1994. Given that the PSR itself is now engaged in a lot of good work—which I congratulate you on—can you understand that, possibly, in the period before the last 12 months at least, there has been genuine concern about how things have been occurring with the PSR?

**Dr Coote:** I do not think there is any doubt there have been concerns. We are seen those expressed in some of the submissions and evidence.

**Senator ABETZ:** It is not only concerns—people can have concerns—but are they valid concerns about the PSR itself now engaging in modifying a lot of its practices?

**Dr Coote:** That is happening. Obviously, my role only started a couple of weeks ago, so I can only comment on what has happened since then and reflect on the excellent work that was done earlier in the year and it is now—

**Senator ABETZ:** Yes, in about the last 12 months. Can we go right to the beginning. Have you ever liaised with Medicare about their auditing methodology?

**Dr Coote:** Me personally?

**Senator ABETZ:** Or anybody in the PSR. As I understand it, it is Medicare that drops it in your lap, sort of like pass the parcel: if the music stops, you have got it and you have to deal with it. Have you ever had reservations about the methodology that throws these cases up to you, when, on investigation, you say, "The auditing methodology is not as flash as it might be"?

**Dr Coote:** It is an enormous challenge for Medicare. If I can go back to a previous role I had when I worked at the AMA in the 1990s, I was closely involved with the then Medical Director of Medicare, Dr Neros. He developed, within Medicare, artificial intelligence processes and a neural network process for trying to better refine how they searched this enormous database they have. I do not know what the number is now but—

**Senator ABETZ:** I can understand that all that is happening, but time is very short. Has PSR ever gone back to Medicare to say, "You're throwing up a few too many of these cases where, when we look at them, we find the complaint has no merit, and therefore you should look at your systems"?

**Dr Coote:** In the process, if the director dismisses case, he is required to give reasons back to Medicare. That is one point. I understand, and Luke may know better than I do, that there have been regular meetings, I think every quarter, with Medicare—certainly since the review.

**Senator ABETZ:** Yes, but do you specifically talk about the audit methodology? It is either yes or no, I would have thought.

**Dr Coote:** In my own case, I have been there two weeks and, yes, I have talked to the deputy—

**Senator ABETZ:** About the methodology?

**Dr Coote:** about the methodology—

**Senator ABETZ:** All right. Thank you.

**Dr Coote:** and I have made a separate visit to talk to the senior medical adviser.

**Senator ABETZ:** How far back to you reach in relation to a doctor's medical records?

**Dr Coote:** At Medicare?

**Senator ABETZ:** At Medicare for the purpose of the audit, which then comes to you.

**Mr Twyford:** Senator, Medicare's referral nominates a review period that constrains Professional Services Review investigations.

**Senator ABETZ:** For how long?

**Mr Twyford:** The legislation sets a maximum of two years.

**Senator ABETZ:** A maximum of two years reach-back?

**Mr Twyford:** From the day—

**Senator ABETZ:** Thank you.

**CHAIR:** Can I just clarify that they do not always specify that—is that right?

**Mr Twyford:** That is correct. It could be shorter.

**CHAIR:** Dr Ruse, you had something to say.

**Dr Ruse:** Although we are charged to only look at the services within a certain calendar period, in my experience, if it is someone that the doctor has had for a long time, we invite him—should he and his lawyer wish to, because they have the records in front of them—to go back more than two or three years to see if they can find evidence such as, 'Here's a specialist letter saying what I did was right,' or, 'Here's my summary.' I am not sure if that was the thrust of your question.

**Senator ABETZ:** No. It was about how far back the doctor's recall needed to be in relation to a particular entry, and what I am being told is two years. Is that right?

**Dr Ruse:** It is around two years—from memory.

**Senator ABETZ:** Thank you. Paragraph 31 tells us, if I am right, that 33 per cent of completed matters are dismissed. That is after the doctor has been alerted—is that correct?

**Mr Twyford:** The section 91 dismissal is—

**Senator ABETZ:** No, I am referring to paragraph 31 of your submission. We are told that 33 per cent of completed matters are dismissed as not being of concern. At what stage are they dismissed? I could not quite get—

**Mr Twyford:** That would be a section 91 dismissal, which occurs after the director of PSR has conducted their review, produced a section 89C report containing their findings and received submissions.

**Senator ABETZ:** Would that involve the doctor in any expense and loss of time?

**Mr Twyford:** Certainly they would have had to produce the medical records for the director and attend a review meeting if requested and accepted.

**Senator ABETZ:** Thank you for that. I take you to paragraph 53. In relation to your panel members, there are 92 panel members—is that right?

**Mr Twyford:** There were at that time. There are currently no panel members

**Senator ABETZ:** Sorry—there were, because we do not have any at the moment. I understand. So there were 92 panel members and it is from that panel that the peer review committees are established—or not?

**Mr Twyford:** That is correct.

**Senator ABETZ:** So we have 92 people from whom you can draw for the purposes of the three-person peer review.

**Dr Coote:** That is broadly correct, but there is provision in the act for appointments to the panel to be made at any time. So, if a particular subspecialist is referred—anecdotally, the first referral that came while I was there was from a practitioner in a subspecialty—and it does go ahead and there is a panel established, obviously peers of that practitioner will have to be appointed. So there is a dynamic process. There is no point appointing multiple people from all those 83 specialties who may never get called.

**Senator BACK:** Just as a supplement—you can either take this on notice or provide the information—how many occasions have there been when outside experts, in a sense, have been called on to be added to a panel?

**Dr Coote:** We would have to take that on notice.

**Senator BACK:** From the experience of others—perhaps Dr Ruse or Dr Radford—

**Dr Ruse:** Do you mean actually called to sit on the panel?

**Senator BACK:** Yes.

**Dr Ruse:** I would say zero.

**CHAIR:** On the panel or on the committee?

**Dr Ruse:** On the committee—sorry. Do you mean on the committee?

**Senator BACK:** Yes, on the committee reviewing somebody under review.

**Dr Ruse:** I think that was Dr Coote's point: that you have the 93 people, most of whom are experienced GPs, for the standard non-subspecialty GP. If your question was, 'Have you called a supplementary member for an actual committee with expertise?'—

**Senator BACK:** Yes.

**Dr Ruse:** The answer would be no, off the top of my head. We will take that on notice.

**Senator BACK:** So the 93 are deemed to have the expertise necessary? If you have not had to call outside expertise then presumably those amongst the 93 are deemed to have that necessary expertise.

**Dr Ruse:** To sit on that committee, yes.

**Senator ABETZ:** I think Dr Coote pre-empted this. If we have 92—I think it is 92—panel members but 83 specialty fields, that does suggest that it might be difficult to fill a full panel with people in that specialty field. If one were to assume that there are 83 out of the 92, you would have only nine people left over. So how do you constitute a full panel?

**Mr Twyford:** The 92 was at a point in time; I think it was 1 January 2010. There are comings and goings from the panel as appointments expire and new people are appointed. The guidelines recently agreed with the Australian Medical Association have included a special category or a special process for what we call 'just in time' appointments. If the director does receive a referral from a unique specialty or one of those 83 that we have not seen before then a 'just in time' appointment to the panel would be undertaken.

**Senator ABETZ:** But that is once again something of relatively recent occurrence?

**Mr Twyford:** The guidelines are a recent occurrence. The just-in-time appointment process I would assume has been used in the past.

**CHAIR:** Could you take on notice to tell us how long that process has been used and whether it was used prior to the guideline being put in place.

**Mr Twyford:** The just-in-time appointment process?

**CHAIR:** Yes.

**Mr Twyford:** Certainly.

**Senator ABETZ:** Thanks for that, Chair. Being a simpleton, if there are 83 fields and you need three people on a committee, if my maths is right one would assume you would need 249 people for three people in each specialty. Clearly you do not have that many people, so that is where I want to ascertain the extent of expertise.

**Mr Twyford:** Certainly. And can I just add that there is only really on average 13 to 15 committees established each year. That is the other quantum to take into account.

**Dr Coote:** Not to confuse the issue too much, but there is a separate provision in the act for the director to appoint a consultant in a specialty area on an occasion, say, when an optometrist is referred.

**Senator ABETZ:** We know there is that provision. We want to know whether the director found within himself that his expertise was not sufficient to avail himself of that opportunity. In relation to paragraphs 133 and 134, there are training sessions and we are told that panel members and deputy directors are expected to attend training sessions. It appears that it is not of a necessity; it is not mandatory, but it is just expected of them but it is not enforced. Is that correct?

**Mr Twyford:** I am unaware of the last training session. I was not at the agency at the time. Those paragraphs are referring to an annual training process. PSR administrative staff or the case secretariat run on-the-day training at pre-hearings prior to each hearing. So, any member who sits on a committee will have received that training prior to—

**Senator ABETZ:** Some training, but not that other training?

**Mr Twyford:** I could not answer that.

**Senator ABETZ:** There has been no commentary in your opening submission about some of the court cases that have made findings about the PSR that have seen the whole panel system being taken apart, if I can use that term, and put you in a state of flux. Do you have any observations to make about those court findings?

**Mr Twyford:** The Kutlu matter is currently before the courts. They have special leave for appeal. That is being managed by the Department of Health and Ageing on behalf of the Commonwealth. I would assume that they could answer.

**Senator ABETZ:** And, is it Tisdall?

**Mr Twyford:** Tisdall.

**Senator ABETZ:** Do you have any observations to make on that case.

**Mr Twyford:** PSR has accepted the findings of the court in that matter. We will be looking at future 80/20 matters and how we provide correct training to committee members and the level of detail they put into their reports in relation to their reasoning.

**CHAIR:** We have some more questions. You are obviously an important witness to the inquiry, so, with your concurrence, I intend to go to 3.30 with you.

**Unidentified speaker:** Yes.

**CHAIR:** We are supposed to go to 3.15, but as you can see there is a lot of interest and there are a lot of questions to ask.

**Senator BACK:** Dr Radford, I think you told us in your evidence that you had been the deputy director of PSR in Victoria prior to your current position. From the Victorian experience—perhaps you could guide me with the words, because when Dr Coote spoke earlier there was reference to the term 'guilt' et cetera—could you tell us the term you would prefer us to use that relates to somebody who has been found in default or whatever of the process once they are a person under review. What term would you prefer us to use?

**Dr Radford:** We always preferred that the strict wording of the act be used: 'The matter which the committee inquires about is inappropriate behaviour with respect to the provision of Medicare benefits.' I may not be quoting exactly. It is an inquiry into that—no charge.

**Senator BACK:** In relation to your time as deputy director, what proportion of cases were actually found to be inappropriate under the act, or what proportion were found to be not inappropriate?

**Dr Radford:** I would not be able to tell you that. All I can say is that there were a significant number where the committee found that there was no inappropriate behaviour, and I still see reports that say there is no inappropriate behaviour, or a very small amount. But I could not give figures.

**Dr Ruse:** I know my figures: 20 per cent of the committees I chaired ended with a finding of 'no inappropriate practice'.

**Senator BACK:** So 80 per cent inappropriate.

**Dr Ruse:** Eighty per cent were found to be inappropriate.

**Mr Twyford:** Since 1994, 27 committee matters have made a finding of 'no inappropriate practice'.

**CHAIR:** Out of how many?

**Mr Twyford:** A total of 177. It equates to about 15 per cent.

**CHAIR:** So 27 out of 177 have been found to be 'no inappropriate practice'.

**Senator BACK:** And 85 per cent have. In terms of the determining authority, I think you mentioned earlier in your opening evidence that it is the minister who appoints the chair of that position. Is there a staff who report to you?

**Dr Radford:** The act provides that the director of PSR has to furnish us with administrative services.

**Senator BACK:** Are they PSR staff or staff who report directly to the authority?

**Dr Radford:** They are PSR staff, but they are separate from other staff in PSR. For the exact fine details of administrative services I would have to ask Mr Twyford. But we have always understood and believe, and it is our experience and it is in the act, that our services must be separate. Also, staff who have acted on a matter that comes before us must not act as our support staff.

**Senator BACK:** In terms of independence and objectivity, from the perceptions of the wider community, are the staff physically located in the same building, Mr Twyford.

**Mr Twyford:** That is correct. There are currently—

**Senator BACK:** You would interact with each other on a day-to-day basis?

**Mr Twyford:** That is correct. There are currently 29 administrative staff reporting to me.

**Senator BACK:** How do you satisfy Dr Radford, as the chairman of the independent Determining Authority, of the fact that there would be no communication between the two parties: the PSR staff and the staff who undertake Dr Radford's work?

**Mr Twyford:** I do not understand what you mean.

**Senator BACK:** The Determining Authority process is independent, presumably, of the PSR process. It falls then to Dr Radford to consider matters raised by the director of PSR. I am trying to come to an understanding

from you as to the arm's length independence and lack of communication and discussion over the coffee table of matters that will ultimately be determined by Dr Radford.

**Mr Twyford:** I think Dr Radford would say in answer to that that he and the Determining Authority base their decisions on the reports of the committees. Those reports are sent from the committee secretariat to the Determining Authority secretariat. Once they reach the Determining Authority secretariat they are stored in secure, restricted-access files and folders in their electronic records management system. But in terms of staff members talking to each other at lunch time, that certainly occurs.

**Senator BACK:** Dr Radford, to whom do you report in your capacity as the chairman? Do you report back to the minister or do you report to the director of PSR?

**Dr Radford:** I do not know that I report to anyone, except perhaps the minister in the sense that I can be dismissed for certain types of misconduct or if I become bankrupt. But we certainly furnish a report that goes into the PSR report. I think that is true.

**Senator BACK:** Certainly. So agreements from the committee level, as I understand it, are sent to you from the director?

**Dr Radford:** No, not agreements from the committee level. Section 92 agreements come from the director. They have not gone to a committee.

**Senator BACK:** Okay, thank you for clarifying that. In the time that you have been the chairman, how many times, if at all, have you overruled the director on an agreement he may have reached with a doctor?

**Dr Radford:** Rarely. I think there have been two or three.

**Senator BACK:** I think one of you was speaking about doctors who may be disqualified for periods of time or have their right to prescribe suspended. Would those agreements come to you for independent verification or determination?

**Dr Radford:** If the section 92 agreement contains an agreement that the practitioner will be disqualified in some circumstances—not necessarily totally disqualified—

**Senator BACK:** No, I understand that.

**Dr Radford:** just disqualified from some particular services—then, yes, he or she would be disqualified.

**Senator BACK:** In your role as chairman of the independent Determining Authority, have you ever had occasion to overrule the director's agreement with a doctor?

**Dr Radford:** Yes, as I said before in response to your previous question, there have been two or three. But we cannot remake the agreement. We either ratify it or reject it. It is as simple as that.

**Senator BACK:** I may have to put other questions on notice. Dr Ruse, we heard evidence earlier in the day about a process by which a doctor attempted to find information, especially related to descriptors. I think the description given to us was that they had approached Medicare and Medicare said 'no, we won't tell you'; they went to the AMA and the AMA said 'we're not able to'; so they went to the PSR. The way it was put to us, it was almost like asking, 'What are the speed limits?' and being told, 'We won't tell you.' 'I want to know do they change?' 'I won't tell you that.' 'I want to know how you determine that I'm speeding.' 'Not going to tell you that.' And so on. Dr Ruse, is that an accurate description? It seems to me as somebody sitting on this side of the table that it is almost setting somebody up to fail, and I am sure legislation and practice would not be directed at that.

**Dr Ruse:** I am not there when they ring Medicare, so I am not aware of the nature of their query. There are two sorts of descriptor. The old-fashioned one was delivery of a professional service as a physician, as a general practitioner, in which the doctor was trusted to do his medical job properly and deliver the goods. As the system evolved, Medicare, under pressure from the organised profession, began to come up with descriptors which were more for management plans of various sorts. And, in this, after the medical job had been done, the rebate included payment for or was just for the payment of the delivery of a plan that had been laid down: 'These are the components which must be seen.' I think that a lot of these calls to Medicare asking for elucidation are less a case of, 'I've just seen Warwick Ruse with a sore toe, but he took a long time to tell me, "Can I be a 23 or a 36?"' and more, 'Can the practice nurse do this and this before I write things into a plan.' It is for these more complicated management plans rather than for the old-fashioned, bread-and-butter patient to doctor consultation.

**Senator BACK:** Thank you.

**CHAIR:** Senator Adams.

**Senator ADAMS:** What percentage of doctors under review go to the director and what percentage go to the committee? Do you have a breakdown of that? Do doctors prefer to go straight to the director and do whatever they have to do, or do they opt to go on to the committee?

**Mr Twyford:** Perhaps it is worth noting the step before that, which is Medicare Australia's Practitioner Review Program. If you point questions to them about that, I think they will tell you that they consider around 200 to 400 practitioners as part of that program each year. Fifty are referred out of that program to the director. So all 50 referrals to PSR come to the director—I am talking broadly, in terms of averages across the years. We then find that the cases for between 30 and 33 per cent of practitioners are dismissed by the director; he or she looks at the medical records and determines that there is no case to answer. The remaining two-thirds have the opportunity to negotiate an agreement, and, if an agreement cannot be reached, they are then referred to a committee of peers. Recent statistics show that it is somewhere around a 30-30 split. So for a third there is no further action; a third, section 92 agreements; and a third, referred to a committee—although there are some fluctuations, and occasionally the section 92s can range up to 50 per cent.

**Senator ADAMS:** Thank you for that. I am interested in overseas trained doctors, once they have their provider number. Could you tell me what percentage they make up of those doctors that come before you or are doctors under review.

**Dr Coote:** I do not have that figure off the top of my head, but we can certainly—

**Senator ADAMS:** Could you take that on notice. I am very interested.

**Dr Coote:** So the percentage of the total number referred who are overseas trained doctors.

**Senator ADAMS:** Overseas trained doctors who have gone through what they have to do to get their provider number. I am really looking at it from a rural perspective once again. My last question is, of course, on rural. I will ask Mr Twyford: how many qualified GPs that have really done a lot of practice in a rural area or an Aboriginal medical service are on your list of committee panel people? I know you have not got one at the moment.

**Mr Twyford:** That is a difficult question. We do not currently have a panel.

**Senator ADAMS:** On the old one, did you cater for anyone that would have come from either of those areas?

**Mr Twyford:** I am not sure if we would have kept a record or a statistic on how they identified themselves. We could potentially give you the postcode for each panel member and do an analysis.

**Senator ADAMS:** What I am looking at, really, is the expertise. We have been told that these panels have experts—and Senator Abetz said there are 83 or whatever—from each specialty. Being a GP in a rural area now is becoming a specialty, and, with the way the new health reforms are going—I have been on about this all day with Medicare Locals and primary health care, plus the Aboriginal medical services—I really would like to know: in the past, have you had people on these expert panels that could deal with it?

**Mr Twyford:** I do not have the data; we can get that for you. But I do know anecdotally that you have received submissions from Dr Bruce Harris from Dubbo and Dr Ingham from Daylesford, both of whom praise the scheme. They have acted on committees; they have been committee members. That is just anecdotal, but we will see what we can find in our data.

**Senator ADAMS:** Coming from Western Australia, it is a little bit different. Dr Harris comes from Dubbo. I am looking at somebody from the Kimberley—that area—where you have Aboriginal medical services, and in the Northern Territory as well. Dr Ruse might be able to help me: who do we have in WA that was on the committee as a nominee?

**CHAIR:** I am really worried about time.

**Senator ADAMS:** Yes, I know.

**CHAIR:** Could we take it on notice. I am not saying it is not an important issue but, Dr Ruse, can you keep your comment very short, because I still have Senator McKenzie to ask some questions.

**Dr Ruse:** There is one: Dr Ralph Chapman from Narrogin is on the panel.

**Senator ADAMS:** Ralph is living in Perth.

**Dr Ruse:** But he was—

**Senator ADAMS:** He was my doctor.

**Dr Ruse:** We need to look at the mechanics of underdoctored practices then providing someone from the Kimberley to come down to Perth for a hearing. It is four or five days plus travel time. It is important to have representative peers, but remember they are volunteers. If we want to go into the Athenian compulsory jury

argument, I am happy to do it. But, as I say in my submission, these people are willing horses and you can only push them so far, particularly if their first loyalty, as is right, is to their rather isolated rural practice.

**CHAIR:** Okay, but we still want the numbers on notice if possible, please.

**Senator McKENZIE:** Given the time and our already extended thing, I might put my questions on notice. You make comments about the consultative approach about the descriptors and how they are developed and the item numbers. I wanted to know about the educative process around the descriptors and whether, with the 50 that end up with you at the end of the day, what role a lack of educative processes or the feed-in in the development of the item numbers and the descriptors plays in the number of people that are ending up at the PSR. I will put that on notice. I guess this is the one I would like you to answer. We have had some evidence that there has been an increase over the last five years in auditing or the vigorousness, I guess, of the auditing. I just wanted your comments on that and what you think the primary drivers of that increase might be.

**Dr Coote:** Are you referring to numbers of practitioners referred from Medicare to PSR? That number does fluctuate; there was one year when it shot up to over 100.

**Senator ADAMS:** It was 2001.

**Dr Coote:** But it has, on average, been around 40 to 50 per annum.

**Senator McKENZIE:** Yes, that is the average. However, I think the average over the last five years is significantly higher than in any other five-year period previously.

**Dr Ruse:** But the number of doctors in practice is steadily going up.

**Senator McKENZIE:** So as a relative proportion it is the same?

**Dr Ruse:** Even if it is the same proportion, one would presume that they would creep up. Presumably these questions should really be referred to Medicare.

**Senator McKENZIE:** I am just asking for your opinion. You have been in the game a while; you might have an opinion about it. With the pap smears—

**Dr Ruse:** The hypothetical pap smears.

**Senator McKENZIE:** The hypothetical pap smears. At a rural practice where there is one female GP in town—it is not identified as a women's clinic; it is the only clinic—that female GP would have every girl in town lining up for her pap smear.

**CHAIR:** Hopefully.

**Senator McKENZIE:** Hopefully, if we have done our education properly. At what point of the eight steps you outlined, Dr Coote, that people have to go through before they end up going through would she be identified and okayed?

**Dr Coote:** I would hope that the Medicare processes are sophisticated enough that, if they do get audited, it would be dealt with in Medicare's own process. The medical advisers do go out. Can I just make one final point. It goes back to that.

**CHAIR:** I have two follow-up things that I think you will need to take on notice, so it may not be your final point, but go for it.

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

**Senator ABETZ:** Am I allowed a supplementary on that?

**CHAIR:** Yes.

**Senator ABETZ:** Thank you very much. It was what Senator Back wanted to ask as well. We had Professor Brazenor this morning. He said he sat in with a mate, and he is a specialist in an area. He thought that the CT scans that were ordered were all proper and all right, but the finding was against the GP. Do you want to offer a comment on that?

**Dr Ruse:** I was not there. These things are all secret.

**Mr Twyford:** I will just add something to that. It was a bit unclear whether that was a result by way of section 92 or by an actual peer review committee. I think the comments suggested that it was the director that made a finding.

**Senator BACK:** No, it was not, if I can correct that. He actually sat there with his associate just giving him support before a committee. But he is a neurosurgeon—that is his frustration. He was uniquely able to observe whether his colleague had done the right thing. He believed he had, and the committee said, 'No, you are in error; you are at fault.' That was his frustration. That is why he came.

**Dr Coote:** I simply do not know anything about that particular case.

**CHAIR:** Could you look at that particular piece of evidence. Could you take that on notice to look at it and give us a response, please. I appreciate that you were not here.

**Dr Ruse:** Can I just make a brief point about expert pieces of paper that are then sent, usually after a draft report. When I am trying to weigh them up I do not know what question the expert was asked—because I have been reviewing my notes—but often they are not related to the actual problem we saw in the practice. This is anecdotal. So, to say that I had expert evidence that was rejected, there is reference, for instance, in one of the submissions to a test—I am not sure what it was; it may have been cardiologic—in which three experts said the test was properly performed, which is important, but the committee may have been looking at what the reasons were for properly performing it. Was it on grounds that other members of the sub-specialty would have thought, 'Well, let's wait'? I will just drop that into the mix.

**CHAIR:** We are over time, so could I ask you to keep your comment brief.

**Dr Radford:** I thought you would like to hear a short comment on the matter of the review tribunal. There used to be the Professional Services Review Tribunal, which was two medical practitioners chaired by a retired judge. It was a merits review that in effect rendered the whole matter re-heard in a very legal environment. It was felt, in the report of 1999, that that had turned out not to be a good thing. It was much better to refer it back to a committee composed of peers, and, although the right to appeal to the Federal Court on matters of law should be retained, it was far better and produced a more equitable and rapid outcome for the practitioner to make it a final peer review scheme. If people want to, as Avant submitted, reinstitute a review tribunal I think they have to remember the words of Hillaire Belloc: '... always keep a-hold of nurse for fear of finding something worse.'

**Senator ABETZ:** Possibly that happened in 1999!

**CHAIR:** I have two questions for you to take on notice. When we were talking about calling experts you, Dr Coote, made a comment about calling consultants. Is that something different from an expert, or are we using two words for the same thing.

**Dr Coote:** They are the same thing.

**CHAIR:** Dr Ruse, in answer to your question to Senator Back, I am still not convinced of the argument, or maybe I did not follow it, in terms of the comment made to us, both in submissions and this morning, that people who come before the committee—and I will not use the word 'charges'—as I understand it do not know what the issue is. Could you take on notice a request for a further explanation about what the circumstances are where somebody cannot be told earlier about what the specific issues are. I accept that you are saying they are not charges, but there are obviously issues that have brought them before the committee. Why is it they cannot be told earlier? Please take that on notice.

**Dr Ruse:** Absolutely.

**CHAIR:** Thank you for your evidence. We have gone over time because you are key witnesses and we had a lot of questions. We have given you a lot of question on notice. If we could have those back by next Thursday that would be appreciated.

**Proceedings suspended from 15:38 to 15:46**

**BARTLETT, Mr Richard, First Assistant Secretary, Medical Benefits Division, Department of Health and Ageing**

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

**REID, Mr Chris, General Counsel, Department of Health and Ageing**

**SHAKESPEARE, Ms Penny, Assistant Secretary, Benefits Branch, Department of Health and Ageing**

**CHAIR:** I welcome representatives and officers from the Department of Health and Ageing. You are already aware of information on parliamentary privilege and the protection of witnesses and evidence. As departmental officers you will not be asked to give opinions on matters of policy, though this does not preclude us asking you for explanations of policies or factual questions about when and how policies were adopted. I invite you to make an opening statement and then we will ask you some questions.

**Mr Learmonth:** Thank you for allowing an opening statement. The PSR considers the Medical Benefits Scheme and the Pharmaceutical Benefits Scheme, which are an integral component of our healthcare system. They are designed to ensure that all Australians have access to affordable medicines and treatment by eligible medical practitioners. These patient benefits are funded by Australian taxpayers. In 2010-11, these schemes together provided just under \$25 billion in combined patient assistance. The PSR scheme is an essential part of the regulatory framework established under legislation to protect the integrity of the MBS and the PBS. Under section 79A of the Health Insurance Act, the objectives of the PSR are to:

- (a) protect patients and the community in general from the risks associated with inappropriate practice; and
- (b) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

This ensures that the community is not exposed to inappropriate medical treatment and that taxpayer funding is directed to genuinely necessary and clinically effective treatment.

The PSR scheme is based on a concept of peer review, which involves review of a practitioner's services by a committee comprising the practitioner's peers to determine whether the provision of services by the practitioner would be considered clinically relevant and appropriate to the general body of members of that profession. The scheme commenced in 1994 and has evolved through judicial interpretation and legislative amendments to better achieve public protection while maintaining procedural fairness.

Judging by some of the submissions that you have had to the inquiry, there appears to be some confusion about the respective roles of this department versus the Department of Human Services and Medicare and the PSR. I will try to clarify that. The department's role is to provide policy advice to the Minister for Health and Ageing on the development and maintenance of the PSR scheme. The department is also responsible for legislation development in relation to the PSR scheme. The Department of Human Services, under which Medicare operates, is responsible for compliance activity relating to MBS and PBS. This includes audits of services billed to Medicare by doctors and analysis of claims data to detect unusual or unexpected claiming patterns.

Following this compliance activity, the chief executive officer of Medicare Australia—now the Medicare chief executive in the new Department of Human Services—may request the director of the PSR agency to review the provision of services by a person in order to assess whether that person engaged in inappropriate practice. Any queries about the Medicare or compliance activity conducted by Medicare will need to be put to the Department of Human Services. The PSR is a separate statutory agency that administers the PSR Scheme, and its working includes providing support to the director in reviewing referrals from the Department of Human Services; and establishing and providing secretariat work to the peer review committees and determining authorities.

I acknowledge that there have been some concerns about PSR processes and, to that end, the department together with the Australian Medical Association have had discussions over time to the PSR director and the agency. We have sought to address these issues with the PSR directly and through the PSR Advisory Committee, which includes the Australian Medical Association and the Department of Human Services. That advisory committee is providing advice on the PSR's operations to ensure that peer review arrangements operate effectively into the future and to provide a forum for that stakeholder discussion. That advisory committee is currently considering new processes and procedures to enhance the transparency and processes of the PSR. Thank you, I will leave it at that.

**Senator ABETZ:** Can I take you section 5 of your submission, headed 'Current Issues.' When did this current liaison start? We are told that the department has provided advice to the PSR about improvements. When did that start?

**Mr Bartlett:** In terms of the current issues?

**Senator ABETZ:** Yes.

**Mr Bartlett:** As the AMA said this morning, we had the first meeting of the reformed PSR Advisory Committee in about August or September of last year.

**Senator ABETZ:** What brought that about?

**Mr Bartlett:** There had been over previous months a degree of media coverage about concerns about the PSR. We had had various comments made by a range of people. We felt it was appropriate to have some discussions and see whether there were issues that needed to be dealt with.

**Senator ABETZ:** Good. Peppered throughout section 5, we are told the department has worked an MOU, that you are liaising with a stack of people, you are finalising an open and transparent merit based recruitment process—all these initiatives that we are talking about all arise from that which you have just described: the concerns that were expressed around this time last year.

**Mr Bartlett:** It was a combination of that and concerns about the appointment process that obviously have been tested in court cases. The memorandum of understanding is fundamentally there to ensure that appointments to the PSR panel and therefore committees work within the legislative requirements but it was also an opportunity to assess and look at other concerns that had been raised by people, again to try and deal with perceptions. I am sure that the perception of the PSR was one that was seen as appropriate.

**Senator ABETZ:** Thank you for that. The MOU to which you refer in 5.2, whose initiative or idea was that?

**Mr Bartlett:** I think that was an idea from within the department. Again it is about trying to ensure that we have got embodied the agreement between the minister and the AMA that is required under the legislation.

**Senator ABETZ:** Are you able to take on notice for us when work on that first started and let us know? In relation to perceptions that you just referred to, Mr Bartlett, I note on the bottom of page 5, the department sees this as also essential referring to a few other matters like panel member appointments 'to restore the confidence of the profession in the PSR Scheme'. I assume by that that the department is accepting that the profession does not necessarily have the degree of confidence in the PSR that the department would like.

**Mr Bartlett:** I think it is fair to say, as the AMA said this morning, that there are a range of issues that have caused various people within the medical profession to express concerns about PSR. Some of them can be addressed; some of them cannot. Again, to the extent that we can ensure that there is a positive perception of the PSR within the medical profession, we are keen to do so.

**Senator ABETZ:** Of course it is not only perceptions because, if you thought that these matters were all ill-founded, one assumes you would not be going to all this work.

**Mr Bartlett:** If you have a process like PSR, it is important that there is a perception of procedural fairness and natural justice. If you look at a lot of the work that is being done, it is about ensuring that the capacity for people to have perceptions that is not afforded to people under review is minimised.

**Senator ABETZ:** We can argue about that, but one would imagine that a lot of the things that you are working on are about not only perceptions but also dealing with issues that have been accepted as being in need of some change.

**Mr Bartlett:** The difficulty that I have in answering these questions is the department has responsibility for PSR and we deal with PSR and others in terms of ensuring that there is confidence in the PSR arrangements and the policy is appropriately set. Again, I have to talk in terms of perception because I have no evidence one way or the other.

**Mr Learmonth:** The work around the advisory committee and so on is really about facilitating an opportunity for the profession, as represented by the Australian Medical Association, to put forward what views they had about how the practice might be improved. Continuous improvement and feedback from stakeholders are important things. The committee served its purpose well in terms of generating views from the AMA and discussions with the PSR as to how it is procedures and processes might be improved. I think that is a worthy objective.

**Senator ABETZ:** For example, page 6 of your submission says, 'The department is finalising an open and transparent merit-based recruitment process.' I congratulate you on that initiative, but one would be forgiven, would one not, for thinking that the department in doing this is accepting that the recruitment process may not necessarily have been as open, transparent and merit-based as it possibly should have been?

**Mr Bartlett:** As to appointment process for the PSR director where that is made, when an appointment process has gone through, as opposed to a decision to reappoint, it is always done under the principles that have been outlined. That is what has been done on this occasion.

**Senator ABETZ:** So why are we 'finalising an open and transparent merit-based recruitment' processes if they have always been in place anyway—in other words, we are not changing anything?

**Mr Bartlett:** The director is appointed on fairly rare occasions. We are saying that one of the changes that is happening at the moment is a new director is coming in and an appointment process for that new director has been finalised and it has been done under the principles that apply to recruitment processes.

**Senator ABETZ:** That apply? So you are not finalising anything?

**Mr Bartlett:** Sorry?

**Senator ABETZ:** So all these things are in place? Therefore, you are not finalising anything because they have been finalised, according to your evidence.

**Mr Bartlett:** We said that we are finalising a recruitment process for a new director.

**Senator ABETZ:** No; you said you are 'finalising an open and transparent merit-based recruitment process.'

**Mr Bartlett:** For the new director.

**Senator ABETZ:** Yes.

**CHAIR:** So what you are saying is that you used that last time. Is that the point you are making?

**Mr Bartlett:** When we go through a selection process.

**Mr Learmonth:** We rely on the processes—

**Senator ABETZ:** Thank you for that clarification—because this, unfortunately, is the sort of spin that misleads even 17 veteran senators.

**CHAIR:** Can we keep the editorial out of it, please?

**Senator ABETZ:** Why didn't you just say that the department is finalising the recruitment process for a new director? Why did you add the words 'an open and transparent merit-based recruitment process'? I read that to mean that you were finalising a new system to appoint; whereas now what you are telling us is that it is business as usual—which, if that is the case, concerns me.

**Mr Bartlett:** The submission outlines the process under which the recruitment takes place and the principles that it follows.

**Senator ABETZ:** Last but not least, in the very last line you tell us:

The report of the review is expected in October 2011.

That is the one from PricewaterhouseCoopers. To your knowledge, is that still on track to be with the department at that time?

**Mr Bartlett:** At this stage, yes.

**Senator ADAMS:** Do you think that that review might be available for us for estimates?

**Mr Bartlett:** At this stage, I am not sure.

**Mr Learmonth:** It is not actually entirely within our hands. It depends on whether the job is done appropriately and completed on time.

**Senator ADAMS:** I do not have my budget papers here, but can I ask what the budget is for PSR?

**Mr Bartlett:** I think I will have to take that on notice.

**Senator MOORE:** I have another question on that. It is just a standard money question. There have been allegations made about the salary being paid to the director of the PSR. Can we get something on record about how that salary is determined, whether it is in line with other things and where it is published?

**Mr Learmonth:** My guess is it is the Remuneration Tribunal. It would be published in the annual report. We will confirm that for you on notice.

**Senator ADAMS:** The number of professions is being widened and I use the midwives and nurse practitioners as examples. I note that the advisory committee has representatives from the department, the AMA, PSR and the Department of Human Services. Is there any way that the guidelines may be expanded to include other professions rather than just staying with the medical side of it? With the new health reforms, the Medicare Locals and the accent on primary health care, I think things are starting to change in that direction. Would it not be advisable to have people from other areas so that you are going to get a more balanced advisory committee?

**Mr Bartlett:** The committee reflects the preponderance of people who are appearing before the PSR. As that evolves, we will obviously look to include representatives from other groups. That is certainly something that has been on the agenda. At this stage, people appearing before committees continue to be overwhelmingly medical.

**Mr Learmonth:** I cannot recall that there has been a referral of an allied health person.

**Mr Bartlett:** I think there have been seven optometrists in the time the scheme has been running and that is it other than medical. In that sense, I think you make a very valid point, but at this stage inviting a series of other representatives, given that they have no exposure to PSR, is probably not appropriate. It may well become appropriate in future as that evolves.

**Senator ADAMS:** Are they consulted in any way by any of the members of the advisory committee as to issues or the way they are represented? At the moment they are not.

**Mr Bartlett:** The provision in the legislation is that, if somebody from a particular treatment group is to appear before PSR, the peer review committee that will deal with their case will have a deputy director from the same group and two panel members from the same group.

**Senator ADAMS:** They definitely will? We have been trying to get to the bottom of this.

**Mr Bartlett:** That is what the legislation prescribes—sorry, I have just been told the deputy director does not have to be. I read the legislation this morning and I read it as saying it does. We will confirm that in writing. We do not want to mislead you.

**Senator ADAMS:** I was thinking that is news to me too.

**Mr Bartlett:** As I said, I read the legislation this morning and the legislation says that the deputy director will be from the group concerned and the minister will consult with a representative body from the group concerned in terms of appointing people to the panel. We will confirm that in writing though.

**Senator ADAMS:** We have just been told in evidence today there are 83 different specialities. With those 83 groups, how are you going to get a deputy director from one of those specialities? That is just the medical specialities without all the others that are there now.

**Mr Bartlett:** You are asking us a question that really comes down to PSR processes. I think Mr Twyford covered that in his evidence in terms of adjusting time processes. I do not really have anything to add to that.

**Senator McKENZIE:** I do have a question about consulting. Is it just the AMA? Do you consult with the Australian Doctors Union or the consumer groups in drafting item numbers or in these matters?

**Mr Bartlett:** As the AMA indicated this morning, we have got a longstanding practice in terms of items. They either go through the Medical Services Advisory Committee, which is made up of medical clinical experts, who will make recommendations about items, among other things. As Mr Learmonth has quite rightly reminded me, that also includes a consumer representative. Now all new items will go through that process and get that consideration. Prior to that a number of items, mainly in the procedural/technology/diagnostics area, went through that process. The remaining items went through the Medicare Benefits Consultative Committee that, as Dr Hambleton pointed out this morning, was chaired by the AMA, and again that was the process by which a fee and a descriptor were negotiated. The MBS has always had high levels of clinical input into the descriptors of the various items and that will continue to be the case.

**Senator BACK:** I understand that the committee process is currently suspended. Can you explain to us how it is operating administratively at the moment without committee members or without a panel from which committee members can be formed?

**Mr Bartlett:** Senator, you are really asking about PSR operational processes, which is a PSR question. I can tell you what the PSR can do legislatively in its current circumstances without a panel.

**Senator BACK:** But it is the case that the panel has been discontinued, isn't it?

**Mr Learmonth:** There is no panel.

**Senator BACK:** In terms of 5.4, what is the role of the department, if any, in the selection of panels from which committees are formed? Is that a departmental role?

**Mr Bartlett:** Traditionally the department has had no role in the selection of panels or panel members.

**Mr Learmonth:** It is a matter for the PSR.

**Senator BACK:** The PSR director has total responsibility. I only have one other question, and it is a hypothetical, Mr Learmonth, but I hope you can assist me.

**Mr Learmonth:** That gives me an easy answer, Senator!

**Senator BACK:** Very good. Let me take the hypothetical case of a person who is a specialist. They come before the panel, the committee, and they are found to have acted inappropriately. A circumstance occurs in which general practitioners find it more risk averse to not refer patients to this hypothetical specialist for fear of

perhaps having attention drawn to themselves. Is it within your remit to be able to tell me who that hypothetical specialist might appeal to? Would they appeal to the PSR director, from whom they probably feel aggrieved anyhow; the independent determining authority, who, whilst independent, seems to have some links to the PSR director; to the department; to the minister? To whom would that person be able to appeal?

**Mr Learmonth:** Appeal what, Senator? The findings of a panel?

**Senator BACK:** What they might perceive to be an injustice that has been rendered upon them.

**CHAIR:** You mean the finding of inappropriate behaviour.

**Mr Learmonth:** It would appear the Federal Court is at least one option to them, Senator, but beyond that—

**Mr Bartlett:** Senator, I would have to say your question is very hypothetical. We have no evidence that a specialist who has been through PSR has the referral behaviour of GPs who traditionally use that person changing. So it is a very difficult question to answer.

**Senator BACK:** Would it be to the department that that information might come? I am not trying to trick you; I am just trying to get a handle on it.

**Mr Learmonth:** There are a few different tracks here, if someone is dissatisfied with the system. It is always open to them to make representations to the agency that has aggrieved them in some fashion, in which case that would be to the PSR and, depending on where it was in the process, one would imagine, to the director. Legal action is always open to people if they feel aggrieved. Of course, the department always receives and, where appropriate, acts on information that someone may wish to provide, not because we necessarily have a legislative or operational responsibility to do something—we do not—but we are interested, from a policy perspective, to understand what is actually happening in the system. And to the extent that the information we receive is actually indicative or leads us to believe that there is an issue going on here, then we are able to raise it in a policy sense—not in a specific redress sense but in a policy sense as to what is happening within the agency—and to perhaps bring it up at the advisory committee.

**Senator BACK:** I appreciate your advice. Thank you.

**Senator MOORE:** In terms of the PSR processes, the person in the determining authority, the third person on that panel, is someone from outside the profession who is appointed directly by the minister. Can you, as a department, indicate the process that is used to determine those people?

**Mr Bartlett:** Essentially, a minute is sent from the PSR—and I am telling of the processes that have worked up to now—and it is a PSR matter: it is a PSR appointment or it has been managed by the PSR in the past.

**Senator MOORE:** I actually kept it to ask the department because it is a ministerial appointment.

**Mr Bartlett:** All panel appointments are also ministerial appointments. I guess I am telling you who manages the appointments.

**Senator MOORE:** We will put it on notice.

**Mr Learmonth:** The interaction is between PSR and the minister.

**Senator MOORE:** My next question is on the process in terms of information about the items. We have heard discussion about how the items are developed. We have heard a lot of evidence about people not being able to get effective advice—that practitioners are not able to get effective advice about how Medicare items operate. We know that these things are evolving as well, but, at the current time, if a practitioner wants to get advice about the operation of a Medicare item, to whom do they turn?

**Mr Bartlett:** There is a range of people who provide advice. There are people within the department, there are people within Medicare Australia—

**Senator MOORE:** I am wanting the whole lot, Mr Bartlett. Is it better to put on notice? And is it best for it to come through you?

**Mr Bartlett:** There is a fair amount of it that should be on notice, but I would also have to say to you that there will not be definitive advice provided because at some point it is the interaction of a couple of things. One of the requirements for a Medicare service to be delivered is that it has to be clinically relevant. To determine whether a particular service is clinically relevant, the person providing the advice would need to have all the information about the service that is being provided and the patient to whom it is being provided. One of the troubles that we have with this is that a number of the people who are asking for definitive advice are, in effect, saying, 'Please second-guess me about my patient and what I have done, and give me a certainty that I will not be found to have done the wrong thing,' and, without all of that information, that is impossible, which is why PSR is

there—it is a system of peer review that is, in effect, designed to actually be able to do that. But we cannot do that in terms of providing advice and give people a definitive answer on every use of every item; it is just not possible.

**Senator MOORE:** What we have been told in evidence, on record, is that people have been told to go away—it is no-one's job to give advice. So, in response to that evidence, which has been put on the record here, I am wanting to find out from the department about access to advice, allowing for the fact, which I have already clarified with previous witnesses, that there is no such thing as a determining advice. For instance, on the new care plans and the extended time people have in terms of providing service: that is a relatively new provision that practitioners can use. There is concern about longer times and how that is actually monitored. I think that was the one they actually mentioned, but certainly in submissions we have heard that there was correspondence around the issues around extended care plans. Where would a practitioner, in good faith wanting to know, get some guidelines, some information, some advice about how you can monitor that, and, most importantly, what kind of records need to be kept, because there has been a great deal of evidence to the inquiry about questions about quality of evidence. I take the point that people need to have ownership of their own practice. I do not think that needs to be tested through a judicial process, which I see the PSR as being in many ways, though it is peer-group. I think there should be enough information around before you get to the stage of being assessed in that way. If you breach guidelines in that way, so be it. But as a practitioner there should be processes for information, and that is what I am wanting to find out. So do they call health? Do they call the PSR? Do they call Medicare? Who do they call?

**Mr Learmonth:** Mr Bartlett will add to this something we all notice as well, but they can certainly call health and they can certainly call Medicare. If people have been told to go away by any of those agencies I would love to know of the examples so I can follow them up.

**CHAIR:** There are some in evidence.

**Mr Learmonth:** I will be going back to have a look at them.

**Senator MOORE:** That would be good.

**Mr Learmonth:** That advice and information is available. As I think Mr Bartlett said, there are other aspects at play here and we rehearsed some of these when we previously talked about the compliance bill that was going through in terms of the responsibility of practitioners to keep such records as will satisfy claims—in particular, their professional obligations in respect of maintaining a patient record which is able to sustain clinical management of that patient. That is separate. It is not something that is prescribed by us, but there is perfectly reasonable information which is available from a number of sources.

**Senator MOORE:** The other area that I want to touch on—and I think it is a policy one to an extent—is the process around concerns about how people are actually selected for PSR referral. I know it is a Medicare item and Medicare do the investigations but I am wondering about the policy aspects around that.

**Mr Learmonth:** Compliance is a matter for Medicare Australia.

**Senator MOORE:** The whole compliance process?

**Mr Learmonth:** They own strategic compliance, I think it is called.

**CHAIR:** Sorry, what was that?

**Senator MOORE:** Strategic compliance, which is a new term.

**Mr Learmonth:** Strategic compliance is what they call it. They have responsibility for the compliance function.

**Senator MOORE:** My other question is to do with the general issue of appropriate places for referral. We have had a number of people talking about the role of AHPRA in the new process. There have been a couple of suggestions that, if someone's performance as a medical practitioner is called into question for any reason, AHPRA is the appropriate place for clinical assessment of someone's performance as opposed to adherence to Medicare guidelines. Has there been any discussion in the department about the development of AHPRA in that area?

**Mr Bartlett:** In the evidence of the PSR I think Dr Coote walked through that. I would reiterate what he said. A lot of what is done there is about ensuring the integrity of the MBS and that system, whereas AHPRA and the medical boards are there to ensure people are considered appropriate to continue practising. It is a different level of requirement and they are fulfilling very different roles. What is happening with the arrangements there is the forming of a mechanism which potentially identifies some of the people who medical boards or AHPRA should be looking at in a way that might not happen unless those mechanisms exist. So I think there is an interaction between them which is quite important.

**Senator MOORE:** Considering the previous answers, I am sure my other question is for Medicare.

**CHAIR:** Following up on the question that Senator Moore asked, I heard what you said about Medicare doing compliance. Is there no involvement by the department in terms of the policy development behind that?

**Mr Learmonth:** It is principally a function of Medicare Australia. The Department of Human Services publish a compliance plan each year. They have an underlying compliance strategy. They manage allocation of resources and targeting within that. They are the experts at it.

**CHAIR:** Dr Coote went through the new process—and I am casting my mind back to the inquiry that the legislative committee did last—

**Mr Learmonth:** On the compliance bill?

**CHAIR:** On the compliance bill. I know we did talk about it, and Dr Coote touched on it earlier. I forget the term he used but my interpretation is a sophisticated approach. When that was developed by Medicare, was there no policy involvement from the department saying, 'We want a more sophisticated approach to the way that this system is being managed?'

**Mr Learmonth:** I think so. There are a couple of things. We will be consulted and have a view, no doubt. They have principal responsibility. The reason it gets a bit crossoverish is that they have responsibility for doing compliance and, yes, they will consult with us, and we have a responsibility for the legislation overall. So we ended up having carriage of things like the compliance bill because we are the portfolio agency but the genesis for the contents, if you like, in terms of what the operational need was to amend the act and to give them different powers came from them and their experience with using the existing act.

**CHAIR:** We have been hearing about some issues today—and I am using the terms that were used with us—like the top end of the bell curve and people who are not at that end not being picked up and audited. Have those issues been raised in a policy sense with the department?

**Mr Bartlett:** Some of these issues are raised and get discussed. One example is the 80-20 rule. Your average level B consultation, using the BEACH data, which got some discussion during Better Access, consists of 12 minutes of face-to-face time. If you take 80 services of 12 minutes each, face to face, you are going to be seeing patients from eight in the morning until midnight and doing absolutely nothing else. So, when we talk about it being at the far end of the bell curve, we are talking way off. The department gets involved in discussions about the appropriateness of those sorts of measures. Again, the analysis that is done tends to support what is there.

**CHAIR:** We tried to have a fairly thorough discussion in the time available on the 20-80 rule. It is more the other concerns that you heard. We have been talking about women's clinics and Pap smears and clinics being closed down or restricting their practice because people are scared of the auditing process. They are fairly strong claims that are made, and it is not just about PSR. The concern that is being raised is: 'If I am seen to be putting my head up above the parapet, I'm going to get pinged, so therefore I'll scale back my length of consultations et cetera.'

**Mr Bartlett:** You are talking about compliance strategy, which again I would say is Medicare. But, in terms of what you are saying, just to give you an example, one of the things that was raised this morning was vitamin D testing. Vitamin D testing has gone from virtually nothing to \$60 million a year in about four years. Again, you would expect that that is going to attract some attention. It is an extraordinary growth. The issues are not quite as black and white as they were cast this morning. Again, what we try to do in policy terms is to understand what is happening with a range of these things.

**CHAIR:** This is where I want to get to. With the other witnesses we have been through those issues, and concerns have been raised about it—that they are getting targeted now. You are talking about exactly what I wanted to ask about, and that is: where does it then cross over to the department and the department starts looking at it and thinking, 'Expenditure on that is going through the roof; it may be affecting the rest of the health budget'? When is it brought to you? Is it brought to you? When do you get involvement and when does it get handed back if and when you make a decision?

**Mr Bartlett:** We have quarterly meetings of PSR, Medicare Australia and ourselves to talk through a range of issues where there may be concerns. I attend a monthly meeting with Medicare Australia that goes through a range of issues that include, to some extent, compliance. We have put in place as a result of the last budget an evolution of what was previously described as a quality framework for the MBS, a comprehensive management framework for the MBS. Part of that is looking at ways in which we review things on the MBS. That is how we would look at dealing with a number of the issues that you are raising, to see whether the descriptor is appropriate and whether we need to look at the fee—has there been a change as happened with vitamin D, where the

technology being used to do it changed, which made it much more available than it had been previously and suddenly it is being used much more and is much more profitable?

We have got a range of mechanisms that we are using that are designed to do exactly that. Equally, they can also be used in areas where people want clarity. We have almost endless committees with Medicare Australia, but another one is a health process committee, which again is designed to look at the log issues that Medicare shares with us where either their processing staff or people are raising issues with them where they are struggling to define what is meant by an item. What we try to do is work through those and understand what the issue is, what is driving it and what we can do about it. To some extent, part of that is about classifying what the issue is. Is it because due processing staff cannot work out what is going on so we are getting differing decisions made about claims? Or is it about a doctor who is trying to work a way through; or is because they are getting a number of complaints and there is a real problem here?

**Mr Learmonth:** Or is it because there is some new technology which can fit easily within the existing framework and which is still travelling through MSAC and they are trying to squeeze it in somewhere?

**CHAIR:** I am trying to get some clarification and some points. If Medicare, in doing its compliance process, suddenly start picking up a large number of requests for vitamin D—and vitamin D is a good one—do they then flag it with you as an outlier and not go back to the doctors and ask, 'What are you doing?' If there is a high number, do they think, 'Oh, there's an issue here,' and go back to the department to discuss it through that process?

**Mr Bartlett:** I think that, as things change, advice is sought from a range of people to try to understand what is going on. Again, one of the things that we are trying to do with some of our changes at the moment is to get more clarity about what drives change in terms of practice so that we can actually deal with it sensibly. I think Medicare takes the same approach, but you would really have to ask them.

**Mr Learmonth:** In short, the answer is yes. We keep a pretty close eye on what happens with the MBS and the PBS. We know where the drivers are. If something does look unusual and it starts spiking, we do tend to have a look at it. There might be any number of legitimate reasons. It might be clinically appropriate. People are discovering that there is a lot more vitamin D deficiency than we thought and think that we had better test all the people in certain age cohorts. That is a fantastic thing in terms of quality. It may be other things. It may be a change of technology which has made delivery of a particular service much less costly than it used to be, which means an item remunerated at the old rate suddenly becomes extremely lucrative. It might be a whole range of things. So we do try to understand what is going on, and there may be a policy response; there may not be.

**CHAIR:** Thank you very much. You have some questions on notice. If we could have the answers back by next Thursday, that would be appreciated; it would help us considerably. That is the conclusion for today. I thank all the witnesses.

**Committee adjourned at 16:27**