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Professional Services Review

Health Insurance Act Cases and Commentary

Bruce Topperwien

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This book is not a substitute for legal advice. The book is intended to assist readers understand the background, general operation, and caselaw concerning the *Health Insurance Act 1973*. The information provided within this book is presented for general information only. Opinions expressed are those of the author and should not be taken to be endorsed by, or be an official position or opinion of, the Commonwealth, the Professional Services Review, or any other Commonwealth officer or entity.

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Preface

The subject matter of this book is set out following the pattern of the *Health Insurance Act 1973*. While the text of the Act is not repeated in the book, it is readily available online at legislation.gov.au.

The book begins with a very brief history of the Australian health system in order that the legislation, which had a controversial beginning, can be seen in some medical, political, and Constitutional context.

A large part of the book concerns the extensive litigation in connection with the Professional Services Review (PSR) Scheme. Most of the relevant case law relating to the Act has arisen out of litigation by practitioners who have sought to challenge aspects of that scheme.

Opinions expressed are my own and should not be taken to be endorsed by, or be an official position or opinion of, the Commonwealth, the Professional Services Review, or any other Commonwealth officer or entity.

I thank the Directors of PSR who have allowed me time to work on this book since I commenced as General Counsel at PSR in 2013. I also acknowledge the input and useful advice I have received from colleagues and legal practitioners working in the jurisdiction.

Bruce Topperwien
June 2023

Access to health services prior to the *Health Insurance Act 1973*

Traditional First Nations healers

Over countless millennia, First Nations Australians developed their own traditional forms of health care. Some of the practices of aboriginal healers are described in the following extract by Dr Philip Clarke,[1] which usefully refers to numerous scholarly and historical articles on the subject:

> Philip Clarke, **Aboriginal healing practices and Australian bush medicine**, (2008) 33 *Journal of the Anthropological Society of South Australia*, pp. 9-12 —
>
> **Aboriginal healers**
>
> Aboriginal societies place great faith in their own healers, who they believe have special powers derived from their spiritual Ancestors to cure the sick. In many varieties of Aboriginal English the healers are referred to as 'doctors' and 'medicine men' (Arthur 1996: 21-2; Berndt 1947; Beveridge 1884: 68-70; Elkin 1977; Tindale 1974: 36; Tonkinson 1994).[2] They are also called 'clever men' or 'powered men', although these terms include other spiritually powerful people such as rain-makers and sorcerers. Healers are considered to have the ability to 'see' into the body of their patients. They deal with emotional problems as well as physical ones. An Aboriginal healer's closest equivalent in contemporary Western European medicine would be a professional who is both a general practitioner and a psychiatrist. There are many different Aboriginal language terms for healers across Australia, such as ngangkari in the contemporary Western Desert (Elkin 1977: 107; Goddard 1992: 82; Ngaanyatjarra et al 2003; Schulze 1891: 235),[3] marrnggitj in

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[1] Dr Philip Allan Clarke is a consultant anthropologist and is Honorary Research Associate (Anthropology) at the South Australian Museum.

[2] **Arthur**, J.M. 1996. *Aboriginal English. A Cultural Study*. Melbourne: Oxford University Press; Berndt, R.M. 1947. Wuradjeri magic and "clever men". *Oceania* 17(4): 327-65; 18(1): 60-86; Beveridge, P. 1884. Of the Aborigines inhabiting the Great Lacustrine and Riverine Depression of the Lower Murray, Lower Murrumbidgee, Lower Lachlan, and Lower Darling. *Journal & Proceedings of the Royal Society of New South*
Wales 17: 19-74; **Elkin**, A.P. 1977. *Aboriginal Men of High Degree*. Second edition. St Lucia, Queensland: University of Queensland Press; **Tindale**, N.B. 1974. *Aboriginal Tribes of Australia. Their Terrain, Environmental Controls, Distribution, Limits, and Proper Names*. 4 maps enclosed. Canberra: Australian National University Press; **Tonkinson**, M. 1994. *Healers*. D. Horton (ed.) *The Encyclopaedia of Aboriginal Australia*. 2 volumes. Pp. 454-456. Canberra: Aboriginal Studies Press for the Australian Institute of Aboriginal & Torres Strait Islander Studies.

[3] **Elkin**, A.P. 1977, Op cit; **Goddard**, C. 1992. *Pitjantjatjara/Yankunytjatjara to English Dictionary*. Second edition. Alice Springs: Institute of Aboriginal Development; **Ngaanyatjarra** Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation. (ed.) 2003. Ngangkari Work–Anangu Way. *Traditional Healers*

present day northeast Arnhem Land (Cawte 1996: 18, 137; Elkin 1977: 117-20; Reid 1983)[4] and garraaji around Sydney at the time of European settlement (Tench 1996: 196-7)[5].

In Aboriginal Australia the healer's job is to diagnose problems, advise on remedies, suggest and perform ritualised healing procedures, explore the impact of community social and cultural issues upon the illness, and to reassure their patients that they can be cured. Most recognised healers are men, although people of both genders have a wide general knowledge of efficacious healing plants. While the healers focus upon treating sick individuals, women specialise in performing ceremonies that promote the general health and wellbeing of their whole family. In pre-European times all adults in the community would have known about basic medicines, although healers were considered to have special access to spiritual powers and assistance.

The healer's set of special skills was considered fundamental for treatment in cases where sickness was blamed upon supernatural things, such as sorcery, contact with spirits and the breaking of taboos. When illness is diagnosed as being caused by foreign objects entering the body, the healers will treat the patient with singing, massage and sucking to 'remove' the offending article, which may be revealed as a fragment of wood, bone, shell, stone and since European colonisation even wire or glass (Berndt 1982; Berndt 1947: 351-5; Berndt & Berndt 1993: chapter 12; Eyre 1845: 2: 359- 60; Hardy 1969: 16-17; Roth 1897: chapter 11; Tonkinson 1982: 234-5).[6] Healers may 'insert' special objects into the patient to affect a cure. In Aboriginal English certain places or areas that make people ill are referred to as 'sickness country' (Arthur 1996: 129-30).[7] 'Devil devil business' is often the stated cause for the most serious and otherwise unexplained illnesses (Cawte 1996: 17).[8]

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of Central Australia. Alice Springs: Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council Aboriginal Corporation; **Schulze**, L. 1891. The Aborigines of the upper and middle Finke River: their habits and customs, with introductory notes on the physical and natural-history features of the country. *Transactions, Proceedings & Report of the Royal Society of South Australia* 14: 210-46.

[4] **Cawte**, J. 1996. *Healers of Arnhem Land*. Sydney: University of New South Wales Press; **Elkin**, A.P. 1977, ibid; **Reid**, J.C. 1983. *Sorcerers and Healing Spirits. Continuity and Change in an Aboriginal Medical System*. Canberra: Australian National University Press.

[5] **Tench**, W. 1996 [1788-92]. *A Narrative of the Expedition to Botany Bay & a Complete Account of the Settlement at Port Jackson*. Edited by T. Flannery. Melbourne: Text Publishing.

[6] **Berndt**, C.H. 1982. Sickness and health in western Arnhem Land: a traditional perspective. J. Reid (ed.) *Body, Land and Spirit. Health and Healing in Aboriginal Society*. Pp. 121-138. St Lucia, Queensland: University of Queensland Press; **Berndt**, R.M. 1947. Wuradjeri magic and "clever men". *Oceania* 17(4): 327-65; 18(1): 60-86; **Berndt**, R.M., **Berndt**, C.H., with Stanton, J.E. 1993. *A World That Was. The Yaraldi of the Murray River and the Lakes, South Australia*. Melbourne: Melbourne University Press at the Miegunyah Press; **Eyre**, E.J. 1845. *Journals of Expeditions of Discovery*. 2 volumes. London: Boone; **Hardy**, B. 1969. *West of the Darling*. Milton, Queensland: Jacaranda Press; **Roth**, W.E. 1897. *Ethnological Studies Among the North-westcentral Queensland Aborigines*. Brisbane: Queensland Government Printer; **Tonkinson**, R. 1982. The Mabarn and the hospital: the selection of treatment in a remote Aboriginal community. J. Reid (ed.) *Body, Land and Spirit. Health and Healing in Aboriginal Society*. Pp. 225-241. St Lucia, Queensland: University of Queensland Press.

[7] Arthur, J.M. 1996. Op cit.

[8] Cawte, J. 1996, Op cit.

Healers draw upon the ancestral powers of their kinship network when treating the seriously ill. In 1846 Dresden missionary Heinrich A.E. Meyer at Encounter Bay in South Australia claimed that Ramindjeri people had 'doctors' who appealed to the object, animal or plant that was their totemic 'friend' or spirit familiar (Meyer 1846 [1879: 197]).[9] One such person used a snake and others an ant or seaweed. In the case of seaweed, Meyer recorded the term parraitye-orn, which was translated by him to mean 'sea-weed man' or 'doctor'. This person was said to be he who:

> … pretends to cure diseases by chewing a small piece of a red-coloured species of sea-weed, which he gives to the patient, bidding him to conceal it about his person. As soon as the seaweed becomes dry it is supposed the disease will have evaporated with the moisture (Meyer 1843: 90).[10]

In the Lower Murray region of South Australia, a healer would invoke the power of the 'war-god' Ancestor Ngurunderi to cure warriors of their spear and club wounds (Clarke 1995: 146; Taplin 1859-79: 20 October 1859: 26).[11]

In the southern Kimberley and northern Western Desert, a traditional 'doctor' receives his power from dreams or by obtaining magical charms, maban, from other recognised living 'doctors' (Akerman 1979: 23-4).[12] Some maban are considered invisible, while others are small trinkets like shells and tektites or 'emu eyes' (Baker 1959: 188-90).[13] Aboriginal people believe that they enter the patient's body to do their work. In the southern Western Desert, healers use charms called mapanpa, which may be comprised of pieces of wood, stone, bone and other objects (Ngaanyatjarra et al 2003: 11, 15, 34-5, 47, 55, 78).[14] Each healer will have their own set of such 'sacred tools'.

There are many ways in which Aboriginal people become healers (Cawte 1974: 30, 41-2, 44, 63-4; Elkin 1977: chapter 3-4; Eyre 1845: 2: 359-60; Gason 1879: 78-9; Howitt 1904: 404-13; Roth 1897: 152-3; Spencer & Gillen 1899: chapter 16; 1927:2: chapter 15).[15] It generally comes through special training, commencing when still a youth, into the methodology and rituals related to discerning causes of illness, and involves spiritual revelation. The role of healer is rarely passed down

[9] **Meyer**, H.A.E. 1846. Manners and customs of the Aborigines of the Encounter Bay tribe, South Australia. Reprinted in J.D. Woods (ed.), 1879, *The Native Tribes of South Australia*. Pp. 183-206. Adelaide: South Australian Government Printer.

[10] **Meyer**, H.A.E. 1843. *Vocabulary of the Language Spoken by the Aborigines of South Australia*. Adelaide: Allen.

[11] **Clarke**, P.A. 1995. Myth as history: the Ngurunderi mythology of the Lower Murray, South Australia. *Records of the South Australian Museum* 28(2): 143-57; **Taplin**, G. 1859-79. *Journals*. Typescript. Adelaide: Mortlock Library

[12] **Akerman**, K. 1979. Contemporary Aboriginal healers in the south Kimberley. *Oceania* 50(1): 23-30.

[13] **Baker**, G. 1959. Uses of tektites and their vernacular terminology. Chapter 13 in G. Baker *Tektites*. No.23, Memoirs of the National Museum of Victoria. Melbourne: National Museum of Victoria.

[14] Ngaanyatjarra et al 2003: Op cit.

[15] Cawte 1974: Op cit; Elkin 1977: Op cit; Eyre 1845: Op cit; **Gason**, S. 1879. The "Dieyerie" Tribe. G. Taplin (ed.) *Folklore, Manners, Customs and Languages of the South Australian Aborigines*. Pp. 66-86. Adelaide: South Australian Government Printer; **Howitt**, A.W. 1904. *Native Tribes of South-east Australia*. London: Macmillan; Roth 1897: Op cit; **Spencer**, W.B. & **Gillen**, F.J. 1899. *The Native Tribes of Central Australia*. London: Macmillan.

directly from father to son, with future healers instead chosen for their developing social skills and an aptitude for learning.

Aboriginal healers observe specific taboos believed to maintain their powers. In northeast Arnhem Land some healers cannot submerge themselves in saltwater (Warner 1958: 200).[16] In many regions, particularly Central Australia and parts of the Kimberley, healers avoid such things as bites from large ants, excessive eating of fat and the drinking of any hot beverages, through their fear of losing power (Elkin 1977: 8-9, 113, 123; Spencer & Gillen 1904: 480-1).[17] It was a recorded custom in a part of western New South Wales that 'medicine men' could never eat their individual totemic animal or plant (Elkin 1977: 91).[18] Across southeastern Australia after European settlement, 'clever men' were said to lose their healing and psychic abilities, such as knowing in advance who was about to arrive, through drinking too much alcohol (Elkin 1977: 93; Howitt 1904: 409).[19]

Colonial Medical Service

When New South Wales was established as a penal colony in 1788, the ships' surgeons from the First Fleet provided medical services to the colonists. The Colonial Medical Service subsequently provided doctors from Britain to serve in New South Wales. While those practitioners provided their services to convicts and military personnel under the Colonial Medical Service arrangements, they also had a right of private practice. But until there were significant numbers of free or emancipated colonists, there was little opportunity for them to treat private patients.

Similarly, when the Swan River Colony (later Western Australia) was established in 1829, the ships' surgeons from *HMS Sulphur* and *Parmelia* (the two ships that brought the military and civilians, respectively) provided medical services to the colonists. Dr Charles Simmons, from the *Parmelia*, was appointed as Colonial Surgeon. The Colonial Hospital was established on 15 June 1830. Dr Simmons died in October 1831 and Dr Alexander Collie (1793-1835), surgeon from *HMS Sulphur*, was appointed in his place.

When the Province of South Australia was established in 1836, a Colonial Surgeon was provided to that colony from the outset. As well as having the duty to provide

[16] **Warner**, W.L. 1958. *A Black Civilization. A Study of an Australian Tribe*. Revised edition. New York: Harper & Row.
[17] Elkin 1977: Op cit; **Spencer**, W.B. & **Gillen**, F.J. 1904. *The Northern Tribes of Central Australia*. London: Macmillan.
[18] Elkin 1977: Op cit.
[19] Elkin 1977: Op cit; Howitt 1904: Op cit.

medical services to the colonists, the Instructions from the Colonisation Commissioners to the Resident Commissioner stated:

> One means by which extensive benefits may probably be conferred on the aborigines at a small cost, will be to afford them gratuitous medical assistance and relief. If such an arrangement should appear to you desirable, you will apply to the Governor to give the necessary instructions to the colonial surgeon.[20]

Private practice

The first practitioner to establish a totally private medical practice in New South Wales was Dr William Bland (1789–1868), himself a former convict. He had been a naval surgeon and was convicted, in Bombay, of murder after being involved in a duel with his ship's purser. He was sentenced to transportation for seven years, sent first to Hobart and then to Sydney. He was permitted to practice as a doctor, and on 27 October 1815 was given a pardon. He then set up a private medical practice. In 1819, Dr Bland was convicted of libeling Governor Macquarie. After 12 months imprisonment, he returned to his private practice, and in 1821 entered into an arrangement with the Benevolent Society under which he would provide medical services.

The following is an extract from an article by Milton J Lewis in a supplement to the *Medical Journal of Australia* in 2014:

> In the early colonial period, because of the penal character of the original colonies, the Crown supplied almost all medical care through the salaried Colonial Medical Service (CMS). Colonial governors also pursued public health measures, applying quarantine to ships carrying infections and providing vaccination against smallpox.
>
> For 50 years after European settlement in 1788, free settlers, as well as convicts, benefited from the care of the CMS surgeons. Even South Australia, settled without convicts in 1836, had a Colonial Surgeon from the outset. Although CMS surgeons had rights of private practice, William Bland (1789–1868), a Sydney emancipist doctor, became the first full-time private practitioner in 1815. In 1832, Bland was the first Australian surgeon to ligate the innominate artery to treat an aneurysm; his report of the procedure was only the seventh in the world.
>
> Given the very small free population and private economy, and the presence of the CMS, private practice developed slowly until about the mid 19th century. In NSW, the number of registered medical practitioners leapt from 284 in 1850 to 691 in 1892. In Victoria in 1862 (after the discovery of gold in the 1850s produced a dramatic increase in population), there were 335; in 1881 there were 454. Outside

[20] *South Australian Gazette and Colonial Register*, 11 Nov 1837, at p 4.

> the larger urban centres, the scattered population, great distances and frontier conditions demanded omnicompetent general practitioners. These were initially naval and military surgeons, along with medically qualified ex-convicts like William Redfern, a full-time practitioner from 1820. Their successors, predominantly British-trained but later also graduates of the three local universities, not only practised medicine but had considerable involvement in political life, commerce, pastoral pursuits and cultural developments. The division of labour (identified by pioneer economist Adam Smith as the organisational key to greater manufacturing productivity) was one of the dominant notions of the 19th century. In medicine, the focus of the new division of labour — the specialties — was variously on body parts, particular diseases, life events or age groups. By the 1880s, more immigrants with specialist qualifications were arriving in the colonies; and in the cities, along with consultant surgeons and physicians, specialists in such fields as pathology, obstetrics and gynaecology, dermatology and ophthalmology emerged.

Friendly societies

On 8 May 1813, Edward Smith Hall and some other colonists formed a charitable organisation called The New South Wales Society for Promoting Christian Knowledge and Benevolence. In June 1818 it became The Benevolent Society, with the purpose to 'relieve the poor, the distressed, the aged, and the infirm'. It also provided cash loans, grants, clothing and food.

There had been a long history in Britain of ‘friendly societies’, dating back at least to the 1500s. These were associations formed by people to provide assistance to each other when in need. Their numbers greatly increased with the industrial revolution in the 1700s. Initially friendly societies provided for funeral benefits for the poor. Their services subsequently also extended to assistance in sickness, and then to medical benefits, life assurance and other financial assistance.[21] By 1800, England had 7,200 societies with a total membership of 638,000 people.[22]

The friendly societies would enter into arrangements with doctors who would accept an agreed fee to see friendly society members. Later, friendly societies employed their own doctors to treat their members.

Early in the colonisation of South Australia, it was not expected that every settler would be provided free medical treatment by the Colonial Medical Service. On 29

[21] N Sissons, ‘Friendly Societies’, (1977-78) 9 *Victoria University of Wellington Law Review* 59-75 at 60.
[22] Pensabene, T S, 1980: *The rise of the medical practitioner in Victoria*, Australian National University, at p. 147.

May 1838, the Colonial Surgeon, Dr Thomas Young Cotter (1805-1882), wrote an open letter 'To the Working Classes of South Australia':[23]

> But, fellow Colonists, prudence and economy without union will not avail you; for sickness comes (and where is the family can claim immunity from it,) with all its train of expences [sic], sweeps away your savings, and probably leaves behind it a load of debt that the utmost endeavour of your future life can scarcely free you from. It is by uniting together therefore, that you can alone secure the full advantages of the position in which you have been placed; it is by forming a sort of Medical Assurance Company that you can alone provide for those casualties which one time or another happen to every one; and it is from this conviction that I claim your attention to the published rules for the establishment of an Independent Medical Club, by which you will be enabled by a trifling monthly subscription, to purchase medical assistance for yourselves and families—it will be thrown open to the whole profession, and each family allowed to select its own medical attendant, and be empowered to demand a full consultation whenever you may consider it necessary. Similar Institutions to this are rapidly being established throughout England, and are invariably found to relieve the anxiety that the classes to which you belong must, under other circumstances, feel as to the means of remunerating their medical attendants, to preserve their independence, to induce habits of economy and forethought, and to be mainly instrumental in the establishment of Benefit Societies wherever they have as yet made their appearance.
>
> South Australians, do not frustrate the endeavours, do not disappoint the hopes, of those who have done so much for you, let your motto be union—and in all your endeavours to economize your expenditure, or to secure your independence, be satisfied that it is by joining together for the furtherance of your object that you can alone render success certain.—Who is there among you that in the time of sickness or of old age, would like to eat the bread of the stranger—to depend on the oftentimes insulting charity of others for subsistence—who would not wish to secure his wife's brow from being wrinkled, or his children's eyes dimmed by care—who would not wish to drive anxiety from his fireside?—Believe then that by joining the institution to which I have called your attention, you will avail yourselves of one of the most powerful means of securing this dearest and most highly prized blessing.

The Colonial Surgeon had had a considerable workload at the establishment of the colony, and in December 1838, rules proposed by the Infirmary Board and approved by the Governor were published concerning the attendance on patients at the Infirmary at Adelaide, which stated:[24]

> 3. Patients who are believed by the Board to be in destitute circumstances shall be entitled to the gratuitous medical attendance of the Colonial Surgeon, and all other benefits of the institution.

[23] *Southern Australian Gazette and Colonial Register*, 2 June 1838, at p 4.
[24] *South Australian Gazette and Colonial Register*, 1 December 1838, p 1.

> 4. Those who, in the opinion of the Board, are able to defray their own expences [sic], or have a claim upon others to do so for them shall be only entitled to admission on giving security for the payment of the following charges:—
>
> Medical attendance and medicines, 7s. per week.
>
> Rations, medical comforts, nurse. &c., 14s. per week.
>
> 5. The Board shall have the power to reduce the above charges in cases where they may deem it expedient.

In Victoria, the first friendly society, the Melbourne Union Benefit Society, was established on 8 May 1839. Contributions were set at 2s 6d per month and Dr P Cussen was employed by the Society to provide medical care for members at a rate of 1 shilling per consultation.[25]

The growth of these societies in Victoria is described by T S Pensabene as follows:[26]

> The Melbourne Union Benefit Society was soon overshadowed by the large British affiliated societies which developed in Victoria. On 1 October 1840 T Strodes, editor of the Port Phillip Gazette, and Dr A F A Greaves, a Melbourne medical practitioner, established the first branch of the Independent Order of Oddfellows, Manchester Unity (MUIOOF). The Australian Felix Lodge, as it was then called, promoted harmony and friendship, granted sickness benefits to members and provided money for charity. Greaves supplied medical services to members for £1 per annum. Like its British counterpart, the MUIOOF was the largest society in Victoria; … [The Ancient Order of Forresters (AOF)] was the second largest society in Victoria with 9,500 members or one-quarter of total membership in 1880. These two societies were the market leaders. Control of the market by the MUIOOF and AOF remained unchallenged until the emergence of the Australian Natives' Association, the first non-British affiliated society.
>
> Inaugurated as the Victorian Australian Natives' Association on 28 April 1871, the ANA united native-born Australians to a benefit society. By 1871 approximately 45 percent of the colonial population was native born. Other societies admitted Australian natives, but only the ANA excluded foreigners. By … 1890 it had toppled the AOF as the second largest society in the colony.
>
> The medical profession initially favoured the societies because they promoted thrift and self-reliance amongst the working class. The doctor derived two major benefits from the societies: first, they provided a source of income unattainable from private practice because most lodge members were workers unable to afford the doctor's private fee and, second, the societies reduced the extent of gratuitous services provided in the out-patient wards of the public hospitals. The larger percentage of the population in the societies, the smaller the percentage of the population treated in the out-patient wards. However, the rapid growth of the societies in the 1880s

[25] Pensabene, T S, 1980: *The rise of the medical practitioner in Victoria*, Australian National University, at p. 148.

[26] Pensabene, T S, 1980: *The rise of the medical practitioner in Victoria*, Australian National University, at pp. 148-151.

> alarmed the profession and, as in Britain, resulted in a campaign to restrict the size and scope of the societies.
>
> The medical profession objected to the growth of societies on three grounds. First, the lodge contract formalized the doctor's employee status and made him subservient to non-professional men who were 'educationally their inferiors'. … The societies' competitive practices were the antithesis of the doctors' ideals: doctors were required to tender for contracts and patients. … Doctors who objected to their servile status were threatened with expulsion: the high inflow of doctors to Victoria in the late nineteenth century meant that replacements were found easily.
>
> Second, the profession objected to high income earners joining the societies. These 'well-to-do' members deprived the doctor of his private fee and restricted the growth of his private practice. Doctors believed that society membership was too widespread within the community. …
>
> Whereas the British societies provided medical aid only to the working man, Victoria societies provided medical coverage to the worker, as well as his wife and children under 18 years of age. This made societies popular amongst middle income earners. …
>
> Finally, the profession objected to the low remuneration paid to lodge doctors. There was no uniform annual capitation fee. In the city of Melbourne the MUIOOF paid its doctors 19s 4d; the Foresters 22s 5d; the St Patricks Society 20s and the Sons of Temperance 14s 8d per member. The ruling rate for the inner suburbs of Richmond, Footscray, Williamstown and North Melbourne was 14s per member, while the better class suburbs of St Kilda, Malvern, Brighton and Caulfield the rate varied from 15s to 16s per member. Doctors received 23s for advice and medicine in country districts. Lodges specifically for women, first commenced in 1897, were avoided by most doctors because they paid only 10s per member. …
>
> … Doctors wanted the per capita pay raised to 20s and the range of services provided to lodge members reduced. The profession also believed that the lodge doctor should receive an extra fee for work involving anaesthetics, midwifery, accidents at sport, some operations, teeth extractions, lunacy certificates, certificates for children unable to attend school, and written opinions in legal cases (collectively referred to as 'extras').

The Victorian Branch of the British Medical Association (BMA) made submissions to the lodges in 1898 and subsequent years, but were all rejected. In December 1913, BMA representatives met with representatives of the societies, submitting an increase in the fees payable. The societies did not respond until 25 July 1914. They rejected the claims of the BMA, including the suggestion that there should be an income limit on membership of societies. Upon the outbreak of war in August 1914, the societies requested the BMA to waive its demands until the 'end of the national emergency'. The BMA agreed to this request. On 28 February 1917, the BMA called for the resumption of negotiations, which resumed in June of that year.

Negotiations broke down, and on 18 January 1918, 406 lodge doctors resigned from friendly societies, refusing to be re-employed except under the BMA's proposed Common Form of Agreement. The BMA refused the government's offer of arbitration. A Royal Commission was appointed to settle the dispute. In its report, handed down on 21 June 1918, it accepted the BMA's argument for an income limit on society membership, but considered the amount suggested by the BMA too low. It accepted the BMA's claim for 20 shillings (one pound) for each member on the city doctors' lists, but the country rate was reduced to 25 shillings. For female lodges the rate of pay was fixed at 12 shillings for single members and 18 shillings for members with dependants. It also recommended an increase in the number of extras. The friendly societies accepted the Royal Commission's recommendations. However, the BMA demanded a further condition to be met before accepting the proposals. It required all medical institutes that had been established since 1 November 1917 to be abolished and the number of doctors employed by the institutes to be reduced to the number that were employed before the lodge dispute. Medical institutes, unlike the societies, engaged doctors on fixed salaries. The dispute remained unresolved for the next 18 months. The societies established more institutes and increased membership levies. But memberships began to fall, and in February 1920, some societies accepted a BMA proposal to allow the continuation of the institutes provided that no new institutes were established over the next four years. By 1922 all the societies had accepted the BMA's proposal.

The effect of this dispute is described by T S Pensabene as follows:[27]

> The acceptance of the doctors' claims resulted in large increases in contributions. The average contribution to the medical and management fund of the societies rose by 15.2 per cent in the AOF, 24.2 per cent in the ANA, and by 28.8 per cent in the MUIOOF between 1917 and 1922. In addition, lodge members were required to pay a supplementary fee for extras, such as anaesthetics and midwifery, whereas previously these services were provided under a single contribution fee. Thus, lodge members paid higher contributions for reduced benefits.
>
> High contribution rates reduced membership amongst lower income earners and resulted in a substitution of lodge treatment with out-patients care. Between 1920 and 1930 the percentage of the state population obtaining medical care from the out-patient wards of the public hospitals rose from 5.9 to 9.7 per cent, the largest rise between 1870 and 1930. Here the patient received medical care at a fraction of the lodge cost. Medical improvements in hospital care and the provision of the best staff and facilities within the public hospitals made out-patients care better, and

[27] Pensabene, T S, 1980: *The rise of the medical practitioner in Victoria*, Australian National University, at pp. 157-158.

more competitive with the societies. These improvements reduced the stigma of poverty associated with out-patients care.

The imposition of income limits on society membership excluded many commercial and professional workers from joining societies. High income earners could now only obtain treatment through private consultation. The exclusion of high income earners from the societies introduced an element of second-class medical care not previously associated with the societies. This had a dampening effect on the growth of society membership in the 1920s.

Finally, rising incomes raised the proportion of the community able to afford private medical care. The price of a private consultation relative to the average manufacturing wage for the lowest paid adult male fell from 30.2 per cent in 1905 to 12.9 per cent in 1930. Private medical care was no longer available only to the well-to-do, but was within the reach of many workers. The fall in community usage of the friendly societies in the 1920s, therefore, was due largely to the community's preference for private medical care and its increasing ability to afford such care.

The dominance of the friendly society as the principal coordinator of primary medical care in Victoria had been abruptly ended. Increased union strength and a reduction in the supply of doctors enabled the BMA to defeat the societies. Few unions could have equaled the victory of the BMA achieved against the societies; few unions could have challenged the wishes of the State Government – and won.

Royal Commission into National Insurance

In 1923, the Commonwealth Government established a Royal Commission into:

(a) National Insurance as a means of making provision for casual sickness, permanent invalidity, old age and unemployment; and

(b) the operation of the maternity allowance system, with a view to the incorporation with National Insurance of a scheme for securing effective pre-natal and other assistance to mothers.

The Final Report of the Royal Commission was presented in 1927. The Commissioners noted:[28]

It has been suggested that the proposed national insurance scheme in Australia should not cover all wage and salary-earners, but should be restricted to those receiving less than a certain income, as it is considered that if an income limit is not fixed many people who do not require assistance would be eligible for the benefits provided. It has also been suggested that if the scheme were made applicable to all persons in receipt of salary or wages not exceeding £500 per annum, with provision for an extension in the case of married men with dependants, the position would be

[28] *Fourth and Final Report of the Royal Commission on National Insurance. Membership Finance and Administration*, 1927, at p. 5.

fairly met. A similar limit might also be applied to workers on their own account and to the small employers of labour admitted to a voluntary scheme.

Under the Workers' Compensation Acts of the several States, an employee whose remuneration exceeds the following maximum is excluded from the provisions of the Act, viz.:— New South Wales, (manual) without income limit, (non-manual) £750 per annum; Victoria, (manual) without income limit, (non-manual) £350 per annum ; Queensland, (manual and non-manual) £10 per week; South Australia, (manual and non-manual) £10 per week; Western Australia, (manual and non-manual) £400 per annum; Tasmania, (manual and non-manual) £5 per week.

The agreements between friendly societies and medical practitioners exclude from medical benefit all members in receipt of annual incomes exceeding in New South Wales, £364 ; Victoria, £312 ; Queensland, £400 ; South Australia, £450; Western Australia, £400; and Tasmania, £312. When receiving more than the maximum income prescribed a member may continue to be eligible for certain medical benefits if he has dependants. The main objection raised by friendly societies to the model agreement relating to medical attendance is in regard to the income limit, as they are generally opposed to any income-limit.

It has been estimated that in the year 1921, 68.5 per cent, of the total wage and salary earners in Australia were in receipt of an income of less than £200 per annum, 94.4 per cent, less than £300 per annum, 97.5 per cent, less than £400 per annum, and 98.6 per cent, less than £500 per annum. It will thus.be seen that, even when allowance is made for the increase in wages since 1921, the percentage in receipt of higher incomes is relatively small. If an income limit is placed on membership any future alteration in the standard of wages may have an important influence on the eligible membership of the scheme and a consequent effect on its financial basis. As the result of an increase in wages since the institution of national insurance, it has been necessary in some countries to raise the maximum income-limit in order to avoid excluding a large number of workers who would normally have benefited by the scheme if wages had not increased. 'When an insured person's income is raised to more than the maximum prescribed, he generally ceases automatically to be liable to the compulsory provisions, but in some cases may continue insurance under voluntary provisions, and experience has shown that where a low income-limit is prescribed the number of compulsory exits from insurance on this account is very appreciable, and results in many anomalies.

(d) Geographical Limitation of the Scheme.

It has been suggested that in many districts in Australia in which the population is very scattered it will be extremely difficult to administer a national insurance scheme, and that if those areas were temporarily eliminated from the scheme, the total number affected would not be large, as only a small percentage of the population is located in such outback areas. It is desirable, however, that the scheme should cover all in need of insurance, and the remoteness of a person or of his residence need not exclude him from benefits so long as satisfactory certification as to eligibility for benefit can be obtained. It is considered that workers m the outback areas should be given special consideration and not penalized by any such exclusion from the benefits of the scheme.

(e) Voluntary Membership.

In the event of a system of compulsory insurance being instituted with certain limitations, many employees, workers on own account, and employers in small businesses who are exempt from the compulsory provisions of the scheme may desire to contribute for similar benefits to those available for employed contributors, and it is desirable that such provision should be made available. Many breadwinners who are not employees and who are in receipt of small income are often in urgent need of the benefits provided by national insurance. In some schemes provision has been made for the following to insure voluntarily, viz.:— Persons exempted from insurance; members of the family of the employer without any specific employment and without remuneration; also proprietors of establishments who regularly employ at the most two persons subject to insurance, provided that their incomes do not exceed a prescribed amount.

Although it is estimated that the majority of the insured population will remain wage-earners for the whole of their working lives, yet it is essential that provision be made for those who cease to be wage-earners and still desire to be eligible for the benefits provided by the scheme and towards which they have contributed for many years. The provision of a surrender value on termination of insurance has not been introduced into any system of national insurance against contingencies, as such is undesirable and would considerably affect the financial basis if instituted.

Notwithstanding that the voluntary provisions in other countries have not proved entirely successful, yet efforts should be made to devise a scheme which will make adequate insurance benefits available for this section of the community.

RECOMMENDATIONS.

Your Commissioners recommend

(i) that the compulsory provisions of the National Insurance Fund shall apply to all wage and salary-earners in Australia who are over the age of 16 years ;

(ii) that the voluntary provisions shall apply to all workers on own account and proprietors of small establishments ;

(iii) that exemption from the compulsory provisions shall be granted to members of mutual benefit associations which guarantee, and to those in employment which secures, equal benefits to those provided by the National Insurance Fund.

The Report of the Royal Commission then discussed in some detail the financial considerations and options for the funding and administration of a national scheme. In discussing the cost of administration, it said: [29]

> The cost of administration of national insurance in Australia will be one of the greatest difficulties to be contended with, and considerable modification of the schemes of administration in operation in other countries will be necessary in order

[29] *Fourth and Final Report of the Royal Commission on National Insurance. Membership Finance and Administration*, 1927, at p. 11.

to meet conditions in Australia. If a system of approved societies' administration is adopted, the cost of administration will depend to a great extent on the rate of remuneration which the Government decides to pay for the work done by the societies. The cost of administration of existing mutual benefit societies in Australia is heavy, and varies considerably in the several societies. The total cost of administration of all friendly societies in Australia in the year 1924-25 was £373,546, equivalent to 20 per cent, of the total contributions for the year and to 13s. 10d. per benefit member, having increased from an average of 10s. 5d. per member in the year 1915. In some societies the cost of administration is as high as 33 per cent, of the total contributions, and equivalent to 20s. 4d. per member per annum. This increase is said to be due to an increase in the remuneration paid to the various officials, to the extension of propaganda work in an endeavour to obtain new members, and to the cost of administering the investment of accumulated funds. Although it might be anticipated that the cost of management per member would decrease as membership increased, yet it is found that the cost of management is heavier in the largest societies and has not decreased with an increase in membership. No particulars are available as to the relative cost of administration of each benefit provided. The Government Registrar has no control over the societies with respect to extravagance in their management expenses, although the societies must raise sufficient contributions to cover the cost of management in each year.

Friendly societies in Australia had 5,465 branches operating in the year 1924-25, and a considerable amount of the administration work is being carried out voluntarily, but under a national insurance scheme incorporating an approved societies' system the cost of administration would probably be increased, as the societies would desire to maintain their present organization and consequent management expenses, whilst, in addition, remuneration for all officials would probably be demanded. It has been stated that in England voluntary service in connexion with the approved societies' administration of national insurance has almost entirely disappeared. The cost of paying adequate remuneration to the administrative officers of 5,465 branches and 162 head offices of approved societies in Australia would throw a very heavy and unnecessary burden on the National Insurance Fund.

The result of investigations shows that a Government controlled national insurance system can operate more cheaply than other organizations, and if insurance in a unified National Insurance Fund is made compulsory in Australia a considerable saving will be effected in agency and operating expenses. The average percentage of overhead charges for the administration of State Accident Insurance offices in Australia is less than 15 per cent, of the premium income, and is lower than that of other offices transacting similar business. The cost of administering the Commonwealth Invalid and Old-age Pensions scheme is equivalent to about 1½ per cent, and War Pensions to 2 per cent, of the total amount of pensions paid. If the question of cost of administration were the only consideration, then the national insurance scheme would necessarily be administered by similar administrative methods to those by which Commonwealth Invalid and Old-age Pensions and War Pensions are now paid.

The Commissioners made the following recommendations in relation to funding the scheme:[30]

> RECOMMENDATIONS
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> Your Commissioners recommend
> (i) that the total cost of the national insurance scheme shall be met by regular weekly contributions payable in respect of each insured person by the Commonwealth, the employer and the insured person;
> (ii) that contributions shall not be payable during any period in which the insured person is unemployed or in receipt of benefit;
> (iii) that a flat-rate of contribution be adopted for all insured males and similarly for all insured females;
> (iv) that the rate of contribution for each benefit shall be that actuarially calculated for entrants at age 16 together with provision for the accumulation of adequate reserves;
> (v) that the employee's contribution shall be deducted from wages and the employer's and employee's contributions collected by means of insurance stamps to be affixed by the employer to the employee's contribution card;
> (vi) that all contributions shall be payable to a central National Insurance Fund;
> (vii) that the accumulated funds be invested in the extension of social services available to insured persons;
> (viii) that actuarial valuations of the Fund shall be made at regular periods.
> (ix) that the Fund shall be subject to audit by the Commonwealth Auditor-General.

In relation to the administration of the proposed scheme, the Commissioners made the following observations and recommendations:[31]

> The national insurance schemes instituted in other countries have been in the nature of experiments in social legislation, and their experience has shown in many cases that amendments in the original system of administration were essential. It has been suggested that considerable difficulty will be met with in operating national insurance over such large territory with such scattered population as Australia, and that conditions of work, wages, and living are so different that an entirely different administrative scheme to those operating in other countries will be required to meet the Deeds of Australia. Further, that it would be more desirable to leave mutual benefit organizations free to continue their operations and for the Government to undertake the administration of National Insurance in a similar manner to that in which the Commonwealth Invalid and Old-age Pensions and the Maternity Allowances are administered at present, and in the administration of which the mutual benefit societies do not take part, the Post Office being utilized for the payment of benefits. The existence of mutual benefit associations must be taken into consideration, and it is suggested that their continuance will be more encouraged if they remain free to continue their present functions unhampered by inclusion in the national insurance scheme. Every effort should be made to prevent

[30] *Fourth and Final Report of the Royal Commission on National Insurance. Membership Finance and Administration*, 1927, at pp. 12-13.
[31] *Fourth and Final Report of the Royal Commission on National Insurance. Membership Finance and Administration*, 1927, at pp. 17-18.

any injury being done to the friendly society system. The opinion has been expressed that a comprehensive system of national insurance will have an injurious effect on existing mutual benefit societies, but although such predictions were made in England, experience has proved that the voluntary societies are now in a better numerical and financial position than they were prior to the inception of the national insurance scheme. National Insurance will only provide certain assured minimum benefits, and not adequate maintenance, and thus wage and salary-earners will be enabled to provide additional benefits by means of voluntary mutual associations. Such an arrangement for additional benefits has many advantages. It is estimated that one-third of the compulsory insured persons in England are also voluntary members of mutual benefit societies.

The advantages of one administrative organization far outnumber any other considerations. The most desirable, effective and economical system will be attained if a central organization is established to administer a unified National Insurance Fund for the whole of Australia through district offices. Such administrative authority should include representatives of the three contributing parties, viz.:—the Government, employers, and insured persons, as it is desirable that all interested sections should take part in the administration of the National Insurance Fund. The various States should be divided into suitable administrative districts, each supervised by a District Insurance Office under the control of the Central Administration. Each district organization will be a complete administrative unit, but it is essential that insurance funds be pooled for the whole of the Commonwealth. A local advisory committee of management could be appointed in each administrative district to enable the most suitable administrative arrangements to be made to meet local conditions ; such committee being comprised of representatives of the various mutual benefit societies operating in the district, trade unions, medical practitioners, and other organizations interested in the national insurance scheme. The local agents appointed in the sub-districts or branches would be, in most cases, part-time officers under the direct supervision and control of the district administration. It will be also necessary to establish an inspection staff to superintend the arrangements for the collection of contributions.

[n determining whether the claimant for sickness or invalidity benefit is incapacitated for work, the administrative officials in other countries are ordinarily guided by the certificates issued by medical practitioners, and suitable arrangements will need to be made with general medical practitioners throughout Australia for the production of certificates as to the insured person’s incapacity for work. It is very desirable that such medical certificates should afford sufficient information with respect to the nature and cause of incapacity, as these records will be of great value for statistical investigations which should be instituted in connexion with the scheme. A system of district medical officers is essential to cope with the questions of malingering and certification, which may seriously affect the solvency of the Fund. Such full-time officers would supervise the arrangements for medical certification in each administrative district, and would be available as medical referees when required; their duties, however, would not include any disciplinary powers or right to treatment of patients. It is desirable that the district medical officers should be associated with the Health Department in order that they may thus establish co-ordination between the public health services and the National Insurance Fund.

> Experience in other countries has shown that it is most essential that the many units administering the various social services should be amalgamated or co-ordinated. In Australia at the present time several more or less independent units have functions which are closely related to the proposed national insurance scheme, and endeavours should be made so far as the Commonwealth Departments at least are concerned, to co-ordinate them with the administration of the National Insurance Fund.
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> RECOMMENDATIONS.
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> Your Commissioners recommend:—
> (i) that the central administration of the National Insurance Fund include representatives of the contributing parties, viz.:—the Commonwealth, employers, and insured persons;
> (ii) that a system of district administration be instituted with a district office in charge of the administration of the Fund within each district (iii) that a local advisory committee comprising representatives of existing mutual benefit societies, employers' associations, trade unions, medical practitioners and other interested organizations be appointed in each district;
> (iv) that arrangements be made with general medical practitioners for the medical certification of applicants for sickness and invalidity benefits;
> (v) that a district medical officer be appointed to supervise the arrangements for medical certification in each district;
> (vi) that efforts be made to co-ordinate the administration of the National Insurance Fund with the administration of Commonwealth Invalid and Old-age Pensions, Maternity Allowances and War Pensions;
> (vii) that the system of labour bureaux recommended in our Second Progress Report be utilized for the purpose of certification of unemployment in connexion with exemption from contributions;
> (viii) that, wherever practicable the administrative machinery of existing mutual benefit associations be availed of in the administration of each district.

In September 1928, the Government introduced a Bill into the Federal Parliament for a National Insurance Scheme. While there were no provisions in this Bill for a national health scheme, the proposed compulsory insurance scheme included flat rate contributions from both employers and employees based on gender. It was heavily criticized by the friendly societies, who claimed that the new scheme would negate freedom in consumers' choice. Employers were concerned with the effect the contributions would have on wage rates, and potential disadvantage against foreign competition. The Bill lapsed when the Bruce-Page government was defeated at the 1929 elections.

The Kinnear Report and the *National Health and Pensions Insurance Act 1938*

In 1935, the Commonwealth Government obtained advice from Sir Walter Kinnear, head of the insurance department in the British Ministry of Health, on developing National Insurance and Health Schemes for Australia. His report, which was delivered to the Government in 1937 recommended providing health insurance for lower income earners financed through taxation, and essentially adopting the British scheme subject to some accommodation for the existing system of friendly societies and hospital funds. One significant recommendation was to establish the capitation method of paying doctors.

Capitation is a payment arrangement by which a fixed amount per period of time is paid to the practitioner for each enrolled person assigned to them, whether or not that person seeks their services. The amount of remuneration is based on the average expected health care usage by the patient.

The proposed scheme would not cover a range of treatments, such as major operations and confinements, which would be capable of being covered by voluntary contributions to the friendly societies or hospital funds. The social insurance parts of the scheme included sickness, disability, old age and widowhood cash benefits, and was recommended to be funded through compulsory contributions by employers and employees, as well as government contributions.

The Government accepted the recommendations of the Kinnear Report and, in May 1938, the National Health and Pensions Insurance Bill 1938 was introduced into the Federal Parliament by R G Casey, Treasurer in the Lyons Ministry. It was proposed that the scheme would be financed by imposing a 2% levy on the wage income.

The Bill was passed in July 1938, but was never implemented. Once again, there was strong opposition to it from the medical profession, which opposed the capitation proposal, and also from the friendly societies, which were concerned about the potential loss of membership. There was also strong opposition from the Labor Party and the union movement who were of the view that the scheme was not broad enough.

Following the election of the Menzies Government in 1939, further work was done to seek to implement a scheme. This work was described by A A Sidorenko as follows:[32]

> Under the Menzies United Australia Party (UAP) and UAP - Country Party (CP) coalition governments, further work went into developing a comprehensive system of health insurance in 1939 - 1941. The responsibility for developing the new plan rested with three major bodies: the Parliamentary Joint Committee on Social Security, the NHMRC, and the Federal Council of the AMA. The Medical Planning Committee was set up by the Joint Committee (JC) to work on the official government recommendations on the issues of health care and finance. Implementation of the proposed changes would be left until after the War. At the same time, the AMA was working on an alternative plan for national health insurance that would satisfy the medical profession. The plans contradicted each other on the methods of reform implementation and the role of the medical profession in the new system. The AMA could not accept a system where medical doctors became salaried government employees. Neither was it content with the capitation as opposed to a fee-for-service reimbursement system. All parties agreed on the flaws within the *National Health and Pensions Insurance Act 1938*, but their proposed remedies were widely different. The government bodies (JC and NHMRC) insisted upon universal free health coverage, financed through the taxation system, with doctors employed by the government. The proposed system would cover not only hospital and out-patient services, but dentistry and ophthalmology as well. Administratively, implementation of this plan would run into the problem of hospital finance. At the time, about forty percent of Australian hospitals were private, and the public ones were in poor financial shape8. The Commonwealth government was considering giving subsidies to the States for providing hospital services free for patients in public hospitals. The policy was to be preceded by the uniform standardisation of hospitals to comply with the major requirements. The AMA plan envisaged expanding the role of the voluntary health insurance to cover a larger scope of benefits and preserving the historically high role of Friendly Societies. Additional measures were proposed in the plan to ensure accessibility of the services by the poor and unemployed. The concept of the "safety net", as perceived by the AMA, evolved from compulsory insurance for low-income groups to retaining voluntary insurance and supplementing it with government subsidies for the poor and unemployed. The ultimate goal of the AMA proposal would be to minimise changes to contemporary medical practice. The idea of abandoning private practice and replacing it with government-contracted salaried services that was supported in the JC and NHMRC proposal was despicable to the medical profession. The final results of the joint efforts of the JC, NHMRC and the AMA were unsatisfactory. A way to reconcile government objectives and the interests of the medical profession was not found.

[32] Alexandra A Sidorenko, 2001: *Health insurance and demand for medical care: Theory and application to Australia*, Australian National University, at pp. 15-16.

Constitutional and other legislative developments

When the Labor party came to power in 1941, more radical steps were proposed, which required Constitutional amendment to implement. These developments are described by A A Sidorenko as follows:[33]

> The Labor party came to power in 1941 and remained in office until 1949 (Curtin Government 1941-45, Forde ministry 1945, and Chifley ministry 1945- 49). Given the history of the ALP fight for a universal national health care system, along with general problems of social security, the return of the health issue to the political agenda was to be expected. During the World War II years, health reform was under consideration, previous recommendations of the NHMRC and JC were carefully studied, and further government reports were produced. Proposed measures were quite radical: at the ALP's General Federal Conference in 1943, Senator Fraser urged the government to undertake active steps to introduce a comprehensive social security act which would include the nationalisation of medical care and other social safety nets. This proposal was rejected, but certain steps aimed at strengthening the Commonwealth's position in health policies and its constitutional powers in general were undertaken, which led to the foundation of the future ALP social program.
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> The corner-stones of the new program included full employment and an equitable (re-distributive) social security system as main policy objectives over the post-war reconstruction period. As the instruments to finance the program the Federal Treasurer J B Chifley proposed compulsory progressive personal and corporate income taxes. Following this proposal, the National Welfare Fund was created in 1943 to accumulate a quarter of the tax revenue which would be channelled into the social security system. Chifley did not advocate that the government take direct control over medical care provision, but argued the state had to intervene in sectors where private markets failed to deliver services efficiently and equitably. As private practices did not seem threatened, the policy was likely to coerce increasing number of doctors to cooperate with the government in the new program. Nevertheless, the opposition parties perceived the policy as trying to "socialise" everything, and that backfired. Thus the ALP's attempt to pass this new health legislation failed.
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> There were also constitutional obstacles as to the powers delegated to the Commonwealth in health management, which traditionally belonged to the States. Labor's proposal to give the Commonwealth powers over national health programs failed in the 1944 referendum, and a second referendum in 1946 provided for limited powers only. The Pharmaceutical Benefits Bill of 1944, according to which the costs of prescribed medicines were to be covered from the National Welfare Fund if the prescriptions were written on the special Government-approved forms, faced strong opposition from the AMA. A tacit policy of non-cooperation, as well as legal action, was commenced. The medical profession refused to accept the rules imposed on them by the new legislation. In October 1945, the High Court of

[33] Alexandra A Sidorenko, 2001: *Health insurance and demand for medical care: Theory and application to Australia*, Australian National University, at pp. 17-19.

> Australia held the Act to be invalid,[34] judging that it inappropriately controlled doctors and chemists. The Hospital Benefits Act introduced in 1945 was the Federal Government's next step towards the financing of institutional health care nationwide. It provided for per diem hospital benefits in both private and public hospitals, and hospital treatment was made free for public beds in public wards.
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> As a result of the 1946 referendum, Paragraph (xxiiiA) was added to Section 51 of the *Constitution*. The Federal Government gained legal power over "the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances". The wording in brackets was added following the suggestion of the President of the Federal Council of the AMA, Sir Henry Newland, supported by then Leader of the Opposition, R G Menzies. Section 51(xxiiiA) became a powerful addition to the existing Section 51(ix), which entitled the Commonwealth to provide for quarantine, and Section 96, which enabled the Commonwealth to "grant financial assistance to any State on such terms and conditions as the Parliament thinks fit." These were the only constitutional channels through which the government could convey its health care finance and policy.
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> Another unsuccessful legal initiative of that time was the Labor National Health Service Act, which was accepted in 1948, amended in 1949, and then repealed in 1953. The implementation of the Act was administered by the Commonwealth Director General of Health. The Act empowered the Commonwealth to provide or arrange for general medical or dental services, specialist services and diagnostics, medical services in universities and schools, to run health facilities, and to manufacture medical supplies. It is worth noting that the AMA perceived the new government initiatives as an attack against doctors' freedom and the freedom of their patients. A new Pharmaceutical Benefits Act of 1947 was boycotted by medical practitioners, and the government retaliated by adding Section 7A to the Act which made it an offence if a medical practitioner failed to use the Government-authorized form for the prescription of the approved medicine. In 1949, the High Court invalidated the amendment, and the medical profession continued their tactics of non-cooperation.
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> There were also several successful legal moves in social welfare and health areas, including the *Maternity Allowance Act 1943*, the *Invalid and Old Age Pensions and Funeral Benefits Act 1943*, the *Unemployment Benefit and Sickness Act 1944*, the *Hospital Benefits Act 1945-47-48*, the *Tuberculosis Act 1945-46-48*, and the *Mental Institutions Benefits Act 1948*.

The provenance of the phrase 'but not so as to authorize any form of civil conscription' in s 51(xxiiiA) of the *Constitution*, which empowers the Commonwealth to legislate with respect to medical benefits, has been the subject of some debate. It has been said that, while Newland suggested a similar concept in a letter to Page, who passed the letter to Menzies, who proposed the amendment to Evatt, Evatt

[34] *Attorney-General (Vic); Ex rel Dale v Commonwealth* (*Pharmaceutical Benefits case*) [1945] HCA 30; (1945) 71 CLR 237.

already had such an idea in mind.[35] Only two years earlier, Constitutional amendment proposals had been defeated at a referendum at which detractors claimed that the proposals amounted to 'industrial conscription', and a Bill had already been introduced relating to the regulation of industrial conditions that used the phrase, 'but not so as to authorize any form of industrial conscription'.

The *National Health Act 1953*

When the Menzies government came to power in 1949, it commenced its own legislative program to restructure the health system. The *National Health Act 1953* was enacted, which consolidated various other pieces of legislation that had been introduced between 1950 and 1953 relating to pharmaceutical benefits, hospital benefits, medical benefits and the pensioner medical service.

In his Second Reading Speech, the Minister for Health, Sir Earle Page, described the structure of the National Health Bill 1953:[36]

> Parts I. and II. are the preliminary and national health services parts, and set out general administrative provisions and authorize arrangements for important public health functions. In Part III., arrangements for providing a comprehensive medical benefits scheme are outlined. This part authorizes the payment of Commonwealth benefits of the amounts set out in the schedule to the bill in respect of the various treatments, procedures and operations, which are carried out by medical practitioners. Between 700 and 800 procedures are itemized. These payments will be made to registered medical benefits organizations, which provide for their own contributors a fund benefit at least equivalent in scope and amount to the First Schedule to the bill. If a person is a contributor, he will be insured by the organization in respect of his wife and dependants and the Commonwealth benefit will be available to him for the medical expenses of his whole family.
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> The Commonwealth medical benefits to be paid are most comprehensive and are set out in the First and Second Schedules to the bill. Benefits in the First Schedule which cover the ordinary services provided by a general medical practitioner, must be matched by the organizations, and it is confidently expected that most organizations will also provide the Second Schedule benefits, which are mainly of a specialist nature. Thus, an insured person will receive a total benefit of at least double the amount shown in the First Schedule, and will also receive double the Second Schedule amounts if lie is so insured. Thus, for a very modest weekly contribution, the contributor and all his dependants will receive very substantial benefits, which will cover the major portion of his medical expenses in the event of sickness, leaving him with only a nominal sum to pay.

[35] Wilde, Sally, 'Serendipity, Doctors and the Australian Constitution' (2005) 7 *Health and History*, pp.41-48.
[36] *Hansard*, House of Representatives 27 March 1953.

It is recognized that there will be people who, because of age or chronic infirmity will be unable to join such organizations, but it is hoped that as the scheme develops and the organizations become stronger financially, they will" be able to give an increasingly wide cover to these persons. Experience in the operation of voluntary hospital insurance organizations has shown that as the number of insured people increases, it becomes possible to progressively reduce and, in some cases, remove, the qualifications of membership and entitlement to benefit, which are imposed by such organizations. Because of this experience, it is confidently expected that organizations conducting medical benefits funds will soon be able to reconsider the provisions in their rules relating to age limits and limitations on benefits, waiting periods and so-called chronic illnesses.

By providing a full and complete medical and pharmaceutical service to pensioners and their dependants in Part IV of this bill, the Government has met the needs of this main group which would normally be unable to insure. It must be remembered that the pensioner medical service is available to all receiving an invalid, age or widow's pension, as, well as those in receipt of a service pension under the Repatriation Act, or a tuberculosis allowance. The experience of the organizations to which I have already referred, together with the departmental experience which is being gained in administering the pensioner medical service, will be a valuable guide. in deciding what steps are necessary to meet the case of people normally unable to insure for medical or hospital benefits. Provision to meet these cases is made in clause 2S of the bill.

The pensioner medical service in Part IV of the bill is provided to the pensioner group and their dependants, and under clause 84 this group is also provided with a full range of medicines free of charge. Because this service is free, it is probably more susceptible to abuse than medical and hospital benefits, where the contributor has an interest in keeping claims to a minimum. For this reason, particular care has been taken to provide control in the part dealing with committees of inquiry as well as in clauses 35 to 37 of the part. The medical profession, and indeed pensioners themselves, have displayed a strong desire to see that this most generous arrangement is not abused. The tremendous value of the pensioner medical service will be more readily appreciated from the fact that there are over 535,000 people enrolled in the scheme, and over 4,000,000 individual services have been rendered up to the end of last year by 3,700 doctors who participate in the scheme. In addition, over 3,000,000 individual prescriptions have been supplied under the scheme.

Part V deals with hospital benefits. This Government recognizes the parlous financial plight into which hospital finances have drifted. We desire to increase hospital revenues, not only by direct assistance to the State, but by the scheme of hospital insurance which we are convinced can extricate hospitals from their financial difficulties in the long term. However, nothing can alter the fact that the provision, management and control of hospitals is a State function. and the States must accept their responsibility to conduct their hospitals efficiently. They must also accept the responsibility for determining the fees payable by patients. I should like to make it quite clear that my Government has not, and will not, determine the level of fees payable in public or private hospitals. This is a matter entirely for the hospital authority or State concerned. Hospital benefits agreements have been

> entered into with all States and contain virtually identical provisions with only slight modifications to meet varying hospital setups in each State. So far as the Commonwealth is concerned, each State has been given the same terms; that is, 8s a day is payable in respect of patients in public hospitals with 12s a day for pensioners and their dependants. Under these agreements the States have been left entirely free to determine their own hospital finances and administrative policies and the Commonwealth has not, and will not, interfere in these matters. In view of recent misleading election propaganda, it is necessary for me to make this position clear.

Disaffection with the health system grew over the next two decades. The issues and resulting action are discussed in the following extract by A A Sidorenko[37]

> Over the first decade of its operation the Earle Page scheme came under sharp criticism both because of the complexity and costliness of its administration, and the economic benefits to the consumers of medical care. For many of them, the out-of-pocket expenses remained too high. By the late sixties, about 15 to 17 per cent of Australians lacked any insurance arrangements to cover their possible medical expenditure14. Problems and deficiencies in the voluntary scheme as perceived by its supporters rested also with "unnecessary and disproportionate increase in the role of the Government, and registered benefit organisations and their contributors ... losing more and more of the advantages of free enterprise and competition on which the Scheme was founded." Private health insurance funds were constrained by "the inequities and anomalies resulting from the unqualified use of community rating as ... applied, and the invalidity of the financial justification ... accepted as validation for the existing tables and rates of contribution", despite actuarial assessments. Interestingly enough, proponents of compulsory health insurance also blamed the community rating principle, but for a different reason. They saw that the community rating led to anti-selection of private health plans by good risk individuals, particularly by young single males. "While it may be rational, at least in a collective sense, for good risk individuals to carry their own insurance, they often do not manage their financial affairs so as to have liquid assets available to meet the costs which they do incur. In practice, therefore, their non-insurance has consequences for the rest of society."
>
> It seemed both parties admitted there were problems inherent in the community rating principle, yet their conclusions were different, ranging from moving towards experience rating with government subsidies for the most disadvantaged, to a hybrid between compulsion and increased subsidisation of voluntary insurance. It was argued that "the Australian voluntary health insurance scheme embodies the very quintessence of a democratic society, because of the manner in which it combines individual freedom of choice of health services with government assistance in meeting the costs of such services", therefore preservation of the private insurance sector was essential. Attempts were made to rectify the voluntary insurance scheme, which was perceived by its many supporters to be the most appropriate for Australia, for a number of reasons:

[37] Alexandra A Sidorenko, 2001: *Health insurance and demand for medical care: Theory and application to Australia*, Australian National University, at pp. 21-23.

"There are many communities...where a voluntary scheme, operating with a government subsidy, would be ideally suited - communities operating on a balance of the economic and humanitarian principles which determine social service policy. The spirit behind it is one of free enterprise, but not of a "cut-throat" nature. It embodies the principles of self-help, but with external aid for those who are not in a position to help themselves. It provides medical care for all at a reasonable cost, whilst creating satisfactory working conditions for the medical profession. And it can do this without sacrificing the principles of responsible, free enterprise. As such, it is the type of health care system most admirably and specifically suited to Australia."[38]

In this atmosphere of discontent with the status-quo, and understanding that the voluntary health insurance was at the crossroads, the alternative ALP health insurance program was developed by Richard Scotton and John Deeble at Melbourne University's Institute of Applied Economic and Social Research (see Scotton and Deeble (1968)).[39] Scotton and Deeble claimed that the costs of private health insurance bore "unduly heavily on low income families", and that noninsurance and underinsurance was "most widespread in the lower income group". In 1968, the government set up a special Commonwealth Committee of Inquiry into Health Insurance to review the performance of the voluntary health insurance scheme. The Chair of the Committee was Justice J. A. Nimmo. The Nimmo Committee concluded that the costs of private health insurance were unbearable for about one million Australians, that out-of-pocket expenditure on medical care was often very high, and that the chronically ill and people with pre-existing conditions were particularly disadvantaged when seeking private health insurance coverage. At the time, there was a split in politics on the basis of the health care scheme. The left of the ALP, supported by some Unions, was in favour of the nationalisation of health services, with the British National Health Scheme serving as an example to follow. The mainstream ALP, then in opposition, advocated the introduction of a universal social insurance. And the Liberal and Country Parties, supported by the Australian Medical Association, were vehemently supporting the Page scheme, acknowledging the fact that it should be rectified to address the issues of public concern (Swerissen and Duckett (1997)).[40]

The program developed by Scotton and Deeble proposed a universal national health scheme, completely financed by the government through the introduction of a health tax, and administered by a government body. The major perceived benefit of the new scheme would be its equitability and efficiency. For a detailed discussion of the Nimmo Committee recommendations and other political issues of that period

[38] Wilson, L L (1970). *The second blessing: an appraisal of voluntary health insurance as the ideal method of financing the costs of essential health care*. Melbourne, Office of Health Care Finance.

[39] Scotton, R B and J S Deeble (1968). "Compulsory Health Insurance in Australia." *Australian Economic Review* (4th Quarter) 9-16

[40] Swerissen, H and S Duckett (1997). "Health Policy and Financing". *Health Policy in Australia*. Edited by H Gardner. Melbourne, Oxford University Press: 13-45.

see Sax (1984),[41] Butler and Doessel (1989).[42] The Scotton and Deeble program attracted sharp criticism from the supporters of a voluntary insurance scheme, and the validity of their major claims was questioned. For example, Turner (1969a)[43] stated that a "voluntary plan, reconstructed by the application of community rating to more homogeneous populations, and the redirection of Government subsidies to provide more effective use of available resources, would provide a more effective "pooling" system than could be provided by a compulsory tax-financed system". He also noted that "the Scotton-Deeble compulsory plan is highlighted by its very dependence on the preservation of voluntary health insurance" which was required "to cover all services beyond basic care". The alternative program of reconstructing a voluntary health insurance scheme was proposed in Turner (1969a) and discussed in Turner (1969b), and the importance of preserving the spirit of individual responsibility as opposed to patronising government intervention in provision and financing of health care was compared to "the difference between a dole and a wage, between negative and positive thinking".

The Gorton Liberal-Country party government aimed at reform and improvement of the voluntary health insurance. The Health Benefits Plan adopted in 1970 included many recommendations from the Committee of Inquiry's Report. Yet, according to the supporters of the compulsory insurance scheme, the aims of equity in access to health care were yet to be achieved. The scheme included subsidised or free health insurance for people on low incomes and other vulnerable groups, yet the commitment to voluntary health insurance was not abandoned. The concept of a "most common fee" was introduced to facilitate adequate adjustment to the government benefits payable for certain medical services. Those common fees were to be revised on a regular basis, but no definite procedures for such a review were agreed upon. Doctors were reluctant to embrace the scheme, up to a threat of an explicit boycott of the Health Benefits Plan, but a firm government position and generous federal funding helped overcome their resistance.

A program of compulsory health insurance became a significant part of the political platform of the ALP, then in opposition. Its pre-election program included the establishment of a universal health insurance fund providing for both hospital and medical benefits to all of the population, with the benefit equal to 85 per cent of the schedule fee, and a $5 gap between fees and benefits. Bulk billing was to be introduced, and free hospital treatment in public hospitals without a means test to be negotiated with the States, and a levy of 1.35 per cent on taxable income and equivalent contributions from the Commonwealth. These principles became major features of the future Medibank program.

[41] Sax, S. (1984). *A Strife of Interests: Politics and Policies in Australian Health Services*. Sydney, George Allen & Unwin

[42] Butler, J R G and D P Doessel, Eds. (1989). *Health Economics: Australian Readings*. Sydney, Australian Professional Publications.

[43] Turner, R. J. (1969a). *The Case Against Compulsion: An Evaluation of the Scotton & Deeble Plan for Compulsory Health Insurance in Australia*. Melbourne, Office of Health Care Finance

Health Insurance Act 1973

Background

The enactment of the *Health Insurance Act 1973* largely implemented the recommendations in the Report of Health Insurance Planning Committee, which was tabled in the Parliament on 2 May 1973. The Health Insurance Planning Committee had been established by the Minister for Social Security, The Hon Bill Hayden, on 22 December 1972, less than 3 weeks after the election of the Whitlam Labor Government.

On 20 July 1973, Cabinet accepted the Committee's recommendations with some variations suggested by the Welfare Committee of Caucus.[44] The Health Insurance Bill 1973 was drafted and then introduced into the House of Representatives on 29 November 1973.

The scheme (then known as Medibank) was opposed by the Coalition parties, which controlled a majority in the Senate. The Health Insurance Bill 1973 and other related Bills were rejected by the Senate on 12 December 1973 and again on 2 April 1974. The Health Insurance Bill 1973 was one of six Bills[45] that formed the basis for the double dissolution of Parliament on 11 April 1974.

Following the re-election of the Whitlam Government in the election held on 18 May 1974, the Bill was reintroduced into both Houses of the Parliament and, on 18 July 1974, it was again rejected by the Senate. However, the Bill was subsequently passed at a joint sitting of Parliament (in accordance with section 57 of the *Constitution*)[46] on 7 August 1974.

When the Bills were first introduced into Parliament in 1973, they included a proposal for a taxpayer levy of 1.35% of taxable income with exemptions for low income earners. The Senate rejected those Bills and so the original Medibank was funded entirely from general revenue. In relation to hospital services, the Medibank scheme involved free treatment for public patients in public hospitals, and subsidies

[44] Cabinet Decision No.1080, 20 July 1973.
[45] The Bills were the Commonwealth Electoral Bill (No. 2) 1973, the Senate (Representation of Territories) Bill 1973, the Representation Bill 1973, the Health Insurance Commission Bill 1973, Health Insurance Bill 1973, and the Petroleum and Minerals Authority Bill 1973.
[46] See *Cormack v Cope ("Joint Sittings case")* [1974] HCA 28; (1974) 131 CLR 432.

to private hospitals to enable them to reduce their fees. The Commonwealth entered into agreements with the State governments in order to fund these services, such that the Commonwealth would give grants to the States equating to 50% of the general operating costs of public hospitals.

Shortly after the election of the Fraser Government in December 1975, a Medibank Review Committee was established. On 1 October 1976, Medibank Mark II commenced, and included a 2.5% levy on taxable income if the taxpayer chose not to take out private health insurance. The legislation permitted the Health Insurance Commission to enter the private health insurance business, which then established Medibank Private.

In 1978 the Government reduced medical benefits to 75% of the Schedule fee, and restricted 'bulk billing' to holders of Pensioner Health Benefit cards and to patients whom the medical practitioner regarded as 'socially disadvantaged'. At the same time, the health insurance levy was abolished.

A further reduction in benefits was made in 1979 to limit them to the difference between $20 and the Schedule fee. In 1981 further restrictions occurred with free hospital treatment restricted to pensioners with Health Care cards, sickness beneficiaries, and those meeting a means test. An income tax rebate of 32% was allowed for taxpayers with private health insurance.[47]

With the election of the Hawke Government in 1983, major changes occurred, substantially returning to the Whitlam Government model of Medibank, but renaming it Medicare. This scheme was enacted by the *Health Legislation Amendment Act 1983*, and commenced on 1 February 1984.

A Medicare levy was introduced at 1% of taxable income, with low-income cut-off points. Subsequently, the levy was increased to the current level of 1.5%.

[47] The *Income Tax Assessment Act 1936* was amended by section 27 of the *Income Tax (Assessment and Rates) Amendment Act 1981*, which inserted:

> 159XA. (1) Subject to this section, a taxpayer is entitled to a rebate of tax in his assessment in respect of income of the year of income of an amount equal to 32% of any amount paid by the taxpayer in the year of income to a registered organization for the purpose of securing, for the personal benefit of the taxpayer, of his spouse or of a child of the taxpayer or his spouse an entitlement to basic hospital benefits or basic medical benefits.

For a more detailed account of the Medicare story, see Anne-marie Boxall and James A Gillespie, *Making Medicare: The politics of universal health care in Australia*, NewSouth Publishing, 2013.

2 Commencement

The *Health Insurance Act 1973* commenced, upon Royal Assent, on 8 August 1974.

3 Definitions

'clinically relevant service'

The concept of a **'clinically relevant service'** is fundamental to the medicare benefits program. A benefit will not be payable unless the service that has been provided is a 'clinically relevant service'. It is defined to be a service rendered by a medical practitioner, dental practitioner or optometrist that is generally accepted in the relevant profession 'as being necessary for the appropriate treatment of the patient to whom it is rendered.'

The word 'necessary' has been interpreted in this context as 'there being no reasonable alternative in the circumstances' in light of the information available to the practitioner at that time: *Sevdalis v Director of Professional Services Review (No. 2)* [2016] FCA 433. In *Nithianantha v Commonwealth of Australia* [2018] FCA 2063, the Federal Court held that the time at which a practitioner can decide the particular item to be claimed or billed is after the service has been rendered.

Doan v Health Insurance Commission [2002] FCA 1160 —

> [81] Further, the definitional chain of "inappropriate practice" in the HI Act and the overall issue of whether the practitioner has engaged in "inappropriate practice" necessarily demands an analysis of particular questions, including whether the service is clinically relevant, whether the services rendered or initiated in the referral period were necessary, whether there was an appropriate level of clinical input and whether the services were appropriate. In this way, from the definition of s 82 of inappropriate practice, one has to go to s 81(1) which defines a "service" as a service for which "at the time it was rendered or initiated, a Medicare benefit was payable", such Medicare benefits being payable where, "on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person..." (s 10(1)). The meaning of "professional service" in s 3 then directs one to the meaning of a "clinically relevant service" which is defined as a "service rendered by a medical ... practitioner ... that is

generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered": s 3.

Sevdalis v Director of Professional Services Review (No. 2) [2016] FCA 433 —

[124] The "service", for the purposes of this assessment (and for the purposes of a practitioner's entitlement), is a service "to which an item relates" under the regulations: see the definition of "professional service" in s 3(1) of the Act. Applying that to items 37 and 5043, the during hours and after hours attendances by Dr Sevdalis at places other than his consulting rooms or an aged care facility (or a hospital, in the case of item 5043) were, by the definition of "professional service" read with the definition of "clinically relevant service" in s 3(1) of the Act, required to be a service that was one "generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered".

[125] In some circumstances, an assessment of whether that requirement was met may touch upon some of the matters which were (in my opinion, wrongly) considered by the Committee in relation to item 37 and item 5043. Nevertheless, it remains the case that, looking at all the instances in which the Committee made an assessment, its approach introduced a gloss, or a consideration of a nature different to that required, by examining in quite an absolute way whether a patient "could have" gone to Dr Sevdalis' consulting rooms. On no view, in my opinion, is the evaluation to be conducted at that absolute level. Even within the terms of the two definitions in s 3(1), the evaluation is what kind of attendance is "necessary for the appropriate treatment" of a patient. That is not an evaluation to be conducted in hindsight, perhaps years later, but on the information available to the practitioner at the time and it should not, in my opinion, be conducted by a Committee asking itself whether a patient "could" have gone to the surgery, even on the information available at the time. Rather, the correct question is whether a during hours or after hours service was, on the information available to the medical practitioner at the time, "necessary for the appropriate treatment of the patient to whom it is rendered", and generally accepted in the medical profession to be so. In my opinion "necessary" imports a standard at the level of there being no reasonable alternative in the circumstances. It does not suggest the Committee should determine whether it was physically possible for a patient to have attended during hours or at the practitioner's consulting rooms, which in my opinion is the standard the Committee seems to have applied.

Sevdalis v Director of Professional Services Review [2017] FCAFC 9 —

[21] It was open to the Committee, as a peer review body, to assess what was "necessary" for the appropriate treatment of patients, including whether it was necessary to consult with those patients at locations other than the appellant's consulting rooms, and to take that into account when determining whether the practitioner's conduct would be "unacceptable to the general body of general practitioners". The definition of "clinically relevant service" defines a service as one that is "necessary" for the appropriate treatment of the patient. Section 79A of the Act describes the object of Part VAA (in which s 82 is found) as follows:

> The object of this Part is to protect the integrity of the Commonwealth medicare benefits, dental benefits and pharmaceutical benefits programs and, in doing so:
> (a) protect patients and the community in general from the risks associated with inappropriate practice; and
> (b) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

[22] The terms in which "clinically relevant service" is defined, and the objects in s 79A, required the Committee, where appropriate, to evaluate and form a view about the appropriateness of the treatment given by a medical practitioner to a patient. The Committee did that as her Honour recorded at [130] of her Honour's reasons:

> Then, at [65] the Committee addressed the s 10 and s 3(1) requirements of "professional service", together with submissions made on behalf of Dr Sevdalis:
>
> > This is further supported by the requirement in the Act that Medicare benefits are payable only in respect of a "professional service" that is a "clinically relevant service". This means that the particular service rendered must be a service that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient. If it was not necessary to conduct a home visit for the treatment of the patient, then it was not a clinically relevant service and was not eligible for the payment of a Medicare benefit. Consequently, a practitioner needs to document the clinical information adequate to explain the type of service rendered, which in respect of home visits should include the fact that it was a home visit, and the reason for having to go to that particular location on that occasion to attend to the patient. For after-hours visits, it should indicate when the attendance occurred and the clinical reasons for needing to attend to the patient at that time. For minimum timed services, the clinical record should record the actual time spent and indicate the clinical reasons for spending at least the minimum amount of time for the MBS item billed.

[23] The Committee had based its conclusion upon its construction of items 37 and 5043 but had considered also the requirements of "professional service" in ss 10 and 3(1). Her Honour was permitted to conclude that despite any supposed erroneous interpretation of the requirements by the Committee of items 37 and 5043, it was substantially correct also to conclude that the requirements of s 10 of the Act, read with s 3(1), permitted it to consider whether the service rendered by Dr Sevdalis was necessary for the appropriate treatment of the patient to whom it had been rendered: see *Eastman v Commonwealth Director of Public Prosecutions (ACT)* (2003) 214 CLR 318, [124]; *Australian Education Union v Department of Education and Children's Services* [2012] HCA 3; (2012) 248 CLR 1, [34]; *Attorney-General (SA) v Corporation of the City of Adelaide* [2013] HCA 3; (2013) 249 CLR 1, [175].

'dental benefit'

The *Dental Benefits Act 2008* operates in conjunction with and in a similar manner to the *Health Insurance Act 1973* to enable the provision of dental benefits for **'dental services'** provided by **'dental practitioners'** to **'eligible dental patients'**. The *Dental Benefits Act 2008* sets up a framework for the provision of dental benefits. A dental benefit is payable if **'dental expenses'** are incurred in respect of a dental service rendered to an eligible dental patient. The amount of dental benefit payable is the amount specified in, or determined in accordance with, the ***Dental Benefits Rules***,[48] made by the Minister under section 60 of the *Dental Benefits Act 2008*.

If a dental benefit is payable, it is payable by the Chief Executive Medicare to the person who incurs the dental expenses in respect of the dental service. In some circumstances, the dental benefit is payable to the dental provider. Claims for dental benefit must be lodged with the Chief Executive Medicare.

The Chief Executive Medicare issues vouchers in relation to a dental service to persons who qualify for a voucher. A person qualifies for a voucher if the person meets the requirements of the *Dental Benefits Act 2008* or if the *Dental Benefits Rules 2014* provide that the person qualifies for a voucher. A person in respect of whom a voucher is issued is, in effect, an eligible dental patient. The *Dental Benefit Rules* may also provide that certain eligible persons are eligible dental patients.

This *Dental Benefits Act 2008* also makes provision in relation to the obtaining of documents relevant to ascertaining whether amounts should have been paid, the disclosure of information, offences against this Act and other matters.

'dental practitioner'

A 'dental practitioner' means a person registered or licensed as a dental practitioner or dentist under a law of a State or Territory. State or Territory legislation provides for the registration or licensing, not only of dentists, but also dental hygienists, dental therapists, dental prosthetists, and oral health therapists as 'dental practitioners'. However, the *Dental Benefits Rules 2014* specify that only a 'dental provider' may provide a dental service.

Section 6 of the *Dental Benefits Act 2008* provides that a 'dental provider' means a dental practitioner who has general registration, or specialist registration, in the

[48] The current rules are the *Dental Benefits Rules 2014*.

dentists division of the dental profession, but that the Rules may specify other classes of practitioners to be dental providers, either generally, or in respect of particular types of dental services.

Prior to 1 July 2022, the *Dental Benefits Rules 2014* did not provide for any practitioner other than a dentist to be able of providing services under the legislation. From that date, the Rules were amended by the *Dental Benefits Amendment (Allied Dental Practitioners) Rules 2022* such that rule 6 was replaced to expand the classes of dental practitioners who could provide services so as to include dental hygienists, dental therapists, and oral health therapists.

Section 7 of the *Dental Benefits Act 2008* is similar in effect to subsection 3(17) of the *Health Insurance Act 1973*, in that it provides that a dental service is taken to be rendered on behalf of a dental provider if, and only if, the dental service is rendered by another person included in a class of persons specified in the Dental Benefits Rules for the purpose of that section, and the other person provides the dental service, in accordance with accepted dental practice, under the supervision of the dental provider.

Rule 7 of the *Dental Benefits Rules 2014* provides for the purposes of section 7 of the Act that a dental service may be rendered on behalf of a registered dentist by a dental hygienist, dental therapist, dental prosthetist, or an oral health therapist. It also provides that if a dental service is provided on behalf of a **'public sector dental provider'**, it may be provided by another public sector dental provider.

The effect of these provisions is that prior to 1 July 2022 only a dentist could provide a dental service. However, in accordance with accepted dental practice, and under the supervision of a dentist who has been given a provider number, a dental service could be rendered by a dental hygienist, dental therapist, dental prosthetist, or an oral health therapist.

The degree and nature of supervision required would depend on what would be acceptable to the general body of dental practitioners for the particular type of service being rendered. The degree and nature of supervision required might also depend on the skills, qualifications and experience of the particular person who actually performs the service and the circumstances in which the service is rendered. Even though the Dental Board's policies, code or guidelines might indicate that the scope of practice for dental practitioners other than dentists would permit them independently to provide some or all of the types of dental services provided for in

the Dental Benefits Rules, section 7 of the *Dental Benefits Act 2008* would not permit them to provide dental services independently of a dentist. It is the responsibility of the dentist who has been allocated a provider number to supervise, and ultimately be responsible for, the rendering of the services provided on their behalf.

Since 1 July 2022, the *Dental Benefits Rules 2014* provide that only certain services may be provided by particular types of dental practitioners. These are specified in a table in rule 8AA. That rule states, in effect, that for certain items a dental benefit is not payable unless it is rendered by or on behalf of a dentist, and that for certain other items a dental benefit is not payable unless it is rendered by or on behalf of a dentist, a dental therapist, or an oral health therapist.

'eligible person'

A 'eligible person' means an '**Australian resident**' or an '**eligible overseas representative'**. These two terms are also defined in subsection 3(1) of the Act.

An 'Australian resident' means a person who resides in Australia and who is:

- an Australian citizen
- a holder of a permanent visa
- a person granted or included in a return endorsement or a resident return visa
- a New Zealand citizen lawfully present in Australia
- a person, not included in the above, who is lawfully present in Australia and whose lawful presence is not subject to a time limitation imposed by law
- the holder of a valid temporary visa who has an authority to work in Australia, or in respect of whom another person, being their spouse, child or parent is an Australian citizen or the holder of a permanent visa.

An 'eligible overseas representative' refers to a person who is the head of a diplomatic mission of another country or a member of the staff of such a mission or consulate, or a member of their household.

Under section 10 of the Act, 'medical benefits' are payable in respect of a 'professional service' rendered to an eligible person.

'general practitioner'

A general practitioner is defined in as a medical practitioner registered as a general practitioner under the National Law, or a medical practitioner of a kind prescribed

by the regulations for the purposes of this definition. Paragraph 16(2)(b) of the *Health Insurance Regulations 2018* provides the alternative basis as:

> (b) immediately before the commencement of Schedule 1 to the *Health Insurance Amendment (General Practitioners and Quality Assurance) Act 2020*:
>
> (i) the practitioner held general registration in the medical profession (and was not registered in the specialty of general practice) under the National Law; and
>
> (ii) the practitioner's name was entered in the Vocational Register of General Practitioners.

Prior to 2020, a **'general practitioner'** was defined as a medical practitioner in respect of whom a determination under section 3EA is in force; or a person registered under section 3F as a vocationally registered general practitioner; or a medical practitioner of a kind specified in the regulations.

Under section 3EA, a medical practitioner could apply to the Chief Executive Medicare for a determination that they are a 'recognised' Fellow of the Royal Australian College of General Practitioners (RACGP). To be 'recognised' they must have been a Fellow of the College and, under section 16 of the *Health Insurance Regulations 2018*, meet the minimum requirements of the RACGP for taking part in continuing medical education and quality assurance.

Under former section 3F, the Chief Executive Medicare had established a register of vocationally registered general practitioners. From 1989 until 1995 medical practitioners already working in general practices could apply to be 'grandfathered' into the Vocational Register of General Practitioners if they also met certain eligibility criteria.

After 1996, medical practitioners with a provider number were eligible to become vocationally registered if they undertook a training program administered by the RACGP and passed an exam. Alternatively, they could become vocationally registered if they worked for five years in general practice, applied for membership with the RACGP, and then sat the college exam.

Medical practitioners could become vocationally registered by applying for a certification of eligibility to the General Practice Recognition Eligibility Committee or by undertaking a pathway to Fellowship with either the RACGP or the College of Rural and Remote Medicine (ACRRM).

The third category of general practitioner was a medical practitioner of a kind specified in the regulations. Former section 22 of the *Health Insurance Regulations 2018* provided that a medical practitioner could apply to the Chief Executive Medicare for a determination under that section. A determination would be made if the person is a Fellow of the Australian College of Rural and Remote Medicine (ACRRM) and is eligible for a determination under section 23 of those regulations.

To meet that eligibility, if the person attained their Fellowship of ACRRM after the requirement to undergo accredited training was first introduced, the person must have either successfully completed accredited training, or been assessed by ACRRM as having training and experience equivalent to successful completion of accredited training. In addition, the person must meet the minimum requirements that apply to a Fellow of ACRRM for taking part in continuing medical education and quality assurance.

If the person attained Fellowship of ACRRM before the requirement to undergo accredited training, the person is eligible if either they have been assessed by ACRRM using an assessment tool approved by the Department, as having the relevant training and experience, or is a vocationally registered practitioner. Additionally, the person must meet the minimum requirements that apply to a Fellow of ACRRM for taking part in continuing medical education and quality assurance.

In *Norouzi v Director of Professional Services Review Agency* [2020] it was argued that as the Regulations that prescribed the relevant MBS items contained a different definition of 'general practitioner' for the purpose of those items from the definition of general practitioner in section 3 of the Act, and that Dr Norouzi fell within the definition of 'general practitioner' in the Regulations but not that of the Act, then the relevant test of inappropriate practice to be applied, under section 82 of the Act, in relation to his conduct in connection with rendering those items should have been that relating to the general body of general practitioners rather than the general body of medical practitioners. This argument was run in the context of an application to the Court to exercise its discretion to extend time to apply for judicial review under the *Administrative Decisions (Judicial Review) Act 1977*. The Court rejected that argument.

Norouzi v Director of Professional Services Review Agency [2020] FCA 1524 —

> [51] Because the discretion is not fettered, in theory, but unusually, an extension of time might be granted even where there is no, or no persuasive, explanation for delay and even where it was possible to discern some subversion of efficient public

administration. The prospective merits of a proposed application under the ADJR Act might be such that the interests of justice nonetheless demanded an extension in the circumstances of a given case. As mentioned already, an extension decision can be multi-factorial and relevant factors can interplay. A truly calamitous sequel to an administrative decision obviously devoid of any lawful authority might require the granting of an extension of time even after substantial delay.

[52] That is not this case.

[53] Here, the prospective merits do not, as a matter of impression, appear to me to be such, when considered in conjunction with the factors already mentioned, as to warrant the granting of an extension.

[54] Confidence in prospects is not enlivened by a flawed underlying premise for the proposed ADJR Act grounds. That premise is that the committee applied an incorrect standard to Dr Norouzi in assessing inappropriate practice, because he was a general practitioner and the committee ought therefore to have applied the test ordained by s 82(1)(a) of the HIA, rather than that ordained by s 82(1)(d).

[55] Section 82(1) of the HIA materially provided:

> **82 Definitions of inappropriate practice**
>
> *Unacceptable conduct*
>
> (1) A practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that:
> (a) if the practitioner rendered or initiated the services as a general practitioner– the conduct would be unacceptable to the general body of general practitioners; or
> ...
> (d) if the practitioner rendered or initiated the services as neither a general practitioner nor a specialist but as a member of a particular profession(-)the conduct would be unacceptable to the general body of the members of that profession.

[56] As a matter of ordinary English usage, one might perhaps describe Dr Norouzi, who was not a member of any specialist college during the Review Period, as a general practitioner. However, s 3 of the HIA gives the term "general practitioner" a particular meaning for the purposes of that Act:

> "general practitioner" means:
> (a) a medical practitioner in respect of whom a determination under section 3EA is in force; or
> (b) a person registered under section 3F as a vocationally registered general practitioner; or
> (c) a medical practitioner of a kind specified in the regulations.

[57] On the evidence, none of the paragraphs of the definition was applicable to Dr Norouzi. Thus, s 82(1)(a) of the HIA was inapplicable to him. Instead, having regard to paragraph (a) of the definition of "practitioner" in s 81 of the HIA, it was his status as a medical practitioner which brought him within the ambit of the test

> specified in s 82(1)(d) of the HIA, and only that test. That being so, the relevant test was whether the conduct would be unacceptable to the general body of medical practitioners. That was the test applied by the committee.

'item'

An **'item'** refers to a particular type of service described in the **'table'** made by regulations or determinations under the Act. The table, described below, consists of the **'general medical services table'**, the **'pathology services table'**, and the **'diagnostic imaging services table'**.

Tisdall v Health Insurance Commission [2002] FCA 97 —

> [25] The word "item" is defined in s 3 as an item in the table. The word "table" is defined in that section as consisting of the general medical services table prescribed under s 4 which provides for regulations prescribing a table of medical services setting out the items of medical services and the amount of fees applicable in respect of each item together with guidelines for the interpretation of the table. …
>
> [28] In summary, a professional service rendered or initiated by a practitioner to an eligible person is one to which an item in the general medical services table relates and which is generally accepted as necessary for the appropriate treatment of the patient. The rendering or initiating of such a service attracts payment by the Commonwealth of a medicare benefit.

'professional service'

In relation to medical practitioners, a **'professional service'** is defined as being a service (other than a diagnostic imaging service) to which an **'item'** relates, being a **'clinically relevant service'** that is rendered by or on behalf of a medical practitioner. Subsection 3(17) sets out when a service may be rendered 'on behalf of' a medical practitioner. The term is also defined in subsection 3(1) in respect services provided by dental practitioners, optometrists, pathology practitioners, and medical practitioners providing diagnostic imaging services.

In relation to the provision of services by other allied health providers, section 5 of the *Health Insurance (Allied Health Services) Determination 2014*, made under subsection 3C(1) of the Act, provides that an **'allied health service'** provided under that Determination is to be treated as if it were a **'professional service'** under the Act and a **'medical service'** under the table.

Tisdall v Health Insurance Commission [2002] FCA 97 —

> [25] The word "item" is defined in s 3 as an item in the table. The word "table" is defined in that section as consisting of the general medical services table prescribed under s 4 which provides for regulations prescribing a table of medical services setting out the items of medical services and the amount of fees applicable in respect of each item together with guidelines for the interpretation of the table. …
>
> [28] In summary, a professional service rendered or initiated by a practitioner to an eligible person is one to which an item in the general medical services table relates and which is generally accepted as necessary for the appropriate treatment of the patient. The rendering or initiating of such a service attracts payment by the Commonwealth of a medicare benefit.

Doan v Health Insurance Commission [2002] FCA 1160 —

> [81] Further, the definitional chain of "inappropriate practice" in the HI Act and the overall issue of whether the practitioner has engaged in "inappropriate practice" necessarily demands an analysis of particular questions, including whether the service is clinically relevant, whether the services rendered or initiated in the referral period were necessary, whether there was an appropriate level of clinical input and whether the services were appropriate. In this way, from the definition of s 82 of inappropriate practice, one has to go to s 81(1) which defines a "service" as a service for which "at the time it was rendered or initiated, a Medicare benefit was payable", such Medicare benefits being payable where, "on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person..." (s 10(1)). The meaning of "professional service" in s 3 then directs one to the meaning of a "clinically relevant service" which is defined as a "service rendered by a medical ... practitioner ... that is generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered": s 3.

Sevdalis v Director of Professional Services Review (No. 2) [2016] FCA 433 —

> [124] The "service", for the purposes of this assessment (and for the purposes of a practitioner's entitlement), is a service "to which an item relates" under the regulations: see the definition of "professional service" in s 3(1) of the Act. Applying that to items 37 and 5043, the during hours and after hours attendances by Dr Sevdalis at places other than his consulting rooms or an aged care facility (or a hospital, in the case of item 5043) were, by the definition of "professional service" read with the definition of "clinically relevant service" in s 3(1) of the Act, required to be a service that was one "generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered".
>
> [125] In some circumstances, an assessment of whether that requirement was met may touch upon some of the matters which were (in my opinion, wrongly) considered by the Committee in relation to item 37 and item 5043. Nevertheless, it remains the case that, looking at all the instances in which the Committee made an assessment, its approach introduced a gloss, or a consideration of a nature different to that required, by examining in quite an absolute way whether a patient "could

> have" gone to Dr Sevdalis' consulting rooms. On no view, in my opinion, is the evaluation to be conducted at that absolute level. Even within the terms of the two definitions in s 3(1), the evaluation is what kind of attendance is "necessary for the appropriate treatment" of a patient. That is not an evaluation to be conducted in hindsight, perhaps years later, but on the information available to the practitioner at the time and it should not, in my opinion, be conducted by a Committee asking itself whether a patient "could" have gone to the surgery, even on the information available at the time. Rather, the correct question is whether a during hours or after hours service was, on the information available to the medical practitioner at the time, "necessary for the appropriate treatment of the patient to whom it is rendered", and generally accepted in the medical profession to be so. In my opinion "necessary" imports a standard at the level of there being no reasonable alternative in the circumstances. It does not suggest the Committee should determine whether it was physically possible for a patient to have attended during hours or at the practitioner's consulting rooms, which in my opinion is the standard the Committee seems to have applied.

The definition of 'professional service' in subsection 3(1) as it relates to a pathology service rendered by an approved pathology practitioner following a request from a treating practitioner does not incorporate the phrase 'clinically relevant service'.[49] However, where a pathology service is performed, without a request from a treating practitioner, by an approved pathology provider, it must be a 'clinically relevant service',[50] that is, it must be necessary for the appropriate treatment of the patient. Nevertheless, under section 16A, it is a requirement that the treating practitioner, who makes a pathology request, determine that it is 'necessary'. The word, 'necessary' in the context of requesting a pathology service, is defined in subsection 16A(12) to mean 'reasonably necessary for the adequate medical care of the patient'. This is different from the definition of 'clinically relevant service' in subsection 3(1) in that the focus is on 'adequate medical care' rather than 'appropriate medical treatment'.

The MBS Book includes an explanatory note indicating that a medicare benefit can be payable for an attendance on a patient at which it is determined that life is extinct.

> **AN.0.5 Services not Attracting Medicare Benefits**
>
> …
>
> Although Medicare benefits are not payable for the issue of a death certificate, an attendance on a patient at which it is determined that life is extinct can be claimed under the appropriate attendance item. The outcome of the attendance may be that a death certificate is issued, however, Medicare benefits are only payable for the attendance component of the service.

[49] Paragraph 3(1)(d).
[50] Paragraph 3(1)(e).

Nevertheless, under the Act, a 'professional service' can only be rendered to a patient who is alive at the time of the service because a corpse is not a 'patient'.

R v Pawsey [1989] TASRp 14 (per Neasey J) —

> In my respectful opinion, the learned trial judge did fall into error in holding that the body of a patient after death could any longer fit that descriptive character. It is, I think, simply a question of the ordinary meaning of the word "patient": unless there is anything in the Act or the Regulations which indicates that the expression should be given a meaning other than that which it ordinarily bears. All the well known dictionaries define a patient in the relevant sense as a living person who is under medical treatment. Thus the *OED* says that a patient is "one who is under medical treatment for the cure of some disease or wound; one of the sick persons whom a medical person attends; an in-mate of an infirmary or hospital': See also, *SOED*, *Macquarie Dictionary*, *Webster's Dictionary*. In my view it is quite beyond the ordinary connotation of the word "patient" to treat it as being applicable to a corpse.
>
> Nothing in the Act or Regulations was cited to us as tending to show that any meaning different from the ordinary meaning is intended. On the contrary, there are a number of provisions which support the proposition that "medical attendance" and "patient" are to be applied in their ordinary sense as referring to professional medical attendances upon a living person for purposes relating to treatment.
>
> Accordingly, in my respectful opinion his Honour's direction to the jury to acquit was based upon an error in law.

R v Pawsey [1989] TASRp 14 (per Crawford J) —

> I turn to consider whether the learned trial judge was correct in concluding that the description of a post-mortem examination being a particular medical service itemised in the Schedule was, or could have been found by the jury to be, a false statement. The relevant provisions of the *Health Insurance Act 1973 (*Cth) were as follows.
>
> Section 10(1) provided:
>
> > "10.(1) Where ... medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, medicare benefit calculated in accordance with subsection (2) is payable, subject to and in accordance with this Act, in respect of that professional service:'
>
> By virtue of s.3(1), unless the contrary intention appeared, " 'eligible person' means an Australian resident or an eligible overseas representative". An "Australian resident" meant a person who was ordinarily resident in Australia and included a person domiciled in Australia. The term "eligible overseas representative" meant such persons as the head of a diplomatic mission, or the head of a consular post established in Australia, representing certain other countries, or a member of the staff of such a mission or post, or a member of the family and of the household of such a person. I find difficulty in accepting that a dead person can be described as

being a person who is ordinarily resident or domiciled in Australia. A dead person is not resident at all. He resides nowhere. If his body is taken overseas permanently, it cannot be said that he becomes resident overseas, nor can it be said that his domicile would therefore be changed. In my view only living persons can have a place of residence and a domicile.

Accordingly where s.10(1) provided that medicare benefit was payable when medical expenses were incurred in respect of a professional service rendered to an eligible person, that person had to be a living person and not a dead person. This does not necessarily provide the answer in this case, because the accused was not charged with making a claim for a benefit to which he was not entitled, but with making a false statement which was capable of being used in support of a claim for benefits. However, s.10(1) shows a legislative policy that medical benefits should only be payable in respect of patients living at the time of the rendering of the professional service.

"Professional service" meant, according to the *Health Insurance Act 1973* (Cth), s.3(1), such things as a medical service to which an item in the Table in the Schedule related, being a service that was rendered by or on behalf of a medical practitioner. This definition does not assist for the purposes of this case.

Section 19(1) provided that a medicare benefit was not payable in respect of a medical examination for the purposes of life insurance, superannuation or provident account schemes, or admission to membership of a friendly society. Section 19(5) provided that unless the Minister otherwise directed, "a medicare benefit is not payable in respect of a health screening service, that is to say, a professional service that is a medical examination or test that is not reasonably required for the management of the medical condition of the patient". Section 19 did not assist to define what a "professional service" or "professional attendance" were, nor what the respective items in the Table meant.

They simply restricted the circumstances in which a claim for benefit could be made and, as I have said, the accused was not charged with making a claim for benefit to which he was not entitled.

Section 20(1) provided:

> "(1) Subject to this Part, medicare benefit in respect of a professional service is payable by the Commission on behalf of the Commonwealth to the person who incurs the medical expenses in respect of that service:'

A dead person cannot incur medical expenses, nor can a dead person receive payment of a benefit. But of course a person other than the person in respect of whom the professional service is rendered, can incur the medical expenses in respect of that service. An example of this would be a parent incurring the medical expense of a professional service rendered to his child. In such event, the medicare benefit would become payable to the parent.

The false statement allegedly made by the accused was made on a medicare assignment form and s.20A applied to such a situation. The relevant passages in it were:

> "20A. (1) Where a medicare benefit is payable to an eligible person in respect of a professional service rendered to the eligible person or to another eligible person, the first-mentioned eligible person and the person by whom, or on whose behalf, the professional service is rendered (in this subsection referred to as 'the practitioner) may enter into an agreement, in accordance with the approved form, under which -
>
> (a) the first-mentioned eligible person assigns his right to the payment of the medicare benefit to the practitioner; and
>
> (b) the practitioner accepts the assignment in full payment of the medical expenses incurred in respect of the professional service by the first-mentioned eligible person.
>
> (2) …
>
> (3) Where an assignment under this section takes effect, or an agreement under this section is entered into, with respect to a medicare benefit, the medicare benefit is, subject to section 208, payable in accordance with the assignment or the agreement, as the case may be.
>
> (5) An assignment of a medicare benefit shall not be made except in accordance with this section:'

This section enabled medical practitioners to do what is called "direct bill': that is to say to render claims for payment of benefit direct to the Commission, instead of rendering accounts for the services to the patients or the other persons who incurred the medical expense.

Because it required that the professional service had to be rendered to an "eligible person": that is to say an Australian resident or an eligible overseas representative, an assignment could only be effective in such circumstances. The section reflected the legislative policy evidenced by s.10(1), that a benefit was only to be payable in respect of patients living at the time of the rendering of the professional service.

The Table of Medical Services was Schedule 1 to the *Health Insurance Act 1973*. Section 4 authorised the variation or alteration of an item, or of a rule of interpretation in the Table by regulation.

By virtue of s.4(3) the Table prescribed by such a regulation had effect as if it were set out in Schedule 1 in the place of the Table in that Schedule. Pursuant to regulations such as the *Health Insurance (Variation of Fees and Medical Service) (No. 31) Regulations 1984* the Table was substantially replaced. The terms of items 15, 16, 41 and 42 are referred to earlier in these reasons. They all required a "professional attendance". Section 3(4) [which his Honour set forth] defined that term.

It is to be further noted that items 41 and 42 required the attendance to be on a "patient": The meaning of the word "patient" is therefore critical. Can a dead person be a "patient" for the purpose of the expression "an attendance by a medical practitioner on a patient"? The word was not defined or explained by the Act. Rule 6(1) of the Rules for the interpretation of the Table of Medical Service provided that " 'attendance' means a physical attendance on not more than one person on the

one occasion": When used in the present tense, a dead man is not usually referred to as a "person", although he may well be referred to as "a dead person".

The *SOED* provides the meaning of "patient" as "one who is under medical treatment for the cure of some disease or wound; one of the sick persons whom a medical man attends; an inmate of an infirmary or hospital". The meaning of "person" is provided as "an individual human being; a man, woman, or child; ... the living body of a human being; either (a) the actual body, as distinct from clothing, etc., or from the mind or soul, or (b) the body with its clothing etc … . Law. A human being (natural p) or body corporate or corporation (artificial p), having rights or duties recognised by law". These meanings expressly or impliedly require that a "patient" or a "person" be living.

The learned trial judge, in the course of his ruling on the admissibility of evidence, referred to the definition of "professional attendance" in 3(4) and said:

[His Honour set out part of the ruling set out on p.191 and continued:]

> With respect I disagree with his Honour when he said that the death of a person cannot terminate the doctor-patient relationship. In my view a patient ceases to be a patient on his death. Further, if one's father dies he no longer is one's father. He was, but no longer is. The relationship of solicitor and client terminates on the death of a client.

There may be some continuing obligations on the part of the solicitor, but they are not owed to the dead body, they are owed to the personal representatives or to some other persons. In *Cordery on Solicitors*, 8th edn, p.73, it is said:

> "Where the client dies the solicitor's authority comes to an immediate end, so that the solicitor can recover no costs for subsequent work unless the personal representatives ratify the retainer by continuing the action and so make themselves liable:"

The conclusion I have come to is that items 15, 16, 41 and 42 require the professional attendance to be on a living person. The items did not apply to an attendance on a dead body, and I say this regardless of whether or not the body belonged to a person who died only a few hours, or as much as many years, before the doctor's attendance on it.

'table'

The **'table'** consists of the general medical services table, the pathology table, and the diagnostic imaging services table. These tables are prescribed by regulations under sections 4, 4A, and 4AA, respectively.

In addition, certain determinations made under the Act are also taken to be part of the table, for example, the *Health Insurance (Allied Health Services) Determination 2014*. That Determination applies through section 12 of the *Health Insurance Regulations 2018*, which prescribes a number of classes of services for the purposes

of paragraph (b) of the definition of **'health service'** in subsection 3C(8) of the Act. They concern services provided by a various different allied health service professions. Section 3C enables the Minister to make legislative instruments that specify particular health services and determine that they shall be treated, for the purposes of the Act, as if they were both a professional service and a medical service, and as if there were an item in the general medical services table, the pathology services table or the diagnostic imaging services table that related to the health service and specified a fee in relation to the health service. The *Health Insurance (Allied Health Services) Determination 2014* is made under section 3C of the Act for that purpose.

3(3) — anaesthesia

If an anaesthetic is administered to a patient, any pre-medication of the patient in preparation for the administration of the anaesthetic, and any pre-operative examination of the patient in preparation for the administration of the anaesthetic (if carried out during the attendance at which the anaesthetic is administered), is taken to be part of the professional service constituted by the administration of the anaesthetic.

There are items in the table for a professional attendance by a specialist anaesthetist (items 17609-17680) as well as items for the initiation of the management of anaesthesia (items 20100-21997) and timed items for the management of the anaesthesia (items 23010-24136). The effect of subsection 3(3) is that an anaesthetist cannot claim a consultation item as a separate service if the consultation was not conducted as a separate attendance to that of the administration of the anaesthetic.

An **'attendance'** is defined in subsection 3(4). Additionally, the table defines an **'attendance by a specialist or consultant physician'** (clause 1.2.2) and **'professional attendance services'** (clause 1.2.3) for the purposes of items 17609 to 17680. Clauses 1.2.4 and 1.2.5 of the table define **'personal attendance by medical practitioners'** for the purposes of the other anaesthesia items.

Subsection 16(1) precludes the payment of medical benefits in respect of anaesthesia in connection with a professional service if it was administered by the same person who performed the professional service for which the anaesthesia was administered.

3(4) — attendance or professional attendance

The terms **'attendance'** and **'professional attendance'** are used interchangeably in the Act and in the table, and are defined to mean an attendance by a medical practitioner on a patient, including an attendance at the medical practitioner's rooms or surgery.

3(5) — the after-care rule

Subsection 3(5) contains what is often called the 'after-care rule'. It provides that unless the Minister otherwise directs, a professional service (other than a professional attendance service) is deemed to include all professional attendances necessary for the purposes of post-operative treatment of the person to whom the professional service is rendered. Therefore, if a surgical procedure is performed on a patient and the relevant item for that procedure is billed, that service is deemed to include all subsequent attendances for the purpose of after-care for that surgical procedure.

Some items in the General Medical Services Table expressly exclude after-care from the item, and in so doing, are taken to be a directions from the Minister for the purpose of this rule.

The Minister has made a direction, with effect from 1 November 2017, enabling a practitioner other than the practitioner who performed the operation to be able to claim for an attendance service when providing aftercare to the patient.

3(5A) — pathology service includes interpretation, analysis and reporting

Subsection 3(5A) makes clear that the rendering of a pathology service includes any necessary interpretation, analysis or reporting.

3(5B) — diagnostic imaging service includes interpretation, analysis and reporting

Subsection 3(5B) makes clear that the rendering of a diagnostic imaging service includes any necessary interpretation, analysis or reporting.

3(5C) — R-type and NR-type diagnostic imaging services

Medicare benefits are not payable for specialist services unless there is a valid referral from another practitioner to the specialist for the service. For example, a specialist cannot bill MBS item 104 for a specialist attendance unless there is a valid referral to them for such a service. However, any medical practitioner, even a specialist, can bill a non-referred attendance item for an attendance service (such as MBS item 53, which pays less than a quarter of the benefit payable for an item 104). Similarly, the diagnostic imaging table distinguishes between requested services (**R-type**) and non-requested services (**NR-type**), and provides a reduced benefit for a diagnostic imaging service if the radiologist provides it without a 'request'.[51] For example, MBS item 55005 is for an ultrasound scan of the head, and is an R-type service, whereas MBS item 55007, which is also an ultrasound scan of the head is an NR-type service and pays a benefit of about a third that payable for the equivalent R-type service.

Subsection 3(5C) makes clear that if the only difference in the descriptions of two otherwise identical MBS items in the diagnostic imaging services table is the R or NR indicator,[52] then for the purposes of the Act, the only difference between those services is the fact that one is a requested service and the other is not a requested service. The content of each service is identical.

The practical effect of the substantial differential in MBS benefits, for what is a clinically identical service, means that general practitioners have the role of gate-keepers to specialist services. Specialist services will usually only be provided if another practitioner, who is unlikely to benefit personally from that service, is of the view that there is a clinical indication for the particular specialist service and recommends that it be provided. The scheme does not prohibit specialists from providing their services to patients without a referral, but only at either a substantially higher cost to the patient or a substantially reduced payment to the specialist.

[51] A 'request' for a diagnostic imaging service is not a 'referral' to a specialist.

[52] R-type and NR-type services are indicated in the table by '(R)' or '(NR)' at the end of the relevant item descriptor. This is explained in clause 1.2.6 of the *Health Insurance (Diagnostic Imaging Services Table) Regulations*.

3(6) — procedure not a professional service if part of a professional attendance

Subsection 3(6) of the Act provides, in effect, that if a procedure is provided as part of a professional attendance, which is claimed as a professional service (for example, by billing an MBS item 23 or item 36 service), then the procedure is deemed not to have been a 'professional service' for the purposes of the Act, and cannot itself be claimed as a separate MBS item.

Most procedural items are paid at a significantly higher rate than the rate for a professional attendance service, and so most practitioners will claim for the procedural item rather than the professional attendance item. But if, a professional attendance item is claimed for some or all of the time taken to perform the procedure, the procedure item cannot also be claimed.

For example, if a patient attended a GP only for a skin excision (for which, say, MBS item 31216 could be payable), and the practitioner claimed a standard level B attendance item (for example, MBS item 23) for the consultation, the practitioner cannot also bill for MBS item 31216 because, by billing for the MBS 23 attendance service, the excision procedure, which would otherwise have been capable of being billed as an MBS item 31216 service, is deemed not to be a professional service.

In order to be able to claim both a procedural item and a professional attendance item, there must have been a separate clinically relevant service provided that was not directly related to the surgical procedure that was performed. It is generally accepted that obtaining informed consent and giving aftercare advice to a patient is directly related to the performance of a surgical procedure, and cannot be separately billed as a professional attendance if the procedure is performed and billed.

3(17) — rendering a service on behalf of a medical practitioner

Subsection 3(17) of the Act provides, in effect, that a person may perform a service on behalf of a medical practitioner if, and only if:

- that person is not a medical practitioner;
- it is rendered in accordance with accepted medical practice;
- it is performed under the supervision of the medical practitioner; and
- it is not a service of a kind specified in regulations made for the purpose of this provision.

An effect of this provision is that a medical practitioner cannot claim for a service that was actually performed by another medical practitioner. However, if it is accepted practice in the profession for, say a nurse, to perform some or all of a particular type of service under the supervision of a medical practitioner, then the medical practitioner may claim for that service if, in fact, it was performed partly or wholly by the nurse under the medical practitioner's supervision.

The degree and nature of supervision required will depend on what would be acceptable to the general body of medical practitioners or of the relevant specialty for that type of service. The degree and nature of supervision required might also depend on the skills, qualifications and experience of the particular person who actually performs the service and the circumstances in which the service is rendered.

Hamor v Commonwealth [2020] FCA 1748 —

> [171] Dr Hamor contended that the Committee misconstrued its statutory task by considering that item 12250 required the qualified sleep medicine practitioner to:
>
> > (1) supervise the investigation by the technicians and scorers, other than by establishing quality assurance procedures for data acquisition, and
> >
> > (2) take a history, or supervise the taking of a history.
>
> [172] By doing so, Dr Hamor argued, the Committee misdirected itself in determining whether his conduct, in connection with rendering or initiating item 12250 services, was such that a committee could reasonably conclude that it would be unacceptable to the general body of consultant physicians in Dr Hamor's speciality.
>
> **Supervision requirement**
>
> [173] At para 117 of the final report, the Committee addressed submissions made by Dr Hamor concerning whether Dr Hamor was responsible for supervision of technicians and scorers who performed elements of the services, as follows:
>
> > The Committee does not agree that the legislation did not require Dr Hamor to have a role in supervising the technicians and scorers or that the functions they performed were not an integral part of the provision of the MBS item 12250 service performed on behalf of Dr Hamor. His responsibility in respect of the technicians and scorers was not displaced by fulfilling a duty to establish quality assurance procedures for data acquisition. This is particularly so in relation to the technicians who did not necessarily have any health qualifications or relevant training, yet were not only assigned the role of obtaining a medical history from the patients, but also confirming the necessity for the investigation, and instructing the patient on the attachment and use of the recording equipment, and dealing with any other matters, whether clinical or technical, concerning the investigation that were, or should have been, dealt with prior to the investigation.

[174] Clause 1.2.8(2) is set out at [9] above. In this case, the Committee was required to consider whether the medical services to which item 12250 was said to apply were given by a person or persons who in accordance with accepted medical practice acted under the supervision of a medical practitioner, to the extent that they were not provided by Dr Hamor himself.

[175] Ultimately, there was no dispute that the relevant medical services were given, in part, by the technicians and scorers engaged by HSS. There was no suggestion that any medical practitioner other than Dr Hamor supervised the technicians or the scorers to the extent that they were involved in giving the relevant medical services.

[176] Dr Hamor contended that his role in supervising the technicians and scorers was limited, by the language of item 12250, to establishing quality assurance procedures for data acquisition of the kind identified in item 12250 clause (e)(i). Clause (e)(i) imposed a separate requirement on the practitioner to establish the specified quality assurance procedures for data acquisition, where the efficacy of the investigation evidently depends upon the acquisition of meaningful data. That requirement is not expressed as a qualification to, or replacement for, the supervision requirement expressed in cl 1.2.8. Dr Hamor did not argue that the role of the technicians and scorers in the provision of the services was confined to data acquisition within the meaning of item 12250.

[177] Accordingly, I do not accept that para 117 of the final report discloses legal error on the part of the Committee.

[178] There is a separate factual question whether, as a matter of accepted medical practice, the establishment by Dr Hamor in advance of quality assurance procedures for data acquisition is sufficient to discharge the requirement of supervision. Putting aside the histories taken by the technicians (which Dr Hamor contended did not form part of the item 12250 service), the technicians supplied the patients with the equipment that the patients would use at home to do the study. Dr Lucy submitted that, in the case of the technicians, there was really nothing to supervise.

History requirement

[179] The Committee made the following findings at paras 109 to 111 of the final report:

> (1) The general body of respiratory and sleep physicians would expect a relevant detailed history to be taken before the test is conducted and the item requires the qualified sleep medicine practitioner to confirm the necessity for the investigation.
>
> (2) While the item does not expressly require a detailed history to be taken, the Committee is of the view that the general body of respiratory and sleep physicians would expect it to be performed, if not by the physician, then by the technician on the physician's behalf so that the physician has an adequate basis for concluding that the test was necessary for that patient.
>
> (3) The role of the qualified sleep medicine practitioner included using their specialist expertise in confirming that the investigation was actually necessary

> for that patient. An essential element in making that assessment would be taking, or at least having available, a reliable and relevant detailed history.
>
> [180] Dr Hamor acknowledged that he was required to decide personally whether the service of an unattended sleep study was necessary, before it took place, and he could not delegate that task to a technician under item 12250.
>
> [181] Dr Hamor submitted that the Committee's criticisms of him for failing to supervise adequately the technicians were principally made on the basis that Dr Hamor did not properly supervise the taking of a history. In support of this submission, he referred to several of the findings made by the Committee concerning the sample cases.
>
> [182] Dr Hamor argued that the Committee's finding that Dr Hamor was required by item 12250 to supervise the taking of a patient history by a technician is "curious" in the absence of any reference to histories or technicians in the item.
>
> [183] Dr Hamor also seemed to suggest that the technicians' histories did not form a part of the medical services given in purported compliance with item 12250. Dr Lucy also noted that, where the item required a clinical opinion of a GP, the GP will have taken a history and, she asserted, it would be normal for the GP to provide that history with the referral.
>
> [184] The Committee's findings indicate that it considered that the qualified sleep medicine practitioner was required to take, or have available, a history in order to confirm the necessity for the provision of a home sleep study under item 12250 investigation. I am not persuaded that the Committee misconstrued item 12250 in reaching that conclusion. It is implicit in item 12250 that the qualified sleep medicine practitioner is required to confirm the necessity for the investigation by reference to relevant information. It was open to the Committee to conclude, as a matter of fact, that this aspect of item 12250 required Dr Hamor to take a history or to supervise a technician who would take such a history, in accordance with accepted medical practice.
>
> [185] Accordingly, Dr Hamor's case based on the Committee's alleged misconstruction of its statutory task also fails.

The medical practitioner remains responsible for the service even if it was wholly performed on their behalf by another person.

Section 56 of the *Health Insurance Regulations 2018* provides for a medical practitioner other than the practitioner who rendered a diagnostic imaging service to bill for the service. However, the billing practitioner must either record the details of the rendering practitioner on the account, the receipt, or the form of an assignment or agreement under section 20A in relation to that service, or else keep a record of that practitioner and the date of the service at the billing practitioner's place of practice. Under subsection 19(6) of the Act a medicare benefit is not payable to the billing practitioner if these details are not recorded in accordance with the

Regulations. Section 56 of the Regulations does not mean that the rendering practitioner renders the service 'on behalf of' the billing practitioner: the practitioner who renders the service in that circumstance remains responsible for the service and may be liable to repay the medicare benefit for that service if he or she is found to have engaged in inappropriate practice in connection with rendering that service. A similar arrangement applies under section 52 of the *Health Insurance Regulations 2018* in respect of certain radiation or nuclear services. However, under that section the rendering practitioner's details must be included on the account, the receipt, or the form of an assignment or agreement under section 20A in relation to that service.

3(18) — specialist trainee may render a service on behalf of a medical practitioner

A specialist trainee may perform a service on behalf of a supervising medical practitioner if the medical practitioner for whom the service is rendered is present at all times while the service is being performed by the specialist trainee. Section 10 of the *Health Insurance Regulations 2018* defines a specialist trainee as a medical practitioner who is enrolled in and undertaking a training program with the Royal Australian College of General Practitioners or with an organization mentioned in column 1 of an item in the table in clause 1 in Schedule 1 to the Regulations. These organisations are the Colleges for each of the recognised medical specialties.

3C Health services not specified in an item

Subsection 3C(1) permits the Minister to determine, by legislative instrument, specified health services to be treated as if they were included in the table by deeming them to be both a professional service and a medical service, and specifying a fee for that service. A 'health service' is defined in subsection 3C(8) and by reference to section 12 of the *Health Insurance Regulations 2018*, which lists various types of allied health services.

Formerly,[53] subsection 3C(1A) permitted the Minister to refer to the Medicare Benefits Advisory Committee the question whether a determination ought to be made under subsection 3(1) in respect of a specified health service or a health service in a specified class of health services. Former subsection 3C(1B) provided that the

[53] Subsections 3C(1A) and (1B) and Part V of the Act, which provided for the Medicare Benefits Advisory Committee, were repealed on 27 November 2020 by the *Health Insurance (Administration) Act 2020*.

Minister was not bound by a recommendation of the Committee. The Medicare Benefits Advisory Committee was established under former section 66.

In *Zador v Minister of Community Services and Health* [1991] FCA 316, the Federal Court dismissed an action concerning a decision by the Minister not to make a determination under section 3C. The case was brought under the *Administrative Decisions (Judicial Review) Act 1977*.[54] In deciding whether there was scope for the Minister to make a determination under this section, the Court considered whether the kind of services that the person sought to have included in a determination included the provision of 'medical treatment' and were services that were not otherwise provided for in the Table.

Zador v Minister of Community Services and Health [1991] FCA 316 —

> [25] Counsel for Dr Zador also contended that some of the attendances claimed by his client amounted to him "patrolling the rooms". But insofar as Dr Zador's activities fell outside the description of a physical attendance upon a particular patient and were not part of group psychotherapy, they were, in my opinion, no more than activities incidental in a general way to the operation by Dr Zador of the Clinic. They were not the provision of medical treatment and thus did not amount to a "health service" within the definition in sub-s. 3C (8).
>
> [26] Accordingly, there was no scope for any determination under s. 3C in favour of Dr Zador.

3D Recognition as specialists

A medical practitioner is taken to be recognised as a specialist in a particular specialty for the purposes of the Act if a relevant organisation gives the Chief Executive Medicare written notice stating that the medical practitioner meets the criteria for the specialty.

Under subsection 3D(2), a medical practitioner meets the criteria for a specialty if the medical practitioner is domiciled in Australia, and is a fellow of a relevant organization in relation to the specialty, and has obtained, as a result of successfully

[54] The parties in this case appeared to assume that the AD(JR) Act applied and that a statement of reasons could be (and was) obtained under section 13 of that Act. I suggest that the AD(JR) Act has no application because the decision whether or not to make a determination under section 3C is of a legislative character rather than administrative: see *Vietnam Veterans Association of Australia v Cohen* [1996] FCA 981.

completing an appropriate course of study, a relevant qualification in relation to the relevant organization.

The *Domicile Act 1982* defines domicile for the purposes of this section. Domicile is not equivalent to residence. In general terms, until a person chooses a different domicile, they are taken to have the domicile of their parents. A person may choose a different place of domicile by being physically present in, and deciding to remain indefinitely at, that other place. An intention to return to a person's homeland at some future time will defeat a claim for change of domicile. Thus, for a foreign practitioner to come within the Act they must decide to remain indefinitely in Australia and not have the intention to return to live long-term in their former country. Nevertheless, section 3E gives the Minister the power, upon application by a medical practitioner who has a foreign domicile, to make a determination in writing that the practitioner be recognised for the purposes of the Act, for a specified period, as a consulting physician or specialist in a particular specialty.

For the purposes of this section, organisations and qualifications within the meaning of **'relevant organisation'** and **'relevant qualification'** are declared in section 13 of the *Health Insurance Regulations 2018*,[55] by reference to Schedule 1 to those Regulations.

The period of a practitioner's recognition as a specialist is set out in section 3DA and alternative methods of recognition are set out in section 3DB.

3DB Alternative method of recognition as a specialist or consultant physician

For those practitioners who have not automatically been recognised as specialists or consultant physicians under the section 3D regime, subsection 3D(2) provides an alternative method for recognition if, for whatever reason, they have not been the subject of a notice from the relevant College under subsection 3D(1). The alternative section 3DB method also applies to those practitioners who are not Fellows with relevant qualifications, but who are merely Australian-domiciled State-registered specialists (subsection 3DB(1)).

Prior to amendments made by the *Health Insurance Amendment (Medical Specialists) Act 2006*, section 61 of the HI Act provided for a referral by the Minister

[55] Formerly, in the *Health Insurance Regulations 1975*.

to a Specialist Recognition Advisory Committee of the question whether a particular medical practitioner should be recognised for the purposes of the Act as a consultant physician, or as a specialist, in a particular specialty. Section 11 of the *Health Insurance Amendment (Medical Specialists) Act 2006* provided that if a determination had been made under section 61 of the HI Act, then that determination continues to have effect as if it had been made by the Minister under section 3DB of the Act.

3E Recognition as consultant physicians etc. of certain medical practitioners

Section 3E provides an exception to the general rule that consultant physicians and specialists must have Australian domicile in order to come within the scheme of the legislation (see section 3D, above). This section gives the Minister the power, upon application by a medical practitioner who has a foreign domicile, to make a determination in writing that the practitioner be recognised for the purposes of the Act, for a specified period, as a consulting physician or specialist in a particular specialty.

3EA Recognised Fellows of the Royal Australian College of General Practitioners

Section 3EA relates specifically to the recognition of Fellows of the Royal Australian College of General Practitioners. Sections 16 to 18 of the *Health Insurance Regulations 2018* concern eligibility for and revocation of a determination under section 3EA.

3F Vocationally registered general practitioners

Section 3F relates to the recognition of vocationally registered general practitioners. Sections 19 to 21A of the *Health Insurance Regulations 2018* concern eligibility for and removal of registration under section 3F.

4 General Medical Services Table

Subsection 4(1) of the Act provides for the making of regulations prescribing a table of medical services (other than diagnostic imaging services and pathology services)

that sets out items of medical services, the amount of fees applicable in respect of each item, and rules for interpreting the table.

Subsection 4(2) provides for the automatic cessation of operation, and repeal, of the regulations made under subsection 4(1) on the day after the 15th sitting day of the House of Representatives after the end of a period of 12 months beginning on the day on which the regulations were notified in the *Gazette*.

Each year a new Regulation is made prescribing the table of General Medical Services. The Regulation usually comes into effect on 1 November of that year, replacing the previous table. Usually the Regulation is amended one or more times before being replaced by the succeeding year's Regulation.

The Department of Health publishes a Medicare Benefits Schedule Book (the MBS Book) on its website. The MBS Book sets out or paraphrases details of the Regulation and contains further explanation of its effect and meaning. Unlike the Regulation, the MBS Book is not legislation and has no force of law, but it is relied on by medical practitioners in their day to day practice as a guide to the Medicare system and its rules.

Tisdall v Kelly [2005] FCA 365 —

> [9] Medical practitioners are provided with a medical benefits schedule, which refers to various kinds of medical services, allocating an item number for each kind, so that medicare benefits may be claimed by reference to the item number for the service provided. Regulation 13(2)[56] of the 1975 Regulations requires the recording of a description of the professional service and the item number of the item, or at least a description of the professional service sufficient to identify the item. For the purposes of the present case, the relevant schedule of item numbers is to be found in the *Health Insurance (1999-2000 General Medical Services Table) Regulations 1999* (Cth).

History

Section 4 has been significantly amended since first enacted in 1974. The table referred to in the original section 4 was contained in a Schedule to the Act. The original section 4 provided for the later effective replacement of the Schedule by Regulations prescribing a table of medical services in accordance with the form of table set out in the Schedule.

[56] This requirement was later contained in subregulation 13(3) of the 1975 Regulations, and is now found in subsection 50(1) of the *Health Insurance Regulations 2018*.

The original section 4 was what is known as a 'Henry VIII clause'.[57] No doubt the Government chose this method of establishing the table because it considered that there was a real risk that if it had relied only on the regulation-making power to establish the table of benefits, the Senate could have rendered the Medibank scheme unworkable by disallowing any regulations made under the Act. Making the original table a Schedule to the Act meant that the table came into effect upon commencement of the Act and, once enacted, could not be disallowed by a hostile Senate. While any subsequent regulations might be disallowed, such disallowance would effectively reinstate the benefits specified in the Schedule to the Act.[58]

Interpretation of the Medicare Benefits Schedule

The Medicare Benefits Schedule, which is made up of numerous legislative instruments, including the Health Insurance (General Medical Services Table) Regulations, is to be interpreted in the context of the whole of the Schedule, applying the interpretation that best gives effect to the purpose and language of the provisions read harmoniously, giving meaning to every word, and giving them the meaning that the legislature is taken to have intended, even if it is not the literal or grammatical meaning. One must also interpret the Schedule so as to best achieve the purpose of object of the Act.

Given that the Schedule necessarily involves technical matters, an interpretation that achieves the most reasonably practical result should be employed, and it is open to a decision-maker to take into account expert opinion evidence concerning the meaning of technical terms.

Sevdalis v Director of Professional Services Review [2017] FCAFC 9 —

> [26] It is true, as her Honour noted at [115], that the text of items 37 and 5043 do not use the term "clinically relevant service" but, rather, the phrase "clinically relevant"; but the defined words "clinically relevant" should be understood as being referred to in items 37 and 5043. The definition of "clinically relevant service" in

[57] A Henry VIII clause delegates the legislative power of Parliament to the Executive to make regulations that amend an Act of Parliament. The original Henry VIII clause was contained in the *Statute of Sewers* in 1531, which gave the Commissioner of Sewers powers to make rules having the force of legislation, including powers to impose taxation rates and powers to impose penalties for non-compliance. The *Statute of Proclamations* of 1539, also passed during the reign of Henry VIII, allowed the King to issue proclamations that had the force of an Act of Parliament. The High Court has held that Henry VIII clauses are not unconstitutional as long as the Parliament retains the right to repeal or amend the primary provision: *Capital Duplicators Pty Ltd v Australian Capital Territory (No 1)* (1992) 177 CLR 248; (1992) 66 ALJR 794.

[58] *Mangano v Mangano* (1974) 23 FLR 303; 4 ALR 303.

s 3(1) should inform the task of the Committee in evaluating whether the service in question was clinically relevant for the fee charged. In *Gill v Donald Humberstone & Co Ltd* [1963] 1 WLR 929 Lord Reid said at 9345:

> They are addressed to practical people skilled in the particular trade or industry, and their primary purpose is to prevent accidents by prescribing appropriate precautions...They have often evolved by stages as in the present case, and as a result they often exhibit minor inconsistencies, overlapping and gaps. So they ought to be construed in light of practical considerations, rather than meticulous comparison of the language of their various provisions such as might be appropriate in construing sections of an Act of Parliament...if the language is capable of more than one interpretation, we ought to discard the more natural meaning if it leads to an unreasonable result, and adopt that interpretation which leads to a reasonably practicable result.

This passage was recently applied by the Full Court in *Secretary, Department of Health (as successor to the Secretary, Department of Social Services) v DLW Health Services Pty Ltd* [2016] FCAFC 108 at [93]. A similar approach should be adopted to the construction of items 37 and 5043.

Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd [2018] FCA 2033 —

[42] The MBS is a compilation of numerous pieces of delegated legislation. The MBS reproduces the words of the "general medical services table", which is updated annually and presently appears at Schedule 1 of the *Health Insurance (General Medical Services Table) Regulations 2018* (Cth) (GMS Table) pursuant to s 4 of the *Health Insurance Act 1973* (Cth). The relevant MBS items in issue in this proceeding, being the Lower Item and the Higher Item, are sourced from the GMS Table.

[43] The parties accept that the general principles of statutory interpretation apply to construing the relevant legislative instruments: *Collector of Customs v Agfa-Gevaert Limited* [1996] HCA 36; (1996) 186 CLR 389 at 398. That is, the principles outlined in *Project Blue Sky Inc v Australian Broadcasting Authority* [1998] HCA 28; (1998) 194 CLR 355 at 381-384 [69]- [78] are to be applied, relevantly:

(a) the provision is to be construed in the context of the instrument viewed as a whole, so that it is consistent with the language and purpose of all the provisions in the instrument (at 381 [69]);

(b) where there is conflict in the language of particular provisions, the meaning of the competing provisions must be adjusted and construed to achieve that result which best gives effect to the purpose and language of the provisions read harmoniously (at 381-382 [70]);

(c) the Court must strive to give meaning to every word of the provision (at 382 [71]); and

(d) the Court must give the words of the provision the meaning that the legislature is taken to have intended those words to have, even if that meaning does not correspond with the literal or grammatical meaning of the provision (at 384 [74]).

[44] Additionally, s 15AA of the *Acts Interpretation Act 1901* (Cth) (see also s 13 of the *Legislation Act 2003* (Cth)) expressly provides for a purposive approach to construction:

> In interpreting a provision of an Act, the interpretation that would best achieve the purpose or object of the Act (whether or not that purpose or object is expressly stated in the Act) is to be preferred to each other interpretation.

[45] Further, because the MBS prescribes technical matters, the provisions are to be construed in light of practical considerations to achieve the most reasonably practicable result. This was explained by Lord Reid in *Gill v Donald Humberstone & Co Ltd* [1963] l WLR 929 at 934-935, and recently applied by the Full Court (Tracey, Pagone and Markovic JJ) in *Sevdalis v Director of Professional Services Review* [2017] FCAFC 9 at [26] as follows:

> They are addressed to practical people skilled in the particular trade or industry ... They have often evolved by stages as in the present case, and as a result they often exhibit minor inconsistencies, overlapping and gaps. So they ought to be construed in light of practical considerations, rather than meticulous comparison of the language of their various provisions such as might be appropriate in construing sections of an Act of Parliament ... if the language is capable of more than one interpretation, we ought to discard the more natural meaning if it leads to an unreasonable result, and adopt that interpretation which leads to a reasonably practicable result.

[46] Consistently with this, opinion evidence can be adduced to assist the Court to understand the context of technical terms used in delegated legislation, or to show that a potential construction of those terms may produce unreasonable or absurd results. Such evidence, however, cannot alter the meaning of the legislation, which remains to be found by the Court through the application of accepted principles of statutory construction: *Woodward v Repatriation Commission* [2003] FCAFC 160; (2003) 131 FCR 473 at 493-494 [113]- [114] (Black CJ, Weinberg and Selway JJ); *Pilbara Infrastructure Pty Ltd v Australian Competition Tribunal* [2011] FCAFC 58; (2011) 193 FCR 57 at 86-87 [60] (Keane CJ, Mansfield and Middleton JJ).

…

[65] … the answer to these issues represents an inquiry into the meaning of the Higher Item, applying accepted principles of statutory construction. It is not the subjective views of the witnesses that are determinative of the objective analysis required, but this evidence does assist in understanding the context of the technical terms, or to show that a potential construction of those terms may produce unreasonable or absurd results.

…

[75] Professor Lee gave evidence that a practical and skilled ophthalmologist would place considerable weight on such advice from the RANZCO in considering the meaning of the Lower Item and the Higher Item, while Associate Professor Forrest agreed that the "College's recommendation should be adhered to". All of the experts also accepted, unsurprisingly, that the 0.25 mg of Xanax had to be medically necessary to permit claims under the Higher Item.

> [76] Having regard to the principle that the MBS provisions are to be construed in light of practical considerations to achieve the most reasonably practicable result, it does not seem to me the least bit strange that the Higher Item would be expressed relatively broadly (so as to encompass all forms of anaesthetic services) and yet be tempered or restricted in its application by reference to the fact that the Higher Item would only be attracted if the relevant anaesthetic service was medically necessary in an individual case.
>
> [77] Part of Bupa's construction argument was that if the Higher Item was attracted when an ophthalmologist administered Xanax, then a perverse incentive would result, encouraging the potential for widespread abuse of the MBS billing system. This doomster argument is unpersuasive. The spectre of ophthalmologists pursuing the Higher Item like they were Augustus Gloop in a chocolate factory seems to me to be both unrealistic and cynical. As I have explained, ophthalmologists must only claim pursuant to the Higher Item when the anaesthetic service performed is medically necessary.
>
> …
>
> [81] I do not doubt that Associate Professor Forrest (and I presume other anaesthetists or reasonable medical practitioners) hold the view that the use of Xanax by the Oral Sedation Procedure does not and cannot constitute an anaesthetic service. Having said that, as noted above, the evidence does not establish a professional consensus among well-respected, competent medical practitioners. It is a matter upon which minds can (and apparently do) legitimately differ. I consider that the administration of low dose Xanax by the Oral Sedation Procedure can constitute an anaesthetic service and can attract the Higher Item when it is required or, in other words, when it is medically necessary in an individual case. …

Rehabilitation Medicine Australia Pty Ltd v N I B Health Funds Ltd (No 2) [2020] FCA 1761 —

> [16] … subordinate legislation that prescribes technical matters, such as the Benefit Rules, is to be interpreted in light of practical considerations to achieve the most reasonably practicable result: *Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd* [2018] FCA 2033, [45]. As stated by Lord Reid in *Gill v Donald Humberstone & Co Ltd* [1963] 3 All ER 180 at 183:
>
> > [T]hey ought to be construed in light of practical considerations, rather than by a meticulous comparison of the language of their various provisions such as might be appropriate in construing sections of an Act of Parliament...if the language is capable of more than one interpretation, we ought to discard the more natural meaning if it leads to an unreasonable result, and adopt that interpretation which leads to a reasonably practicable result.
>
> This approach has been adopted in the construction of other legislative instruments which provide for the payment of benefits or subsidies for the provision of medical services: see, eg, *Sevdalis v Director of Professional Services Review* [2017] FCAFC 9 at [26] where the Full Court held that the principle applied in construing the Medicare Benefits Schedule under the *Health Insurance Act 1973* (Cth)); *Secretary, Department of Health v DLW Health Services Pty Ltd* [2016] FCAFC 108; (2016) 246 FCR 456 at 471 [93] where the Full Court held that the principle

> applied in construing the Classification Principles under the *Aged Care Act 1997* (Cth). It does not, however, permit the Court "to embark on a wholescale rewriting of the instrument" (*Wingecarribee Shire Council v De Angelis* [2016] NSWCA 189, [20]). Regard must still be given to the text itself.

Kew v Director of Professional Services Review [2021] FCA 1607 —

> [56] Third, the committee was required to construe and apply various provisions of the Act and relevant sub-ordinate instruments. And in the present context that has raised several legal issues. Now generally speaking, I would not accord any deference to the committee's views on construction questions. Having said that, where the relevant instruments embody concepts within the committee's field of expertise, I have taken their views into account on construction questions, although their views cannot be dispositive.

A general rule of interpretation of the MBS is that each item represents a 'complete medical service'. The Services Australia website[59] states as follows:

> **Complete medical service**
>
> Each professional service listed in the MBS is a complete medical service in itself.
>
> A complete medical service covers all components required to perform the service described.
>
> There are also items that describe comprehensive or combined services. This means the item includes other individual services, which are essential to that complete medical service.
>
> If you bill a comprehensive or combined item, you can't also bill the individual services that make up the comprehensive or combined item.
>
> If more than one item covers a service, you need to understand each item's description and requirements. This will help you bill the correct item and prevent claiming errors.

MBS item 37

MBS item 37 is described in Group A1 of the Health Insurance (General Medical Services Table) Regulations as:

> Professional attendance by a general practitioner (other than attendance at consulting rooms or a residential aged care facility or a service to which another item in the table applies), lasting at least 20 minutes and including any of the following that are clinically relevant:
> (a) taking a detailed patient history;
> (b) performing a clinical examination;
> (c) arranging any necessary investigation;

[59] <https://www.servicesaustralia.gov.au/billing-multiple-mbs-items?context=20>

(d) implementing a management plan;
(e) providing appropriate preventative health care;
for one or more health-related issues, with appropriate documentation—an attendance on one or more patients at one place on one occasion—each patient.

MBS item 36 is the equivalent service if it is provided at consulting rooms, and MBS item 43 applies if the service is provided at an aged-care facility to residents of the facility. In the *Sevdalis* case, the PSR Committee had found that the practitioner's use of MBS item 37 was not justified because many of the patients did not need to be seen in their home. Instead, they could have attended the surgery the next day. The Court held that this was an irrelevant consideration.

Sevdalis v Director of Professional Services Review [2016] FCA 433 —

> [113] In the [MBS] Book, items 37 and 5043 are described as "non urgent attendances". The text of the book does not suggest any evaluative aspect to services claimed under these items, in contrast to the way it describes an "urgent attendance". However, given the role of the Book, I am not persuaded this takes the applicant's argument any further than the text of the regulations themselves.
>
> [114] The first respondent's answer to this ground is to focus on the phrase "clinically relevant" in the text of each item. He does so by reference back to the definition of "clinically relevant service" in s 3 of the Act, which I have extracted at [41] above.
>
> [115] In my opinion, this submission involves a conflation of the defined term in s 3(1) and the text of items 37 and 5043 as set out in the regulations. The text in the items does not use the defined term "clinically relevant service". Indeed, the adjectival phrase "clinically relevant" in the regulations relates not to the "service" as a whole, but to the five activities set out in each item. It is one of more of those activities which must be "clinically relevant". In my opinion that means one or more of those activities (such as performing a clinical examination) must be relevant, in a clinical sense, to one or more of the "health related issues" a patient had at the time of the attendance.
>
> [116] There is simply nothing in the text or context of the regulations dealing with items 37 and 5043 which supports a construction of these items making it part of the Committee's task to decide whether, in the Committee's opinion, a "home visit" was justified.
>
> …
>
> [119] In all these instances, and others relied on the by the applicant in his submissions, the Committee is clearly reading into each of item 37 and item 5043 a requirement which is not there: namely, that the location of the attendance (i.e. out of the consulting rooms) must be necessary and justifiable, and (it appears the Committee considered this was also required) that the notes of the attendance should, contemporaneously, record the justification at a level of detail considered by the Committee to be sufficient.

[120] The items do not require any such necessity or justification. Rather, in their text they require, at a factual level, a consultation of a certain duration (lasting at least 20 minutes), and a specific time of day (in usual hours for item 37, after hours for item 5043). The items also require the medical practitioner to have performed at least one of the five specified activities, which are to be clinically relevant to the patient's health related issues as the patient presented at the time. Each of these requirements must be appropriately documented.

[121] Unlike items 597 to 600, read with reg 2.15.1, the regulations do not require, or authorise, the Committee to engage in any evaluative exercise about whether in its opinion the attendance at a location other than the consulting rooms was justified. Nor do they authorise or require the Committee to engage in the function of determining whether the justification is one which would be acceptable to the body of medical practitioners the Committee represents.

[122] The first respondent's invitation to focus on the requirement in the item descriptions for there to be "appropriate documentation" for the attendance does not alter my opinion. The documentation required by this item description is documentation which is appropriate to describe the "health related issue" the patient was experiencing, which activity or activities of the five specified activities were performed by the medical practitioner during the attendance, and some indication of why that activity was "clinically relevant" to the health related issue.

[123] Nevertheless, the first respondent is correct to submit that in each case in which a medicare benefit is claimed, a medical practitioner must meet the two requirements in the definition of "professional service" in s 3(1) of the Act in order to be entitled to the benefit as claimed under s 10. That means, as the first respondent submits, that for each service rendered and for which a medicare benefit is claimed, the service must be a clinically relevant service. This in turn imports an evaluative standard, as the terms of the definition of "clinically relevant service" in s 3(1) make clear. A Committee investigating a practitioner must, as part of its function, form a view whether the service rendered was one "generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered".

[124] The "service", for the purposes of this assessment (and for the purposes of a practitioner's entitlement), is a service "to which an item relates" under the regulations: see the definition of "professional service" in s 3(1) of the Act. Applying that to items 37 and 5043, the during hours and after hours attendances by Dr Sevdalis at places other than his consulting rooms or an aged care facility (or a hospital, in the case of item 5043) were, by the definition of "professional service" read with the definition of "clinically relevant service" in s 3(1) of the Act, required to be a service that was one "generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered".

[125] In some circumstances, an assessment of whether that requirement was met may touch upon some of the matters which were (in my opinion, wrongly) considered by the Committee in relation to item 37 and item 5043. Nevertheless, it remains the case that, looking at all the instances in which the Committee made an assessment, its approach introduced a gloss, or a consideration of a nature different to that required, by examining in quite an absolute way whether a patient "could

> have" gone to Dr Sevdalis' consulting rooms. On no view, in my opinion, is the evaluation to be conducted at that absolute level. Even within the terms of the two definitions in s 3(1), the evaluation is what kind of attendance is "necessary for the appropriate treatment" of a patient. That is not an evaluation to be conducted in hindsight, perhaps years later, but on the information available to the practitioner at the time and it should not, in my opinion, be conducted by a Committee asking itself whether a patient "could" have gone to the surgery, even on the information available at the time. Rather, the correct question is whether a during hours or after hours service was, on the information available to the medical practitioner at the time, "necessary for the appropriate treatment of the patient to whom it is rendered", and generally accepted in the medical profession to be so. In my opinion "necessary" imports a standard at the level of there being no reasonable alternative in the circumstances. It does not suggest the Committee should determine whether it was physically possible for a patient to have attended during hours or at the practitioner's consulting rooms, which in my opinion is the standard the Committee seems to have applied.

MBS items 104 and 105

MBS item 104 is described in Group A3 of the Health Insurance (General Medical Services Table) Regulations as:

> Professional attendance at consulting rooms or hospital by a specialist in the practice of his or her specialty after referral of the patient to him or her—each attendance, other than a second or subsequent attendance, in a single course of treatment, other than a service to which item 106, 109 or 16401 applies.

MBS item 105 is an attendance at consulting rooms or hospital by a specialist after the initial attendance in a single course of treatment other than a service to which item 16404 applies.

Clause 1.2.5 of the Health Insurance (General Medical Services Table) Regulations provides:

> (2) A professional attendance includes the provision, for a patient, of any of the following services:
> (a) evaluating the patient's condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19(5) of the Act;
> (b) formulating a plan for the management and, if applicable, for the treatment of the patient's condition or conditions;
> (c) giving advice to the patient about the patient's condition or conditions and, if applicable, about treatment;
> (d) if authorised by the patient—giving advice to another person, or other persons, about the patient's condition or conditions and, if applicable, about treatment;
> (e) providing appropriate preventive health care;
> (f) recording the clinical details of the service or services provided to the patient.

Clause 1.1.6 of the Health Insurance (General Medical Services Table) Regulations define 'a single course of treatment' as follows:

> (2) A ***single course of treatment*** for a patient:
>
> (a) includes:
> (i) the initial attendance on the patient by a specialist or consultant physician; and
> (ii) the continuing management or treatment up to and including the stage when the patient is referred back to the care of the referring practitioner; and
> (iii) any subsequent review of the patient's condition by the specialist or consultant physician that may be necessary, whether the review is initiated by the referring practitioner or by the specialist or consultant physician; but
>
> (b) does not include:
> (i) referral of the patient to the specialist or consultant physician; or
> (ii) an attendance (the later attendance) on the patient by the specialist or consultant physician, after the end of the period of validity of the last referral to have application under section 102 of the *Health Insurance Regulations 2018* if:
> (A) the referring practitioner considers the later attendance necessary for the patient's condition to be reviewed; and
> (B) the patient was most recently attended by the specialist or consultant physician more than 9 months before the later attendance.

Kew v Director of Professional Services Review [2021] FCA 1607 —

> [115] Now the committee's conclusions of inappropriate practice in respect of co-billing item 104 or 105 together with diagnostic imaging items are the product of the committee's factual findings.
>
> [116] And they were reached after a detailed review of the documents about the sample services and the relevant evidence, and the application of s 82(1)(b) to those findings. These factual findings are set out in copious detail, particularly in the voluminous appendices.
>
> [117] Importantly, the committee observed in the report that the legislative scheme did not preclude billing for item 104 or 105 in conjunction with a specific radiological service. Indeed, it said that where a consultation was a clinically relevant service, there was a valid referral and sufficient clinical input was provided into the service and this was recorded, it is appropriate and permissible for diagnostic imaging and consultation services to be concurrently billed.
>
> [118] So the committee said (at [140]):
>
> > The Committee accepts that the MBS Schedule does allow for the billing of consultation services (such as MBS items 104 and 105) in conjunction with a diagnostic imaging service and notes where services are provided concurrently the Medicare rebate is reduced under the Multiple Services Rule. The Committee has never indicated that it considered such billing was precluded. Of course, where a consultation was a clinically relevant service, there was a

> valid referral, sufficient clinical input was provided into the service and this was recorded, it is appropriate and permissible for diagnostic imaging and consultation services to be concurrently billed. What the Committee has found in examining the services provided by Dr Kew is that the circumstances in which such co-billing would be acceptable to Dr Kew's peers were not met (for the reasons set out in the appendices).

[119] So, on the facts applicable to Dr Kew, the committee found, for the reasons set out in the appendices, that "the circumstances in which such co-billing would be acceptable to Dr Kew's peers were not met" (at [140]).

[120] The assertion that the committee's findings of inappropriate practice for co-billing were based on a misconstruction of the MBS cannot be maintained on the face of the reasons given by the committee in the report.

[121] Further, as the committee observed, items 104 and 105 are in a group headed "Specialist attendances to which no other item applies". It observed (at [88]):

> One of the aspects of MBS item 104, which is an overriding element, is that it is an item for 'Specialist attendances to which no other item applies'. This means that if the things that were being done in the course of an attendance were, in fact, what the general body of radiologists would expect to be done as part of another MBS item, then those matters cannot be billed as an MBS item 104 service. Instead, they are part of the other MBS service that is being billed. For example, if the general body of radiologists expects that, in the course of rendering a particular radiological procedural service, the radiologist would examine the patient, discuss treatment options, obtain consent, perform the procedure itself, and provide advice regarding the after-effects of the procedure, then all of those matters would be part of what is expected to be done in rendering the procedural item, and cannot be billed as a separate attendance item.

[122] A similar point could be made concerning item 105.

[123] That approach is consistent with the definition of "clinically relevant service", which turns on whether the treatment rendered "is generally accepted in the [medical profession] as being necessary", and that the treatment rendered that is an "essential element of" or "part of" a service performed and billed is not billable as a separate service.

[124] Generally, as the committee recognised, it follows that the legislative scheme permits but does not require co-billing. So, whether co-billing was permitted in a particular case turned on a question of fact. And relevantly to the present context, the committee found against Dr Kew on the facts.

[125] In my view, when the report is carefully read and the committee's comments contextualised, no anterior legal construction error of the type asserted by Dr Kew has been made out. As a matter of construction, the committee accepted that in certain circumstances co-billing was permitted and could be justified. But in assessing Dr Kew's conduct it was not justified.

Former MBS item 597

Former MBS item 597 was described in Group A11 of the Health Insurance (General Medical Services Table) Regulations as:

> Professional attendance by a general practitioner on not more than one patient on one occasion—each attendance (other than an attendance in unsociable hours) in an after-hours period if:
> (a) the attendance is requested by the patient or a responsible person in, or not more than 2 hours before the start of, the same unbroken after-hours period, and the patient's medical condition requires urgent treatment; and
> (b) if the attendance is performed at consulting rooms—it must be necessary for the practitioner to return to, and specially open, the consulting rooms for the attendance.

Clause 2.15.1 of the Health Insurance (General Medical Services Table) Regulations, which applied in relation to that item stated:

> (1) For items 597 to 600, a patient's medical condition requires urgent treatment if:
> (a) medical opinion is to the effect that the patient's medical condition requires treatment within the unbroken after-hours period in, or before, which the attendance mentioned in the item was requested; and
> (b) treatment could not be delayed until the start of the next in-hours period.
>
> (2) For subclause (1), medical opinion is to a particular effect if:
> (a) the attending practitioner is of that opinion; and
> (b) in the circumstances that existed and on the information available when the opinion was formed, that opinion would be acceptable to the general body of medical practitioners.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

> [189] I accept the applicant's submission that the focus of MBS item 597and reg 2.15.1 is on the "medical opinion" as to whether the patient's condition requires treatment. However, I do not accept the argument referred to at [184] above. In my view the term "requires" where used in MSB item 597(a) and in reg 2.15.1(1)(a) is not susceptible of the meaning "might require", which would be necessary to adopt the interpretation contended for by the applicant.
>
> [190] It might be that there are many occasions on which a practitioner could, at the time of receiving a request for services in the unbroken after hours period, form an opinion with a high degree of certainty that the patient's condition requires urgent treatment. However, that cannot be determined definitively – as the term "requires" implies – until a consultation has taken place. I do not accept the applicant's argument that the language of reg 2.15.1(2)(b) "in the circumstances that existed and on the information available when the opinion was formed" would be redundant if the opinion was to be formed after consultation. The circumstances in which an urgent after hours consultation takes place may well be far from ideal and the practitioner may well only have limited information available to him or her

(for example, because the patient has limited capacity to communicate effectively). Accordingly the language referring to circumstances in reg 2.15.1(2)(b) is required on both interpretations proposed by the parties. Before the consultation, the practitioner can only form a view, having regard to the circumstances which have been conveyed to him or her by someone who may not be the patient. The best the practitioner can do at that point is form a view of what might be required at that time, not what is required. What is required can only be determined following consultation which can, if necessary, include examination.

[191] It is true that the doctor must, at the time he or she receives a call requesting an attendance, make the decision whether to provide the attendance. While there would be plain unfairness if the practitioner were not to be remunerated at all for after-hours effort, that is not the effect of the scheme of the regulations. I am persuaded by the respondents' arguments for the application of the different after-hours period rates reflected in Group A11 and Group A22 and that that scheme tends towards an interpretation of MBS item 597 and reg 2.15.1 for which the respondents contend.

[192] Further, although the objects set out in s 79A apply to Part VAA, in my view they are objects which inform much of the regime; to avoid risk to patients and the community which may result from inappropriate practice and to protect the Commonwealth from costs associated with that. Those objects support the rationale suggested by the respondents for the interpretation of MBS item 597 and reg 2.15.1 in a way that promotes payment at the higher rates only where the medical opinion (that is the practitioner's opinion supported by the opinion of the general body of medical practitioners) is that the patient's medical condition requires treatment in the unbroken after hours period. The interpretation contended for by the applicant does not promote those objects.

[193] I also reject the applicant's argument that, having regard to the existence of debate about the time at which entitlement to MBS item 597 arises, it was not open to the Committee to make the finding it did concerning the applicant's conduct in making the claims he did under MBS item 597. While Dr Nithianantha put into evidence an opinion that had been obtained by someone (it is not clear that it was the applicant) from the Provider Services Branch of the Department of Human Services which supported his reading of MBS item 597 (see [38(6)] above), the Committee rejected that advice on the basis that it was not correct. Dr Nithianantha could not have relied on that advice because it was obtained after the review period (at [60]-[62] of the final report). There was no other evidence of the debate. In any event, as noted in *Sevdalis* FCAFC at [21], the Committee is a peer review body. Under s 95(5) of the Health Insurance Act, where the person under review is a general practitioner, the members of the Committee must also be general practitioners. The Committee was in a position to form a view of whether the claims made by the applicant under MBS item 597 would be unacceptable to the general body of members of that profession having regard to their (in my view correct) interpretation of that item and reg 2.15.1, notwithstanding that some practitioners may have had a different view.

Since the circumstances of the *Nithianantha* case, the Regulations have changed and the 'urgent after-hours' services now require the practitioner to be satisfied that the

patient required 'urgent assessment' rather than 'urgent treatment'. Nevertheless, as with the former urgent treatment test, the test of whether the patient required urgent assessment is to be applied at the time that the service is claimed and after the patient has been attended upon and assessed. It is not to be applied on the practitioner's understanding of the patient's condition as at any earlier time.

MBS item 5043

Sevdalis v Director of Professional Services Review [2016] FCA 433 —

> [113] In the [MBS] Book, items 37 and 5043 are described as "non urgent attendances". The text of the book does not suggest any evaluative aspect to services claimed under these items, in contrast to the way it describes an "urgent attendance". However, given the role of the Book, I am not persuaded this takes the applicant's argument any further than the text of the regulations themselves.
>
> [114] The first respondent's answer to this ground is to focus on the phrase "clinically relevant" in the text of each item. He does so by reference back to the definition of "clinically relevant service" in s 3 of the Act, which I have extracted at [41] above.
>
> [115] In my opinion, this submission involves a conflation of the defined term in s 3(1) and the text of items 37 and 5043 as set out in the regulations. The text in the items does not use the defined term "clinically relevant service". Indeed, the adjectival phrase "clinically relevant" in the regulations relates not to the "service" as a whole, but to the five activities set out in each item. It is one of more of those activities which must be "clinically relevant". In my opinion that means one or more of those activities (such as performing a clinical examination) must be relevant, in a clinical sense, to one or more of the "health related issues" a patient had at the time of the attendance.
>
> [116] There is simply nothing in the text or context of the regulations dealing with items 37 and 5043 which supports a construction of these items making it part of the Committee's task to decide whether, in the Committee's opinion, a "home visit" was justified.
>
> …
>
> [119] In all these instances, and others relied on the by the applicant in his submissions, the Committee is clearly reading into each of item 37 and item 5043 a requirement which is not there: namely, that the location of the attendance (i.e. out of the consulting rooms) must be necessary and justifiable, and (it appears the Committee considered this was also required) that the notes of the attendance should, contemporaneously, record the justification at a level of detail considered by the Committee to be sufficient.
>
> [120] The items do not require any such necessity or justification. Rather, in their text they require, at a factual level, a consultation of a certain duration (lasting at least 20 minutes), and a specific time of day (in usual hours for item 37, after hours

for item 5043). The items also require the medical practitioner to have performed at least one of the five specified activities, which are to be clinically relevant to the patient's health related issues as the patient presented at the time. Each of these requirements must be appropriately documented.

[121] Unlike items 597 to 600, read with reg 2.15.1, the regulations do not require, or authorise, the Committee to engage in any evaluative exercise about whether in its opinion the attendance at a location other than the consulting rooms was justified. Nor do they authorise or require the Committee to engage in the function of determining whether the justification is one which would be acceptable to the body of medical practitioners the Committee represents.

[122] The first respondent's invitation to focus on the requirement in the item descriptions for there to be "appropriate documentation" for the attendance does not alter my opinion. The documentation required by this item description is documentation which is appropriate to describe the "health related issue" the patient was experiencing, which activity or activities of the five specified activities were performed by the medical practitioner during the attendance, and some indication of why that activity was "clinically relevant" to the health related issue.

[123] Nevertheless, the first respondent is correct to submit that in each case in which a medicare benefit is claimed, a medical practitioner must meet the two requirements in the definition of "professional service" in s 3(1) of the Act in order to be entitled to the benefit as claimed under s 10. That means, as the first respondent submits, that for each service rendered and for which a medicare benefit is claimed, the service must be a clinically relevant service. This in turn imports an evaluative standard, as the terms of the definition of "clinically relevant service" in s 3(1) make clear. A Committee investigating a practitioner must, as part of its function, form a view whether the service rendered was one "generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered".

[124] The "service", for the purposes of this assessment (and for the purposes of a practitioner's entitlement), is a service "to which an item relates" under the regulations: see the definition of "professional service" in s 3(1) of the Act. Applying that to items 37 and 5043, the during hours and after hours attendances by Dr Sevdalis at places other than his consulting rooms or an aged care facility (or a hospital, in the case of item 5043) were, by the definition of "professional service" read with the definition of "clinically relevant service" in s 3(1) of the Act, required to be a service that was one "generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered".

[125] In some circumstances, an assessment of whether that requirement was met may touch upon some of the matters which were (in my opinion, wrongly) considered by the Committee in relation to item 37 and item 5043. Nevertheless, it remains the case that, looking at all the instances in which the Committee made an assessment, its approach introduced a gloss, or a consideration of a nature different to that required, by examining in quite an absolute way whether a patient "could have" gone to Dr Sevdalis' consulting rooms. On no view, in my opinion, is the evaluation to be conducted at that absolute level. Even within the terms of the two definitions in s 3(1), the evaluation is what kind of attendance is "necessary for the

appropriate treatment" of a patient. That is not an evaluation to be conducted in hindsight, perhaps years later, but on the information available to the practitioner at the time and it should not, in my opinion, be conducted by a Committee asking itself whether a patient "could" have gone to the surgery, even on the information available at the time. Rather, the correct question is whether a during hours or after hours service was, on the information available to the medical practitioner at the time, "necessary for the appropriate treatment of the patient to whom it is rendered", and generally accepted in the medical profession to be so. In my opinion "necessary" imports a standard at the level of there being no reasonable alternative in the circumstances. It does not suggest the Committee should determine whether it was physically possible for a patient to have attended during hours or at the practitioner's consulting rooms, which in my opinion is the standard the Committee seems to have applied.

MBS items 18216 and 18222

Kew v Director of Professional Services Review [2021] FCA 1607 —

[174] As to the relevant item numbers, item 18216 stated "Intrathecal or epidural infusion of a therapeutic substance, initial injection or commencement of, including up to 1 hour of continuous attendance by the medical practitioner (Anaes.)", and item 18222 stated "Infusion of a therapeutic substance to maintain regional anaesthesia or analgesia, subsequent injection or revision of, if the period of continuous medical practitioner attendance is 15 minutes or less".

[175] Now in assessing the services rendered by Dr Kew under items 18216 and 18222, the committee found that she did not satisfy the MBS item descriptor for those items. The basis for this finding was its construction of "infusion", which it found did not cover the procedures performed by Dr Kew, which it characterised as being an "injection".

[176] Now Dr Kew pointed out that if item numbers 18216 or 18222 did not apply, then she would have been able to bill those same services under item 18232 which provided:

> Intrathecal or epidural injection of substance other than anaesthetic, contrast or neurolytic solutions, other than a service to which another item in this Group applies (Anaes.).

[177] Accordingly, she says that the use of items 18216 and 18222 resulted in a significantly reduced fee payable to her by Medicare.

[178] Dr Kew says that the committee ought to have considered whether the rendering of the service could have been supported under a different item number, because to do so would involve no failure to comply with the MBS.

[179] She also says that there was evidence that Medicare had accepted this proposition by, subsequent to the review period, permitting Dr Kew to render the equivalent services under item 18232.

[180] Generally, Dr Kew says that the committee did not bring this into account in its reasons.

[181] She also says that the committee did not confront the essential question: why would the general body of specialists regard it as unacceptable for a radiologist to render the service under a particular item number that resulted in a significant reduction in the amount payable to her? And she says that the significance of this is twofold.

[182] First, it indicates that the committee erred in its construction of the word "infusion" as excluding an "injection". She posed the question: why would that strict construction be preferred, when it would only work to increase the fees for the service rendered, by requiring it to be billed under a more expensive item number? On this aspect, I am unconvinced of Dr Kew's assertion of error as I will discuss in a moment.

[183] Second, she says that there was a failure to address a submission centrally relevant to the decision being made, giving rise to a failure to have regard to relevant material. Now the committee addressed this issue by stating that "the Committee is not tasked with considering potential alternative appropriate MBS item numbers". But in doing so, Dr Kew says that it too narrowly conceived of its statutory task. She says that such an analysis was capable of being accommodated within the broader task of evaluating whether the practitioner had engaged in inappropriate practice. Accordingly, she says that the committee erroneously refused to have regard to a relevant matter, and so reached the untenable conclusion that Dr Kew had engaged in inappropriate practice by charging less for the rendered services than she was entitled to.

[184] But I would reject these grounds of review, notwithstanding their superficial allure.

[185] In my view the committee properly concluded that item 18216 was applicable only if:
(a) the therapeutic substance was infused into the intrathecal space or epidural space;
(b) it was the initial injection or commencement of that infusion; and
(c) the practitioner attended for a period of up to an hour whilst the therapeutic substance was infused.

[186] Similarly, item 18222 was for an "infusion".

[187] The committee explained its conclusion on those items as follows (at [191]):

> ...The Committee has applied the ordinary meaning of the word infusion when considering the meaning of the MBS item descriptors. The Committee considers the MBS describes a clearly identifiable clinical procedure in relation to both MBS items 18216 and 18222. The procedures performed by Dr Kew were not an infusion, but an injection...

[188] That is an unremarkable example of the reasoning of an expert committee applying technical standards to factual findings within their field of expertise.

> [189] Further, there was no failure to take into account a relevant consideration or legal unreasonableness.
>
> [190] The committee accepted that Dr Kew incorrectly understood that she was able to bill those items for injections, rather than only infusions. Nevertheless, the committee "consider[ed] this practice to be so removed from that of the general body of radiologists, that it would be considered unacceptable by Dr Kew's peers" (at [146]).
>
> [191] Further, as to Dr Kew's misunderstanding having the consequence that she was billing less for those services than she might otherwise have done, the committee observed that "the [c]ommittee is not tasked with considering potential alternate appropriate MBS item numbers and has not assessed each service to determine if another item number was appropriate" (at [146]). I should note here that contrary to Dr Kew's submission, the committee did not accept that she could have alternatively billed in all or most cases.
>
> [192] In my view, the committee was entitled to make the findings it made, both at the level of fact and professional opinion, on the evidence before it in coming to the conclusion that Dr Kew had engaged in inappropriate practice within the meaning of s 82(1)(b).

4AAA Multiple general medical services

Section 4AAA permits the regulations to provide for a reduction in the medicare benefit payable for a service under the general medical services table if another service is provided to the same patient, which may be a service under that table, the pathology services table, or the diagnostic imaging services table.

4AA Diagnostic imaging services table

Subsection 4AA(1) of the *Health Insurance Act* 1973 (the Act) provides for a Diagnostic Imaging Services Table, which sets out the diagnostic imaging services for which a Medicare payment can be claimed. It states:

> (1) The regulations may prescribe a table of diagnostic imaging services that sets out the following:
>
> (a) items of R-type diagnostic imaging services;
> (b) items of NR-type diagnostic imaging services;
> (c) the amount of fees applicable in respect of each item;
> (d) rules for interpretation of the table.
>
> Note: See also section 4BAA (conditional specification of services in table items).

The current regulations made under that provision are the *Health Insurance* (*Diagnostic Imaging Services Table*) *Regulations* (*No. 2*) *2020*.

An **R-type** diagnostic imaging service is one that can be billed if a relevant type of practitioner (as specified in section 16B of the Act) has made a request for the service. An **NR-type** diagnostic imaging service is one that can be billed without a request. The Table indicates the distinction by placing '(R)' or '(NR)' at the end of each item descriptor.

Subsection 3(5B) of the Act provides that a diagnostic imaging service is taken to include any necessary interpretation, analysis or reporting.

Request for a diagnostic imaging service

Section 16B of the Act provides that, subject to certain specified exceptions, a Medicare benefit is not payable in respect of an R-type diagnostic imaging service unless the service was rendered pursuant to a written request made by a practitioner of a type authorised to make such a request under the Act.

Part IIB of the Act sets out special provisions relating to diagnostic imaging services. Section 23DQ provides that regulations may specify the form in which requests for diagnostic imaging services may be made. Section 70 of the *Health Insurance Regulations 2018* provides those specifications, and states:

> **70 Requests for diagnostic imaging services—information and form requirements**
>
> (1) This section is made for the purposes of subsection 23DQ(1) of the Act.
>
> *Information that must be included*
>
> (2) The following information must be included in a subsection 16B(1) request:
> (a) the name of the person making the request;
> (b) the address of the place of practice, or the provider number in respect of the place of practice, or the requester number, of the person making the request;
> (c) the date of the request;
> (d) a description of the diagnostic imaging service being requested that provides, in terms that are generally understood throughout the medical profession, sufficient information to identify the item of the diagnostic imaging services table that relates to the service.
>
> *Branded diagnostic imaging request forms*
>
> (3) Subsection (4) applies to a subsection 16B(1) request if:
> (a) the request is made using a document for use in making a subsection 16B(1) request that is supplied, or made available to, a practitioner (within the meaning of section 23DQ of the Act) by a diagnostic imaging provider on or after 1 August 2012; and
> (b) the document, as supplied or made available, contains:

(i) the registered name or trading name of the diagnostic imaging provider; and
(ii) one or more locations where the diagnostic imaging provider renders diagnostic imaging services.

(4) The request must include a statement that informs the person in relation to whom the diagnostic imaging service is requested that the request may be taken to a diagnostic imaging provider of the person's choice.

(5) In this section:
diagnostic imaging provider means:
(a) a person who renders diagnostic imaging services; or
(b) a person who carries on the business of rendering diagnostic imaging services; or
(c) a person who employs, or engages under a contract of service, a person mentioned in paragraph (a) or (b).

A '**request**' for a diagnostic imaging service might be made in conjunction with a '**referral**' for a consultation or another service under the General Services Table made under section 4 of the Act. The requirements for a valid referral are set out in sections 95 to 101 of the *Health Insurance Regulations 2018*, and enable the referring practitioner to refer to a specialist or consultant physician for the purposes of an item in the General Medical Services Table (section 95). A radiologist cannot bill an item under the General Medical Services Table that requires a referral unless a valid referral has been made, which requires the referring practitioner to intend there to be a referral for a service from that Table, that the referring practitioner considered the need for the referral (section 97 of the HI Regs), and the referral must be in writing (section 98 of the HI Regs), and explain the reasons for the referral (section 99 of the HI Regs).

While a chiropractor, physiotherapist, podiatrist, osteopath, or participating midwife may request a diagnostic imaging service,[60] they cannot refer a patient to a radiologist (compare subsection 16B(9) of the Act and section 96 of the HI Regs). Thus, any consultation by a radiologist arising from a request for diagnostic imaging from one of those allied health providers cannot be billed under the General Medical Services Table as a referred attendance (MBS items 104 or 105), but only as a non-referred attendance (MBS items 52 to 57).

Some items within the Diagnostic Imaging Services Table state that a 'referral' is required (see for example, MBS item 55850). These items are ones where the

[60] Sections 39 to 44 of the *Health Insurance Regulations 2018* specify which diagnostic imaging services may be requested by dental practitioners, chiropractors, physiotherapists, osteopaths, podiatrists, participating midwives, and nurse practitioners.

radiologist has been asked to make an independent assessment of the patient and decide whether the service is clinically indicated before performing it. The reason that a 'referral' is required as part of the request for such a service is that if the radiologist decides that the service is not clinically indicated, the radiologist is then permitted to bill a referred attendance item from the General Medical Services Table, such as item 104. Without a referral, only a non-referred attendance item could be billed (such as MBS item 53). The Medicare benefit payable for these diagnostic imaging items includes a component to compensate for the time and skill required by the radiologist to attend the patient and make the relevant assessment (compare the benefit payable for MBS item 55850 with MBS item 55848), and so it is usually not appropriate to bill a separate attendance item under the General Medical Services Table in conjunction with one of these diagnostic imaging service items.

The Diagnostic Imaging Register

In order to carry on the business of rendering diagnostic imaging services for the purpose of claiming Medicare benefits, the proprietor of diagnostic imaging premises must apply for the premises at which diagnostic imaging is to occur, to be registered. Once registered, the premises is allocated a location specific practice number (LSPN).

Subsection 23DZK(1) of the Act provides that the Minister must keep a ***Diagnostic Imaging Register***. Subsection 23DZK(2) states:

> (2) The Register is kept for the following purposes:
> (a) gathering information on the provision of diagnostic imaging services, including (but not limited to) the structure of medical practices connected with the provision of those services, for the purposes of planning and developing the Commonwealth medicare benefits program;
> (b) identifying whether medicare benefit is payable for a particular diagnostic imaging service rendered to a person;
> (c) assisting in identifying whether inappropriate practice (as defined for the purposes of Part VAA of this Act) is taking place;
> (d) assisting in identifying whether contraventions of Part IIBA in relation to diagnostic imaging are taking place.

Diagnostic imaging premises

Section 23DZM defines '**diagnostic imaging premises**' as a building or part of a building at which diagnostic imaging procedures are carried out under a single business name.

Section 23DZN provides that the 'proprietor' of diagnostic imaging premises may apply to the Minister for registration of the premises.

Section 23DZO defines a '***proprietor***' as the person or government agency who has effective control of:

> (a) the premises, whether or not the holder of an estate or interest in the premises; and
> (b) the use of the diagnostic imaging equipment used at the premises; and
> (c) the employment of staff (including medical practitioners) connected with the premises.

For the purposes of that provision, '***employment***' is stated to 'include':

> (a) appointment or employment by the Commonwealth, a State or Territory; and
> (b) appointment or employment by a government agency; and
> (c) full-time, part-time and casual work; and
> (d) work under a contract for services.

Registration of diagnostic imaging premises

Division 5 of Part IIB provides for schemes of ***registration*** and ***accreditation*** of diagnostic imaging premises. If diagnostic imaging premises are not registered, a Medicare benefit is not payable.

Subsection 16D(1) provides:

> (1) Unless the Minister otherwise directs, a medicare benefit is not payable in respect of a diagnostic imaging service rendered by or on behalf of a medical practitioner unless the diagnostic imaging procedure used in rendering that service is:
> (a) carried out using diagnostic imaging equipment that:
> (i) is ordinarily located at registered diagnostic imaging premises; and
> (ii) is of a type that, on the day on which the procedure is carried out, is listed for the premises; …

An application for registration must be in writing and contain certain specified information (section 23DZP).

Under section 23DZQ, if an application is received, the Minister must register the premises by allocating a unique location specific practice number to the premises and include certain specified information on the Register. Registration takes effect on the later of either the day on which the application is properly made, or the day specified by the applicant in their application.

Certain information required to be included on the Register is called '***primary information***' and is defined in section 23DZR, which provides:

> (1) The following information is primary information:
> (a) details of the proprietor (including, where the proprietor is a company, its Australian Company Number) of the diagnostic imaging premises or the base for mobile diagnostic imaging equipment (as the case requires);
> (b) the business name under which diagnostic imaging procedures are carried out;
> (c) the ABN under which diagnostic imaging procedures are carried out:
> (i) in the case of diagnostic imaging premises—using diagnostic imaging equipment that is ordinarily located at the premises; or
> (ii) in the case of a base for mobile diagnostic imaging equipment—using diagnostic imaging equipment ordinarily located at the base when not in use that is not ordinarily located at diagnostic imaging premises;
> (d) in the case of diagnostic imaging premises:
> (i) the address of the premises; and
> (ii) a statement identifying the types of diagnostic imaging equipment ordinarily located at the premises;
> (e) in the case of a base for mobile diagnostic imaging equipment:
> (i) the address of the base; and
> (ii) the address of the proprietor; and
> (iii) a statement identifying the type of each piece of diagnostic imaging equipment that is ordinarily located at the base when not in use and is not ordinarily located at diagnostic imaging premises;
> (f) details of the legal relationships that give rise to a right to use the equipment.
>
> (2) The regulations may prescribe types of diagnostic imaging equipment for the purposes of this section.

Registration may be cancelled or suspended, and ceases to have effect if cancelled or while suspended. Cancellation or suspension by the Minister may occur if the proprietor of premises fails to comply with a request for information under section 23DZW.

The kinds of information the Minister may request must be relevant to the purposes for which the Register is kept. As noted above, the purposes of the Register are set out in subsection 23DZK(2), which include for the purposes of investigating whether inappropriate practice is taking place. As the Minister cannot delegate the power to issue notices to the Director or an officer of PSR (see section 131, which limits the persons to whom the Ministers power may be delegated), it is a power that could be exercised by staff in Department who act as, or assist, delegates of the Chief Executive Medicare in deciding whether to make requests of the Director of PSR under section 86 of the Act.

Listing of diagnostic imaging equipment

The diagnostic imaging equipment used at registered diagnostic imaging premises must be ***listed*** for the relevant diagnostic imaging service. Subsection 16D(4) provides:

> (4) Diagnostic imaging equipment is of a type listed for particular diagnostic imaging premises at a particular time if, at that time:
>
> (a) the Diagnostic Imaging Register states that equipment of a particular type is ordinarily located at the premises; and
>
> (b) the equipment is of that type.

Accreditation of diagnostic imaging premises

If diagnostic imaging premises are not accredited, a Medicare benefit is not payable. Subsection 16EA(1) provides:

> (1) Unless the Minister otherwise directs, a medicare benefit is not payable in respect of a diagnostic imaging service rendered by or on behalf of a medical practitioner unless the diagnostic imaging procedure used in rendering that service is carried out:
>
> (a) at diagnostic imaging premises that are, or at a base for mobile diagnostic imaging equipment that is, accredited for that procedure under a diagnostic imaging accreditation scheme;
>
> (b) using diagnostic imaging equipment that:
>
> (i) when not in use, is ordinarily located at a base for mobile diagnostic imaging equipment that is accredited for that procedure under a diagnostic imaging accreditation scheme; and
>
> (ii) is not ordinarily located at diagnostic imaging premises;
>
> (c) using diagnostic imaging equipment that is ordinarily located at diagnostic imaging premises that are accredited for that procedure under a diagnostic imaging accreditation scheme.

Under section 23DZZIAA, the Minister may make an instrument establishing one or more schemes under which diagnostic imaging premises may be accredited for diagnostic imaging procedures. The Minister may also approve one or more persons to be '**approved accreditors**' to accredit premises.

Under section 6 of the *Health Insurance (Diagnostic Imaging Accreditation — Approved Accreditors) Instrument 2020* the Minister has approved three companies as approved accreditors:

- HDAA Australia Pty Ltd;
- National Association of Testing Authorities Australia; and
- Quality Innovation Performance International Pty Ltd.

The *Health Insurance (Diagnostic Imaging Accreditation) Instrument 2020* (the DIA Instrument), made under section 23DZZIAA establishes a scheme for accreditation.

Initial accreditation

If a diagnostic imaging practice has not previously been accredited it is taken to be an 'entry level practice', and may apply to any approved accreditor for accreditation (section 9 of the DIA Instrument). The approved accreditor must grant accreditation if satisfied that the diagnostic imaging practice meets the entry level standards, which are defined in section 6 as Standards 1.2, 1.3 and 1.4 in Schedule 1 to the DIA Instrument. Meeting those standards requires evidence of:

- the licences and qualifications of the staff and practitioners eligible to provide or assist in the provision of diagnostic imaging services to the practice to undertake such diagnostic imaging services (Standard 1.2);
- licences or registration relevant to Commonwealth, State, or Territory radiation safety laws for equipment, and radiation safety plans (Standard 1.3);
- an equipment inventory demonstrating that relevant equipment used to provide diagnostic imaging services is registered with Services Australia and complies with the Health Insurance Act and Regulations (Standard 1.4).

The proprietor of a diagnostic imaging practice must ensure that the practice complies with these standards and provide the accreditor with this evidence on request (para 9(5)(b) of the DIA Instrument).

If an accredited practice does not continue to meet the entry level standards or satisfy a condition of accreditation, the proprietor must notify the accreditor immediately after becoming aware of that failure.

If a practice has been accredited for 2 years at the entry level, the accreditor must revoke the accreditation (subsection 9(7) of the DIA Instrument). Consequently, in order for the practice to continue to operate under the scheme, it must apply for re-accreditation before the end of that period (section 8 of the DIA Instrument).

Re-accreditation

A practice may apply for re-accreditation under either section 10 or 11 of the DIA Instrument. It is also possible for an initial accreditation application to be made under section 10 or 11 if the practice can meet all the relevant requirements at that time.

Section 11 applies if the practice has Medical Imaging Accreditation Program (MIAP) approval. MIAP is a diagnostic imaging accreditation program that is jointly administered by the National Association of Testing Authorities Australia (NATA) and the Royal Australian and New Zealand College of Radiologists (RANZCR).

If an application is made under section 10, the proprietor of the practice must ensure that, at all times, the diagnostic imaging practice complies with the standards in Schedule 1 to the DIA Instrument, and provide to the responsible accreditor the required evidence, as specified in the Schedule, on request by the accreditor.

In addition to the Standards for an 'entry level practice' (Standards 1.2, 1.3 and 1.4), there must be evidence of:

- a Safety and Quality Manual, which addresses all of the practice's diagnostic imaging accreditation scheme policies, and evidence that demonstrates that mechanisms are in place to evaluate, audit, review and monitor each of the Standards and their specific requirements (Standard 1.1);
- records and reports demonstrating that equipment used to acquire, manipulate, print or report images for diagnostic imaging procedures is safe and appropriate for its intended use (Standard 1.5);
- a documented policy and procedure for preventing transmission of infectious agents, including a process for identifying, assessing and managing risks and reporting, investigating, and responding to the transmission when they occur (Standard 1.6);
- a documented policy and procedure for practitioners in response to inappropriate requests for diagnostic imaging services, de-identified samples of records demonstrating such responses, and de-identified samples of records documenting the clinical need for non-referred services (Standard 2.1);
- a documented policy and procedure for obtaining patient consent prior to a diagnostic imaging procedure being provided, and a sample of de-identified records demonstrating such consent and advice provided concerning risk, as well as de-identified records documenting the patient's health status relevant to the procedure being undertaken, with regard to: asthma, previous exposure to intravenous contrast, allergies, medical conditions such as diabetes, kidney disease, or heart disease, pregnancy status, medications such as metformin hydrochloride, breastfeeding, and medical devices and implanted devices (Standard 2.2);
- a documented policy and procedure for matching patients to their intended diagnostic imaging procedure including the report for that procedure,

through all stages of the service and when transferring responsibility of care, and a sample of de-identified records documenting the use of identifiers, and a documented policy and procedure that sets out the process for reporting, investigating, and responding if mismatching occurs (Standard 2.3);

- a documented policy and procedure describing the procedures for storing, preparing, and disposing of medications, identifying 'at risk' patients, administering medications safely, monitoring and recording the effects of medication, and reporting, investigating and responding to adverse reactions or medication mismanagement incidents when they occur; and a documented management plan that identifies the procedures for managing adverse reactions at the time they occur; de-identified records documenting information about the patient's medication use and/or history regarding previous reactions to medications, and examples of records demonstrating management of adverse reactions at the time they occur (Standard 2.4);
- documented protocols for routine diagnostic imaging procedures or groups of diagnostic imaging procedures rendered ta the practice, with evidence that they have been reviewed a minimum of once per accreditation cycle (Standard 3.1);
- a technique chart, consistent with the 'as low as reasonably achievable' (ALARA) exposure to ionizing radiation, for each unit of ionizing radiation equipment located at the practice; evidence that the settings for the equipment have been reviewed and authorized by a qualified person annually; evidence that system generated dose metrics have been logged and reviewed by a qualified person annually; evidence of a program established to ensure that radiation doses administered to a person for diagnostic purposes are annually compared with diagnostic reference levels (DRLs) that have been established in Australia, and if DRLs are consistently exceeded, reviewed to determine whether radiation protection has been optimised (Standard 3.2);
- a documented policy for the provision of reports to requesting practitioners and patients, a sample of de-identified imaging reports, consistent with the practice's documented policy for reporting;
- a sample of de-identified records documenting the image findings of self-determined services setting out the findings of the procedure and indicating that it has been retained in the patient record (Standard 4.2);
- a documented policy for inviting, recording, managing, and responding to feedback and complaints; and evidence of staff training in managing and responding to feedback and complaints; a sample of de-identified feedback and complaints received and records of the actions taken (Standard 4.3).

If an application is made under section 11, the proprietor of the practice must ensure that, at all times, the diagnostic imaging practice complies with the standards and requirements of the MIAP. The MIAP Standards essentially incorporate the same standards as the DIA Instrument.

Accreditation under section 10 expires after 4 years, and under section 11, accreditation expires on the MIAP expiry date.

An application for accreditation must be made in accordance with section 12 of the DIA Instrument. It must be made in writing to an approved accreditor, be lodged by the proprietor or an employee of the proprietor of the practice; specify the section under which accreditation is being sought; specify the diagnostic imaging practice that is to be granted accreditation; and specify the diagnostic modalities for which the practice is to be granted accreditation (section 12(2)).

An applicant must provide the accreditor with such information as the accreditor reasonably requires in support of the application, and the application must authorize the accreditor to check the accuracy of the information provided by whatever means the approved accreditor sees fit, and to store and use the information for the purposes of Division 5 of Part IIB of the Act and for the purposes of the DIA Instrument.

The approved accreditor may decide an application for accreditation by granting accreditation for some or all of the modalities requested in the application, with or without conditions, or it may refuse accreditation (subsection 12(5)). A decision must be accompanied with a statement of reasons, and appeal rights.

Under section 18 of the DIA Instrument, an applicant may apply for reconsideration of a decision. If dissatisfied with a reconsideration decision, the applicant may apply to the Minister under section 23DZZIAD of the Act for further reconsideration of the decision.

A proprietor must notify the accreditor of any change in the diagnostic imaging modalities carried out by the practice, and an accreditor may vary a practice's accreditation for additional or fewer modalities (section 13).

Conditions on accreditation

Section 14 of the DIA Instrument provides that an accreditor may impose conditions of accreditation on the practice. Subsection 14(2) sets out certain conditions of accreditation that apply to all practices, namely, the accreditor may, at any time:

- access and inspect the premises and equipment of the practice;
- access, inspect and copy documents, materials, books and records, however stored, in the custody or under the control of the proprietor, its officers, employees, agents or contractors; and
- require the provision of information by the proprietor, its officers, employees, agents or contractors,

for the purpose of the accreditor determining whether the practice meets, or continues to meet requirements for accreditation under the DIA Instrument.

Accreditation can be varied, suspended or cancelled if the accreditor considers that a practice no longer meets the relevant standards in the Schedule to the DIA Instrument or the MIAP standards (if applicable) (Section 16).

10 Entitlement to medicare benefit

Under subsection 10(1), a benefit is payable where medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person. For the purposes of the Act, **'Australia'** includes Norfolk Island, the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island.[61]

The amount of the benefit payable is determined under subsection 10(2).

Subsection 10(1A) clarifies that a service rendered in the course of a domestic journey is taken to have been rendered within Australia even if the person was outside Australia when it was rendered. The term 'domestic journey' is defined in subsection 10(1B) to mean one that begins and ends within Australia. Applying the extended definition of 'Australia', this means that a professional service rendered

[61] 'Australia' is defined in s 3 of the Act. Section 7A of the Act expressly extends the Act to Norfolk Island, the Territory of Cocos (Keeling) Islands and the Territory of Christmas Island. Additionally, s 2B of the *Acts Interpretation Act 1901* provides that, subject to a contrary intention (see subsection 2(2) of the *Acts Interpretation Act 1901*), in any Act, '***Australia*** means the Commonwealth of Australia and, when used in a geographical sense, includes the Territory of Christmas Island and the Territory of Cocos (Keeling) Islands, but does not include any other external Territory. Section 7A and the definition of 'Australia' in section 3 were amended to include Norfolk Island in 2015 (*Norfolk Island Legislation Amendment Act 2015*). Prior to that time, residents of Norfolk Island were not entitled to medicare benefits.

over the Indian ocean outside Australia on a journey from Perth to Christmas Island would be a service for which a benefit could be payable.

Subsection 10(2) provides for the calculation of the amount of benefit payable for a professional service:

> (a) in the case of a service provided as part of an episode of hospital treatment, or as part of an episode of hospital-substitute treatment in respect of which the patient chooses to receive a benefit from a private health insurer, the benefit payable is 75% of the Schedule fee;
> (aa) in the case of a service to which paragraph (a) does not apply and that is prescribed by the regulations for the purposes of paragraph 10(2)(aa), the benefit is 100% of the Schedule fee;
> (b) in any other case, the benefit is 85% of the Schedule fee.

Section 28 of the *Health Insurance Regulations 2018* prescribes services in the General Medical Services Table for the purposes of paragraph (aa).[62] These services include most of the professional attendance services billed or claimed by general practitioners. Usually these are billed at 100% of the Schedule fee.

Subsection 10(2) is subject to section 14 of the Act, which provides that a medical benefit payable in respect of a professional service shall not exceed the medical expenses incurred in respect of the service. This means that if a practitioner charges a fee less than the fee specified in the Schedule, the benefit payable cannot be more than the fee charged.

Sevdalis v Director of Professional Services Review (No. 2) [2016] FCA 433 —

> [71] … the structure of the legislative scheme involves an entitlement to receive a "medicare benefit" in respect of each "professional service" rendered (relevantly) in Australia to an eligible person. The amount to which the practitioner is entitled by way of medicare benefit is to be calculated in accordance with s 10(2), read with the relevant regulations …
>
> [72] In other words, so long as what the practitioner does meets the definition of "professional service" in the Act – including, relevantly, because it is a "clinically relevant" service to which an item in the applicable regulations relates – the practitioner is entitled (again, relevantly to this proceeding and putting to one side hospital treatment) to either 100% or 85% of the Schedule fee set out in the regulations.
>
> …
>
> [133] … it was substantially correct also to consider the requirements of s 10 of the Act, read with s 3(1). The latter [i.e., "necessary for the appropriate treatment of a

[62] Formerly this was contained in regulation 6EF of the *Health Insurance Regulations 1975*.

patient",[63]] are the most fundamental prerequisites to entitlement to a medicare benefit for a service.

Tisdall v Kelly [2005] FCA 365 —

> [6] The scheme known as Medicare, a national scheme of medical benefits, is established by the Health Insurance Act 1973 (Cth) ('the Health Insurance Act'). By s 10(1) of that Act, where medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person, Medicare benefit calculated in accordance with s 10(2) is payable, subject to, and in accordance with the Health Insurance Act, in respect of that professional service. Section 19(6) provides:
>
> > 'A medicare benefit is not payable in respect of a professional service unless the person by or on behalf of whom the professional service was rendered, or an employee of that person, has recorded on the account, or on the receipt, for fees in respect of the service or, if an assignment has been made, or an agreement has been entered into, in accordance with section 20A, in relation to the medicare benefit in respect of the service, on the form of the assignment or agreement, as the case may be, such particulars as are prescribed in relation to professional services generally or in relation to a class of professional services in which that professional service is included.'
>
> [7] By s 20(1), medicare benefit in respect of a professional service is payable by the HIC on behalf of the Commonwealth to the person who incurs the medical expenses in respect of that service. By s 20A, where a medicare benefit is payable to an eligible person in respect of a professional service, the eligible person and the person by whom, or on whose behalf, the professional service is rendered may enter into an agreement, in accordance with the approved form. Under such an agreement, the eligible person assigns his or her right to the payment of the medicare benefit to the practitioner, and the practitioner accepts the assignment in full payment of the medical expenses incurred in respect of the professional service. The practice of assigning the entitlement to medicare benefit to the practitioner is commonly known as 'bulk billing'.
>
> [8] Regulation 13 of the *Health Insurance Regulations 1975* (Cth) ('the 1975 Regulations') prescribes the particulars to be recorded, for the purposes of s 19(6) of the Health Insurance Act. By subregs (1A)(b) and (1B)(b), the information to be recorded must, or may, include the provider number of the medical practitioner concerned, depending upon circumstances not material to this proceeding. A medical practitioner may have more than one provider number, if he or she practises at more than one location, because a provider number is allocated in respect of a particular location of practice.
>
> [9] Medical practitioners are provided with a medical benefits schedule, which refers to various kinds of medical services, allocating an item number for each kind, so that medicare benefits may be claimed by reference to the item number for the service provided. Regulation 13(2) of the 1975 Regulations requires the recording

[63] See paragraph [131] of the judgment.

> of a description of the professional service and the item number of the item, or at least a description of the professional service sufficient to identify the item.

Doan v Health Insurance Commission [2002] FCA 1160 —

> [81] Further, the definitional chain of "inappropriate practice" in the HI Act and the overall issue of whether the practitioner has engaged in "inappropriate practice" necessarily demands an analysis of particular questions, including whether the service is clinically relevant, whether the services rendered or initiated in the referral period were necessary, whether there was an appropriate level of clinical input and whether the services were appropriate. In this way, from the definition of s 82 of inappropriate practice, one has to go to s 81(1) which defines a "service" as a service for which "at the time it was rendered or initiated, a Medicare benefit was payable", such Medicare benefits being payable where, "on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person..." (s 10(1)). The meaning of "professional service" in s 3 then directs one to the meaning of a "clinically relevant service" which is defined as a "service rendered by a medical ... practitioner ... that is generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered": s 3.

While subsection 10(1) provides that a medicare benefit is 'payable' where medical expenses are incurred in respect of a professional service, that provision merely indicates the right to start a process leading to a right to payment. In *DCT v Donnelly* [1989] FCA 399, von Doussa J considered the time at which medicare benefits became 'payable' for the purposes of a notice under section 218 of the *Income Tax Assessment Act 1936*.

Re Deputy Commissioner of Taxation v Donnelly as Trustee of the Bankrupt Estate of Geoffrey Walter Edelsten; Geoffrey Walter Edelsten and Health Insurance Commission [1989] FCA 399 (per von Doussa J)—

> [16] It will be seen from the foregoing provisions that the entitlement to medical benefit is, by subs.10(1), dependent upon the incurring of medical expenses by an eligible person (i.e. the patient). Then "medicare benefit calculated in accordance with subsection (2) (of s.10) is payable, subject to and in accordance with the Act". The point in time when that entitlement leads to the creation of an identifiable debt due by the Health Insurance Commission depends not on subs.10(1) but on the other provisions of the Act. The entitlement established by s.10 is in the nature of a right to put in train the processes of the Act which have the potential to lead to payment. The entitlement, although capable of assignment to the provider of the medical service under s.20A, is not "payable" until a claim is made within a specified time (s.20(B)) and is accepted. The condition of acceptance is to be implied from the language of sub.s.10(3), from the implicit requirement that the complex process of calculation laid down in the Act is to be undertaken by the Health Insurance Commission to assess the proper medical benefit, and from subs.20B(3). It is clear enough from the scheme of the Act that medicare benefit does not become presently payable until the process of calculation or assessment and the act of acceptance

> makes a certain sum actually payable. The more difficult question is whether medicare benefit becomes owing, and owing as an identifiable sum though not presently payable, at some earlier point in time so that a s.218 notice can operate to impose an obligation on the Health Insurance Commission to pay that sum to the Commissioner of Taxation when it has "become due".
>
> [17] Subsection 20A(1) by its terms would suggest that a right to payment of medicare benefit arises in the patient when the professional service is rendered which is thereupon capable of assignment under the general law. However the terms of the sub-section are part of a tightly drawn scheme and the apparently general words used must be construed in context. In particular, by subs.20A(3), medicare benefit, under an assignment under that section "is, subject to s.20B, payable in accordance with the assignment." Section 20B imposes not only a time limit within which claims must be made, but by subs.20B(3), makes payment dependent upon the Commission being satisfied as to one of the states of fact required by paras.(c) or (d). Until the Commission is so satisfied an assignee under s.20A has a right to claim benefits, but no right to payment, let alone payment of a particular sum of money that is identifiable in the hands of the Health Insurance Commission. Until a claim is made the Health Insurance Commission would have no knowledge that the relevant professional services had been rendered, and no knowledge about particular facts which could entitle the eligible person to whom the service was rendered to a greater or lesser payment of benefit than would arise under the general formula for calculating benefit in subss.10(1) and (2). Until a claim is made, and assessed and accepted for payment, there is no identifiable sum of money owing, and an essential condition on which the imposition of an obligation by notice given under s.218 depends does not exist.
>
> [18] The right to claim medical benefits assigned to Dr Edelsten by an eligible person under s.20A is however "property" within the meaning of s.5 of the Bankruptcy Act, and from the commencement of the bankruptcy must be treated under the relation back doctrine as passing to Dr Edelsten's trustee: *In re Pollitt Ex parte Minor* (1893) 1 QB 455 at 457-458. So in respect of claims made by Dr Edelsten between 22 May 1987 and the date of the sequestration order, when the benefits were assessed and accepted for payment, they belonged to the trustee. The indebtedness that arose in the Health Insurance Commission on a claim lodged after 22 May 1987 being accepted for payment was not one which then or at any time answered the terms of subs.218(1) or the notices. There was not then or at any time any identifiable sum of money due to the taxpayer. For these reasons I agree with the conclusion reached by Burchett J. that the notices upon which the appellant relies did not have the effect contended for. The Commissioner of Taxation was not at any stage a secured creditor in respect of moneys which became payable by the Health Insurance Commission in respect of claims lodged by Dr Edelsten after 22 May 1987.

The payment of benefits can be withheld if the Chief Executive Medicare is not satisfied that the person is entitled to the payment.

Hatfield v Health Insurance Commission [1987] FCA 286 —

> [20] I would add that the decision not to pay the item 793 benefits was not dependent upon its being established that an offence had been committed. The Commission was correct in withholding payment of the item 793 benefits if it was not satisfied that Dr Hatfield was entitled thereto.

14 Medicare benefit not to exceed medical expenses incurred

Subsection 14(1) provides that a medical benefit payable in respect of a professional service shall not exceed the medical expenses incurred in respect of the service. This means that if a practitioner charges a fee less than the fee specified in the Schedule, the benefit payable cannot be more than the fee charged.

Subsection 14(2) is an exception to this rule, and provides that subsection 14(1) does not apply if the rendering of a professional service is covered by an agreement between a private health insurer and another person and the amount payable under the agreement for the professional service is not determined on a fee for service basis. Examples of such arrangements are the negotiated contracts developed with the assistance of the National Procedure Banding Committee, which has an advisory role to the private health insurance industry.

The terms of reference for the National Procedure Banding Committee state, at clause 1.2:[64]

> Under the system each Medicare Benefit Schedule (MBS) item is allocated a Procedure Band in accordance with the Procedure Banding Methodology … Each Procedure Band represents a cost range. Under Hospital Purchaser Provider Agreement (HPPA) arrangements charges and benefits are therefore individually agreed between providers and payers for each of the 15 (fifteen) bands rather than for the 5,000 (five thousand) or so procedures listed in the MBS.

Bupa HI Pty Ltd v Andrew Chang Services Pty Ltd [2018] FCA 2033 —

> [55] … On the other hand, the Lower Item and the Higher Item have been banded differently, meaning they each attract different "second tier default benefits" payable to the private hospital. This has been achieved through a process by which private hospitals and private health insurers negotiate the amount of benefits payable under the negotiated contracts assisted by the National Procedure Banding Committee. This Committee provides and maintains a banding for MBS items, apparently to enable private hospitals and private health insurers to negotiate the amount of benefits payable according to the bands, rather than for each of the thousands of individual items in the MBS. Bupa points to evidence which

[64] National Procedure Banding Committee Terms of Reference, 19 February 2015.

establishes that MBS items are allocated to appropriate bands "depending on the level of direct costs generated by a specific procedure": see Exhibit J, Procedure Banding Committee Terms of Reference Methodology at 8 [3.4.1].

15 Medicare benefit in respect of 2 or more operations

Section 15 is the multiple operations rule. The effect of the provision is that if more than one operation is performed for the same patient on the same occasion, the benefit payable for each of those services is reduced by the method described in paragraph 15(1)(a), and the totality of the operations is deemed (for the purpose of ascertaining whether a medicare benefit is payable, or for calculating the amount of a medicare benefit that is payable) to be one single professional service, where the amount of the benefit for that service is taken to be the total of the amount calculated under paragraph 15(1)(a).

The effect of paragraph 15(1)(a) is that the total benefit payable is the sum of the benefit payable for the service attracting the highest benefit, 50% of the benefit payable for the service attracting the next highest benefit, and 25% of the benefit payable for each of the other services.

While paragraph 15(1)(b) deems all the operations to be one professional service, that is only for the purpose of determining whether, or calculating how much, medicare benefit is payable. For all other purposes of the Act, such as for a review or investigation of particular services under Part VAA of the Act, each operation remains a separate service.

A similar **'multiple services rule'** applies under the regulations to other services such as diagnostic imaging services: see clauses 1.2.11 and 1.2.12 of the Health Insurance (Diagnostic Imaging Services Table) Regulations; and similarly, there is what is known as the **'coning rule'** for pathology services: see clause 1.2.6 of the Health Insurance (Pathology Services Table) Regulation.

16 Administration of anaesthetic and assistance at operation

Subsection 16(1) provides that, except with the approval of the Minister, a separate benefit is not payable for the administration of anaesthesia in connection with a service unless the anaesthetic is administered by a practitioner other than the practitioner who renders the service for which the anaesthesia was necessary.

Those items where anaesthesia may be necessary, and for which an anesthetic item can be separately billed by another practitioner administering that anaesthesia, are identified in the table by '(Anaes.)' in the item description. Group T10 of the Health Insurance (General Medical Services Table) Regulations sets out the rules relating to benefits payable for anaesthesia in connection with certain services.

Subsection 16(2) provides that a separate benefit is not payable for the provision of assistance at an operation if the assistance is rendered by the anaesthetist or a practitioner assisting the anaesthetist.

Those items in respect of which a benefit may be payable for an assistant are identified in the item in the table by '(Assist.)'. Group T9 of the Health Insurance (General Medical Services Table) Regulations sets out the rules relating to benefits payable for assistance in operations.

Subsection 16(3) provides that where an item provides for a benefit for anaesthesia or assistance at an operation, the amount of benefit is the same whether provided by one or more than one practitioner.

16A Medicare benefits in relation to pathology services

Subject to certain specified exceptions, a Medicare benefit is not payable in respect of a pathology service unless the service was rendered pursuant to a written request made by a practitioner of a type authorised to make such a request under the Act.

Part IIA of the Act sets out special provisions relating to pathology services. Sections 29 to 37 of the *Health Insurance Regulations 2018* specify pathology services that can be requested by particular types of practitioners and the requirements for requests for pathology services. Sections 54 and 55 of those Regulations specify the particulars that must be provided in relation to billing for such services.

For the benefit for a pathology service to be payable, certain requirements must be met, including:

- a request for the pathology test must be provided by a 'treating practitioner' who has determined the service to be 'necessary';
- an Approved Pathology Laboratory (APL) must analyse the sample; and
- a report has to be provided by an Approved Pathology Practitioner (APP).

The word, 'necessary' in the context of requesting a pathology service, is defined in subsection 16A(12) to mean 'reasonably necessary for the adequate medical care of the patient'. This is different from the definition of 'clinically relevant service' in subsection 3(1) in that the focus is on 'adequate medical care' rather than 'appropriate medical treatment'.

The definition of 'professional service' in subsection 3(1) as it relates to a pathology service rendered by an approved pathology practitioner following a request from a treating practitioner does not incorporate the phrase 'clinically relevant service'.[65] However, where a pathology service is performed, without a request from a treating practitioner, by an approved pathology provider, it must be a 'clinically relevant service',[66] that is, it must be necessary for the appropriate treatment of the patient.

Accreditation of APLs is conducted by the National Association of Testing Authorities (NATA), Australia's national laboratory accreditation authority.

Pathology practitioners apply each year to the Minister for acceptance as an APP. Decisions are made by delegates of the Minister within Services Australia. A Schedule to the application form contains an undertaking the practitioner is required to make for the purposes of subsection 23DB(1) of the Act.

Subsection 16A(5AA) specifies various types of locations at which a pathology specimen may be collected for a benefit to be payable. In *Melbourne Pathology Pty Ltd v Health Insurance Commission*, the Federal Court considered whether a specimen collected in premises in part of a 'recognised hospital' building leased by the proprietor of the hospital to an approved pathology proprietor was 'collected … at' that hospital.[67] It was argued that as the pathology service provider, through a lease agreement with the hospital, had exclusive possession of the premises from which it collected the specimens, the collection did not occur 'at … a recognised hospital'.

Melbourne Pathology Pty Ltd v Health Insurance Commission [1997] FCA 92 —

> My conclusion is that at relevant times the premises were in the exclusive possession of the applicant under the scheduled document which conferred on the applicant a leasehold estate in the premises.

[65] Paragraph 3(1)(d).
[66] Paragraph 3(1)(e).
[67] At that time, the relevant provision stated, 'at … a recognised hospital'. The current wording is 'at … premises of a recognised hospital, being premises at which hospital treatment is provided'.

The respondent submits that in sub-paragraph 16A(5AA)(d) (iii) the word "hospital" is used in reference to a place, the boundaries of which are defined by reference to the possession of the person or entity which there carries on hospital activities. Accordingly the premises, not being in the possession of the body corporate to which I refer as "the hospital", are not within the boundaries of that place and are not part of this "recognised hospital". The applicant insists, rightly, that the word "at" is used in ordinary speech and in legislative provisions - in several senses and that the meaning of the word is to be ascertained upon a consideration of the subject matter and the idiomatic context of the sentence in which it is used. (see *Mintern-Lane v Kercher* [1968] VicRp 71; [1968] VR 552 at 553-555; *Attorney General's Reference (No. 1 of 1976)* [1977) 3 AllER 557; *Collector of Customs (Tasmania) v Flinders Island Community Association* [1985] FCA 232; (1985) 60 ALR 717 at 722-726; *Collector of Customs v Rottnest Island Authority* [1994] FCA 876; (1994) 119 ALR 406 at 421-422.)

But for a consideration upon which Mr Maxwell of counsel for the respondent relied (to be considered later) I would understand the expression "at ... a recognised hospital" as comprehending a place within the boundary of the land on which the recognised hospital was situated and of which as a whole the person or entity conducting the hospital had possession. I say "as a whole" in order to accommodate the circumstance that within such a boundary there may be land the exclusive possession of which is in another. Examples which come to mind are a retail chemist shop or a cafe or newsagency or a medical research institute or, in the case of a hospital where education in medicine is carried on, a building occupied by a university. It may be uncommon that possession of some of such places is in this country in a person or entity other than that which conducts the hospital. But I cannot think it to be unknown. Where such an enclave existed within the boundary, it would be an entirely natural use of language to say that the shop or cafe or research institute was "at" the hospital. And the same can be said of the premises of which the applicant has exclusive possession.

The consideration upon which Mr Maxwell relied derives from Division 4A of Part II of the *Health Insurance Act 1973* and the Minister's speech to the House of Representatives on the occasion of his moving the second reading of the Bill which upon its enactment inserted that Division into the Act. The Bill was enacted as the *Health Insurance (Pathology) Amendment Act (No.2) 1991*. Until amended in 1991 Part II of the *Health Insurance Act 1973* had provided that a medicare benefit was not payable in respect of a pathology service unless the service was rendered by or on behalf of a pathology practitioner approved by the Minister in an accredited pathology laboratory the proprietor of which was an approved pathology authority. In the second reading speech the Minister said, inter alia:

> "The purpose of this Bill is to make amendments to the Health Insurance Act 1973 in relation to pathology services. This is one of four Bills to put in place the Government's reforms for the restructuring of the pathology industry that were announced in the Budget. …
>
> The pathology initiatives which I announced in the Budget were in response to two things - first, the National Health Strategy Background Paper No 6 'Directions in Pathology' and second, longer term statistical evidence which has

indicated that pathology services have been increasing at a disproportionate rate when compared with other medical services. …

The key components of the initiative are the introduction of a licensing scheme for pathology specimen collection centres and proposed regulatory amendments to the Pathology Services Table. …

In an attempt to increase their share of pathology service delivery, there are indications that some pathology practices compete with each other by providing significant inducements for treating practitioners to request pathology services from their practice. Some pathologists may place their trained staff within a doctor's surgery, and this action may not only reduce the doctor's ability to choose between pathologists on a service-by-service basis, but may have the undesirable effect of significantly increasing the amount of pathology ordered.

From 1 February, in order to be licensed, a collection centre must be an independent facility, owned or leased by an approved pathology authority, which is set up with appropriate equipment and supplies for the collection of pathology specimens. The centre must be staffed by employees of that approved pathology authority and include staff trained in specimen collection procedures.

It is generally recognised within the pathology profession that there are too many collection centres in this country, many of which are operating in very close proximity. Often this has the effect of being inefficient and adding unnecessary expense to the provision of pathology services. The number and location of collection centres will be reviewed in cooperation with representatives from the pathology profession, with a view to reducing the number significantly over a two-year period.

The formula for the allocation of licences for permanent collection centres is based on the volume of pathology services, the number of full time equivalent specialist pathologists associated with the practice and the number of treating practitioners who request pathology from that practice. The number of centres operated by some pathology practices will exceed the number which may be granted a licence under the new arrangements. Excess centres may receive temporary licensing and will be phased out over two years. From 1 February 1992, private approved pathology authorities will be required to hold a licence for each of their collection centres, to enable the payment of Medicare benefits in respect of pathology services rendered at those centres. The licence fee has been set at $1,000.

Recently established pathology practices will be eligible to apply for up to three licences, and so new market entrants will be assisted during their first year of operation. In addition, on a proven needs basis, special consideration may be given to granting licences to centres which service rural areas currently. The new transaction fees are intended to cover costs other than the test procedure itself and include indirect operational costs, professional quality assurance, courier and collection costs. …

The Bill provides for specific circumstances under which a Medicare benefit for a pathology service will not be payable. A medicare benefit for a pathology service will not be payable where the pathology specimen is collected in an

> unlicensed collection centre. Any person who operates an unlicensed centre will be required to take all reasonable steps to inform both the person from whom the specimen is to be taken and the pathologist who may perform the pathology service that medicare benefits will not be payable for the service. A Medicare benefit for a pathology service will not be payable where inappropriate agreement, arrangement or incentive for ordering the service exists between the approved pathology practitioner rendering the service, the treating practitioner requesting the service or a medical entrepreneur.
>
> The reform of collection centre arrangements is being undertaken to negate the potential for this nexus. There must be no functional, direct or indirect, pecuniary or other beneficial contractual arrangement or understanding in relation to the ordering of pathology between the approved pathology authority, a pathologist, the treating practitioner, employer or employee of the practitioner, or any other party. …
>
> The crucial role of general medical practitioners in primary health care will continue to be encouraged, as will the collection of patient samples in their surgeries, wherever possible. Bulkbilling arrangements will continue.
>
> Patients will not suffer loss of existing entitlements to pathology services. However, the significant reduction in the number of collection centres will encourage general practitioners to collect specimens themselves. The patients should, therefore, be inconvenienced only when their doctor insists on directing them to a collection centre which may be some distance from that referring doctor."

Division 4A gave effect to the policy disclosed by the second reading speech by establishing a system of licensing specimen collection centres.

Mr Maxwell's submission was that the result of the arrangements between the hospital and applicant, which was at all material times an approved pathology proprietor, was that the premises contained a specimen collection centre for which no licence under Division 4A had been sought. Mr Maxwell submitted that an interpretation of the expression "at ... a recognised hospital" which enabled a medicare benefit to be payable in respect of a pathology service, the pathology specimen required for the rendering of which had been collected on those unlicensed premises, would defeat and not promote the purpose underlying the *Health Insurance Act 1973*.

The variability of meaning of the word "at" makes sub-paragraph 16A(5AA)(d)(iii) "ambiguous" if not "obscure", within the meaning of those words in s.15AB(1)(b)(i) of the *Acts Interpretation Act 1901*, and recourse to the second reading speech is accordingly authorised.

I cannot think that the *Health Insurance Act 1973* or the second reading speech discloses a policy against an unlicensed collection centre occupied under a lease, but not against an unlicensed collection centre occupied under a licence. No policy which I can discern influences to a construction of the expression "at" ... a recognised hospital" which denies the application of the expression to the former, but not to the latter. I therefore give to the expression what in its context I take to be its natural meaning.

> There will be an order that each of the decisions the subject of the further amended application filed 16 February 1996 be set aside, a declaration that the pathology specimen or specimens required for the rendering of the pathology service the subject of each of the said decisions was or were "collected ... at ... a recognised hospital" within the meaning of those words in paragraph 16A(5AA)(d) of the *Health Insurance Act 1973* … .

A challenge to the constitutional validity of sections 16A and 16B was dismissed by the High Court in 1980 in *General Practitioners Society v Commonwealth*.

General Practitioners Society v Commonwealth (1980) 145 CLR 532; [1980] HCA 30 (per Barwick CJ) —

> [6] It is apparent to my mind from the analysis of the provisions of the statute which my brother Gibbs makes, and with which I agree, that the statute does not impose upon any medical practitioner the obligation to perform for a patient any service, pharmaceutical, medical or otherwise. In my opinion, the statute does no more than provide that if the patient is to receive the prescribed Commonwealth benefit he may only do so if the practitioner has aided him by following the incidental provisions of the statute.

General Practitioners Society v Commonwealth (1980) 145 CLR 532; [1980] HCA 30 (per Gibbs J) —

> [15] With respect to the matters so far discussed, the Act and regulations do not on their proper construction have an operation which could on any view be held to amount to the imposition of any form of civil conscription. However, some of the provisions of the Act, regulations and undertaking do have the effect - legal or practical - of compelling medical practitioners to observe certain positive requirements, and I now proceed to consider the nature of the things which those provisions compel medical practitioners to do in the course of carrying on their practices, and whether a law which compels a medical practitioner to do those things is a law which imposes any form of civil conscription.
>
> [16] In the first place, it may be agreed that some medical practitioners, who request an approved pathology practitioner to render a pathology service, will be compelled to make the request in a written form that complies with reg. 5, or, if the request was not made in writing, to give written confirmation in accordance with reg. 5. The compulsion in such a case will be not legal but practical, resulting from the fact that the provisions of s. 16A (1) make the payment of medical benefits depend upon the making of a written request or confirmation as prescribed. The request or confirmation, to satisfy reg. 5, must specify the matters detailed in that regulation, and one of those matters - "each service to which the instrument relates" - must be specified in the handwriting of the person signing the instrument (reg. 5 (8)). This means that it is no longer possible to follow the practice, which was formerly widely adopted, of marking (perhaps only with a tick) the appropriate part of a printed request form which set out a list of available pathology services. Secondly, it appears to be intended that there shall be recorded on an account, or receipt, for fees in respect of a service to which s. 16A (1) applies, or, if an agreement has been entered into under s. 20 (3) in relation to the medical benefit in respect of the

service, on the form of agreement, the particulars described by reg. 6. It is not made clear by s. 16A (2) on whom this duty lies, or what is the sanction for a failure to perform it, but an approved pathology practitioner may be obliged, by virtue of cl. 3 of the undertaking, to ensure that the duty is carried out. Thirdly, an approved pathology practitioner who has rendered a pathology service in pursuance of a request made or confirmed in accordance with s. 16A (1) must retain for eighteen months the written request or written confirmation, and must produce the same on being given proper notice within that period (s. 16A (3)). Fourthly, an approved pathology practitioner must, in accordance with the undertaking, take appropriate action to ensure that his employees, and other persons who by arrangement perform duties or services for him, act in accordance with the relevant provisions of the Act, regulations and undertaking (cl. 3) and must also furnish to the Minister such information relating to the requesting or rendering by or on behalf of the practitioner of applicable pathology services as is from time to time reasonably requested by the Minister (cl. 10).

[17] The word "conscription", in the sense that seems to be most apposite for present purposes, means the compulsory enlistment of men (or women) for military (including naval or air force) service. The expression "civil conscription" appears to mean the calling up of persons for compulsory service other than military service. The meaning of the words "but not so as to authorize any form of civil conscription" in s. 51 (xxiiiA) was considered in *British Medical Association v The Commonwealth* [1949] HCA 44; (1949) 79 CLR 201. In that case the Court had to decide upon the validity of the *Pharmaceutical Benefits Act 1947-1949* (Cth), which established a scheme under which members of the public were entitled on compliance with certain conditions to obtain, free of charge, the medicines specified in a formulary and the appliances specified in an addendum. One of the conditions of entitlement was that the medicine or appliance must be prescribed by a medical practitioner on a prescription form supplied by the Commonwealth. The statement of claim, to which the defendants demurred, alleged that a very large number of ordinary prescriptions and appliances were contained in the formulary and addendum, and that a medical practitioner could not carry on his practice without writing prescriptions for such medicines and appliances. Section 7A of that Act was in the following terms:

> "(1) Subject to this section, a medical practitioner shall not write, in respect of a person entitled to receive pharmaceutical benefits, a prescription for -
> (a) an uncompounded medicine the name of which, or a medicinal compound the formula of which, is contained, or is deemed to be included, in the Commonwealth Pharmaceutical Formulary; or
> (b) a material or appliance the name of which is contained in the prescribed addendum to the Commonwealth Pharmaceutical Formulary,
> otherwise than on a prescription form supplied by the Commonwealth for the purposes of this Act.
> Penalty: Fifty pounds.
>
> (2) The last preceding sub-section shall not apply -
> (a) in any case in which the person in respect of whom, or at whose request, the prescription is written requests the medical practitioner not to write the prescription on a prescription form supplied by the Commonwealth for the purposes of this Act; or

(b) in such other cases or circumstances as are prescribed."

It was held by a majority that s. 7A imposed a form of civil conscription and was invalid. (at p556)

[18] I have already said that a majority of the Court in that case held that the relevant words of s. 51 (xxiiiA) qualify "medical and dental services", and it follows that the compulsory service which cannot be imposed is service of a medical or dental kind. It was further held that the expression "civil conscription" in the paragraph is not limited to compulsory service which is performed full-time, or regularly, and that the relevant words are intended to prevent any form of compulsion to perform particular services (1949) 79 CLR, at pp 249-250, 278, 287, 293-294 . However, some members of the majority went further and held that a law which compels people to perform services in a particular manner is a law which imposes civil conscription. Latham C.J. said (1949) 79 CLR, at p 249 that the term "civil conscription" "could properly be applied to any compulsion of law requiring that men should engage in a particular occupation, perform particular work, or perform work in a particular way". Williams J. (1949) 79 CLR, at p 290 said that a submission that "a law which merely compels medical practitioners to act in some particular manner in the course of or as incidental to the carrying on of their profession does not authorize any form of civil conscription" would unduly narrow the effect of the wide words "any form of" in the expression in parenthesis. Webb J. seems to have been of a similar opinion (1949) 79 CLR, at p 294 . The other member of the majority, Rich J., who was content to say (1949) 79 CLR, at p 255 that the phrase "civil conscription" means "compulsion in connection with 'medical and dental services'", perhaps did not intend to go so far. The dissentients, Dixon and McTiernan JJ., did not agree with the wide view of the majority.

[19] With the greatest respect, I am unable to agree with those observations by Latham C.J. and Williams and Webb JJ. as to the meaning and effect of the expression "any form of civil conscription". That expression, used in its natural meaning, and applied, as the context of par. (xxiiiA) requires, to medical and dental services, refers to any sort of compulsion to engage in practice as a doctor or a dentist or to perform particular medical or dental services. However, in its natural meaning it does not refer to compulsion to do, in a particular way, some act in the course of carrying on practice or performing a service, when there is no compulsion to carry on the practice or perform the service. It would be an abuse of language to say that a soldier who has voluntarily enlisted in the army becomes a conscript because he is obliged to obey orders as to the manner in which he performs his military duties. Similarly it could not properly be said that it would be a form of civil conscription to require a person who had voluntarily engaged in civilian employment to perform the duties of that employment in accordance with the instructions given to him by his employers. For example, a clerk who was instructed to write out orders for goods or services only on a specified form could not be said to be thereby subjected to a form of civil conscription. There is nothing in the Constitution that would indicate that the expression "any form of civil conscription" where it appears in s. 51 (xxiiiA) should be given an enlarged meaning which its words do not naturally bear. The words "any form of" do not, in my opinion, extend the meaning of "conscription", and that word connotes compulsion to serve rather than regulation of the manner in which a service is performed. Of course no express power is conferred on the Parliament to make laws to regulate the manner of

performance of medical or dental services, but it appears clearly necessary to the effective exercise of the power conferred by s. 51 (xxiiiA) that the Parliament should be able to make laws as to the way in which medical and dental services provided by the Commonwealth under the authority of that paragraph are performed, and laws annexing conditions to the entitlement to any of the benefits provided under that authority even if those conditions may have the result that a medical or dental service must be rendered in a particular way if the benefit is to be obtained. I find it impossible to discern in the words in parenthesis in par. (xxiiiA) any intention to prevent the Parliament from making laws of that kind, provided that no compulsion to serve is imposed. I respectfully agree with the opinion expressed by Dixon J. in *British Medical Association v The Commonwealth* (1949) 79 CLR, at p 278 that "a wide distinction exists between on the one hand a regulation of the manner in which an incident of medical practice is carried out, if and when it is done, and on the other hand the compulsion to serve medically or to render medical services"; the latter is within the prohibition but the former is not. If the incident of practice which is regulated is not medical or dental, but financial and administrative, it is clearly outside the prohibition.

[20] Latham C.J. and Webb J. were influenced in reaching this conclusion by the opinion that if the bracketed words of par. (xxiiiA) did not have the effect which they attributed to them, the Parliament would be able to legislate so as to bring about a complete control of medical and dental practices (1949) 79 CLR, at pp 251, 294 . Williams J. (1949) 79 CLR, at p 290 expressed a similar opinion, although the examples he gave suggest that he thought that the sort of control which might be exerted would be rather more limited. No doubt their Honours had in mind the principle of interpretation under which a statutory provision, if ambiguous, may be construed so as to avoid inconvenience and injustice. However, it would seem to me impermissible to give to the words of a constitutional prohibition a meaning wider than that which they naturally convey out of an apprehension that the legislative powers, if not heavily fettered, might be used to effect a wide control of professional activities. In any case, it does not in my opinion necessarily follow, as Latham C.J. and Webb J. feared, that if the construction which those Justices adopted is rejected, it would be possible for the Parliament, without infringing the prohibition of civil conscription, to provide that a doctor or dentist should carry on his practice at a particular place, or at a particular time, or only for a particular class of patients. In some circumstances, at least, provisions having that result might well be regarded as imposing a form of civil conscription. It is necessary in every case to consider the true meaning and effect of the challenged provisions, in order to determine whether they do compel doctors or dentists to perform services generally as such, or to perform particular medical or dental services; if so, they will be invalid.

[21] It follows from what I have said that if the *ratio decidendi* of *British Medical Association v The Commonwealth* was expressed in the observations with which I have disagreed, I should regard the case as wrongly decided. However, I consider that the decision may be supported on narrower grounds and that those observations may be treated as dicta. In the first place it may be observed that s. 7A of the Pharmaceutical Benefits Act 1947-1949 required that a doctor should write any prescriptions for any medicines included in the formulary on the form supplied by the Commonwealth, whether or not the medicines were to be obtained free.

Therefore the section had no necessary relationship with any pharmaceutical benefit or medical services provided by the Commonwealth: see per Latham C.J. (1949) 79 CLR, at p 247. It is noteworthy that s. 8 of that Act, which provided that a person should not be entitled to receive pharmaceutical benefits from an approved pharmaceutical chemist, except, inter alia, on presentation of a prescription written and signed by the medical practitioner and, except as prescribed, written on a prescription form supplied by the Commonwealth, was upheld as valid. Unlike s. 7A, s. 8 did no more than prescribe a condition of giving a pharmaceutical benefit. Latham C.J. said: "But it is one thing to provide as a condition of giving a pharmaceutical benefit that a prescription shall be written on a particular form, and another thing to provide that a doctor shall write any prescription for medicines which are included within a formulary upon a particular form, whether or not such medicines are to be supplied free under the Act. Section 7A (1) is a provision of the latter description." Secondly, the majority of the Court appear to have considered that, in the light of the history of the earlier legislation, and having regard to the scheme of the Pharmaceutical Benefits Act considered as a whole, s. 7A could be seen to have the intention to compel medical practitioners to join in the Commonwealth scheme for the provision of free pharmaceutical benefits, and to provide, against their will, a medical service for the Commonwealth. This view was clearly expressed by Williams J. (1949) 79 CLR, at pp 289-290 , and by Webb J. (1949) 79 CLR, at pp 293-294 , and Latham C.J. and Rich J. appear to have been of a similar opinion (1949) 79 CLR, at pp 253, 256 . In both these respects that case is distinguishable from the present.

[22] The provisions in question in these proceedings do compel medical practitioners to perform certain duties in the course of carrying out their medical practices, but they do not go beyond regulating the manner in which some of the incidents of those practices are carried out, and they do not compel any medical practitioner to perform any medical services. Most of the duties imposed relate only to things done incidentally in the course of practice, rather than to a medical service itself. The only possible exception is s. 16A (1), which requires that a request by a medical practitioner to an approved pathology practitioner to render a pathology service shall be made or confirmed in writing as prescribed. A request of that kind may be regarded as a medical service. However, s. 16A (1) does not compel any medical practitioner to make such a request. What it requires is that the request, if made, be made or confirmed by a written instrument which satisfies reg. 5. There is nothing in that regulation which affects in the slightest the performance by a medical practitioner of his medical duties and functions. The statutory requirements may impose on him more administrative work. In particular he is required to specify, in his own handwriting, the services to which the instrument relates, and cannot simply mark a form on which is printed a list of possible services. The reason why a condition of this kind is attached to the entitlement to medical benefits is no doubt that the use of the printed form might reasonably be regarded as likely to contribute to laxity and to facilitate fraud. However that may be, to require a practitioner to write out particulars of the service which he has decided to request another practitioner to perform is not to compel the practitioner making the request to perform a medical service. Even more clearly, the requirements of s. 16A (2) with regard to accounts and receipts, and those of s. 16A (3) with regard to the retention and production of any written request or confirmation, do not compel any medical practitioner to perform any medical service. Clause 3 (b) of the undertaking, which obliges a medical practitioner to exercise some supervision over

his servants and agents, and cl. 10, which requires a medical practitioner to furnish such information as is reasonably requested with regard to the requesting or rendering of pathology services in respect of which medical benefits are payable, are also no more than a regulation of the incidents of medical practice and do not compel a medical practitioner to perform any medical service.

[23] For these reasons none of the provisions in question imposes any form of civil conscription contrary to s. 51 (xxiiiA) of the *Constitution*.

16B Medicare benefits in relation to R-type diagnostic imaging services

Subject to certain specified exceptions, a Medicare benefit is not payable in respect of an R-type diagnostic imaging service unless the service was rendered pursuant to a written request made by a practitioner of a type authorised to make such a request under the Act.

Part IIB of the Act sets out special provisions relating to diagnostic imaging services. Section 23DQ provides that regulations may specify the form in which requests for diagnostic imaging services may be made. Section 70 of the *Health Insurance Regulations 2018* provides those specifications, and states:

> **70 Requests for diagnostic imaging services—information and form requirements**
>
> (1) This section is made for the purposes of subsection 23DQ(1) of the Act.
>
> *Information that must be included*
>
> (2) The following information must be included in a subsection 16B(1) request:
> (a) the name of the person making the request;
> (b) the address of the place of practice, or the provider number in respect of the place of practice, or the requester number, of the person making the request;
> (c) the date of the request;
> (d) a description of the diagnostic imaging service being requested that provides, in terms that are generally understood throughout the medical profession, sufficient information to identify the item of the diagnostic imaging services table that relates to the service.
>
> *Branded diagnostic imaging request forms*
>
> (3) Subsection (4) applies to a subsection 16B(1) request if:
> (a) the request is made using a document for use in making a subsection 16B(1) request that is supplied, or made available to, a practitioner (within the meaning of section 23DQ of the Act) by a diagnostic imaging provider on or after 1 August 2012; and
> (b) the document, as supplied or made available, contains:
> (i) the registered name or trading name of the diagnostic imaging provider; and

> (ii) one or more locations where the diagnostic imaging provider renders diagnostic imaging services.
>
> (4) The request must include a statement that informs the person in relation to whom the diagnostic imaging service is requested that the request may be taken to a diagnostic imaging provider of the person's choice.
>
> (5) In this section:
> ***diagnostic imaging provider*** means:
> (a) a person who renders diagnostic imaging services; or
> (b) a person who carries on the business of rendering diagnostic imaging services; or
> (c) a person who employs, or engages under a contract of service, a person mentioned in paragraph (a) or (b).

A '**request**' for a diagnostic imaging service might be made in conjunction with a '**referral**' for a consultation or another service under the General Services Table made under section 4 of the Act. The requirements for a valid referral are set out in sections 95 to 101 of the *Health Insurance Regulations 2018*, and enable the referring practitioner to refer to a specialist or consultant physician for the purposes of an item in the General Medical Services Table (section 95). A radiologist cannot bill an item under the General Medical Services Table that requires a referral unless a valid referral has been made, which requires the referring practitioner to intend there to be a referral for a service from that Table, that the referring practitioner considered the need for the referral (section 97 of the HI Regs), and the referral must be in writing (section 98 of the HI Regs), and explain the reasons for the referral (section 99 of the HI Regs).

While a chiropractor, physiotherapist, podiatrist, osteopath, or participating midwife may request a diagnostic imaging service,[68] they cannot refer a patient to a radiologist (compare subsection 16B(9) of the Act and section 96 of the HI Regs). Thus, any consultation by a radiologist arising from a request for diagnostic imaging from one of those allied health providers cannot be billed under the General Medical Services Table as a referred attendance (MBS items 104 or 105), but only as a non-referred attendance (MBS items 52 to 57).

Some items within the Diagnostic Imaging Services Table state that a 'referral' is required (see for example, MBS item 55850). These items are ones where the radiologist has been asked to make an independent assessment of the patient and

[68] Sections 39 to 44 of the *Health Insurance Regulations 2018* specify which diagnostic imaging services may be requested by dental practitioners, chiropractors, physiotherapists, osteopaths, podiatrists, participating midwives, and nurse practitioners.

decide whether the service is clinically indicated before performing it. The reason that a 'referral' is required as part of the request for such a service is that if the radiologist decides that the service is not clinically indicated, the radiologist is then permitted to bill a referred attendance item from the General Medical Services Table, such as item 104. Without a referral, only a non-referred attendance item could be billed (such as MBS item 53). The Medicare benefit payable for these diagnostic imaging items includes a component to compensate for the time and skill required by the radiologist to attend the patient and make the relevant assessment (compare the benefit payable for MBS item 55850 with MBS item 55848), and so it is usually not appropriate to bill a separate attendance item under the General Medical Services Table in conjunction with one of these diagnostic imaging service items.

19 Medicare benefit not payable in respect of certain professional services

Section 19 sets out some of the general circumstances where a medicare benefit is not payable. Other provisions within the Act set out other circumstances.

If a reimbursement arrangement, as defined in the *Health and Other Services (Compensation) Act 1995*, has been made in respect of an injury to a compensable person, and the person is entitled under the arrangement to compensation by way of reimbursement of expenses as those expenses are incurred, a medicare benefit is not payable in respect of a professional service. If a medicare benefit has already been paid, the person entitled to the reimbursement is liable to pay to the Commonwealth an amount equal to the medicare benefit that was paid.

Similarly, if an amount of compensation is fixed under a judgment or settlement made in respect of an injury to a compensable person, and a medicare benefit has already been paid in respect of a professional service rendered to that person in the course of treatment of, or as a result of, the injury, and liability has not already arisen under a reimbursement arrangement, the person is liable to pay to the Commonwealth an amount equal to the medicare benefit that was paid.

Subsection 7(2) of the *Health and Other Services (Compensation) Act 1995* provides:

> (2) Despite Part II of the *Health Insurance Act 1973*, medicare benefit is not payable in respect of a professional service if, under the reimbursement arrangement, the

> whole or any part of the amount payable for the service has already been reimbursed before a claim for medicare benefit in respect of the service is made.

Subsection 3(1) of that Act defines 'reimbursement arrangement' as:

> **"reimbursement arrangement"** means an agreement in writing, an order of a court or compensation authority, or a decision of a person or body, to the effect that the person against whom a claim for compensation is made is liable to pay compensation to reimburse the claimant for expenses as they are incurred by the claimant that:
>
> (a) are incurred in respect of any service or care rendered or provided in the course of treatment of, or as a result of, the claimant's injury; and
>
> (b) are expenses in respect of which an eligible benefit is or may become payable (whether or not the eligible benefit is payable to the claimant).

19(1) — benefit not payable in respect of life insurance, superannuation, etc.

Unless the Minister otherwise directs, a medicare benefit is not payable in respect of an examination for the purposes of life insurance, superannuation or provident society account schemes, or admission to membership of a friendly society.

19(2) — benefit not payable for a service rendered for or under an arrangement with a government body.

Unless the Minister otherwise directs, a medicare benefit is not payable in respect of a professional service rendered by, or on behalf of, or under an arrangement with the Commonwealth, a State, a local government body, or an authority established by a law of the Commonwealth, a law of a State or a law of an internal Territory.

19(3) — benefit not payable for a service if expenses incurred by the employer or in connection with an industrial undertaking.

Unless the Minister otherwise directs, a medicare benefit is not payable in respect of a professional service if the medical expenses in respect of that service were incurred by the employer of the person, or the person was employed in an industrial undertaking and the professional service was rendered to him or her for purposes connected with the operation of that undertaking.

19(4) — benefit not payable for a service rendered in the course of mass immunization.

A medicare benefit is not payable in respect of a professional service rendered in the course of carrying out a mass immunization.

19(5) — benefit not payable in respect of a health screening service

Unless the Minister otherwise directs, a medicare benefit is not payable in respect of a health screening service. Clause 1.2.3(2) of Schedule 1 of the General Medical Services Table Regulations provides in respect of the term 'professional attendance':

> '(2) A professional attendance includes the provision, for a patient, of any of the following services:
> (a) evaluating the patient's condition or conditions including, if applicable, evaluation using a health screening service mentioned in subsection 19 (5) of the Act'.

This means that where the Minister has directed that certain health screening services are specified for the purpose of the exemption in subsection 19(5), then such a service can be provided as part of a professional attendance. The Minister has directed that medicare benefits be paid for the following categories of health screening:

- a medical examination or test on a symptomless patient by that patient's own medical practitioner in the course of normal medical practice, to ensure the patient receives any medical advice or treatment necessary to maintain their state of health. Benefits would be payable for the attendance and tests which are considered reasonably necessary according to patients individual circumstances (such as age, physical condition, past personal and family history). For example, a cervical screening test in a person, blood lipid estimation where a person has a family history of lipid disorder. However, such routine check-up should not necessarily be accompanied by an extensive battery of diagnostic investigations;
- a pathology service requested by the National Heart Foundation of Australia, Risk Evaluation Service;
- age or health related medical examinations to obtain or renew a licence to drive a private motor vehicle;
- a medical examination of, and/or blood collection from persons occupationally exposed to sexual transmission of disease, in line with

conditions determined by the relevant State or Territory health authority, (one examination or collection per person per week). Benefits are not paid for pathology tests resulting from the examination or collection;

- a medical examination for a person as a prerequisite of that person becoming eligible to foster a child or children;
- a medical examination being a requisite for Social Security benefits or allowances;
- a medical or optometrical examination provided to a person who is an unemployed person (as defined by the *Social Security Act 1991*), as the request of a prospective employer.

19(6) — benefit not payable unless particulars are recorded

Subsection 19(6) requires particular details to be recorded by the practitioner performing the service before a benefit can be payable. The details are prescribed in Division 5 of the *Health Insurance Regulations 2018*.[69] Section 49 of those Regulations applies to all professional services and says:

> The following particulars are prescribed in relation to a professional service:
> (a) the name of the patient to whom the service was rendered;
> (b) the date on which the service was rendered;
> (c) the amount charged in respect of the service;
> (d) the total amount paid in respect of the service;
> (e) any amount outstanding in respect of the service.

Formerly, the regulations were contained in regulation 13 of the *Health Insurance Regulations 1975*.

Tisdall v Kelly [2005] FCA 365 —

> [8] Regulation 13 of the *Health Insurance Regulations 1975* (Cth) ('the 1975 Regulations') prescribes the particulars to be recorded, for the purposes of s 19(6) of the Health Insurance Act. By subregs (1A)(b) and (1B)(b), the information to be recorded must, or may, include the provider number of the medical practitioner concerned, depending upon circumstances not material to this proceeding. A medical practitioner may have more than one provider number, if he or she practises at more than one location, because a provider number is allocated in respect of a particular location of practice.
>
> [9] Medical practitioners are provided with a medical benefits schedule, which refers to various kinds of medical services, allocating an item number for each kind,

[69] Formerly, these requirements were contained in regulation 13 of the *Health Insurance Regulations 1975*.

> so that medicare benefits may be claimed by reference to the item number for the service provided. Regulation 13(2) of the 1975 Regulations requires the recording of a description of the professional service and the item number of the item, or at least a description of the professional service sufficient to identify the item. For the purposes of the present case, the relevant schedule of item numbers is to be found in the *Health Insurance (1999-2000 General Medical Services Table) Regulations 1999* (Cth).

Sections 50 to 60 in Division 5 of the *Health Insurance Regulations 2018* impose other requirements for particular classes of services, including:

- a description of the service sufficient to identity the item that specifies the service (s 50(1));
- if the service is rendered as part of an episode of hospital treatment, it must be identified as such (s 50(2));
- if the service is rendered as part of an episode of hospital-substitute treatment and the person who receives the treatment chooses to receive a benefit from a private health insurer in respect of that service, it must be identified as such (s 50(3));
- the name of the person who rendered the service and the address of the place of practice where it was rendered, or the practitioner's **provider number** (s 51(2), s 52(2));
- in respect of certain radiation or nuclear services (MBS items 12500 to 12533, 15000 to 15600, and 16003 to 16015), in addition to the information required by s 52(2), the name of the billing practitioner if that practitioner did not render the service and the address of the place of practice of the billing practitioner, or the billing practitioner's provider number (s 52(3));
- the **location specific practice number** for the premises in respect of certain radiation oncology services (s 53(2));
- for pathology services (other than Group P9), the approved pathology practitioner by whom, or on whose behalf, the service was rendered; or, if the service was rendered completely in a single accredited pathology laboratory, any approved pathology practitioner rendering services in that laboratory; or, if rendered in more than one laboratory owned and controlled by an approved pathology authority, any approved pathology practitioner in one of those laboratories where the service was partly rendered (s 54(2));
- for requested pathology services, the name of the treating practitioner who requested the service and the location or provider number for that location

of the treating practitioner, and the date on which the treating practitioner determined that the service was necessary (s 55(2));

- for a pathologist-determinable service, an indication that the service was determined to be necessary by that approved pathology practitioner (s 55(3));
- for a diagnostic imaging service, the name of the medical practitioner who is claiming the benefit for the service and the address of place of practice the practitioner or their provider number in respect of that place (s 56(2));
- for a diagnostic imaging service, if the medical practitioner who is claiming the benefit for the service (the billing practitioner) is not the practitioner who rendered the service (the service practitioner), in addition to the information required by s. 56(2), the name and address of the service practitioner or their provider number for that location, unless that information as well as the date of the service is recorded at the billing practitioner's place of practice (s 56(3));
- for an R-type diagnostic imaging service, the name and address of the practice of the person who requested the service, or their provider number, and the date on which it was requested (s 57(2));
- the location specific practice number for where the equipment is located or based (s 57(3));
- for referred services rendered by a specialist or consultant physician, the name and practice address of the referring practitioner or their provider number, and the date on which the patient was referred, and the period of validity of the referral (s 58(2));
- if a medical practitioner, dental practitioner, optometrist, participating midwife, or participating nurse practitioner attends the same patient more than once on the same day, the time at which the attendance started for each professional service (s 59) ;
- for management of anaesthesia, the name of each medical practitioner who performed a procedure for which the anaesthesia was administered, and if MBS item 25025 applies to the service, the time when the service began, ended and the duration of the service (s 60(2)).
- if the service is a perfusion to which item 25050 applies, the time when the service began, ended and the duration of the service (s 60(3))
- if the service is assistance in the management of anaesthesia, the name of the principal anaesthetist, the name of each medical practitioner who

performed a procedure for which the anaesthesia was administered, and if item 25030 applies to the service, the time when the service began, ended and the duration of the service (s 60(4)).

19AB Medicare benefits are not payable in respect of services rendered by certain overseas trained doctors etc.

As a general rule, a medicare benefit is not payable in respect of a professional service rendered by (subsection 19AB(1)) or on behalf of (subsection 19AB(2)) a person who is an overseas trained doctor or who is a foreign graduate of an accredited medical school unless certain conditions are satisfied relating to when they became registered or licensed in Australia as a 'medical practitioner' or their subsequent training and examination in Australia.

Under subsection 19AB(3), the Minister may grant an exemption from the operation of these rules in respect of a person or a class of persons, and must determine guidelines for the administration of this provision. The current guidelines are the *Health Insurance (Section 19AB Exemptions Guidelines) Determination 2019*. Section 6(2) of the guidelines provides:

> (2) When making a decision under subsection 19AB(3) of the Act, the Minister must take into account as a primary consideration whether the service location is in a Distribution Priority Area or District of Workforce Shortage in respect of the type of medical practitioner to which the application relates.

A dissatisfied applicant for an exemption may apply to the Administrative Appeals Tribunal for review of the Minister's decision.

Re Rules of the Supreme Court 1971 (WA); Ex parte Van Den Berg [2020] WASC 233 —

> **Judicial review of area of need**
>
> [53] The plaintiff seeks a judicial review of and 'abolishment of the "area of need" visa regulation' on the basis that it discriminates against overseas trained doctors. He contended that it was a breach of anti-discrimination law (in Western Australia, the *Equal Opportunity Act 1984* (WA)) for 'migrant' doctors to be treated differently to 'similarly qualified non-migrant' doctors.
>
> [54] I turn first to the allegation that the 'area of need' regulation is a breach of the *Equal Opportunity Act*. Under the *Equal Opportunity Act*, any complaint that a person has contravened the Act is made to the Equal Opportunity Commissioner who has the power to investigate complaints and refer matters to the State Administrative Tribunal for determination. For this reason, any complaint by the

plaintiff about whether the area of need regulation is discriminatory should be made to the Equal Opportunity Commissioner.

[55] I also note that under s 52 of the *Equal Opportunity Act*, the Act does not apply to any act that discriminates between Australian citizens and non-citizens. It is apparent from the material filed by the plaintiff that he has been resident in Australia since 1978. However, the plaintiff's affidavit does not disclose whether he is an Australian citizen, an Australian resident or whether he is in Australia on a visa and if so, what type. This fact is material to each of the plaintiff's complaints on this ground.

[56] As stated above, in order for the plaintiff to have standing to seek judicial review, it is necessary that there be a decision by an official or other body or institution and that he be aggrieved by the decision beyond that of the general public.

[57] It is not clear from the plaintiff's originating summons or affidavit whether there is any relevant decision and whether the plaintiff is subject to any restrictions as to where he can work connected with his registration, as part of any visa he might hold or as a consequence of s 19AB of the *Health Insurance Act 1973* (Cth).

[58] The regulation of medical practitioners is governed by the *Health Practitioner Regulation National Law (WA) Act 2010* (WA) (National Law). The stated objects of the National Law includes the establishment of a national registration and accreditation scheme for the regulation of health practitioners. The objectives of this scheme include, among other things, the facilitation of the rigorous and responsive assessment of overseas-trained health practitioners.

[59] Part 6 of the *National Law* addresses accreditation of health practitioners. There is a process for the approval of accreditation standards which, once approved, must be published on the AHPRA website and takes effect from that date, unless otherwise stated. Eligibility for specialist registration is governed by s 57 and s 58 of the *National Law* and any registration standards issued by the relevant National Board.

[60] Part 7 of the National Law concerns the registration of health practitioners. Division 2 of pt 7 specifically deals with the registration of specialists. A specialist can obtain a limited registration for an area of need under s 67 of the National Law.

[61] AHPRA has three assessment pathways, including a specialist pathway. Overseas-trained specialists can apply for specialist recognition, which is an assessment of the comparability of the qualifications to the standard of a specialist trained in that speciality in Australia, or an area of need specialist position. Areas of need are designated by the relevant State or Territory health authorities.

[62] The National Law also includes a requirement for recency of practice. That is, a practitioner is required to have recent practice in the area in which they intend to work. From 1 October 2016, it is necessary for medical practitioners to have completed 450 hours of work in their area of practice in the three years prior to registration.

[63] The plaintiff's complaint appears to be that, notwithstanding that he had been registered to practice as a specialist in Australia from 1980, when he applied for registration in 2018 he was required to be re-assessed and was subject to these provisions as an overseas-trained specialist. However, this complaint does not take account of the plaintiff's decision to allow his registration to lapse in 2013 or 2014. At the time he sought to re-registration, his registration had lapsed for more than three years. As a consequence, he was required to re-register and did not meet the recency of practice requirement. At that time, as the plaintiff acknowledges, the requirements of registration had changed.

[64] It appears from the papers filed by the plaintiff that he has sought registration as an area of need specialist rather than seeking specialist recognition of his qualifications, although this is not clear. It is also not clear whether the plaintiff's registration is limited to area of need under the National Law. There is no evidence before the court that the proposed second defendant has not followed the requirements of the registration process in the National Law.

[65] In any event, under the National Law, the plaintiff had a right to appeal to the State Administrative Tribunal in relation to the imposition of conditions on his licence or the refusal to remove a condition. In oral submissions, the plaintiff informed me that he had not exercised his appeal rights.

[66] Section 19AB of the *Health Insurance Act* limits the circumstances in which Medicare benefits will be paid for services delivered by overseas trained doctors. In essence, the effect of this section is that for 10 years after arrival in Australia (or until the medical practitioner becomes a permanent resident), Medicare benefits will only be paid in respect of services provided by an overseas trained doctor where the services are delivered in rural or remote areas.

[67] Pursuant to s 19AB(3) of the Health Insurance Act , the Minister for Health may grant an exemption to any person or class of persons subject to such conditions as the Minister thinks fit. If a person is dissatisfied with the decision of the Minister, they can request a review of the decision. The Minister is required to make a decision within 28 days and is deemed to have confirmed the original decision if the person is not informed of the reconsidered decision within 28 days. If the person is still dissatisfied with the decision, the applicant may apply to the Administrative Appeals Tribunal for a review.

[68] There is no evidence before the court whether the plaintiff has a Medicare provider number, whether he is subject to the restrictions in s 19AB of the Health Insurance Act, and if so, whether he has applied for an exemption and whether he has requested a review of any decision.

[69] It is well settled that certiorari (which appears to be the remedy sought by the plaintiff) is a discretionary remedy. As a matter of discretion, an order for a writ of certiorari to issue should not be made if, among other things, there is a more convenient and satisfactory alternate remedy. In respect of both the plaintiff's registration and any restrictions under the *Health Insurance Act*, there is a more convenient alternative remedy, namely the review rights under the relevant legislation.

> [70] For these reasons, I consider that the claim for judicial review of the area of need regulation in the proposed originating motion has no reasonable prospects of success and is, as a result, vexatious.

19ABA Medicare benefits are not payable in respect of services rendered by doctors who breach certain contracts with the Commonwealth

Section 19ABA was inserted into the Act to enable the Commonwealth to enforce obligations under certain contracts, for example, its Medical Rural Bonded Scholarship program, under which medical students who accept the scholarship are bonded to practice in rural areas upon completing their medical training. A challenge to its constitutional validity was dismissed in *Edwards v Commonwealth of Australia (No.2)*.

Edwards v Commonwealth of Australia (No.2) [2012] FMCA 702 —

> [121] Mr Edwards served a lengthy and convoluted notice under s.78B of the *Judiciary Act 1903* (Cth) which, as with his pleadings, affidavits and submissions, is a document not easily digested and understood. Doing the best I can, it might be considered to make contentions that:
>
> - The MRBS Scheme in all its aspects was invalid or legally ineffective because it relied upon the insertion of s.19ABA of the *Health Insurance Act 1973* (Cth). That amendment was an invalid exercise of legislative power under s.51(xxiiiA) of the Constitution because it offended the injunction against "any form of civil prescription" which controls the power to make laws with respect to "the provision of ... medical and dental services".
> - The Commonwealth and the University "made decisions" and "acted" in contravention of s.61 of the Constitution, which vests the executive power of the Commonwealth in the Queen, makes it exercisable by her representative, and extends executive powers to include "the execution and maintenance of this Constitution, and of the laws of the Commonwealth".
> - The Commonwealth respondents "breached s.51(xxxi) of the *Constitution*", because their actions amounted to an "acquisition of property" which was not on "just terms".
> - The University legislation and Faculty rule which allowed the exclusion of Mr Edwards from further enrolment in the medical course were "inconsistent with a law of the Commonwealth" and therefore ineffective by reason of s.109 of the Constitution.
>
> [122] However, I do not accept any of these contentions, and can explain my reasons shortly.
>
> [123] In my opinion, Mr Edwards' attack on s.19ABA of the Health Insurance Act fails upon an application of the reasoning of the High Court in *Wong v Commonwealth* [2009] HCA 3; (2009) 236 CLR 573. In that case, a challenge was

made to a professional services review scheme, which allowed the imposition of sanctions on qualified medical practitioners by excluding them from providing medical services attracting Medicare benefits for their patients, and by requiring them to reimburse the Commonwealth for Medicare rebates paid to their patients. The plurality of the Court found no infringement of s.51(xxiiiA) of the Constitution. French CJ and Gummow J applied the construction which they explained at [60]:

> [60] The legislative history and the genesis of s 51(xxiiiA) supports a construction of the phrase "(but not so as to authorize any form of civil conscription)" which treats "civil conscription" as involving some form of compulsion or coercion, in a legal or practical sense, to carry out work or provide services; the work or services may be for the Commonwealth itself or a statutory body which is created by the Parliament for purposes of the Commonwealth; it also may be for the benefit of third parties, if at the direction of the Commonwealth.

[124] Their Honours at [68] held that there was no 'practical compulsion' applied by the provisions of the Health Insurance Act on medical practitioners to perform a medical service which might give rise to sanctions under the Medicare professional review scheme. They said: "these provisions condition the enjoyment of membership of the scheme established by the Act. They do not amount to practical compulsion to perform a professional service". Hayne, Crennan and Kiefel JJ reasoned similarly at [192] and [209]-[210], as did Heydon J at [226]. Kirby J was in dissent.

[125] In my opinion, this reasoning is equally applicable to a contention that the Parliament has no power to legislate to provide in the Medicare legislation a provision which excludes a medical practitioner from participation in Medicare, by reason of his or her breach of a scholarship contract with post-qualification employment conditions. As with the general practitioners who were threatened with exclusion from Medicare as a sanction for professional misconduct in Wong (supra), in my opinion neither the general provisions of the Medicare Scheme, nor the exclusion provided under s.19ABA of the *Health Insurance Act*, carried any "practical compulsion to perform a professional service".

[126] Moreover, looking at the MRBS Scheme broadly, there was no legal or 'practical' compulsion or coercion on Mr Edwards or any other applicant for a MRBS scholarship and student place, to enter the scholarship contract and thereby to become prospectively bound by s.19ABA and other conditions of the Medicare Scheme, if and when they sought to practise medicine in Australia. Students who elected to gain their medical qualifications by means of a MRBS scholarship were in no sense involuntarily 'conscripted' into providing medical services within or outside Medicare, after gaining their qualifications. They would become voluntary, not conscripted, rural doctors for the contracted period.

[127] It is irrelevant whether Mr Edwards' medical career suffered because he failed to achieve an offer of an un-bonded and unconditional entry to a medical school in 2001, since, as I have found above, this was the outcome of a selection process for standard entry places which was unaffected by the MRBS Scheme.

[128] I therefore do not accept Mr Edwards' submissions invoking the proviso to s.51(xxiiiA) .

[129] It is unnecessary for me to consider other possible difficulties facing his submissions. These include questions of his standing to challenge s.19ABA, in the circumstances where he never became a qualified medical practitioner subject to the Medicare legislation, including its sanction under that section. They also include the utility of the Constitutional point raised by Mr Edwards, since it is difficult to see how a finding of Constitutional invalidity of the MRBS Scheme or of any of its components could benefit him in any practical way (cf. *Lambert v Weichelt* (1954) 28 ALJR 282 at 283, *ICM Agriculture Pty Ltd v Commonwealth* [2009] HCA 51; (2009) 240 CLR 140 at [141]). A finding of invalidity or unenforceability of his MRBS contract and the funding by the Commonwealth of his MRBS student place could not give him a right of enrolment in a 'standard' student place, nor an added prospect of his otherwise becoming qualified to participate in the Medicare Scheme, nor any other circumstance sounding in damages, injunction, or other remedy (as to damages, see *Kruger v Commonwealth* [1997] HCA 27; (1997) 190 CLR 1 at 46, 93, 125-126, and 146-147).

[130] I have not been able to give any coherent content to Mr Edwards' submissions concerning s.61 of the *Constitution*, nor to understand how his claims for relief would be assisted by a finding that there is no provision of the Constitution which enabled the Commonwealth to make contracts with medical students and to provide grants to universities to enable the provision of medical education to bonded students. This unsettled area of Constitutional law was very poorly, if at all, addressed by the parties' submissions.

[131] I am reluctant to say more than that the payments and contracts made when implementing the MRBS Scheme appear prima facie to be supported on High Court authorities which preceded and survived *Williams v Commonwealth* [2012] HCA 23; (2012) 288 ALR 410. I have above concluded that the funding arrangements with the universities for the MRBS Scheme grants were authorised by the Funding Act. I am not persuaded that the Commonwealth's making and funding of the scholarship contracts were not sufficiently incidental to the legislation empowering grants under the Funding Act. I am also not persuaded that the scholarship contracts and stipends were not authorised by implication of s.19ABA and other provisions of the Health Insurance Act (see generally *Williams* (*supra*) per French CJ at [22], [34], and [83], Gummow and Bell JJ at [91] and [145], Hayne J at [193]-[194], [252], [285]-[286], Heydon J at [441], Crennan J at [532]-[534], and Kiefel J at [573] and [594]).

[132] The short answer to Mr Edwards' contentions based on s.51(xxxi) of the Constitution is that no element of the MRBS Scheme, including such parts of it as could affect Mr Edwards, involved a compulsory 'acquisition of property' under an exercise of Commonwealth statutory power (see *Mutual Pools & Staff Pty Ltd v Commonwealth* [1994] HCA 9; (1994) 179 CLR 155 at 172-174, 177, 188, 200, *Health Insurance Commission v Peverill* [1994] HCA 8; (1994) 179 CLR 226 at 235, 245, 256, and *Smith v ANL Ltd* (2000) 204 CLR 493 at [128]). There was no compulsion on Mr Edwards to gain entry to the Medical School on the terms attaching to a MRBS scholarship, including his payment of HECS semester fees.

> Nor was he compelled to abandon his scholarship and lose his place at the Medical School in the circumstances which existed in 2004. Mr Edwards' hopes of qualifying as a doctor after completing the medical course which he commenced in 2001 at the Medical School, came to an end as a result of his own voluntary election to withdraw from his MRBS student place. It is not necessary to examine whether any of these events involved a species of rights which could be described as 'property' capable of an 'acquisition'.
>
> [133] Mr Edwards' invocation of s.109 of the *Constitution* and principles of inconsistency between Commonwealth and State legislation is also misconceived. There was nothing inconsistent with Commonwealth legislation in the University retaining and exercising a power under its own legislation to cancel Mr Edwards' enrolment in 2004 (cf. *Dickson v The Queen* [2010] HCA 30; (2010) 241 CLR 491 at [13]). In particular, no inconsistency can be found with the provisions of the Funding Act, whether in its Scheme providing funds for tertiary education generally, or in its use of that Act to support a special scholarship scheme such as the present. Rather, in my opinion, the provisions and scheme of the Funding Act, both in relation to grants to universities and the payment of students' course fees under the HECS Scheme, left to the University its powers to apply a rule precluding the continuing enrolment of former MRBS scholarship students in Mr Edwards' circumstances in 2004. In my opinion, the University's action recognised and gave effect to a condition on the Commonwealth's funding of Mr Edwards' enrolment at the Medical School, and was not inconsistent with the terms of that funding, nor with the terms of any other funding of the University under the Funding Act, nor with any other source of Commonwealth law.

19B Medicare benefit not payable in respect of services rendered by disqualified practitioners

A practitioner may be disqualified for various reasons from being able to make claims under the medical benefits scheme. If a practitioner is disqualified, a medicare benefit is not payable.

In *Lewis v Minister for Health*, a practitioner had been disqualified because of conviction for the offence of aiding or abetting another practitioner in making a false statement in a medicare benefits claim. It was argued that as the relevant provision of the Act required the practitioner to have 'committed' a relevant offence before section 19B or 19D applied, and that the practitioner had been convicted of aiding and abetting the commission of an offence, the section did not apply to him. This argument was rejected by the Court.

Lewis v Minister for Health [1985] FCA 140 —

> The purposes of the Legislature in enacting s.19B of the Health Insurance Act (followed by the ss. 19C and 19D consequences) include deterrence of conduct by practitioners that facilitated abuse of the system of payment of medicare benefits with consequent loss of revenue to the Commonwealth. A distinction between commission of offences against ss.129, 129AA or 192AAA and aiding and abetting the commission of such offences would frustrate the implementation of this purpose.
>
> Reference should be made to counsel's arguments as to the significance of including in the definition of "relevant offence" an offence against ss. 6, 7 or 7A of the Crimes Act. These sections, like s.5, are concerned with "law(s) of the Commonwealth", including the Crimes Act itself, providing for offences. Section 6 fixes a penalty which may, depending on the law of the Commonwealth against which the principal offence is committed, be much less severe than that for an offence committed by operation of s.5 against the same law of the Commonwealth - e.g. an offence against s.83A of the Health Insurance Act achieved by aiding and abetting could be punished by imprisonment up to seven years; whereas being an accessory after the fact in respect of the same offence would attract a penalty of only up to two years' imprisonment; yet s.6 is mentioned in s.19B and s.5 is not mentioned. Accepting that the Legislature regards a practitioner who is an accessory after the fact in relation to a s.129 offence as less culpable than one who commits the same offence by the process of aiding and abetting, it would be anomalous if the former attracted the consequences of e.g. ss.19B and 19D while the latter escaped particularly if one has regard to the reprehensible conduct that the Health Insurance Act seeks to deter. The anomaly is found not to be present when one remembers that by the operation of s.5 alone there is not any offence, i.e. without recourse to other "law(s) of the Commonwealth". Therefore it would be quite inappropriate, even meaningless, to add, after the words "an offence against", "s.5" in the definition of "relevant offence" in s.19B. I do not accept counsel's argument as to the absence of reference to s.5 and the inclusion of ss.6, 7 and 7A in the definition of "relevant offence".

Minister for Human Services and Health v Haddad [1995] FCA 1404 —

> [33] The relevant offence in the present case, is that under s.128A. That offence is made out upon proof that a person has made or authorised a statement that is false or misleading in a material particular and is capable of being used in connection with a claim for a benefit or payment under the Act. Knowledge is not a constituent element of the offence. However, by sub-section 5 it is a defence if a person charged did not know, and could not reasonably be expected to have known, that the statement was false or misleading in a material particular or that it was capable of being used in connection with a claim for a benefit or payment under the Act.
>
> [34] Under s.128B, on the other hand, the prohibition is on a person making or authorising the making of a statement if the person knows that the statement is false or misleading in a material particular and is capable of being used in connection with a claim for a benefit under the Act.

[35] A question of construction which arises is whether, where a person is convicted of an offence under s.128A and that person does have knowledge of the falsity of the statement, such knowledge can be taken into account as a circumstance concerning the commission of the offence under s.124F(3) of the Act.

[36] The language in which s.124F(3) is cast indicates that it is not intended to limit the range of matters to be taken into account by the Committee. It is rather directed to requiring the Committee to consider two particular aspects, namely the nature of, and the circumstances concerning, the commission of the offence and the necessity to comply with guidelines in force under s.124H. There is nothing in the terms of s.128A to indicate that knowledge is not a relevant matter to take into account. By sub-section (5), the absence of knowledge, either actual or constructive, is a defence. On a literal reading, knowledge of falsity of a statement in the present case, is a "circumstance" in which the offence was committed, in the sense that it is part of the factual context. Although Dr Haddad was not convicted of an offence which had, as one of its ingredients, knowledge of falsity, nevertheless, the fact that such knowledge existed, can be accurately described as a circumstance concerning the commission of that offence.

[37] To have regard to the existence of knowledge of falsity, which is not an ingredient of an offence under s.128A, is not to involve the substitution of a conviction under s.128B for the conviction of the relevant offence. The consequence rather is that the fact of conviction under s.128A is taken into account, together with the circumstance that the offence was committed with actual knowledge of the falsity of the claim.

[38] The respondent submits that the Committee was bound to comply with the Guidelines. It did not do so, the argument runs, therefore it erred. This result is said to flow from the provisions of s.124F(3)(b) which requires compliance by the Committee with the guidelines in force under s.124H.

[39] It is submitted that the Guidelines require a presumption to be made by the Committee, which is not rebuttable, namely, that in view of Dr Haddad's convictions for "relevant offences", a maximum period of six months disqualifications is fixed. This is said to result from cl.8(1)(ii) of the Guidelines.

[40] Whilst it is correct to say that the Committee must have regard to the presumption that because the practitioner has been convicted of an offence under s.128A, and has not, on a previous occasion, been convicted of a relevant offence, disqualification for a period of not more than six months would be appropriate, it is not correct to say that the presumption cannot be rebutted so that the Committee is bound to impose a disqualification for a period of not more than six months. The Committee is not directed by the Guidelines to impose a disqualification of not more than six months but only to have regard to the presumption that such a period would be appropriate.

[41] Under s.124H the Minister has power to make guidelines to be applied by Committees with respect to the making of determinations.

[42] The Guidelines in the present case have been made by the Minister "to be applied" by Committees in the making of determinations. The Schedule in which the Guidelines are set out describes them as "Guidelines to be Applied".

[43] Under s.124H(3), the provisions of the Acts Interpretation Act 1901 ss.48-50, relating to the making, disallowance and repeal of regulations, are made to apply to the Guidelines as if references to regulations were references to provisions of guidelines and as if references to repeal were references to revocations.

[44] While the Guidelines are not to be taken to be statutory rules within the meaning of the Statutory Rules Publication Act 1903, nevertheless certain provisions of that Act apply in relation to the Guidelines as they apply to statutory rules.

[45] Accordingly, the Guidelines in the present case, are to be regarded as having the same binding force as the statutory rule. Although they are referred to as "guidelines" they can more properly be described as rules which in fact circumscribe the discretion which the Authority has, to use the language of Hill J in *Smoker v Pharmacy Restructuring Authority* [1994] FCA 1487; (1994) 53 FCR 287 at 301.

[46] The Guidelines are not mere internal policy directives drawn up within the Department to assist staff in the implementation of general policy, nor are they in the nature of administrative rulings.

[47] The real issue in the present case is not whether the Guidelines are binding or have legislative force, but rather what their effect is, on their true construction and what they require the Committee to do when making a determination under s.124F.

[48] Clause 2 requires the Committee to have "regard to the matters and comply with the directions" set out in the Guidelines.

[49] Clause 3 states that nothing in the Guidelines will be taken to limit the powers conferred by the Act on a Committee. Further, nothing in the Guidelines is to be read to limit the capacity of the Committee to take into account matters that the Committee considers relevant to the making of the determination, being matters not dealt with in the Guidelines.

[50] Clause 5 makes it clear that when considering a relevant offence under the Guidelines, which has been dealt with by a Court, the Committee shall not be entitled to review the decision of the Court in relation to that offence.

[51] Under cl.6, in making a determination in relation to a conviction of a relevant offence, the Committee must have regard, among other things, to the nature and circumstances concerning the commission of the relevant offence including the seriousness of each relevant offence and any statements made by the Court in relation to its consideration of a relevant offence.

[52] In the present case the Magistrate included in his remarks on sentence, a statement that the defendant "well knew what the situation was and obviously knew what he was doing".

> [53] Under cl.7, in making a determination, a Committee must have regard to certain matters such as the length of time the practitioner has been in active professional practice; the effect that a determination might have on the practitioner and on the practitioner's patients and the community in which he practises, together with "any other matters which the Committee considers relevant".
>
> [54] The presumption as to the limitation on the period of disqualification is framed as a presumption which the Committee shall have regard to. It is not stated that the Committee is bound to apply that time limit on disqualification. Thus, the period of six months is a "presumption" which is rebuttable. Accordingly, on its ordinary meaning, it is a prima facie period which may be varied if the Committee thinks it appropriate after having regard to other relevant matters. What it means is that the Committee begins with the presumption that the maximum six month period applies, but other evidence, circumstances and matters may outweigh it to justify the imposition of a longer period. The weight of particular considerations is a matter for the Committee.
>
> [55] Accordingly, in the present circumstances, we do not accept that the Committee erred when it imposed a ten month period of disqualification by stepping outside the six month period. The imposition of a longer period of disqualification was open to it, after taking all relevant circumstances into account.

If a practitioner is disqualified, paragraph 4.3A.1 of the *Treatment Principles* made under the *Veterans' Entitlements Act 1986* provides that the Repatriation Commission cannot accept financial responsibility for the cost of a medical service under that legislation:

> **4.3A Disqualified Medical Practitioners**
>
> 4.3A.1 The Commission is not to accept financial responsibility for the cost of a medical service provided to an entitled person by, or on behalf of, a LMO, other GP or a medical specialist if, at the time the service was provided, a medicare benefit would not have been payable in respect of the service under section 19B or section 19C of the *Health Insurance Act 1973* (in force from time to time) if the LMO, other GP or medical specialist had provided the service as a practitioner under that Act.

In an interlocutory proceeding in an appeal to the Federal Court of a decision of the Administrative Appeals Tribunal affirming the disqualification of a practitioner, the Court had ordered a stay on the implementation of the disqualification until the substantive proceedings were determined. Following the dismissal of the appeal, the Court varied the disqualification to give the practitioner time to arrange for another practitioner to care for his patients:

Reddy v Medicare Participation and Review Committee [1994] FCA 1373 —

> [32] An order was made on 8 March 1994 staying the disqualification from that date until the hearing and determination of this appeal. Some period of the disqualification has already been served. It would be inappropriate for the balance to of the disqualification be served immediately. Time should be given so as to allow Dr Reddy to obtain a replacement physician to service his patients. An order should therefore be made that the decision of the Administrative Appeals Tribunal should be varied so that the balance of the disqualification is served during the period commencing 28 days from this date, that is to say commencing on and from 28 October 1994.

In a matter in which the Determining Authority had issued a final determination disqualifying the person under review for a period of time, an application for judicial review was made to the Federal Court a short time after the final determination had come into effect. In an interlocutory order, the Court granted a stay of the implementation of the final determination, and to preserve the effect of the time period of the disqualification should the final determination be upheld, made the following order, which took advantage of the 35 day period specified in section 106V in which, if litigation is commenced within 35 days of the final determination being made, it is not taken to have effect until the end of that litigation:[70]

> The following directions made in the Final Determination by the first respondent concerning the applicant dated 28 June 2022 be stayed pursuant to s 15(1)(b) of the *Administrative Decisions (Judicial Review) Act 1977* (Cth):
> (a) The direction at paragraph 82 that the applicant repay $433,488.52; and
> (b) The direction at paragraph 83 that the applicant be fully disqualified from rendering MBS item services for 18 months,
> such that, unless set aside, that Final Determination takes effect as set out in s 106V(2) of the *Health Insurance Act 1973* (Cth) as though this proceeding had been commenced within 35 days of 28 June 2022.

19D Offences in relation to a disqualified practitioner

If a practitioner is disqualified, the Minister may, by instrument in writing, served on the practitioner, direct that the practitioner or a person acting for or on behalf of a practitioner, render or initiate a specified professional service or a professional service in a specified class of professional services for which, under section 19B or 106ZPM of the Act, a medicare benefit is not payable, unless before commencing to render or initiate that professional service, the practitioner gives to the patient a copy of the notice, which sets out particulars of the disqualification of the

[70] *Li v Determining Authority*, NSD 593 of 2022, Order of Bromwich J, 10 August 2022.

practitioner and explaining such of the effects of that disqualification as the Minister considers appropriate.

Under subsection 19D(3), the Minister may also, by instrument in writing served on the practitioner, direct the practitioner to display in such place or places and manner, as specified in the instrument, such notice or notices as furnished to the practitioner with that instrument for the purpose of being displayed by the practitioner for the purpose of publishing to the patients of the disqualified practitioner a statement setting out the effects of that disqualification.

Such written instruments are usually made by a delegate of the Minister.

A practitioner who fails to comply with a direction contained in the instrument or causes a person acting on his or her behalf to fail to comply, or fails to display a notice is guilty of an offence.

20 Persons entitled to medicare benefit

Medicare benefits are paid, primarily, to the person who incurs the medical expenses in respect of each service (subsection 20(1)), and is paid in such manner as the Chief Executive Medicare determines (subsection 20(1A)). However, if the person to whom the benefit is payable has not paid the medical expenses, a cheque made out to the provider of the service is sent to the person's address (subsection 20(2)). If that cheque is not presented for payment within 90 days, the Chief Executive Medicare may pay the practitioner directly if the claim for the benefit was made electronically.[71] Subsections 20(5) and (6) provide that an amount may be paid by electronic transmission to a bank account in such circumstances and subject to such restrictions and in such manner as are prescribed in the regulations. Sections 63 and 64 of the *Health Insurance Regulations 2018* prescribe those matters.

20(1) — benefit payable to the person who incurs the medical expenses

Tisdall v Kelly [2005] FCA 365 —

> [7] By s 20(1), medicare benefit in respect of a professional service is payable by the HIC on behalf of the Commonwealth to the person who incurs the medical expenses in respect of that service. By s 20A, where a medicare benefit is payable

[71] Subsections 10(3) and (6).

> to an eligible person in respect of a professional service, the eligible person and the person by whom, or on whose behalf, the professional service is rendered may enter into an agreement, in accordance with the approved form. Under such an agreement, the eligible person assigns his or her right to the payment of the medicare benefit to the practitioner, and the practitioner accepts the assignment in full payment of the medical expenses incurred in respect of the professional service. The practice of assigning the entitlement to medicare benefit to the practitioner is commonly known as 'bulk billing'.

The entitlement to a medicare benefit, being a statutory gratuity, can be altered or revoked, including retrospectively, by legislation, and is not 'property' of a person for the purposes of s 51(xxxi) of the *Constitution*, which requires 'acquisition of property on just terms'. Additionally, the retrospective diminution of the value of a medicare benefit is not a tax.

Health Insurance Commission v Peverill [1994] HCA 8; (1994) 179 CLR 226 (per Mason CJ, Deane and Gaudron JJ) —

> [10] It is significant that the rights that have been terminated or diminished are statutory entitlements to receive payments from consolidated revenue which were not based on antecedent proprietary rights recognized by the general law. Rights of that kind are rights which, as a general rule, are inherently susceptible of variation. That is particularly so in the case of both the nature and quantum of welfare benefits, such as the provision of medicare benefits in respect of medical services. Whether a particular medicare benefit should be provided and, if so, in what amount, calls for a carefully considered assessment of what services should be covered and what is reasonable remuneration for the service provided, the nature and the amount of the medicare benefit having regard to the community's need for assistance, the capacity of government to pay and the future of health services in Australia. All these factors are susceptible of change so that it is to be expected that the level of benefits will change from time to time. Where such change is effected by a law which operates retrospectively to adjust competing claims or to overcome distortion, anomaly or unintended consequences in the working of the particular scheme, variations in outstanding entitlements to receive payments under the scheme may result. In such a case, what is involved is a variation of a right which is inherently susceptible of variation and the mere fact that a particular variation involves a reduction in entitlement and is retrospective does not convert it into an acquisition of property. More importantly, any incidental diminution in an individual's entitlement to payment in such a case does not suffice to invest the law adjusting entitlements under the relevant statutory scheme with the distinct character of a law with respect to the acquisition of property for the purposes of s.51(xxxi) of the *Constitution* ((9) See *Mutual Pools and Staff*, unreported, High Court of Australia, 9 March 1994 at 9 per Mason CJ, 28 per Deane and Gaudron JJ).
>
> [11] Dr Peverill's alternative submission is that the Amending Act is a law imposing taxation and that it contravenes s.55 of the Constitution. The short answer to this submission is that the Act does not impose an obligation on Dr Peverill or anyone else to make a payment to the Commonwealth or the Commission. The

> essence of a tax is that there is an exaction, levy, contribution, duty or charge. A tax commonly takes the form of the imposition of an obligation to pay money. But there can be no basis for holding that a reduction in the value of a chose in action or the substitution of a chose in action for a lesser amount for another chose in action can amount to the imposition of a tax.

Health Insurance Commission v Peverill [1994] HCA 8; (1994) 179 CLR 226 (per McHugh J) —

> [19] The entitlement under s.20 of the Principal Act must be taken to be conferred subject to repeal or alteration – including retrospective repeal or alteration – at the discretion of the Parliament. The plenary power conferred by s.51(xxiiiA) extends to altering or repealing the entitlement to a gratuitous benefit conferred under that paragraph even where a person has met the conditions giving rise to the entitlement. It could not be maintained, for example, that a person who had turned 65 had a vested right, protected by s.51(xxxi), to receive an age pension or that, consistently with the guarantee, the Parliament could not change the conditions upon which the pension was payable. Similarly, the right of payment under s.20 to a person who has incurred a medical expense is subject to the condition that Parliament may alter, reduce or revoke the right.[72] Nothing in s.20 specifically, or in the Principal Act generally, indicates a legislative intention by the Parliament that it will not alter, reduce or abolish s.20 entitlements, prospectively or retrospectively. In the absence of any legislative expression to the contrary, the entitlement conferred by s.20 – like any other statutory entitlement – must be taken to be subject to the condition that it may be altered, reduced or revoked at any time. Indeed, s.4 specifically declares that the regulations may provide that the Principal Act is to have effect as if the general medical services table were varied by inserting or omitting an item or rule of interpretation in or from the table or by substituting another amount for an amount set out in an item in the table.

There is no right of merits review of a decision not to pay a medicare benefit. A medicare benefit is not a social security benefit.

Chambers v Chief Executive Medicare [2022] FCA 1164 —

> [20] Section 10 of the HI Act provides an entitlement to a Medicare benefit for a professional service, calculated by reference to the tables comprising the Medicare Benefits Schedule. The Medicare Benefits Schedule sets out the amount of Medicare rebate payable for a medical service item, such as a diagnostic imaging service: see s 4AA of the HI Act; see also *Wong v Commonwealth* (2009) 236 CLR 573 at [203]-[207] (Hayne, Crennan and Kiefel JJ).
>
> [21] Section 20(1) is expressed to be subject to Part II of the HI Act, entitled, "Medicare benefits". The Part outlines the circumstances in which Medicare benefits will and will not be payable in respect of certain medical expenses (ss 16 – 19C), including in relation to diagnostic imaging services (ss 16B – 16EA). Section 19CA of the HI Act provides a specific avenue for review by the Tribunal

[72] *Allpike* [1948] HCA 19; (1948) 77 CLR 62.

of decisions by the Minister to refuse to direct that a Medicare benefit is payable in respect of a professional service under ss 19C(3) or (4) of the HI Act, where a medical practitioner renders a service they are not authorised to provide. However, no such decision was made in the present case. Part II of the HI Act does not otherwise provide an avenue for review of the respondent's decision to refuse to pay a Medicare rebate in respect of diagnostic imaging services.

[22] The respondent submits that none of the relevant legislation and legislative instruments which give effect to the payment of Medicare benefits under the Medicare Benefits Schedule provide for review by the Tribunal of a decision made by the Chief Executive Medicare under s 20 of the HI Act. These Acts, regulations and instruments are: the HI Act, the *Health and Other Services (Compensation) Act 1995* (Cth), the *Health Insurance Regulations 2018* (Cth), the *Health Insurance (Diagnostic Imaging Services Table) Regulations (No. 2) 2020* (Cth) and the *Health Insurance (Section 3C Diagnostic Imaging – Cardiac MRI for Myocarditis) Determination 2021* (Cth). The respondent's submission is correct.

[23] Accordingly, there was no error in the Tribunal's conclusion that it did not have jurisdiction to determine the application for review.

[24] The applicant submits, alternatively, that a Medicare benefit payable under s 20 of the HI Act is a, "social security benefit", or a "social security periodic payment", and is thereby reviewable by the Tribunal under the Administration Act.

> [25] Section 23(1) of the *Social Security Act 1999* (Cth) defines a "social security benefit" as:
>
> ***social security benefit*** means:
> (aab) youth allowance; or
> (aac) austudy payment; or
> (a) jobseeker payment; or
> (d) special benefit; or
> (f) benefit PP (partnered); or
> (g) parenting allowance (other than non benefit allowance).

[26] A "social security periodic payment" is defined in Sch 1 of the Administration Act as:

> ***social security periodic payment*** means:
> (a) a social security benefit; or
> (b) a social security pension; or
> (c) carer allowance; or
> (f) double orphan pension; or
> (g) mobility allowance; or
> (i) pensioner education supplement; or
> (k) Disaster Recovery Allowance.

[27] It is apparent from the above definitions that a Medicare rebate is not a "social security benefit" or a "social security periodic payment" within the meaning of the Social Security Act or the Administration Act.

20A Assignment of Medicare benefit

A person to whom a medicare benefit is payable may enter into an agreement with the practitioner who provided the service to assign their right to the benefit to that practitioner. The assignment must be in accordance with the approved form. If such an assignment agreement is entered into, the practitioner must accept the assignment in full payment of the medical expenses incurred in respect of that professional service. This is commonly called 'bulk-billing'.

Medicare is not required to accept, at face value, a purported assignment under section 20A, but may suspend administration of payments until satisfied that the assignment, or the service, is genuine.

Udechuku v Health Insurance Commission [1990] FCA 481 —

> [7] It is immediately apparent that it is a necessary condition of the entitlement to a Medicare benefit and, flowing from that, the entitlement to payment under an assignment under s.20A, that medical expenses are incurred "in respect of a professional service rendered in Australia." There is nothing in s.20A to bind the Commission, in making payment, to accept at face value the assignment agreement tendered by the relevant medical practitioner or any other person. No doubt as a matter of administrative practicality it does so in the vast bulk of cases. And that, as I understand from submissions made by counsel for the Commission today, is the case in the great majority of cases.

While, for the purposes of taxation law, a separate payment to a medical practice is not taxable income of the practitioner, but of the practice (*Re Ho and Commissioner of Taxation* [2008] AATA 783), it might constitute a payment in respect of a professional service that is contrary to section 20A (*Sood v The Queen* [2006] NSWCCA 114). However, depending on the circumstances, it might not be contrary to the section (*Business and Professional Leasing Pty Ltd v Akuity Pty Ltd* [2008] QCA 215).

Re Ho and Commissioner of Taxation [2008] AATA 783 —

> [71] Section 20A constitutes a statutory contract by which a patient's right to be reimbursed by the HIC is assigned to the practitioner in full discharge of the costs chargeable by the practitioner. The payment to the practitioner for a medical service rendered to a patient is income derived from personal exertion of the practitioner. The practitioner is, relevantly in this case, a medical practitioner by definition. The operator of a clinic may or may not be a medical practitioner. Thus, while Supercare was the operator of Supercare it is not a registered medical practitioner. Again by definition of the term 'professional service' it is the service provided by the practitioner to the patient for which an item fee is payable. Thus, for instance, Supercare cannot be a practitioner for the purposes of the definition as no

professional service is rendered by it to as patient. Nor, in the context of the provisions, can it be said that a service was rendered 'on behalf of' Supercare, as Supercare, is unable to provide professional service which extends to 'a clinically relevant service'.

[72] The respondent's submissions that s 20A of the HIA Act limits the assignment only to the medical practitioner rendering the service to the patient. That agreement for the assignment must be in a prescribed form. No further provision in the HIA Act exists for further assignment of the benefit. These legislative measures provide further support for the finding which the respondent urges on the Tribunal.

[73] Thus in the Tribunal's opinion neither CPS Pty Ltd, Supercare or Mr John Chong are providing the type of service which is contemplated by s 20A of the HIA Act. A 'professional' can assign payment to a third party but that assignment *per se* does not constitute income in the hands of the third party as the third party has not derived it by personal exertion. Only a medical practitioner has, under the provisions of the HIA Act, the capacity to achieve that outcome. This effectively determines that the income generated by the applicant from HIA sources is derived income for the purposes of the ITAA.

Sood v The Queen [2006] NSWCCA 114 (per Spigelman CJ) —

[35] The Crown's submissions are based on the width of the phrase "in respect of" in s20A(1)(b) reflected, in terms, in the declaration on the claim form. The Crown relies on the judgment of Enderby J in *Dalima Pty Ltd v Commonwealth of Australia* (New South Wales Supreme Court, Unreported, 22 October 1987).

[36] In *Dalima* a "facilities fee" was charged to patients attending medical centres. The issue that arose was whether or not these fees constituted "an amount payable in respect of medical services" rendered at the centres within the meaning of s20A of the *Health Insurance Act 1973*. One of the issues was whether or not a medical practitioner who made the statement that "no payments have been sought from any person for professional services" was false or misleading in a material particular within s129 of the Act, which proscribed the making of false or misleading statements.

[37] Enderby J accepted the submission that the words "in respect of" were of "notoriously wide import" and were "sufficiently wide to make the facility fee an additional fee in respect of the service rendered". He rejected a submission on behalf of the medical service provider in that case to the effect that the medical services could only be said to be provided when the doctor and patient were "face to face". His Honour said:

> "I hope the law reflects reality and I have no doubt that the reality of what is happening in the two sentences is that a fee called a 'facility fee' is being charged by Dr Edelstein's company to patients as a condition of them being able to use the centres and gain access to a doctor and receive medical services from a doctor.

The facility fee is an amount payable in respect of the service. It matters not that the service is being rendered also relates to an item in the table."

[38] His Honour went on to hold that the imposition of a facility fee prevented the medical service provider in that case from accepting an assignment and bulk billing. …

[52] The Court should be very slow to find in such a statutory context that the words "in respect of a professional service" are not intended to encompass all matters directly incidental to the provision of that service. …

[58] His Honour also relies on the proposition that a "minimum standard" is an "assumption inherent in the item". There is no evidentiary basis for any such "assumption". Nor is there, in my opinion, any warrant for the inference that charging patients for a 'higher standard' of services is consistent with the bulk billing regime. Indeed, in my opinion, bulk billing is, in part, directed to preventing such conduct which results in higher charges to patients.

[59] Each of the additional payments in issue in the present case were identified as being for counselling and theatre fees, although sometimes there were separate charges. The evidence by the various employees of the medical centre operated by the Appellant, and of the Appellant herself, confirmed that the counselling and theatre fees charged were inextricably connected with the termination itself. In the case of a theatre component of the fee it was a fee for the location in which the termination was conducted. In the case of the counselling component it was payment for a consultation as to whether or not the termination should proceed.

[60] In the Appellant's own evidence she gave the following answers:

> "Q. If they were having a termination they were charged for the theatre because they were in there having a termination?
> A. Yes, you are right.
> Q. They were charged for counselling because they were there to have a termination?
> A. Yes they were. We had patients who did not have termination and had counselling also and we had patients who were not for termination and had counselling also.
> Q. I'm just asking you about the patients who had terminations at the moment, all right? The patients who had terminations were charged for counselling because they were there to have a termination, correct?
> A. It's a juggling of words I think. We were charging counselling which was just counselling. It could be for anything."

[61] In subsequent questioning she was asked whether or not the counselling was "part of the process" and replied that it was a "pre-requisite" for the termination but not "part of the termination". In my opinion, a "pre-requisite" is sufficiently closely connected to be "in respect of the professional service" for which it is a "pre-requisite".

[62] As indicated above, the fee, most often a single fee for both matters, was charged on the sliding scale depending on the length of the pregnancy. Indeed, where persons had been charged a certain amount on the assumption that a pregnancy was of a certain period, but it transpired subsequently that the period was in fact longer, then an additional fee was charged.

[63] I am of the view that the position with respect to the theatre charges is quite clear. It was an essential part of the provision of the medical service for a termination of pregnancy that a sterile place be provided for the conduct of the operation. Under the bulk billing arrangements, there is no more justification for charging extra for this service than there would be for charging extra for other matters necessarily incidental to the conduct of a physical facility in which the service is to be provided. In this respect it is identical to the "facility fee" found to be inextricably linked in *Dalima*.

[64] The "consultation fee", for those few cases when it was separate, is not so clear. The evidence suggests that this is a consultation by a nurse as to whether or not the abortion should proceed at all. It is not clear why this is separate from the consultation by Dr Sood herself for which a separate charge was made in each case. These claims were not challenged in the proceedings as outlined above at [15]. Presumably, where the result of the consultation with a nurse is that the abortion does not proceed, no Medicare benefit claim could be made under Item Number 35643. In such a case there could be no assignment of the Medicare benefit and it could not be said that any consultation fee paid was "in respect of the professional service", being the termination.

[65] The issue for present purposes is what is the position with respect to those occasions on which the consultation resulted in the termination proceeding, when a claim was made. My mind has fluctuated on this but, in the event, I have formed the view that the words "in respect of" in the context are so wide that they cannot be relevantly read down. In my opinion, the preliminary consultation is encompassed within the termination to which the relevant item number relates.

[66] I am influenced in this conclusion by a number of considerations of the facts of this case. First, no patient was offered a choice. It was an essential precondition of any termination that there be such a consultation. Secondly, in many, it appears most, cases, there was no differentiation between the "theatre" and the "consultation" fee. Thirdly, in every case, the fee was increased depending on the length of the pregnancy. Each of these matters suggest that, as a matter of practice in this medical clinic, the consultation fees were inextricably linked to the termination itself. Accordingly, these fees were paid "in respect of the professional service" to which Item 35643 refers.

Business and Professional Leasing Pty Ltd v Akuity Pty Ltd [2008] QDC 42 —

[50] The question is whether co-billing is lawful under the *Health Insurance Act 1973* (Cth). Akuity and Mr Gillion rely on s20A. Macquarie argues that section does not render the facility fee unlawful. Any illegality, it says, rests upon a false declaration by the radiologist in the assignment form submitted to Medicare. That form includes a declaration by the practitioner that no payment has been sought from any person "in respect of professional services" specified in the assignment form. If that declaration is false then the practitioner is exposed to prosecution. (s129 HIA and s 134.2 *Criminal Code Act 1995*) No doubt this was GCMI's fear.

[51] Certainly s20A does not expressly prohibit co-billing. However, it forms part of a scheme for government subsidy of medical expenses. The assignment of a Medicare benefit cannot be made except in accordance with s 20A. It permits a

patient to assign their Medicare benefit to a practitioner if the practitioner accepts the assignment "in full payment of the medical expenses incurred in respect of the professional service". Further, the patient's assignment of their Medicare benefit must be made by the approved form. That is the form which includes the practitioner's declaration.

[52] That scheme "manifests a policy objective of limiting patient expenditure on medical services, whilst retaining the traditional doctor/patient relationship. Medical practitioners receive the certainty of payment without any bad debts, in exchange for restraint on the fees they can charge." (*R v Sood* per Spigelman J at [44])

[53] If a practitioner cannot lawfully make the necessary declaration, the assignment would operate to defraud the public revenue and would be unenforceable. (*The National Mutual Life Association of Australasia Ltd v S H Hallas Pty Ltd*)

[54] The question is not whether s20A contains an express prohibition of co-billing arrangements but whether Macquarie's practice, continued by Akuity, involved seeking a payment "in respect of professional services".

[55] Macquarie argued it was not, because the fee was not inextricably linked to the professional service. In *Sood's case*, Spigelman J examined the ubiquitous use of the phrase "in respect of a professional service" in the HIA. He determined "the court should be very slow to find in such a statutory context that the words 'in respect of a professional service' are not intended to encompass all matters directly incidental to the provision of that service." (at [52])

[56] The service provided was diagnostic imaging, specifically x-rays. Without a facility in which to house the necessary equipment, no x-rays could be taken. The sole purpose of the facility was to allow them to be taken. The facility fee was apparently a charge for access to the facility. It served no other purpose and the costs of providing the service were the same, whether the fee was charged or not. Providing access to the facility is directly incidental to the diagnostic imaging service. In that sense, it is a charge "in respect of" the service. (*Dalima Pty Ltd v Commonwealth of Australia*).

Business and Professional Leasing Pty Ltd v Akuity Pty Ltd [2008] QCA 215 —

[62] For present purposes it is unnecessary to determine which of paragraphs (a), (f) or (g) of the definition of "professional service" applies to the provision of x-ray services.

[63] That is because the evidence does not disclose the making of an assignment in breach of s 20A. The evidence is to the effect that the radiologist referring patients to the subject x-ray service would enter into an agreement with patients "in accordance with the approved form" under which the radiologist would accept the "assignment in full payment of medical expenses incurred in respect of the professional service by" the radiologist, including the x-ray service. There is no evidence that the radiologist was aware that a "facility fee" was being charged by Miami Medical Imaging.

> [64] The facility fee was a sum of $5 requested of some patients. If they showed reluctance to pay the fee the receptionist did not persist with the request. The primary judge concluded that the "facility fee was apparently a fee for access to the facility".
>
> [65] However, the facility fee is categorised, it was not a component or term of any assignment by a patient to the radiologist in accordance with the approved form. Nor did the evidence disclose that it was a requirement or pre-condition for any such assignment. The facility fee may have been "expenses incurred in respect of the professional service" by the assignor but, on the evidence, it was distinct from the transactions of assignment. The way in which the facility fee was charged is quite different from the way in which the impugned fee was imposed in *Dalima Pty Ltd v Commonwealth of Australia*, a case relied on by Akuity. In that case a similar fee was charged by the company which owned the medical centre in which the radiologists operated. A patient could see a radiologist only after payment of the fee. The radiologists in the medical centre paid a fee equal to 60 per cent of their bulk billing receipts to the centre owner. It was thus difficult to contend that the radiologists, who presumably were aware of how the system operated, accepted the assignment by the patient "in full payment of the medical expenses incurred in respect of the professional service ...".
>
> [66] Neither the primary judge nor this Court was called upon to find whether the charging of the facility fee was otherwise unlawful.
>
> [67] For the above reasons, the primary judge erred in finding that the charging of the facility fee breached s 20A and was therefore illegal.

An assignment of a medicare benefit cannot be made except in accordance with section 20A. Section 20AA prohibits a security interest being created in a medicare benefit. The nature of the assignment was discussed by the High Court in *Health Insurance Commission v Peverill*.

> ***Health Insurance Commission v Peverill*** [1994] HCA 8; (1994) 179 CLR 226 (per Mason CJ, Deane and Gaudron JJ) —
>
> > [1] The facts and the relevant statutory provisions are set out in the reasons for judgment prepared by Dawson J As his Honour points out, the effect of the *Health Insurance (Pathology Services) Amendment Act 1991* (Cth) ("the Amending Act") was to reduce, with retrospective effect, the benefit of $34.50 which was previously payable under item 1345 of the schedule for what was known as the ELISA test. The Amending Act was expressed to operate retrospectively from 1 January 1980 being a date prior to the provision of those medical services by Dr Peverill which are relevant to these proceedings. The Amending Act excluded the ELISA test from item 1345. Instead, the Amending Act inserted items 2294 and 2295 covering ELISA tests for rubella and prescribed a fee for that test of $15.40 which was amended upwards over time culminating for relevant purposes in a fee of $17.20. Hence, the amounts payable to Dr Peverill for ELISA tests which he performed for patients were reduced retrospectively from $34.50 to the fees prescribed in item 2294.

[2] The reason for the enactment of the Amending Act with retrospective effect, as stated by the Minister in his second reading speech, was[73] for the establishment of that Committee to advise the Minister about the contents of the table in the schedule of benefits to that Act. A determination by the Minister on the basis of the Committee's recommendation to vary the schedule requires certain steps to be taken to give effect to the recommendation. For a period of time these steps were not taken. Nonetheless, the Commission, the public and many pathologists acted on the basis that the Committee's advices were effective to vary the table of benefits in the schedule. The advent of the ELISA test resulted in considerable time and cost savings so that, acting on the recommendations of the Committee, the Department issued in 1984 a Medicare Benefits Assessment Advice which specified items 2294 and 2295 for the ELISA test. Subsequent advices were issued for these items, generally to increase the amount of the benefit payable. In 1987 the Minister made determinations under s.4A of the Principal Act to give effect to the recommendations but the recommendations were set aside for procedural deficiencies. In 1990, the Federal Court (Burchett J) held that the ELISA tests fell within item 1345 not items 2294 and 2295 which offered a benefit of $4.60.[74]

[3] According to the explanatory memorandum, the purpose of the Amending Act was to:

> "validate the Advices so that claims and payments made in accordance with them will become valid and proper, to bring the legislation into line with the general practice in fact adopted at that time".

The memorandum continued:

> "There will be transitional provisions to ensure that no-one will be required to make any refund of any payment already made as a result of this Bill, to preserve a right to additional payment in respect of anyone who, on the basis that the amendments contained in the Advices are valid, has been underpaid, and to exclude any liability for any additional windfall payments to pathologists for the procedures covered by the Advices in excess of the amounts (sic) specified in the Advices. The amount specified in the Advices for payment were fixed on the recommendation of the (Committee) as proper remuneration for such procedures."

According to the financial impact statement contained within the memorandum, the Amending Act would prevent additional expenditure of up to $100 million that could result from additional payments for ELISA tests if the fee recommendations of the Committee were not applied.

[4] The principal question, as we see it, is whether the retrospective reduction in the amount of the benefits payable to Dr Peverill (and others similarly placed) by virtue of the patients' assignments of their benefits to him, whereby he accepted the assignments in full payment of the services rendered, invested the relevant

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[73] ((1) *Commonwealth, House of Representatives, Parliamentary Debates* (Hansard), 11 April 1991, at 2464.): "to validate certain recommendations made by the Medicare Benefits Advisory Committee relating to the payment of Medicare benefits that were not given legal effect through failure to make necessary ministerial determinations".

[74] *Peverill v Meir* (1990) 95 ALR 401.

provisions of the Amending Act with the character of a law with respect to the "acquisition of property" within the meaning of s.51(xxxi) of the Constitution. In our view, it did not.

[5] The assignments, pursuant to s.20A of the Principal Act, by patients to Dr Peverill of their entitlements to medical benefits vested a statutory right in Dr Peverill to receive payment by the appellant Commission from consolidated revenue. But the acquisition of that statutory right by Dr Peverill was not an acquisition of property which fell within s.51(xxxi) . That provision is directed, in our view, to requisition, not to voluntary acquisition.[75] The assignments were voluntary; there was no element of legislative compulsion about them.

[6] Dr Peverill's argument is that the retrospective substitution of a statutory right to receive payment of a lesser amount in substitution for his earlier entitlement is an "acquisition of property" for the purposes of s.51(xxxi). It may be accepted that the entitlement to payment for each service is a valuable "right" or "interest" of a kind which constitutes "property" for the purposes of that paragraph.[76] But it does not follow that the legislative substitution of another and less valuable statutory right to receive a payment from consolidated revenue for that previously existing brings about an "acquisition" of the earlier right for the purposes of s.51(xxxi).

[7] Dr Peverill's argument is that, in the case of a fixed liquidated obligation of the Commonwealth to which an individual is presently entitled, the cancellation of the obligation is an "acquisition of property" because the effect of the Amending Act is that the Commonwealth acquires the original entitlement and replaces it with another. A mere extinguishment of a right, it is conceded, will involve no acquisition[77] but it is said that it is otherwise when the Commonwealth derives a financial advantage from the termination and that financial advantage is the precise equivalent in amount of the deprivation suffered by the owner of the original right.

[8] There is no doubt that the derivation by the Commonwealth of a financial advantage in association with the extinguishment of a right to receive a payment from the Commonwealth may constitute an acquisition of property for the purposes of s.51(xxxi) of the Constitution.[78] That could even be so in some cases in which extinguishment of the right takes place in the context of some genuine adjustment made in the common interests of competing claims, rights and obligations between another party and the Commonwealth. However, here, the extinguishment of the earlier right to receive payment of a larger amount has been effected not only by way of genuine adjustment of competing claims, rights and obligations in the

[75] *John Cook and Co. Pty. Ltd. v The Commonwealth* [1924] UKPCHCA 2; (1924) 34 CLR 269 at 282; *British Medical Association v The Commonwealth* [1949] HCA 44; (1949) 79 CLR 201 at 269-271 per Dixon J; *Poulton v The Commonwealth* (1953) 89 CLR 540 at 573 per Fullagar J; *Trade Practices Commission v Tooth and Co. Ltd.* [1979] HCA 47; (1979) 142 CLR 397 at 416-417 per Stephen J; but cf. *R*. v *Registrar of Titles (Vict.); Ex parte The Commonwealth* [1915] HCA 59; (1915) 20 CLR 379 at 392 per Isaacs J.

[76] *Minister of State for the Army v Dalziel* (1944) [1944] HCA 4; 68 CLR 261 at 285, 290, 295; *Mutual Pools and Staff Pty. Ltd. v The Commonwealth*, unreported, High Court of Australia, 9 March 1994 at 10 per Mason CJ, 23 per Deane and Gaudron JJ.

[77] *Reg. v Ludeke; Ex parte Australian Building Construction Employees' and Builders Labourers' Federation* [1985] HCA 84; (1985) 159 CLR 636 at 653.

[78] See *Mutual Pools and Staff*, unreported, High Court of Australia, 9 March 1994 at 10 per Mason CJ, 23-24 per Deane and Gaudron JJ.

common interests between parties who stand in a particular relationship[79] but also as an element in a regulatory scheme for the provision of welfare benefits from public funds.

[9] The Amending Act seeks to correct a defect in the administration of the Principal Act in that, according to the decision of the Federal Court, the payments for the relevant tests carried out by Dr Peverill which it provided for were thought to be excessive. Before the Federal Court gave its decision there was a dispute as to whether item 1345 was the relevant item. Dr Peverill contended that it was. The Commission and many pathologists, acting on the basis of Medicare Assessment Advices, thought otherwise and considered that item 2294 was appropriate. What the Amending Act does in this situation is to bring about the position that was thought by the Commission to have existed before the Federal Court decision. By achieving that result, the Amending Act brought about a genuine legislative adjustment of the competing claims made by patients, pathologists including Dr Peverill, the Commission and taxpayers. Clearly enough, the underlying perception was that it was in the common interest that these competing interests be adjusted so as to preserve the integrity of the health care system and ensure that the funds allocated to it are deployed to maximum advantage and not wasted in "windfall" payments.[80]

[10] It is significant that the rights that have been terminated or diminished are statutory entitlements to receive payments from consolidated revenue which were not based on antecedent proprietary rights recognized by the general law. Rights of that kind are rights which, as a general rule, are inherently susceptible of variation. That is particularly so in the case of both the nature and quantum of welfare benefits, such as the provision of medicare benefits in respect of medical services. Whether a particular medicare benefit should be provided and, if so, in what amount, calls for a carefully considered assessment of what services should be covered and what is reasonable remuneration for the service provided, the nature and the amount of the medicare benefit having regard to the community's need for assistance, the capacity of government to pay and the future of health services in Australia. All these factors are susceptible of change so that it is to be expected that the level of benefits will change from time to time. Where such change is effected by a law which operates retrospectively to adjust competing claims or to overcome distortion, anomaly or unintended consequences in the working of the particular scheme, variations in outstanding entitlements to receive payments under the scheme may result. In such a case, what is involved is a variation of a right which is inherently susceptible of variation and the mere fact that a particular variation involves a reduction in entitlement and is retrospective does not convert it into an acquisition of property. More importantly, any incidental diminution in an individual's entitlement to payment in such a case does not suffice to invest the law adjusting entitlements under the relevant statutory scheme with the distinct

[79] See ibid. at 9 per Mason CJ, 28 per Deane and Gaudron JJ.

[80] See Hanks, "Adjusting Medicare Benefits: Acquisition of Property?", [1992] *Sydney Law Review* 34; 14 *Sydney Law Review* 495 at 500-501.

character of a law with respect to the acquisition of property for the purposes of s.51(xxxi) of the Constitution.[81]

[11] Dr Peverill's alternative submission is that the Amending Act is a law imposing taxation and that it contravenes s.55 of the Constitution. The short answer to this submission is that the Act does not impose an obligation on Dr Peverill or anyone else to make a payment to the Commonwealth or the Commission. The essence of a tax is that there is an exaction, levy, contribution, duty or charge. A tax commonly takes the form of the imposition of an obligation to pay money. But there can be no basis for holding that a reduction in the value of a chose in action or the substitution of a chose in action for a lesser amount for another chose in action can amount to the imposition of a tax.

[12] In the result we are of the view that the Amending Act is valid and we would allow the appeal.

Health Insurance Commission v Peverill [1994] HCA 8; (1994) 179 CLR 226 (Per Brennan J) —

[7] … A practitioner's right to the payment of a medicare benefit assigned by a patient is conferred by statute exclusively upon the assignee practitioner when the conditions prescribed by the Principal Act are satisfied. It is not capable of assumption by third parties. It is a right ultimately to be paid by the Commission a sum of money out of Consolidated Revenue. The Commission is under a corresponding statutory duty. That duty is enforceable by a public law remedy: by mandamus or mandatory order under the *Administrative Decisions (Judicial Review) Act 1977* (Cth). I respectfully agree with Burchett J when he said in *Peverill v Meir*:[82]

> "Where legislation endows a statutory body with the duty of administering a scheme to provide for the making to claimants of payments on behalf of the Commonwealth, in accordance with statutory criteria, the determination whether a particular claim falls within those criteria will generally be a decision of an administrative character, made under an enactment, within the meaning of the Judicial Review Act. There is nothing in the nature of such a determination to exclude it from the scope of judicial review. A decision applying, or purporting to apply, the statutory criteria is a decision 'required to be made' by the legislation in question."

If too little is paid, the duty is not properly discharged and a public law remedy is available. That is the nature of the remedy sought by Dr Peverill in his statement of claim.

[8] Once it is appreciated that the right conferred by the Principal Act upon an assignee practitioner is to be discharged by a statutory authority when certain statutory criteria are fulfilled, it is clear that that Act does not create a debt enforceable by action. The Principal Act is a code prescribing the benefits to be

[81] See *Mutual Pools and Staff*, unreported, High Court of Australia, 9 March 1994 at 9 per Mason CJ, 28 per Deane and Gaudron JJ.
[82] (1990) 95 ALR 401 at 421.

paid and the manner of paying them. The only way in which a medicare benefit can be paid to a claimant is by acceptance of a claim made within time followed by a payment by the Commission in an amount prescribed by the statutory Tables out of Consolidated Revenue in such manner as the General Manager of the Commission determines. The money thus to be paid is the only money appropriated for the purpose of paying medical benefits. The principle is stated by Isaacs J in *Josephson v Walker*:[83]

> "Prima facie, where the same Statute creates a new right and specifies the remedy, that remedy is exclusive. The natural presumption to begin with is that Parliament in creating the novel right attaches to it the particular mode of enforcement as part of its statutory scheme. To that extent the enactment is a code."

In the leading case of *Pasmore v Oswaldtwistle Urban Council*,[84] the Earl of Halsbury LC said:

> "The principle that where a specific remedy is given by a statute, it thereby deprives the person who insists upon a remedy of any other form of remedy than that given by the statute, is one which is very familiar and which runs through the law. ... the statute which creates the obligation is the statute to which one must look to see if there is a specified remedy contained in it. There is a specified remedy contained in it, which is an application to the proper Government department."

In *Federal Commissioner of Taxation v Official Receiver*,[85] the nature of a taxpayer's right to a refund of overpaid P.A.Y.E. instalments fell for consideration. A majority (Dixon CJ, Williams and Fullagar JJ) denied that that right was an ordinary debt. Fullagar J said:[86]

> "we have here nothing really analogous to an ordinary 'debt', but simply a statutory direction to an officer of the Commonwealth to cause a payment to be made out of consolidated revenue to a specified person and an appropriation of consolidated revenue for the purpose of that payment and of no other payment."

[9] Similarly, the Principal Act creates no debt recoverable as such in any court of competent jurisdiction. The scheme of that Act is to appropriate Consolidated Revenue to the extent necessary to allow the Commission, after acceptance of claims made to it within the times prescribed, to pay out to claimants the amounts prescribed by the Principal Act. The Principal Act confers on assignee practitioners a right to be paid medicare benefits subject to the conditions prescribed but it does not create a debt.

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[83] [1914] HCA 68; (1914) 18 CLR 691 at 701.

[84] (1898) AC 387 at 394-395 cited by Griffith CJ in *Josephson v Walker* (1914) 18 CLR at 695-696; cf. *Mallinson v Scottish Australian Investment Co. Ltd*. [1920] HCA 51; (1920) 28 CLR 66 where an industrial award did not alter the character of the payment to be made under a contract of employment but only its amount: see at 72.

[85] (1956) [1956] HCA 24; 95 CLR 300.

[86] ibid. at 324; see per Williams J at 310-312. Dixon CJ agreed with both Williams J and Fullagar J at 305.

[10] The right so conferred on assignee practitioners is not property: not only because the right is not assignable (though that is indicative of the incapacity of a third party to assume the right) but, more fundamentally, because a right to receive a benefit to be paid by a statutory authority in discharge of a statutory duty is not susceptible of any form of repetitive or continuing enjoyment and cannot be exchanged for or converted into any kind of property. On analysis, such a right is susceptible of enjoyment only at the moment when the duty to pay is discharged. It does not have any degree of permanence or stability. That is not a right of a proprietary nature, though the money received when the medicare benefit is paid answers that description.[87]

[11] Such a right can be contrasted with the right to payment considered in *O'Driscoll v Manchester Insurance Committee*.[88] There, doctors were entitled under their agreements with the Insurance Committee to be credited with specified amounts for their treatment of insured patients and to be paid a share proportioned to their credits out of a fund to which insurance premiums and payments under a statute were contributed. It was held that the amounts to be paid to the doctors under their respective agreements were debts, albeit the precise amounts had not been calculated. In *O'Driscoll v Manchester Insurance Committee* the debt to which a doctor was entitled was attached under a garnishee order. A debt can be assigned or is otherwise within the disposition of the creditor. But, under the Principal Act, neither the Commission nor the Commonwealth becomes a debtor to an assignee practitioner although the right conferred on the assignee practitioner is discharged by the payment of money by the Commission on behalf of the Commonwealth.

[12] The Principal Act provides for the payment of what is, as between the Commonwealth and the claimant for the medicare benefit, a gratuitous payment. If a statute provided for money in a particular amount to be paid to a person from whom property had been acquired, a diminution of the amount to be paid enacted after the acquisition might well attract the protection of the just terms requirement in s.51(xxxi). Again, if a statute provided for money in a particular amount to be paid to a person who had given good consideration for the payment, the right to payment in that amount might well be regarded as property which could not be diminished by a law enacted after the consideration was given that did not provide just terms. But the Principal Act does not fall into either of those categories. True it is that an assignee practitioner acquires a right to claim a medicare benefit under s.20A only by agreement to give up a right to payment of a fee for services rendered but that agreement is between the assignee practitioner and the patient. Consideration passes from the assignee practitioner to the patient and from the patient to the assignee practitioner. What the assignee practitioner acquires is a statutory right which, as between the practitioner and the Commonwealth (or the Commission), is a gratuity.

[13] Perhaps it should be mentioned that s.51(xxxi) is not attracted by the acquisition by an assignee practitioner of a right to claim a medicare benefit: that acquisition is effected simply by the agreement between the patient and the assignee practitioner. In any event, there can be no doubt as to the justice of the terms on

[87] See *Federal Commissioner of Taxation v Official Receiver*, ibid. per Fullagar J.
[88] (1915) 3 KB 499.

which the assignee practitioner acquires that right from the patient: the assignee practitioner foregoes the debt which the patient owes for the services rendered.

[14] When the right conferred by the Principal Act is thus analysed, it is clear that the amount which the Commission is commanded to pay to an assignee practitioner whose claim is accepted is the amount prescribed by that Act at the time when the duty to pay is performed. The Parliament, having power to authorize the Commission by legislation to pay medicare benefits, has power by legislation to vary the Commission's authority. Though it was held in *Peverill v Meir* that the duty to pay was not fully performed, an order now to pay the amount prescribed by the Principal Act as amended would be futile, for the Principal Act as amended now prescribes the amount to be paid as the amount which Dr Peverill has in fact received. The question in this case is not whether the Amending Act should be interpreted as having a retrospective operation. Section 6 of the Amending Act makes clear its operation. The question is whether the Amending Act provided for the acquisition of property. The answer to that question is: no.

[15] Perhaps an assignee practitioner might think that the distinction between a debt and a statutory right to claim a medicare benefit and to have the claim accepted and paid is artificial. But the distinction reflects an important difference. When, by statute or otherwise, a debt is created, the creditor is by law entitled to payment in the amount of the debt and that entitlement is immune from legislative acquisition under s.51(xxxi) unless just terms are provided. But where a pecuniary benefit payable out of Consolidated Revenue is gratuitously provided by the Parliament to the beneficiary, the amount of the benefit remains until payment within the unfettered control of the Parliament. The distinction between a debt and the right conferred on assignee practitioners by the Principal Act is the difference between something owned and something expected, the fulfilment of the expectation being dependent on the continued will of the Parliament.

Tisdall v Kelly [2005] FCA 365 —

[7] By s 20(1), medicare benefit in respect of a professional service is payable by the HIC on behalf of the Commonwealth to the person who incurs the medical expenses in respect of that service. By s 20A, where a medicare benefit is payable to an eligible person in respect of a professional service, the eligible person and the person by whom, or on whose behalf, the professional service is rendered may enter into an agreement, in accordance with the approved form. Under such an agreement, the eligible person assigns his or her right to the payment of the medicare benefit to the practitioner, and the practitioner accepts the assignment in full payment of the medical expenses incurred in respect of the professional service. The practice of assigning the entitlement to medicare benefit to the practitioner is commonly known as 'bulk billing'.

20B Claims for medicare benefit

Section 20B provides that a claim for a medicare benefit must be in accordance with the approved form and lodged with the Chief Executive Medicare, or (in such

circumstances and subject to such conditions as are prescribed by the regulations) sent to the Chief Executive Medicare in such manner as the Chief Executive Medicare determines. A medicare benefit does not become payable until a claim is lodged and accepted.

Health Insurance Commission v Peverill [1994] HCA 8; (1994) 179 CLR 226 (per Brennan J) —

> [3] … A medicare benefit is not payable until the claim for it is duly lodged and accepted.[89] On acceptance of a claim, the amount payable is paid out of the Consolidated Revenue Fund of the Commonwealth which is appropriated for that purpose.[90]

20BA Confirmation of referral to a consultant physician or specialist

If a patient is referred to a physician or specialist, the physician or specialist must retain the referral for at least 2 years, and must produce the referral, if asked to do so by the Chief Executive Medicare, to a medical practitioner who is a Departmental employee within 7 days after receiving the request.

R v Harris [1999] TASSC 5 discussed the manner in which a request to produce referrals may be made and the requirements for compliance with such a request. While the request specified how the records were to be produced, it was not necessary that they be provided in that manner.

R v Harris [1999] TASSC 53 —

> [37] The defence submits that Mr Stutter's letter of 21 September 1994 was insufficient to oblige the accused to provide the referrals, as the letter included the following sentences:
>
> > "The written referrals detailed or photocopies should be returned in the pre-addressed envelope supplied. All documents will be treated with complete confidentiality and originals will be returned to you at the completion of this matter."
>
> [38] Section 20BA(1) obliges a medical practitioner to produce referrals when asked to do so. It does not specify the manner in which the referrals are to be produced. Accordingly, insofar as the letter told the accused he should return the referrals in the enclosed pre-addressed envelope, he was not obliged to adopt that course. See *Ex parte Wickens* [1898] 1 QB 543. The letter was an unequivocal request for the production of the referrals pursuant to s20BA. That the letter

[89] It is acceptance for payment (not the payment) of a claim for medicare benefits that determines whether the patient contribution is reduced in respect of later claims for medicare benefits: s.10(3).
[90] Section 125.

specified the means of producing the referrals did not vitiate that request. The accused could have produced the referrals by means which differed from those indicated in the letter. The accused, having acquiesced to and acted on the request in the letter, there is no basis for a finding that he did not produce the referrals pursuant to s20BA(1).

[39] The above approach is consistent with the decision of the Full Court of South Australia in *Bartlett v R* (1991) 100 ALR 177. An issue in that case was whether documents provided by the appellant in response to a notice to furnish information which purported to have been given under the *Social Security Act 1947* (Cth), s163, were given pursuant to that section. If so, that Act, s165, applied to make the documents inadmissible in evidence against the appellant. It was contended that the notice did not conform with the requirements of s163 so that there was no obligation to comply with it and, in result, that the documents were not furnished or produced pursuant to that section. King CJ, agreed with by Perry J, said at 180:

> "I do not think that it is necessary to resolve the question whether the document in question in each of the counts under discussion is a valid notice under s 163 so as to give rise to an obligation to comply with it. It would not follow from the existence of grounds for refusal to comply with the purported notice that any information furnished or any document produced in compliance with it is not furnished or produced in pursuance of the section. I think that the question whether the recipient of the notice is obliged to comply with it and the question whether the compliance enjoys the protection of s 165 are distinct questions which are to be answered on different considerations. The recipient of a notice purporting to be given under the authority of s 163 may be entitled to refuse or fail to comply by reason of some defect of form or procedure relating to the notice. If, however, he complies with the notice, notwithstanding such defect, perhaps in ignorance of it, by furnishing information or producing a document, it seems to me that such information is furnished or such document is produced in pursuance of the section and that such information or document therefore attracts the protection of s 165. Each of the documents in question demanded the information sought by the questions contained therein and expressly purported to do so by the authority of s 163 or its predecessor. I think that the information furnished in those answers and the documents produced by filling in the answers and signing the forms were furnished and produced respectively in pursuance of s 163 irrespective of whether the appellant may have had grounds for refusing to comply with the demands."

[40] The letter advised that the original referrals would be returned at the completion of the matter. It is evident from s20BA(5) that there was no entitlement to keep the original referrals until the end of the matter. Subject to a right to make and retain copies of any referral, or take and retain extracts from any referral, they had to be returned. The inclusion in the letter of the misconceived indication that the referrals would be retained did not nullify the request or make it anything other than a request pursuant to s20BA(1)(e). Notwithstanding that indication, had the accused been so minded, he could have insisted on the immediate return of the referrals.

[41] The defence submits that the obligation to "produce the referrals" is an obligation to produce them to the designated medical practitioner face to face. As

this was not done, it is contended that the referrals were not produced. The defence relies on the following passage in *Button v Evans* [1984] 3 NSWLR 191, Carruthers J at 199:

> "To 'produce' a document to a Customs officer on the other hand involves, to my mind, the concept of a person presenting a document to a Customs officer, whilst they are in each others' presence."

In that case, Carruthers J was construing a provision of the *Customs Act 1901* (Cth) that referred to a "document produced ... to an officer". The facts were that the accused had handed the relevant document to an officer. Carruthers J was not directing his mind to whether the document could have been produced to the officer other than in a face to face situation. He was not dealing with the *Health Insurance Act 1973*. In the circumstances I do not find what he said to be of assistance. In *Hanfstaengl v American Tobacco Company* [1895] 1 QB 347 at 355, Rigby LJ said of the word "produced" that it is "a word that has not got an exact legal meaning, but requires an interpretation to be put upon it in the statute in which it occurs."

[42] A meaning ascribed for "produce" in *The Concise Oxford Dictionary* (supra) at 884 is: "Bring forward for inspection or consideration". To my mind that meaning is consistent with the requirements of the Act and I can see no reason for imposing a requirement that the production of a referral pursuant to s20BA should be made on a face to face basis. The obligation imposed on the accused by the request to produce the referrals was to bring them forward or provide them for the inspection of Dr Lewis. Provided that that objective was achieved, the means by which it was achieved is irrelevant. The accused could have produced the referrals in person, or by an agent, or as he did, by posting them to the address where he had been requested to make them available for inspection by Dr Lewis. By doing so, the accused produced the referrals. To find otherwise involves the proposition that a practitioner who, in response to an s20BA(1) request to produce referrals, made them available for examination otherwise than by means of a face to face meeting would be in breach of his or her obligation to produce them. That would be an absurd result.

[43] The defence submits that as there is no evidence that Dr Lewis ever personally received or examined the referrals, it has not been established that they were produced as required for the purposes of s20BA(1)(e), in which case they have not been furnished in pursuance of the Act for the purposes of s129(2). This submission is based on the misconception that some positive action on the part of Dr Lewis is necessary for the referrals to have been produced. That is not so. The documents were produced once they were brought forward and made available for the inspection of Dr Lewis at the specified address. It is irrelevant that he apparently did not inspect them. What I have said in relation to the production of the referrals applies with equal force to the issue of whether they were furnished. The relevant meaning of furnish is: "Provide, afford or yield", *The Concise Oxford Dictionary* (*supra*). Upon the referrals being delivered to the designated address, as requested, they were provided or, more particularly, furnished, regardless of anything that Dr Lewis did or did not do.

[44] For these reasons, I am satisfied that evidence of the delivery of the referrals is relevant and admissible.

21 Meaning of *eligible midwife*

Under the Act, a 'participating midwife' is able to request particular types of pathology services and diagnostic imaging services, and provide certain MBS items. An 'eligible midwife' may apply to become a participating midwife. Section 21 defines an 'eligible midwife' by reference to regulations under which the requirements for eligibility are specified.

Regulation 66 of the *Health Insurance Regulations 2018* provides:

> For the purposes of paragraph 21(1)(b) of the Act, the requirement for a person to be an eligible midwife is that the person is endorsed by the Nursing and Midwifery Board of Australia.

21B Undertaking by eligible midwife

In order to become a participating midwife, an eligible midwife must give the Minister an undertaking under section 21B in the form approved by the Minister under section 21A. The Minister may accept or refuse an undertaking and give written notice of that decision. An undertaking comes into force when accepted by the Minister.

A participating midwife may terminate an undertaking at any time in the approved form, and an undertaking will cease to be in force on the date specified in that form.

An undertaking will also cease to be in force if an agreement under section 92 specifies that the Minister's acceptance of the undertaking is taken to be revoked, or a determination by the Determining Authority under section 106U directs that the Minister's acceptance is taken to be revoked.

22A Undertaking by eligible nurse practitioner

Under the Act, a 'participating nurse practitioner' is able to request particular types of pathology services and diagnostic imaging services, and provide certain MBS items. An 'eligible nurse practitioner' may apply to become a participating nurse practitioner. Subsection 3(1) defines an 'eligible nurse practitioner' as a nurse practitioner who meets the requirements, if any, specified in regulations. Currently, the regulations do not specify any requirements.

In order to become a participating nurse practitioner, an eligible nurse practitioner must give the Minister an undertaking under section 22A in the form approved by the Minister under section 22. The Minister may accept or refuse an undertaking and give written notice of that decision. An undertaking comes into force when accepted by the Minister.

A participating nurse practitioner may terminate an undertaking at any time in the approved form, and an undertaking will cease to be in force on the date specified in that form.

An undertaking will also cease to be in force if an agreement under section 92 specifies that the Minister's acceptance of the undertaking is taken to be revoked, or a determination by the Determining Authority under section 106U directs that the Minister's acceptance is taken to be revoked.

Part IIA – Special provisions relating to pathology

In order to provide pathology services, a pathology provider must be approved by the Minister, and give the Minister an undertaking in the approved form.

23DB Forms of undertaking

The form of undertaking for an approved pathology provider is contained in a schedule to the application form. It provides:

> **Part 1—Undertaking**
>
> **1 Interpretation**
>
> Note: A number of expressions used in this undertaking are defined in the Act, including the following:
> (a) accredited pathology laboratory
> (b) approved pathology authority
> (c) approved pathology practitioner
> (d) medical practitioner
> (e) participating midwife
> (f) participating nurse practitioner
> (g) pathology service
> (h) relevant civil contravention
> (i) relevant offence
> (j) relevant person
> (k) treating practitioner
>
> (1) In this undertaking:

Act means the Health Insurance Act 1973.

APA means an approved pathology authority.

APP means an approved pathology practitioner.

APL means an accredited pathology laboratory.

account means an itemised list of pathology services rendered that may be eligible for payment under Medicare including a claim for assigned benefits pursuant to the Act.

Assistant Secretary in the Provider Benefits Integrity Division of the Department of Health means any person from time to time holding, acting in, or performing the duties of the position titled Assistant Secretary in the Provider Benefits Integrity Division within the Department of Health.

Chief Executive Medicare means the person for the time being holding the position titled Chief Executive Medicare in the *Human Services (Medicare) Act 1973* and includes an officer holding a valid delegation to make a particular decision in place of the Chief Executive Medicare.

Services Australia means the Agency administered by the Minister who administers the *Human Services (Centrelink) Act 1997*.

Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing means the person from time to time holding, acting in, or performing the duties of the position titled Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing within Services Australia.

independent body has the same meaning as in the *Health Insurance (Accredited Laboratories—Approval) Principles 2017*, or any legislation made in substitution for those Principles.

laboratory means accredited pathology laboratory, given approval under section 23DN of the Act.

Minister means the Minister of the Commonwealth for the time being administering the Act and includes an officer holding a valid delegation to make a particular decision in place of the Minister.

quality assurance program means a program offered for the purpose of testing proficiency in the testing of pathology specimens.

scientist means a person who possesses one of the following qualifications:
(a) a degree in science or applied science with subjects relevant to the field of pathology awarded after not less than three years full-time study, or an equivalent period of part-time study, at a university in Australia, that provides for direct entry or following examination to a professional class of membership of the Australasian Association of Clinical Biochemists, Australian Institute of Medical Scientists, Australian Society for Microbiology, Australian Society of Cytology, Human Genetics Society of Australasia;
(b) an associate qualification conferred by the Australian Institute of Medical Technologists before 1 December 1973.

service means:

(a) pathology service as defined under the Act; and
(b) a health service as defined under section 3C of the Act which under that section is to be treated as if there were an item in the pathology services table which related to it.

State accredited laboratory means:

(a) a pathology laboratory which is accredited pursuant to State legislation; and

(b) in relation to a laboratory which is situated in Victoria—an accredited pathology laboratory under the *Pathology Services Accreditation Act 1984* of Victoria.

workday means, in respect of a laboratory, a calendar day during which the laboratory provides pathology services.

(2) A reference in this undertaking to writing, documents and records includes material in electronic form where recorded and submitted in accordance with the *Information Technology Standard Notice of Information Technology (IT) Requirements under the Electronic Transactions Act 1999 for Public Key Technology (PKI)*, dated 1 September 2009, made by Medicare Australia, as in force on that date.

Note: the Information Technology Standard is available from Services Australia at: <www.servicesaustralia.gov.au/pki>

2 Compliance with legislation

(1) I have familiarised myself with the operation of the legislation listed in Part 2 of this Schedule.

(2) I undertake to comply with the legislation listed in Part 2 of this Schedule, as in force from time to time, or any legislation made in substitution for that legislation.

(3) I undertake not to take any action that would constitute a relevant offence or relevant civil contravention as defined in subsection 124B(1) of the Act.

(4) I acknowledge that a failure to comply with the requirements of subsection (2) or (3) constitutes a breach of this undertaking whether or not that failure has been, or is likely to be, proven in court proceedings.

(5) I am aware that if the Minister grants the application in support of which this undertaking is given the undertaking may outlast the period for which the Minister's approval is given.

3 Personal supervision

(1) I acknowledge that it is my obligation, subject to subsections (3) and (4), personally to supervise any person who renders any service on my behalf and I undertake to accept personal responsibility for the rendering of that service under the following conditions of personal supervision:
(a) subject to the following conditions, I will usually be physically available in the laboratory while services are being rendered at the laboratory;
(b) I may, subject to paragraph (f) below, be physically absent from the laboratory while services are being rendered outside its normal hours of operation but in that

event I will leave with the person rendering the service particulars of the manner in which I may be contacted while the service is being rendered and I must be able to personally attend at the laboratory while the service is being rendered or formally designate another APP present while I am absent;
(c) I may, subject to paragraph (f) below, be absent from the laboratory for brief periods due to illness or other personal necessity, or to take part in activities which, in accordance with normal and accepted practice, relate to the provision of services by that laboratory;
(d) I will personally keep a written log of my absences from the laboratory that extend beyond one workday in respect of that laboratory and will retain that log in the laboratory for 18 months from date of last entry;
(e) if I am to be absent from the laboratory for more than 7 consecutive workdays, I will arrange for another APP to personally supervise the rendering of services in the laboratory. That arrangement shall be recorded in writing and retained in the laboratory for 18 months from date of last entry. Until such person is appointed, and his or her appointment is recorded in writing, I will remain personally responsible to comply with this undertaking;
(f) if a service is being rendered on my behalf by a person who is not:
(i) a medical practitioner; or
(ii) a scientist, or
(iii) a person having special qualifications or skills relevant to the service being rendered;
and no person in the above groups is physically present in the laboratory, then I must be physically present in the laboratory and closely supervise the rendering of the service
(g) I accept responsibility for taking all reasonable steps to ensure that in regard to services rendered by me or on my behalf:
(i) all persons who render services are adequately trained; and
(ii) all services which are to be rendered in the laboratory are allocated to persons employed by the APA and, these persons shall have appropriate qualifications and experience to render the services; and
(iii) the methods and procedures in operation in the laboratory for the purpose of rendering services are in accordance with proper and correct practices; and
(iv) for services rendered, proper quality control methods are established and reviewed to ensure their reliability and effectiveness; and
(v) results of services and tests rendered are accurately recorded and sent to the treating practitioner and, where applicable, a referring practitioner;
(h) if I render, or there is rendered on my behalf, a service which consists of the analysis of a specimen which I know, or have reason to believe, has been taken other than in accordance with the provisions of section 16A(5AA) of the Act I will endorse, or cause to be endorsed, on the assignment form or the account for that service, as the case may be, particulars of the circumstances in which I believe, or have reason to believe, the specimen was taken.

(2) Where services are to be rendered on my behalf in a Category B laboratory as defined in the *Health Insurance (Accredited Pathology Laboratories—Approval) Principles 2017*, I undertake to take all reasonable measures to ensure that the service is rendered under the supervision of an appropriate person as required by those Principles.

(3) I acknowledge that any act or omission by a person acting with my express or implied authority that would, had it been done by me, have resulted in a breach of this undertaking, constitutes a breach of this undertaking by me.

(4) Paragraphs (1)(a) – (f) and subsection (2) do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in Part 4 of this Schedule.

4 Dealings with relevant person

(1) I undertake to inform the Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing if, to my knowledge, any of the following occur:
(a) I become a relevant person;
(b) I become in control of operations of a relevant person;
(c) any person who derives, or can reasonably be expected to derive (whether directly or indirectly) financial benefit from the services I render within a laboratory becomes a relevant person;
(d) I become financially associated with a relevant person;
(e) I am required to appear before the state or territory body which has jurisdiction to affect my registration as a medical practitioner for misconduct or unprofessional conduct.

(2) I undertake not to employ or enter into a contract or understanding with a person who is, to my knowledge, a relevant person.

5 Information to be accurate

(1) I undertake to ensure that information provided to Services Australia for services rendered by me or on my behalf, including information relating to claims for payment, is accurate and complete.

(2) If I become aware that information which has been provided to Services Australia is or becomes inaccurate or incomplete, I undertake to provide the Agency with such further information as will correct the earlier information as soon as possible.

(3) If information provided to Services Australia is inaccurate or incomplete I undertake to provide the Agency with such further information as it requests. The information will be provided in such reasonable form as the Agency requires.

(4) I undertake to advise the Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing in writing of any change in information already provided for the purpose of approval as a pathology practitioner.

6 Quality assurance

(1) On request of an independent body, I undertake to provide the independent body with copies of all quality assurance program reports and related information relating to the conduct of my activities as an APP.

(2) Where I participate in a quality assurance program for the purpose of proficiency testing, I undertake to authorise the provider of any such quality

assurance program to release reports and information generated as part of the quality assurance program to an independent body.

(3) I undertake to take reasonable steps to obtain any necessary consents to enable me to provide reports or information to the independent body in accordance with subsection (1).

(4) Nothing in this section obliges me to provide reports or information to the independent body, or to authorise any other person to do so, in contravention of any law.

7 Request and use of information

(1) If:
(a) the Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing; or
(b) an Assistant Secretary in the Provider Benefits Integrity Division of the Department of Health;
makes a written request, I undertake to provide any relevant information specified in the request relating to services provided by or on my behalf, including any matter arising out of this undertaking.

(2) I acknowledge that information provided pursuant to this undertaking may be copied, disseminated or otherwise made available to any of the following:
(a) the independent body;
(b) officers of the Department of Health;
(c) persons performing the duties of an officer of the Department of Health;
(d) the Chief Executive Medicare;
(e) Agency employees as defined in the *Human Services (Medicare) Act 1973*.

8 Notice to practitioners, patients or other persons

(1) I undertake to notify in writing any practitioner, participating nurse practitioners, participating midwives, patient or other person requesting or relying on services rendered by me or on my behalf if approval to render those services has been revoked, varied or refused by the Minister.

(2) A notice under subsection (1) shall be restricted to services rendered to practitioners, participating nurse practitioners, participating midwives, patients or other persons who, according to a report of the independent body, may have received inaccurate or otherwise unreliable reports.

(3) I undertake to provide a notice pursuant to subsection (1) within 5 working days of being notified that my approval to render services have been revoked, varied or refused.

(4) In the event that I am unable to comply with subsection (1), I undertake to provide such assistance as requested by the Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing that will enable such a notice to be given on my behalf.

9 Agreements, arrangements and contracts of employment with Approved Pathology Authority

(1) I undertake not to render any service in a laboratory in the absence of an agreement, arrangement or contract of employment between the laboratory proprietor and me.

(2) I undertake to ensure that any contract of employment or other agreement or arrangement between myself and an Authority and any amendment or variation thereto, is in writing signed by all the parties and does not, in any way, control me in the discharge of my responsibilities as set out in this undertaking.

10 Accounts for services rendered by employed APP

Where a service has been rendered by or on my behalf, I undertake to ensure that an account for that service is raised on my behalf by the APA, being the proprietor of the laboratory in which the service was rendered and that, no further account will be raised by me. I undertake to ensure that such account includes, and is supported by, information and particulars required by the Act.

11 No inducement to use services

(1) I undertake not to accept a request for services by me or on my behalf where any benefit or incentive (other than an item set out in Part 3 of this Schedule) has been directly or indirectly offered or supplied to the requesting practitioner or employer of that practitioner by the APA with which I have an agreement, arrangement or contract of employment.

(2) The obligation under subsection (1) only arises where I ought reasonably to have known that such benefit or incentive has been offered or supplied.

12 Time and method of complying with undertakings

(1) I undertake to comply with any obligation imposed by this undertaking within 14 days of the obligation arising, unless otherwise specified.

(2) Any information I am required by this undertaking to provide to the Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing must be:
(a) delivered or posted to
The Director, Pathology, Diagnostic Imaging and Veterans' Affairs Processing Services Australia PO Box 1001 TUGGERANONG DC ACT 2901 or another address specified by the Agency by notice in writing to me; or
(b) emailed to co.gp.manager.pathology@servicesaustralia.gov.au

There may be risks with sending personal information through unsecured networks or email channels.

(3) Any information provided under paragraph (2)(a) must be signed by me or by a person authorised in writing to sign on my behalf.

(4) I undertake to take adequate steps to ensure that only authorised persons have access to my email system.

(5) I acknowledges that section 163 of the *Evidence Act 1995* will apply to any document posted to me by Services Australia at the address nominated in the application in support of which this undertaking is given or at such other address as may later be provided by me in writing to Services Australia.

Part 2—Legislation

Health Insurance Act 1973
Health Insurance Regulations 2018
Human Services (Medicare) Act 1973
Human Services (Medicare) Regulations 2017
Health Insurance (Pathology) (Fees) Act 1991
Health Insurance (Approved Pathology Specimen Collection Centres) Tax Act 2000
Health Insurance (Pathology Services) Regulations 2020
Health Insurance (Pathology Services Table) Regulations 2020
Health Insurance (Accredited Pathology Laboratories – Approval) Principles 2017
Health Insurance (Approvals for Eligible Collection Centres) Principles 2020
Health Insurance (Pathologist-Determinable Services) Determination 2015
Health Insurance (Permitted Benefits-Pathology Services) Determination 2018
Health Insurance (Prescribed Pathology Services) Determination 2011
Health Insurance (Eligible Pathology Laboratories) Determination 2015

Part 3—Items an Authority may provide requesting practitioners

Note: In general, these are items which can only be used for the collection of specimens for pathology testing or, if other uses are possible, when supplied by APPs to referrers, will only be used for collection purposes. These are mostly single use items employed in the collection of pathology samples. These are the only items/services an APP/APA may supply free of charge, discounted or on a non-commercial basis, to a practitioner that requests or, intends to request, pathology services. There is no obligation for a pathologist to supply any of the accepted items to a requesting practitioner.

Blood collection

- Needle Barrel Holders;
- Vacutainer (or equivalent) needles;
- Syringes 5mls or larger;
- Needles 21, 23 gauge;
- Alcowipes (or similar individual alcohol wipes);
- Spreaders for blood films;
- Small test tube racks;

Cervical cytology collection materials

- Spray fixative;
- Cervix spatulas;
- Cyto brush;

- Direct to vial kits;
- Slides and slide carriers/holders;

Histology

- Formalin or other fixative;
- Appropriate containers and media for specimens;
- Punch biopsy;

Microbiological specimens

- All microbiological or virology swabs and transport media;
- Urine containers;
- Faeces containers;
- Paediatric urine collection kits;
- Chlamydia specific collection and transport receptacles;
- TB specific collection receptacles;
- Blood culture bottles;
- Petri dishes;
- Specimen biohazard bags/rubber bands;

Non cervical cytology

Appropriate containers and media for urine, sputum and other body fluid cytology and cytology samples collected directly from tissues by the procedure of Fine Needle Aspiration Cytology (FNA);

Biochemistry

- Timed urine (eg 24 hour) collection containers;
- Faecal fat collection containers;
- Glucose drink for GTT;
- Centrifuges, but to remain the property of APA, and only if practice demographics (in terms of time) from laboratory are such that failure to separate sera/plasma will damage specimen;

Stationery/Instruction Sheets

- Paper or electronic request pads/forms/software;
- Medicare assignment forms DB3, including software facilitating electronic assignment;
- Repatriation assignment forms, including software facilitating electronic assignment;
- Telephone result pads;
- Stock request pads;
- Miscellaneous forms eg tube guides, practice information handbooks;
- All patient instruction sheets/education material;

Other

- Fridge, where refrigeration is vital for the preservation of specimens (ie Laboratory being a long distance from collection point). Fridge must be labelled with Pathology Company name, and used exclusively for pathology purposes;
- Insulated containers such as eskies for specimen transport (must be labelled as property of laboratory);
- Other specimen transport containers (must be labelled as property of laboratory);
- Specimen pick up receptacles (eg night boxes), must be labelled as property of laboratory;
- Pathology download software specifically to retrieve pathology results for the laboratory. Pathology download software which is part of a larger suite should not be provided – where additional functionality cannot be separated from the software, a written licence agreement at normal commercial rates must exist between the APA and requesting practitioner or, agreement must be established in writing prohibiting use of non-pathology software reporting components.
- Disposable vaginal speculums

Part 4—Laboratory Services

Note: Paragraphs 3(1)(a) to (f) and subsection 3(2) of Part 1 of this Schedule do not apply where a laboratory is limited to services (and associated equipment for those services) as detailed in this Part. These services will be updated from time to time in consultation with the Royal College of Pathologists Australasia.

- Blood gas analysis
- Haemoglobin Ometer
- Glucose Reading

23DL Breaches of undertakings by approved pathology practitioners and approved pathology authorities

Under Part IIA of the Act, approved pathology practitioners and approved pathology authorities must give certain undertakings. Breaches of such undertakings may result in referral to a Medicare Participation Review Committee.

Gribbles Pathology (Vic) Pty Ltd v Cassidy [2002] FCA 859 —

> [136] A notice under s 23DL(1) clearly serves a number of purposes. It gives the approved pathology authority notice that the Minister has reasonable grounds for believing that it has breached its undertaking. It provides the basis upon which that authority can make submissions as to why the Minister should take no further action. Finally, it sets the outer limits for any subsequent notice to the MPRC, and for its inquiry and determination.

[137] A notice under s 23DL(1) can only serve these purposes if adequate particulars of the allegations are provided. General and non-specific allegations are of little utility.

[138] The principal allegation in the purported first notice constituted by the letter of 24 December 1999 was that Gribbles had breached par 16 of its undertaking "not to take any action that would constitute a relevant offence". The particulars of that allegation that were provided referred to s 129(2) of the Act which renders the furnishing of "a return or information that is false or misleading in a material particular" a criminal offence. The conduct said to constitute the breach lay in Gribbles having answered "Nil" to questions 10 and 11 of the standard form application inviting it to provide details of persons or businesses with which it had a "financial association", or a direct or indirect cost or profit sharing "arrangement." It was alleged that Gribbles had such an association, or such an arrangement, with AMMS.

[139] I have little doubt that if Gribbles had been charged with an offence under s 129(2), the particulars which were provided by the delegate would be regarded as inadequate: *S v The Queen* [1989] HCA 66; (1989) 168 CLR 266 at 274-275. Those particulars did not come close to satisfying the requirements identified by Dixon J in *Johnson v Miller* (supra) albeit in context of a criminal prosecution. The delegate failed to set out the date upon which the section was allegedly contravened. He failed to set out the facts which were said to make the answers to questions 10 and 11 "false or misleading in a material particular." He failed to identify the leasing arrangements by reason of which he contended that those answers contravened the section, whether by date, parties, consideration or premises. He provided no particulars of the alleged involvement of Medtronic whether as to date, parties or consideration. He provided no particulars which cast any light upon the meaning attributed by the Minister, through his delegate, to the terms "financial association" or "arrangement". It scarcely needs to be said that the meaning to be accorded to terms such as these is difficult to ascertain. The concepts are loose and uncertain. To the extent that the delegate inferred that there existed an association or arrangement or the relevant kind, the facts upon which he drew that inference were not sufficiently identified.

[140] The matter is made all the more difficult by the confusion regarding the date upon which Gribbles was said to have contravened the section. It is unclear whether that date was 21 June 1995 or 14 September 1995. The MPRC, in its reasons for decision, concluded that it had to be the second of those dates because the June undertaking was not accepted until 30 June. However, the first notice did not make that clear, and the defect could not be cured by later analysis on the part of the MPRC.

[141] I accept that there is nothing in the Act to suggest that an approved pathology authority is entitled to be informed of all of the minutiae of possible matters that could lead to the conclusion that it had breached an undertaking and, in particular, contravened s 129(2). Though the proceedings before the MPRC were potentially extremely serious for Gribbles, it cannot be said that those proceedings were to be equated, to any significant degree, with a criminal prosecution. As such, Gribbles was not entitled to the full and detailed particulars to which it might be entitled if it

were facing a criminal prosecution: *Peverill v Backstrom* (1994) 54 FCR 410 at 436.

[142] Nonetheless, the level of particularity required in order to constitute a valid notice under s 23DL(1) is informed, to some degree, by the analogy which may be drawn with a prosecution under the very section of the Act alleged to have been contravened by the breach of the undertaking. The Minster chose to proceed by alleging a breach of par 16. If he chooses to refer such an allegation to an MPRC, rather than causing a charge to be laid before the courts, he must appreciate that the consequence is likely to be that he will be fixed with a high measure of compliance with the obligations of procedural fairness

[143] I am fortified in my view that the first notice did not adequately particularise the allegations made regarding the first breach by a consideration of other authorities dealing with the sufficiency, or otherwise, of notices in other statutory contexts: see for eg *Bannerman v Mildura Fruit Juices Pty Ltd* [1984] FCA 156; (1984) 2 FCR 581 at 591. A notice should not be read technically or narrowly and it may be expressed in ordinary language. Nevertheless, the notice must convey to the recipient with "reasonable clarity" what is the duty which its service imposes upon him. The recipient should not have to strain for a meaning or be left in confusion as to what was intended. Vague allegations, drafted with imprecision and lack of specificity, may constitute a denial of natural justice and lead to the conclusion that an inquiry has been conducted without jurisdiction or authority: *Kelson v Forward* [1995] FCA 1584; (1995) 60 FCR 39 at 64.

[144] A notice which refers a matter relating to a relevant criminal activity to the National Crime Authority ("the NCA) is required to describe the "matter": *AB v National Crime Authority* (1988) 85 FCR 538. In principle, and as a matter of common sense, greater latitude in relation to particulars is likely to be accorded to a purely investigatory body such as the NCA than to a body which conducts hearings, and makes determinations, such as an MPRC.

[145] It has been held that even where no allegation of misconduct is made against a person, but merely an allegation that that person has been "inefficient", they are entitled to know, with precision, what specific behaviour has led to that conclusion. There is no reason in principle why procedural requirements preceding dismissal from employment should be read down simply because they are not to be classified as "disciplinary". Considerations of efficiency cannot override basic rights to procedural fairness: *Panagopoulos v Secretary, Department of Veteran Affairs* (1995) 60 FCR 524 at 538-539, Gribbles' entitlement to adequate particulars must be, if anything, greater than that of an employee in such a case.

[146] The deficiencies in the s 23DL(1) notice cannot be cured by subsequent events. The provision of a detailed case statement by the delegate to the MPRC does not overcome the fact that Gribbles did not have that information at the time it sought to persuade the Minister not to refer the matter for determination. Although it is not entirely clear when the delegate came into possession of the details which he provided to the MPRC in the case statement, it is at least likely that he was in position to assemble much of that information without great

difficulty. There is nothing to indicate that at least some of the information sought by Gribbles, though correspondence, could not with relative ease, have been provided. The delegate took what seems to me to be a somewhat peremptory approach to what was a reasonable request, merely contending that Gribbles neither required, nor was entitled to, the particulars sought.

[147] It follows that in my view the MPRC was not entitled to embark upon a hearing of the first alleged breach. I should indicate however, that this conclusion is based solely upon the invalidity of the first notice by reason of its failure to provide adequate particulars, a failure which rendered invalid both the second and third notices as well.

[148] The failure to provide adequate particulars regarding the first alleged breach does not, however, affect the validity of the first notice insofar as it describes the second, third and, in part, fifth alleged breaches. The particulars provided of those breaches were adequate to allow Gribbles to understand fully the complaint which it was required to meet. Although one of the particulars sought in relation to the second alleged breach was similar to several particulars sought in relation to the first alleged breach, the need for that information was much less pressing in relation to that breach.

23DN Accredited pathology laboratories

Upon application, the Minister may approve, or approve in principle, premises as an accredited pathology laboratory. An application for review of a decision under this provision may be made to the Administrative Appeals Tribunal under section 23DO.

Lynch v Minister of Human Services and Health [1995] FCA 1756 (per Davies and Lehane JJ) —

[1] Section 23DN of the *Health Insurance Act 1973* (Cth) ("the Act") provides *inter alia*:

> "23DN. (1) Where a person ... makes an application, in writing in the approved form, to the Minister for the approval of premises as an accredited pathology laboratory, the Minister may, in writing:
> (a) approve in principle the premises as an accredited pathology laboratory; or
> (b) refuse to approve the premises as an accredited pathology laboratory.
> ...
>
> (2A) An approval in principle under subsection (1), and an approval under subsection (2), of premises as an accredited pathology laboratory must specify:
> (a) the kind of pathology services in respect of which the premises are approved for the purposes of this Act; and
> (b) the category of accreditation allocated to the premises; and
> (c) the period (not exceeding 3 years) for which the approval is to have effect."

The review by the Administrative Appeals Tribunal of such decisions of the Minister is provided for by s.23DO(5) of the Act which reads:

> "(5) Applications may be made to the Administrative Appeals Tribunal for review of:
> (a) a decision by the Minister, under subsection 23DN (1), approving in principle or refusing to approve premises as an accredited pathology laboratory for the purposes of this Act; ..."

[2] In the operation of these provisions, an approval in principle of premises as an accredited pathology laboratory under s.23DN(1) is an approval in principle also for the purposes of s.23DO(5)(a), notwithstanding that the applicant for approval may be dissatisfied with an aspect of the matters specified under s.23DN(2A). Section 27 of the *Administrative Appeals Tribunal Act 1975* (Cth) ("the AAT Act") provides that, where an enactment provides that an application may be made to the Administrative Appeals Tribunal ("the Tribunal") for a review of a decision, the application may be made by or on behalf of any person or persons whose interests are affected by the decision. An applicant for approval who is dissatisfied with a matter specified under s.23DN(2A) of the Act is such a person.

[3] Although s.23DO(5)(a) does not refer in terms to the specification of matters under s.23DN(2A), the reference to approving in principle of premises or refusing to approve of premises as an accredited pathology laboratory includes a reference to matters dealt with under s.23DN(2A), for the specification of those matters is an integral part of the giving of an approval in principle. Section 43(1) of the AAT Act provides that, for the purposes of reviewing a decision, the Tribunal may exercise all the powers and discretions that are conferred by any relevant enactment on the person who made the decision. Such powers and discretions include the specification of the matters referred to in s.23DN(2A) of the Act.

[4] Similar issues were discussed in *Hip Kwok Ma v Minister for Immigration and Ethnic Affairs* (unreported, 13 October 1995, Davies J), where the Court held that, for the purpose of the review provisions in the *Migration Act 1958* (Cth), the grant of a visa subject to conditions constituted the grant of and not a refusal to grant a visa. In that case, as the Migration Act limited review to the circumstance where a visa had been refused, review was held not to be available.

[5] In the present case, on 5 December 1991, a delegate of the Minister approved in principle, as an accredited pathology laboratory, premises at 1-13 East Street, Rockhampton, Queensland, which were occupied by the applicant, Dr TB Lynch, a pathologist. The approval specified seven kinds of pathology services in respect of which the premises were approved, but it omitted histopathology, a pathology service for which Dr Lynch had sought approval. On the following day, a formal instrument of approval was signed by a delegate of the Minister. It was to the same effect as the approval in principle.

[6] Dr Lynch applied to the Tribunal for a review of the decision of 5 December 1991. On 31 May 1995, the Tribunal declared that it did not have jurisdiction to hear and determine the matter.

[7] The Tribunal considered that, as there was not before the Minister a report by an inspection agency that the subject premises complied with the standards referrable to histopathology, the Minister's delegate did not enter upon a decision-making process which would lead to an approval or a refusal to approve. We are

satisfied, however, that the delegate of the Minister did enter upon a decision-making process and made a decision which was reviewable under s.23DO(5)(a). On 5 December 1991, a delegate of the Minister approved the premises in principle as an accredited pathology laboratory. Dr Lynch, whose interests were affected by that decision, applied to the Tribunal for review, as he was entitled to do, being a person affected by the decision. The Tribunal therefore had jurisdiction to hear and determine the matter.

[8] Section 23DNA, which provides for the promulgation of principles to be applied in the exercise of the s.23DN discretion, provides, inter alia:

> "23 DNA (1) The Minister may, in writing, determine the principles that are to be applied in the exercise of his or her powers under subsection 23DN(1).
>
> (2) Without limiting the generality of subsection (1), the principles may provide for the allocation of different categories of accreditation as a pathology laboratory to different premises in accordance with the criteria set out in the principles."

Section 23DN(3) provides:

> "(3) The Minister shall, in exercising the Minister's powers under this section at a particular time, apply the principles determined under section 23DNA that are in force at that time."

[9] The Minister promulgated such principles on 26 November 1987. These principles were published in the *Government Gazette* on 9 December 1987. Amendments to the principles were made on 26 July 1989 and were published in the Gazette on 29 July 1989. Part IV of the principles provided:

> "4.1 An inspection agency shall be approved to inspect premises the subject of an application for approval as an accredited pathology laboratory if there is in existence an agreement between it and the Commonwealth for the inspection of premises for the purpose of approval as an accredited pathology laboratory.
>
> 4.2 Premises shall not be approved as an accredited pathology laboratory unless the applicant has, at the time that the application was made, provided evidence that -
> (a) the premises have been inspected by an agency which has reported that the premises comply with the Standards; or
> (b) the premises are at the time that the application is made, registered with the National Association of Testing Authorities and the Royal College of Pathologists of Australasia, provided that -
> (i) the premises were registered by reason of complying with the Standards; and
> (ii) the Minister is satisfied that the premises have, since being registered, complied with the Standards."

The words "shall not" and "unless" in clause 4.2 of the principles were inserted by amendments made in July 1989.

[10] A body called the National Association of Testing Authorities ("NATA") has been approved as the inspection agency. NATA inspected Dr Lynch's premises and operations. The agency reported favourably, save that it was not satisfied that the

operations proposed by Dr Lynch with respect to histopathology complied with the standards for pathology laboratories specified by the National Pathology Accreditation Advisory Council, which were standards to which the principles referred.

[11] However, the Minister is not empowered by s.23DNA of the Act to confer a decision-making role upon an inspection agency. The primary decision-making power is conferred upon the Minister, which includes his delegates. The Minister and his delegates are the primary decision-makers and, in respect of all relevant decisions of the Minister and his delegates, the Act provides for review by the Tribunal, which under the AAT Act has the power to review decisions on their merits and to exercise the powers and discretions of the primary decision-maker. Those are the authorities on which Parliament has reposed the decision-making powers and functions. Section 23DNA (1) provides for the promulgation of principles to be applied in the exercise of the Minister's powers, and therefore by the Tribunal, not for the conferral of a decision-making power upon another body.

[12] Had cl 4.2(a) of the principles merely provided a procedure whereby the Minister and his delegates could be advised with respect to relevant matters, there would have been no problem with it. The Minister is entitled to take advice, as other clauses of the principles, such as cl 7.4, contemplate. But cl 4.2(a) of the principles purports to have a determining effect.

[13] A decision-making power is conferred when, inter alia, the exercise of a function or power serves as an "ultimate and operative determination" which affects legal rights and obligations: *Australian Broadcasting Tribunal v Bond* [1990] HCA 33; (1990) 170 CLR 321 at 335-9, or when, to use the words of Deane J in *Director-General of Social Services v Chaney* [1980] FCA 87; (1980) 31 ALR 571 at 590, there is "a determination effectively resolving an actual substantive issue." If the formation by NATA of a view unfavourable to an applicant's case determines the application, as cl 4.2(a) provides, then the inspection agency has a decision-making role. Its adverse finding operates as the final and operative decision determining the application.

[14] The conferral of such a decision-making role upon the inspection agency is not authorised by s.23DNA(1). The Act does not enable the Minister to repose in an inspection agency a power to refuse applications for the approval of premises or (which is substantially the same thing) a power, by the terms of its report, to compel the Minister to refuse such an application. It is also inconsistent with the Act that any such decision of an inspection agency should not be reviewable by the Tribunal or should effectively exclude the Minister's decision from the Tribunal's review. Cf. *Riddell v Secretary, Department of Social Security* [1993] FCA 261; (1993) 42 FCR 443.

[15] This Court should declare that the Tribunal has jurisdiction to hear and determine the application for review lodged by Dr Thomas Brendan Lynch. …

23DNG Revocation of approval

The Minister may revoke an approval if satisfied of a number of matters set out in the section. An application for review of a decision under this provision may be made to the Administrative Appeals Tribunal under section 23DO. The factual circumstances and degree of seriousness of the matters will be important in deciding whether or not to revoke approval.

Re Trezise Services Pty Ltd and Health Insurance Commission [1995] AATA 367 —

> [9] Section 23DNG(1) uses the word "may" and as Cotton LJ observed in *Nichols v Baker* (1890) 44 ChD 262 in relation to its statutory meaning,
>
> > " 'May' never can mean 'must', so long as the English language retains its meaning; but it gives a power, and then it may be a question in what cases, where a judge has a power given him by the word 'may', it becomes his duty to exercise that power."
>
> At one time it was generally accepted that enabling words contained within legislation were construed as compulsory if the object of the exercise of the power was to effectuate a legal right (see Lord Blackburn in *Julius v Lord Bishop of Oxford* (1880) 5 App Cas 214). Australian authorities determine that the word "may" confers an authority on a decision-maker and that it is the context in which that authority is conferred which must be examined to determine whether an authority, once granted, ought to be exercised (see the comments of Windeyer J in *Finance Facilities Pty Ltd v Federal Commissioner of Taxation* [1971] HCA 12; (1970) 127 CLR 106 at 134-135 and the Full Court of the Federal Court in *Khoshabeh v Minister for Immigration, Local Government and Ethnic Affairs* [1994] FCA 1158; (1994) 122 ALR 453 at 454-459 (inclusive)).
>
> [10] The Tribunal notes that some provisions in the Act, even within the confines of Division 4A of Part IIA, use the word "may", for example s.23DND(4), whereas other provisions use the word "must", for example, ss.23DNF(1), (2), (3) and 23DNK. It is plain upon examination of each such provision in relation to the application of s.23DNG(1) however, that no distinction can be drawn between the legislative requirement necessary to fulfil the conditions precedent for the grant of a licence and that necessary to fulfil the conditions precedent in respect of the revocation of a licence. Thus in attributing statutory meaning to the words "may" and "must", each provision must be examined in its own context, that is, each provision must be viewed in light of the Parliament's intention. For example, s.23DNK provides that the consequence of not displaying a notice at all times that a centre is licensed can attract a penalty of up to a $100, whereas pursuant to s.23DNG(1)(b) the same breach may result in the revocation of a licence. Obviously, the seriousness of the circumstance in which a breach of s.23DNK occurs may vary. A breach may be minor – for example, a notice affixed to a wall may fall down and become obscured and remain unobserved by the licensee for a day or two, or a breach may be serious – for example, a licensee may persistently omit or refuse to erect a notice. In the former example it may be sufficient for the breach to be recognised by the imposition of a penalty rather than by the harsher consequence of revocation of a licence. In the latter example, it might be considered

that the imposition of a small monetary penalty would give insufficient recognition to the need to comply with the condition and that licence revocation should be considered. It would indeed be strange that if in both examples it was thought necessary to revoke a licence. As can be seen with respect to a breach of s.23DNK, there are two possible penalties and a discretion lies in the decision-maker to determine which form of penalty should be imposed, namely, a fine under s.23DNK itself or the revocation of a licence under s.23DNG(1)(b).

[11] In contrast, non-fulfilment of the conditions precedent contained in s.23DND(4) arise in a different context to the aforementioned example. In this instance the only penalty open to the decision-maker is the revocation of a licence, as provided for in s.23DNG(1)(a). When this factor is considered together with the use of the adverbial "only" in s.23DND(4), which operates so as to import a restriction of exclusivity and which, in the context of the section, results in the grant of a licence occurring only if all the conditions precedent are fulfilled, it follows that where a condition precedent under s.2DND(4) is not fulfilled, then revocation under s.23DNG(1)(a) must follow.

[12] Mr Jones conceded that the conditions other than sub-paragraph (b) that were imposed by s.23DND(4) had been complied with by the applicant, namely that the same function was carried out at 873 Centre Road as that carried out when the licence was granted for the premises at 869 Centre Road, the applicant employed the same staff and it operated within the same quota numbers. A decision which results in the applicant not having a licence for the period following the move of its operations may seem unduly restrictive. This is particularly so in circumstances where a licence has subsequently been granted for the premises at 873 Centre Road and, where, had the applicant applied for the licence on 29 November 1993, there seems little doubt it would have been granted. However, the Tribunal is of the opinion that this is not remedial legislation of the kind discussed by Wilcox J in the *Commonwealth of Australia v Ford* (1986) 65 ALR 323, at 329 and, consequently, the argument put by Mr Titshall that the respondent in reaching a decision interpreted the statute "in the spirit of meticulous literalism" is not persuasive.

[13] The Tribunal, standing in the shoes of the Minister or, as is this case, the Minister's delegate, is bound to arrive at the correct or, if there is more than one possible decision open, the preferable decision (*Drake v Minister for Immigration and Ethnic Affairs* (1979) 24 ALR 577 at 589 per Bowen CJ and Deane J). It is clear that the original decision-maker and the decision-maker upon review took the view that there was a duty to conclude, in the reaching of their decisions, that the applicant did not comply with the strict conditions of the licence and consequently was operating a specimen collection centre from unlicensed premises. That decision is consistent with the applicant having failed to fulfil the statutory requirements of s.23DND(4) and is accordingly, in the view of the Tribunal, the correct decision.

Part IIBA Prohibited practices in relation to pathology services and diagnostic imaging services

Part IIBA prevents requesters of pathology and diagnostic imaging services from asking for or accepting, or being offered or provided, any benefits (other than 'permitted benefits') in order to induce them to request the services from providers of those services, and to protect requesters of those services from being threatened in order to induce the requesters to request services from providers of those services.

Prior to Part IIBA being inserted into the Act, provisions not involving civil penalties, but instead could result in referral to the Medicare Participation Review Committee concerning what was called 'prohibited diagnostic imaging practice'.

Re Reddy and Medicare Participation and Review Committee [1994] AATA 8 —

> [2] It was alleged that the applicant had engaged in a prohibited diagnostic imaging practice. Relevantly, this is defined as follows -
>
> > "23DZG For the purposes of this Act, a person is taken to be engaged in a prohibited diagnostic imaging practice if: …
> > (c) the person is a practitioner, or the employer of a practitioner, who, without reasonable excuse, asks, receives or obtains, or agrees to receive or obtain, any property, benefit or advantage of any kind for himself or herself, or any other person, from a service provider or a person acting on behalf of the service provider; or"
>
> [3] "Service Provider" is defined in s 23DZF in these terms -
> means a person who:
> (a) renders diagnostic imaging services; or
> (b) carries on the business of rendering diagnostic imaging services, or
> (c) is a proprietor of premises at which diagnostic imaging services are rendered; or
> (d) employs a person who:
> (i) renders diagnostic imaging services; or
> (ii) carries on the business of rendering diagnostic imaging services."
> …
>
> [5] It was alleged that the applicant, a medical practitioner, without reasonable excuse asked to receive or obtain a benefit or advantage to himself from a service provider. In particular, it was alleged the he had asked for a commission to be paid to him of 10 per cent of fees rendered by the service provider in relation to diagnostic imaging services carried out at the request of the applicant and in relation to the applicant's patients.
>
> [6] The matter arose as a result of a complaint made by a radiographer, Mr Kreft, originally to the Tasmanian Branch of the Australian Medical Association and later

to the Health Insurance Commission. The complaint related principally to a conversation said to have taken place on the evening of Sunday, 26 May 1991. The complaint was not made until some 2 months had passed, for reasons to which reference will later be made. When the complaint was investigated by an officer of the Commission, a statement was taken from Mr Kreft.

…

[10] Although the crucial conversation took, according to the evidence, between 5 and 10 minutes, both parties to it were cross-examined extensively before this Tribunal over a period of 2 full days. A preliminary objection was made on behalf of the applicant on the basis that the evidence did not disclose the commission of an offence no matter what view was taken of the conversation. This was because it was alleged that the service provider was PW Burden Pty Ltd, the professional company which provided the service of reporting on diagnostic images. It was submitted that Mr Kreft went to the surgery that night on behalf of Launceston Radiodiagnostic Pty Ltd, a non-medical company providing only diagnostic imaging services to PW Burden Pty Ltd. It was common ground between the parties that Launceston Radiodiagnostic Pty Ltd could not be regarded as a service provider under the Act. It was further submitted that Mr Kreft was acting on behalf of the non-medical company, because the purpose of his visit to the applicant's surgery was 2-fold, namely, to pick up or to deliver exposed x-rays (it was not clear which of those functions he was carrying out) and also to deliver the book, Imaging Guidelines, which had been paid for by the non-medical company.

[11] In our opinion, this is too narrow a view to take of the facts. At all material times, the actions of Mr Kreft were on behalf of the practice as a whole. He was technically employed by the medical company, as Exhibit 1, a group certificate, shows and as was attested in his statement quoted above. The work carried out by him in managing the practice as a whole, in supervising the radiographers, in maintaining contact with medical practitioners and in generally looking after the interests of both the non-medical and medical company are sufficient in our view to identify him as the agent at all relevant times of PW Burden Pty Ltd, a service provider. The arrangements for fee sharing between the medical and non medical companies would, in any event, render them an integrated undertaking. Mr Kreft's actions on the night of 26 May 1991 were in the course of his duties as an agent of the practice constituted by 2 separate entities but nevertheless a practice which, as a whole, must on any reading of the definition be regarded as a service provider. It follows that if a medical practitioner asked Mr Kreft for a benefit for himself within the terms of the definition, then he was asking for a benefit from a service provider.

[12] Whether Dr Reddy asked for a benefit that night within the meaning of the definition, seems to us to be a question of fact. We respectfully agree that the standard of proof adopted by the Committee, being the standard propounded by Dixon J in *Briginshaw v Briginshaw* (1938) 66 CLR 336 at 361, is the appropriate standard. No special meaning is to be given to the words "without reasonable excuse". They are ordinary English words. No doubt they were inserted into the paragraphs to avoid too inflexible an interpretation which might imperil accepted and reasonable practices in the profession. Thus, if a practitioner asked a service provider to guarantee prompt service within 24 hours after every referral, and

promised that if such a guarantee were given, the practitioner would send all his references to that service provider, this could, on one reading of the paragraph, constitute a request for a benefit for "any other person" namely the practitioner's patients. Such an arrangement, however, would clearly be reasonable and would fall within the exception of reasonable excuse. This is but one example. It would be unwise to attempt to attempt to set out exhaustively all excuses which might be regarded as reasonable.

[13] Counsel for the applicant submitted that the section required that the asking should be a matter of substance and not of form. Thus, if valuable equipment were to be lent to a medical practitioner on permanent loan without fee on a wink and nod basis, this could constitute an asking for a benefit. On the other hand, it was submitted that the mere fact that a form of words was used would not necessarily amount to an asking if the intention to suborn the service provider was not there. We do not consider it necessary to read into the plain words of the statute implications of this nature. The exculpatory phrase "without reasonable excuse" will be sufficient in all cases to extend to circumstances in which a literal reading would be inappropriate.

[14] Counsel for the applicant urged us to prefer the version of events given by his client for 8 reasons. He pointed firstly to the fact that prior to May 1991 there had been an ongoing relationship between the 2 practices and that apart from the jocular suggestions referred to in the statements above, there had been no previous hint of any request for a benefit. Secondly the ostensible purpose of the meeting, it was submitted, was not to pick up x-rays or to deliver the book but to inquire why referrals from Dr Reddy to the imaging practice had fallen off. As we read the figures, there had in fact not been a falling off. In the absence of any direct evidence from either party that this was the purpose of the meeting, it seems to us fanciful to propound this suggestion.

[15] The third reason related to the alleged presence of the applicant's son at the surgery at the time of the conversation. Dr Reddy said his son was not there, although it was his custom, as referred to in the above statement, to have his son attend to receptionist duties for payment from time to time. Mr Kreft, on the other hand, clearly remembers Dr Reddy's son being there and being present no more than one and half metres from where the conversation was carried on. Counsel for Dr Reddy said that if the son was there, it was highly improbable that a serious bribery offer would have been made. Nevertheless, it seems to us that in the absence of any evidence from the son either that he was not there, or that his father's version was correct, one must conclude that his evidence would not have been helpful to the applicant.

[16] The fourth reason referred to a change in the position of the parties at the time of the meeting. There was evidence that the imaging practice had acquired new capital equipment and that the decline in referrals could well be worrying to that practice. At the same time however, it is clear that Dr Reddy's own financial position was worsening. His estate was subsequently sequestrated in bankruptcy and he has not yet received his discharge. Although the formal sequestration occurred some time after the May 1991 meeting, it seems to us inconceivable that he could not then have been aware of the precariousness of his financial position.

One of the features of his evidence before this Tribunal was the unsatisfactory nature of the information we received concerning his financial affairs at the time of the conversation. This troubled the Committee and it troubled us.

[17] The fifth aspect of his client's case to which counsel invited our attention was the character of the applicant. References were provided to the Committee and an additional 5 references were provided to this Tribunal. Two of the new references were from the 2 proprietors of the opposition imaging practice. Both Drs Paech and Grant denied in their references that Dr Reddy had ever solicited benefits from them. As that has never been alleged against Dr Reddy, such a denial does not seem to have taken the matter much further. Although it is common ground in both versions of the conversation that Dr Reddy said that he received money from the opposition practice, it is not alleged by either party that this was in fact true and we accept that there is no evidence of the truth of any such arrangement. The other references principally relate to the applicant's professional capacity and his devotion to his patients. As none of these aspects was in question, an affirmation of their existence did not help us greatly in resolving the issues to be determined in this application. We did not receive any references relating to Mr Kreft but we have no reason to doubt his integrity.

[18] Counsel submitted that there was a logical consistency in the final version of events given by Dr Reddy. This may be so looked at from one point of view. However, the inconsistency between the final version and the earlier versions, seems to us not to be a hallmark of honesty, as counsel would have it. Indeed, the longer the interval between the conversation and the statement, the more coloured the applicant's recollection appears to be. In any event, some of the later version of the conversation we find hard to accept. It is difficult to imagine a mature and financially experienced medical practitioner telling a radiographer that he received commissions from the opposition in cash because he thought that that was what the radiographer wanted to hear. On the other hand, the version of events given by Mr Kreft has been consistent from the beginning. The statement was prepared much closer to the events in question and has been adhered to, notwithstanding rigorous cross-examination before the Committee and before this Tribunal. The fact that complaint was not made until some 2 months after the event, is satisfactorily explained, in our view, by the fact that Mr Kreft did not know how to take the extraordinary statements made by Dr Reddy on that night until referrals began to fall quite significantly in the subsequent months. It was only then that he realised that Dr Reddy could have been serious and that the circumstances warranted the matter being taken further.

[19] Counsel submitted as his seventh reason that these reduced referrals were entirely neutral in relation to credit. They could be regarded as the result of what Dr Reddy perceived to be an insult to him from Mr Kreft. This is inherently unbelievable. If the applicant had felt that he had been so dishonoured as to affect his professional judgment on behalf of his patients, he would not have sent any further referrals to the practice. Dr Reddy however explained the decline in referrals by the decline in the quality of service provided, both before and after the May 1991 incident. Examples are contained in the T-documents of radiological reports which he considered to be inferior. In almost all cases, the defect alleged is a statement by

the radiologist that previous x-rays were not available for comparison. Dr Reddy pointed to several of his requests, which contained what can only be described as enigmatic terms, but which he justified as the basis for expecting a radiologist to refer to earlier x-rays and to report on them as well as the current x-rays. This evidence was obscure and unconvincing. There was no evidence that we are prepared to accept of any decline in the quality of service of the Burden practice.

[20] We were also invited to compare the demeanour of the 2 parties concerned. In our view, Dr Reddy was articulate and careful (as his counsel pointed out) but also lacking in candour and frankness. He responded carefully to questions, some of which had to be repeated a number of times, before he was satisfied with the text of his answer. His concern can be understood, having regard to the consequences of the complaint. Nevertheless we have the same feeling that was expressed by the Committee that the applicant was not totally forthcoming in all his recollections. He explained that he did not tell the Committee that he was an undischarged bankrupt because (he said) he was not asked whether he was. Such a concern for concealment of facts that could have a bearing on the issues to be determined, left us uneasy about accepting the totality of Dr Reddy's evidence.

[21] Another instance of the unease we felt related to the evidence given concerning Dr Reddy's tape recorder. He said that when Mr Kreft arrived, he had been dictating matters relating to his practice and put down the voice activated recorder without turning it off. We were meant to assume, no doubt, that what took place that night was duly recorded, although Dr Reddy would not say that specifically. He then explained that the following day the tape had been erased by his receptionist following normal practice. Nevertheless, later he agreed that he had received back from the receptionist typed up copies of material in the earlier part of the tape. He assumed that she had wiped out the balance of it because it was "mere chatter". He could not, however, remember who was the receptionist, nor was there any evidence of what in fact had been transcribed from that night's material on the recorder. The absence of evidence concerning this recording, like the absence of evidence from the applicant's son, left us uneasy that Dr Reddy's version of events was correct. Dr Reddy's evidence in relation to the tape recorder contrasts with the responsiveness of Mr Kreft in what appeared to us to be frank answers to questions concerning his alleged tape recorder.

[22] On balance, we are satisfied on the evidence that the applicant, without reasonable excuse, asked to receive a benefit for himself from a service provider, that the asking was serious even though disguised as a tentative joke, and that the intention behind the statements made by Dr Reddy in the Kreft version, which we prefer to his, was to suborn the service provider and to subvert the purposes of the Act.

[23] We are therefore obliged to make a determination in terms of s 124FF(2). We consider that the circumstances are so serious that the remedies of counselling or reprimand would not be appropriate. Like the Committee, we consider that the applicant should be disqualified pursuant to paragraph (d). As sub-section (4) prescribes a maximum disqualification period for this offence of 5 years, some indication is given of the seriousness with which Parliament viewed this particular offence. If the prohibited practice had involved receiving benefits in accordance

> with a longstanding arrangement, no doubt the maximum period of disqualification would be appropriate. In this case, we have found that the applicant in fact asked for a benefit. There is no evidence that he ever received any. The evidence in relation to the x-ray viewing boxes is too vague and contradictory to support a finding that he received a benefit in the form of a long term loan of this equipment. That being so, we share the view of the Committee that the offence should be recognised as being at the lower end of the range. The period of 6 months disqualification imposed by the Committee, it seems to us, also is an appropriate period.

In *Gheko Holdings Pty Ltd v The Chief Executive Medicare* judicial review was sought of a search warrant that sought computer records and other documents relating to the suspected commission of offences under Part IIBA. It was alleged that the warrant was defective as it concerned 'prohibited benefits', which was said not to be a defined term. The Court dismissed the application.[91]

Gheko Holdings Pty Ltd v The Chief Executive Medicare [2013] FCA 164 —

> [29] The first point the applicant made is that the references to "prohibited benefits" in the second and fourth paragraphs of the third condition of the warrant are meaningless because there is no such thing as a "prohibited benefit" in the statutory scheme. This argument is without substance. For one thing, it overlooks the effect of s 13 of the *Acts Interpretation Act 1901* (Cth) which provides:
>
> > (1) All material from and including the first section of an Act to the end of:
> > (a) if there are no Schedules to the Act—the last section of the Act; or
> > (b) if there are one or more Schedules to the Act—the last Schedule to the Act;
> > is part of the Act.
> >
> > (2) The following are also part of an Act:
> > (a) the long title of the Act;
> > (b) any Preamble to the Act;
> > (c) the enacting words for the Act;
> > (d) any heading to a Chapter, Part, Division or Subdivision appearing before the first section of the Act.
>
> [30] Accordingly, headings to sections in the Health Insurance Act form part of the Act, as do the simplified outlines which commence various provisions of that Act. The simplified outline for Div 2 Pt IIBA of the Health Insurance Act states that a benefit is prohibited if it is not a permitted benefit. The headings to ss 23DZZIK, 23DZZIL 23DZZIQ and 23DZZIR all refer to "prohibited benefits" in the context of relevant civil penalty provisions and relevant offences. It is true that in the substance of the sections themselves the reference is to a benefit which is "not a

[91] Subsequently an appeal was lodged to the Full Court and an application made for an injunction to stay the inspection of documents seized under the search warrant. The application was dismissed: *Gheko Holdings Pty Ltd (administrator appointed) v Chief Executive Medicare* [2013] FCA 293. The appeal was not pursued.

permitted benefit", but there is no doubt from the simplified outline and from the headings that the statute treats a benefit which is not a permitted benefit as a "prohibited benefit".

[31] For another thing, even without the assistance provided by s 13 of the Acts Interpretation Act, the applicant's approach is inconsistent with relevant principles.

[32] In *Different Solutions Pty Ltd v Commissioner, Australian Federal Police (No 2)* (2008) 190 A Crim R 265; [2008] FCA 1686 at [98] – [118] Graham J analysed many authorities dealing with the sufficiency of descriptions of offences in search warrants. At [108] Graham J noted that:

> Although a warrant must comply strictly with the statutory conditions for its issue (see *George v Rockett* [1990] HCA 26; (1990) 170 CLR 104 at 110–11 and *State of New South Wales v Corbett* [2007] HCA 32; (2007) 230 CLR 606 at [1], [3], [18]–[19], [87] and [95]–[100]), it should, like other documents, be read fairly and not perversely. The language used need not be elegant (see per Burchett in *Beneficial Finance* at 544 and 546; see also per Hely J in *Williams v Keelty* at [135]–[139]).

[33] To read the references to "prohibited benefits" in the third condition of the warrant in isolation from their context and without any regard to the relevant statutory scheme established by the legislation which is expressly identified in the third condition is both unfair and perverse.

[34] The second point the applicant made is that the reference to "Intelligent Chiropractic Supplies (ICS)" is itself meaningless or ambiguous because the warrant otherwise contains references to Intelligent Chiropractic Supplies Pty Ltd, Intelligent Chiropractic Supplies and Radiology Reporting Services Pty Ltd, ICS Imaging and Radiology Reporting Services Australasia Pty Ltd, and Gheko Holdings Pty Ltd trading as Intelligent Chiropractic Supplies and Chiropractic Practitioners. This complaint is also not well founded. The warrant is a warrant to enter the premises of Intelligent Chiropractic Supplies Pty Ltd. The warrant otherwise asserts that Gheko Holdings Pty Ltd trades by Intelligent Chiropractic Supplies Pty Ltd and through the same business name, albeit without the "Pty Ltd". In context the reference to "Intelligent Chiropractic Supplies (ICS)" is a reference to the company Intelligent Chiropractic Supplies Pty Ltd and the business of Intelligent Chiropractic Supplies. Again it would be perverse to read the third condition any other way in the context of the warrant as a whole.

[35] The third point made by the applicant is that the third paragraph of the third condition refers to Medicare provider benefits being "redirected" from Radiology Reporting Services Australia to Intelligent Chiropractic Supplies. The applicant contended that this was meaningless because it is not apparent from the description to where the original Medicare provider benefits were directed. This complaint also involves the perverse reading of the third paragraph. It is apparent that the benefits are being alleged to flow from Radiology Reporting Services Australia to Intelligent Chiropractic Supplies and thence to various chiropractic entities which have entered into service agreements with ICS.

[36] The fourth point made by the applicant is that the first sentence of the fourth paragraph of the third condition is meaningless because it asserts that s 23DZZIJ of the Health Insurance Act details circumstances in which a person can breach the "prohibited practice legislation" when in fact the section does no more than define a person who is connected to another person. It is true that s 23DZZIJ merely defines persons who are connected to other persons. But it does so in the context of Div 2 of Pt IIBA of the Health Insurance Act which deals with civil penalty provisions. Those civil penalty provisions include requirements for persons to be connected with other persons. Read in the context of the third condition as a whole, particularly the references to civil contraventions in the first paragraph of the third condition, it is apparent that the first sentence of the fourth paragraph of the third condition is identifying that the scheme involving the flow of Medicare provider benefits from Radiology Reporting Services Australia to Intelligent Chiropractic Supplies and thence to Chiropractic Entities engages the civil penalty provisions.

[37] The fifth point the applicant made is that the second sentence of the fourth paragraph of the third condition is also meaningless not only because it refers to "prohibited benefits (an argument rejected) above but also because it moves straight from s 23DZZIJ, which is relevant to civil penalty provisions, to s 23DZZIR which concerns offences. The mere fact that one sentence follows on from another and the two sentences deal with two different topics does not make either sentence meaningless, garbled or confused as the applicant contended. It is also apparent that by the second sentence it is being asserted that the scheme referred to in the third condition also engages the offence provisions contained in s 23DZZIR. Another point the applicant made about this same sentence is that the s 23DZZIR contains two offences. The offence in s 23DZZIR(1) involves a person offering or providing a prohibited benefit whereas the offence in 23DZZIR(3) involves the offence of a provider knowing that another person offers or provides a prohibited benefit. The fact that there are two offences does not support the applicant's contention that the warrant fails to state the nature of the relevant offence in relation to which the entry and search is authorised. As disclosed in the reasoning in Different Solutions a broad practical approach is taken to the requirement for the nature of the offence to be disclosed in a warrant rather than a narrow pedantic approach. In particular at [103] Graham J noted that:

> There is no room for a notion that if separate offences are rolled up in a search warrant, the warrant is in some way invalidated on grounds analogous to duplicity (per Hely J in *Williams v Keelty* [2001] FCA 1301; (2001) 111 FCR 175 at [142]).

[38] At [111] and [112] Graham J said:

> [111] The statement of an offence in a search warrant need not be made with the precision required for an indictment. That would be impossible, and indeed to attempt it would be irrational, bearing in mind the stage of the investigation at which a search warrant may issue. The purpose of the statement of the offence in a search warrant is not to define issues for trial, but to set bounds to the area of search which the execution of the warrant will involve, as part of an investigation into a suspected crime. The appropriate contrast is not with the sort of error which might vitiate an indictment, but with the failure to focus the

> statutory suspicion and belief upon any particular crime, with the result that a condition of the issue of the warrants is not fulfilled (per Burchett J in *Beneficial Finance* at 533 which was cited with approval by Heerey J in *Chong v Shultz* [2000] FCA 582; (2000) 112 A Crim R 59 ('*Chong v Shultz*') at [7]).
>
> [112] What the rule requires is identification (and so limitation) of an area of search by reference to a suspected offence, not the formulation of a pleading before the offence is capable of prosecution (per Burchett J in *Beneficial Finance* at 533–34).

[39] Further, as held in *Beneficial Finance Corporation v Commissioner of Australian Federal Police* (1991) 21 FCR 523 at 525 it is not essential that a warrant refer to a particular offence and authorise seizure by reference to that offence. As Burchett J said at 543, when assessing whether a warrant discloses the nature of the offence:

> The matter should be viewed broadly, having regard to the terms of the warrant in the circumstances of each case ... The precision required in a given case, in any particular respect, may vary with the nature of the offence, the other circumstances revealed, the particularity achieved in other respects, and what is disclosed by the warrant, read as a whole, and taking account of its recitals.

[40] In the present case it is apparent that when the warrant is read as a whole it concerns a complicated scheme involving the applicant and companies and businesses related to the applicant and their arrangements with numerous companies, businesses, medical practitioners and other people asserted to involve asking for, accepting, being offered, or being provided benefits which are not permitted benefits because the benefits are related to the number, kind or value of requests made by requesters. In the context of the warrant as a whole the nature of the potential civil contraventions and offences involved in the scheme are identified.

[41] The sixth point which the applicant made is that the third condition refers to a period from 1 March 2008 which is a period of over four years. The applicant contended that this was such a long period that length of time had to be taken into consideration when considering whether the warrant satisfied the requirements of s 8Y(5) of the Human Services (Medicare) Act. It is not apparent why the length of time involved places any greater compliance burden under s 8Y(5) than would otherwise be the case. Nor was any cogent argument put by the applicant to support its proposition that the length of time involved otherwise invalidated the warrant.

[42] The final point which the applicant made is that the third condition read as a whole, without the benefit of legal advice, is garbled, confused and meaningless. This submission seems to involve nothing more than wishful thinking on the applicant's part. Whether the third condition may be described as an example of elegant drafting or not is immaterial. What it is not is meaningless. In the context of the subject matter of the warrant the third condition, read in the context of the warrant as a whole satisfies the requirements of s 8Y of the Human Services (Medicare) Act.

> [43] For these reasons no inference can be drawn that the magistrate was misled as to the effect of the relevant legislation, nor that Mr McMillan was confused about the operation of the relevant legislation. The assertion by the applicant that the magistrate "must have been completely misled" is simply without foundation. The affidavit put before the magistrate by Mr McMillan does not support the applicant's case. To the contrary it provides further information in the third condition about the scheme said to provide reasonable grounds for suspecting the Commission of offences.

79A Object of this Part

Interpretation consistent with the objects of the PSR Scheme

The objects of the PSR Scheme, in section 79A, indicate that its function is to protect the integrity of the Commonwealth medicare benefits, dental benefits and pharmaceutical benefits programs, and in so doing, protect patients and the community in general from the risks associated with inappropriate practice, and protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

The protection of patients and the community and the protection of the Commonwealth, as provided for in paragraphs (a) and (b) of section 79A, are objects of Part VAA within the principal object of protecting the integrity of the specified programs.

Hamor v Determining Authority [2023] FCA 267 —

> [143] The fifth matter relied upon by the applicant is the proposition that protection of the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice is not an object of Part VAA of the Act, as such; and that, rather s 79A of the Act indicates that such protection may be achieved through the protection of the integrity of the Commonwealth Medicare benefits program. The appellant submitted that the Authority erred and acted unreasonably to the extent that it treated protection of Commonwealth funds as a stand-alone object.
>
> [144] I do not accept these submissions. Protection of the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice is clearly part of the object of Part VAA of the Act (see s 79A(b)) and thus was a matter properly taken into account. Further, it was not the only matter taken into account – as is clear from the Final Determination the Authority also took into account the protection of patients and the community in general from the risks associated with inappropriate practice (s 79A(a)) and the protection of the integrity of the medical benefits program (s 79A chapeau).

When interpreting provisions of the scheme in Part VAA of the Act, it is necessary to have regard to those objects and give the legislation a beneficial rather than a restrictive interpretation consistent with those objects. The NSW Supreme Court case of *Gorman v Health Care Complaints Commission* [2000], illustrates this approach to interpretation in the context of healthcare complaints legislation.

Gorman v Health Care Complaints Commission [2000] NSWSC 1228 —

> [30] … The first is the object of the Act. It is concerned with the protection of the health and safety of the public and requires the provision of mechanisms that are designed to ensure, inter alia, that medical practitioners are fit to practise medicine. The complaint procedure is one such mechanism. Proper ethical and professional standards must be maintained, "primarily for the protection of the public, but also for the protection of the profession" (*Health Care Complaints Commission v Litchfield* [1997] NSWSC 297; (1997) 41 NSWLR 630 at 637). The situation of the medical profession in relation to disciplinary powers is similar to the situation of the legal profession. (*Clyne v NSW Bar Association* [1960] HCA 40; (1960) 104 CLR 186 at 201-202; *NSW Bar Association v Evatt* [1968] HCA 20; (1968) 117 CLR 177 at 183-184). When construing procedural and like provisions of the Act relating to complaints, the object of the Act must be borne in mind as must the function of the Board expressed in s.132(2)(a) requiring it to promote high standards of medical practice. These considerations bespeak a beneficial rather than a restrictive construction of the Act.

80 Main features of the Professional Services Review Scheme

History

When the *Health Insurance Act 1973* commenced, it provided for a scheme of Medical Services Committees of Inquiry (MSCIs) to look into over-servicing by medical practitioners. In 1977, MSCIs were established in each State under section 80, as it then was. Each Committee had five members, four appointed by the Minister after consultation with the Australian Medical Association (the AMA), and the fifth being the Commonwealth Director of Health in each State. An Optometrical Services Committee of Inquiry was also established.

By agreement with the AMA, before a doctor was referred to an MSCI, the practitioner was first counselled by a Departmental Medical Officer and, if appropriate, warned that a failure to correct overservicing would lead to a reference to am MSCI. On referral, an MSCI conducted a hearing and reported to the Minister. An MSCI could recommend recovery of benefits for specifically identified excessive medical services, and it could issue a reprimand.

In December 1979, a submission was made to Cabinet[92] indicating the following difficulties with the system:

- an MSCI was required to discuss with the doctor each individual patient involved, and an MSCI could spend many months on the one case alone;
- some doctors had declined to attend the hearing;
- as membership of the MSCI was fixed, a specialist could claim that the MSCI members did not have the clinical competence to consider his or her case.

It was recommended that:

- in cases where there were a large number of patients, the MSCI could examine a representative sample and extrapolate the result to cover all patients;
- an MSCI be able to require a practitioner to attend and provide clinical notes;
- an MSCI be able to recommend that all or part of a practitioner's medical services be ineligible for medical benefits for a set period;
- MSCI membership be flexible, such that it could be expanded from time to time where particular medical specialties were involved;
- An MSCI be able to recommend counselling regarding a practitioner's pattern of servicing.

Cabinet did not immediately accept the recommendations, but agreed that there be consultation between the Minister for Health and the Attorney-General on the legal aspects of the recommendations. In May 1980 a further submission was made to Cabinet,[93] which agreed to amend the Act to provide for:

- MSCIs to be able to require the practitioner under review to attend the hearing and produce clinical notes, and be able to recommend that the doctor be counselled, in addition to existing sanctions (reprimand, or repayment of medical benefits);
- temporary members to be appointed to an MRSI where a vacancy occurs, pending the formal appointment of a replacement member.

Cabinet also agreed that the Minister for Health continue to consult with the Attorney-General regarding more effective procedures and penalties for the control of overservicing, including those suggested in December 1979, with a view to bringing in legislative amendments in 1981.

[92] Cabinet Submission No. 3733, 18 December 1979.
[93] Cabinet Submission 4007, 21 May 1980.

In 1981, the Act was amended:[94]

- to enable the Minster to appoint a member for up to 3 months without consulting the AMA;
- the permit a member to summon the practitioner to attend a hearing and produce documents;
- to enable a practitioner who attended in response to a summons to be represented at the hearing by another person, and to call witnesses;
- to enable an MSCI to recommend that a practitioner be counselled.

In December 1992, in its report, *Medifraud and excessive servicing: Health Insurance Commission*,[95] the Australian National Audit Office found that the MSCIs were not operating satisfactorily and needed further powers:[96]

> A major complaint in the ANAO report was that the MSCI process did little to discourage the provision or initiation of excessive services. The MSCIs did not provide an effective deterrent because, in many instances, the level of benefits recovered from practitioners was totally eclipsed by the level of overservicing that had actually occurred.
>
> The inability to impose penalties commensurate with the extent of a practitioner's overservicing was largely due to a lack of power to make decisions on the extent of overservicing on the basis of generalised evidence. MSCI judgements about overservicing could only be made on the basis of individual services—that is, benefit recovery and penalties could only be made in respect of the identified excessive services.

In 1994, the scheme was overhauled, and the PSR Scheme replaced the MSCI scheme. Under the PSR Scheme, the broader concept of 'inappropriate practice' replaced the concept of 'excessive servicing', and permitted a sampling process to occur to enable findings from a representative sample to be extrapolated to the entire class of services. (Due to complexities in the sampling system, the sampling regime was repealed in 1997, but was replaced with a new system when the scheme was reviewed and amended in 1999.)

The 1994 legislation provided for the following scheme, as described in *The Report of the Review Committee of the Professional Services Review Scheme*, 1999, at p. 10:

- The HIC monitors the Medicare claiming patterns of health practitioners. The HIC identifies and counsels practitioners with atypical behaviour for which a reasonable explanation was not apparent. Where no or insufficient change

[94] *Health Acts Amendment Act 1981*, Act No. 118 of 1981.
[95] Audit Report No.17 1992-93.
[96] *The Report of the Review Committee of the Professional Services Review Scheme*, 1999, at p. 9.

in behaviour occurs following counselling, the HIC prepares and refers cases to the DPSR.

- The DPSR must dismiss a referral or establish a PSRC (the members of which are selected from the practitioners on the Professional Services Review Panel) to consider whether the practitioner concerned has engaged in inappropriate practice.
- The PSR Scheme examines professional practices in relation to Medicare and aspects of the Pharmaceutical Benefits Scheme (PBS). If a PSRC, in the course of its examination of a referral, comes to the view that the PUR may have committed fraud, it must report its concerns to the HIC and suspend its consideration of the referral. The HIC may subsequently return the referral, possibly modified, to the PSRC, and it would recommence consideration of the referral.
- If a PSRC thinks that the material before it indicates that action should be taken against the PUR 'in order to lessen a serious threat to the life or health of any person', it must report its concerns to the relevant regulatory body, for example, a State Medical Board, without suspending its consideration of the referral (s.106P).
- The PSRC conducts hearings, makes findings and prepares a report setting out its findings on whether the practitioner has, in its opinion, engaged in inappropriate practice.
- A report is given to the Determining Officer (DO) and, if the report makes a finding that the practitioner has engaged in inappropriate practice, the DO must make a draft determination. This must be given to the practitioner to enable him or her to make submissions in response.
- The DO must then make a final determination containing one or more directions of the kind set out in section 106U(1), for example, that the practitioner be reprimanded, counselled, repay to the Commonwealth an amount equivalent to any medicare benefit paid for inappropriate services, or that the practitioner be suspended (or disqualified) for periods up to three years in respect of the provision of Medicare services.
- If the practitioner is aggrieved by the final determination, he or she has a right of appeal to the PSRT. A practitioner can be legally represented at a Tribunal.
- A PSRT has power to review a determination. The Act provides a PSRT's decision is final, subject to the Constitution, and except for an appeal to the

Federal Court on a question of law only, or an appeal brought in accordance with the Federal Court of Australia Act 1976.

- Section 106X of the Act mandates that a practitioner with two effective final determinations must be referred to a Medicare Participation Review Committee (MPRC). Such referrals can have serious consequences for a practitioner, including suspension from the Medicare arrangement for a period up to five years.

In 1999, a Committee chaired by Dr Bill Coote, Secretary General of the AMA, and including Dr John Holmes, the Director of PSR, conducted a review of the PSR Scheme, and recommended a number of changes, including: [97]

- consolidating the existing PSR functions into a single agency with increased funding to support its expanded investigative and administrative functions;
- providing legal support to the peer review committees through a legal adviser who will assist the committee on matters of law, and by introducing comprehensive training and operating protocols for committee members;
- allowing greater legal support to the practitioner under review (PUR) so that his or her legal adviser has the right to address the committee throughout the hearing on matters of law and a right to a final address to the committee on the merits of the case as well as matters of law;
- replacing the Determining Officer (currently in the Department of Health and Aged Care) with a Determining Panel (comprising a permanent medical practitioner chair, a permanent lay person and a third member who is a representative of the profession of the PUR) also to be serviced by the new agency;
- structuring the Agency so that support (including legal support) for investigations, committees and determining panels will be clearly separated; and
- removing the PSR Tribunal from the process in recognition that review on the merits of the final determination is not appropriate in a scheme in which the key judgment is a professional judgment by the practitioner's peers about the practitioner's conduct.

The Committee's recommendations were largely adopted by the Government, and in 1999, the Act was amended to implement the new PSR structure.

[97] *The Report of the Review Committee of the Professional Services Review Scheme*, 1999, at p.2.

Pradhan v Holmes [2001] FCA 1560 —

> [6] The Scheme itself involves four tiers or steps. The first three relate to determining whether (inter alia) a medical practitioner has engaged in "inappropriate practice" in connection with the rendering or initiation of services for which a medicare benefit was payable. The fourth tier or step involves the imposition of a sanction on a practitioner who has been found to have engaged in "inappropriate practice".

Health Care Complaints Commission v Do [2014] NSWCA 307 (per Meagher JA) —

> [35] The objective of protecting the health and safety of the public is not confined to protecting the patients or potential patients of a particular practitioner from the continuing risk of his or her malpractice or incompetence. It includes protecting the public from the similar misconduct or incompetence of other practitioners and upholding public confidence in the standards of the profession. That objective is achieved by setting and maintaining those standards and, where appropriate, by cancelling the registration of practitioners who are not competent or otherwise not fit to practise, including those who have been guilty of serious misconduct. Denouncing such misconduct operates both as a deterrent to the individual concerned, as well as to the general body of practitioners. It also maintains public confidence by signalling that those whose conduct does not meet the required standards will not be permitted to practise.

Sevdalis v Director of Professional Services Review [2016] FCA 433 —

> [73] Part of the role and function of Pt VAA in the legislative scheme is to monitor and, if necessary, investigate whether what a practitioner has been paid by way of her or his entitlement under s 10 accords with the scheme. Since the introduction of the concept of "inappropriate practice" as the touchstone for the review, as well as the investigation and determination functions in Pt VAA, there is no doubt that practitioners' conduct is exposed to review on broader grounds than their entitlement to payment in accordance with the Act and regulations.
>
> …
>
> [77] As these observations make clear, the two-stage system established by Pt VAA for peer review by, first, a Committee and then, the Determining Authority, authorises a broad review and investigation of the way in which a practitioner delivered services to patients, well beyond whether the practitioner was entitled to a medicare benefit for a particular service in accordance with the Act and regulations.

Procedural fairness

The PSR Scheme involves a multi-step process, which provides a person under review with many opportunities to respond to concerns and matters that might result in an adverse outcome. The Scheme should be considered as a whole before seeking to impose further requirements of procedural fairness that are not expressly provided

for in the legislation. Nevertheless, situations may arise where a person under review misunderstands the nature of concerns put to them that may call for a further opportunity to be heard.

Phan v Kelly [2007] FCA 269 —

> [42] The question is whether the statutory provisions are effective to exclude any supplementary duty of fairness under the common law. In order to exclude the rules of natural justice, the legislative intent must be clearly evident and cannot be discerned from indirect references, uncertain inferences or equivocal considerations: *Commissioner of Police v Tanos* [1958] HCA 6; (1958) 98 CLR 383 at 396.
>
> [43] In assessing the procedural fairness requirements in the present case, a relevant consideration is whether the respective decisions of the Director and the Committee may be said to part of the one decision-making process. In the matter of *Ainsworth v Criminal Justice Commission* [1992] HCA 10; (1992) 175 CLR 564, the High Court considered whether the operation of the Criminal Justice Commission of QLD and Parliamentary Criminal Justice Committee could be said to be part of a unitary decision-making process. This, in their Honours' view, was an essential requirement in excluding the duty. At 578, Mason CJ, Dawson and Toohey JJ noted:
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> > 'It is not in doubt that, where a decision-making process involves different steps or stages before a final decision is made, the requirements of natural justice are satisfied if "the decision-making process, viewed in its entirety, entails procedural fairness" (*South Australia v O'Shea* [1987] HCA 39; (1987) 163 CLR 378 at 389).'
>
> [44] Accordingly, it is permissible to have regard to the scheme as a whole. Looking at the process in the present case in its entirety, the contested decisions of the Director and Committee were clearly part of, and directed to, the ultimate determination by the Determining Authority. They may be characterised as part of a single, sequentially-stepped decision-making process leading to a final outcome. This consideration leads to the conclusion that the legislative scheme is sufficiently exhaustive to indicate a legislative intent to exclude the application of additional measures to achieve procedural fairness.
>
> [45] As counsel for the Respondents points out, and as appears from the material attached to the Adjudicative Referral, the reports prepared by Dr Davidson and Dr Dawson were not before the Committee, which proceeded to hear the matter on the material before it. Accordingly, it cannot be said that the Committee's decision was "infected" or "poisoned" in any way by the two reports.
>
> [46] In this case, I am satisfied that the statutory scheme, considered as a whole, exclusively provided for procedural fairness principles to the extent that the legislature intended those principles to apply. I am satisfied that in its entirety, the process in fact afforded procedural fairness to the Applicant in respect of the Director's decision. Accordingly, I do not consider that there is any substance in the procedural fairness argument based on the Director's examination of the reports of Dr Davidson and Dr Dawson.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2020] FCA 386 —

Ground 5: Procedural fairness

[127] NHDS's procedural fairness complaint was pressed on two limbs, being that:
(a) it was not given adequate notice of significant matters in the s 93 referral and report; and
(b) procedural unfairness arises from [91] of the s 93 report.

[128] For the reasons which follow, I consider that both limbs of NHDS's procedural fairness claims should be upheld.

(a) No adequate notice of significant matters in s 93 referral and report

[129] NHDS's complaint under the first limb is that it was not provided with the following information prior to the Director's decision to make the s 93 referral:
(a) how any of the 15 practitioners mentioned in the s 89C report or any of the 56 practitioners mentioned in the s 93 report may have engaged in conduct that constituted inappropriate practice during the review period;
(b) how any of those practitioners may have been employed by NHDS; and
(c) how NHDS may have knowingly, recklessly or negligently caused or permitted any inappropriate conduct of each of those practitioners.

[130] NHDS complains that it was only provided with generalised information without it having any way of knowing how that information related to any of the particular practitioners mentioned in either of those reports or the services rendered. It submitted that it was procedurally unfair for the Director to lead NHDS to believe that the 15 unidentified practitioners in the s 89C report would be the subject of the potential referral, but then identify 56 different practitioners in both the s 93 referral and related report. It complains that it was denied an opportunity to make submissions to the Director as to whether or not it was appropriate for the Director to make a referral with specific reference to those 56 practitioners and the services they had rendered as MBS item 597.

[131] Unsurprisingly, there was no serious contest as to the relevant legal principles concerning procedural fairness. The Director accepted that the statutory scheme imposed various procedural fairness obligations on her and that the content of those obligations had to be determined in the context of the statutory scheme. The Director submitted, however, that, in determining the content of procedural fairness obligations, it was relevant to take into account that a s 93 referral occurs at a relatively early stage of the review process and prior to an investigation of whether inappropriate practice has in fact occurred, not to mention well before the imposition of any sanction. It was submitted that a s 93 referral "lacks any quality of finality" and "is not a substantive determination".

[132] While it is relevant to take into account the different tiers of decision-making under the PSR Scheme, I consider that the Director has overstated the relevance of that matter in determining the content of procedural fairness requirements in tier 2. Different considerations may arise with a multi-staged decision making process which, unlike the legislative regime here, does not contain its own rich supply of

procedural fairness requirements. It is also relevant to take into account the essentially investigative nature of tier 2 and that the person under review will have a right to be heard before the Committee if a referral is made under s 93. Of particular relevance and significance, however, is the Director's obligation under s 89C to make a decision under s 91(1) to take no further action in relation to the review, rather than enter into a s 92 agreement (which was not an option in the case of NHDS) or make a referral under s 93.

[133] The point is well illustrated by a decision of the Victorian Court of Appeal in *Byrne v Marles* [2008] VSCA 78; 27 VR 612, which the Court drew to the parties' attention. There, Nettle JA (with whom Dodds-Streeton JA and Coghlan AJA agreed) highlighted the difference between the circumstances in *Cornall v AB (A Solicitor)* [1995] VICSC 7; [1995] 1 VR 372 and the circumstances in 2004 after amendments were made to the State legislation regulating the legal profession in Victoria. His Honour made the following observations at [85] to [87], which are apposite to the position under the PSR Scheme (footnotes omitted and emphasis added):

> [85] Now, however, because the Commissioner is compelled by s 4.2.8 of the 2004 Act to give notice of the complaint to the solicitor as soon as practicable after receipt, and to make a preliminary decision whether to dismiss the complaint summarily before going further with the investigation, it appears to me that the statute evinces an intention that the Commissioner should give notice of a complaint to the solicitor more or less immediately after receipt, and then take into account anything about the complaint which the solicitor may wish to submit, before determining whether to dismiss the complaint summarily or to go on to investigate it further or to refer it to the Institute for investigation. Otherwise, why provide, as s 4.2.8 so clearly does provide, that the Commissioner must notify the solicitor of the complaint as soon as practicable after receipt?
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> [86] As has been seen, the essence of the reasoning of the court in *Cornall v AB* was that, because the function of the Secretary under the 1958 legislation did not involve any more than satisfaction as to facts sufficient to form a prima facie case, there was little practical merit in providing the solicitor with an opportunity to make submissions or adduce facts. The solicitor's right to natural justice was said to be adequately protected by his right to be heard before the tribunal which would decide the charge. Now, however, the position under the 2004 Act appears to be such that the Commissioner has an independent obligation under s 4.2.10 to determine whether a complaint is to be dismissed summarily or not proceeded with further. If so, there is practical merit in providing the solicitor with an opportunity to make a submission or adduce facts to the Commissioner before the Commissioner determines that the complaint is a disciplinary complaint which needs be investigated. *The right to be heard at that stage affords the solicitor an opportunity to head off the complaint* in limine*, by persuading the Commissioner not to treat it as a disciplinary complaint or to dismiss it or not proceed with it under s 4.2.10. And such a right to be heard is essentially different to any which the solicitor may later be accorded by the Institute or the Board.*
>
> [87] In the result, it appears to me as a matter of statutory construction that the structure and operation of Part 4.2 imply an expectation that the Commissioner

will give the solicitor a right to be heard at the outset before making the preliminary decision for which s 4.2.10 provides. The position is analogous to *Ainsworth* and *Johns*.

[134] These observations are directly pertinent to the proceeding here having regard to the terms and effect of s 89C(1) and with its particular reference to s 91. A right to be heard by the person under review affords that person an opportunity to persuade the Director to terminate the complaint at a relatively early stage. That right is different from the rights which the person under the review who is the subject of a subsequent referral has before the Committee.

[135] I shall now explain why I consider that NHDS was denied procedural fairness in respect of the s 93 referral and the related report.

[136] As has been emphasised above, a not insignificant part of the s 89C report refers to findings made by the Director in respect of 15 NHDS practitioners. Their conduct provided an important basis (even if it was not the only basis) for the Director's decision that she would not make a decision under s 91 to take no further action in relation to the review and that, instead, she would proceed to determine which of the available courses of action specified in s 89C(2) she might take in respect of NHDS, having regard to any written submissions made by NHDS within the prescribed timetable about those matters.

[137] It is plain that NHDS understood that the Director's continuing review related, at least in part, to the conduct of those 15 practitioners. This is reflected in the contents of NHDS's written submissions dated 30 May 2019 (see [102] ff above).

[138] Given the wording of the s 89C report, I accept NHDS's submission that it did not, and could not, reasonably have contemplated the possibility that the Director would make a referral in respect of the 56 NHDS practitioners identified in Item 2 to the referral, who were entirely separate to those 15 practitioners, and whose conduct as reflected in the Medicare data was also taken into account by the Director. The Director did not dispute NHDS's contention in the proceeding that the data provided by Medicare relating to total services billed as MBS items 597, 598, 599 and 600 by NHDS practitioners included the 56 practitioners identified in Item 2 of the referral. The Director gave NHDS no prior notice that she intended to rely upon the conduct of those 56 practitioners in determining that their conduct should be the focus of the s 93 referral.

[139] Thus NHDS was denied a prior opportunity to seek to persuade the Director that she could not reasonably be satisfied that the conduct of these 56 practitioners involved inappropriate practice in respect of MBS item 597 and that the review should be terminated.

[140] I also accept NHDS's contention that the submissions it made, and was entitled to make, in accordance with s 89C(1)(b)(ii) would not necessarily have been the same if it had been given proper notice of the Director's intention to rely upon the conduct of the 56 NHDS practitioners specified in Item 2 of the s 93 referral.

[141] It is important to bear in mind that there were three elements of "inappropriate practice" which the Director relied upon in making the s 93 referral, namely:
(a) knowingly, recklessly, negligently causing or permitting certain conduct;
(b) which included the conduct of one or more practitioners employed by NHDS; and
(c) the conduct constituted "inappropriate practice" as defined in s 82.

[142] Procedural fairness obliged the Director to provide NHDS with a reasonable opportunity to address those three elements, which required the Director to provide NHDS with appropriate particulars and/or information in respect of those three matters with reference to the 56 identified NHDS practitioners. There is an obvious connection between the provision of a s 89C report and the obligation of the Director to invite submissions as to the future course of action, as required by s 89C(1)(b)(ii). Having regard to the contents of the s 89C report, NHDS reasonably believed that the conduct of the other 15 NHDS practitioners formed an important part of the Director's decision not to terminate the review at that point and that their conduct would also be relevant in determining what future course of action the Director might take. That this was NHDS's belief is abundantly clear by the terms of its 30 May 2019 submissions (see [102] ff above).

[143] There is also a plain connection between the making of those submissions and the effect they may have on the Director's decision under s 93, as is emphasised by the explicit obligation on the Director under s 89C(2) to take into account those submissions in deciding whether or not to make a referral to a Committee.

[144] The Director effectively shifted the goal posts after receiving NHDS's submissions so as to bring to the forefront of the Director's further deliberations the conduct of 56 other NHDS practitioners. The Director took their conduct into account (as well as other matters, including the conduct of the other 15 NHDS practitioners), in referring the matter to the Committee. NHDS was given no notice of this significant change in the focal point of the review. The statutory requirements of procedural fairness under the PSR Scheme would be seriously compromised if the Director proceeded as she has done without giving NHDS proper notice and relevant information about the significant change in direction she had taken.

[145] As NHDS pointed out at [28] of its written submissions in the proceeding, disclosing that it is alleged, for example, that "the person knowingly permitted their employee Dr A to engage in such-and-such inappropriate practice says nothing as to whether Dr B engaged in that or some other inappropriate practice, whether this was knowingly permitted by the person, or whether Dr B was employed by them". This proposition is patently correct.

[146] As noted, the Director did not submit that the PSR Scheme in the HI Act constituted an exhaustive procedural code which precluded the implication of any additional requirements of procedural fairness. Nor would I have accepted any such submission. The richness of the statutory procedural requirements in the multi-stage process under the PSR Scheme are not exhaustive. In particular, the procedural fairness rights and obligations under tier three do not deny the need for procedural fairness at the tier two level. The Director has a statutory power under s 91 at that stage to terminate a review and not make a referral under s 93.

[147] The regime in force in 1989 (i.e. well before the PSR Scheme was first inserted in 1994), and which was the subject of the Full Court's decision in *Edelsten v Health Insurance Commission* (1990) 27 FCR 56; 96 ALR 673, was notably different from that which was introduced in 1994 and later by the 2002 Amendment Act. It is that regime which was in force at the relevant time for the purpose of the current proceeding. One of the significant changes was the introduction of the four tiers and the enhancement of the Director's powers under tier 2, including the power to terminate a review in accordance with s 91. In particular, there was no provision such as s 91 under that previous regime. The significance of such a provision in a multi-stage decision-making process is highlighted by what was said analogously in *Byrne*, as referred to at [133] above.

[148] I also accept NHDS's submission that the Director may have reached a different decision on the matter had NHDS been afforded the opportunity to respond to particulars or information concerning the 56 practitioners, including as to whether a Committee might reasonably find that those 56 practitioners had engaged in conduct that constituted inappropriate practice (with particular reference to the three matters identified in [10(a)] of the s 93 report).

[149] I reject the Director's submission that the procedural unfairness was not material, relying upon cases such as *Minister for Immigration and Border Protection v SZMTA* [2019] HCA 3; 264 CLR 421 at [4], [41] and [93] and *Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Lam* [2003] HCA 6; 214 CLR 1 at [37] per Gleeson CJ regarding the concern of the law of procedural fairness being "to avoid practical injustice".

[150] In *SZMTA*, the plurality (Bell, Gageler and Keane JJ) said the following in respect of the requirement of materiality in the case of an undisclosed notification (at [45] and [46]):

> [45] Materiality, whether of a breach of procedural fairness in the case of an undisclosed notification or of a breach of an inviolable limitation governing the conduct of the review in the case of an incorrect and invalid notification, is thus in each case essential to the existence of jurisdictional error. A breach is material to a decision only if compliance could realistically have resulted in a different decision.
>
> [46] Where materiality is in issue in an application for judicial review, and except in a case where the decision made was the only decision legally available to be made, the question of the materiality of the breach is an ordinary question of fact in respect of which the applicant bears the onus of proof. Like any ordinary question of fact, it is to be determined by inferences drawn from evidence adduced on the application.

[151] The plurality's further observations at [49] of *SZMTA* are also apposite (footnotes omitted):

> [49] Where non-disclosure of a notification has resulted in a denial of procedural fairness, the similar question that remains for the court on judicial review of a decision of the Tribunal is whether there is a realistic possibility that the Tribunal's decision could have been different if the notification had been disclosed so as to allow the applicant a full opportunity to make

submissions. Whilst "[i]t is no easy task for a court ... to satisfy itself that what appears on its face to have been a denial of natural justice could have had no bearing on the outcome", the task is not impossible and can be done in these appeals.

[152] I accept that NHDS carried the burden of establishing that the procedural unfairness was material, but I do not accept the Director's contention that this burden was not discharged. First, it is no answer to say, as the Director did, that any submission that NHDS says it was prevented from making to the Director prior to her s 93 referral decision will be able to be made to the Committee. This ignores the importance of the opportunity afforded to NHDS under the PSR Scheme to seek to persuade the Director as to what future course she should take in circumstances where, having reviewed the s 86 request, she determined on 3 April 2019 that, at that stage of her review, the review process should proceed and not be terminated at that point.

[153] Secondly, nor is it an answer to contend, as the Director did, that some significance should attach to the fact that NHDS was in no different position *viz a viz* its lack of information concerning the services rendered by the 56 practitioners than was the case in relation to the 15 practitioners. This ignores the explicit complaints raised by NHDS in its 30 May 2019 submissions regarding the lack of more detailed information concerning the conduct of those 15 practitioners and that its submissions were thus necessarily confined to those practitioners alone. Moreover, as will shortly emerge, the second limb of NHDS's procedural fairness complaint, which is directed to the lack of detailed information provided to it concerning those 15 practitioners, will be upheld.

[154] Thirdly, contrary to the Director's contention, I do not consider that it was incumbent on NHDS to adduce evidence in the proceeding that it was misled or did not contemplate a referral extending beyond the 15 practitioners, or that it would have made different submissions if it had been provided with information regarding the 56 practitioners. There is nothing in *SZMTA* which casts doubt on the correctness of what Gageler and Gordon JJ said on this subject in *Minister for Immigration and Border Protection v WZARH* [2015] HCA 40; 256 CLR 326 at [60]. Their Honours said there that if the procedure adopted by the relevant decision-maker can be shown itself to have failed to afford a fair opportunity to be heard, "a denial of procedural fairness is established by nothing more than that failure, and the granting of curial relief is justified unless it can be shown that the failure did not deprive the person of the possibility of a successful outcome". As their Honours explained, the practical injustice in such a case "lies in the denial of an opportunity which in fairness ought to have been given".

[155] Finally, I should add that I reject the Director's contention, made in oral address, that if she had appreciated that a focus of the first limb of NHDS's procedural fairness case related to the non-provision to NHDS of details of the 300 plus particular services which the Director had sampled, she would have wished to put on some evidence which explained the reasons why that information had not been provided. That this matter figured in NHDS's procedural fairness case was made sufficiently clear in [18] and [19] of its FAOA. Indeed, the Director was aware as early as 30 May 2019 that this was NHDS's position, having regard to the explicit complaint it made in its written submissions of that date.

[156] The procedural unfairness has the effect of vitiating the s 93 referral.

(b) Procedural unfairness arising from [91] of the s 93 report

[157] The second limb of NHDS's procedural fairness case relates to [91] of the s 93 report, which is set out at [115] above. In substance, the Director conceded there that NHDS had insufficient information regarding the 15 practitioners and the 300 plus services rendered by them which had been reviewed by the Director for the purposes of the s 89C report. Thus it was unable to conduct an analysis of those services and make any substantive submissions in relation to each of those 15 practitioners' conduct. The Director then reasoned that she would draw no adverse inference from the lack of any substantive response by NHDS on those matters but added that the 15 practitioners themselves had each responded to the relevant concerns. She said that, despite those responses, her concerns remained and that nothing in NHDS's submissions had allayed those concerns.

[158] This reasoning is a patently inadequate response to NHDS's complaint of procedural unfairness. It is to be recalled that it was NHDS whom the Director was proposing to be the person under review. Moreover, the other 15 NHDS practitioners had been the subject of an earlier separate review which had produced the outcomes described at [123] above. Merely because the Director was dissatisfied with the responses of those 15 practitioners did not excuse her from providing NHDS, as the person under review, with relevant and significant information concerning the 15 NHDS practitioners and the services rendered by them which the Director reviewed, as well as an opportunity to respond to that material. The Director was, of course, entitled to take into account and assess the adequacy of the individual responses she received from the 15 medical practitioners, but that did not obviate the need for her to provide appropriate procedural fairness to NHDS given that it was the person referred for review. It is possible that NHDS may have been able to provide the Director with information by way of response which allayed some or all of the concerns she had. This required the Director to provide sufficient information to NHDS to enable it, if it so wished, to conduct an analysis of the services and of the 15 practitioners' conduct. The failure to provide that opportunity and information amounted to procedural unfairness, which also vitiates the s 93 referral.

[159] It is no answer to say, as the Director did in her submissions in the proceeding, that NHDS could have done its own sampling. That submission is inconsistent with the Director's own acknowledgement in [91] of her s 93 report of NHDS's disadvantage with particular reference to the lack of information it had on the 300 plus services provided by the 15 practitioners which the Director had reviewed and relied upon in her s 89C report. Moreover, it is plain from the terms of the s 93 report that, even though the central focus may have switched from those 15 practitioners to 56 other NHDS practitioners, the Director continued to rely upon information relating to those 15 practitioners in determining to make the s 93 referral. There are numerous references in the s 93 report to the Director's analysis of and findings in respect of those 15 practitioners.

[160] For similar reasons to those given above in respect of the first limb of NHDS's procedural fairness case, I also find that the procedural unfairness under the second limb was material and amounted to a jurisdictional error.

80A Additional operation of this Part

Section 80A clarifies the extent of the effect of those provisions in the scheme that require the repayment of benefits (paragraphs 92(2)(b), 106U(1)(ca) and (cb)). While those provisions expressly concern repayment of benefits where the services were rendered or initiated, section 80A clarifies that the requirement to repay benefits can also apply, whether or not the services were rendered or initiated, but where the practitioner received a payment for, or billed for, the particular services.

This provision, while not referred to by the Court in *Health Insurance Commission v Grey* [2002] or in *Selia v Commonwealth* [2017], would provide a further basis for the decisions of the Court in those cases that it is open for a Committee to make findings of inappropriate practice, and for the Determining Authority to require repayment of benefits, where the particular services were not actually rendered, but were claimed for, by the person under review.

81 Definitions

'adequate and contemporaneous records'

Subsection 81(1) provides that adequate and contemporaneous records of the rendering or initiation of services means records that meet the standards prescribed by the regulations for the purpose of this definition. Section 6 of the *Health Insurance (Professional Services Review Scheme) Regulations 2019* provides:

> For the purposes of the definition of adequate and contemporaneous records in subsection 81(1) of the Act, the standards for a record of the rendering or initiation of services to a patient by a practitioner are that:
> (a) the record must include the name of the patient; and
> (b) the record must contain a separate entry for each attendance by the patient for a service; and
> (c) each separate entry for a service must:
> (i) include the date on which the service was rendered or initiated; and
> (ii) provide sufficient clinical information to explain the service; and
> (iii) be completed at the time, or as soon as practicable after, the service was rendered or initiated; and
> (d) the record must be sufficiently comprehensible to enable another practitioner to effectively undertake the patient's ongoing care in reliance on the record.

This definition relates to the requirement in subsection 82(3) that a Committee must, in determining whether a practitioner's conduct in connection with rendering or initiating services was inappropriate practice, have regard to whether or not the

practitioner kept adequate and contemporaneous records of the rendering or initiation of the services.

'findings'

In relation to a draft report or final report of a Committee, 'findings' means the Committee's findings as to whether the person under review engaged in inappropriate practice in the provision of some or all of the services specified in the referral made to the Committee. Section 106KD provides that a Committee must prepare a draft report of preliminary findings, including the respective preliminary findings of each of the Committee members if they are not agreed on their findings, and setting out reasons for those preliminary findings. Similarly, section 106L provides that a Committee must prepare a final report setting out its findings or the findings of each of its members if they are not agreed on their findings.

'practitioner'

Subsection 81(1) defines 'practitioner' for the purposes of the profession of health practitioner who can be the subject of a request for review by the Chief Executive Medicare. It means, a medical practitioner, a dental practitioner, a participating optometrist (other than a polity, or a corporation), an optometrist other than a participating optometrist, a midwife, a nurse practitioner, a chiropractor, a physiotherapist, a podiatrist, an osteopath, or a health professional of a kind determined by the Minister under subsection 81(1A) to be a practitioner for the purposes of Part VAA of the Act.

The *Health Insurance (Professional Services Review—Allied Health and Others) Determination 2012* determines the following professions to be 'practitioners' for the purposes of Part VAA of the Act: audiologists, diabetes educators, dieticians, exercise physiologists, mental health nurses, occupational therapists, psychologists, social workers, speech pathologists, Aboriginal and Torres Strait Islander health practitioners, Aboriginal health workers, and orthoptists.

'provides services'

Subsection 81(2) provides that a person provides services if the services are rendered or initiated by the person, or a practitioner employed or otherwise engaged by the person, or a practitioner employed or otherwise engaged by a body corporate of which the person is an officer.

I-MED Radiology Network Limited v Director of Professional Services Review [2020] FCA 1645 —

> [9] The effect of s 81(2) is, according to its terms, to expand the reach of the person who has rendered or initiated a service beyond a practitioner who has so done.
>
> …
>
> [45] … The expansion of the definition of "provides services" beyond the individual practitioner who has physically provided them doubtless reflects recognition by Parliament of contemporary arrangements in the medical, dental and pharmaceutical professions and allied health-related occupations. …

Peverill v Backstrom [1994] FCA 1565 [this case refers to previous provisions of similar effect] —

> [100] … it should be noted that sub-s. 105 (2A) contains provisions, equivalent to sub-s. (2), with respect to the disciplining of employers who cause or permit employed practitioners to render excessive services. However, this sub-section was not utilised by the Committee in making its recommendations. The recommendations were expressly made pursuant to sub-s. 105 (2). This is not surprising as Dr Peverill had declared upon the relevant Medicare assignment form in respect of every service the subject of investigation that he had "actually rendered the services". He was the person who received the Medicare payment in respect of the services. This was because he was the pathology practitioner who had given the relevant undertaking.
>
> [101] In view of the fact that the Committee's concern was with the system administered by Dr Peverill, that Dr Peverill was clearly the controlling hand behind his practice and that all the procedures the subject of inquiry were authorised and approved by Dr Peverill, it is difficult to see any error made by the Committee in approaching the matter on the basis that Dr Peverill was fully responsible for the rendering of the relevant services. …

'service'

'Service' is defined in subsection 81(1) mean a service for which a medicare or dental benefit was payable at the time it was rendered, or a service for which a medicare benefit would have been payable at the time it was initiated if it had been rendered, or the prescribing or dispensing of a pharmaceutical benefit under Part VII of the *National Health Act 1953*.

Doan v Health Insurance Commission [2002] FCA 1160 —

> [81] Further, the definitional chain of "inappropriate practice" in the HI Act and the overall issue of whether the practitioner has engaged in "inappropriate practice" necessarily demands an analysis of particular questions, including whether the service is clinically relevant, whether the services rendered or initiated in the referral period were necessary, whether there was an appropriate level of clinical

input and whether the services were appropriate. In this way, from the definition of s 82 of inappropriate practice, one has to go to s 81(1) which defines a "service" as a service for which "at the time it was rendered or initiated, a Medicare benefit was payable", such Medicare benefits being payable where, "on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person..." (s 10(1)). The meaning of "professional service" in s 3 then directs one to the meaning of a "clinically relevant service" which is defined as a "service rendered by a medical ... practitioner ... that is generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered": s 3.

'service' — DVA treatment service

Paragraph (c) of the definition of **'service'** provides for a service rendered in connection with the provision of treatment under a relevant DVA law, and is of a kind that, if the service had not been rendered under the relevant DVA law, medicare benefit or dental benefit would have been payable in respect of the service. Relevant DVA law is defined in subsection 81(1) to mean any of the following:

(a) the *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006*;

(b) Chapter 6 of the *Military Rehabilitation and Compensation Act 2004*;

(c) the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*;

(d) the *Treatment Benefits (Special Access) Act 2019*;

(e) Part V of the *Veterans' Entitlements Act 1986*;

(f) any other Commonwealth law prescribed by the regulations for the purposes of this paragraph.

Legislative instruments have been made for the purposes of each of these Acts that provide the detail of the rules relating to the provision of **'treatment'** under DVA law.[98] For example, under the *Veterans' Entitlements Act 1986*, there is a legislative

[98] Section 16 of the *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006* (the APBNTBCOC(T) Act) provides, in effect, that the *Treatment Principles* made under section 90 of the *Veterans' Entitlements Act 1986* apply in relation to eligible persons under the APBNTBCOC(T) Act. The *MRCA Treatment Principles* is the legislative instrument made under subsection 286(2) of the *Military Rehabilitation and Compensation Act 2004*. Under section 144B of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, employees are eligible for treatment for their DRCA injury under section 280A of the *Military Rehabilitation and Compensation Act 2004*, or subsection 85(2A) of the *Veterans' Entitlements Act 1986*, and thus, either the *MRCA Treatment Principles* made under the *Military Rehabilitation and Compensation Act 2004* or the *Treatment Principles* made under the *Veterans' Entitlements Act 1986* apply for their treatment services. Section 18 of the *Treatment Benefits (Special Access) Act 2019* provides, in effect, that the

instrument called the *Treatment Principles*. Clause 4.2.1 of the *Treatment Principles* provides that 'an entitled person may be provided with only those services included in the Medicare Benefits Schedule.' Clause 1.4.1 defines **'Medicare Benefits Schedule'** as meaning:

> (a) Schedule 1 to the *Health Insurance Act 1973* as substituted by regulations made under subsection 4(2) of that Act; and
>
> (b) Schedule 1A to the *Health Insurance Act 1973* as substituted by regulations made under subsection 4(2) of that Act; and
>
> (c) the table of diagnostic imaging services prescribed under subsection 4AA(1) of that Act as in force from time to time.

The effect of this is to incorporate into the *Treatment Principles* the regulations made, from time to time, for the purposes of sections 4 (the general medical services table) and 4AA (the diagnostic imaging services table) of the *Health Insurance Act 1973*.[99]

The inclusion of DVA treatment services in the scheme in Part VAA of the *Health Insurance Act 1973* permits those services to be included within the services counted towards the **'prescribed pattern of services'** referred to in section 82A and defined in the *Health Insurance (Professional Services Review Scheme) Regulations 2019*.

As the general medical services table is incorporated by reference into both the *Treatment Principles* and the *MRCA Treatment Principles*, then any DVA treatment services that are within those 'groups' in the general medical services table are included within the definition of 'service' for the purposes of Part VAA of the Act and regulations.

Section 106U of the Act limits the scope of directions for the repayment of benefits that can be imposed on a person under review in respect of DVA treatment services by excluding amounts paid for DVA treatment services where the Committee's Report made findings based on random sampling and subsequent extrapolation to classes of services (subsection 106K(2)) or generic findings of inappropriate practice (subsection 106KE(3)).[100] The only direction for the repayment of benefits in respect of DVA treatment services that can be included in a Determination under section

Treatment Principles made under the *Veterans' Entitlements Act 1986* apply to eligible persons under the *Treatment Benefits (Special Access) Act 2019*.

[99] Clause 4.2.1 of the *MRCA Treatment Principles* and the definition of 'Medicare Benefits Schedule' in clause 1.4.1 of the *MRCA Treatment Principles* are in identical terms to the corresponding provisions of the *Treatment Principles* made under section 90 of the *Veterans' Entitlements Act 1986*.

[100] Subparagraph 106(1)(da)(ii).

106U is a repayment for services rendered as part of a 'prescribed pattern of services'.

While section 92 does not contain the same express limitation in relation to specified actions, the definition of **'inappropriate practice'** in subsection 82(1) excludes DVA treatment services from the general rule regarding inappropriate practice.[101] This means that as a person under review could not acknowledge inappropriate practice in connection with rendering or initiating DVA treatment services under the general inappropriate practice rule, repayment of benefits for such services could not be a specified action for the purposes of a section 92 agreement. The only action for the repayment of benefits in respect of DVA treatment services that can be included in a section 92 agreement is a repayment for services rendered as part of a **'prescribed pattern of services'**.

82 Definitions of inappropriate practice

The general test for inappropriate practice is that a practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that the conduct would be unacceptable to the general body of the relevant specialty or profession.

In applying that test, a Committee represents the general body of practitioners.

Joseph v Health Insurance Commission [2005] FCA 1042 —

> [33] The relevant definition of 'inappropriate practice' is contained in subs 82(1) of the Act, which is set out in [9] above. The terms of the definition are such that a practitioner will have engaged in inappropriate practice within the meaning of the Act if a Committee concludes on reasonable grounds that the practitioner's conduct in connection with rendering or initiating services would be unacceptable to a relevant peer group. The conclusion of the Committee, expressed in its final report, was that the applicant's conduct would be, in the Committee's opinion, 'unacceptable to the general body of medical practitioners and therefore constitutes inappropriate practice'.
>
> [34] The applicant contended that the general body of medical practitioners was irrelevant to the standard that s 82 required the Committee to apply in his case. He

[101] That is, 'the conduct in connection with rendering or initiating services … is such that a Committee could reasonably conclude that … the conduct would be unacceptable to the general body of' the relevant profession or specialty.

argued that the correct test was whether the applicant's conduct was conduct unacceptable to the general body of general practitioners (see s 82(1)(a)).

[35] The expression 'general practitioner' is defined by s 3 of the Act in the following terms:

> 'general practitioner means:
> (a) a medical practitioner in respect of whom a determination under section 3EA is in force; or
> (b) a person registered under section 3F as a vocationally registered general practitioner; or
> (c) a medical practitioner of a kind specified in the regulations.'

[36] Section 3EA of the Act allows for a determination to be made that a medical practitioner is a recognised Fellow of the Royal Australian College of General Practitioners ('RACGP'). The applicant did not contend that he had applied for such a determination or that he is in fact a Fellow of the RACGP.

[37] Section 3F of the Act provides for the registration of certain medical practitioners as 'vocationally registered general practitioners'. The applicant did not contend that he had applied for registration under this section or that he was otherwise a person registered under s 3F as a vocationally registered medical practitioner.

[38] It does not appear that any regulations made under the Act have specified a kind of medical practitioner for the purposes of paragraph (c) of the above definition of 'general practitioner'. In any event, the applicant did not place reliance on this paragraph of the definition.

[39] I conclude that the applicant is not a general practitioner within the meaning of the Act. The appropriate peer group in his case was thus, as the Committee concluded, the general body of medical practitioners.

[40] It is appropriate also to note the definition of 'general practitioner' contained in Part 1 of Schedule 1 of the Medical Services Table Regulations. Part 2 of Schedule 1 of these regulations contains a table of the medical services (other than diagnostic imaging services and pathology services) prescribed for the purposes of the Act. Part 1 of Schedule 1 contains rules of interpretation for the Schedule 1 table of medical services. The definition of 'general practitioner' contained in Part 1 of Schedule 1 is similar, but not identical, to the definition of 'general practitioner' contained in the Act. The definition in Part 1 of Schedule 1 of the Medical Services Table Regulations is as follows:

> 'general practitioner means:
> (a) a practitioner who is vocationally registered under section 3F of the Act; or
> (b) a practitioner who:
> (i) is a Fellow of the RACGP; and
> (ii) participates in the quality assurance and continuing medical education of the RACGP; and
> (iii) meets the RACGP requirements for quality assurance and continuing education; or

(c) a practitioner who is undertaking an approved placement in general practice:
(i) as part of a training program for general practice leading to the award of the Fellowship of the RACGP; or
(ii) as part of another training program recognised by the RACGP as being of an equivalent standard.'

[41] The importance for present purposes of the above definition derives from the references contained in items 53 and 59 of the table of medical services to 'a medical practitioner (not being a general practitioner)' (see [13] above). The applicant was entitled to fees under the Act in respect of the services prescribed by items 53 and 59 because he was not a 'general practitioner' within the meaning of Schedule 1 of the Medical Services Table Regulations.

[42] I reject the contention that the Committee erred by applying the standards of the general body of medical practitioners in determining whether the applicant had engaged in inappropriate practice within the meaning of subs 82(1) of the Act. As the applicant was not a 'general practitioner' within the meaning of the Act, it was appropriate for the Committee to apply the standards of the general body of members of his profession (see par 82(1)(d)).

While the Committee may have regard to the standards of the relevant College or other professional body, those standards do not constitute the test to be applied by the Committee, rather it is whether, in all the circumstances, the person's conduct would be 'unacceptable' to the general body of the relevant profession or specialty.

Adams v Yung [1998] FCA 506 (per Burchett and Hill JJ) —

The relevance of the doctor's certification by the Royal Australian College of General Practitioners was a matter commented on by His Honour and raised in submissions to us.

The ability to charge the scheduled fees in items 3 and 23 is given to a person who is, within the meaning of the regulations, a general practitioner. One qualification for a general practitioner, as defined, is fellowship of the College, participation in continuing medical education at the College and meeting the College's requirements for quality assurance. It is not the only qualification. The holding of that qualification, which was not in dispute at any stage, is a matter of fact.

It does not follow from that, that one can extrapolate from a definition by the College of General Practice which includes, although it is not limited to, "comprehensive whole care to individuals families and their community", that the furnishing of care not being as comprehensive will involve conduct unacceptable to the general body of general practitioners. The test to be applied in the legislation is a test related to the body of general practitioners generally. It is a not a test to be formulated by reference to particular standards of the College although those standards may no doubt be accepted by the general body of general practitioners.

In *Norouzi v Director of Professional Services Review Agency* [2020] it was argued that as the Regulations that prescribed the relevant MBS items contained a different definition of **'general practitioner'** for the purpose of those items from the definition of general practitioner in section 3 of the Act, and that Dr Norouzi fell within the definition of 'general practitioner' in the Regulations but not that of the Act, then the relevant test of inappropriate practice to be applied in relation to his conduct in connection with rendering those items should have been that relating to the general body of general practitioners rather than the general body of medical practitioners. This argument was run in the context of an application to the Court to exercise its discretion to extend time to apply for judicial review under the *Administrative Decisions (Judicial Review) Act 1977*. The Court rejected that argument.

Norouzi v Director of Professional Services Review Agency [2020] FCA 1524 —

> [51] Because the discretion is not fettered, in theory, but unusually, an extension of time might be granted even where there is no, or no persuasive, explanation for delay and even where it was possible to discern some subversion of efficient public administration. The prospective merits of a proposed application under the ADJR Act might be such that the interests of justice nonetheless demanded an extension in the circumstances of a given case. As mentioned already, an extension decision can be multi-factorial and relevant factors can interplay. A truly calamitous sequel to an administrative decision obviously devoid of any lawful authority might require the granting of an extension of time even after substantial delay.
>
> [52] That is not this case.
>
> [53] Here, the prospective merits do not, as a matter of impression, appear to me to be such, when considered in conjunction with the factors already mentioned, as to warrant the granting of an extension.
>
> [54] Confidence in prospects is not enlivened by a flawed underlying premise for the proposed ADJR Act grounds. That premise is that the committee applied an incorrect standard to Dr Norouzi in assessing inappropriate practice, because he was a general practitioner and the committee ought therefore to have applied the test ordained by s 82(1)(a) of the HIA, rather than that ordained by s 82(1)(d).
>
> [55] Section 82(1) of the HIA materially provided:
>
> > 82 Definitions of inappropriate practice
> >
> > *Unacceptable conduct*
> >
> > (1) A practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that:
> > (a) if the practitioner rendered or initiated the services as a general practitioner– the conduct would be unacceptable to the general body of general practitioners; or

> ...
> (d) if the practitioner rendered or initiated the services as neither a general practitioner nor a specialist but as a member of a particular profession(-)the conduct would be unacceptable to the general body of the members of that profession.
>
> [56] As a matter of ordinary English usage, one might perhaps describe Dr Norouzi, who was not a member of any specialist college during the Review Period, as a general practitioner. However, s 3 of the HIA gives the term "general practitioner" a particular meaning for the purposes of that Act:
>
> > "general practitioner" means:
> > (a) a medical practitioner in respect of whom a determination under section 3EA is in force; or
> > (b) a person registered under section 3F as a vocationally registered general practitioner; or
> > (c) a medical practitioner of a kind specified in the regulations.
>
> [57] On the evidence, none of the paragraphs of the definition was applicable to Dr Norouzi. Thus, s 82(1)(a) of the HIA was inapplicable to him. Instead, having regard to paragraph (a) of the definition of "practitioner" in s 81 of the HIA, it was his status as a medical practitioner which brought him within the ambit of the test specified in s 82(1)(d) of the HIA, and only that test. That being so, the relevant test was whether the conduct would be unacceptable to the general body of medical practitioners. That was the test applied by the committee.

'inappropriate practice'

The concept of 'inappropriate practice' is central to the PSR Scheme. It is defined in section 82 of the Act by reference to conduct in connection with rendering or initiating a service that a PSR Committee could reasonably conclude would be unacceptable to the general body of the practitioner's profession or specialty. In *Wong v Commonwealth*, French CJ and Gummow J compared this term with the phrase 'infamous conduct in any professional respect' found in s 29 of the *Medical Act 1858* (UK), which was construed in *Allinson v General Council of Medical Education and Registration* with use of the phrase 'disgraceful or dishonourable'. Their Honours noted that the essential question in such cases is whether 'the practitioner was in such breach of the written or unwritten rules of the profession as would reasonably incur the strong reprobation of professional brethren of good repute and competence'. The use of the 'inappropriate practice' concept in the Health Insurance Act to regulate practitioners' access to Commonwealth funds is reflective of a normative requirement that the professional activities of practitioners be professional rather than unprofessional in character.

The purpose of their Honours' reference to the English precursor legislation and caselaw was not to equate 'inappropriate practice' with that standard, but to indicate the derivation of the practice of professional standards being determined by the peers in the profession who are of good repute and competence.

Hayne, Crennan and Kiefel JJ also referred to the English antecedents, and then referred to more modern concepts and broader scope of regulation of the professions, and noted that the concept of 'inappropriate practice' in the Act 'can be seen as maintaining the thread common to many earlier forms of professional discipline and regulation, by which the standards of conduct are set by reference to prevailing professional opinion.'

Similarly, Kirby J indicated his agreement with Hayne, Crennan and Kiefel JJ, and noted that professional standards change over time and that the requirement in the definition that a Committee could 'reasonably' conclude that the conduct would be unacceptable to the general body of the profession or specialty is an objective test. Practitioners can practice however they choose, but when seeking to draw on Commonwealth funds, they must keep appropriate records and practice consistently with professional standards, as determined by their peers.

The importance of the standard being determined by peers in the profession who are of good repute and competence was highlighted in another context in *Health Care Complaints Commission v Litchfield*, where the NSW Supreme Court held in relation to 'professional misconduct', that it is not a standard determined by reference to the worst cases, but by the extent to which the practitioner's conduct departs from proper standards. Similarly, in determining 'inappropriate practice', it is not a question of how the conduct compares to the worst cases, but how it compares to the proper standards accepted by the general body of the practitioner's peers. The use by the Courts of the words 'proper' to qualify standards, and 'good repute and competence' to describe the peers, indicates the kind of assessment required of a PSR Committee in determining whether particular conduct would be 'unacceptable': did the practitioner's conduct fall below the proper standard that would be acceptable to peers of good repute and competence such that it could be said by them to be 'unacceptable' conduct?

The nature of healthcare practice is such that clinical standards and guidelines, treatments, and modes of practice are constantly evolving and changing. It would be impossible to legislate comprehensive written standards for the purpose of determining 'inappropriate practice'. Additionally, guidelines are not rules, and a

practitioner's conduct needs to be viewed in light of the particular circumstances in which he or she rendered or initiated each service. Even if there were rules defining standards, what might be unacceptable conduct in a particular set of circumstances may be acceptable in others. Every patient is different and the circumstances, situations, and facilities in which services are provided will vary. For these reasons, it is proper that a Committee of peers is tasked with making an assessment of a practitioner's conduct in light of all such factors, having due regard to the norms of the profession or specialty.

Nevertheless, the legislation does have rules regarding the content and nature of MBS items numbers, requirements for particular PBS prescribing, and the standard for adequate and contemporaneous records, and the professions, colleges, and state regulatory bodies publish clinical, ethical, and practice guidelines. These are taken into account by PSR Committees, but they are not, in themselves, determinative, or the measure, of 'unacceptable conduct'.

In *Carrick v Health Insurance Commission*, the Federal Court said that having a practice profile outside the norm does not necessarily indicate inappropriate practice. Whatever the nature of a practitioner's practice profile, their responsibility, and the focus of the Act is that they ensure that their practice is in accordance with appropriate clinical standards. As noted by Kirby J, the focus is not only on clinical standards, but on professional standards more generally. However, the scope of the inquiry regarding the practitioner's conduct is limited by the phrase 'in connection with rendering or initiating services', and so the Act is not concerned with conduct that is unrelated to rendering or initiating services.

In *Health Insurance Commission v Grey*, the Federal Court rejected an argument that because the particular type of service that was billed was not, in fact, rendered by the practitioner, it could not be said that the practitioner engaged in inappropriate practice in connection with that service. In that case, the practitioner had billed for long consultations, when they were actually standard consultations. He argued that a Committee could not find that he had engaged in inappropriate practice in rendering a long consultation because he did not render a long consultation, but only a standard one. The Court rejected that argument on the basis that the practitioner would be estopped from relying on his misrepresentation of the service as a defence

to a finding of inappropriate practice in connection with such a service,[102] even if it were an innocent misrepresentation.

In *Selia v Commonwealth*, the Federal Court held that a practitioner's conduct in failing to bill in accordance with legislative requirements was clearly conduct that could be the subject of a finding of inappropriate practice as it was closely related to ensuring the integrity of the medicare benefits program, which is one of the objects of the PSR Scheme.

In *Hatfield v Health Insurance Commission* [1987] FCA 286, Davies J discussed the phrase 'in connection with' in the context of a provision in the *Administrative Decisions (Judicial Review) Act 1977*, noting that the meaning of the phrase depends on the particular statutory context in which it is used and the object or purpose of the provision in question.

Hatfield v Health Insurance Commission [1987] FCA 286 —

> [9] As the letter of 28 April did not satisfy the requirements of s.13(1) of the Act and as Dr Hatfield is a person interested in the decision expressed in that letter, I turn to the question whether the respondent was bound to furnish a statement, on request, which complied with the requirements of s.13(1) of the Act.
>
> [10] Section 13(11) of the Act provides that the section does not apply to a decision included in any of the classes of decision set out in Schedule 2 of the Act. Schedule 2 (e) specifies:–
>
> > "(e) decisions relating to the administration of criminal justice, and, in particular –
> > (i) decisions in connection with the investigation or prosecution of persons for any offences against a law of the Commonwealth or of a Territory;
> > (ii) decisions in connection with the appointment of investigators or inspectors for the purposes of such investigations;
> > (iii) decisions in connection with the issue of search warrants under a law of the Commonwealth or of a Territory;
> > (iv) decisions in connection with the issue of Writs of Assistance, or Customs Warrants, under the *Customs Act 1901*; and
> > (v) decisions under a law of the Commonwealth or of a Territory requiring the production of documents, the giving of information or the summoning of persons as witnesses".
>
> [11] The effect of s.13(11) of the Act and of para (e) of the Second Schedule to the Act is to exclude from the operation of s.13 of the Act the following decisions, *inter alia*, namely "decisions relating to the administration of criminal justice" and

[102] The legal maxim, *nullus commodum capere potest de injuria sua propria* (a person may not benefit from their own wrong), would also apply.

"decisions in connection with the investigation, or prosecution of persons for any offences against a law of the Commonwealth".

[12] Expressions such as "relating to", "in relation to", "in connection with" and "in respect of" are commonly found in legislation but invariably raise problems of statutory interpretation. They are terms which fluctuate in operation from statute to statute. As was said by Blackburn, Gallop & Neaves JJ in *Butler v Johnston & Others* [1984] FCA 118; (1984) 55 ALR 265 at 268:–

> "It is clear that the words "in respect of" can convey a meaning of wide import, but their exact width will depend upon the context in which they appear. Reference to individual cases on different statutes is of little assistance in determining their particular meaning. The court has to construe the meaning of the words with reference to the purpose or object underlying the legislation in which they appear (s 15AA of the *Acts Interpretation Act 1901*)."

The terms may have a very wide operation but they do not usually carry the widest possible ambit for they are subject to the context in which they are used, to the words with which they are associated and to the object or purpose of the statutory provision in which they appear. In *Ausfield Pty Ltd v Leyland Motor Corporation of Australia Ltd (No 2)* [1977] FCA 6; (1977) 14 ALR 457 it was said at p 460 by Bowen CJ, with whom Northrop J agreed, that the words "in relation to" in s.51(2)(a) of the *Trade Practices Act 1974* require a direct relationship and by Deane J at p462 that the words require a relationship which is direct and immediate. In *Perlman v Perlman* [1984] HCA 4; (1984) 51 ALR 317 at p 321 Gibbs C.J. said of the words "in relation to" in the definition of "matrimonial cause" in s.4 of the *Family Law Act 1975* (Cth):–

> "The words 'in relation to' import the existence of a connection or association between the two proceedings, or, in other words, that the proceedings in question must bear an appropriate relationship to completed proceedings of the requisite kind: See *R v Ross-Jones; Ex parte Beaumont* [1979] HCA 5; (1979) 23 ALR 179 at 183-4; [1979] HCA 5; 141 CLR 504 at 510. An appropriate relationship may exist if the order sought in the proceedings in question is consequential on or incidental to a decree made in the completed proceedings ...".

In *Johnson v Johnson* (1952) P 47 at 50-51, Somervell LJ found helpful the discussion by McFarlane J in *In re Nanaimo Community Hotel Ltd* (1944) 4 DLR 638 of the term "in connexion with" including His Honour's remark that "The phrase 'having to do with' perhaps gives as good a suggestion of the meaning as could be had." It is unnecessary to give further examples.

[13] The general operation of para (e) was explained in *Ricegrowers Co-operative Mills Ltd v Bannerman and Trade Practices Commission* [1981] FCA 211; (1981) 38 ALR 535 in which it was enunciated that the phrase "decisions relating to the administration of criminal justice" encompassed the decisions referred to in sub-paras (i) to (v) and that those sub-paragraphs were not to be read down by reason of the opening words of the paragraph. As Morling J said in *Harper & Others v Costigan* [1983] FCA 303; (1983) 50 ALR 665 at p 670 "the paragraph provides its own dictionary."

[14] Those cases do not, however, resolve the issue in the present case. The decision in question had some connection with the investigation of a person or persons for an offence or offences against a law of the Commonwealth. The decision arose out of an enquiry into Dr Hatfield's entitlement to the medical benefits claimed. That enquiry encompassed an enquiry into possible criminal action. In the course of that enquiry, warrants were obtained pursuant to the *Crimes Act 1903* (Cth). As a result of consideration of documents obtained pursuant to those warrants as well as to other information held, Mr McAnulty decided to refer to the Director of Public Prosecutions the question of the prosecution of Dr Hatfield and possibly of other persons and of the recovery from Dr Hatfield of medical benefits previously paid. At the same time Mr McAnulty decided that the currently held claims and future claims for item 793 benefits in respect of referrals from the Edelsten Group would not be paid.

[15] Thus, the material obtained pursuant to warrants issued in the course of that investigation formed part of the material which Mr McAnulty took into account in arriving at his decision. Moreover, one part of the reasoning process was common to all the decisions taken and that was the crucial point that Dr Hatfield was a member of the Edelsten Group.

[16] However the terms “decisions relating to the administration of criminal justice” and “decisions in connection with the investigation ... of persons for any offences against a law of the Commonwealth” are not to be interpreted as encompassing all decisions found to have any connection whatever with the administration of criminal justice or the investigation of persons for offences. In *Collins and Dunn v Minister for Immigration and Ethnic Affairs (No.3)* (1982) 5 ALN No. 3, Lockhart J held that a decision by the Minister for Immigration and Ethnic Affairs on a reconsideration of his earlier decision to deport a person from Australia was not a decision in connection with the “conduct of proceedings in a civil court” (see para (f) of Schedule 2) notwithstanding that there were proceedings on foot under the *Administrative Decisions (Judicial Review) Act 1977* (Cth) challenging the Minister's earlier decision. Lockhart J held that the nexus between the reconsideration and the Judicial Review proceedings was essentially only temporal. Likewise, in *Murphy & Others v KRM Holdings Pty Limited* (1985) 63 ALR 397, Fox, Beaumont and Pincus JJ held that the seizure by Customs officials of goods imported into Australia and believed on reasonable grounds to be forfeited was not a decision falling within paras (e) and (f) of Schedule 2. At p 402 Pincus J, with whose reasons Beaumont J agreed, said:–

> “It follows that decisions taken in connection with the investigation or prosecution of persons for offences under s 234(1) of the Customs Act are within para (e)(i) of Sch 2 of the Judicial Review Act. Nevertheless, on the particular facts of this case, the sub-paragraph should be held inapplicable, as it was by the learned primary judge. That is so because the most that was proved was that there would have been no seizure had the department not been satisfied that there was evidence of commission of an offence under s 234(1). No doubt a prosecution may follow on from the seizure. It was not said, however, nor is it necessarily the case, that the seizures had to do with the process of investigation; they may equally well have simply had the purpose of reducing into possession the goods claimed to be forfeited. It does not appear to be necessary or desirable to attempt to lay down a rule as to the sort of

> connection between a seizure and an investigation which is necessary to be shown in order to bring the matter within para (e)(i) of Sch 2. To dispose of the present matter, it is enough to say that there was not sufficient evidence to establish the requisite connection. In other factual situations, seizures of goods unlawfully imported may well be so connected with investigation of offences as to fall within the relevant sub-paragraph."

The words of Pincus J which are of greatest import were:–

> "It was not said, however, nor is it necessarily the case, that the seizures had to do with the process of investigation ..."

His Honour was pointing to the fact that para (e) uses the words "relating to" not primarily with respect to matters which are peripheral to the administration of criminal justice or to the investigation of persons for offences but to matters which form part of the process of the administration of justice and of the investigation of persons for offences.

[17] In my opinion para (e) refers to decisions which are part of the administration of justice and part of the investigation of persons for offences and also, I would accept, to decisions that are ancillary or incidental thereto or made in assistance thereof. The paragraph does not, however, encompass decisions which are not made in the course of the administration of justice or the investigation of persons for offences but which are simply connected in an indirect manner therewith. Decisions of the latter type do not have the necessary relationship.

[18] As in *Murphy & Others v KRM Holdings Pty Limited* cited above, there is in this case no evidence that the decision not to pay current and future claims for item 793 benefits in respect of referrals from the Edelsten Group was ancillary or incidental to or a part of the administration of criminal justice or the investigation of Dr Hatfield for an offence. It was not put in the affidavit that the decision was taken as a step in the prosecution of Dr Hatfield or as a step in the recovery of past claims or to assist such action.

[19] Mr McAnulty deposed, inter alia:–

> "During the investigation, which involved an analysis of documents obtained by search warrant from bank accounts operated in Dr Hatfield's name and which also involved an analysis of statements made by the applicant to me in an interview with him in December 1985, I formed the opinion that offences against the *Health Insurance Act 1973* had been committed by the Applicant. In connection with the investigation I then decided to withhold payment of further benefits claimed by the Applicant pending further investigation and forwarding of the matter to the Office of the Director of Public Prosecutions for consideration whether offences had been committed which may result in prosecution of the Applicant."

However, although Mr McAnulty used the words "in connection with", he did not depose to any relevant connection other than his reliance upon the material contained in the criminal investigation. For that matter, he did not explain why he categorised the inquiry as an inquiry into alleged offences as distinct from an

inquiry into Dr Hatfield's entitlement to make and to have made the item 793 claims.

[20] I would add that the decision not to pay the item 793 benefits was not dependent upon its being established that an offence had been committed. The Commission was correct in withholding payment of the item 793 benefits if it was not satisfied that Dr Hatfield was entitled thereto. Whether Dr Hatfield and possibly others should be prosecuted and if so for what offence or offences was a matter for the Director of Public Prosecutions.

[21] For these reasons, therefore, there was not the requisite relationship between the subject decision and the administration of criminal justice or the investigation of a person for an offence against a law of the Commonwealth.

[22] The applicant is therefore entitled to a declaration that he was entitled to a statement under s.13(1) of the Act in respect of the decision set out in Mr McAnulty's letter of 28 April 1986 "that no further item 793 benefits will be paid to your client for services performed on referral from practitioners within the Edelsten Group until ... we are satisfied the pre-requisites of item 793 claims are being met." In furnishing that statement, the respondent may rely upon the provisions of s.13A of the Act if it is appropriate to do so.

Wong v Commonwealth [2009] HCA 3 (per French CJ and Gummow J) —

[64] The statutory criterion of conduct unacceptable to the general body of general practitioners, of which the appellants also complain, is an adaptation for the operation of the Act of principles of professional responsibility developed in the second half of the 19th century. The phrase "infamous conduct in any professional respect" found in s 29 of the *Medical Act 1858* (UK)[103] and memorably construed in *Allinson v General Council of Medical Education and Registration*[104] with use of the phrase "disgraceful or dishonourable", has been seen since as not necessarily requiring an appeal to a moral standard.[105] The essential question in such cases is whether "the practitioner was in such breach of the written or unwritten rules of the profession as would reasonably incur the strong reprobation of professional brethren of good repute and competence".[106] The rendering of services not reasonably necessary for the care of the patient may be dubbed "overservicing", but may also attract the reprobation just described.

[65] A legislative scheme for the provision of medical services supported by appropriation of the Consolidated Revenue Fund established under s 81 of the *Constitution*, by requiring the professional activities of medical practitioners to conform to the norms derived from *Allinson*, does not conscript them. Those norms

[103] 21 & 22 Vict c 90.

[104] [1894] 1 QB 750 at 760-761. See also *A Solicitor v Council of Law Society (NSW)* [2004] HCA 1; (2004) 216 CLR 253 at 264-265 [13]; [2004] HCA 1.

[105] *Epstein v The Medical Board of Victoria* [1945] VicLawRp 54; [1945] VLR 309 at 310; *Ex parte Meehan; Re Medical Practitioners Act* [1965] NSWR 30 at 36.

[106] *Qidwai v Brown* [1984] 1 NSWLR 100 at 105; *Pillai v Messiter [No 2]* (1989) 16 NSWLR 197 at 199-200, 208; cf *Hoile v The Medical Board of South Australia* [1960] HCA 30; (1960) 104 CLR 157 at 162-163; [1960] HCA 30.

are calculated to ensure that the activities be professional rather than unprofessional in character.

Wong v Commonwealth [2009] HCA 3 (per Hayne, Crennan and Kiefel JJ) —

[211] The concept of "inappropriate practice" was introduced into the Health Insurance Act by the *Health Legislation (Professional Services Review) Amendment Act 1994* (Cth) ("the 1994 Amendment Act"). Before the amendments made by the 1994 Amendment Act, the Health Insurance Act provided[107] for a Medical Services Committee of Inquiry to examine whether a practitioner had rendered or initiated "excessive services", defined[108] as "services in respect of which medicare benefit has become or may become payable and which were not reasonably necessary for the adequate medical or dental care of the patient concerned". If satisfied that a practitioner had rendered or initiated excessive services, the Committee could recommend[109] the imposition of any of a number of sanctions, ranging from reprimand to a requirement for repayment to the Commonwealth of amounts that had been paid as benefits.

[212] Section 82 of the Health Insurance Act as amended by the 1994 Amendment Act defines "inappropriate practice". Both s 81 and the heading to s 82 treat the provisions of s 82 as assigning a number of meanings to the expression, but for present purposes it is sufficient to notice three particular features of the provisions of s 82.

[213] First, and most importantly, "inappropriate practice" is confined to a practitioner's "conduct in connection with rendering or initiating services". For this purpose, "service" means:[110]

> "(a) a service for which, at the time it was rendered or initiated, medicare benefit was payable; or
> (b) a service rendered by way of a prescribing or dispensing of a pharmaceutical benefit by a medical practitioner or a dental practitioner".

That is, inappropriate practice is confined to conduct "in connection with rendering or initiating" services for which a Medicare benefit is payable under the Health Insurance Act or a pharmaceutical benefit is payable under Pt VII of the *National Health Act 1953* (Cth).

[214] The Explanatory Memorandum for the Bill for what was to become the 1994 Amendment Act recorded[111] that the concept of inappropriate practice would

[107] s 94.
[108] s 79(1B).
[109] s 105.
[110] s 81.
[111] Explanatory Memorandum for the Health Legislation (Professional Services Review) Amendment Bill 1993 (Cth) at 4.

encompass "the existing concepts of excessive rendering and excessive initiating but also [introduce] the concept of excessive prescribing". It continued:[112]

> "In addition, it will allow a Committee to examine, where relevant, aspects of a practitioner's practice broader than purely the excessive servicing of patients. A Committee will have the capacity to consider the conduct of the person under review in his or her practice and determine whether that conduct is acceptable to the general body of his or her profession or specialty." (emphasis added)

The breadth of what has since been asserted to be the reach of the provision is indicated by a report,[113] made in 1999, following a review of the operation of the provisions of Pt VAA. That report identified[114] the categories of conduct which involved inappropriate practice. Those categories included such matters as "issues of professional concern in relation to clinical competence and performance", "aberrant professional behaviour or beliefs", "physical or mental impairment", "substance abuse" and "[o]rganisational issues which affect patient safety", as well as matters going more directly to the number and types of services said to have been performed by a practitioner.

[215] At least some of these categories of conduct assume a very large meaning of, and application for, the expression "conduct in connection with rendering or initiating services". There may be room for debate about whether issues like general questions about a practitioner's physical or mental competence or a practitioner's substance abuse will come within the expression "conduct in connection with rendering or initiating services". There may also be room for debate about whether all questions about clinical competence and performance, or all organisational issues affecting safety, will come within that expression. No doubt the expression "in connection with" is not to be given a narrow or confined construction. But the provision requires that a connection be demonstrated between identified conduct and rendering or initiating services for which benefits are payable. It is not necessary to examine further the nature of, or limits to, that connection.

[216] The Health Insurance Act recognises that examining a practitioner's conduct in connection with rendering or initiating services may reveal conduct that does not fall within the statutory concept of inappropriate practice but which may fall within some other definition of unprofessional practice. Provision is therefore made by s 106XA for referring to an appropriate regulatory body any significant threat to life or health that comes to light "in the course of the performance of functions or the exercise of powers" under Pt VAA of the Act. And s 106XB provides for reference to an appropriate regulatory body of any non-compliance by a practitioner with professional standards. These provisions show that it is neither necessary nor appropriate to attempt to stretch the concept of "inappropriate practice", or its definition as "conduct in connection with rendering or initiating services", to embrace all forms of conduct by a practitioner that would merit professional

[112] Explanatory Memorandum for the Health Legislation (Professional Services Review) Amendment Bill 1993 (Cth) at 4.

[113] Australia, *Report of the Review Committee of the Professional Services Review Scheme*, (1999).

[114] Australia, *Report of the Review Committee of the Professional Services Review Scheme*, (1999) at 15-16.

condemnation. Rather, the focus of Pt VAA must remain fixed upon conduct in connection with rendering or initiating services for which benefits are payable.

[217] And it was no doubt with just such a focus in mind that provision was made in 1999, by the *Health Insurance Amendment (Professional Services Review) Act 1999* (Cth), for a Committee considering whether a practitioner has engaged in inappropriate practice to have regard to only samples of classes of services[115] before finding that a practitioner has engaged in inappropriate practice in relation to services of the relevant class; for a Committee to make a finding of inappropriate practice[116] if it is established that a practitioner's conduct in rendering or initiating services constitutes a "prescribed pattern of services"; and for a Committee to make a generic finding of inappropriate practice [fn 240: s 106KB] where it cannot make a finding by reference to samples of services provided or to prescribed patterns of services because clinical or practice records are insufficient.

[218] The second point to notice about s 82 is that it requires that the conduct be "such that a Committee could reasonably conclude that ... the conduct would be unacceptable to the general body" of relevant practitioners (emphasis added). The addition of the word "reasonably" reinforces the conclusion that might otherwise have been drawn in any event that the standard against which conduct is to be measured is an objectively determined standard. Moreover, the use of the word "reasonably" may take on particular significance in the application of the ADJR Act. In particular, it may bear upon whether a decision to which the ADJR Act applies was "authorized by the enactment in pursuance of which it was purported to be made",[117] whether the decision "involved an error of law",[118] as well as whether "the decision was otherwise contrary to law"[119] or involved an "improper exercise of ... power".[120] It is not necessary to explore in any further detail these questions about the application of the ADJR Act.

[219] Thirdly, the references in s 82(1) to a conclusion that "the conduct would be unacceptable to the general body" of relevant practitioners cannot be understood divorced from some aspects of the history of legislative regulation of the medical profession.

[220] For many years, both in England and in Australia, medical practitioners would be struck off the register if found "to have been guilty of infamous conduct in any professional respect".[121] In *Allinson v General Council of Medical Education and Registration*,[122] the Court of Appeal of England and Wales identified one form of conduct amounting to "infamous conduct in a professional respect" as a medical practitioner, in the pursuit of that profession, doing "something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency". Proof of conduct of that

[115] s 106K.
[116] s 106KA.
[117] *Administrative Decisions (Judicial Review) Act 1977* (Cth), s 5(1)(d).
[118] s 5(1)(f).
[119] s 5(1)(j).
[120] s 5(1)(e).
[121] *Medical Act 1858* (UK), s 29.
[122] [1894] 1 QB 750 at 760-761 per Lord Esher MR, 763 per Lopes LJ, 766 per Davey LJ.

kind resulted in striking the offender's name from the register of practitioners. No lesser punishment could be imposed. Not surprisingly, then, there was much litigation over the years about what was "infamous conduct in a professional respect". In particular, much attention was given to whether it was necessary to establish moral turpitude, fraud or dishonesty.

[221] For the most part these issues were put to rest in Australia by this Court's decision in *Hoile v The Medical Board of South Australia*[123] holding that what amounts to "infamous conduct" is "best represented by the words 'shameful' or 'disgraceful'; and it is as conduct of a medical practitioner in relation to his profession that it must be considered shameful or disgraceful".[124]

[222] More recent legislation regulating the conduct of professional practitioners such as medical and legal practitioners has moved away from the notion of "infamous conduct" and has provided for a much greater range of punishments for professional default than termination of the right to practise by striking off the appropriate register.[125] And as Lord Hoffmann, delivering the opinion of the Judicial Committee of the Privy Council in *McCandless v General Medical Council*,[126] pointed out, "the public has higher expectations of doctors and members of other self-governing professions [and] [t]heir governing bodies are under a corresponding duty to protect the public against the genially incompetent as well as the deliberate wrongdoers".

[223] But from *Allinson's Case* to today, a common thread can be identified running through most statutes regulating the conduct of what Lord Hoffmann referred to as the "self-governing professions". The standard of conduct expected of practitioners is an objective standard and is often identified, at least in part, by reference to the opinion of members of the profession, or members of the profession "of good repute and competency".[127] Hence, the reference in s 82(1) to conduct that "would be unacceptable to the general body" of relevant practitioners can be seen as maintaining the thread common to many earlier forms of professional discipline and regulation, by which the standards of conduct are set by reference to prevailing professional opinion. And in particular, the conduct which may be identified as "inappropriate practice", as defined in s 82 of the Health Insurance Act, is conduct which has two features. First, the conduct must be "in connection with rendering or initiating services" for which a Medicare benefit or a pharmaceutical benefit is

[123] [1960] HCA 30; (1960) 104 CLR 157 at 162; [1960] HCA 30.

[124] See also, *R v The Medical Board of Victoria; Ex parte Epstein* [1945] VicLawRp 8; [1945] VLR 60; *Epstein v The Medical Board of Victoria* [1945] VicLawRp 54; [1945] VLR 309; *Re Appeals of Johnson and Anderson* [1967] 2 NSWR 357; *Mercer v Pharmacy Board of Victoria* [1968] VicRp 9; [1968] VR 72; *Basser v Medical Board of Victoria* [1981] VicRp 88; [1981] VR 953.

[125] See the provisions relating to "professional misconduct" or cognate expressions in, for example, *Medical Practice Act 1992* (NSW), s 36; *Health Professions Registration Act 2005* (Vic), s 3; *Medical Practice Act 2004* (SA), s 3; *Health Practitioners (Professional Standards) Act 1999* (Q), s 3; *Medical Practitioners Registration Act 1996* (Tas), s 45; *Health Practitioners Act* (NT), s 56(2); *Health Professionals Act 2004* (ACT), s 18; cf *Medical Act 1894* (WA), s 13.

[126] [1996] 1 WLR 167 at 169.

[127] *Allinson v General Council of Medical Education and Registration* [1894] 1 QB 750 at 761. See also, for example, *In re A Solicitor; Ex parte Law Society* [1912] 1 KB 302 at 312; R v *The Medical Board of Victoria; Ex parte Epstein* [1945] VicLawRp 8; [1945] VLR 60; *Epstein v The Medical Board of Victoria* [1945] VicLawRp 54; [1945] VLR 309; *Re Appeals of Johnson and Anderson* [1967] 2 NSWR 357.

payable. Secondly, the conduct must be such as a Committee could reasonably conclude would be unacceptable to the general body of relevant practitioners.

[224] As noted earlier, it may be accepted that the Health Insurance Act has the practical effect of requiring those medical practitioners who wish to practise as general practitioners to participate in the Medicare scheme. The Act requires those practitioners not to engage in inappropriate practice. It therefore follows that the Health Insurance Act practically compels those practitioners to abide by a particular standard of professional behaviour in connection with rendering or initiating services. Even if the definition of inappropriate practice in s 82 is as broad in its application as has been asserted (and as noted earlier, it is not necessary to decide whether it is) the standard of conduct that is thus imposed is framed by reference to professional opinion. It is, therefore, not different in kind from the standard of professional conduct that, since *Allinson's Case*, has been expected of medical practitioners in the conduct of their profession.

[225] Whether such a broad view of s 82 could present any question about whether, in some of its applications, the law, so construed, was a law with respect to medical and dental services was not explored in argument. It is neither necessary nor appropriate to express any opinion about whether any such question would be presented, or about how such a question should be answered. The only attack mounted on the provisions of the Health Insurance Act which are impugned in these proceedings was that they provided for a form of civil conscription.

[226] Assuming, without deciding, that s 82 does require medical practitioners to conform to the standard thus prescribed in relation to what the appellants called "matters going to the mode or manner of provision of medical services", the requirement to comply with that standard does not constitute a form of civil conscription. Section 82 and the other provisions which the appellants alleged to be invalid do not deny that a medical practitioner is free to choose whether to practise. A practitioner may choose whether to practise on his or her own account, or as an employee. The impugned provisions do not confine a practitioner's freedom[128] to choose where to practise. If the practitioner practises on his or her own account, the practitioner may decide when to be available for consultation and who to accept as a patient. The practical compulsion to meet a prescribed standard of conduct when the practitioner does practise is not a form of civil conscription. To adopt and adapt what Dixon J said[129] in the BMA Case, "[t]here is no compulsion to serve as a medical [practitioner], to attend patients, to render medical services to patients, or to act in any other medical capacity, whether regularly or occasionally, over a period of time, however short, or intermittently".

[128] Reference was made in passing during oral argument to arrangements made under s 19ABA of the Health Insurance Act with respect to agreements to work in rural or remote areas. Reference may also be made to s 19AB and arrangements made with respect to certain overseas trained doctors. Neither the operation of any of these arrangements nor their validity was examined in argument.

[129] [1949] HCA 44; (1949) 79 CLR 201 at 278.

Wong v Commonwealth [2009] HCA 3 (per Kirby J) —

> [156] Central to my opinion in this respect is a conclusion similar to that expressed by Hayne, Crennan and Kiefel JJ.[130] After the adoption of the defined criterion of "inappropriate practice", proper care has to be taken in the provisions of the Act, to limit the conduct that will attract that description. In part, the phrase is still defined by reference to the provision of excessive services, which is of proper and legitimate concern to the Commonwealth and its agencies as guardians of public moneys raised from the people. So far as wider considerations of "unprofessional conduct" are concerned, two provisions in s 82 (which the appellants challenge) save the legislation from invalidity. The first is the adoption of a criterion that the supervising committee's conclusion must be "reasonable". The second is the requirement that the committee must ask itself whether the conduct of the healthcare professional "would be unacceptable to the general body" of relevant practitioners involved in supplying the "medical and dental services" concerned.[131]
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> [157] These criteria, in combination, necessarily require that committee opinions are determined not by considerations attractive to federal officials, as such, or supposed overall health-management objectives. Instead, in every case, the committee must reach a reasonable conclusion by reference to the standards of the general body of the profession concerned, judged in a therapeutic context. That conclusion is, in turn, susceptible (as in the appellants' cases) to procedures for judicial review, further appeal to the courts and ultimately a constitutional appeal to this Court.
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> …
>
> [159] Specifically, I agree with what Hayne, Crennan and Kiefel JJ have written about the analogy between the statutory criteria expressed in the Act and the long-established law on professional standards stated in such decisions as *Allinson v General Council of Medical Education and Registration*[132] with the elaboration now afforded by Lord Hoffmann in *McCandless v General Medical Council*.[133] The concept of "inappropriate practice" is not exactly the same as "unprofessional conduct" existing in the 1890s when *Allinson* was decided.[134] The statutory criterion today, in a modern regulatory state with a universal, national health scheme, contemplates detailed record-keeping to comply with basic constitutional and statutory principles. Poor book-keeping might not have been "unprofessional conduct" in the century before last.[135] However, in the contemporary Australian context, where what is involved is overcharging, overservicing or inadequate clinical care in the nominated time, it could well be so. In any case, the close similarity of the two concepts is plain.

[130] Reasons of Hayne, Crennan and Kiefel JJ at [211].
[131] Reasons of Hayne, Crennan and Kiefel JJ at [217].
[132] [1894] 1 QB 750 at 760-761, 763, 766. See reasons of Hayne, Crennan and Kiefel JJ at [220]-[223].
[133] [1996] 1 WLR 167 at 169 (PC). See reasons of Hayne, Crennan and Kiefel JJ at [222].
[134] cf reasons of Heydon J at [234]-[241].
[135] Reasons of Heydon J at [241].

Pradhan v Holmes [2001] FCA 1560 —

> [7] Before describing those various tiers it is appropriate to explain the concept of "inappropriate practice". It is defined, insofar as presently relevant, in s 82(1):
>
> > "A practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that:
> >
> > …
> >
> > (b) if the practitioner rendered or initiated the referred services as a specialist (other than a consultant physician) in a particular specialty - the conduct would be unacceptable to the general body of specialists in that specialty."
>
> [8] This definition was introduced into the HI Act in 1994 when the PSR Scheme was established. Previously the mechanism employed to protect public revenues was by policing "excessive servicing" by a practitioner. The change to concern with "inappropriate practice" was remarked on in the Second Reading Speech on the 1993 amending bill in the following terms (Hansard, House of Representatives, 30 September 1993, at 1551):
>
> > "A significant change in the bill is the replacement of the concept of excessive servicing with one of inappropriate practice. Whereas excessive servicing is currently defined as the rendering or initiation of services not reasonably necessary for the adequate care of the patient, the concept of inappropriate practice goes further. It covers a practitioner engaging in conduct in connection with the rendering or initiating of services that is unacceptable to his or her professional colleagues generally."

Doan v Health Insurance Commission [2002] FCA 1160 —

> [81] Further, the definitional chain of "inappropriate practice" in the HI Act and the overall issue of whether the practitioner has engaged in "inappropriate practice" necessarily demands an analysis of particular questions, including whether the service is clinically relevant, whether the services rendered or initiated in the referral period were necessary, whether there was an appropriate level of clinical input and whether the services were appropriate. In this way, from the definition of s 82 of inappropriate practice, one has to go to s 81(1) which defines a "service" as a service for which "at the time it was rendered or initiated, a Medicare benefit was payable", such Medicare benefits being payable where, "on or after 1 February 1984, medical expenses are incurred in respect of a professional service rendered in Australia to an eligible person..." (s 10(1)). The meaning of "professional service" in s 3 then directs one to the meaning of a "clinically relevant service" which is defined as a "service rendered by a medical ... practitioner ... that is generally accepted in the medical ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered": s 3.

Carrick v Health Insurance Commission [2007] FCA 984 —

> [32] … Professional practice is not inappropriate practice merely because the practice profile of the practitioner concerned departs significantly from the norm.

There may be good reasons for the departure. The reverse is also true. Professional practice is not appropriate practice merely because the practice profile of the practitioner is normal. A normal practice profile may mask inappropriate practice. The concern of a medical practitioner, as Dr Carrick was advised, should be to ensure that his or her practice is in accordance with appropriate clinical standards; not to ensure that his or her practice profile accords with any statistical standard.

Health Care Complaints Commission v Litchfield [1997] NSWSC 297 —

The Tribunal next found that the first two complaints were "relatively minor matters". We cannot so view these complaints on the Tribunal's findings and it was not appropriate for the Tribunal to compare them "with many cases that are dealt with in this Tribunal". The gravity of professional misconduct is not to be measured by reference to the worst cases, but by the extent to which it departs from proper standards. If this is not done there is a risk that the conduct of the delinquents in a profession will indirectly establish the standards applied by the Tribunal. The approach of the Tribunal in this case stood the proper principle on its head.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

[57] Two bases of challenge to the Committee's decision as pleaded in the originating application were the same as two made to the Director's decision:

(a) "subjective comparison" rather than "objective standard"; and

(b) failure to take into account incompleteness of medical records and Dr Karmakar's inability to obtain the complete records.

[58] As to the first, the Committee's role was to investigate and then make findings in respect of the referred services. Those findings had to be whether or not Dr Karmakar had engaged in inappropriate practice, as defined, in respect of the referred services. As so defined, the Committee was required to make an evaluation by reference to its understanding (or at least that of a majority of the Committee) as to whether Dr Karmakar's conduct in connection with the rendering of those services would be unacceptable to the general body of general practitioners. To take up an expression favoured in Dr Karmakar's statement of claim, s 82 contains the "legislatively endorsed" standard. To take up another such expression, s 95 specifies what constitutes "peer review". The specified standard and review body is not unacceptability to the general body of general practitioners of Dr Karmakar's length of registration as determined by a committee comprised of such practitioners. Further, the required finding, one way or the other, is wholly evaluative by the Committee. There is no "objective standard". All that is necessary is that the Committee's evaluation be reasonable.

[59] Whether or not this statutory standard and by whom the evaluation is made is, as Dr Karmakar submitted was required, "formally taught" is nothing to the point. The HIA forms part of the law of Australia. Perhaps, given the pervasiveness of impact on the Australian medical profession of the HIA, a general understanding of the professional standards review system found in Pt VAA of that Act should form part of the curriculum of each and every medical school in Australia. Perhaps, too, for these same reasons, it ought to form the subject of compulsory, continuing professional development education for the medical profession. But any absence of

such inclusions does not render the decisions successively made in this case by the Director, the Committee and the Determining Authority unlawful.

[60] It is not for the Court on judicial review to remake the evaluative finding consigned to the Committee. Indeed, the professional evaluative judgement which the Committee was required to make, and did make in respect of its findings of "inappropriate practice", as defined is a paradigm example of a "matter of opinion or policy or taste": *Buck v Bavone* [1976] HCA 24; (1976) 135 CLR 110, at 119 in respect of which it is always difficult to demonstrate a ground of judicial review is present. This may perhaps be a case where reasonable minds might reasonably differ as to whether Dr Karmakar's professional constituted "inappropriate practice", as defined. Dr Turnbull evidently considered that it did not. But that does not make the Committee's findings unreasonable: *Minister for Immigration and Multicultural Affairs v Eshetu* [1999] HCA 21; (1999) 197 CLR 611, at [137], per Gummow J.

[61] By s 106L(1B) of the HIA, a committee can only make a finding of inappropriate practice if the proposed finding and the reasons for the finding were included in the draft report prepared and furnished to Dr Karmakar under s 106KD of the HIA. The Committee observed this requirement. The Committee's final report makes explicit it took into account the resultant submissions in reply made by Dr Karmakar. In particular, the Committee took into account views expressed by Dr Turnbull in a report relied upon by Dr Karmakar. The Committee was not obliged to accept Dr Turnbull's opinions. The Committee's final report discloses a reasoned, rational basis for the findings which it made.

[62] As to the second, the Committee's report of 30 January 2019 makes plain that it took into account the completeness of medical records, the reasons for that and the extent to which there was inability to obtain complete records. The Committee's report reveals that it explored the subject of the adequacy of Dr Karmakar's record keeping in meticulous detail. The Committee's report discloses that it was well seised with, and took into account, all of the explanations offered by Dr Karmakar in relation to the adequacy of her recordkeeping and the completeness of the records available to the Committee. Some of these explanations were accepted by the Committee, others were not. It is not for the Court on judicial review itself to engage in the investigation consigned to the Committee.

[63] For these reasons, there is no substance in the grounds of review as pleaded in the originating application in relation to the Committee. As with the Director, the bases of challenge ranged more widely in the statement of claim and then in submissions.

[64] It was put that Dr Karmakar's provision of the referred services had not been investigated by a committee of her peers. As I understood it, foundation for this submission was that she was a junior, general practitioner and ought therefore to have been investigated by a committee so comprised. That submission must be rejected. The constitution of the Committee was dictated by s 95 of the HIA. The Chairperson of the Committee had to be a Deputy Director. Given that Dr Karmakar was, during the review period, a general practitioner, the other members of the Committee had to be (and were) general practitioners: s 95(5) of the HIA. Neither

explicitly nor implicitly did the HIA additionally require that those general practitioners be of the same number of years post-registration as Dr Karmakar.

[65] As to the meaning of "urgent" for the purpose of item 597, this was ordained by the meaning given in [2.15.1] of Sch 1 to the *Health Insurance (General Medical Services Table) Regulation 2015* (Cth) made under the HIA. It was not, as Dr Karmakar seemed to suggest, dictated by the meaning adopted by Dr Turnbull for the purposes of a report prepared by him, which formed part of the submission made on behalf of Dr Karmakar to the Committee. Both in its interim as well as its final report, it is explicit that the Committee adopted the ordained definition.

Health Insurance Commission v Grey [2002] FCAFC 130 —

[173] … Making a claim under an incorrect item is capable of constituting conduct which amounts to "inappropriate practice". …

[186] We reject the arguments advanced by the notice of contention. In our view, the primary Judge correctly held (at [16]) that the Referral properly raised the possibility that by rendering so many services Dr Grey could not provide an appropriate level of "clinical input". Implicit in this expression of the Commission's concern was acceptance, albeit a necessarily provisional acceptance at that stage, of the accuracy of Dr Grey's numbers and of the classification of the services in terms of appropriate levels. If it were to turn out that Dr Grey had wrongly described (and thus misrepresented, even by an innocent mistake) an item, it could hardly follow that the Referral was thereby invalidated from the beginning. Dr Grey would be estopped from relying on his misrepresentation. Another answer would be that Dr Grey would be seeking, impermissibly, to take advantage from his own default (see, e.g. *Akbarali v Brent London Borough Council* [1983] 2 AC 309 at 344).

…

[189] … It should not be forgotten that Dr Grey's claim, upheld by the primary Judge, was that the Committee had exceeded its jurisdiction when it continued its inquiry (originally valid as we have held) in circumstances where it emerged, in the course of the inquiry, that information previously provided to the Commission was incorrect in a material respect, viz. Dr Grey's description of the appropriate "Levels". As has been said, it may give rise to an estoppel against Dr Grey, or this may be a case of an impermissible attempt by Dr Grey to take advantage of his own default. But, on any analysis, the emergence of the truth, of a matter very much bound up, or interrelated, with the subject of the Referral could hardly operate to place that field of inquiry beyond the limits of the Committee's purview. Put differently, given the obvious importance in the legislative scheme of correct item description, it is impossible that an inquiry in that area could be beyond power.

Selia v Commonwealth of Australia [2017] FCA 7 —

[79] The applicant contends that billing cannot fall within the meaning of "inappropriate practice" for the purposes of s 82 of the Act and cannot therefore lawfully be a referred service under s 93 of the Act. Accordingly in the applicant's submission, the PSR Committee had no jurisdiction to make findings about Dr Selia's pre-billing practices. Specifically, the applicant submits that:

(1) Performing administrative tasks such as billing is not the provision of services as defined and therefore cannot be the subject of a referral under s 93(1).
(2) Nor is billing conduct "in connection with rendering or initiating services" so as to fall within the definition of "inappropriate practice" in s 82(1) of the Act.

[80] These submissions rely primarily upon the fact that the power to make a referral to a Committee under s 93(1) is to "make a referral to the Committee to investigate whether the person under review engaged in inappropriate practice *in providing the services* specified in the referral" (emphasis added). Similarly "*findings*, in relation to a draft report or final report of a Committee" are defined in s 81 to mean "the Committee's findings as to whether the person under review engaged in inappropriate practice *in the provision of* some or all of the services specified in the referral made to the Committee." (emphasis added). Accordingly, the PSR Committee's power to make findings cannot exceed the terms of the referral (s 106H(1)). The submissions also rely upon the definition of the term "service" in s 81(a) for the purposes of Part VAA to mean (relevantly) "a service for which, at the time it was rendered or initiated, medicare benefit was payable". The services which may be referred with their corresponding Medicare item numbers are set out in Sch 1 to the 2007 Determination and are all concerned with clinical matters (e.g. oral surgery).

[81] These submissions, with respect, misconstrue the relevant provisions and must be rejected. First, it was not in issue that the services specified in the Referral (quoted above at [27]) met the statutory definition of "services". Equally, it was not in issue that billing of itself is not a "service" as defined. However, the phrase in s 93(1) "in providing the services" is apt to require that there be a connection between the conduct said to constitute "inappropriate practice", on the one hand, and the services specified in the Referral, on the other hand. So understood, the phrase does not limit the concept of what may constitute "inappropriate practice" as defined in s 82 where such a connection may exist. The pivotal issue is, therefore, whether billing falls within the definition of "inappropriate practice".

[82] Secondly, "inappropriate practice" as defined by the Act is not limited to the provision of services, but expressly includes conduct "in connection with rendering or initiating" of services. As a matter of ordinary language, billing for services may constitute "conduct" in connection with the rendering or initiating of the services to which the bill relates. The terms "in connection with" are, as the applicant accepted, words of broad import: see also *Wong* at 635 [215] (quoted below at [90]). For the reasons earlier mentioned, there is no warrant in the text for effectively reading those words out so as to limit inappropriate practice to conduct "in the provision of the services"; nor to substitute for the words "in connection with", the words "in the course of" or "forming part of." If the Parliament had intended to so limit the concept of inappropriate practice, there is no reason why the Parliament would not have said so in the definition of "inappropriate practice" itself.

[83] Thirdly, this construction is confirmed by the expressed object of Part VAA, being relevantly to protect the integrity of the Medicare benefits programme (s 79A). Given that object, Part VAA should not be narrowly construed: *Health Insurance Commission v Grey* [2002] FCAFC 130; (2002) 120 FCR 470 (Grey) at 504 [173] (the Court). It is, with respect, difficult to conceive of a matter more closely connected to protecting the integrity of a system for the payment of benefits

for the provision of medical services from public monies than the billing for those services by the practitioner under that scheme in accordance with its requirements. Those requirements, in turn, are ultimately directed to ensuring transparency and accountability for the expenditure of those public monies. Consistently with this, French CJ and Gummow J observed in *Wong* at 593 [63] that:

> The keeping of adequate and contemporaneous records of the rendering or the initiation of services provided by the practitioner is, as the place of s 82(3) within the definition of "inappropriate practice" indicates, apt to assist the Committees in reaching their reasonable conclusions as to unacceptable conduct for s 82(1).

[84] Justice Kirby also held at 620 [159] that:

> ... I agree with what Hayne, Crennan and Kiefel JJ have written about the analogy between the statutory criteria expressed in the Act and the long-established law on professional standards stated in such decisions as *Allinson v General Council of Medical Education and Registration* [[1894] 1 QB 750] with the elaboration now afforded by Lord Hoffmann in *McCandless v General Medical Council*. The concept of "inappropriate practice" is not exactly the same as "unprofessional conduct" existing in the 1890s when *Allinson* was decided. The statutory criterion today, in a modern regulatory state with a universal, national health scheme, contemplates detailed record-keeping to comply with basic constitutional and statutory principles. Poor book-keeping might not have been "unprofessional conduct" in the century before last. However, in the contemporary Australian context, where what is involved is overcharging, overservicing or inadequate clinical care in the nominated time, it could well be so.

[85] Thus, the PSR Committee as an expert professional body will form its assessments "in a therapeutic context" as Kirby J explained in *Wong* at 620 [157]. Nonetheless, as Kirby J also accepted, the Act is legitimately concerned with matters concerning the legality and financial integrity of payments made under the Medicare system (at 618 [152]- 619 [153]) and the context of inappropriate practice may extend to such matters as the keeping of inadequate records. Similarly, in *Grey* at 504 [173(3)], the Court identified among the areas of consensus emerging from the cases in the interpretation of the Act, that "[m]aking a claim under an incorrect item is capable of constituting conduct which amounts to 'inappropriate practice'."

[86] Equally in *Sevdalis*, Mortimer J observed at [73] that:

> Since the introduction of the concept of "inappropriate practice" as the touchstone for the review [under Part VAA], as well as the investigation and determination functions in Pt VAA, there is no doubt that practitioners' conduct is exposed to review on broader grounds than their entitlement to payment in accordance with the Act and regulations.

[87] The applicant seeks to read down the ordinary meaning of these provisions so as to confine the concept of "inappropriate practice" to the provision of clinical matters and to exclude so-called "administrative" matters on the basis that this "is consistent with a legislative scheme which is concerned with reviewing professional clinical practice and which has its roots in common law principles of

professional responsibility, as recognised in *Wong*." However, the historical context against which the scheme was enacted cannot prevail against the words of the Act which do not confine inappropriate practice to professional clinical practice; nor can it prevail over the object of Part VAA to protect the integrity of the Medicare benefit scheme, in line with s 15AA of the *Acts Interpretation Act 1901* (Cth) (the Interpretation Act) requiring that preference be given to the construction which best promotes the legislative objects (e.g. *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355 at 381 [69] (McHugh, Gummow, Kirby and Hayne JJ)).

[88] Nor do I accept the applicant's submission that his construction is supported by the decision in Wong. To place that decision in context, in that case the High Court rejected the contention that Part VAA of the Act was invalid on the ground that it amounted to or authorised "civil conscription" within the meaning of s 51(xxiiiA) of the Constitution. That provision empowers the Commonwealth to make laws with respect to the provision (relevantly) of medical and dental services "but not so as to authorize any form of civil conscription". In so holding, the High Court by majority held that there was no compulsion under the scheme to perform a professional service (so as to amount to civil conscription), but only a practical compulsion to adhere to professional standards in respect of any services provided, for which Medicare benefits are payable either to the patient or to the practitioner: see *Wong* at 595 [68] (French CJ and Gummow J), 633 [209] and 638 [224] (Hayne, Crennan and Kiefel JJ).

[89] In this regard, it is true that Hayne, Crennan and Kiefel JJ held that the requirement in s 82 that "the conduct would be unacceptable to the general body" of relevant practitioners is an objective standard often identified as the opinion of members of the profession of good repute and competency, and that it can, therefore, "be seen as maintaining the thread common to many earlier forms of professional discipline and regulation, by which the standards of conduct are set by reference to prevailing professional opinion." (*Wong* at 638 [223]; see also at 593-594 [64]-[65] (French CJ and Gummow J)). However, the existence of that common thread does not mean that the Parliament must be understood as having been concerned only with inappropriate practice with respect to clinical matters. To the contrary, the common thread identified by their Honours was that practitioners are required to abide by a particular standard of professional conduct which "is framed by reference to professional opinion." (*Wong* at 638 [224]). It is on this basis that Hayne, Crennan and Kiefel JJ held that the standard of conduct "...is, therefore, not different in kind from the standard of professional conduct that, since *Allinson's Case*, has been expected of medical practitioners in the conduct of their profession." (ibid) (emphasis added).

[90] Furthermore, while (as the applicant points out) Hayne, Crennan and Kiefel JJ considered in Wong at 635 [215] that there was room for debate about whether "all questions about clinical competence and performance, or all organisational issues affecting [patient] safety" would be "conduct in connection with rendering or initiating services", their Honours' concern was only with whether the requisite connection in s 82(1) would be made out in all such cases. As their Honours continued at 635 [215] to explain:

> No doubt the expression 'in connection with' is not to be given a narrow or confined construction. But the provision requires that a connection be demonstrated between identified conduct and rendering or initiating services for which benefits are payable.

[91] Contrary to the applicant's submission, nothing in those passages or otherwise in the majority judgments can be said to have "exhibited caution in the construction of the words 'in connection with'" (emphasis added); nor that their Honours suggested that only clinical matters could constitute inappropriate practice.

[92] It follows that the pre-billing for services for which a Medicare benefit is payable can constitute inappropriate practice in providing services specified in a referral under s 93(1) of the Act and otherwise for the purposes of the investigation and making of findings by a PSR Committee under Part VAA of the Act. The applicant's submissions to the contrary must be rejected.

[93] No issue was taken with any of the PSR Committee's views as to the effect of the Act and regulations with respect to the provision of services by dentists employed by Dr Selia and in particular with its opinion at [35] of the Final Report that "the legislation did not permit another dentist, including an employee of Dr Selia, to render services under the Health Insurance Act 1973 on behalf of Dr Selia".

[94] Nonetheless, in the applicant's contention, the PSR Committee was not empowered to make the employed dentist findings given that:
(1) the employed dentist findings are not findings about Dr Selia's clinical practice; nor are they "findings" as defined in s 81(1) because they are not findings that he engaged in inappropriate practice "in the provision of services";
(2) the PSR Committee's finding that an employer's conduct in billing for services rendered by an employed dentist was not capable of constituting "inappropriate practice" because it could not reasonably be concluded that it was unacceptable to the general body of the members of the profession. In effect, the applicant's submission was that the finding was unreasonable and therefore beyond the scope of the Committee's power to make findings.

[95] The first ground must fail for the same reason that the equivalent submission with respect to the PSR Committee's finding that Dr Selia's pre-billing practice constituted inappropriate practice must fail: see above at [81]-[92]. The concept of "inappropriate practice" under the Act is not limited to clinical matters; nor is that concept limited to conduct in the provision of services.

…

[105] In support of the submission that Dr Selia's conduct in billing services rendered by employed dentists against his Medicare provider number could reasonably constitute inappropriate practice, Dr Selia submitted that:

> A dentist who engaged in such conduct could not reasonably be considered to be 'in such breach of written or unwritten rules of the profession as would reasonably incur the strong reprobation of professional brethren of good repute and competence' (*Wong* ... French CJ and Gummow J at 593 [64]).

[106] While, that submission notwithstanding, the applicant accepted that the concept of inappropriate practice "is not exactly the same as 'unprofessional conduct' existing in the 1890s when *Allinson* was decided", he submitted that:

> The words "conduct unacceptable" are nevertheless to be read in light of the common law tradition of professional discipline. The words "strong reprobation" employed by French CJ and Gummow J in Wong, are not so much a gloss on s 82 ... as a reflection of the circumstance that a high level of reprobation is necessary before conduct can properly be described as being "unacceptable" to a profession, taking into account the tradition of which s 82 forms a part.

[107] It is this construction which would seem to underlie the argument that, absent a fraudulent intent, the applicant's practice with respect to his employed dentists could not reasonably have been found to be unacceptable for the purposes of s 82 of the Act.

[108] It cannot be doubted, as the applicant submits, that a finding of inappropriate practice under the Act is a finding of a serious kind with potentially devastating consequences for the practitioner concerned. As such, it is not to be made lightly. Nonetheless, it is the words in s 82 in their statutory context which fall to be applied. Consistently with this, French CJ and Gummow J in *Wong* (on whose reasons the applicant relies) explain at 593 [64] that the statutory criterion of conduct unacceptable to the general body of general practitioners "is an adaptation for the operation of the Act of principles of professional responsibility developed in the second half of the nineteenth century" (emphasis added). The test which the applicant quotes in the passage set out at [105] above is a passage quoted by French CJ and Gummow J as encapsulating the essential test "in such cases" (*Wong* at 594 [64]). Thus while French CJ and Gummow J explain at 594 [65] that the requirement is that the professional activities of medical practitioners "conform to the norms derived from *Allinson*" (emphasis added) and that those norms are "calculated to ensure that the activities be professional rather than unprofessional in character", those norms are to be construed in the context of "[a] legislative scheme for the provision of medical services supported by appropriation of the Consolidated Revenue Fund established under s 81 of the Constitution". That view in any event aligns with the construction adopted by the four other members of the majority in *Wong* and is therefore binding upon this Court: see the discussion above especially at [84] and [89]-[90] above.

[109] Given that context, it follows in my view that the finding by the PSR Committee that the practice in question was not acceptable to the general body of practitioners was reasonably open to it and the applicant's submissions, with respect, fall well short of establishing that the high threshold of legal unreasonableness has been crossed in this case. First, as mentioned, there is no challenge to the PSR Committee's findings that the legislation did not permit dentists employed by Dr Selia to render services on his behalf. Secondly, for reasons I have earlier given, an inappropriate practice may include matters concerning the legality and financial integrity of payments under the Medicare system in line with the object in s 79A where they are connected with the provision of services. Thirdly, the PSR Committee drawing upon its expertise gave clear and cogent reasons in its Final Report for finding that on the facts of this case, Dr Selia's

practice with respect to his use of employed dentists in the manner described would not be acceptable to the general body of dentists, namely:

> [60] It was submitted that Dr Selia's use of employed dentists to provide services under the Scheme was an 'innocent error', which would not be unacceptable to the general body of dentists, especially as it was suggested that Dr Selia could gain no advantage from this arrangement because the other dentists could have obtained their own provider numbers, or used them if they had them, and, by agreement, directed payment of the benefit to Dr Selia in return for the salary paid to them.
>
> [61] The Committee rejects the notion of 'innocent error' and doubts the proposition that Dr Selia did not gain an advantage from the use of employed dentists.
>
> [62] The Committee is of the view that the general body of dentists would have expected a dentist taking advantage of the Scheme, in Dr Selia's circumstances, to have familiarised himself properly with the requirements for the payment of Medicare benefits, especially as he conducted an enterprise by which millions of dollars in Commonwealth benefits were paid to him.

[110] As to the last point, counsel for the applicant said on a number of occasions that Dr Selia had one of the busiest practices in Australia and without objection mentioned that he had 16 employed dentists.

[111] Ultimately, therefore, the applicant's submissions, made without any expert or other evidence, are essentially assertive as the Commonwealth submits, and reduce to an impermissible attempt to ask the Court to revisit the merits of the PSR Committee's finding that the conduct in question would not be acceptable to the general body of dentists.

[112] It will be recalled that inappropriate practice is confined (relevantly) to "conduct in connection with rendering or initiating services" (s 82(1)). It will also be recalled that the "conduct" which may investigated and the subject of findings by the PSR Committee is confined to conduct in connection with the rendering or initiating of the "referred services", being those specified in the Director's referral under s 93 of the Act.

[113] Given these matters, the applicant contends (in the alternative to its argument that pre-billing falls outside s 82) that it was not open to the PSR Committee to find that his practice of pre-billing was in connection with the initiating or rendering of "the referred services" in the case of those services rendered after the review period or not rendered at all. Not only were those services not "render[ed]" within the review period, but the applicant also contends that they were not "initiat[ed]" within the review period either. Rather, in the applicant's submission, the services were "initiat[ed]" for the purposes of s 82 by the referral by a general practitioner of the patients in question to Dr Selia as is required by the 2007 Determination (see above at [20]), and the services could not therefore have been initiated again when the patient attended the initial consultation. The logical consequence of this construction of the word "initiating" in s 82(1) is, as the applicant accepts in his submissions, that "it is only a dentist's conduct in connection with rendering services which may constitute 'unacceptable conduct' within s 82(1)."

[114] That argument must be rejected.

[115] The starting point, as the applicant appears implicitly to accept, is that the umbrella paragraph to s 82(1) is concerned with the practitioner's conduct in connection with the rendering or initiating *by the practitioner* of services. In other words, the phrase "in connection with rendering or initiating services" forms part of the definition of the practitioner's conduct which can constitute inappropriate practice. This construction is confirmed by subs (1)(a) to (d) inclusive which set the standard for inappropriate practice. Thus, for example, s 82(1)(d) provides that "*if the practitioner rendered or initiated the services* as neither a general practitioner nor a specialist but as a member of a particular profession – the conduct would be unacceptable to the general body of the members of that profession." (emphasis added). In this regard, s 81(2) provides that:

> For the purposes of this Part, a person *provides services* if the services are rendered or initiated by:
> (a) the person; or
> (b) a practitioner employed by the person; or
> (c) a practitioner employed by a body corporate of which the person is an officer

[116] However, the applicant's construction wrongly assumes that a referral by a general practitioner to a dentist is the initiating conduct for any service which is subsequently given by the dentist. It may be accepted that a referral by a general practitioner "initiates" or "begins" the course of conduct undertaken by the dentist (or specialist) in treating the patient in the generalised sense that a referral was the necessary (or, in the applicant's words, "formal") precursor to bringing the dental service within the Medicare scheme under the 2007 Determination. However, to suggest that the word "initiating" in s 82 bears this meaning ignores the fact that the reason for setting professional standards such as those in Part VAA is to create standards with which practitioners participating in the Medicare system must comply and for which they will be held responsible if they fail to comply. In that context, the concept of "initiating" a service is plainly concerned with conduct which has an immediate causal connection with the rendering of the services – a construction which falls well within the ordinary English meaning of the word, as the Commonwealth submits.

[117] For example, where a dentist (Dr A) decides that an X-ray should be taken or a Crown inserted, Dr A takes responsibility for those services being undertaken even though the patient was referred to Dr A by a general practitioner and, in the case of the X-ray, Dr A did not herself or himself take the X-ray. It is, in other words, the decision by the dentist to insert the Crown or to X-ray the patient that initiates the service in an immediate and proximate way, as opposed to the general practitioner's decision to refer the patient to the dentist.

[118] This construction is consistent with the definition of "initiate" in s 3(1) of the Act (on which the applicant relies) which reads:

> ***initiate***, in relation to a pathology service or a diagnostic imaging service, means make the decision by reason of which the service is rendered.

[119] This construction also ensures that conduct with an immediate causal connection is captured by s 82, thereby best promoting the purpose of Part VAA by providing a means for addressing issues such as over-servicing which lead to the enactment of Part VAA.

[120] Applying this construction, it is apparent that the services rendered outside the review period (or not rendered at all) were initiated at the initial consultations of the patients at which the treatment plan for the patient was established and the services were scheduled. Specifically, the PSR Committee found with respect to all of the services examined by it aside from the initial consultations (MBS item 85011) that:

(1) Dr Selia had engaged in inappropriate practice by pre-billing either on the day or within a few days of the initial consultations;
(2) the initial consultation and pre-billing occurred within the review period;
(3) during the initial consultations, the patients' treatment plans were established; and
(4) the treatment plans included the scheduling of the MBS item 85615, 85661 and 85672 services.

[121] There is no challenge to those factual findings. To the contrary, they are consistent with a preliminary submission made by Dr Selia and given to the PSR Committee at the commencement of the hearing on 29 August 2013 as to his invariable practice.

[122] It follows therefore from a correct construction of the word "initiates" that the services which were rendered after the review period or were not rendered at all were nonetheless initiated within the review period and therefore that the PSR Committee had jurisdiction to make the findings with respect to pre-billing of those services, contrary to the applicant's submissions.

[123] In reply the applicant raised a further submission, contending in effect that it was not open to the Committee to find that services which were not rendered could constitute "inappropriate practice". The basis for the argument is set out as follows:

> [18] At the time each of the services considered by the PSRC was initiated (that is, the time of the third party referral), no medicare benefit was payable because no medical expenses had been incurred in respect of that service (see Act, s 10). No medicare benefit became payable until the service was "rendered" by Dr Selia. This is the basis for the bulk of the findings made against Dr Selia: that he claimed a medicare benefit before it was payable because it had not been rendered. Any service which was not "rendered" by Dr Selia during the review period, then, is not a "service" within the definition and is not within the PSRC's jurisdiction.
>
> [19] The definition of "inappropriate practice" also assumes a service has been rendered or initiated before practice may be "inappropriate". Section 82(1) provides, relevantly, that "[a] practitioner engages in inappropriate practice if the practitioner's conduct in connection with rendering or initiating services is such that a Committee could reasonably conclude that: ... (d) if the practitioner rendered or initiated the services as neither a general practitioner nor a specialist but as a member of a particular profession—the conduct would be unacceptable to the general body of the members of that profession." The

> words "rendered or initiated" assume that the practitioner has, in fact, provided the services. Whilst these words may be open to a different reading in light of the 2012 amendment to the definition of "services," before that amendment they reinforced the conclusion that services had to be provided before a finding of inappropriate conduct could be made

[124] The submission must be rejected. First, for the reasons earlier given, the services were "initiat[ed]" for the purposes of the definition of inappropriate practice at the initial consultation when the treatment plan was prepared and the services scheduled.

[125] Secondly, the submission overlooks the fact that in billing for the scheduled services, Dr Selia represented that they had in fact been rendered when they had not.

[126] Thirdly, taken to its logical conclusion, the submission would mean that any conduct undertaken prior to the rendering of a service for which a Medicare benefit was payable would fall outside the concept of "inappropriate practice". In this case, it would mean that pre-billing for services never rendered could not constitute inappropriate practice and therefore could not be the subject of investigation and review by the PSR Committee and directions by the Determining Authority. It would also mean, for example, that services not reasonably required for the treatment of the patient, and for which no medicare benefit was therefore payable by virtue of s 19(5), would fall outside Part VAA. That construction undermines the object in s 79A and would permit conduct of a most egregious kind to fall beyond the purview of Part VAA. However, that is not the only construction available. Sensibly read, it is sufficient if the practitioner's conduct is in connection with "initiating" services (properly construed) for which a Medicare benefit would be payable when (or if) the services are rendered. This construction gives effective work for the word "initiating" in s 82 to do and reads the definition of "service" in s 81(1) in the context of s 82(1), being the lead provision. In this regard, the interaction between these provisions plainly cannot be determined by the insertion in 2012 of subs (ab) to the definition of "service" in s 81(1) providing that "a service that has been initiated (whether or not it has been or will be rendered) if, at the time it was initiated, medicare benefit would have been payable in respect of the service had it been rendered at that time." It is not permissible to construe a provision by reference to a later amendment. In any event, in my view by the amendment Parliament has simply made express that which was previously implicit.

Sevdalis v Director of Professional Services Review [2017] FCAFC 9 —

[19] Section 10(1) of the Act provides that a medical benefit is payable in respect of "a professional service rendered" in Australia to an eligible person subject to and in accordance with the Act "in respect of that professional service". The expressions "eligible person", "medical expenses", "medical benefits" and "professional services", amongst others, are defined in s 3(1). Professional service is defined in s 3(1) to include:

> (a) a service (other than a diagnostic imaging service) to which an item relates, being a clinically relevant service that is rendered by or on behalf of a medical practitioner;

[...]

Section 3(1) also contains a definition of "clinically relevant service" which is defined to mean:

> ...a service rendered by a medical ... practitioner ... that is generally accepted in the medical, ... profession ... as being necessary for the appropriate treatment of the patient to whom it is rendered.

Her Honour considered that these provisions permitted the Committee to evaluate whether the service was necessary for the appropriate treatment of a patient and her Honour was persuaded on the balance of probabilities that the Committee had assessed Dr Sevdalis' conduct against the standard required by s 10 read with the definition in s 3(1). There was no error in her Honour's approach.

[20] Ground 5 of the notice of appeal is that her Honour erred in upholding the decision by reference to the test in ss 3 and 10 of whether the service rendered was "necessary for the appropriate treatment of the patient" because the test to be applied by the Committee was whether the practitioner's conduct would be "unacceptable to the general body of general practitioners" within the meaning of s 82. The consideration of whether the conduct of a practitioner would be "unacceptable to the general body of general practitioners" within the meaning of s 82 of the Act does not exclude, but may be answered by, a consideration of whether a service was "necessary for the appropriate treatment of the patient" within the meaning of ss 3 and 10.

[21] It was open to the Committee, as a peer review body, to assess what was "necessary" for the appropriate treatment of patients, including whether it was necessary to consult with those patients at locations other than the appellant's consulting rooms, and to take that into account when determining whether the practitioner's conduct would be "unacceptable to the general body of general practitioners". The definition of "clinically relevant service" defines a service as one that is "necessary" for the appropriate treatment of the patient. Section 79A of the Act describes the object of Part VAA (in which s 82 is found) as follows:

> The object of this Part is to protect the integrity of the Commonwealth medicare benefits, dental benefits and pharmaceutical benefits programs and, in doing so:
> (a) protect patients and the community in general from the risks associated with inappropriate practice; and
> (b) protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.

[22] The terms in which "clinically relevant service" is defined, and the objects in s 79A, required the Committee, where appropriate, to evaluate and form a view about the appropriateness of the treatment given by a medical practitioner to a patient. The Committee did that as her Honour recorded at [130] of her Honour's reasons:

> Then, at [65] the Committee addressed the s 10 and s 3(1) requirements of "professional service", together with submissions made on behalf of Dr Sevdalis:

> This is further supported by the requirement in the Act that Medicare benefits are payable only in respect of a "professional service" that is a "clinically relevant service". This means that the particular service rendered must be a service that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient. If it was not necessary to conduct a home visit for the treatment of the patient, then it was not a clinically relevant service and was not eligible for the payment of a Medicare benefit. Consequently, a practitioner needs to document the clinical information adequate to explain the type of service rendered, which in respect of home visits should include the fact that it was a home visit, and the reason for having to go to that particular location on that occasion to attend to the patient. For after-hours visits, it should indicate when the attendance occurred and the clinical reasons for needing to attend to the patient at that time. For minimum timed services, the clinical record should record the actual time spent and indicate the clinical reasons for spending at least the minimum amount of time for the MBS item billed.
>
> [23] The Committee had based its conclusion upon its construction of items 37 and 5043 but had considered also the requirements of "professional service" in ss 10 and 3(1). Her Honour was permitted to conclude that despite any supposed erroneous interpretation of the requirements by the Committee of items 37 and 5043, it was substantially correct also to conclude that the requirements of s 10 of the Act, read with s 3(1), permitted it to consider whether the service rendered by Dr Sevdalis was necessary for the appropriate treatment of the patient to whom it had been rendered: see *Eastman v Commonwealth Director of Public Prosecutions (ACT)* (2003) 214 CLR 318, [124]; *Australian Education Union v Department of Education and Children's Services* [2012] HCA 3; (2012) 248 CLR 1, [34]; *Attorney-General (SA) v Corporation of the City of Adelaide* [2013] HCA 3; (2013) 249 CLR 1, [175].

In *Kew v Director of Professional Services Review*, it was argued that the Committee should not have found that Dr Kew's conduct in co-billing items 104 or 105 with a diagnostic imaging service would be unacceptable to the general body of radiologists because there were statistical data that demonstrated that many other radiologists also co-billed these items to a similar extent. The Court rejected that argument, indicating that statistics were unlikely to trump the detailed analysis the Committee had made of the sampled cases, the Committee was not obliged to take the statistics into account, and it was not required to investigate the circumstances behind those statistics. While the Committee appropriately took into account the usual variances of practice and differences of opinion within the specialty, it was not required to base its assessment of the opinion of the general body by reference to one member, or a part of, the general body of radiologists.

Kew v Director of Professional Services Review [2021] FCA 1607 —

> [136] Now as to the statistical material, Dr Kew's submissions to the committee were to the effect that a majority of radiologists billed items 104 or 105 in

association with a diagnostic imaging item and item 18222 was rendered in association with item 104 or 105 in almost A% of cases and item 18216 was rendered in association with item 104 or 105, B% of the time. Therefore, so it was said, the committee could not be satisfied that Dr Kew's peers would consider the conduct unacceptable.

[137] But whether co-billing was justified or not depended on the facts of each case.

[138] In my view, the committee appropriately disposed of Dr Kew's argument without error (at [156] and [175]). I have already set out [156]. Let me set out [175]:

> Both the Submissions and the submissions on the Draft Report relied on data provided to Dr Kew by the Committee (via the Department of Health) which reflected how many radiologists in Australia co-billed certain diagnostic procedure and consultation items during the Review Period. The Committee considers the statistical information to be of limited use in its task as it has not had an opportunity to investigate the systems of work of other radiologists. It does not follow that simply because many other radiologists have a similar billing profile to Dr Kew, or that certain MBS items such as 104 and 105 are regularly billed with procedures such as MBS item 18222, that Dr Kew's particular practice in billing these services would be deemed acceptable by her peers. The Committee's review of the Referred Services is not based on statistics but is conducted with the benefit of the records and Dr Kew's evidence about particular services.

[139] In my view the committee was entitled so to proceed.

[140] First, its approach was, if I might say so, transparently rational. Statistics are one thing, and they were considered by the committee. But they could not or at least did not trump the committee's more detailed consideration. I also note here that the label "statistics" may over-state what was really being provided, which was in essence summarised aggregate data.

[141] Second, of course the committee was not bound to take the statistics into consideration. But it did consider them as part of the matrix of material before them.

[142] Third, I reject the suggestion that the committee was obliged to go away and investigate the particular circumstances behind the underlying data.

[143] Fourth, I have little difficulty with the committee's analysis in [150] addressed in context to the expression "the general body of specialists". Perhaps the reference to "singular threshold" is a little infelicitous. No matter. All that the committee was saying was that the hypothetical views of "one member, or a part of, the general body of radiologists" was not the relevant lens, although of course they could be taken into account. And as they say. "the usual variances of practice and differences of opinion" are relevant.

[144] Fifth, if one appreciates the point that I have just made, then the committee's observations at [153] are both consistent and unremarkable. Moreover, the latter part of [153] is grounded in the factual reality of the precise circumstances before them concerning Dr Kew's conduct and what the records reflected or otherwise.

> [145] Sixth, notwithstanding how the committee expressed itself at [175], Dr Kew was not required to establish the positive proposition that what she had done was acceptable to her peers. She did not carry the onus. Moreover, s 82(1)(b) required the committee to consider whether her conduct would be unacceptable. But on a review of the reasons as a whole, I am satisfied that the committee did not reverse any onus.
>
> [146] Seventh, there was no positive other evidence of peer practice before the committee apart from the statistics. But then there did not need to be given the direct evidence of Dr Kew's conduct, the legal requirements and the fact that the members of the committee had relevant specialist expertise.
>
> [147] Eighth, for all one knows in terms of the statistics, where other specialists were charging both fees they may have been doing so where there was meaningful consultation. But in Dr Kew's specific case the committee concluded otherwise.

Prescribed pattern of services

A practitioner is taken to having engaged in inappropriate practice if they rendered or initiated services during a particular period if the circumstances in which some or all of the services were rendered or initiated constitute a 'prescribed pattern of services' as provided for in section 82A (see below).[136] Subsection 82(1B) provides that a practitioner does not engage in inappropriate practice in rendering or initiating such services on a particular day if a Committee could reasonably conclude that, on that day, exceptional circumstances existed that affected the rendering or initiating of the services.

If exceptional circumstances are found to have existed on a particular day, that does not affect the finding of inappropriate practice in respect of other days within the relevant period.[137]

Section 7 of the *Health Insurance (Professional Services Review Scheme) Regulations 2019* prescribes certain circumstances to be exceptional circumstances for the purposes of this subsection 82(1B), but those circumstances are not taken to be exhaustive of what may constitute exceptional circumstances.[138] It provides:

> For the purposes of subsection 82(1D) of the Act, each of the following circumstances are exceptional circumstances for a particular day for a practitioner:
> (a) an unusual occurrence causing an unusual level of need for relevant services on the day;

[136] Subsection 82(1A) of the Act
[137] Subsection 82(1C) of the Act
[138] Subsection 82(1D) of the Act

(b) an absence, on the day, of other medical services for the practitioner's patients, having regard to:
(i) the location of the practitioner's practice; and
(ii) the characteristics of the practitioner's patients.

Paragraph (a) refers to 'an unusual occurrence'. The word 'occurrence' was discussed in a different context by the High Court.

Law v Repatriation Commission (1980) 29 ALR 64 —

> [An occurrence is] … an event or incident, something that happens or takes place. It does not require the quality of unexpectedness, of chance or misfortune that tends to accompany the term accident.

Repatriation Commission v Law [1980] FCA 92, (1980) 47 FLR 57 —

> The word "occurrence" is not defined by the Act. *The Oxford English Dictionary* defines the word "occurrence", so far as relevant, as "something that occurs, happens, or takes place; an event, incident."
>
> In our opinion, the word "occurrence", in the context of para (a), refers to the event, incident or mishap causing incapacity or death: see *Distillers Co. Biochemicals (Aust.) Pty. Limited v Ajax Insurance Co. Limited* (1974) 130 CLR 1 per Stephen J at p.19. It is an event, incident or mishap which is susceptible of differentiation from the course of events which constitute the ordinary course of life.

An earlier version of these regulations was contained in regulation 11 of the *Health Insurance (Professional Services Review) Regulations 1999*. Similarly, provisions analogous to subsections 82(1A) to (1D) were previously contained in section 106KA of the Act. A number of the cases, below, refer to those previous provisions.

Oreb v Willcock [2005] FCAFC 196 (per Black CJ and Wilcox J) —

> [6] As Lander J observes, the term 'exceptional circumstances' is not defined by the Act. However, it is clear that 'exceptional circumstances', within the meaning of the Act, may be established in either of two ways. First, a person under review may argue the existence of circumstances that are 'exceptional', in the ordinary English meaning of that word, and that may have nothing to do with the terms of reg 11. If so, it will be for the Committee to determine whether the relevant circumstances are truly exceptional, having regard to the usual operation of a practice of the kind conducted by the person under review. In the case of a general medical practitioner, as here, the touchstone will be the circumstances ordinarily faced by general practitioners.
>
> [7] If the Committee finds in favour of the practitioner on this issue, in respect of a particular day or days during the period specified in the Commission's notice, then the next question for the Committee to determine will be whether those circumstances 'affected the rendering or initiating of services by the person'. There must be a causal connection between the existence of the circumstances and the

provision of the services. We agree with Lander J, however, that the identified circumstances need not be the sole, or even dominant, cause of the provision of the services.

[8] Second, a person under review may rely on reg 11. That regulation itself provides two alternatives, paras (a) and (b). Those paragraphs are as follows:

> '(a) an unusual occurrence causing an unusual level of need for professional attendances;
> (b) an absence of other medical services, for patients of the person under review during the relevant period, having regard to:
> (i) the location of the practice of the person under review; and
> (ii) characteristics of the patients of the person under review.'

[9] If either paragraph is demonstrated to apply, that is enough to establish 'exceptional circumstances' for the purposes of the Act. This is because the chapeau to reg 11 declares that the circumstances set out in those paragraphs 'constitute exceptional circumstances'. It is immaterial whether or not they are exceptional, in the ordinary meaning of that word. Whether or not they are in fact exceptional to the ordinary experience of other practitioners, they are deemed to be exceptional for the purposes of s 106KA of the Act.

[10] Of course, if the requirement of either para (a) or para (b) is made out, it remains necessary for the practitioner to establish a causal connection (in the sense explained above) between the established circumstances and the provision of the relevant services.

[11] In his submissions to the Committee, Dr Oreb did not specify whether he was relying on exceptional circumstances, in the ordinary meaning of that term, or reg 11 or both. Certainly, he did not rely on para (a) of reg 11. Accordingly, it is possible to pass over that paragraph. However, he may have relied on para (b) of reg 11. Therefore, we should indicate our view of its proper construction.

[12] With respect, we do not agree with Lander J that placita (i) and (ii) state criteria to be satisfied before it can be concluded that para (b) applies. These placita specify matters to be considered by the Committee in forming a judgment whether there was 'an absence of other medical services' and, if so, whether there was a causal connection between that absence and the provision of the services. In our view, the list of matters to which regard is to be had in forming a judgment about whether there was an 'absence of other medical services' should not be interpreted as involving a requirement that each matter be present. That would be to read the words 'having regard to' as 'because of" and to read the list of matters as being reasons for forming that judgment rather than as matters to be considered. In addition, it seems to us that there is no complementarity between the two placita; there is no apparent reason why they should both *need* to be present. It is not difficult to conceive how each matter, separately, advances the policy underlying the provision. The absence of other medical services may conceivably be solely a function of location; for example, the practitioner may be the only practitioner in a remote location. The patients in such a place may have no particular 'characteristics' at all, other than that they live in that location. The absence may also, however, be very much a function of the characteristics of the patients; for

example, the person under review might service patients who suffer from an unusual medical condition in relation to which the alternative available practitioners do not have the requisite capabilities.

[13] As we have said, it is not clear upon what basis Dr Oreb put his case to the Committee. To the extent that he relied on the ordinary English meaning of the term 'exceptional circumstances', it seems to us the Committee adequately addressed the points made in his submission and answered them in a legally unexceptional way. As we read the Committee's report, it expressed the qualified view that '"exceptional circumstances" were seen as most likely to be of an intermittent or episodic nature' and did accept that 'some extreme on-going circumstance' may be an exceptional circumstance. It was for the Committee to determine the facts of the case, including whether the circumstances advanced by Dr Oreb should be regarded as exceptional, having regard to the usual operation of a general practitioner's practice. In making that determination, the Committee might be required to consider whether particular circumstances were foreseeable or avoidable. In relation to this type of case, there is room for consideration of the way in which a particular practice is managed.

[14] However, to the extent that Dr Oreb may have relied on reg 11(b), we agree with Lander J that concepts of foreseeability and avoidance were immaterial. So is practice management. The only relevant question was whether there was an absence of other medical services, having regard to the location of Dr Oreb's practice (Newtown) and the characteristics of his patients (predominantly people with a connection to the former Republic of Yugoslavia).

[15] Dr Oreb's submission did not specifically address the terms of reg 11(b). On one view of the matter, it failed to raise material that would have entitled the Committee to find an absence of other medical services for his patients in the period under review. However, the matters raised by Dr Oreb (if factually correct) might arguably support the inference that there was such an absence. That being so, the possible application of reg 11(b) needed to have been addressed by the Committee in terms, and in reasoning that was free of consideration (irrelevant in the context of reg 11) of patient management measures that might have been available and desirable.

[16] Other matters considered by the Committee (patient demand, the special mental and health care needs of Dr Oreb's patients, inability to attract/retain additional resources in the practice and Dr Oreb's work pattern) were, we think, relevant to reg 11. Dr Oreb's linguistic ability to deal with patients was arguably relevant to reg 11(b), although only if it was demonstrated there was an absence of satisfactory interpretation services. However, whether or not Dr Oreb could have better organised his practice was irrelevant. The focus of reg 11 is the need of the patients, not the management skills of practitioners.

[17] To the extent that the Committee must be regarded as having examined the issue arising under reg 11(b), it took into account an irrelevant circumstance: practice management measures. If the Committee must be regarded as having failed to consider reg 11(b), it ought to have done so. On either basis, the omission vitiated its decision. We agree with Lander J that the matter ought to be remitted to the Committee for further consideration and determination.

Oreb v Willcock [2005] FCAFC 196 (per Lander J) —

[57] It follows that if a general practitioner renders 80 or more services that are professional attendances on each of 20 or more days in a 12 month period the general practitioner will have engaged in inappropriate practice.

[58] If, however, the general practitioner satisfies the Committee that on a particular day or particular days during the relevant period, which is a period referred to in s 106KA(1) 'exceptional circumstances existed that affected the rendering or initiating of services by the (general practitioner), the (general practitioners') conduct in connection with rendering or initiating services on that day or those days is not taken by subsection (1) to have constituted engaging in inappropriate practice': s 106KA(2).

[59] Where it is established that a general practitioner has rendered 80 or more services that are professional attendances on each of 20 or more days in a 12 month period, the onus is cast upon the general practitioner to satisfy the Committee of the matters in s 106KA(2) so that that particular day or particular days during the relevant period should not count in determining whether the prescribed pattern of services has been established under s 106KA(1).

[60] Section 106KA(5) provides for the making of regulations which might constitute exceptional circumstances in s 106KA(2).

[61] Section 106KA(5) makes it clear, however, that the Regulations do not constitute a code of circumstances which would amount to 'exceptional circumstances'. The circumstances which are declared by the Regulations to be 'exceptional circumstances' are deemed to be exceptional circumstances by force of the Act and Regulations.

[62] Regulation 11 of the Regulations provides:

> '11 For subsection 106KA(5) of the Act, the following circumstances are declared as constituting exceptional circumstances:
> (a) an unusual occurrence causing an unusual level of need for professional attendances;
> (b) an absence of other medical services, for patients of the person under review during the relevant period, having regard to:
> (i) the location of the practice of the person under review; and
> (ii) the characteristics of the patients of the person under review.'

[63] In my opinion, it is clear, when one reads s 106KA and the regulations made thereunder, that the Committee must consider what services that were professional attendances were rendered on a particular day in order to determine whether there is a prescribed pattern of services of the kind which would constitute engaging in inappropriate practice. It must first satisfy itself that the medical practitioner has rendered 80 or more services that were professional attendances on each of 20 separate days in a 12 month period. Unless it is satisfied of that, it cannot, at least under s 106KA(1), find that the medical practitioner has engaged in conduct which constitutes inappropriate practice.

[64] Once the Committee has identified the particular days upon which 80 or more services that were professional attendances were rendered and is satisfied that that pattern of services existed on 20 or more days, then the onus falls upon medical practitioner, if the number of days upon which the prescribed pattern of services is to be reduced, to satisfy the Committee that on a particular day or particular days during that period exceptional circumstances existed of the kind referred to in s 106KA(2) or reg 11.

[65] That means there must be a consideration as to whether exceptional circumstances of the kind referred to in s 106KA(2) existed on each of the particular days which form the prescribed pattern of services.

[66] In my opinion, to constitute exceptional circumstances, the circumstances must be unusual or out of the ordinary or they must be circumstances of the kind that reg 11 prescribes as exceptional circumstances. More needs to be said about the construction of reg 11(b) in relation to one of the issues raised on the cross-appeal.

…

[175] That it is a consideration of individual days is reinforced by reference to s 106KA(2) which talks of a particular day or particular days. Therefore, for the purpose of s 106KA(2), in considering whether exceptional circumstances exist, the decision-maker must have regard to whether exceptional circumstances exist on any of the days which it has taken into account under s 106KA(1).

[176] Thus it is that in considering whether exceptional circumstances exist reference is made to the particular days which have been identified for the purpose of s 106KA(1) and which, by force of that section, has deemed the medical practitioner to have engaged in inappropriate practice.

[177] In a sense it is quite irrelevant that the exceptional circumstances might have existed for the whole of the period under consideration, because after the decision-maker has identified the particular days under s 106KA(1), within the period not exceeding one year, the rest of the days when the decision-maker has not rendered 80 or more services are irrelevant.

[178] I will come to the Regulations shortly. However, before doing so, I should observe that a general practitioner might seek to establish 'exceptional circumstances' without reference to the Regulations. Section 106KA(5) preserves a general practitioner's right to establish exceptional circumstances without reference to the Regulations. If the general practitioner seeks to invoke the provisions of s 106KA(2) without reference to the Regulations the general practitioner must establish that exceptional circumstances existed. In that case, the general practitioner will need to establish that the circumstances, whatever they were, were exceptional in the sense that they are unusual or out of the ordinary. As I have said, however, it is not appropriate to substitute other words for the words in the statute. The test must remain, were the circumstances exceptional? If the general practitioner establishes that exceptional circumstances existed, he must then establish that those circumstances affected the rendering or initiating of services by that general practitioner on a particular day or particular days. In establishing that the exceptional circumstances affected the rendering or initiating of services, the general practitioner does not need to establish that those circumstances were the

only circumstances affecting that matter. Indeed, the general practitioner does not need to establish the circumstances were the dominant circumstances affecting the rendering or initiating of services. The section only requires that the exceptional services affected the services rendered or initiated by the general practitioner. 'Affected' is used in s 106KA(2) in the sense of acted upon or influenced. Thus, there must be a relationship between the exceptional circumstances and the rendering or initiating of services in the sense that the former acted upon or influenced the latter. However, the exceptional circumstances need not be the only matter acting or influencing the rendering or initiating of services. Other matters which might be quite unexceptional might also affect the rendering or initiating of services.

[179] Whether there are other matters affecting, in the sense of acting upon or influencing the rendering or initiating of services, is quite irrelevant unless it can be established that they were the only matters affecting the rendering or initiating of services so that it can be said that the exceptional circumstances did not affect the rendering or initiating of services.

[180] The general practitioner's management of his practice will, in all cases, affect the way in which he or she renders or initiates services. The hours that general practitioner works will affect the number of patients that general practitioner sees. It may be that by reducing the hours the general practitioner will reduce the number of services rendered. However, that does not mean that a general practitioner cannot establish that exceptional circumstances affected the rendering or initiating of services. The general practitioner's management of the practice becomes irrelevant if the general practitioner has established that exceptional circumstances affected the rendering or initiating of services on the particular day or days.

[181] Of course, the general practitioner must establish also that those exceptional circumstances existed and affected the services rendered or initiated on the particular day or days. The particular day or days are any of the days identified by the Committee which form part of the prescribed pattern of services in s 106KA(1).

[182] A regulation has been made under s 106KA(5). Regulation 11 has been promulgated to provide circumstances which are, by force of that subsection, exceptional circumstances.

[183] Regulation 11 has two separate limbs and in the second limb two criteria.

[184] In neither limb does a practitioner have to establish exceptional circumstances according to the general meaning of that term in s 106KA(2) because the two limbs are separately, by force of s 106KA(5) of the Act, exceptional circumstances.

[185] Regulation 11(a) will operate in conjunction with s 106KA(2) to extinguish a particular day from the decision-maker's consideration of s 106KA(1) if the general practitioner can establish that an 'unusual occurrence causing an unusual level of need for professional attendances' 'that affected the rendering or initiating of services by the practitioner' occurred on that particular day or those particular days.

[186] For that paragraph of the regulation to be enlivened the occurrence must be unusual. That means it must be out of the ordinary or indeed exceptional. An unusual circumstance will also be an exceptional circumstance. An unusual or exceptional circumstance is a circumstance which is out of the ordinary. Whilst an unusual circumstance is something which is out of the ordinary or exceptional, there is no warrant for using those words in lieu of the word unusual in a consideration of this subregulation. The question is always whether the occurrence was unusual.

[187] Not only must the occurrence be unusual, that unusual occurrence must also cause an unusual level of need for professional attendances. An unusual level of need must be a level which is out of the ordinary or indeed, again, exceptional. The deemed 'exceptional circumstances' in reg 11(a) are circumstances which would ordinarily be considered to be exceptional circumstances because two unusual circumstances must operate together, the second being consequent upon the first.

[188] Therefore, if a particular set of circumstances prevailed over the whole of the period under consideration and operate, for example, on all of the particular days under consideration within that relevant period, it would be hard to say that those circumstances are exceptional, unusual or out of the ordinary. That must be so because there must not only be an unusual occurrence but that must itself cause an unusual level of need for professional services.

[189] It is hard to think of a set of circumstances which are unusual which would operate over the relevant period and on 20 or more days during that period, especially where the relevant period might be as long as one year. If the occurrence operated over the whole of the period and on all of the particular days, it might be said that those circumstances are usual. That is not to say that reg 11(a) can never operate if the unusual occurrence operates to cause the unusual level of need during the whole of the period, but it is difficult to think of circumstances in which it would apply.

[190] Therefore, for the operation of reg 11(a), ordinarily it will ordinarily be a single event which pertains to a particular day or particular days which operates to allow the decision-maker to conclude that, in respect of that particular day or particular days, there was an unusual occurrence which caused an unusual level of need for professional services.

[191] Regulation 11(a) is deemed by s 106KA(5) to be circumstances that amount to exceptional circumstances. As has already been shown, a practitioner may argue that exceptional circumstances exist without relying upon reg 11. That is permissible: s 106KA(5). The practitioner may simply claim that circumstances other than those contained in reg 11 are exceptional circumstances. That being so, the circumstances in reg 11(a) must be something other than the exceptional circumstances predicated in s 106KA(2). If it were otherwise, there would be no need for reg 11(a).

[192] Once the general practitioner has established the circumstances in reg 11(a), the next question for the decision-maker, in this case the Committee, is whether the unusual occurrence which has caused an unusual level of need for professional attendances 'affected the rendering or initiating of services by the [general practitioner]': s 106KA(2).

[193] It is always a two step inquiry. First, whether reg 11(a) has been made out and, secondly, whether those circumstances affected the rendering or initiating of services by the general practitioner on the particular day or days identified by the Committee which form part of the prescribed pattern of services in s 106KA(1).

[194] In conducting the second stage of the inquiry the Committee will consider the affect on the rendering and initiating of services by the practitioner in the same way as previously advised. The reg 11(a) circumstances need not be dominant. Other circumstances which affect those matters will only be relevant if they are to exclude the reg 11(a) circumstances from affecting those matters.

…

[210] The medical practitioner, in relying upon reg 11(b), does not have to establish that the circumstances in reg 11(b) are exceptional. They are exceptional if they are made out because, as I have said, reg 11(b) makes them so.

[211] Whether or not, ordinarily, anyone else would think those circumstances are exceptional is not to the point.

[212] The primary judge said:

> '[215] Committee 298 thought that the meaning of "exceptional circumstances" was unclear. It seemed to the Committee that s 106KA(2) limited the type of circumstances which would be exceptional to those which were of an episodic or intermittent nature whereas Reg 11(b) seemed to include events of an ongoing nature. It sought to resolve this apparent ambiguity by reference to extrinsic material. This led it to the view that exceptional circumstances would ordinarily be intermittent and that it would be "difficult to justify" circumstances of an ongoing nature.'

[213] Later, he said:

> '[220] Exceptional circumstances under Reg 11(b) therefore include an absence of other medical services during that period, having regard to the location of the practice and the characteristics of the patients. There is nothing in the language which restricts this to episodic events. Indeed, Reg 11(b) seems to have been deliberately drawn so as to broaden the category of circumstances beyond those contemplated by Reg 11(a).'

[214] He also found:

> '[223] The Committee found that the matters put forward by Dr Oreb, which included the location of his practice and the characteristics of his patients, were foreseeable and did not constitute exceptional circumstances. The question of whether there were exceptional circumstances was a question of mixed fact and law, but it seems to me that Committee 298 reached its conclusion on the basis of its incorrect interpretation of the "exceptional circumstances" provision. That is to say it approached its finding on the basis that Dr Oreb had a heavier onus of satisfying the Committee in relation to ongoing circumstances than in a case of an episodic or unusual event.'

[215] In my opinion, the primary judge's decision was correct.

[216] A Professional Services Review Committee which is charged with the obligation of considering whether the medical practitioner has engaged in inappropriate practice by conduct constituting a pattern of services under s 106KA(1) should approach the matter by first considering whether or not there was a prescribed pattern of services of the kind prescribed in reg 10.

[217] If the Professional Services Review Committee finds that the medical practitioner has during the relevant period rendered or initiated services which constitute a prescribed pattern of services in that, in the case of a general practitioner he or she has rendered services that are professional attendances of more than 80 on 20 or more days, then the Professional Services Review Committee must consider whether any of those days should not be reckoned because exceptional circumstances existed.

[218] If the Professional Services Review Committee reaches such a conclusion, and if the medical practitioner asserts that on a particular day or particular days on which 80 or more services were rendered or initiated there were exceptional circumstances in existence, the Professional Services Review Committee must turn to consider that question.

[219] If the medical practitioner does not rely upon reg 11 but simply relies upon circumstances which the medical practitioner says are exceptional circumstances, then an inquiry must be made into those circumstances to see whether they are exceptional in the sense as I have described it.

[220] If, on the other hand, the general practitioner relies upon either or both of the paragraphs of reg 11 an inquiry must be had to determine whether the circumstances fit the description of the circumstances in either of those paragraphs.

[221] That means that the Committee will have to determine whether the circumstances which have been adduced by the medical practitioner constitute an unusual occurrence causing an unusual level of need for professional attendances or, separately, whether the circumstances adduced show an absence of other medical services for the general practitioner's patients during the relevant period having regard to the location of the general practitioner's practice and the characteristics of the general practitioner's patients.

[222] As I have already said, it is not necessary, if the general practitioner is relying upon reg 11, for the general practitioner to establish exceptional circumstances. All the general practitioner must do is establish that the circumstances relied upon come within either paragraph (a) or (b).

[223] If the general practitioner can make out that exceptional circumstances existed or that an unusual occurrence causing an unusual level of need for professional services existed or that there was an absence of other medical services for the general practitioner's patients during the relevant period because of the location of the general practitioner's practice and the characteristics of the general practitioner's patients, then the Committee must next consider whether, whichever of the three different circumstances has been relied on and established by the general practitioner affected the general practitioner's rendering or initiating of

services. In carrying out that aspect of its inquiry the Committee will need only to be satisfied that the rendering or initiating of services was affected.

[224] If the Committee is satisfied that one of those three different circumstances did affect the rendering or initiating of services by the general practitioner, then the Committee must next consider whether the circumstances did so on a particular day or days which have been identified by the Committee as being the day or days which constituted the prescribed pattern of services in s 106KA(1).

…

[227] In my opinion, the primary judge was right to conclude that the Professional Services Review Committee 298 fell into error.

[228] In its findings, the Committee refers from time to time to circumstances which, in the Committee's opinion, were foreseeable. It argues that because circumstances are foreseeable they could not be unusual or exceptional circumstances.

[229] In my opinion, that reasoning demonstrates error in two respects. First, whether the circumstances are foreseeable or not is not relevant in a consideration of a case advanced under reg 11(b).

[230] If the general practitioner relies upon reg 11(b), what needs to be addressed is whether there is an absence of other medical services for the general practitioner's patients. No other onus apart from proving placita (i) and (ii) of reg 11(b) is cast upon the general practitioner. The general practitioner does not have the obligation of establishing that he has made attempts to find other medical services for his or her patients.

[231] The first inquiry is to determine objectively whether there is an absence of other medical services for the general practitioner's patients.

[232] If that is determined, the further inquiry must be into the reason or reasons for the absence of other medical services and if the two reasons in reg 11(b) are made out then the burden falling upon the general practitioner is discharged if the matters established and affected the general practitioner's rendering or initiating of services on any particular day or particular days which form part of a pattern of services under s 106KA(1).

[233] For those reasons, the Committee was wrong to categorise s 106KA(2) and reg 11 as only applying to episodic events. For the reasons I have given, the exceptional circumstances in s 106KA(2) must be different to the circumstances in reg 11(a) which, in turn, are different from the circumstances in reg 11(b).

[234] It is not possible to categorise all three circumstances as 'exceptional circumstances' which require proof of episodic events. In my opinion, 'foreseeable circumstances' has no application to an inquiry under reg 11(b).

[235] Secondly, if the general practitioner is relying upon reg 11(a), and even if a circumstance is foreseeable, that does not necessarily mean that the circumstance is not unusual. A circumstance may be unusual in that it is out of the ordinary, even

though it is foreseeable. A circumstance may be exceptional even though it is foreseeable. It is exceptional because it is out of the ordinary, not because it is not foreseeable. In my opinion, an inquiry into the foreseeability of the circumstances adduced by the general practitioner is only likely to lead to error as it has in this case.

[236] The inquiry should be into whether the particular circumstances relied upon by the general practitioner are exceptional (s 106KA(2)) or, alternatively, unusual (reg 11(a)).

Lee v Kelly [2005] FCAFC 197 (per Lander J) —

[43] Because Dr Lee was relying upon reg 11(b), he did not have to establish exceptional circumstances existed. For the reasons I gave in *Oreb v Willcock*, he had to establish that there was an absence of other medical services for his patients during the relevant period. Next, he had to establish that that absence was due to the location of his practice. Finally, he had to establish that that absence was also due to the characteristics of his patients.

[44] If he established those matters, he thereby established by force of the Regulations and s 106KA(5) that the circumstances were exceptional.

[45] The correct inquiry for the Committee was into whether he had established those matters. It was not correct to inquire into whether or not he had established there were exceptional circumstances.

[46] For those reasons, although the Committee addressed the factual matters raised by Dr Lee, it did so in circumstances where it measured those matters against the incorrect criterion, namely, 'exceptional circumstances'.

[47] It is also clear that the Committee had regard to irrelevant matters.

[48] It said, when considering the question of exceptional circumstances, which as I have said was not the correct question:

> '[59] In the Committee's view, Dr Lee's management of his patients reinforced their reliance on his surgery. Arguably, this is to the disadvantage of his Korean patients who, though preferring a Korean doctor for the reasons Dr Lee stated, would have been better served by an increased familiarity and comfort with the general medical services available in the community.
>
> [60] Having considered Dr Lee's evidence, the Committee was not satisfied that the above matters constituted exceptional circumstances which affected the rendering of services on the days in question. It considered that Dr Lee could and should have managed his practice so as to bring patient attendance rates down and not breach section 106KA of the Act and Part 3 of the Regulations.'

[49] The matters to which it had regard in paragraphs 59 and 60 could not have been relevant to the case advanced by Dr Lee under reg 11(b). The question of Dr Lee's management practice was simply not relevant in an inquiry whether Dr Lee had established the matters under reg 11(b). In my opinion, in a consideration of

reg 11(b), the question whether the medical practitioner could have done something in the management of his practice to bring patient attendance rates down is simply not relevant. The question is whether there is an absence of medical services for the reasons in reg 11(b).

[50] There is a further error disclosed in paragraph 60 where the Committee talks of a breach of s 106KA of the Act and Part 3 of the Regulations. It is not appropriate to consider the question of 'breach' of s 106KA or of the Regulations. The medical practitioner cannot breach s 106KA(1) and cannot, by failing to discharge the onus in s 106KA(2) 'breach' that subsection. Section 106KA(1) is a deeming provision. With the assistance of reg 10, s 106KA(1) deems the conduct, there referred to, to be inappropriate practice. There is no question of a 'breach' of the section.

[51] In my opinion, the Committee asked itself the wrong question. It thereby conducted its inquiry into the facts by reference to the wrong criterion. It had regard to irrelevant matters.

[52] The primary judge said at [47]:

> 'Counsel for Dr Lee submitted that Committee 348 fell into a similar error to that made by the Committee in *Hatcher*. In particular, it was said, that Committee 348 asked itself the wrong question about the need for the services and took into account irrelevant considerations about the need for the patients to integrate into the wider Australian community.'

[53] The primary judge then said at [53]:

> 'Accordingly, in my opinion, Committee 348's findings were affected by errors of law. As in *Oreb*, it commenced with a misunderstanding of what was meant by "exceptional circumstances". It then failed to ask itself the correct question as to what had given rise to the claimed exceptional circumstances and whether they fell within the terms of Reg 11(b). It distracted itself from addressing the correct question by taking into account an irrelevant consideration, namely the need for the patients to integrate within the wider community. These were jurisdictional errors; see *Minister for Immigration and Multicultural Affairs v Yusuf* (2001) 206 CLR 323 ("*Yusuf*") at [84] (McHugh, Gummow and Hayne JJ).'

[54] In my opinion, for the reasons I have given, the primary judge's conclusions were correct. It follows that I agree with the primary judge's order finding that exceptional circumstances did not exist should be set aside and that the matter should be remitted for further hearing.

Lee v Grigor [2005] FCAFC 198 (per Lander J) —

[43] The Committee said:

> '65. The Committee considers that in times of increased demand for his services, Dr Lee had available to him the options of referring patients to:
>
> - the Department of Emergency Medicine at Ryde Hospital;
> - another Korean-speaking practitioner, 300 metres away;
> - local twenty-four hour medical practices; in addition to

- requesting patients to make an appointment to see him the following day.

66. The Committee finds worthy of note that the NSW Multicultural Health Communication Service has developed and implemented a state wide infrastructure within mainstream health services to ensure that appropriate, timely, accessible and equitable information about health issues and health care/services is available to people who speak languages other than English. This approach is congruent with the Australian Government's multicultural policy statement, A New Agenda for Multicultural Australia, which emphasises that for multiculturalism to be a unifying force it needs to be inclusive.

67. Established general practitioners and their practices generally experience patients who prefer to see a particular doctor, thus this does not constitute an exceptional circumstance in Dr Lee's case. The Committee considers it the responsibility of practitioners, such as Dr Lee, to put mechanisms in place to enable them to regulate the number of daily attendances and, in the case of an ethnic minority, proactively enlist strategies to reform patients' expectations within Australian health care/service conventions and to utilise available mainstream infrastructures in place for this purpose.

68. Furthermore, the Committee also noted that the patient profile was a regular and longstanding feature of the Practice, with the result that it was not an exceptional occurrence on particular days. Rather, it was the kind of ongoing practice management issue, which could be addressed through practice planning and reform.'

[44] In my opinion, the Committee was wrong to reject Dr Lee's claim for the reasons it gave.

[45] It is not relevant, in my opinion, that Dr Lee had the option available to him of referring patients to the hospital and other practitioners: [65]. The question was not what Dr Lee could have done to reduce the number of patients to whom he was rendering or initiating services. The question was objectively whether there was an absence of services. It may be that the facts referred to in [65] suggest that there was no absence of medical services in the area of Dr Lee's practice, but that is not the finding which has been made by the Committee.

[46] The Committee was also wrong, in my opinion, to have regard to the Australian Government's multicultural policy statement 'which emphasises that for multiculturalism to be a unifying force it needs to be inclusive'. In my opinion, that was wholly irrelevant. The Australian Government's policy on multiculturalism had nothing to do in determining whether there was an absence of medical services for both of the reasons mentioned.

[47] The Committee was also wrong, in my opinion, to have regard to Dr Lee's responsibility to put mechanisms in place to regulate the number of daily attendances. The question which has to be addressed under reg 11(b) does not raise for consideration questions of practice management of the kind referred to in [67].

[48] There is nothing in the Act or Regulations which require a medical practitioner to put mechanisms in place to regulate the number of daily attendances or to

proactively enlist strategies to 'reform patients' expectations'. So far as the Committee assumed the role of advising Dr Lee on practice management, it exceeded its authority.

Willcock v Do [2008] FCAFC 15 (per Emmett J, with whom Middleton J agreed and Mansfield J generally)—

[67] While reg 11(a) may not constitute an exhaustive definition of what constitutes exceptional circumstances for the purposes of s 106KA(2), Dr Ho and Dr Do did not advance substantive arguments in support of any contention that the circumstances relied upon by them did not constitute exceptional circumstances as that term would be understood in ordinary English. I do not consider that the Committees erred in their conclusion, after a consideration of the particular circumstances relied upon by Dr Ho and Dr Do, that those circumstances were not exceptional circumstances within the meaning of that phrase as it would be understood in ordinary English. The Committees are constituted by practitioners who must be taken to have brought to bear their experience and knowledge in relation to the conduct of general medical practices.

[68] The contentions of Dr Do and Dr Ho emphasised the failure by the Committees to advert in express terms to reg 11(a) in their consideration of the circumstances relied upon by them. The primary judge, while referring in general terms to s 106KA(2) appears, on a fair reading of his Honour's reasons, to have based his Honour's conclusion on that contention, namely, the failure to have express regard to the language of reg 11(a).

[69] Regulation 11(a) requires that two unusual matters be established. First, it must be shown that there has been an unusual occurrence. Secondly, it must be shown that there has been an unusual level of need for professional attendances. In addition, it must be shown that the latter, the unusual level of need, was caused by the former, the unusual occurrence. The appellants contend that, because the circumstances relied upon by Dr Do and Dr Ho were incapable of satisfying those three requirements, there was no error on the part of the Committees in failing to advert expressly to reg 11(a).

[70] Public holidays, while they do not occur every week in New South Wales, occur regularly throughout the year. Furthermore, they are known well in advance. It was not suggested that Dr Ho and Dr Do did not know well in advance when the public holidays would fall in the first half of 2000. I do not consider that it would have been open to the Committees to find that public holidays constituted unusual occurrences within the meaning of reg 11(a).

[71] The same conclusion would apply in relation to the absence from the practice by reason of illness of one of the practitioners. Illness, while it is not predictable, is not unusual. There was no suggestion that any instance of illness on the part of Dr Do or Dr Ho was out of the ordinary or so unexpected that it could be said to be unusual. It might have been possible, for example, for evidence to be adduced that the health of Dr Do and Dr Ho was such that the occurrence of illness was unusual. However, no suggestion to that effect was made to the Committees.

[72] Further, the material before the Committee would not support a finding that the level of need for professional attendances following the public holidays or the illness of one of the doctors or the moving of the practice from one location to another, was unusual. There was no evidence before the Committees to indicate that the numbers of patients who attended after the occasions in question were different from what was usual or expected at the practice following a public holiday. There was no suggestion that the numbers of patients were unusual.

[73] I do not consider that the material before the Committees was capable of supporting a finding that there was an unusual level of need for professional attendances caused by any unusual occurrence within the meaning of reg 11(a).

[74] Both Dr Ho and Dr Do also relied heavily upon the departure of Dr Nguyen-Phuoc as constituting an unusual occurrence within the meaning of reg 11(a). Added to that was their difficulty in finding an employed practitioner to take the place of Dr Nguyen-Phuoc. I do not consider that, if a three person practice is, for a temporary period, reduced to two practitioners, that in itself is capable of being an exceptional circumstance. The conditions that flow from the departure of a partner are predictable and foreseeable.

[75] Dr Do and Dr Ho were engaged in a partnership practice. Dr Do and Dr Ho were apparently prepared to take on Dr Nguyen-Phuoc's patients, rather than suggest that they see another medical practitioner in the area. The material advanced by Dr Do and Dr Ho made no reference to any unusual level of need for professional attendances. The most that they said is that the two remaining partners wanted to keep all of the patients who were previously serviced by three partners. There was no suggestion that there was an unusual level of need for professional attendances beyond the number of patients who previously relied upon the practice. Accordingly, I do not consider that the circumstance of the departure of Dr Nguyen-Phuoc was capable of constituting an unusual occurrence causing an unusual level of need for professional attendances, on the basis of the material that was before the Committees.

Willcock v Do [2008] FCAFC 15 (per Mansfield J) —

[9] Emmett J has rightly emphasised the necessary causal relationship between the unusual occurrence and the unusual level of need for professional attendances. With one reservation, which I do not need to explore, I agree with his Honour's view that the matters raised by Dr Do and Dr Ho in any event could not attract the shield of reg 11(a). The one reservation concerns the two days when Dr Ho said his partner went home ill so he had to deal with an abnormal number of patients. I am not sure that that circumstance would attract the shield of reg 11(a) for those two days. It is easy to conceive of circumstances, e.g. an accident on the way to work preventing a doctor from attending the practice, when a practice or a doctor might be called upon to treat a larger than anticipated number of patients. It is not clear, in those circumstances, that the unusual occurrence (assuming it to be so) will have caused an unusual level of need for professional services. The level of need for professional services of the practice will be the same. So, if the contention of Dr Ho in respect of those days is correct, in such a case reg 11(a) must mean an unusual level of need for professional attendances by a particular doctor. But that would appear to cut across the general claims of Dr Do and Dr Ho that the unusual level of need for

professional services was that of their practice (albeit, as Committee 295 pointed out, a level of need arising at least in part from their decision to take on the patients previously treated by the doctor who left the practice). I note that reg 11(b)(1) refers to "the practice".

Tisdall v Webber [2011] FCAFC 76 —

[27] Having regard to the concession made by Dr Tisdall before the Committee that on each of the 66 days during the referral period he had rendered 80 or more services (as defined) the question to be determined by the Committee by reference to the Act in making findings arising out of its adjudication of the matters relevant to the referral was whether having regard to Regulation 11(b), it could be satisfied by Dr Tisdall, that on each of the 66 days during the referral period there was, as a matter of objective analysis, an absence of other medical services for patients of Dr Tisdall having regard to the statutory matters of the location of Dr Tisdall's practice and the characteristics of his patients seeking services on each of those days. If the Committee could be so satisfied, the second question for it under s 106KA(2) of the Act was whether it could be satisfied that those circumstances affected, in a causal sense, the rendering of Dr Tisdall's services on each of those days: *Oreb v Wilcock* [2005] FCAFC 196; (2005) 146 FCR 237 at [10] per Black CJ and Wilcox J and at [230] to [232] per Lander J.

The notion of "absence"

[28] The primary Judge at [19] regarded the notion of "absence", in its statutory setting, as extending beyond a literal absence and connoting a lack of "readily or reasonably available" alternative medical services for Dr Tisdall's patients having regard to the Regulation 11(b) factors. As Buchanan J observes, that formulation of the statutory concept of absence (accepted by the appellant) is consistent with the "practical approach" to Regulation 11(b) adopted by Dowsett J in *Hatcher v Fry* [2000] FCA 1573; (2000) 183 FCR 1 at [16] in formulating the question to be asked by a Professional Services Review Committee, namely (as applied in this case), if a patient of Dr Tisdall on the relevant days during the referral period could not have seen Dr Tisdall within an appropriate timeframe (that is, within a reasonable timeframe) would the patient have been able, reasonably, to consult another medical practitioner? An answer to that question will involve consideration of the elements of a counter-factual contention based upon an assumption that the patient could not have seen Dr Tisdall. The question, of course, for the Committee is slightly different to that formulated by Dowsett J. It is whether, having regard to the relevant factors, the Committee can be affirmatively satisfied by Dr Tisdall (having regard to the body of evidence put to it for adjudication by the Committee members as general practitioners), on the matter of objective counter-fact, whether a patient of Dr Tisdall would have been able, reasonably, to see another medical practitioner rather than Dr Tisdall. Many considerations may be relevant to that question but they include questions of access to alternative practitioners, the location of the practice of an alternative medical practitioner, the hours during which such a practitioner might be available and the patient numbers or patient cohort seeking access to the alternative medical practitioner.

Hatcher v Fry [2009] FCA 1573 —

> [14] The applicant submits that a perusal of the whole of the committee's reasons discloses that it interpreted this phrase as meaning a total absence of medical services, rather than medical services which are not readily available, or the level of which was such as to justify the applicant rendering 80 or more services on the days in question. The question is dealt with by the committee at paras 25-57. In particular, the applicant points out that in para 40 the committee observed that it was "not satisfied that there was an absence of services for [the applicant's] patients, having regard to the location of his practice, on the relevant days". In para 48 it said that it was "not satisfied, however, that there was an absence of bulk-billing services for [the applicant's] disadvantaged patients on the relevant days". In para 52 it said that there was no evidence that any increase in demand for medical services during cattle sales days was such that it could be said that "there was an absence of services for [the applicant's] patients during those times having regard to the location of his practice". Finally, in para 56 the committee observed that there was no evidence that increases in demand over long weekends during the referral period or during winter was so large that it could be said that there was "an absence of services for [the applicant's] patients during those times having regard to the location of his practice".
>
> [15] The committee's language reflects the wording of the regulation. Fairly clearly, reg (b) contemplates an absence of medical services, other than those provided by the practitioner whose conduct is under review, to treat patients of that practitioner. In other words, the question is whether there is some other source of medical services available to them at the relevant time. The applicant's point is a little obscure. It seems to involve the assertion that the committee dismissed the "defence" that there was an absence of other medical services, for the purposes of reg 11, simply because there were other medical practitioners in the area. The submission may also contain the further implicit assertion that notwithstanding the fact that there were other medical practitioners, they would not, or could not, have serviced the applicant's patients. As I understand it, the point is distinct from the submission concerning the alleged preference of patients for the applicant's services and the submission concerning the allegedly high patient/doctor ratio. However the three submissions are probably connected.
>
> [16] In my view the regulation dictates a practical approach to the availability of other medical services. Within Australia it can hardly be said that anybody has no access to medical services. For a person in Roma there would always be the option of travelling to Brisbane for such services. However such a requirement might not be practicable simply because the requirement for such services might not justify the journey. In other cases that solution would not enable the patient to obtain the required services in a suitable timeframe. In others it would simply involve too much of a disruption to a patient's day-to-day life. On the other hand, it is conceivable that in a small country town having, say, two medical practitioners, both may be so busy that neither is, in a practical sense, able to fit in the other's patients other than by seeing more patients in the same timeframe. The question to be addressed is simply whether or not, if a patient could not have consulted the applicant within an appropriate timeframe, he or she would reasonably have been able to consult another medical practitioner. Such an enquiry involves consideration

of the geographical locations of other practitioners, the hours during which they were available and their history of patient numbers.

[17] The committee did not dismiss the practitioner's submissions simply because there were other medical practitioners in the area. A considerable amount of time was spent in trying to identify the number of other practitioners and the amount of time spent by them in providing medical services. Reference was had to various prescribed patient/doctor ratios. It is relatively clear that the committee was attempting to identify the capacity of other practitioners to see patients who were, in fact, seen by the applicant. The committee concluded that it was not satisfied that there was an absence of other medical services reasonably available to patients. I see no evidence of any misinterpretation of the kind alleged by the applicant. The committee cannot be criticized for using the words of the regulation.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

[108] It is useful to note that, although the regulations considered by the Committee in this case were relevantly the same as those considered in *Tisdall v Webber* and *Oreb v Willcock*, s 106KA(2) of the Health Insurance Act was not in exactly the same form as s 82(1B) which now replaces it. Justice Buchanan set out the terms of s 106KA(2) in Tisdall v Webber at [95] as follows:

> 106KA Patterns of services
>
> ...
>
> (2) If the person under review satisfies the Committee that, on a particular day or particular days during the relevant period, exceptional circumstances existed that affected the rendering or initiating of services by the person, the person's conduct in connection with rendering or initiating services on that day or those days is not taken by subsection (1) to have constituted engaging in inappropriate practice.

[109] Unsurprisingly, having regard to the language of s 106KA(2), in *Tisdall v Webber* at [108], Buchanan J accepted that Dr Tisdall bore the onus of persuading the Committee that there was an "absence" of service available to his patients which affected his own provision of services, relying on *Oreb v Willcock* at [204]-[205], [208] and [223]. The language of s 82(1B) is not express as to onus; the question is whether, on the evidence before it, a Committee could reasonably conclude that on the day that the practitioner rendered or initiated more than 80 services exceptional circumstances existed that affected the rendering or initiating of those services.

[110] Section 82(1B) was introduced into the Health Insurance Act by s 3 and cl 3 of Sch 2 of the *Health Insurance Amendment (Professional Services Review) Act 2012* (Cth) and s 106KA was repealed. The Explanatory Statement to the Bill is not helpful in relation to the interpretation of s 82(1B): see pp 15-16 which discusses these changes. Relevantly the second reading speech on 9 May 2012 provides as follows:

> The bill also includes a number of provisions that strengthen the Professional Services Review's capacity to protect the integrity of Medicare, improve the

> operations of the scheme, and respond to the recommendations of a review of the scheme in 2007.
>
> ...
>
> The bill includes amendments to improve the protection of the public under the Professional Services Review.
>
> ...
>
> The quality of patient care can be placed at risk if practitioners undertake unreasonably high numbers of services. In 1999, medical professional groups agreed that 80 or more unreferred attendances on 20 or more days in a 12-month period constituted inappropriate practice.
>
> This bill clarifies in legislation that a practitioner who performs this number of services is automatically deemed by the legislation to have practised inappropriately, unless they can provide evidence that exceptional circumstances existed.

[111] At [64] of the draft and final report, the Committee correctly identified the test in s 82(1B). At [65]-[66] the Committee also referred to the interaction of s 82(1B) and reg 11.

[112] It is clear from the language of s 82(1A), and as explained in the second reading speech, that Parliament has determined that the prima facie position is that a practitioner engages in inappropriate practice if he or she renders more than 80 professional attendances on more than 20 days. Parliament relied for that view on the position taken by medical professional groups in 1999 based on the risk posed to patients by the provision of unreasonably high numbers of services. In that context, s 82(1B) poses the question of whether the Committee could reasonably conclude that, on a day on which the practitioner rendered more than 80 professional attendances, exceptional circumstances existed that affected the rendering or initiating of the services. The second reading speech recognises the practical reality that it is for the practitioner who claims it to do enough to show that exceptional circumstances existed on the relevant days so that the Committee could reasonably conclude that exceptional circumstances existed on those days.

[113] In those circumstances, it is my view that the Committee was correct when it said at new [15] that "while there is no legal onus of proof in Committee proceedings, once a prescribed pattern of services has been found to exist there is a practical or evidentiary onus on Dr Nithianantha to establish that there was an absence of alternative medical services for his patients". That is so, notwithstanding the fact that the Committee's processes are inquisitional in nature, as submitted by Dr Lucy.

…

[130] … although in *Oreb v Willcock* at [203], Lander J said that "Whilst those circumstances might exist over the whole period, the question for the decision-maker is still whether they operated on the particular day or days which have been reckoned as determining the pattern of services", that question must be answered by reference to the evidence before the Committee. In this case, the applicant had put his case by reference to the whole of the period and Ms Martin's evidence responded to and contradicted the factual basis of the applicant's claim. The

Committee did not bear the onus of establishing that the doctors at the Centre were available to provide services on the relevant 28 days for the purpose of forming its view in relation to whether there was an absence of medical services under reg 11(b) or whether the Committee could reasonably conclude that exceptional circumstances existed under s 82(1B).

[131] The test in s 82(1B) is whether the Committee could reasonably conclude that exceptional circumstances existed which affected the provision of the applicant's services on any day on which more than 80 services were provided in the "relevant period".

[132] Where a practitioner claims that there were "exceptional circumstances" on the basis set out in reg 11(b) (and only on that basis), the determination of whether reg 11(b) is satisfied is the required first step having regard to the express terms of s 82(1D). It might be doubted that it is necessary for the practitioner in such a case to show that exceptional circumstances existed throughout the whole of the "relevant period"; being the review period, albeit that Lander J observed that the inquiry is in relation to that period in *Oreb v Willcock* at [201]. However, it is easy to agree that it is necessary for there to be evidence that on the relevant days on which 80 or more services were rendered, exceptional circumstances existed (Lander J at [201]) having regard to reg 11(b)(i) or 11(b)(ii): (Black CJ and Wilcox J at [12]). As observed by Greenwood J in *Tisdall v Webber* at [68], it is likely that a practitioner who seeks to rely on reg 11(b) will adopt the course of attempting to show that the circumstances existed throughout the whole of the relevant period because it is likely to be forensically difficult to satisfy a committee that there was an absence of medical services for the practitioner's patients on individual days.

[133] Section 82(1D) expressly refers to the fact that circumstances that constitute "exceptional circumstances" for the purposes of s 82(1B) include but are not limited to those prescribed by the regulations. Where a practitioner relies only on reg 11(b), it is only if exceptional circumstances are made out by evidence which allows the Committee to conclude that reg 11(b) is satisfied that it is possible to move to the next step. The next step is the determination of whether the Committee could reasonably conclude that those exceptional circumstances existed on some or all of the days on which more than 80 professional attendances were rendered or initiated and that they affected the rendering or initiation of services by the practitioner. The force of s 82(1B) is that the days on which that intersection occurs will not be days on which the practitioner engaged in "inappropriate practice".

[134] This is an interpretation which involves no extension of the impact of reg 11 beyond the scope of s 82(1B); it is required by the express language of s 82(1D). In my view, that interpretation is wholly consistent with the approach adopted by Lander J in *Oreb v Willcock* at [221]-[223].

[135] Having regard to that interpretation, where the applicant claimed that exceptional circumstances existed on all days in the review period and the Committee was not able reasonably to make that conclusion having regard to Ms Martin's unchallenged evidence, there were no "exceptional circumstances" to fall within the definition in s 82(1B). I do not accept that s 82(1B) created an onus on the Committee to seek out evidence to displace this finding.

While subsection 82(1B) refers to a Committee being able to 'reasonably conclude' that exceptional circumstances existed, the Director may take into account material relating to possible exceptional circumstances in deciding what action to take under section 91, 92 or 93 in a matter that raises the question of a prescribed pattern of services.

Kelly v Daniel [2004] FCAFC 14 —

> [94] In our view, the Director's powers, once a breach of the 80/20 rule has been demonstrated to his satisfaction, are at least as extensive as those of the Commission. He is not obliged to refer the case to a Committee, although he may decide, ultimately, to do so. He must have regard to any submissions made to him under s 88(2) inviting him to dismiss the referral without setting up a Committee. He must take into account any relevant considerations that bear upon whether or not a Committee should be constituted. These would obviously include the fact that the Commission had counselled and reviewed the practitioner's conduct, and that there had been no repetition of the breach of the 80/20 rule.

82(2) — knowingly, recklessly or negligently causes or permits a practitioner employed or otherwise engaged by the person to engage in inappropriate practice

Subsection 82(2) expands the scope of 'inappropriate practice' to include where the person under review knowingly, recklessly, or negligently causes or permits a practitioner employed or otherwise engaged by the person to engage in conduct that constitutes inappropriate practice. In this context, a 'person' incudes a body corporate. Thus a 'person under review' may be a company that employs or otherwise engages practitioners who render or initiate services.

I-MED Radiology Network Limited v Director of Professional Services Review [2020] FCA 1645 —

> [45] … The expansion of the definition of "provides services" beyond the individual practitioner who has physically provided them doubtless reflects recognition by Parliament of contemporary arrangements in the medical, dental and pharmaceutical professions and allied health-related occupations. …
>
> …
>
> [60] The "provision of services" by a person, which is defined in s 81(2) of the HIA, is not necessarily assimilated with the rendering or initiating of that service by that person. It can be, if that person is the practitioner concerned, but the reach of the scheme in Pt VAA of the HIA is wider than that. That is the whole point, as discussed above, of the expansive definition in s 81(2), and of the differentiation evident in s 82.

> [61] The consequence of the possibility appearing was that the Director was obliged, by s 88A(2) of the HIA to undertake the review of the provision of services by I-MED Radiology, or as the case may be I-MED NSW. In this sense, s 88A of the HIA operates in a similar way to s 65(1) of the *Migration Act 1958* (Cth) in that, once the requisite state of mind is formed by the decision-maker, an obligation to make a decision in a particular way arises per force of statute, there being no residual discretion reserved to the decision-maker.
>
> [62] Once the reach of the scheme beyond the practitioner who has rendered or initiated a service is appreciated, there is not, or ought not to be, any great mystery or difficulty of understanding, even in the absence of formal reasons from the Director, as to her remit in undertaking the review.
>
> [63] Neither I-MED Radiology nor I-MED NSW is a practitioner but each, as a body corporate, is, juristically, a "person" (s 2C(1), *Acts Interpretation Act 1901* (Cth)). That being so, then, having regard to s 82 of the HIA, each could only engage in "inappropriate practice" if, in terms of s 82(2) of that Act, each had caused or permitted inappropriate practice. The admitted fact of what "appeared" to the Director is the possibility that I-MED Radiology, or as the case may be I-MED NSW, may have engaged in inappropriate practice during the Review Period. Necessarily, even in the absence of formal reasons, that means, and can only mean, that the possibility of "inappropriate practice" arose under s 82(2) of the HIA. In turn, as is patent from the language of s 82(2), a necessary element of that type of "inappropriate practice", and thus of the possibility, is during the Review Period, "a practitioner employed or otherwise engaged by the person to engage in conduct that constitutes inappropriate practice by the practitioner" under, materially, s 82(1). I have emphasised "possibility" because that is the requisite statement of mind for the Director.

In deciding whether a person had engaged in inappropriate practice under this expanded definition, a two-step decision-making process is involved:

- First, did a practitioner who was engaged by the person, or a company of which the person was an officer, engage in conduct amounting to inappropriate practice?
- Second, did the person knowingly, recklessly, or negligently cause or permit the practitioner to engage in that conduct?

'Knowingly' involves awareness and understanding of the inappropriate practice, but not necessarily intending that it occur. 'Knowingly' may also include constructive knowledge, that is, what the person *should* have known.

'Negligently' involves failure to exercise the degree of care that a prudent person in the same circumstances would have exercised.

'Recklessly' involves ignoring the risk of such inappropriate practice being engaged in by the practitioner.

'Causes' means that the person's conduct produces the effect or result. While it need not be the sole or dominant cause, it must play a part in, or contribute to, the practitioner's inappropriate practice.

'Permits' means that the person's conduct allows or gives an opportunity for the inappropriate practice to happen.

82(3) — adequate and contemporaneous records

A Committee must, in determining whether a practitioner's conduct in connection with rendering or initiating services was inappropriate practice, have regard to (as well as to other relevant matters) whether or not the practitioner kept adequate and contemporaneous records of the rendering or initiation of the services. Formerly, the definition of adequate and contemporaneous records was contained in regulation 5 (which defined 'adequate records') and regulation 6 (which defined 'contemporaneous records') of the *Health Insurance (Professional Services Review) Regulations 1999*. It is now contained in section 6 of the *Health Insurance (Professional Services Review Scheme) Regulations 2019*, which provides that:

- the record must include the name of the patient; and
- the record must contain a separate entry for each attendance by the patient for a service; and
- each entry for a service must:
    - include the date on which the service was rendered or initiated; and
    - provide sufficient clinical information to explain the service; and
    - be completed at the time, or as soon as practicable after, the service was rendered or initiated; and
- the record must be sufficiently comprehensible to enable another practitioner to effectively undertake the patient's ongoing care in reliance on the record.

A finding of 'inappropriate practice' may be based solely on a failure by the person under review to keep an adequate and contemporaneous record of the rendering or initiation of a service.

The concept of 'keeping' an adequate and contemporaneous record involves more than merely making an adequate and contemporaneous record, but implies a requirement that there be a system in place to keep them safe from loss or destruction and ensuring that they are available for access by another practitioner to treat the patient.

While the matters specified in the regulation describe 'the standards' for an adequate and contemporaneous record, it is an evaluative exercise by a Committee using its own expertise. The requirement that there be a separate entry for each attendance is not to focus merely on the 'attendance by the patient', but to focus on the service provided on that occasion and be evidence that is was a *meaningful* attendance or consultation (*Kew v Director of Professional Services Review* at [157]).

A Committee may also have regard to any other relevant matters in concluding whether or not the practitioner had engaged in conduct that would be unacceptable to the general body of their profession or specialty, including any other matters relating to the content and manner in which the general body of the profession or specialty would expect the keeping of clinical records.

Joseph v Health Insurance Commission [2005] FCA 1042 —

> [53] … The standard prescribed by that regulation [regulation 5 of the *Health Insurance (Professional Services Review) Regulations 1999* concerning the standard required for an 'adequate record'] requires compliance with each of the requirements of (a)-(d) of the regulation. …

Saint v Holmes [2008] FCA 987 —

> [164] Dr Saint also contended that the findings of inappropriate practice were based on "minor record keeping transgressions of the record keeping test it adopted". It was said that the Committee's finding that inadequate record keeping alone was sufficient to amount to inappropriate practice, was contrary to s 82(3) of the Act. This was because that section required that the keeping of the practitioner's records was just a relevant matter that had to be considered in conjunction with other relevant matters. It could not by itself found a finding of inappropriate practice.
>
> [165] In my view, the intention of s 82(3) of the Act is to emphasise, not diminish, the importance Parliament placed on the requirement that a medical practitioner keep adequate and contemporaneous records. The addition of the bracketed words "(as well as to other relevant matters)" in that section is not to be regarded as a requirement that a finding of inappropriate practice in respect of record keeping can only be made in conjunction with one or more other incidents of practice which would amount to inappropriate practice. The additional words are there to emphasise that record keeping is not the only matter to which the Committee should have regard in assessing inappropriate practice.

Sevdalis v Director of Professional Services Review [2016] FCA 433 —

> [84] … The keeping of adequate and contemporaneous records is a relevant consideration in the Committee's determination concerning inappropriate practice: *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* [1986] HCA 40; 162 CLR 24, 39-42 (Mason J), 56 (Brennan J). If the consideration is either not taken into account, or misunderstood, this is likely to be a legal error of a jurisdictional kind:

Minister for Immigration and Multicultural Affairs v Yusuf [2001] HCA 30; 206 CLR 323, [37]-[39] (Gaudron J), [82] (McHugh, Gummow and Hayne JJ, Gleeson CJ agreeing).

[85] The phrase is defined in s 81(1) and then in regs 5 and 6 of the Professional Services Review Regulations, which I have set out at [35] above.

[86] I note that this definition describes the function of the regulations as prescribing "standards". That description, combined with the text of the regulations themselves, indicates that there is some need for an evaluative exercise by the Committee, as fact finder, whether the records kept by the practitioner in respect of the relevant services meet the prescribed standard. …

[95] Insofar as the applicant makes a distinction between what is meant in reg 5(d) by the standard that a record be "comprehensible" to another medical practitioner, I accept that this imposes a standard directed to something other than accessibility. It is about whether the record is adequate for the purposes of enabling another medical practitioner to understand the patient's clinical history and past treatment sufficiently well that she or he can effectively treat the patient. "Adequate" in this context must, it seems to me, include whether the record contains enough information, and whether the information it contains is expressed and recorded in a way that a medical practitioner accessing it for the first time can understand and apply the information. …

[98] … the Committee's focus was on the standards set out in reg 6(a) and (b), both of which concern the timeliness of records made by a practitioner measured against the time at which a service was provided. Timeliness in making a record of what occurred during the provision of a service is no doubt important for reasons of maximising accuracy and ensuring that, if further treatment is required, past treatment is ascertainable. Further treatment for a patient may be required very soon after past treatment. It may be required when the medical practitioner who provided the past treatment is not available. It may be required by a different medical practitioner because of a choice made by the patient about where to go for treatment. Numerous other examples could be given. …

[107] … The regulations say nothing about electronic data entry, just as they say nothing about handwritten entries. The standard is silent about the form of the record (whether electronic, typed or handwritten). That is presumably because of the myriad of circumstances in which medical practitioners may find themselves having to provide treatment, and the variety of resources available to practitioners depending on the nature and circumstances of their practices. Adequacy and contemporaneity can be achieved just as readily through a handwritten note as an electronic one, although whether the standard is met or not for a given service will depend on an evaluative assessment of that particular service. Illegible handwriting, for example, may render a record incapable of meeting the adequate standard in reg 5. Incompetent typing may do the same for an electronic one.

Sevdalis v Director of Professional Services Review [2016] FCAFC 9 —

[12] The requirement in reg 6 that a record be "contemporaneous" with the rendering or initiation of the service is, as the Committee said and as her Honour

upheld, a requirement of timeliness. The Committee found gaps in time between the service and the recording of relevant services. It found that the standard of timeliness had not been met and explained its reasoning by the proposition that during the gap between the service and the record there would have been a gap in time when a record of the service would not have been available to another practitioner. Her Honour was, with respect, correct to observe at [99] that at least part of the reason for the standard in reg 6 was to enable another practitioner to have access to the record of the service rendered or initiated. It may also be assumed that its accessibility by the practitioner making the entry was also a reason for the requirement. Neither the Committee's reasons, nor her Honour's judgment, construed reg 6 as imposing an obligation that the record be accessible or available to another practitioner or to the medical practitioner who had rendered or initiated the service. Accessibility of the record, however, during a period between the service and its recording, bore upon the inquiry into whether the record had been completed contemporaneously. Her Honour was correct to conclude that the statutory scheme permitted consideration of accessibility or availability of records to an inquiry into whether the records had been made contemporaneously with the service. The fact that the record was not accessible to someone during the "gap" revealed that it had not been made contemporaneously.

[13] … No part of her Honour's judgment is susceptible to the criticism imbedded in ground 2 of the notice of appeal as construing regs 5 and 6 to require a handwritten record to be either readily available to another practitioner or subsequently to be entered into a database or other system. Her Honour's conclusion was, rather, that the Committee had been correct in its finding that what Dr Sevdalis had produced was not a record that was contemporaneous with the service. He had not produced records made contemporaneously with the service but rather, had produced records made subsequently but said to have been based upon earlier handwritten records which he did not produce except for four handwritten records which the Committee found to be then recently fabricated. …

[15] There was similarly no foundation to the criticism that her Honour was wrong in holding that the Committee's findings of inappropriate practice had been part of a "broader assessment" for the purposes of s 82(1) rather than a finding based on the submitted misconstruction of regs 5 and 6. The task for the Committee was to determine whether Dr Sevdalis had engaged in inappropriate practice within the meaning of s 82 of the Act. In that task the Committee was required to determine whether it "could reasonably conclude" that the conduct of a practitioner rendering or initiating a service as a general practitioner "would be unacceptable to the general body of general practitioners". Section 82(3) required the Committee to determine those questions having regard to whether or not Dr Sevdalis had kept adequate and contemporaneous records of the rendering or initiation of the services "as well as to other relevant matters". The Committee was neither required nor permitted to restrict its inquiry only to the terms of regs 5 and 6.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

[82] That is not to say that some factors highlighted by Dr Karmakar in her submissions might not permissibly be taken into account by a committee in its

evaluation of whether to make a finding of inappropriate practice as defined in respect of a referred service. Mentioned in her submissions to the Court were:
(a) Inconsistencies (not detailed by reference to the item numbers in the referred services) in the guidance offered by the Minister's department either in a publication termed the "MBS Book" (MBS being Medical Benefits Schedule), other online resources and documentation produced by the Australian Medical Association;
(b) That none of these publications and resources were authoritative;
(c) That, materially, the definition of an "adequate record" in reg 5 of the *Health Insurance (Professional Services Review) Regulations 1999* (Cth) (PSR Regulations) was vague, ultimately leaving it to a matter of evaluative judgement as to whether each entry in a record was "sufficiently comprehensible that another practitioner, relying on the record, can effectively undertake the patient's ongoing care".
(d) Corporatisation of medicine with junior medical practitioners employed by large medical service companies having little, if any, control over billing practices.

[83] However, to the extent that Dr Karmakar chose to develop these considerations in submissions, the Committee took them into account, as its final report reveals. For better or for worse, the definition of "adequate record" in the PSR Regulations bound the Committee: *Sevdalis v Director of Professional Services Review* [2017] FCAFC 9, at [7] – [8]. The Committee was obliged to make an evaluative judgement on this, as in respect of all of the referred services, by reference to the standard found in the definition of "inappropriate practice" as applicable to a general practitioner such as Dr Karmakar. Those appointed to the Committee were eligible to be members of the Committee and, as their final report discloses, made that evaluation.

[84] Perhaps there may be policy considerations arising from the "corporatisation" of aspects of general practice, the pervasive application of the HIA and a related predicament for junior medical practitioners aspiring to gain experience for accreditation as general practitioners. If so, these are for resolution in the political arena, not in the courts.

Kew v Director of Professional Services Review [2021] FCA 1607 —

[150] Now as I have already indicated, the definition of "inappropriate practice" requires the committee to assess whether the practitioner has made an adequate and contemporaneous record (s 82(3)). And as I have indicated, the requirements for an adequate and contemporaneous record were set out in reg 5 of the *Health Insurance (Professional Services Review) Regulations 1999*. It relevantly provided in reg 5(b) that to be adequate, the patient or clinical record needs to "contain a separate entry for each attendance by the patient for a service and the date on which the service was rendered or initiated". Reg 5(c) provided that each entry needs to "provide clinical information adequate to explain the type of service rendered or initiated".

[151] Now with respect to a number of services under review, the committee concluded that Dr Kew had failed to maintain an adequate and contemporaneous record.

[152] Now Dr Kew says that in doing so, it construed such regulations as if they required an "identifiably separate record of an attendance in the patient's record". So, for example, in relation to the conclusions for patient 1 in appendix 1, the committee stated:

> **Clinical Record**
>
> Paragraph 5(b) of the *Health Insurance (Professional Services Review) Regulations 1999*, which defines an "adequate record" for the purpose of the definition of "adequate and contemporaneous records" in section 81 and subsection 82(3) of the Act requires that "the record contain a separate entry for each attendance by the patient for a service" and paragraph 5(c) of those regulations requires that "each entry provide clinical information adequate to explain the type of service rendered or initiated".
>
> There is no identifiably separate record of an attendance in the patient's record from that relating to the diagnostic imaging and the procedure that was performed. The entry for the diagnostic imaging and the procedure that was performed does not state that a separate attendance was rendered nor does it contain any information other than that which the general body of radiologists would expect to see within a standard report of the diagnostic imaging and the procedure that was performed. Accordingly, neither paragraphs 5(b) nor 5(c) of the Regulations have been satisfied in relation to an attendance service.
>
> There is no record of a meaningful consultation having occurred. While Dr Kew said that she would have taken a history and examined the patient as part of a separate attendance, it has not been recorded as such. Thus no adequate and contemporaneous record of an MBS item 104 service has been kept by Dr Kew.

[153] Dr Kew says that in so concluding, the committee erred. It misconstrued reg 5(b) by requiring a separate entry for each "attendance". And insofar as it referred to reg 5(c), it made the error of requiring a separate consultation from a radiological service.

[154] Further, Dr Kew says that with respect to the relevant documentation, there were four patients where the committee concluded that the patient history had been recorded by the radiographer, rather than Dr Kew. But she says that in each case she gave unchallenged evidence that she took the history not the radiographer. Accordingly, Dr Kew says that the conclusion of the committee to the contrary was not open on the evidence.

[155] But I would reject these grounds. Let me deal with ground 5 first and make some general points concerning the question of record keeping.

[156] First, the function of the regulations is to prescribe standards. But their content and application very much require an evaluative exercise that the committee was best placed to undertake with its expertise.

[157] Second, s 82(3) focuses on the question of records concerning the rendering or initiation of the *services*. So, it is focusing on services rather than attendances per se. And this is a point that has been glossed over by Dr Kew. There must be a record of the service. In terms of the attendance, it is the attendance to provide the

service. So, if there is an inadequate or no record of the service, then there is an absence of evidence for a *meaningful* attendance or consultation. Further, regs 5(b) and (c) in terms make it plain that the focus of record keeping concerns services.

[158] Generally, s 82(3) requires the committee, when determining whether a practitioner has engaged in inappropriate practice in respect of the services in the Director's referral, to examine and take into account "whether or not the practitioner kept adequate and contemporaneous records of the rendering or initiation of the services". The keeping of adequate and contemporaneous records is a relevant consideration in the committee's determination concerning inappropriate practice. Clearly, the committee took that consideration into account. And as to the kinds of findings that it made, they were at the level of fact and professional opinion that the committee was entitled to make (see, in a generally analogous case, *Sevdalis* at [105] per Mortimer J).

[159] Now in identifying its concerns about items 104 and 105, the committee, in assessing the facts, stated (at [79]):

> The Committee's overarching concern with the reviewed MBS item 104 and 105 services was the lack of evidence in the records of a meaningful consultation having occurred. The history, examinations and advice provided at these services as described by [the applicant] during the hearing were persistently absent from the reviewed records. The report of the diagnostic imaging service provided on the date of the billing of the consultation service was entirely consistent with the reporting of an imaging service, but not consistent with the reporting of both an imaging service and a separate consultation service.

[160] In explaining the factual basis for its conclusion of inappropriate conduct in respect of those items, the committee stated (at [141]):

> The Submissions contain information regarding how [the applicant] performed her consultation services. The Committee has considered this evidence alongside the medical records available to it and finds it hard to reconcile [the applicant's] description of her services with the lack of records supporting the process she has described including taking patient histories, formulating a management plan, providing advice on appropriate treatment and obtaining patient consent...

[161] Now Dr Kew refers to particular verbal formulations in the appendices as demonstrating a failure to properly apply reg 5. But the committee's reasons must be read as a whole. And when one does so, they do not demonstrate any error.

[162] Now at [188], the committee explained:

> In the absence of any record of a consultation service, or even of part of the imaging report explaining that a consultation service was provided, the Committee considers that if a consultation service did occur, the record does not contain adequate information to explain the service and Dr Kew did not keep an adequate record...

[163] In my view that conclusion has not been successfully impugned.

Some State and Territory legislation[139] requires practitioners and healthcare practices to retain clinical records for a minimum period. For example, in New South Wales, subsection 25(1) of the *Health Records and Information Privacy Act 2002* (NSW) provides:

> (1) A private sector person who is a health service provider must retain health information relating to an individual as follows—
> (a) in the case of health information collected while the individual was an adult—for 7 years from the last occasion on which a health service was provided to the individual by the health service provider,
> (b) in the case of health information collected while the individual was under the age of 18 years—until the individual has attained the age of 25 years.

82A Meaning of *prescribed pattern of services*

The cases relating to a **'prescribed pattern of services'** are discussed more fully under the text relating to subsection 82(1A), above. A prescribed pattern of services is defined by the *Health Insurance (Professional Services Review Scheme) Regulations 2019*. Section 8 of those Regulations provides:

> For the purposes of section 82A of the Act, circumstances in which services rendered or initiated by a medical practitioner constitute a prescribed pattern of services are that:
> (a) the medical practitioner renders or initiates 80 or more relevant services on each of 20 or more days in a 12 month period; or
> (b) the medical practitioner renders or initiates 30 or more relevant phone services on each of 20 or more days in a 12 month period.

Section 5 of those Regulations defines **'relevant service'** as:

> ***relevant service*** means a service specified in any of the following items of the general medical services table:
>
> (a) an item in Group A1, A2, A5, A6, A7, A9, A11, A13, A14, A15, A17, A18, A19, A20, A21, A22, A23, A27, A35, A39, A41, A42, A43 or A45;
>
> (b) an item in Subgroup 1 or 4 of Group A36;
>
> (c) an item in any of the following Subgroups of Group A40:
>
> (i) Subgroup 1;
> (ii) Subgroup 2;

[139] In the **Australian Capital Territory**, see *Health Records (Privacy and Access) Act 1997* (ACT) – Schedule 1 The Privacy Principles; Principle 4.1: Storage, security and destruction of personal health information – safekeeping requirement (3). In **Victoria**, see *Health Records Act 2001* (Vic) – Schedule 1, Section 19 The Health Privacy Principles, 4.2. In **New South Wales**, as well as section 25 of the *Health Records and Information Privacy Act 2002* (NSW), also see *Health Practitioner Regulation (New South Wales) Regulation 2010* – Section 10.

(iii) Subgroup 3;
(iv) Subgroup 10;
(v) Subgroup 11;
(vi) Subgroup 13;
(vii) Subgroup 15;
(viii) Subgroup 16;
(ix) Subgroup 19;
(x) Subgroup 20;
(xi) Subgroup 21;
(xii) Subgroup 27;
(xiii) Subgroup 28;
(xiv) Subgroup 29;
(xv) Subgroup 39;
(xvi) Subgroup 40;
(xvii) Subgroup 41;

(d) an item listed in the following table.

Relevant services – individual items		
Item	**Column 1** **Group or Subgroup**	**Column 2** **Items of the general medical services table**
1	A29	139
2	A36	90264, 90265
3	Subgroup 17 of Group A40	92142
4	Subgroup 25 of Group A40	92170, 92171
5	Subgroup 26 of Group A40	92176, 92177

Such services are services that require the medical practitioner to attend on the patient. They do not include specialist medical attendance services.

Section 5 of those Regulations defines **'relevant phone service'** as:

relevant phone service means a service specified in any of the following items of the general medical services table:

(a) an item in any of the following Subgroups of Group A40:

(i) Subgroup 2;
(ii) Subgroup 8;
(iii) Subgroup 10;
(iv) Subgroup 16;
(v) Subgroup 20;
(vi) Subgroup 28;
(vii) Subgroup 40;
(viii) Subgroup 41;

(b) an item in Subgroup 3 of Group A45;

(c) an item listed in the following table.

Relevant services – individual items		
Item	**Column 1** **Group or Subgroup**	**Column 2** **Items of the general medical services table**
1	Subgroup 26 of Group A40	92176, 92177
2	Subgroup 1 of Group A41	93302, 93305
3	Subgroup 2 of Group A41	93308, 93311
4	Subgroup 2 of Group A42	93423
5	Subgroup 4 of Group A42	93453

Paragraph (c) of the definition of **'service'** in subsection 3(1) of the Act provides for a service rendered in connection with the provision of treatment under a relevant DVA law, and is of a kind that, if the service had not been rendered under the relevant DVA law, medicare benefit or dental benefit would have been payable in respect of the service. Relevant DVA law is defined in subsection 81(1) to mean any of the following:

(a) the *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006*;

(b) Chapter 6 of the *Military Rehabilitation and Compensation Act 2004*;

(c) the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*;

(d) the *Treatment Benefits (Special Access) Act 2019*;

(e) Part V of the *Veterans' Entitlements Act 1986*;

(f) any other Commonwealth law prescribed by the regulations for the purposes of this paragraph.

Legislative instruments have been made for the purposes of each of these Acts that provide the detail of the rules relating to the provision of **'treatment'** under DVA law.[140] For example, under the *Veterans' Entitlements Act 1986*, there is a legislative

[140] Section 16 of the *Australian Participants in British Nuclear Tests and British Commonwealth Occupation Force (Treatment) Act 2006* (the APBNTBCOC(T) Act) provides, in effect, that the *Treatment Principles* made under section 90 of the *Veterans' Entitlements Act 1986* apply in relation to eligible persons under the APBNTBCOC(T) Act. The *MRCA Treatment Principles* is the legislative instrument made under subsection 286(2) of the *Military Rehabilitation and Compensation Act 2004*. Under section 144B of the *Safety, Rehabilitation and Compensation (Defence-related Claims) Act 1988*, employees are eligible for treatment for their DRCA injury under section 280A of the *Military Rehabilitation and Compensation Act 2004*, or subsection 85(2A) of the *Veterans' Entitlements Act 1986*, and thus, either the *MRCA Treatment Principles* made under the *Military Rehabilitation and Compensation Act 2004* or the *Treatment Principles* made under the *Veterans' Entitlements Act 1986* apply for their treatment services. Section 18 of the *Treatment Benefits (Special Access) Act 2019* provides, in effect, that the

instrument called the *Treatment Principles*. Clause 4.2.1 of the *Treatment Principles* provides that 'an entitled person may be provided with only those services included in the Medicare Benefits Schedule.' Clause 1.4.1 defines **'Medicare Benefits Schedule'** as meaning:

> (a) Schedule 1 to the *Health Insurance Act 1973* as substituted by regulations made under subsection 4(2) of that Act; and
>
> (b) Schedule 1A to the *Health Insurance Act 1973* as substituted by regulations made under subsection 4(2) of that Act; and
>
> (c) the table of diagnostic imaging services prescribed under subsection 4AA(1) of that Act as in force from time to time.

The effect of this is to incorporate into the *Treatment Principles* the regulations made, from time to time, for the purposes of sections 4 (the general medical services table) and 4AA (the diagnostic imaging services table) of the *Health Insurance Act 1973*.[141]

The inclusion of DVA treatment services in the scheme in Part VAA of the *Health Insurance Act 1973* permits those services to be included within the services counted towards the 'prescribed pattern of services'. As the general medical services table is incorporated by reference into both the *Treatment Principles* and the *MRCA Treatment Principles*, then any DVA treatment services that are within those 'groups' in the general medical services table are included within the definition of 'service' for the purposes of Part VAA of the Act and regulations.

'prescribed pattern of services' — the '80/20' rule

Until the 30/20 rule was introduced in 2022 in relation to phone services, there was only one 'prescribed pattern of services'- the so-called 80/20 rule.

Oreb v Willcock [2005] FCAFC 196 (per Lander J) —

> [132] The legislation was enacted following upon an inquiry into the Professional Services Review Scheme and the report of the Review Committee of the Professional Services Review Scheme which was published in March 1999.
>
> [133] That Committee observed:

Treatment Principles made under the *Veterans' Entitlements Act 1986* apply to eligible persons under the *Treatment Benefits (Special Access) Act 2019*.

[141] Clause 4.2.1 of the *MRCA Treatment Principles* and the definition of 'Medicare Benefits Schedule' in clause 1.4.1 of the *MRCA Treatment Principles* are in identical terms to the corresponding provisions of the *Treatment Principles* made under section 90 of the *Veterans' Entitlements Act 1986*.

> 'The medical profession generally accepts that high volume provision of services by a practitioner prohibits adequate critical input.'

[134] The respondents/cross-appellants argued that this Court should follow a decision of Gray J in *Tisdall v Kelly* [2005] FCA 365 ('*Tisdall v Kelly*'). In that judgment, his Honour said at [66]:

> '... it is plain that the purpose of the legislative scheme is to ensure that a medical practitioner is not so busy as to be unable to give proper care and attention to each patient to whom the medical practitioner renders a service.'

[135] I agree that that is the purpose of the legislation. The purpose of the legislation is achieved by a combination of the Act and Regulations.

[136] Section 106KA(1) deems conduct which constitutes a prescribed pattern of services in reg 10 of the Regulations inappropriate practice.

[137] The regulation maker has determined that 80 or more services that are professional attendances on a day is as many attendances as a general practitioner can deliver on a particular day and still give proper care and attention to each patient to whom the general practitioner has rendered a service. If a medical practitioner exceeds that number on 20 or more days then his conduct in rendering or initiating more than 80 services is deemed to be inappropriate practice.

[138] However, the other thing to be kept in mind is that if a Committee reaches a conclusion that a general practitioner has engaged in conduct that constitutes a prescribed pattern of services, it will make a finding that he has engaged in inappropriate practice. Such a finding is a very serious matter for a general practitioner, not only because that finding carries with it a referral to a Determining Authority but because of the odium attached to such a finding.

[139] Moreover, if such a finding is made, the Determining Authority can make determinations of the kind referred to in s 106U of the Act. Those determinations include a reprimand, counselling, or that a Medicare benefit ceases to be payable. Moreover, the Determining Authority can disqualify the practitioner in respect of the provision of specified services. The Determining Authority has the power to make determinations which could involve a general practitioner in significant financial hardship.

83 The Director of Professional Services Review

Subsection 83(1) provides that the Minister may appoint a medical practitioner to be the Director of Professional Services Review. The Director is pivotal to the PSR Scheme. The Director is a statutory office holder, appointed by the Minister with the agreement of the AMA, for a period of not more than 3 years,[142] and is eligible for

[142] Subsection 106Y(1) of the Act.

reappointment.[143] The Director's appointment can be terminated by the Minister for misbehaviour or mental incapacity, or a number of other specified reasons.[144]

The Director receives requests for review from the Chief Executive Medicare,[145] and may make various decisions in relation to such requests, including deciding whether to conduct a review,[146] deciding to take no further action,[147] entering into an agreement with a practitioner,[148] and make a referral to a Committee.[149] In conducting a review, the Director may request further information from the Chief Executive Medicare[150] and may require the production of documents.[151] To assist the Director in making decisions, the Director may engage consultants.[152]

The Director has a duty to provide the necessary administrative services to the other PSR bodies.[153]

The Director is an 'officer of the Commonwealth' for the purposes of an action under s. 75(v) of the Constitution.[154]

The Director cannot delegate the powers, functions or duties of the office.

Amir v Director of Professional Services Review [2021] FCA 745 —

> [56] … the Director is responsible for deciding about all reviews under s 88A(1). The power of delegation in s 131 of the Act is limited to the Minister, the Secretary or the Chief Executive Medicare.

84 The Professional Services Review Panel

The PSR Panel has no functions or powers. It is merely a body comprising members from whom are selected persons to constitute Committees and persons who may be

[143] Subsection 106Y(2) of the Act.
[144] Subsection 106ZD of the Act.
[145] Subsection 86(1) of the Act.
[146] Section 88A of the Act.
[147] Section 91 of the Act.
[148] Section 92 of the Act.
[149] Section 93 of the Act.
[150] Section 88 of the Act.
[151] Section 89B of the Act.
[152] Section 90 of the Act.
[153] Section 106ZPL of the Act.
[154] Paragraph 75(v) of the *Constitution* provides that the High Court has jurisdiction in all matters in which a writ of mandamus or prohibition or an injunction is sought against an officer of the Commonwealth. Section 39B of the *Judiciary Act 1903* extends that jurisdiction to the Federal Court of Australia.

consulted by the Director for the purpose of assisting the Director to make a decision in relation to a review. Panel members and Deputy Directors (who must be panel members) are appointed by the Minister following consultation with the relevant professional organisation, for a period of not more than 5 years, and may be reappointed.[155]

The Minister must consult with the AMA before appointing a medical practitioner to the Panel, and must make an arrangement with the AMA under which the AMA consults other specified organisations and associations before advising the Minister on the appointment. The same consultation requirements also apply to re-appointments.

> ***Kutlu v Director of Professional Services Review*** [2011] FCAFC 94 (per Rares and Katzmann JJ) —
>
> > [2] The *Health Insurance Act 1973* (Cth) requires the Minister to consult with the Australian Medical Association (AMA) before appointing a medical practitioner to be a member of the Professional Services Review Panel (s 84(3)) or a Deputy Director of Professional Services Review (s 85(3)).
> >
> > [3] In 2005, without first consulting the AMA, the then Minister appointed as Deputy Directors, three medical practitioners, who were also then Panel members. In 2009, the present Minister re-appointed some Panel members without first consulting the AMA on those appointments. In addition, in 2009 the Minister also appointed as Deputy Directors some medical practitioners, who were then Panel members, without first consulting the AMA or expressly re-appointing them as Panel members.
> >
> > [4] Each of the appointees was a member or Deputy Director of a Professional Services Review Committee (Committee) that made adverse findings against each of the five applicant medical practitioners in conducting reviews of those practitioners' rendering of professional services for which the Commonwealth paid Medicare benefits. In late 2010, the Commonwealth made public that the Ministers had not complied with the statutory requirement of prior consultation before making, among others, those appointments. The five medical practitioners contend that the consequence is that the Committees were not validly constituted and the findings by those Committees against them are of no effect.
> >
> > …
> >
> > [16] Once appointed, a Panel member and a Deputy Director will be an officer of the Commonwealth for the purposes of s 75(v) of the *Constitution*. He or she will perform an important public function under the Act. Each of ss 84(3) and 85(3) requires the Minister to undertake two specific tasks before making an appointment. First, he or she must consult with the AMA about the appointment. Secondly, the Minister must make an arrangement with the AMA under which it consults other

[155] Section 106ZG of the Act.

specified organisations "before advising the Minister on the appointment". The express purpose of each section in requiring the Minister to consult the AMA is so that it can advise the Minister on each proposed appointee's suitability. The requirement that the Minister must make the arrangement with the AMA for it to consult with other specified organisations and associations apparently seeks to ensure that the professional body of relevant medical specialty practised by a proposed appointee is also consulted about that medical practitioner and that the AMA only gives advice to the Minister on a proposed appointee after it has consulted with that body.

[17] The extent of the Minister's statutory obligation to consult the AMA before the appointment of a medical practitioner under ss 84(3) and 85(3) is slightly different from the obligation to consult with other professional bodies before appointing Panel members and Deputy Directors from other professions under ss 84(4) and 85(4). In the latter cases the Minister is not required to make arrangements concerning any specialties or subcategories within other professions than medicine. However, the purpose of requiring such consultation is the same.

[18] Importantly, ss 84(3) and 85(3) contemplate that, after consultation with and advice from the AMA about them, the Minister can appoint persons, whose appointment the AMA did not support or opposed. That is in sharp contrast to the AMA's power of veto over the appointment of the Director under s 83(1) and (2). Unlike s 83, s 106ZPB(2) does not give the AMA a power of veto. Rather, s 106ZPB(2) expresses in prohibitory language the same concept that ss 84(3) and 85(3) express in positive language, namely, that it is a precondition of the Minister's ability to exercise the power of appointment that he or she has first consulted the AMA on the appointment. However, this distinction in the statutory description of the roles played by the AMA in the different processes of appointment does not gainsay the purpose of requiring the Minister to consult with, and be advised by, the AMA before appointing Panel members and Deputy Directors under ss 84(3) and 85(3). Such consultation and advice can expose significant matters for the Minister to consider about a prospective appointee as part of the deliberative process.

[19] The legislative intention discernible in Div 2 of Pt VAA is that the AMA (and other professional representative bodies) will have a substantive opportunity to give advice to the Minister on a proposed appointee before that person is appointed to a position where he or she will sit on a peer review body, being a Committee. It is implicit in ss 84(3) and 85(3) that the Minister must have regard to the consultation with, and advice of, the AMA in exercising the power to make an appointment. That is to say, the advice of the AMA is a relevant, though not decisive, consideration for the Minister in arriving at a decision to make an appointment.

[20] Part VAA contemplates a system of professional peer review to investigate and make determinations about whether a practitioner has engaged in inappropriate practice. The task of a Committee is to make a determination about inappropriate practice by a professional in the relevant discipline as assessed by his or her peers in that discipline. That requires it to make a determination as to whether the conduct of the practitioner in rendering or initiating the services under review would be unacceptable to the general body of that person's profession or specialty. The appointment process contemplated in ss 84 and 85 is intended not only to ensure

public confidence in the decisions reached after involvement of Committees, but also to ensure the confidence of the relevant professions, as well as the professional whose conduct is being reviewed. In the case of medical practitioners, that process was intended by the Parliament to be one for which the persons carrying out the review had been selected only after the Minister had received advice from the AMA and, through it, any other relevant professional organisation or association about a proposed appointee. It follows that the provisions of ss 84(3) and 85(3) provide indicia of a legislative intention that prior consultation by the Minister is an essential pre-requisite to the validity of an appointment of officeholders under those sections.

…

[24] Here, the consultative process provided for in ss 84(3) and 85(3) involves private communications between the Minister and the AMA. In addition, the Minister is not constrained from appointing as he or she later decides by anything that the AMA says or advises in the consultation process, so long as he or she has regard to the advice that the AMA gives about the proposed appointee. The public, and persons whose conduct is or may become subject to review under Pt VAA of the Act, may never become aware of whether, or to what extent, consultation and advice occurred prior to the appointment of a Panel member or Deputy Director. And, self-evidently, if the Minister's failure to consult with, and be advised by, the AMA concerning an appointee in accordance with ss 84(3) or 85(3) resulted in the appointment being invalid, then it is possible that several or many decisions or reviews in which the appointee participated would be invalid.

[25] No doubt, the Parliament would not have anticipated the significant, but apparently unintended, failures of each Minister to consult the AMA at all on the impugned appointments he and she made in 2005 and 2009. Those failures appear to have resulted from an incorrect view of the meaning of consultation taken by those advising the Ministers as opposed to any conscious decision not to comply with the requirements of the Act by either Minister. The magnitude of the consequences of the Court finding invalidity here is simply the product of the scale of the breaches of both Ministers' statutory obligations over a considerable period. It must be accepted that these consequences would not promote the express object of Pt VAA in s 79A of the Act. These factors relating to public inconvenience, on their own, are suggestive of a legislative intention that a failure to consult as required in ss 84 and 85 will not spell invalidity on any appointment made without prior consultation: *Project Blue Sky Inc v Australian Broadcasting Authority* (1998) 194 CLR 355 at 392-393 [97]-[100] per McHugh, Gummow, Kirby and Hayne JJ who cited *Clayton v Heffron* [1960] HCA 92; (1960) 105 CLR 214 at 247; *TVW Enterprises Ltd v Duffy (No 3)* [1985] FCA 382; (1985) 8 FCR 93 at 104-105 per Sheppard J, and *Montreal Street Railway Co v Normandin* [1917] AC 170 at 175. Those were all cases in which a failure to consult, or take some step as required by legislation, had not resulted in invalidity.

[26] For example, in *TVW Enterprises* [1985] FCA 382; 8 FCR 93 a statutory provision required the Minister to consult with representatives of the broadcasting and television industry "[i]n discharging his responsibilities", among other things, to plan the development of broadcasting and television in Australia. A challenge to a decision under another section of the statute to invite interested parties to apply

for the grant of a new television licence failed even though the Minister had not consulted the industry about proposed specifications on the new licence. In substance, the Minister's obligation to consult there was in relation to the development of policy: see 8 FCR at 112 per Beaumont J. And in *Clayton* 105 CLR at 247 Dixon CJ, McTiernan, Taylor and Windeyer JJ said:

> "... the performance of a public duty or the fulfilment of a public function by a body of persons to whom the task is confided is regarded as something to be contrasted with the acquisition or exercise of private rights or privileges and the fact that to treat a deviation in the former case from the conditions or directions laid down as meaning complete invalidity would work inconvenience or worse on a section of the public is treated as a powerful consideration against doing so."

[27] These considerations do not displace the express words of ss 84(3) and 85(3). Those words impose essential preliminaries or preconditions to the exercise of the Minister's power to appoint a person, as an officer of the Commonwealth, being a Panel member and a Deputy Director: cf. *Leichhardt Municipal Council v Minister for Planning* (1992) 78 LGERA 306 at 340 per Sheller JA, with whom Priestley and Meagher JJA agreed. The preconditions to the exercise of the power are that the Minister has consulted with, and been advised by, the AMA on the appointment. The advice of the AMA was a matter to which the Act required the Minister to have regard as a relevant and necessary consideration in making an appointment. As McHugh, Gummow, Kirby and Hayne JJ pointed out in *Project Blue Sky* 194 CLR at 391 [94]-[95]:

> "The fact that s 160 regulates the exercise of functions already conferred on the ABA rather than imposes *essential preliminaries to the exercise of its functions* strongly indicates that it was not a purpose of the Act that a breach of s 160 was intended to invalidate any act done in breach of that section.
>
> That indication is reinforced by the nature of the obligations imposed by s 160. *Not every obligation imposed by the section has a rule-like quality which can be easily identified and applied*. ... When a legislative provision directs that a power or function be carried out in accordance with matters of policy, ordinarily the better conclusion is that the direction goes to the administration of a power or function rather than to its validity (cf *Broadbridge v Stammers* (1987) 16 FCR 296 at 300)." (emphasis added)

[28] The Commonwealth's argument that the power of appointment under ss 84(3) and 85(3) was better characterised as a legislative direction to appoint in accordance with matters of policy should be rejected. The obligations imposed by the sections have a rule-like quality which can be easily identified and applied. The Parliament used the words "must consult" and "before advising" to achieve the purposes described in [19]-[20] above. To read them in the way the Commonwealth urges would defeat that purpose. It could not be suggested that if the AMA had not agreed to the appointment of the Director under s 83(2), any appointment to that office would be valid. Likewise, ss 96 and 96A also contemplate that Committees must be constituted validly at all times and that, in some circumstances, they will not be so constituted and cannot proceed with their functions. These matters are indications that the processes of appointment to offices and Committees in the scheme of Pt VAA were considered by the Parliament to be essential preliminaries

or preconditions to the exercise of the important functions that the Act conferred on Committees and the persons who constituted them.

[29] The Commonwealth referred to a considerable number of authorities in support of its suggested construction of ss 84(3) and 85(3). None of those cases had considered those sections. The task of statutory construction must begin with a consideration of the text of the provision or provisions concerned: *Alcan (NT) Alumina Pty Ltd v Commissioner of Territory Revenue* [2009] HCA 41; (2009) 239 CLR 27 at 46-47 [47] per Hayne, Heydon, Crennan and Kiefel JJ. Their Honours noted there that the meaning of the text may require consideration of the context, including the general purpose and policy of the provision and, in particular, any mischief it is seeking to remedy. In addition, the principles of statutory construction are relevantly explained by the majority in *Project Blue Sky* [1998] HCA 28; 194 CLR 355. For these reasons it is neither necessary nor appropriate to consider the various decisions about other statutes enacted in different contexts to which the Commonwealth referred.

[30] The Commonwealth placed particular reliance, however, on the construction of s 70(1) of the *Australian Broadcasting Corporation Act 1983* (Cth) favoured by Mason CJ, Deane and Gaudron JJ in *Australian Broadcasting Corporation v Redmore Pty Ltd* [1989] HCA 15; (1989) 166 CLR 454 at 457-460. That section provided that "... the Corporation shall not, without the approval of the Minister" enter into certain types of contract. Their Honours held that the question whether s 70(1) should be construed as confining power, or as directory of the manner of its exercise, was finely balanced. They noted that the section there dealt with the exercise, not existence, of the corporation's power to contract and was directed to the corporation, rather than an innocent third party with whom it was dealing. Their Honours referred to the natural presumption that a third party would make, namely, that the corporation would have complied with any statutory obligation to obtain the Minister's approval. They observed that s 70(1) did not specify whether the Minister's approval need be in writing nor did it provide for any consequence of a failure by the corporation to obtain approval: *Redmore* 166 CLR at 457. Finally, they held that if the legislature had intended the consequence of the corporation's failure to obtain the Minister's approval was the invalidity of a contract it had made with an innocent third party, that intention had to be discerned from the words of the section construed in the context of the Act as a whole. Their Honours concluded that a failure by the corporation to obtain the approval of the Minister did not invalidate the contract or make it unenforceable.

[31] That decision is distinguishable. First, it concerned the private law consequences of a failure by a statutory corporation to obtain Ministerial approval for a contract. Mason CJ, Deane and Gaudron JJ said that, if there were a failure to comply with the direction to obtain Ministerial approval, a construction favouring invalidity could have the effect of either confining the powers of the corporation or of invalidating any contract with an innocent third party. They also pointed to similar provisions in the same statute that supported their conclusion that the Parliament had not intended that the corporation's failure to obtain the Minister's approval would result in a third party supplier of goods or services being put in the position of having no contractual rights to payment for having provided those goods or services: *Redmore* 166 CLR at 457-459. Those considerations do not apply to

the public law requirements to appoint a person as an officer of the Commonwealth in accordance with preconditions that the Parliament specified. Moreover, the statutory contexts are different.

[32] The public inconvenience resulting from a finding of invalidity of the various impugned appointments is likely to be significant. However, the scale of both Ministers' failures to obey simple legislative commands to consult the AMA before making the appointments is not likely to have been a matter that the Parliament anticipated. If the appointments were treated as valid, the unlawfulness of the Ministers' conduct in making them would attract no remedy. And, if that were so, the appointees would hold the offices to which the Minister had unlawfully appointed them and they could not be prevented by injunction or other orders of a court from exercising the powers of those offices: cf. *Project Blue Sky* 194 CLR at 393 [100].

[33] In summary, the requirements of ss 84(3) and 85(3) are essential preliminaries to the Minister's exercise of the power of appointment. They have a rule-like quality that is easily identified and applied. The sections do not direct the Minister to carry out his or her powers of appointment in accordance with matters of policy. Instead, they confer a discretion to appoint after the preconditions of consultation with, and advice by, the AMA have been fulfilled and the Minister has had regard to that advice.

[34] It follows that all the impugned appointments were invalid.

[35] In addition, the Committees on which the persons whose appointments are impugned served were not capable of exercising any functions or powers under the Act. That latter consequence also arises because none of the five medical practitioner applicants had given consent under s 96A for the Committees to proceed when one or more of their three members had not been validly appointed under ss 84(3) or 85(3): cf. *Tu v University of New South Wales* (2003) 57 NSWLR 376 at 386 [21]. As Fullagar J pointed out *in Australian Communist Party v The Commonwealth* [1951] HCA 5; (1951) 83 CLR 1 at 258 a stream cannot rise higher than its source. Persons cannot exercise the powers of a Committee under the Act unless each of the members of that body, in fact, is and continues to be validly appointed.

[36] The Minister was required to, but did not, take the AMA's advice into consideration when making an appointment under ss 84(3) and 85(3). A failure to have regard to a relevant consideration is a jurisdictional error. An administrative decision that is made in excess of the jurisdiction or power conferred on the decision-maker by the Act or other legislation that authorises the making of such a decision, is no decision at all. The proper characterisation of such a purported decision is that it involves jurisdictional error and, in the absence of legislative validation or prescription against challenge, the decision is of no legal effect: *Plaintiff S157/2002 v Commonwealth* (2003) 211 CLR 467 at 506 [76] per Gaudron, McHugh, Gummow, Kirby and Hayne JJ. Thus, each impugned appointment was affected by jurisdictional error and was also invalid for that reason.

[37] After judgment was reserved, the Court invited the parties to make submissions on the effect, if any, of a considerable number of sections in the Act that expressly provided that a decision made after a failure by a person, including the Minister, to comply with a requirement under the Act, did not affect the validity of the decision. In *Commissioner of the Australian Federal Police v Oke* [2007] FCAFC 94; (2007) 159 FCR 441 at 447 [33] Branson and Lindgren JJ, with Besanko J's agreement, said that in determining the consequence that the Parliament intended to follow from a failure to comply with a particular requirement in one section of an Act, weight, but not compelling weight, could be given to the fact that a saving provision existed in other sections of that Act in respect of failures to comply with those provisions. Here, Pt VAA contains such savings provisions in ss 87(2), 88A(5) and (7), 89B(5), 93(7D), 105A(5), 106G(5), 106R(5), 106T(4) and 106TA(2). These provisions were in the Act in 2005 and 2009 when the impugned appointments were made. It is not necessary to rely on the existence in the Act of these other provisions to construe ss 84(3) and 85(3). Nonetheless, the presence of those other saving provisions provides some further support for the conclusion that, had the Parliament intended a similar outcome from a failure by the Minister to comply with the requirements of consultation and advice before making appointments under ss 84(3) and 85(3), it would have said so.

Kutlu v Director of Professional Services Review [2011] FCAFC 94 (per Flick J) —

[76] In the present statutory context of the Health Insurance Act, and in the context of Part VAA in particular, a number of factors peculiar to that context point to the fundamental importance of the consultation there referred to. These factors include the following.

[77] First, any inquiry as to whether the consequence of non-compliance with a particular statutory requirement is invalidity must necessarily at least start with the statutory language which imposes the requirement that has not been met. And, in the present context, ss 84 and 85 repeatedly employ the term "must". Although it may readily now be accepted that the use of such a term (previously regarded as imposing a "mandatory" requirement) may be but the start of the inquiry and not the conclusion, the statutory language in fact employed remains a valuable guide to resolving the inquiry. It remains a fact that the use of the imperative term "shall" – as opposed to the facultative and permissive term "may" – has long been recognised as usually imposing a duty to comply with the requirement imposed: *Ward v Williams* [1955] HCA 4; (1955) 92 CLR 496 at 508; *Scurr v Brisbane City Council* [1973] HCA 39; (1973) 133 CLR 242 at 255 per Stephen J. Although by no means determinative, the use of the term "must" in ss 84 and 85 can similarly be contrasted with the language employed in s 90 where it is stated that "the Director may consult" (inter alia) a Panel member or "any consultant or learned professional body that the Director considers appropriate". Differences in statutory language expressed elsewhere in the Act, it is considered, provide no reason to do anything other than to construe ss 84 and 85 within the context of Part VAA.

[78] The starting point for the inquiry to be undertaken may thus be accepted as a legislative intention to impose upon the Minister a series of duties to "consult" and that the duties imposed were not intended to be "empty term[s]".

[79] Second, ss 84 and 85 occur within Part VAA of the Health Insurance Act. And within that Part it is only a Professional Services Review Committee that can make a determination as to whether a medical practitioner has engaged in "inappropriate practice". The Director may not make such a determination, his function being confined to that of a "screening role": Carrick at [12]. A determination that a practitioner has engaged in "inappropriate practice" is not only in itself a serious adverse finding; it is also an adverse finding having the additional imprimatur of a medical practitioner's own peers. It is a finding which prejudicially affects the reputation and standing of the medical practitioner concerned. As Casio exclaimed in *Othello*:

> Reputation, reputation, reputation! O, I have lost my reputation! I have lost the immortal part of myself, and what remains is bestial. My reputation, Iago, my reputation!

Others, of course, may disagree. Iago's response was thus:

> As I am an honest man, I thought you had received some bodily wound; there is more sense in that than in reputation. Reputation is an idle and most false imposition: oft got without merit, and lost without deserving: you have lost no reputation at all unless you repute yourself such a loser. What, man! There are ways to recover the general again: you are but now cast in his mood, a punishment more in policy than in malice, even so as one would beat his offenceless dog to affright an imperious lion: sue to him again, and he's yours.

A medical practitioner who has lawfully been found to have rendered what was previously termed "excessive services", and who may now have been found to have engaged in "inappropriate practice", may well be expected to endure the damage to their reputation that such a finding may attract. But all practitioners are entitled to have their conduct reviewed by a Committee appointed in accordance with law.

[80] Part VAA, not unexpectedly, details the manner in which inquiries may be initiated and the manner in which they are to be resolved. One essential aspect of that Scheme is the establishment of the Professional Services Review Panel and the opportunity for a practitioner whose practice is under scrutiny to have his conduct reviewed by both other practitioners and practitioners who have been appointed after consultation by the Minister.

[81] Third, any requirement to "consult" with the AMA as to the appointment of Panel members cannot be regarded as a mere technicality or mere formality having little significance. Nor can the reappointment of practitioners who have previously been the subject of consultation with the AMA be regarded as a mere formality. The role played by the AMA, and as endorsed in Part VAA, is pivotal to the operation of Part VAA. It may readily be accepted that the Minister may have little (if any) knowledge as to the identity or suitability for appointment of individual medical practitioners. Central to the manner of operation of Part VAA was not the implementation of a bureaucratic structure of Panel members who so happened to be medical practitioners who sought appointment. Those qualified for appointment were not, for example, persons solely having particular qualifications: e.g., *Administrative Appeals Tribunal Act 1975* (Cth), s 7. The practitioners to be appointed were to be persons presumably regarded by the AMA as suitable for appointment – although mere endorsement by the AMA did not preclude the

Minister making a contrary decision. And, a medical practitioner previously appointed, may have proved (for whatever reason) to be inappropriate for subsequent reappointment. Panel members were persons appointed for a term of years, not exceeding 5 years: s 106ZG. A medical practitioner previously appointed may, during the period of his appointment, have proved to be manifestly inappropriate for reappointment. Or a medical practitioner previously appointed may no longer wish to be reappointed.

[82] Given both the importance ascribed by the Legislature to an assessment as to "inappropriate practice" being made by those persons who have requisite knowledge as to current medical practice and the importance ascribed by the Legislature to assessments being made by a medical practitioner's own peers, the need for Committees to be properly constituted is itself fundamental to the very administration of Part VAA. The central role played by a medical practitioner's own peers in an assessment as to whether he has rendered what were previously termed "excessive services" or engaged in what is now termed "inappropriate practice" has long been recognised. Thus, in *Minister for Health v Thomson* [1985] FCA 208; (1985) 8 FCR 213 at 217, Fox J there said of the then Medical Services Committee of Inquiry:

> It is not disputed that the Committee is one of experts. The Act requires that it comprise five medical practitioners. It seems reasonably clear that the intention of the Act is that the Committee sit as a Committee of the peers of the medical practitioner whose conduct is in question and exercise its own judgment in relation to the evidence before it, using its own collective knowledge in its evaluation.

Subsequently, in *Tisdall v Health Insurance Commission* [2002] FCA 97 Tamberlin J observed in respect to the Professional Services Review Committee:

> [10] The Director must set up a Committee to consider whether a person under review has engaged in inappropriate practice unless satisfied that there are insufficient grounds on which a Committee could reasonably find that the person has engaged in inappropriate practice in connection with the referred service or that the Director has disqualified the person under review (s 93). Neither of those circumstances apply in the present case. The Committee set up under s 93 is to be composed of a Chairperson who is a Deputy Director and two other Panel members. Under s 95(2) the Chairperson and the other Panel members must be, (i) practitioners, (ii) who belong to the profession in which the practitioner was practising, (iii) when he or she rendered or initiated the referred services. The constitution of the Committee can therefore be seen as one of peer experts in general practice, who were engaged in practice at the time the services were rendered. In the present case the Committee consisted of three experienced general practitioners. Two members had general practices in country areas and one member conducted a general practice in an outer suburban area.

And Committee members are "entitled to consider and undertake their adjudicative function concerning the statutory factors against the background of their own professional experience as general practitioners especially having regard to s 95 of the Act which requires the Committee to be comprised of general practitioners in a

case where a general practitioner is the person under review ...": *Tisdall v Webber* [2011] FCAFC 76 at [86] per Greenwood J (Tracey J agreeing).

[83] In the present context, it is concluded that a medical practitioner – and the general public – is entitled to assume that the consultation required by ss 84(3) and 85(3) has been undertaken. Whether or not there has been consultation is a matter very much within the knowledge and control of the Minister and the AMA – but not the medical practitioner appearing before a Committee (or the general public). Although it would be open to a medical practitioner appearing before a Committee to make inquiries as to the circumstances relevant to the appointment of each Committee member, it is concluded that a practitioner would generally be entitled to assume that the Minister has complied with the law. Facts peculiar to a particular case may put a medical practitioner on inquiry. In some circumstances a legislative intention may be discerned that a person who has secured a favourable administrative decision should not be denied the benefit of that decision unless he has undertaken his own "independent investigation" as to whether there has or has not been prior consultation: cf. *Attorney-General v J N Perry Constructions Pty Ltd* (1961) 79 WN (NSW) 235. But such is not the present case.

[84] The importance ascribed by the Legislature to such matters is not only apparent from the terms of the legislation itself; it is an importance expressly referred to during the course of debate in the House of Representatives. Thus, during the course of the Second Reading Speech on 30 September 1993, the Parliamentary Secretary to the Minister for Health said when these provisions were introduced by way of the Health Legislation (Professional Services Review) Amendment Bill (Australia, House of Representatives, Debates (1993), p 1551):

> The amendments to the Health Insurance Act outlined in this bill reflect the outcome of a close consultative process with the Australian Medical Association. The AMA has played a key role in the development of the new measures and, in so doing, has demonstrated that it takes seriously its expressed belief that it has a duty to cooperate in ensuring that the public resources earmarked for health care are appropriately utilised.

A little later it was also said:

> The bill provides for the replacement of medical services committees of inquiry by professional services review committees. Whereas the basic composition of committees of inquiry remains constant regardless of the nature of the services that are subject to examination, the composition of the professional services review committees will vary according to types of services that are subject to review. For example, the empanelling of a committee to review the rendering or initiation of services by a specialist in a particular speciality would be on the basis that the majority of the committee would be specialists in the same speciality. This means that there should be little cause for a practitioner to question the committee's competence to deal with the matters referred to it.
>
> A significant change in the bill is the replacement of the concept of excessive servicing with one of inappropriate practice. Whereas excessive servicing is currently defined as the rendering or initiation of services not reasonably necessary for the adequate care of the patient, the concept of inappropriate practice goes further. It covers a practitioner engaging in conduct in connection

> with the rendering or initiating of services that is unacceptable to his or her professional colleagues generally.

[85] A fourth and further factor not to be ignored when considering the consequences that may follow where there has been a failure to consult as required by ss 84(3) and 85(3) is the fact that the administrative proceeding to be conducted has some of the characteristics of a disciplinary hearing, albeit an administrative process also directed to "protecting patients and the Commonwealth". Thus, in *Pradhan v Holmes* [2001] FCA 1560, 125 FCR 280 the question to be resolved concerned the consequences that followed from a failure to refer specified conduct to a Committee for investigation. Section 86(1) of the Health Insurance Act required the Commission to refer to the Director "the conduct" of the medical practitioner; s 93(6) referred to the writing of a report by the Director to the Committee "in respect of the services to which the referral relates"; s 93(7) referred to "services that may be specified in the ... referral"; and s 93(1) required the Director to make a referral to a Committee "to consider whether conduct by the person under review ... constituted engaging in inappropriate practice". In that context, Finn J observed:

> [121] Again, in my view, the section ought be interpreted as requiring that the referral be of specified conduct - a conclusion reinforced by the s 93(6) procedural fairness requirement that the Director prepare a written report giving reasons why the Director considers that "conduct by the person under review ... may have constituted engaging in inappropriate practice". Significantly the emphasis upon the requirement of specification at the level of an adjudicative referral is emphasised in the need to identify the particular services that are referred: s 93(1) and s 93(7); and it is only in respect of these services that the Committee can make findings: s 106H(1). This is unsurprising. One is after all at the point in the disciplinary process where the boundaries of the case to be met by the person under review should be settled and fairly particularised: see Forbes, above, Ch 10. In saying this I do not overlook the powers of the Committee further to narrow the case to be met: see s 101(2) together with s 102(1) and s 102(3); s 106J.

The reference to Forbes was a reference to Forbes, *JRS Disciplinary Tribunals* (2nd ed., Federation Press, 1996). The conclusion of his Honour as to invalidity, it should be noted, was subsequently rejected by the Full Court in *Health Insurance Commission v Grey* [2002] FCAFC 130 at [179], [2002] FCAFC 130; 120 FCR 470 at 505.

[86] The "disciplinary" aspect of an investigation conducted by a Committee, however, has been repeatedly referred to by other Judges of this Court. Albeit addressing the administrative scheme as then in place, in *Yung v Adams* (1997) 80 FCR 453 at 460, Davies J observed that "the proceedings are disciplinary in nature". His Honour went on to further observe, however, that the sanctions which may be imposed were not punitive in nature. The decision, according to his Honour:

> "... with respect to a reprimand, counselling, the repayment of benefits and disqualification are not imposed as a punishment. They are imposed with a view to protecting patients and the Commonwealth against abuse of the system ..."[(1997) 80 FCR 453 at 472]

On appeal, Burchett and Hill JJ stated that Davies J had "not inappropriately" referred to the proceedings as "disciplinary proceedings": *Adams v Yung* (1998) 83 FCR 248 at 294. Similarly in *Health Insurance Commission v Grey* [2002] FCAFC 130 at [173], [2002] FCAFC 130; 120 FCR 470 at 504, Beaumont, Sundberg and Allsop JJ stated both the disciplinary aspect of proceedings and the public purpose to be served as follows:

> [173] ... Although disciplinary powers are conferred under the legislative scheme, the purpose or object of the statute is to protect both patients and the Commonwealth against abuse of the system. That is to say, as "public protective" legislation, Pts VAA and VA should not be narrowly interpreted ...

Neither aspect of the legislation can be questioned, including the consequences to a medical practitioner of an adverse finding.

[87] Common to the consultation required by both ss 84 and 85 is the appropriateness of the medical practitioners to discharge the functions entrusted to Professional Services Review Committees. The further requirement that there be separate consultation as to the appointment of a medical practitioner to be a Deputy Director is a recognition of the additional responsibilities entrusted to a Deputy Director as a member of a Committee. These additional responsibilities include:

- being the Chairperson of a Committee (s 95(1)(a)) and presiding "at all meetings at which he or she is present" (s 99(1)); and
- engaging consultants on behalf of the Commonwealth (s 106ZP(1)).

[88] The particular statutory context of Part VAA, it is concluded, imposes upon the Minister a mandatory obligation – or "duty" – to consult with the AMA and the further conclusion that the failure on the part of the Minister to do so vitiates any purported decision that may have been made by a Committee constituted by any member who has not been appointed after the process of consultation required by the Health Insurance Act. It is also concluded that it is only a Panel member who has been appointed in accordance with law who may be appointed a Deputy Director. The failure to properly appoint the Panel members necessarily has the consequence that those Deputy Directors have also not been appointed in accordance with law and a further reason to vitiate any purported decision of a Committee over which such a Deputy Director has presided.

…

[91] First, the Commonwealth contended that where the Legislature intended consultation to be an "essential precondition to appointment" it made its intention clear – as it did in s 83(2). That section provides as follows:

> **The Director of Professional Services Review**
>
> (1) The Minister may appoint a medical practitioner to be the Director of Professional Services Review.
>
> (2) The Minister must not appoint a person unless the AMA has agreed to the appointment.
>
> (3) The Director has such functions, duties and powers as are conferred on him or her by this Part or the regulations.

Some support for the Commonwealth's argument is unquestionably gained from the terms of s 83(2). But the terms of that provision do not lead to any different conclusion in respect to s 84(3) and s 85(3). An appointment to the position of Director, and the central role played by the Director in the administration of Part VAA, may well have been the reason why appointment to that position attracted the specific attention of the Legislature and a requirement that the AMA agree to the appointment. But the agreement of the AMA to an appointment to the position of Director, it is respectfully considered, does not diminish the importance of the role played by the AMA in the appointment of Panel members. Panel members may be appointed by the Minister even contrary to any submissions or comments made by the AMA during the course of s 84(3) and s 85(3) consultation. The AMA pursuant to s 84(3) and s 85(3) has no "veto power", as it does in s 83(2). But the importance of consultation nevertheless remains. Although there may be no "veto power" conferred by s 84(3) and s 85(3), the central importance of the role played by Panel members appointed to Committees nevertheless remains. The existence of a "veto power" in respect to the appointment of a single individual, it is considered, ultimately says little as to the legislative intention otherwise apparent in the terms employed in s 84(3) and s 85(3).

…

[97] But the arguments of the Commonwealth founded upon "public inconvenience" are rejected. The terms of s 84(3) and s 85(3), and the statutory context in which those provisions appear, do not permit of ambiguity (or any substantial ambiguity) so as to permit recourse to "public inconvenience" as an aid to statutory construction. And, in any event, any such "inconvenience" as may or will be occasioned necessarily has to be balanced together with the interests of the individual practitioners and the more generally expressed public interest in ensuring that the conduct of medical practitioners is judged by the medical peers of those whose conduct is subject to scrutiny.

[98] Any "public inconvenience" is an "inconvenience" for which the Minister alone must remain accountable. It is, after all, the Minister who failed to comply with an important statutory requirement considered appropriate and necessary by the Parliament. It is to the Parliament that the Minister must account. The importance of recognising the role played by Ministers and the manner in which they remain accountable was adverted to by Gleeson CJ and Gummow J in *Minister for Immigration and Multicultural Affairs v Jia Legeng* [2001] HCA 17, 205 CLR 507 at 528 where they observed in the context of decisions taken under the *Migration Act 1958* (Cth):

> [61] As the facts of the present cases show, the powers conferred upon the Minister by ss 501 and 502 form part of a statutory scheme which involves a complex pattern of administrative and judicial power, and differing forms of accountability. The Minister is a Member of Parliament, with political accountability to the electorate, and a member of the Executive Government, with responsibility to Parliament. As French J recognised in his decision at first instance in the case of Mr Jia, the Minister functions in the arena of public debate, political controversy, and democratic accountability. At the same time, the Minister's exercise of statutory powers is subject to the rule of law, and the form of accountability which that entails. ...

[99] No explanation was forthcoming as to why there had been non-compliance.

[100] To employ the language of *Project Blue Sky* (at [99]), ss 84(3) and 85(3) not only impose a "legal duty" upon the Minister, but the consequence of non-compliance is "invalid[ity]".

85 Deputy Directors of Professional Services Review

Deputy Directors may be appointed as chairpersons of PSR Committees. They have no other statutory role in the PSR Scheme. As chairperson, a Deputy Director convenes and presides[156] at all meetings of the Committee to which they have been appointed. Under the Remuneration Tribunal determination concerning payment of PSR Panel members, the chairperson is responsible for approving payment of Committee members' claims for remuneration.

86 Requests by Chief Executive Medicare to Director to review provision of services

The Chief Executive Medicare has a broad investigatory function in relation to inappropriate practice by practitioners under section 27 of the *Human Services (Medicare) Regulations 2017* [157] (made under section 44 of the *Human Services (Medicare) Act 1973* for the purposes of section 6 of that Act), which provides:

> **27 Inappropriate practices**
>
> (1) The following are prescribed functions of the Chief Executive Medicare:
> (a) to devise and implement measures to:
> (i) prevent practitioners and other persons from engaging in inappropriate practice; and
> (ii) detect cases where practitioners or other persons have engaged in inappropriate practice in relation to rendering or initiating services; and
> (iii) prevent or detect activities relating to claims for medicare benefits, or receipt of medicare benefits, that may constitute an offence under the Health Insurance Act, the *Crimes Act 1914* or the Criminal Code ;
> (b) if there are reasonable grounds to suspect that a person has engaged in inappropriate practice—to investigate the conduct of the person to decide whether to make a request under subsection 86(1) of the Health Insurance Act for the provision of services by the person to be reviewed;
> (c) to investigate cases where there are reasonable grounds to suspect that:

[156] Section 99 of the Act.

[157] Formerly this was regulation 24 of the *Human Services (Medicare) Regulations 1975*.

(i) an act in relation to a claim for medicare benefits, or receipt of medicare benefits, may constitute an offence under the Health Insurance Act, the *Crimes Act 1914* or the Criminal Code ; or

(ii) a person may have committed an offence against section 23DP, 106D or 106EA, or subsection 19D(2), 19D(7), 106E(1) or 106E(2), of the Health Insurance Act;

(d) if an investigation under paragraph (c) discloses enough evidence for a prosecution--to refer the case and the evidence to the Australian Federal Police or the Director of Public Prosecutions;

(e) to take action (including starting legal proceedings) to recover from a person an amount of medicare benefit that is recoverable by the Commonwealth, including under the Health Insurance Act.

(2) In this section:

"practitioner" has the meaning given by section 81 of the Health Insurance Act.

"service" has the meaning given by section 81 of the Health Insurance Act.

The investigatory function includes not only the function of investigating inappropriate practice, but also offences that may have been committed in connection with the PSR Scheme, such as failure to attend a hearing upon being served with a summons by a PSR Committee member, refusal to be sworn or to answer questions, or contempt of a PSR Committee. The Regulations do not specify how those functions are to be performed, but gives the Chief Executive Medicare the broad direction to 'devise and implement measures' to carry them out.

Prior to the creation of the Professional Services Review Scheme, a similar provision to paragraph 27(1)(b) applied in relation to the preliminary investigation of matters before referral to a Medical Services Committee of Inquiry, which had the function of determining whether a practitioner had 'rendered excessive services'. That provision was paragraph 3(2)(b) of the Health Insurance Commission Regulations, which stated that the Health Insurance Commission had the function:

> (b) to investigate cases where there are reasonable grounds to suspect that a practitioner or an optometrist may have rendered excessive services and, where an investigation discloses that there is sufficient evidence to warrant a referral of the case investigated to a Committee established under Division 3 or 3A of Part V of the Health Insurance Act, as the case may be, to refer the case and the information obtained in the course of the investigation, with appropriate comments and recommendations, to the Minister or the delegate of the Minister.

Dr Edelsten challenged the decision to refer his case to the Minister's delegate who then referred his case to such a Committee. The Court considered the meaning of

'reasonable grounds to suspect', and whether the rules of procedural fairness applied to the process.

At first instance, the Federal Court held that the decision to refer his case to a Committee was a reviewable decision under the *Administrative Decisions (Judicial Review) Act 1977*. On appeal, the Full Court overturned that aspect of the judgment on the basis of the High Court's decision in *Australian Broadcasting Tribunal v Bond* [1990] HCA 33, which had been delivered after the initial judgment in *Edelsten's* case. At first instance, the Court said:

Edelsten v Health Insurance Commission [1990] FCA 17 —

> [12] In *Re Guardian Investments Pty. Ltd.; Wade v Guardian Investments* [1984] VicRp 81; (1984) VR 1019 Ormiston J., and in *National Companies and Securities Commission v Sim (No. 2)* [1987] VicRp 36; (1986) 4 AC LC 719 Nicholson J., considered the shades of meaning with which in several statutory contexts the phrase "reasonable grounds to suspect" and similar expressions have been invested by superior courts. When the object of the verb "suspect" is not a fact, as it was in *Queensland Bacon Pty Ltd v Rees* [1966] HCA 21; (1966) 115 CLR 266, but merely a possibility, as it is in Regulation 3(2)(b), the application to this case of the observation of Kitto J. in that case - "A suspicion that something exists is more than a mere idle wondering whether it exists or not; it is a positive feeling of actual apprehension or mistrust, amounting to 'a slight opinion, but without sufficient evidence', as *Chambers's Dictionary* expresses it" (115 CLR at 303) – is perhaps unwise. But in my opinion it ought to be concluded that what is required to warrant referral by the Commission to the Minister is evidence which the Commission thinks may be sufficient to justify such a conclusion by the Committee, if the Minister refers the matter to a Committee, as satisfies the requirement expressed in s.94(c). Regulation 3(2)(b) ought not in my opinion to be understood to require that the Commission should find the evidence sufficient to bring the Commission to the conclusion which s.94(c) requires. That would be to confer on the Commission the same function as the Act confers on the Committee. It would be enough to warrant referral that the Commission thought that it might, on that evidence, appear to the Committee that the practitioner may have rendered excessive services. The provisions of s.82 confer on a Minister of State, who is not required by law, nor commonly found, to be a medical practitioner, a power of reference without any qualification except those expressed in paragraphs (a) and (b) of that section. I find nothing in the *Health Insurance Act 1973* to indicate that the power conferred by s.82 may be exercised by the Minister, in a matter relating merely to the possibility of the rendering of excessive services, only if the Minister (or his delegate) has formed the conclusion that the evidence before him would justify a finding or belief that the practitioner may have rendered excessive services. Section 94(c) demonstrates the legislative intention that a Committee of five medical practitioners, not the Minister or a delegate of his, shall conclude whether a practitioner may have rendered excessive services and that the Committee shall form that conclusion on a consideration of the matter referred to it by the Minister and of any documents that accompany the reference. It would be expected that the

evidence before the Minister or a summary of that evidence would be contained in the documents accompanying the reference. It is in my opinion consistent with those provisions of s.94(c), and with the rest of the Act, that the Minister should be free, if he thought fit, to refer such a matter to a Committee without having formed his own opinion that the evidence before him would justify the conclusion specified in s.94(c). No doubt the Minister would err in law if he referred such a matter when he had been persuaded that a medical practitioner could not reasonably reach the specified conclusion on the evidence before him, if that were the only evidence he could transmit to the Committee. But if he were in doubt whether the evidence would justify the conclusion specified in s.94(c), he would not in my opinion lack power, derived from s.82, to refer the matter to a Committee. If that be so, what shall be "sufficient evidence" for the purposes of Regulation 3(2)(b) could be what the Minister advised the Commission that he regarded as sufficient, either generally or in respect of particular classes of matter.

…

[15] … The decision to make the referral was, I conclude, a decision to which that Act [the *Administrative Decisions (Judicial Review) Act 1977*] applies. It was not, however, in my opinion a decision before the making of which any reference to Dr Edelsten was required by any principle of natural justice so that he could communicate to Dr Nearhos anything in opposition to making the referral. If it be assumed that the decision of the Minister or of a delegate of his to refer such matters to the Committee was one which could not without breach of the rules of natural justice be made unless the medical practitioner concerned had been first afforded an opportunity to dissuade the decision maker from making the decision, the prior decision under Regulation 3(2)(b) is nevertheless no more than a step – and not an essential step – in the administrative process of reaching the Ministerial decision, and a step which in my opinion works against the interests of the medical practitioner no such a prejudice as would require that he be afforded an opportunity to dissuade the Commission from taking that step. Neither the Commission's decision nor any comment, report or recommendation accompanying the referral is given by law any particular effect, evidentiary or persuasive, in relation to the exercise of the Ministerial function conferred by s.82. It is merely a step which increases the risk that consideration will be given by the Minister or his delegate to the question whether the power conferred on the Minister by s.82 should be exercised, a risk to which every medical practitioner rendering professional services is at all times subject. Referral under Regulation 3(2)(b) is not a condition precedent to the exercise of that power.

[16] It was Dr Edelsten's submission that, if upon any of the grounds alleged the decision of Dr Nearhos were held to have been "unlawful", it would follow that the decision of Dr Dash was legally flawed as lacking what Dr Edelsten submitted was a legal prerequisite to the exercise of the power conferred by s.82. I cannot accept that submission. In my opinion a failure by the Commission, or a delegate of the Commission, to perform, or lawfully and effectively to perform the function conferred on the Commission by Regulation 3(2)(b) has in itself no effect on the legal efficacy of the exercise by the Minister or his delegate of the function conferred by s.82. Of course that is not to deny that the legal efficacy of the performance of the latter function may in a particular case be impaired in

consequence of the Minister's reliance, in performing his function, on some erroneous action of the Commission in relation to the performance of the function conferred on it by Regulation 3(2)(b).

…

[20] When dealing with the phrases "reasonable grounds to suspect" and "sufficient evidence to warrant a referral" I made some reference to that which is the object clause of "suspect" in Regulation 3(2)(b) and of "appears" in s.94(c) : "that a practitioner ... may have rendered excessive services". It is in my opinion of great importance to recognise that what is in question in those provisions, and therefore in s.82 also, is not the occurrence of any event or other circumstance, but only the possibility that an event of a particular description has occurred. No doubt the clause should be so construed as to exclude a possibility which has a very low probability, of a kind sometimes described as remote or fanciful or merely theoretical. But, subject to that qualification, a possibility of the occurrence of the rendering of an excessive service is all that is required by the clause. If that be so, evidence which justifies an opinion that among a number of instances of professional services a substantial proportion was excessive, but which affords no, or no sufficient, means of identifying the instances that were excessive, may justify a conclusion in respect of each instance that it may have been excessive.

…

[24] It was a ground of each application that a breach of the rules of natural justice occurred in connection with the making of the decision. I have already stated my conclusion that those rules are inapplicable in relation to the decision made by Dr Nearhos. I am of the opinion that there is a duty to accord a medical practitioner procedural fairness in relation to the making of a decision as to whether a matter, involving a question whether he may have rendered excessive services, should be referred to a Medical Services Committee of Inquiry under s.82.

[25] The legislative intention is plainly to be discerned in the provisions of Division 3 of Part V that a hearing to be held by such a Committee into a question concerning excessive services shall conform to the detailed provisions ensuring procedural fairness to the medical practitioner which are contained in that Division. Division 3 answers both the question whether the principles of natural justice are to apply and the question as to what the particular requirements of those principles are in relation to such a hearing. All the proceedings which precede publication of the Minister's determination giving effect to any finding and recommendation of the Committee adverse to the medical practitioner are held in private. It was submitted by Mr. T. North, who appeared for the respondents other than the members of the Committee, that, because ample procedural fairness is statutorily accorded the medical practitioner in relation to the only inquiry from which perceptible prejudice to his interests may result, no basis exists for allowing him a role in the preliminary inquiries of the Commission and the Minister. On the other hand the Minister's reference and, perhaps more important, the transmission of "documents that accompany the reference", to the Committee expose the medical practitioner to several substantial disadvantages. Upon the contents of those documents will be decided the question whether "it appears to the Committee that" .... the practitioner "may have rendered excessive services" and must submit to a hearing by the Committee. Once the Committee falls under the obligation imposed by s.94 to

conduct a hearing, the practitioner is liable to suffer not only the expense, the inconvenience and, commonly no doubt, the embarrassment of participating in the hearing, but also the further embarrassment and the harm to his professional reputation of having patients of his called before the Committee to give evidence. If patients are called to give evidence, the provision that meetings of the Committee shall be held in private may afford but limited protection of the practitioner's professional reputation. The professional reputation of a medical practitioner, particularly the reputation of a practitioner in general practice among those who are, or who may be minded to become, his patients, is commonly of very great economic as well as personal value to him. My conclusion is that there is a requirement that a medical practitioner, in respect of whose rendering of a professional service the Minister or his delegate is considering whether to make a reference under s.82 on the ground that it may have been an excessive service, have the opportunity to be informed what is the substance of the case for a reference and the opportunity to state his case against a reference.

[26] It will be recalled that at, or immediately before, the time of Dr Nearhos's decision, Dr Edelsten was discouraged from meeting Dr Nearhos by the letter dated 26 April 1989. However, after Dr Nearhos had made the referral to the Minister's delegate further communications between Dr Edelsten and Dr Nearhos took place, both in writing and at a meeting on 25 May 1989. Notes of the meeting and copies of correspondence between the two doctors were considered by Dr Dash in making his decision. But for circumstances to which I have not yet referred I would have concluded that no breach of the rules of natural justice had occurred in connection with the making of Dr Dash's decision because a sufficient opportunity had been afforded Dr Edelsten to learn what the substance of the case for a reference to the Committee was and to state his case against a reference. But it was revealed by Dr Nearhos during his cross-examination on the hearing of these applications that in making his decision he had taken into account statements made to him by Dr Lewis. The substance of these statements was that some of the claims for medicare benefits under consideration by Dr Nearhos in making his decision were for professional services said by the patients not to have been rendered. (The claims were made, not by the patients, but by Dr Edelsten, under the provisions of the legislative scheme called “bulk billing”.) Dr Nearhos was told, he swore, that some patients in respect of whom claims were made for laser treatment of tattoos had told investigating officers of the Commission that some of the treatments specified in claims had not in fact been given; and he swore that he had also been told that each of several patients had informed investigating officers of the Commission that a wound in respect of the surgical repair of which a claim for a medicare benefit had been made was not a wound the repair of which would fall within the description assigned to the particular item, in the table of medical services, under which the claim had been made by Dr Edelsten. By way of example Dr Nearhos gave evidence that he was told by Dr Lewis that a patient had identified the subject of a claim for a medicare benefit as the repair of a small cut below the eye. The claim was for the repair of a full thickness laceration of the eyelid, under an item in the table for which the specified fee was much greater than the fee for repair of a small cut below the eye. No reference to these statements by Dr Lewis to Dr Nearhos, or to the statements Dr Lewis alleged that patients had made to officers of the Commission, was made to Dr Edelsten until Dr Nearhos gave the evidence I have summarised on the

hearing of these applications. No reference to those statements appears in the statement by Dr Nearhos, or in the statement by Dr Dash, in each case pursuant to s.13 of the Administrative Decisions (Judicial Review) Act 1977, of reasons for the decision under review.

[27] Dr Nearhos gave evidence that he told Dr Dash what Dr Lewis had told him. I infer that the conversation between Dr Nearhos and Dr Dash occurred before Dr Dash made his decision.

> "A person whose interests are likely to be affected by an exercise of power must be given an opportunity to deal with relevant matters adverse to his interests which the repository of the power proposes to take into account in deciding upon its exercise: *Kanda v Government of Malaya* [1962] UKPC 2; [1962] AC 322, at p 337; *Ridge v Baldwin* [1964] AC, at pp 113-114 per Lord Morriss; *De Verteuil v Knaggs* [1918] AC, at pp 560, 561. The person whose interests are likely to be affected does not have to be given an opportunity to comment on every adverse piece of information, irrespective of its credibility, relevance or significance.
>
> Administrative decision-making is not to be clogged by inquiries into allegations to which the repository of the power would not give credence, or which are not relevant to his decision or which are of little significance to the decision which is to be made.
>
> Administrative decisions are not necessarily to be held invalid because the procedures of adversary litigation are not fully observed.
>
> As Lord Diplock observed in *Bushell v Environment Secretary* [1981] AC, at p 97.
>
> > 'To "over-judicialise" the inquiry by insisting on observance of the procedures of a court of justice which professional lawyers alone are competent to operate effectively in the interests of their clients would not be fair.'
>
> Nevertheless in the ordinary case where no problem of confidentiality arises an opportunity should be given to deal with adverse information that is credible, relevant and significant to the decision to be made.
>
> It is not sufficient for the repository of the power to endeavour to shut information of that kind out of his mind and to reach a decision withour reference to it. Information of that kind creates a real risk of prejudice, albeit subconscious, and it is unfair to deny a person whose interests are likely to be affected by the decision an opportunity to deal with the information. He will be neither consoled nor assured to be told that the prejudicial information was left out of account."
>
> (per Brennan J. in *Kioa v West* [1985] HCA 81; (1985) 159 CLR 550 at 628-629.)

[28] It will be observed that the reported allegations of patients are not that any professional service rendered by Dr Edelsten was not reasonably necessary for the adequate medical care of the patient concerned. The allegations are of two kinds: that a claim for a service was false in that the service was not rendered, and that a

claim was false in that the service for which claim was made was not the service rendered. But the allegations, if credible, are in my opinion relevant and significant to the decision to be made by Dr Dash. They are allegations of conduct concerning which an inference arises that it was designed to increase the practitioner's income from medicare benefits by dishonesty. The existence of a propensity to engage in such conduct increases the probability that the person displaying that propensity may at about the same time have rendered excessive services, which is also conduct likely to increase a practitioner's income from medicare benefits. Further, in a case where the decision maker is of the opinion that excessive services have been rendered, but is uncertain whether that has been caused by honest medical misjudgment or by dishonesty, the existence of that propensity increases the probability of dishonesty, and may reasonably influence the decision maker to refer the matter to a Committee rather than to attempt to convince the practitioner that he has been making errors of medical judgment.

[29] On the material which the evidence discloses the patients' allegations could not in my opinion be thought unworthy of credence. Dr Dash was not called to give evidence on any of the issues which Dr Nearhos's evidence raised. I infer that Dr Dash took into account in making his decision what Dr Nearhos told him that Dr Lewis had said about the allegations.

[30] In my opinion Dr Dash was under an obligation, derived from the principles of natural justice, to inform Dr Edelsten of the allegations and to afford Dr Edelsten an opportunity to put before Dr Dash his reply. The failure to take that course establishes the ground that a breach of the rules of natural justice occurred in connection with the making of the decision, in my opinion. In exercise of the discretion conferred by s.16 of the *Administrative Decisions (Judicial Review) Act 1977* I consider that the decision should be set aside. It might be inferred from the evidence of Dr Nearhos that, because the allegations were elicited in the course of an investigation carried on in exercise of another function of the Commission, it was thought by Dr Nearhos - and perhaps by Dr Dash - that the exercise of the functions being performed by Dr Nearhos and Dr Dash ought to be kept, in a formal sense at least, separate from that other function. The existence, and the influence on him, of the allegations were frankly and voluntarily revealed by Dr Nearhos in evidence, and I have no suspicion at all that he or Dr Dash might have intended to conceal what they thought should be revealed. But the breach of the principles of natural justice was in my opinion serious, and ought to entail the consequence that the decision be set aside.

[31] Although I have held that no obligation falls on the Commission to accord a medical practitioner an opportunity to be heard before making a referral of the kind contemplated by Regulation 3(2)(b), I am not to be taken to suggest that the opportunity which I have held that the Minister or his delegate is obliged to accord a medical practitioner before making a reference concerning excessive services under s.82 could not be provided by offering that opportunity, before referral under Regulation 3(2)(b), by way of one or more communications by the practitioner to the Commission, and through the Commission to the Minister or his delegate.

The Full Court of the Federal Court allowed the Health Insurance Commission's cross-appeal against this judgment on the basis that a decision to refer to a Committee is merely a step in the process is not, in itself, a reviewable decision under the *Administrative Decisions (Judicial Review) Act 1977*.

Edelsten v Health Insurance Commission [1990] FCA 449 —

> [46] Turning first to Dr Nearhos's decision. It is agreed by the parties that in making that decision Dr Nearhos acted as delegate of the Commission (see s. 8H(1) of the Health Insurance Commission Act). The decision was therefore deemed to be the decision of the Commission (s. 8H(2)). It was made pursuant to regulation 3(2)(b) of the Health Insurance Commission Regulations, the terms of which are set out earlier. Dr Nearhos may or may not have decided to refer the matter to the Committee. No provision of any of the relevant statutes or regulations was pointed to by counsel as imposing any duty on the Minister or his delegate to do anything about the reference to him or his delegate by Dr Nearhos pursuant to regulation 3(2)(b) nor can we find any. At most, the reference by Dr Nearhos to the Minister's delegate obliged Dr Dash to consider it and make a decision as to what he should do about it. The Minister has power (implied from s. 82) to refer to the Committee "any matter ... that is relevant to the operation or administration of" the Health Insurance Act or the National Health Act (other than Part VII of that Act) and that "arises out of or relates to the rendering of a professional service (other than a pathology service), on or after 15 April 1977, in the State for which the Committee is established" (s. 82). The reference made by Dr Nearhos to Dr Dash on 26 April 1989 plainly may be the subject of the Minister's reference to the Committee pursuant to s. 82.
>
> [47] No rights of Dr Edelsten are affected by Dr Nearhos's decision, nor does any "legitimate expectation" arise from it. During the course of the investigations being made by Dr Nearhos, Dr Edelsten spent much time and energy in supplying information to Dr Nearhos and other officers of the Commission. This action by Dr Edelsten can be understood, but that action does not "constitute rights of Dr Edelsten" in any relevant sense. Nor does that action form the basis for any "legitimate expectation". Dr Edelsten was not required by law to take that action or to give any information or explanation. The legal "rights" of Dr Edelsten were not affected by what the officers did. Dr Edelsten could have refused to co-operate and in so doing would not have committed any offence. For similar reasons, neither did the subsequent decision of Dr Dash to refer, as delegate of the Minister, the matter to the Committee pursuant to s. 82 affect any rights of Dr Edelsten or give rise to any legitimate expectation. Indeed, even when the Minister or his delegate refers a matter to the Committee pursuant to s. 82, the Committee, though bound by s. 94 to consider the matter, may decide no more than that Dr Edelsten may have rendered excessive services (s. 94(c)). But the Committee is not empowered to decide at that preliminary stage whether Dr Edelsten has or has not rendered excessive services, simply whether he may have rendered excessive services. It is only when the Committee reaches an affirmative view on that question that it is required to conduct a hearing into the matter (s. 94(j) and (k)). The machinery of the Health Insurance Act then comes into operation, requiring the Committee to

give notice of the hearing to Dr Edelsten and particulars of the matter to which the hearing relates (s. 95); empowering it to issue summonses to Dr Edelsten and others for the production of documents and the giving of evidence at the hearing; and giving Dr Edelsten the right to legal representation at the hearing which must be conducted in private. Sections 94 to 105 of the Health Insurance Act contain provisions commonly found with respect to administrative inquiries, conferring powers on the inquisitor and rights and duties on the person whose conduct is the subject of the inquiry.

[48] There is no doubt that the rules of natural justice apply to the hearing before the Committee. Dr Edelsten must be given full opportunity to answer all of the particular matters set out in the notice of hearing under s. 95(2) if a hearing in fact takes place. Whether there will be such a hearing will depend on whether the Committee reaches a preliminary conclusion that Dr Edelsten may have rendered excessive services.

[49] The making of an adverse report and recommendations by the Committee to the Minister does not itself in law affect Dr Edelsten's rights, though it is the genesis of a series of steps which ultimately may seriously affect his rights. The Minister must first consider the report and recommendations and may make a determination in writing in accordance with the recommendations: see s. 106(1), the terms of which are set out earlier. Dr Edelsten then has a right to request a review of the determination or to apply for judicial review under s. 106(3). It is only when the processes of review by a Medical Services Review Tribunal under Division 3 or judicial review under Division 4 of Part VA of the Act are completed that the Minister's determination takes effect. The Minister is then required, by s. 106AA to publish the requisite particulars of the determination and certain other matters and to cause a copy of the relevant statement to be laid before each House of the Parliament.

[50] An adverse report of the Committee pursuant to s. 104 and adverse recommendation under s. 105 may clearly lead to serious injury to Dr Edelsten, his livelihood and reputation. But the decisions of Dr Nearhos and Dr Dash are at very early stages of the administrative process for determining if Dr Edelsten has rendered excessive services, and they are no more than steps in an administrative process that may lead to an ultimate or operative determination affecting his position. In themselves the decisions of Dr Nearhos and Dr Dash are steps remote from any such consequences. Those decisions lack any quality of finality and they are not substantive determinations.

[51] The finding of the primary Judge that the decisions of Dr Nearhos and Dr Dash are reviewable decisions under the Judicial Review Act cannot be reconciled in our opinion with the judgment of the High Court in *Bond* which, as we mentioned earlier, was given after his Honour's judgment was delivered in this case.

[52] Section 3(3) of the Judicial Review Act was relied on by counsel for Dr Edelsten in support of his argument that the decisions of Dr Nearhos and Dr Dash were reviewable decisions. Section 3(3) provides:

> "Where provision is made by an enactment for the making of a report or recommendation before a decision is made in the exercise of a power under that enactment or under another law, the making of such a report or recommendation shall itself be deemed, for the purposes of this Act, to be the making of a decision."

[53] In our opinion s. 3(3) applies where there is a provision in an enactment that a particular report or recommendation be made as a condition precedent to the making of a decision under that enactment or under another law. The sub-section was considered by Mason CJ in *Bond* at 468, second column but as an indication that the word "decision" as used in the Judicial Review Act has a relatively limited field of operation. The Chief Justice's remarks did not touch the present question. We agree with the view expressed by Ellicott J. in *Ross v Costigan* (1982) 59 FLR 184 at 198 that s. 3(3):

> "contemplates a case where there is provision in an enactment for a specific report or recommendation as a condition precedent to the making of a decision under that enactment or some other."

[54] Regulation 3(2)(b) is an enactment, but it makes no provision of the kind envisaged by s. 3(3). Nor is any referral itself under regulation 3(2)(b) a condition precedent to the exercise of any power conferred upon the Minister or his delegate under any enactment whether under s. 82 of the Health Insurance Act or otherwise. Any report and recommendation made by the Committee under ss. 104 and 105 is an illustration of a report which constitutes a decision by reason of s. 3(3) of the Judicial Review Act. Such a report is a condition precedent to the exercise of the power conferred on the Minister by s. 106 of the Health Insurance Act.

[55] Our finding that the decisions under challenge are not reviewable decisions under the Judicial Review Act must result in dismissing Dr Edelsten's appeal and allowing the cross appeal in matter VG 59 of 1990 and allowing the appeal in matter VG 60 of 1990.

In *Freeman v McCubbery*, the Full Federal Court considered the nature of the material on which the Minister (under the former legislation) could make a referral to a Medical Services Committee of Inquiry and on which the Committee could decide to conduct an investigation into possible excessive servicing of patients.

Freeman v McCubbery & Ors [1985] FCA 379 —

> [12] It is true that on the information before it the Committee could not form an opinion with respect to any particular service as to whether it was appropriate or excessive or whether it was actually rendered by the appellant. However, on behalf of the respondents it is pointed out that the Committee is comprised of medical practitioners with experience covering private practice and other branches of medical practice. Pursuant to s.80(1) of the Act the members were appointed by the Minister after consultation with the Australian Medical Association. It is pointed out also that s.94 provides that the Committee shall, that is to say must, conduct a hearing into a matter referred to it if, after considering the reference and the documents accompanying it, it appears to the Committee that the medical

practitioner concerned "may" have rendered excessive services. It is said that the critical event is not satisfaction of any standard of proof but a mere appearance of possibility.

[13] No doubt it is required that a degree of satisfaction to the extent that it so appears to the Committee, shall be carried to the minds of the members of the Committee that, in the services rendered, some of them may have been excessive but not more than that. If the Committee felt that the services rendered did not exceed the extent of service reasonably to be expected in the practice of the appellant it would theoretically still have been possible for it to decide that it appeared to it that there may have been excessive servicing. In such a case it would be a question whether the quality of satisfaction required by the statute was established. But in this case it is to be gathered from the stated reasons for the decision that the Committee took the view that an appearance to it that there may have been excessive servicing by the appellant did arise from the circumstances disclosed in the annexures. Clearly it considered that those circumstances pointed to that possibility.

[14] It was pointed out also that s.94 expressly limits the materials to which the Committee is to have regard in considering whether there is, to it, an appearance that there may have been excessive servicing, to the terms of the reference and the accompanying documents. Section 94 is in Division 3 of Part V of the Act and is headed "Medical Services Committees of Inquiry". It is part of the machinery devised to provide supervision of the claims made under Medibank in respect of the servicing of patients by medical practitioners. The information provided by practitioners to Medibank in support of claims does not disclose the circumstances under which services to patients are rendered or provide any evidence of the propriety of rendering particular services. The appropriateness of the rendering of particular services is for practical purposes in the knowledge of the practitioner alone.

[15] Some control or supervision such as provided in the Act was clearly a useful and one would think a necessary part of the medibank system. Inquiries by a competent body where it appears to it that there may have been overservicing and provision for co-operation in such an inquiry by the practitioner concerned does not seem unreasonable or unfair in the public interest. So, under s.82 the Minister may refer the matter of the services rendered by a practitioner to a Committee. Not having information as to the circumstances of any of the services rendered, the Minister, in referring the matter to the Committee, stated to that Committee the identity of the practitioner concerned, where his practice was located, the nature and frequency of the services rendered, and the names of the patients to whom the services were rendered. It was for the Committee to decide on those materials whether there was an appearance to it that the appellant may have rendered excessive services. Whether, in fact, there has been excessive servicing will be considered by the Committee in the hearing which it is directed to conduct if it so decides. No doubt, it is because of the limited nature of the materials before a Committee, when it performs the task of deciding whether it appears that there may have been excessive servicing, that the standard of satisfaction upon which an inquiry is directed to be undertaken is fixed at a level which, in relation to legal

> proceedings, is minimal. But it is clear that the Committee is to perform that task upon only the reference and such accompanying documents as the Minister provides. Clearly, it is not contemplated that at that stage the Committee will embark upon any additional investigation of the matter referred to it.

Pradhan v Holmes [2001] FCA 1560 —

> [9] The formal statutory process of investigation into a practitioner under the PSR Scheme is initiated by the Commission making an "investigative referral" to the Director under s 86 of the HI Act. Both that section and the Guidelines made under it envisage that an investigative referral will be preceded by the Commission's own inquiry into, and examination of, the conduct of the practitioner in question.
>
> [10] It was likewise envisaged by the architects of the PSR Scheme that a counselling process would be engaged in by the Commission with a practitioner in which he or she would be advised of the Commission's concerns about his or her practice and would be given a chance to consider his or her position. Such a counselling system has in fact been instituted. It is unnecessary to enlarge upon it at this stage.
>
> [11] The matter to be noted about the Commission's own examination is that, save in exceptional circumstances: see *Health Insurance Commission Act 1973* (Cth) s 3A and Part IID; it has no investigative powers it can deploy to pursue and/or obtain information that may be relevant to its inquiry. Nonetheless, such examination as the Commission makes must be such as to lead the Commission to consider that "the person under review may have engaged in inappropriate practice": s 86(4)(b) of the HI Act.
> …
>
> [79] It was well settled in decisions of this Court prior to the 1999 amendment that, under the then HI Act scheme, the material attached to a referral to the Director constituted part of the referral itself: *Retnaraja v Morauta* [1999] FCA 80; (1999) 93 FCR 397; *Mercado v Holmes* [2000] FCA 620; *Grey v Health Insurance Commission* [2001] FCA 1257. There is, in my view, nothing in the 1999 amendments to the Act to suggest that a different view should be taken of attachments to investigative referrals made after the amendments came into force. On the contrary, the provisions of s 86(4) in referring to matters that the investigative referral must contain – and which in the present case were included in the attachments – seems to lend support to the view taken in the cases to which I have referred. The respondents have not submitted otherwise. In consequence I intend to treat the attached material as part of the referral.

The delegate of the Chief Executive Medicare may take into account a statistical comparison of the practitioner's billing pattern and that of other practitioners of the same profession or specialty.

Artinian v Commonwealth [1996] FCA 1903 —

> [36] On behalf of the applicant it is submitted that the Commission in referring to the Director and the Director in acting under s93 of the Act, took into account irrelevant matters being Dr Artinian's statistical standing in comparison to other practitioners.
>
> [37] So far as emerges in the material before me, it is clear that Dr Artinian came to the notice of the Commission, at least in recent times, as a result of "service patterns in his profile". When Dr Artinian's practice was compared with the practices of other active general practitioners in Australia, it was noticed that Dr Artinian provided substantially more services in a year (23,706) than 99% of all active general practitioners in Australia. The 99 percentile was in fact 16,961. While general practitioners on average spent 39 hours per week in contact with patients (and worked 55 hours per week), Dr Artinian it would seem averaged 464 services per week with 70 hours of total patient contact per week, seeing an average of 6.5 patients per hour. These and other figures might well lead to the conclusion either that Dr Artinian would be so exhausted from seeing a large number of patients as not to give his patients appropriate medical attention or alternatively was misstating the number of patients he had personally seen or the time in which he spent with them.
>
> [38] An interview was ultimately held between Dr Artinian and medical advisers at which certain Provider summary statistics were discussed and the concerns of the Commission that the volume of patients being treated was inappropriate was made clear to Dr Artinian.
>
> [39] The submission, as I understand it, is that the Commission or the Director, as the case may be, were not entitled to take into account these statistics. There is some suggestion in the submission that statistics were the only matters taken into account and that the record of interview and a subsequent recommendation by Dr Whitby, a general practice consultant, recommending that it was appropriate that Dr Artinian be referred to the Director of Professional Services Review, were not taken into account. Factually, there is no support for that submission.
>
> [40] It seems to me almost unarguable that the Commission was not entitled to take into account the statistical material in determining whether or not to refer Dr Artinian's conduct in connection with his rendering of services, to the Director. The time spent by Dr Artinian, even if considered without reference to the time spent by other practitioners, would seem enough to raise questions for consideration. When, however, the time he spent is compared with time spent by other practitioners, the point is even more obvious. No doubt it is possible that there could be good explanations. But this is not to say that the statistical material would be irrelevant in considering the issue under s86.

A decision of delegate of the Chief Executive Medicare to make a request of the Director is not subject to the rules of procedural fairness.

Yoong v The Chief Executive Medicare [2021] FCA 701 —

[63] Section 86(1) was brought into a form close to its current form under s 30 of the *Health Insurance Amendment (Professional Services Review and Other Matters) Act 2002* (Cth) (the 2002 Amending Act). The Explanatory Memorandum for the Bill introducing that provision stated:

> New Section 86 provides that the Commission may request the Director to review the provision of services by a person. The request by the Commission relates to the provision of services during the period specified in the request. The request emanates from an examination by the Commission of the person's Medicare and Pharmaceutical benefits claiming profile. On the basis of inferences drawn from the statistical data, the Commission may request a review by the Director. The Commission's request is merely an initiating step within the PSR review process, following which particular aspects of the services provision (in other words, conduct) by a person may be reviewed by the Director and investigated by a Committee. The concept of the request by the Commission replaces the current 'investigative referral'.

[64] Section 86(1) of the HI Act does not expressly limit the circumstances in which the power may be exercised by the Chief Executive. The provision omits the requirement contained in an earlier iteration of s 86(1) that the Chief Executive consider whether the person under review, "may have engaged in inappropriate practice". However, s 88A(2) requires the Director to undertake the review if it appears to the Director that, "there is a possibility that the person may have engaged in inappropriate practice during the review period". On this basis, it may be inferred that the intention of s 86(1) is to require that the Chief Executive at least suspect that there is a possibility that the practitioner has engaged in inappropriate practice. However, since it is literally possible that any practitioner may have engaged in inappropriate practice, the "possibility" referred to in s 88A(2) must be understood to be one that is, not merely speculative, but based upon facts that reasonably ground the possibility. The same limitation must apply under s 86(1). I consider that s 86(1) requires that the Chief Executive must suspect on reasonable grounds that there is a possibility that the practitioner may have engaged in inappropriate practice during a specific period.

[65] It may be observed that reg 27(1)(b) of the *Human Services (Medicare) Regulation 2017* (Cth), provides that a prescribed function of the Chief Executive is to investigate the conduct of a person to decide whether to make a request under s 86(1) of the HI Act, "if there are reasonable grounds to suspect that a person has engaged in inappropriate practice". That investigation occurs at a stage anterior to making a request to the Director to conduct a review under s 86(1). A regulation cannot generally be used to interpret a statutory provision, but the regulation is consistent with my construction of s 86(1).

[66] The requirement that the Chief Executive suspect on reasonable grounds that there is a possibility that the person may have engaged in inappropriate practice is a fairly low barrier. In *George v Rockett* (1990) 170 CLR 104, the High Court held at 115:

> Suspicion, as Lord Devlin said in *Hussien v Ching Fook Kam* [1970] AC 942, at p. 948, "in its ordinary meaning is a state of conjecture or surmise where proof is lacking: 'I suspect but I cannot prove.'" The facts which can reasonably ground a suspicion may be quite insufficient reasonably to ground a belief, yet some factual basis for the suspicion must be shown.

[67] The High Court also held at 112:

> When a statute prescribes that there must be "reasonable grounds" for a state of mind - including suspicion and belief – it requires the existence of facts which are sufficient to induce that state of mind in a reasonable person.

[68] It is unsurprising that the barrier is a fairly low one, given that a request under s 86(1) of the HI Act merely enlivens the power of the Director to undertake a review, or investigation. The request requires the Director to decide under s 88A(1) whether to undertake a review, and to conduct a review in the circumstances described in ss 88A(2) and 89.

[69] It is well established that a person whose rights and interests may be affected by an administrative decision made under a statutory power is entitled to procedural fairness unless there is a clear contrary legislative intention. In *Annetts v McCann* (1990) 170 CLR 596, Mason CJ, Deane and McHugh JJ held at 598:

> It can now be taken as settled that, when a statute confers power upon a public official to destroy, defeat or prejudice a person's rights, interests or legitimate expectations, the rules of natural justice regulate the exercise of that power unless they are excluded by plain words of necessary intendment.

That statement of principle was affirmed in *Plaintiff M61/2010E v Commonwealth* (2010) 243 CLR 319 at [74].

[70] To similar effect, in *Minister for Immigration and Border Protection v WZARH* (2015) 256 CLR 326, Kiefel, Bell and Keane JJ held at [30]:

> [I]n the absence of a clear, contrary legislative intention, administrative decision-makers must accord procedural fairness to those affected by their decisions.

[71] A decision by the Chief Executive to make a request to the Director under s 86(1) of the HI Act does not directly affect the rights or interests of the practitioner concerned, but triggers a process that may eventually result in financial and reputational harm to the practitioner. The parties proceeded on the tacit basis that the principle from *Annetts v McCann* applies to a decision under s 86(1) even though the potential affectation of rights or interests is remote from the decision. In the absence of argument upon the issue, I will proceed upon the assumption that the principle is engaged.

[72] Section 86 of the HI Act does not expressly exempt the Chief Executive's exercise of power from a requirement to provide procedural fairness. If a clear statutory intention to exclude procedural fairness is to be discerned, it must be from

the language, context, structure and purpose of the provisions comprising the PSR Scheme.

[73] An important matter of context and structure is that the PSR Scheme provides a staged system of decision-making. The PSR Scheme has, as Griffiths J observed in NHDS, four tiers, each providing for different decisions to be made by different administrative decision-makers on the way towards a possible determination that a practitioner has engaged in inappropriate practice and of the consequences.

[74] The PSR Scheme exposes practitioners to a process involving serious allegations with the potential for serious consequences, including findings of inappropriate practice, cessation of Medicare benefits and damage to personal and business reputation. In this context, it is unsurprising that the PSR Scheme has in place a carefully calibrated regime with inherent checks and balances to ensure a thorough and fair process. At various stages in the process, decision-makers are expressly required to take measures designed to provide procedural fairness.

[75] However, as McHugh J observed in *Re Minister for Immigration and Multicultural Affairs; Ex parte Miah* (2001) 206 CLR 57 at [146]:

> … Natural justice requirements are less likely to attach to decisions that are preliminary in nature. Examples are decisions to lay charges or commence disciplinary proceedings. The closer a decision is to having finality and immediate consequences for the individual, however, the more likely it is that natural justice requirements apply. …

[76] In *Ainsworth v Criminal Justice Commission* (1992) 175 CLR 564 the plurality, quoting from *South Australia v O'Shea* (1987) 163 CLR 378 at 389, observed at 578:

> It is not in doubt that, where a decision-making process involves different steps or stages before a final decision is made, the requirements of natural justice are satisfied if "the decision-making process, viewed in its entirety, entails procedural fairness".

[77] Until this case, there has been no judicial consideration of whether the Chief Executive owes a practitioner obligations of procedural fairness when making a request under the current iteration of s 86(1) of the HI Act. However, several cases have held that that there is no such obligation under provisions concerning referral of possible inappropriate practice to the Director or to a Committee for investigation under earlier versions of the HI Act. Those cases have held, in the context of obligations of procedural fairness being provided for at later stages of a sequentially-stepped decision-making process, that procedural fairness does not apply at the initial stage of referral for investigation.

[78] The first of these cases was *Edelsten v Health Insurance Commission* (1990) 27 FCR 56. In *NHDS*, Griffiths J at [147] distinguished *Edelsten* on the basis that since that decision, the PSR Scheme has been introduced and provides a significantly different process. In particular, His Honour noted that there are now the four tiers and that the second tier includes s 91 which gives the Director an express power to terminate a review. In *NHDS*, Griffiths J was concerned with s

89C, which applies following the conduct of a review by the Director, and requires the Director to choose between taking no further action, or entry into an agreement with the practitioner, or referral to a Committee. *Edelsten* was concerned with two decisions to make a referral to a Committee, which was at that time the step that initiated the review process. The current s 86(1) was inserted by the *Health Insurance Amendment (Professional Services Review) Act 2012* (Cth) as a new initiating step, which precedes any referral to a Committee. The analysis in *Edelsten* as to whether any obligations of procedural fairness applied at the initiating step is instructive when considering the current s 86(1). In contrast, NHDS was concerned with procedural fairness at the later s 89C stage, so that *Edelsten* had much less relevance to that case.

[79] In *Edelsten*, the Full Court considered s 82 of the HI Act, which gave the Minister, or delegate, an implied power to refer a matter to a Committee for investigation where there were reasonable grounds to suspect that a practitioner may have rendered excessive services. Section 94 then required the Committee, where it considered that the practitioner may have rendered excessive services, to conduct a hearing into the matter. The Full Court held that the rules of natural justice did not apply to either the delegate's referral or the Committee's decision. Justices Northrop and Lockhart held at 71:

> We see no warrant for importing into any anterior stage of the matter, including the deliberations and decisions, if any, of the Minister's delegate or the Committee at the s 94(c) stage, a requirement that procedural fairness be afforded to Dr Edelsten.

[80} Justice Davies held at 73:

> [The delegate's] action did not breach principles of procedural fairness. [The delegate's] reference merely initiated an inquiry; it did not decide or formally recommend anything. It would be inconsistent with the Act to imply any requirement as to notice to Dr Edelsten or as to giving to Dr Edelsten of a right to be heard at that stage of the proceedings. The Act lays down a complicated procedure protective of the position of medical practitioners…These provisions are lengthy and detailed and it is inconsistent with them that the Minister or his delegate should, at the initiating stage, be required to give particulars to the medical practitioner concerned or make extended inquiries of the medical practitioner concerned or of the patients of the medical practitioner.

[81] The PSR Scheme commenced in 1994. In *Yung v Adams* (1997) 80 FCR 453, Davies J was concerned with s 86 of the HI Act, which then provided that, "The Commission may…refer to the Director the conduct of a person relating to…whether the person has engaged in inappropriate practice". The scheme provided for the Director to dismiss a referral or set up a Committee (s 89), and for the Committee to hold a hearing if it considered that the practitioner may have engaged in inappropriate practice (s 101). Referring to s 86(1), Davies J held at 461:

> The Health Insurance Commission was not obliged to provide Dr Yung with procedural fairness at that stage. What was done was simply to refer an issue to the Director for consideration.

On appeal, in *Adams v Yung* (1998) 83 FCR 248, this ruling was not challenged.

[82] In *Phan v Kelly* (2007) 158 FCR 75, it was alleged that the applicant was denied procedural fairness in respect of a decision by the Director to set up a Committee. That argument was rejected by Tamberlin J, who held:

> [44] Accordingly, it is permissible to have regard to the scheme as a whole. Looking at the process in the present case in its entirety, the contested decisions of the Director and Committee were clearly part of, and directed to, the ultimate determination by the Determining Authority. They may be characterised as part of a single, sequentially-stepped decision-making process leading to a final outcome. This consideration leads to the conclusion that the legislative scheme is sufficiently exhaustive to indicate a legislative intent to exclude the application of additional measures to achieve procedural fairness.
>
> …
>
> [46] In this case, I am satisfied that the statutory scheme, considered as a whole, exclusively provided for procedural fairness principles to the extent that the legislature intended those principles to apply.

[83] The description given by Tamberlin J of "a single, sequentially-stepped decision-making process leading to a final outcome" remains apt. However, as I will later discuss, the express requirements of procedural fairness under the HI Act in its current form cannot be regarded as providing an exclusive or exhaustive code for procedural fairness.

[84] In *Daniel v Kelly* (2003) 200 ALR 379, Ryan J was concerned with a form of s 86(1) of the HI Act that provided, relevantly, "[t]he Commission may, in writing, refer to the Director the conduct of a person relating to…whether the person has engaged in inappropriate practice in connection with rendering of services". Section 88 required the Commission to send a copy of the investigative referral (after the referral had been made) to the person under review, accompanied by a notice inviting the person to make written submissions to the Director stating why the referral should be dismissed without setting up a Committee. In that case, the applicant's principal complaint was that the Commission had applied a policy of "automatic referral" without consideration of the merits of his individual case. In the course of considering that ground, Ryan J stated at [26]:

> Given that the process under consideration is an investigative one which may result in serious consequences for a medical practitioner, including the cancellation or suspension of rights conferred by statute, there is a presumption, not disputed by counsel for the respondents, that the practitioner will be accorded procedural fairness….

His Honour went on to hold that the Commission, in making the investigative referral, had failed to take into account relevant considerations.

[85] In *Kelly v Daniel* (2004) 134 FCR 64, the Full Court dismissed an appeal from the judgment of Ryan J. The Full Court held at [82]:

> … Section 86 confers upon the Commission a broad discretion to refer the question whether a practitioner has engaged in inappropriate practice to the Director. The Commission is obliged to take into account any explanation offered by the practitioner for what may be a temporary, and perhaps understandable breach of the rule. Its task is to consider not merely whether the number of services exceeds the number permitted under that rule, but whether the practitioner's conduct is capable, potentially, of falling within the definition of "inappropriate practice" in s 82(1)(a). The Commission is certainly entitled, in our view, to exercise its discretion having regard to the fact that the practitioner has been counselled, and his conduct subsequently reviewed, without any apparent repetition of the breach, or likelihood of that breach recurring.

The Full Court's view that the Commission was required to take into account any explanation offered by the practitioner suggests that the Full Court considered that procedural fairness must be provided in the exercise of the power under s 86(1) of the HI Act.

[86] In *Daniel v Kelly*, it was conceded at first instance that s 86(1) of the HI Act in its extant form imposed obligations of procedural fairness upon the Commission, and the question does not seem to have been argued on appeal. That may have been because the relevant ground of review was whether the Commission had applied a policy without consideration of the merits of the case, not whether the practitioner had been denied procedural fairness. In any event, that case is distinguishable. The present iteration of s 86(1) allows the Chief Executive only to request that the Director review the provision of services, not to refer conduct to the Director for investigation. A referral under the iteration considered in Daniel v Kelly required the Director, under s 89(1), to conduct an investigation unless persuaded by the practitioner to dismiss the referral. Under the current iteration, a request by the Chief Executive does not compel the Director to undertake the review (subject to the exception under s 89 which is not relevant in this case). Accordingly, a referral by the Commission under the previous version of s 86(1) had a more direct impact upon the rights and interests of a practitioner than the current version.

[87] A number of provisions under the PSR Scheme expressly require the taking of steps intended to provide a measure of procedural fairness. The content of these requirements, and the potential consequences of non-compliance, vary between provisions. The express requirements are:

- Section 87: If the Chief Executive requests the Director to review the provision of services, the Chief Executive Medicare must give the person written notice of the request within seven days (but failure to comply does not affect the validity of the request).
- Section 88A: The Director must give written notice of the decision as to whether to accept the request to the relevant person within seven days and, if the Director decides to undertake the review, the notice must set out the terms of section 89B (but failure to comply does not affect the validity of the decision).
- Section 89C(1): Following a review, if the Director does not make a decision under s 91 to take no further action, the Director must give the person under

review a written report setting out the reasons why the Director has not made a decision under s 91 and an invitation to make written submissions to the Director about the action the Director should take.

- Section 89C(2): The Director must take into account any submissions made by the person under review in deciding whether to take no further action under s 91, or to enter into an agreement under s 92; or to make a referral to a Committee under s 93.
- Section 93(7): The Director must give to the person under review, the report prepared for the Committee within seven days (but failure to comply dies not affect the validity of the referral).
- Section 102(1) and (2): If a Committee proposes to hold a hearing, it must give the person under review written notice of the time and place at least 14 days before the hearing.
- Section 103(1)-(3): The person under review is provided with express entitlements, including to attend the hearing, be accompanied by a lawyer or other person, call witnesses, question witnesses and address the Committee.
- Section 106H(4): A Committee must notify the person under review of any intention to make a finding of inappropriate practice, provide its reasons and give the person an opportunity to respond.
- Section 106KD(3): A Committee must give the person under review a written draft report of its preliminary findings and a notice inviting the person to provide written submissions suggesting changes to the draft report.
- Section 106KE: If the draft report does not contain a unanimous or majority finding of inappropriate practice, the Committee must provide the person with a written notice stating, inter alia, that no further action will be taken.
- Section 106L(3)-(5): The committee must give its final report to the person under review and a written notice stating that a copy will be given to the Determining Authority, but if there is no unanimous or majority finding that the person engaged in inappropriate practice, a notice that, inter alia, no further action will be taken.
- Section 106QB(3): If the Director or the Determining Authority decides and gives notice that it would be impossible for an action specified in the agreement to take effect, the notice must set out the circumstances and the Director must, within seven days of giving or receiving the notice, give a copy of the notice to the person under review.
- Section 106R(3)-(4): The Determining Authority must give notice in writing of its decision (either ratifying or refusing to ratify the agreement) to the person under review within seven days after the decision is made or taken to have been made, and in the case of a refusal decision, the notice must set out the reasons for the refusal (but failure to comply with these requirements does not affect the validity of the decision).
- Section 106RB(1)-(3): If the Director or the Determining Authority decides and gives notice that it would be impossible for a proper draft determination or a final determination to be made by the Authority in relation to the person under review, the notice must set out the circumstances and the Director must, within seven days of giving or receiving the notice, give a copy of the notice to the person under review.
- Section 106S(3): If the Director gives the Determining Authority any information that the Director considers is relevant to the Authority making

its draft determination or final determination, the Director must also give the information to the person under review at the time.

- Section 106SA(1)-(5): The Determining Authority must invite the person under review to make written submissions to the Authority about directions the Authority should make in the draft determination, and if the Director gives the Determining Authority further information after such an invitation has been made, the Authority must invite the person under review to make further submissions.
- Section 106T(1)-(2): The Determining Authority must take into account any submissions made by the person under review and give a copy of the draft determination to the person under review within one month of the draft determination, together with an invitation to make written submissions suggesting changes to any directions.
- Section 106UA: As soon as practicable after making a final determination, the Determining Authority must give a copy of it to the person under review.

[88] It may be seen that where a decision-maker is required to provide procedural fairness, the PSR Scheme tends to specify the steps that must be taken to fulfil the obligation. In contrast, s 86 does not specify any requirement or content of procedural fairness.

[89] Against this, it may be accepted that the PSR Scheme in its current form does not constitute an exhaustive code of procedural fairness. In NHDS, Griffiths J observed at [146]:

> As noted, the Director did not submit that the PSR Scheme in the HI Act constituted an exhaustive procedural code which precluded the implication of any additional requirements of procedural fairness. Nor would I have accepted any such submission. The richness of the statutory procedural requirements in the multi-stage process under the PSR Scheme are not exhaustive. In particular, the procedural fairness rights and obligations under tier three do not deny the need for procedural fairness at the tier two level ...

An example of an unstated obligation of procedural fairness is, as Griffiths J held at [142]-[146], that the Director's obligation under s 89C of the HI Act to provide a practitioner with an opportunity to make a submission is an obligation to provide a reasonable opportunity. Another example is that s 106(1) provides that the procedure for the conduct of a hearing by a Committee is within the discretion of the presiding member, but there obviously exist implied requirements of procedural fairness, including providing the practitioner with a reasonable opportunity to make submissions upon contentious matters of procedure and upon the substantive issues.

[90] Nevertheless, where a decision-maker is positively required to give the person under review an opportunity to be heard as to whether a particular decision should be made, the PSR Scheme tends to make the requirement express, and does not leave it to implication. For example, ss 89C(1), 103(1)(g) and 106H(4) specify that the practitioner must be permitted to make submissions before the relevant decision is made. This is reinforced by s 80(11) which states that, "[p]rovision is made throughout the scheme for the person under review to make submissions before key decisions are made or final reports are given." The fact that s 86 of the HI Act does

not expressly provide for a right to make submissions as to why the Chief Executive should not make a request to the Director, while not of itself determinative, strongly suggests that no obligation of procedural fairness is implied.

[91] The Chief Executive's request under s 86(1) of the HI Act is the step that initiates the PSR review. Such a request does not itself affect any substantive rights. To adopt the language of Northrop and Lockhart JJ in *Edelsten* at 70, the request is no more than a step in an administrative process that may lead to an ultimate or operative determination, and is remote from any such consequences. And, to adopt the language of Davies J in that case at 73, the request does not decide or formally recommend anything.

[92] The Chief Executive's powers of investigation under the HI Act are limited, and do not include coercive powers. In contrast, the Director's powers are wider, and include the power to require a practitioner to provide documents and give information (s 89B). The powers of a Committee are wider still, and include conducting hearings (s 101). As Griffiths J observed in *NHDS* at [27]:

> It should also be noted that the Chief Executive Medicare has limited investigative powers to obtain information that may be relevant to his or her consideration of whether or not to make a request to the Director to review the provision of services by a person or a practitioner. It is evident that a decision whether to make such a request will generally be based upon the Chief Executive Medicare's review of statistical data concerning a practitioner's Medicare billing and any other information which the Chief Executive Medicare obtains by other means, including a voluntary interview with one or more practitioners, as occurred in this case.

[93] This is the context in which the Chief Executive makes a request under s 86(1) of the HI Act initiating consideration by the Director as to whether to undertake a review. The context demonstrates why a fairly low barrier is imposed for the Chief Executive's decision. The Explanatory Memorandum for the Bill introducing the 2002 Amending Act indicated that a review may be requested on the basis of inferences drawn from the statistical data. This context also demonstrates that the Chief Executive's decision is envisaged to be made without substantial investigation of the kind required at later stages.

[94] A practitioner's rights and interests may be directly affected at the second, third and fourth tiers of the PSR Scheme, culminating in a Determining Authority making a final determination under ss 106TA and 106U, which may have direct financial and reputational consequences. In that context, the PSR Scheme expressly imposes increasing requirements of procedural fairness at various stages under those tiers. In view of the opportunities at Tiers 2, 3 and 4 for a practitioner to make submissions that may head off any further progression of an inquiry, it is unsurprising that there would be no requirement to provide any such opportunity at the initiating stage.

[95] In the context of the imposition of substantial obligations of procedural fairness at later stages, is seems unlikely that the legislative intention is that a practitioner should have an opportunity to try to persuade the Chief Executive to not make a request under s 86(1) of the HI Act. A requirement of this type would

be administratively cumbersome and significantly repetitious. It is unlikely that such a requirement would be implied, rather than being expressly stated.

[96] As McHugh J observed in *Miah* at [146], natural justice requirements are less likely to attach to decisions that are preliminary in nature. His Honour gave examples of such preliminary decisions as being the laying of charges or the commencement of disciplinary proceedings. A decision under s 86(1) to request a review occurs at an even more preliminary stage.

[97] In addition, it may be noted that under s 86(1A) of the HI Act, if the Chief Executive becomes aware that the circumstances in which services were rendered or initiated constitute a prescribed pattern of services, the Chief Executive must make a request under s 86(1) in relation to the services. In view of the obligation to make such a request, there cannot be any implied requirement to allow a practitioner to make submissions before the request is made. That there is no implied obligation of procedural fairness under s 86(1) in one circumstance tends to support the view that there is no general obligation of that kind.

[98] Section 87(1) provides that if the Chief Executive requests the Director to review the provision of services by a person, the Chief Executive must give the person written notice of the request. The express imposition of that obligation of procedural fairness after a decision under s 86(1) is made suggests that there is no implied anterior obligation to give the practitioner notice.

[99] Although Griffiths J in *NHDS* considered that the opportunity to head off progression of the process at s 89C of the HI Act was a reason for implying an obligation of procedural fairness, the content and form of s 86(1) is quite different. For the reasons that follow, I do not accept Dr Yoong's submission that the reasoning of Griffiths J in *NHDS* as to procedural fairness at the s 89C stage can be transposed into an implication of procedural fairness at the s 86(1) stage.

[100] In *NHDS*, the Director had decided to refer the applicant to a Committee pursuant to s 93 of the HI Act to investigate whether the corporate applicant may have engaged in inappropriate practice by permitting or causing 56 specified medical practitioners allegedly employed by the applicant to engage in conduct that constituted inappropriate practice. The Director had earlier provided a written report to the applicant as was required under s 89C(1)(b) which had led the applicant to believe that only 15 medical practitioners would be the subject of potential referral to a Committee. His Honour held that the applicant had been denied an opportunity to make a submission under s 89C(2) that the Director could not reasonably be satisfied that the conduct of those 56 practitioners involved inappropriate practice and to terminate the review. The applicant had thereby been denied procedural fairness.

[101] In order to understand the basis of Griffiths J's decision, it is necessary to consider the relevant statutory provisions. Under s 89C(1), after conducting a review, the Director must either: make a decision to take no further action; or give the person under review a written report setting out the reasons for not deciding to take no further action, and an invitation to make written submissions about the action the Director should take. Section 89C(2) provides that the Director must take

into account any such submissions, and decide whether to take no further action in accordance with s 91; or enter into an agreement with the person under s 92; or make a referral to a Committee under s 93.

[102] Justice Griffiths held:

> [131] Unsurprisingly, there was no serious contest as to the relevant legal principles concerning procedural fairness. The Director accepted that the statutory scheme imposed various procedural fairness obligations on her and that the content of those obligations had to be determined in the context of the statutory scheme. The Director submitted, however, that, in determining the content of procedural fairness obligations, it was relevant to take into account that a s 93 referral occurs at a relatively early stage of the review process and prior to an investigation of whether inappropriate practice has in fact occurred, not to mention well before the imposition of any sanction. It was submitted that a s 93 referral "lacks any quality of finality" and "is not a substantive determination".
>
> [132] While it is relevant to take into account the different tiers of decision-making under the PSR Scheme, I consider that the Director has overstated the relevance of that matter in determining the content of procedural fairness requirements in tier 2. Different considerations may arise with a multi-staged decision making process which, unlike the legislative regime here, does not contain its own rich supply of procedural fairness requirements. It is also relevant to take into account the essentially investigative nature of tier 2 and that the person under review will have a right to be heard before the Committee if a referral is made under s 93. Of particular relevance and significance, however, is the Director's obligation under s 89C to make a decision under s 91(1) to take no further action in relation to the review, rather than enter into a s 92 agreement (which was not an option in the case of NHDS) or make a referral under s 93.
>
> (Underlining added.)

[103] His Honour then referred to observations made by the Victorian Court of Appeal in *Byrne v Marles* (2008) 19 VR 612, and continued:

> [134] These observations are directly pertinent to the proceeding here having regard to the terms and effect of s 89C(1) and with its particular reference to s 91. A right to be heard by the person under review affords that person an opportunity to persuade the Director to terminate the complaint at a relatively early stage. That right is different from the rights which the person under the review who is the subject of a subsequent referral has before the Committee.

[104] His Honour concluded:

> [142] Procedural fairness obliged the Director to provide NHDS with a reasonable opportunity to address those three elements [of inappropriate practice], which required the Director to provide NHDS with appropriate particulars and/or information in respect of those three matters with reference to the 56 identified NHDS practitioners. There is an obvious connection between the provision of a s 89C report and the obligation of the Director to

> invite submissions as to the future course of action, as required by s 89C(1)(b)(ii) …
>
> [143] There is also a plain connection between the making of those submissions and the effect they may have on the Director's decision under s 93, as is emphasised by the explicit obligation on the Director under s 89C(2) to take into account those submissions in deciding whether or not to make a referral to a Committee.
>
> [144] The Director effectively shifted the goal posts after receiving NHDS's submissions so as to bring to the forefront of the Director's further deliberations the conduct of 56 other NHDS practitioners …
>
> (Underlining added.)

[105] The Director has express obligations of procedural fairness under ss 89C(1) and (2) of the HI Act to provide a written report, to invite submissions as to the course the Director should take and to take into account any submissions. I understand Griffiths J to have held that these obligations imply a requirement that the Director's report must give the practitioner a reasonable (or fair) opportunity to seek to persuade the Director not to make a referral to a Committee and, instead, to take no further action. His Honour held that the failure of the report to disclose the allegation that the conduct of 56, rather than only 15, practitioners may involve inappropriate practice had deprived the applicant of the reasonable opportunity that was required to be given.

[106] It is important to understand the parameters and limits of Griffiths J's reasons. First, the Director had accepted that obligations of procedural fairness obligations were imposed upon her. That concession was correctly made since, relevantly, s 89C of the HI Act required the Director to provide a written report to the practitioner and take into account submissions made in response to the report. Accordingly, his Honour's reasons at [131]-[134] were not concerned with whether there was an obligation of procedural fairness, but with the content of the obligation. Second, his Honour was only dealing with the content of procedural fairness after the requirement to provide a report under s 89C(1)(b) had been engaged. That report is only provided after the Director has made an initial decision not to take no further action under s 91. His Honour's reasons do not suggest that the Director is required to provide an opportunity to the practitioner to be heard prior making the initial decision as to whether to take no further action.

[107] I do not accept that Griffiths J's views upon the requirements of procedural fairness at the s 89C stage can be translated into a conclusion that an obligation of procedural fairness exists at the s 86(1) stage. In fact, his Honour's reasons are against the proposition that the Chief Executive must give the practitioner an opportunity to make submissions as to why a request should not be made. In respect of the Director's decision under s 88A as to whether to undertake a review, his Honour stated at [67]:

> … Although there is no explicit statutory provision which requires the Director to invite the person the subject of the requested review to make submissions or give information as to whether or not the Director should undertake the review,

> I see no reason why the Director could not, in his or her discretion, extend an invitation to that effect (bearing in mind the 1 month time period within which the Director is required to make a decision whether or not to conduct the review) or, indeed, why (with or without an invitation) the person the subject of the request could not provide submissions or information to the Director before that time expired on the question whether or not the Director should undertake the requested review. I emphasise that I am ***not*** suggesting that these are procedural fairness requirements. Rather, they are discretionary.
>
> (Emphasis in the original.)

His Honour's view that the Director is not required to provide procedural fairness when considering whether to undertake a review must apply with at least equal force to the position of the Chief Executive under s 86(1) when deciding whether to request that the Director undertake a review.

[108] In my opinion, the Chief Executive does not owe a practitioner an obligation of procedural fairness when exercising the power under s 86(1) of the HI Act. In particular, there is no obligation to give the practitioner an opportunity to make submissions as to why a request to the Director should not be made.

[109] As a matter of administrative practice, the Chief Executive's delegate provided Dr Yoong with particulars for concerns and invited him to make submissions addressing those concerns. However, there was no implied obligation upon the Chief Executive to provide that opportunity.

A decision of delegate of the Chief Executive Medicare to make a request of the Director is not subject to judicial review under either the *Administrative Decisions (Judicial Review) Act 1977* or the *Judiciary Act 1903*.

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Reviewability under the ADJR Act

[152] The decisions of the Chief Executive and the Director will not be reviewable under s 5 of the ADJR Act unless they are, "a decision to which this Act applies". That expression is defined in s 3(1) to mean, "a decision of an administrative character made, proposed to be made, or required to be made…under an enactment…".

[153] In *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321, Mason CJ (with whom Brennan and Deane JJ agreed) at 335-338 distinguished between "decisions" reviewable under s 5 of the ADJR Act and "conduct" reviewable under s 6. The former entails decisions that are final, operative and substantive, whereas the latter are essentially procedural.

[154] In *Edelsten*, Northrup and Lockhart JJ described *Bond* in these terms at 68:

> *Bond* is authority for the principle that generally, for a decision to be reviewable under the Judicial Review Act it must have a quality of finality, not

> being merely a step taken on the way to the possible making of an ultimate decision; and it must have the essential quality of being a substantive as distinct from a procedural determination.
>
> The rationale underlying *Bond* is that Parliament could not have intended the Judicial Review Act to be a vehicle for judicial review of every decision of a decision-maker under a Commonwealth enactment. Some decisions will have real impact upon a person's rights, privileges or obligations; some will have no such impact, whilst others are mere stepping stones which may lead ultimately to the making of a decision which does affect the person's position.

[155] Their Honours held at 70 that the referrals to a Committee for investigation were merely, "steps in an administrative process that may lead to an ultimate operative determination affecting [the practitioners] position", and were in themselves, "remote from any such consequences". They lacked the quality of finality and were not substantive determinations. They were not reviewable decisions under the ADJR Act.

[156] Dr Yoong submits that *Edelsten* is distinguishable on three bases. First, the referral to the Minister under reg 3(2)(b) of the *Health Insurance Commission Regulations 1975* (Cth) (Repealed) was not a condition precedent to the Minister taking any action, whereas, a request under s 86(1) of the HI Act is a precondition to the Director's decision to undertake or not undertake a review.

[157] Second, Dr Yoong submits that such a request is deemed to be a decision under an enactment pursuant to s 3(3) the ADJR Act.

[158] Third, Dr Yoong submits that, in contrast to s 86(2) of the current HI Act, there was no requirement under the iteration considered in *Edelsten* that the referral be in relation to a two year period immediately preceding the request. He contends that decisions under ss 86(1) and 88A therefore have an element of finality that was missing from the legislation considered in *Edelsten*.

[159] A decision under s 86(1) of the HI Act is not a final or operative determination of a substantive kind. A request to review does not directly affect any rights of a practitioner, but only triggers the Director's obligation to make a decision as to whether or not to undertake a review. In that respect, a request under s 86(1) is analogous to the referral by the Minister to a Committee considered in *Edelsten*. Although the referral activated the Committee's duty to enquire and report, it was held in *Edelsten* not to be a decision under an enactment.

[160] That a request under s 86(1) of the HI Act can only relate to a two year period immediately preceding the request, does not somehow convert the request into a final or operative determination affecting rights or obligations of a practitioner.

[161] A decision made by the Director under s 88A of the HI Act also lacks the quality of a final or operative determination of a substantive kind. A decision as to whether to undertake a review does not directly affect any right or obligation of a practitioner, but simply determines whether the Director will undertake a review. Any effect on a person's legal rights or obligations would be the result of separate

decisions made by the Director following the conduct of a review. The Director's decision to undertake the review is not a decision under an enactment, and is no more than a step in the administrative process that may lead to a final or operative decision.

[162] Section 3(3) of the ADJR Act deems the making of a "report or recommendation" to be the making of a decision a decision in certain circumstances. The section provides:

> Where provision is made by an enactment for the making of a report or recommendation before a decision is made in the exercise of a power under that enactment or under another law, the making of such a report or recommendation shall itself be deemed, for the purposes of this Act, to be the making of a decision.

[163] In *Eastman v Australian Capital Territory* (2008) 163 ACTR 14 , Moore and Stone and JJ held at [15]:

> It is tolerably clear that [s 3(3) of the ADJR Act) was intended to encompass reports leading to decisions of the type to which the ADJR Act generally applies. That is, decisions made under enactments. A necessary characteristic of such decisions is that the decision must itself confer, alter or otherwise affect legal rights or obligations whether new or existing.

[164] The ADJR Act does not define the words "report" or "recommendation". They may be taken to have their ordinary meanings. A request made under s 86(1) of the HI Act is not a "report" or a "recommendation" in the ordinary senses of those words. It is merely, and expressly, a request.

[165] In any event, s 3(3) of the ADJR Act only operates where the report or recommendation is a precondition to making another decision to which the ADJR Act would apply. A decision under s 88A(2) is not a decision of that kind. A decision under s 88A(2) also lacks a final or operative quality. It follows that s 3(3) of the ADJR Act does not operate to deem a decision under s 86(1) of the HI Act to be a decision under an enactment.

[166] The decisions made by the Chief Executive and the Director are not reviewable under the ADJR Act.

Reviewability under the Judiciary Act

[167] Dr Yoong also seeks orders pursuant to s 39B of the Judiciary Act quashing the decision of the Chief Executive under s 86(1) and of the Director under s 88A(2) of the HI Act.

[168] The Chief Executive submits that certiorari is not available. She argues that decision under s 86(1) was merely preliminary in nature and, in addition, that neither decision affected any right.

[169] In *Hot Holdings Pty Ltd v Creasy* (1996) 185 CLR 149 at 159–160, the plurality held:

> … [F]or certiorari to issue, it must be possible to identify a decision which has a discernible or apparent legal effect upon rights. It is that legal effect which may be removed for quashing.
>
> This formulation encompasses two broadly typical situations where the requirement of legal effect is in issue: (1) where the decision under challenge is the ultimate decision in the decision-making process and the question is whether that ultimate decision sufficiently "affects rights" in a legal sense; (2) where the ultimate decision to be made undoubtedly affects legal rights but the question is whether a decision made at a preliminary or recommendatory stage of the decision making process sufficiently "determines" or is connected with that decision.
>
> The form in which a decision-making structure is established may be likely to indicate the nature of the function exercised at each stage within that structure. Nevertheless, the difference between the two situations outlined above is one of substance as well as form. In the second situation, the question becomes whether the stage of the process under challenge has the necessary effect on the final or ultimate decision.

[170] In *Byrne v Marles* (2008) 19 VR 612, the Victorian Court of Appeal was concerned with the *Legal Profession Act 2004* (Vic), which required the Legal Services Commissioner to investigate disciplinary complaints and authorised the Commissioner to refer a disciplinary complaint for investigation. Following the investigation, the Commissioner, if satisfied that there was a reasonable likelihood that the practitioner would be found guilty of professional misconduct, was required to apply to the tribunal for an order. The Court of Appeal held that a decision of the Commissioner to treat a complaint as a disciplinary complaint and to investigate it did not attract certiorari.

[171] Justice Nettle (with whom the other members of the Court agreed) considered that *Bond* and *Edelsten* demonstrated that the Commissioner's decision did not affect rights, and that the decision was not sufficiently connected with a final decision that affected rights. His Honour held:

> [70] … I do not consider that the decision of the commissioner to treat Mr Marsh's complaint as a disciplinary complaint for the purposes of ss 4.4.7 and 4.4.9 affected the appellant's rights in a legal sense. All it meant was that an investigation of the complaint would be carried out which, depending upon the result of the investigation, might lead to the Commissioner making a further determination under s 4.4.13 to apply to the Tribunal. Nor in my view could it properly be said that the commissioner's determination to treat the complaint as a disciplinary complaint for the purposes of ss 4.4.7 or 4.4.9 sufficiently determined or was sufficiently connected with a decision that affects rights as to come within the second class of case identified in Hot Holdings. Unlike the administrative decision in that case (which was bound to have a discernible legal effect upon a subsequent exercise of ministerial discretion bearing upon legal rights), a decision of the commissioner to investigate a complaint as a disciplinary complaint does not have any discernible effect upon a decision of the tribunal upon application later made under s 4.4.13 of the Act.

> [71] No doubt a decision by the commissioner to treat a complaint as a disciplinary complaint and to investigate it as such or to refer it for investigation by the institute enlivens the investigative powers of the commissioner and the institute, including powers to compel the production of documents and explanations. In that limited sense it may be said that such a decision is one which satisfies a condition precedent to the exercise of power which may in turn affect rights or otherwise give rise to legal consequences. But that is not sufficient to attract certiorari. It does not necessarily follow from the commissioner's decision to investigate or refer that compulsive powers will be invoked. It is conceivable that an examination could be carried out without any reference to the subject of the complaint or alternatively by means of interview without any compulsion.

[172] The circumstances of *Marles* are analogous to the present situation. The Chief Executive's request under s 86(1) of the HI Act does not itself affect a practitioner's rights and is only indirectly and remotely connected with those decisions under the PSR Scheme that do affect rights. A request by the Chief Executive does not have any direct effect upon any later decision that a practitioner has engaged in inappropriate practice. While such a decision is a condition precedent to the exercise of power by the Director which may affect rights, like in *Marles*, the connection between the request and such exercise of power is too remote.

[173] Further, I do not accept that the Director's decision under s 88A of the HI Act affects a practitioner's rights, or is sufficiently connected with decisions that do affect rights. As in *Marles*, such a decision only means that an investigation is conducted, which may lead to no further consequence. It is not until and unless the Director uses her powers to compel production of information and documents, or the Director comes to make a decision in accordance with s 89C, that rights may be affected.

[174] I consider that the decisions of the Chief Executive and the Director are not susceptible to certiorari.

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> [18] The decisions which s 89C(2) summarises as open to the Director to make are not merely procedural. Decisions to take no further action or to enter into an agreement bring the Pt VAA process to an end. Once made, they become the source of substantive rights. If not made, those substantive rights are denied to the practitioner. These features, in my view, give each the necessary quality of finality to make each of the decision options mentioned in s 89C(2) decisions to the ADJR Act applies.
>
> [19] It does not follow from this conclusion that the anterior decisions of the CEO under s 86 to request the Director to undertake the review of services and a decision of the Director under s 88A as to whether or not to undertake that review have that same quality. Neither such decision entails what Mason CJ in *ABT v Bond*, at 337, described as a "substantive determination". Each is wholly procedural. The administrative states of mind which inform the making of these decisions have no

consequential binding effect whatsoever in respect of any later stage in the Pt VAA review processes.

[20] For completeness, I should record that, after judgment was reserved, my attention was drawn by the parties to *Yoong v The Chief Executive of Medicare* [2021] FCA 701 (*Yoong*). It is evident from *Yoong*, at [3], that the applicant in that case invoked both the ADJR Act and the Judiciary Act as sources of jurisdiction. Unsurprisingly in those circumstances, the question as to whether a decision under s 86 was a decision amenable to review under the ADJR Act did not arise as an issue, because the Court would any event have retained jurisdiction, albeit to review for jurisdictional error rather than on a ground specified in s 5 of the ADJR Act.

Director's decision to proceed

[21] By s 89C(1)(b) of the HIA, if the Director decides under s 91 not to take no further action, she is then obliged to give the practitioner:

(i) a written report setting out the reasons why the Director has not made a decision under section 91; and

(ii) an invitation to make written submissions to the Director, within 1 month, about the action the Director should take in relation to the review.

In the face of this explicit provision for the affording to the practitioner of an opportunity to be heard, and when that opportunity is to be given, it would, in my respectful view and as a matter of initial impression, be an odd construction of s 91 of the HIA to conclude that, before making any decision not to proceed, the Director was under some general, procedural fairness obligation to extend to the practitioner a prior opportunity to be heard.

[22] The Director is obliged (s 89C(2)) to take into account any submission made in response to the invitation given pursuant to s 89C(1)(b)(ii). After having so done, the Director may decide to take no further action under s 91 (s 89C(2)(a)). There are thus two opportunities for the Director to decide under s 91 to take no further action – initially upon a review (s 89C(1)(a)) or following the consideration of submissions made by the practitioner in response to the invitation (s 89C(2)(a)). Thus, I respectfully agree with this observation made by Griffiths J in the *First NHDS Case*, at [39]:

> There is no single point in time in which the Director may make a decision under s 91 to, in effect, terminate a review. It may be exercised from time to time within the tier 2 stage. Such a decision might be made, for example, as contemplated in s 89C(1)(a), at the point in time when the Director has conducted a review of the provision of services by a person. The Director could also make a decision under s 91 to take no further action after taking into account any written submissions received from the person under review as contemplated by s 89C(1)(b). This is made clear in the terms of s 89C(2).

[23] As Griffiths J highlighted in in the *First NHDS Case*, at [132] – [134], based on an analogy with *Byrne v Marles* [2008] VSCA 78; (2008) 19 VR 612 (*Byrne v*

Marles), the procedural fairness obligation in s 89C(1)(b) of the HIA is an important one, offering the practitioner an opportunity to persuade the Director to bring the Pt VAA process to an end at a relatively early stage. It does not follow from this that, at the earlier stage of deciding under s 88A whether to undertake a review at all, the presence of a requirement to notify the practitioner of a decision to undertake the review means that, at that point, the practitioner has a right to be heard. Nor does it follow that the Director is by implication under any procedural fairness obligation before making the initial decision under s 89C(1) not to take no further action under s 91 but rather to give the practitioner the report and invitation under s 89C(1)(b) of the HIA. In the face of the express obligation in s 89C(1)(b), it is an unlikely construction of the provisions governing this stage of the Pt VAA process that additional procedural fairness obligations are present by implication.

[24] *Byrne v Marles* can be reconciled with the High Court's earlier judgment in *Medical Board (Qld) v Byrne* [1958] HCA 40; (1958) 100 CLR 582 (*Medical Board (Qld) v Byrne*) not just on the basis of a different statutory scheme but also on the basis that, the earlier decisions which fall to the Director to make are procedural with a substantive right or interest affected only at the stage when the Director decides it is necessary to furnish the practitioner with a report and extend an invitation to make submissions. In *Medical Board (Qld) v Byrne*, the formation of an anterior administrative opinion by the Medical Board that a practitioner should be subjected to disciplinary punishment, which was a condition precedent to a hearing on the merits by a medical assessment tribunal, was not regarded as carrying with it an obligation to afford the medical practitioner concerned an opportunity to be heard before the Board decided whether to form its opinion. In Pt VAA of the HIA scheme, the earlier decisions which fall to the Director to make are likewise conditions precedent but, given the express incorporation, via s 89C(1)(b)(ii), of a procedural fairness opportunity to the practitioner to persuade the Director to decide under s 91 to take no further action, there is no reason to construe s 88A, s 89C or s 91 as entailing any earlier such obligation. A corollary of this procedural quality of these earlier decisions of the Director is that they are not amenable to review under the ADJR Act.

[25] I respectfully consider that an analysis offered by Tamberlin J in *Phan v Kelly* [2007] FCA 269; (2007) 158 FCR 75 (*Phan v Kelly*) of the then Pt VAA of the HIA remains pertinent to that Part as it stood during the review period. It is not necessary to rehearse the authorities there discussed by his Honour, only to apply them in the context of the scheme revealed by Pt VAA of the HIA. Considering that scheme, it contains such provision as Parliament intended in respect of procedural fairness: *Phan v Kelly*, at [46]. It is true, as Dr Karmakar submitted, that Pt VAA was amended after *Phan v Kelly* was decided but not, in my view, in a way which affects the reasoning of Tamberlin J. If anything, the later amendments underscore that express prescriptions in respect of procedural fairness obligations leave no room for their supplementation by implication.

[26] I note that, in *Yoong*, Rangiah J accepted, without analysing it in relation to s 89C, the correctness of the conclusion reached by Griffiths J in the *First NHDS Case*. However, the issue in *Yoong* was whether that conclusion could be translated so as to imply a procedural fairness obligation into s 86 of the HIA. It was sufficient in that case to assume the correctness of that conclusion about s 89C. In the result,

> at [106] – [107], his Honour was unpersuaded that the reasoning in the *First NHDS Case* that led Griffiths J to his conclusion about s 89C translated in a conclusion that s 86 of the HIA entailed any procedural fairness obligation by implication.
>
> [27] For these reasons, I reject Dr Karmakar's submission that, before making any decision not to proceed, the Director was under some general, procedural fairness obligation to extend to the practitioner concerned a prior opportunity to be heard. The only obligation was that specified in s 89C(1)(b) of the HIA.

The Chief Executive Medicare has limited powers of investigation and usually bases the request for review on the analysis of statistical information and non-compulsory means of investigation.

> ***National Home Doctor Service Pty Ltd v Director of Professional Services Review*** [2020] FCA 386 —
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> > [27] It should also be noted that the Chief Executive Medicare has limited investigative powers to obtain information that may be relevant to his or her consideration of whether or not to make a request to the Director to review the provision of services by a person or a practitioner. It is evident that a decision whether to make such a request will generally be based upon the Chief Executive Medicare's review of statistical data concerning a practitioner's Medicare billing and any other information which the Chief Executive Medicare obtains by other means, including a voluntary interview with one or more practitioners, as occurred in this case.

In order to make more certain the jurisdiction of the Chief Executive Medicare to make a request, subsection 86(1) was amended[158] to provide that a request may be made:

> … if it appears to the Chief Executive Medicare that there is a possibility that the person may have:
> (a) provided services during the period; and
> (b) engaged in inappropriate practice in the provision of the services.

This means that Chief Executive Medicare need not make any findings of fact in relation to those matters before making a request of the Director, but merely have reasonable grounds for a suspicion about them, and it does not affect the validity of a request if those suspicions were not, in fact, correct.

[158] Schedule 1, item 3, *Health Legislation Amendment (Medicare Compliance and Other Measures) Act 2022*.

86(3) — reasons for the request

Subsection 86(3) provides that the request for review from the Chief Executive Medicare must include reasons for the request. Formerly, that requirement was contained in paragraph 86(4)(b) of the Act.

Doan v Health Insurance Commission [2002] FCA 1160 —

> [105] Additionally, it is sufficient to say that a breach of s 86(4)(b) will not automatically result in the invalidity of a referral. As was said by McHugh, Gummow, Kirby and Hayne JJ in *Project Blue Sky* at pp 388-399:
>
> > "An act done in breach of a condition regulating the exercise of a statutory power is not necessarily invalid of and of no effect. Whether it is depends upon whether there can be discerned a legislative purpose to invalidate any act that fails to comply with the condition. The existence of the purpose is ascertained by reference to the language of the statute, its subject matter and objects, and the consequences for the parties of holding void every act done in breach of the condition."
>
> [106] I can discern nothing in the HI Act which demonstrates a legislative purpose to invalidate a referral given in breach of s 86(4)(b). That is especially so when one considers that the referral is the first step in the process of an inquiry during which procedural fairness must be accorded to a practitioner.

88A Director must decide whether to review

The Director has one month, from the date of receiving a request, to decide whether to conduct a review. While the Director might form a preliminary view whether to conduct a review, even a strongly held view, it is not until the Director has irrevocably decided whether or not to do so, that there is a 'decision' for the purposes of the section.

Amir v Director of Professional Services Review [2021] FCA 745 —

> [34] Extensive written and oral submissions were made for Dr Amir. The key propositions for Dr Amir included that:
> (1) the scheme of the Act consistently distinguishes between the act of making a decision and the act of notifying the making of that decision – see, for example, ss 86(1) and 87(1), 88A(1) and 88A(4), 91(1) and 91(2), 93(1) and 93(7);
> (2) the distinction between the making of a decision and its notification is also apparent from ss 87(2) and 88A(5) and (7), to the effect that failure to comply with the notice requirement does not affect the validity of the decision;
> (3) "decision" and "decide" should take their ordinary meaning in the Act of "a making up of one's mind": Macquarie Dictionary online.
> (4) in *National Home Doctor Service Pty Ltd v Director of Professional Services Review* [2020] FCA 1016; (2020) 276 FCR 382 at [48] Griffiths J said that a decision was a decision "in fact" rather than a valid decision. The same approach

should be applied in the present case as a matter of comity as Griffiths J is not plainly wrong;
(5) as the Director has not given evidence it should be inferred that the evidence she would give would not have assisted her case, consistent with *Jones v Dunkel* (1959) 101 CLR 298;
(6) the cases upon which the Director relies to support the proposition that a decision must be externally manifested concern different statutory regimes and different legal issues (specifically, the operation of the doctrine of *functus officio*) and do not govern the construction of s 94(1)(b) of the Act; and
(7) the construction proposed by the Director does not support the purpose of the Act which is to encourage the Director not to be dilatory.

[35] A number of these propositions may be accepted (propositions (1), (2), (3), and (6)). On analysis, however, they do not lead to the conclusion for which Dr Amir advocates.

[36] Assume, for the purpose of the argument, that the Director receives a request under s 88A(1) from the Chief Executive Medicare for a review of a person's provision of services on 1 January. The Director must decide whether or not to undertake a review within one month of receiving the request, failing which the Director is taken to have decided to undertake the review. What constitutes the Director "deciding" for the purpose of s 88A(1)? The options are: (a) the Director making up her mind without communicating the decision to anyone, (b) the Director making up her mind and communicating the decision to her staff, or (c) the Director making up her mind and communicating the decision to the person and the Chief Executive Medicare under s 88A(4).

[37] I am unable to accept that the Director "decides" whether or not to undertake a review as provided for in s 88A(1) (and thus s 94(1)(a) and (b)) of the Act as described in option (a). Option (a), in my view, is plainly untenable. If the Director does not externally manifest the decision in some way then the content and the time of the decision will be unknown other than to the Director. Further, inevitable questions arise as to both the quality of the Director's state of mind which is necessary to amount to a decision and the capacity of the Director to change her mind within the one month period.

[38] Option (b), which the submissions for Dr Amir contend was satisfied in the present case, is potentially equally problematic. The same questions arise. Having communicated a state of mind said to be a decision only to her staff, and not to any external person, why would the Director not be free to change her mind at any time within the period of one month of receipt of the request? If that is so, then the only relevant decision must be the last decision the Director communicates to her staff within the period of the month. Earlier decisions would not be decisions within the meaning of s 88A(1).

[39] It was submitted for Dr Amir that arguments of uncertainty about the time at which a decision is made and associated inconvenience are insufficient to displace the ordinary meaning of "decision" of making up one's mind: *ConnectEast Management Ltd v Commissioner of Taxation* [2009] FCAFC 22 at [41], *Minister for Immigration, Multicultural Affairs and Citizenship v SZRNY* [2013] FCAFC 104; (2013) 214 FCR 374 at [103]. However, the present issue does not concern

mere odd or anomalous consequences or bureaucratic efficiency. Within the statutory scheme it is necessary to know when the Director decides within the meaning of s 88A(1) because that determines the beginning of the 12 month period referred to in s 94(1). Options (a) and (b) both inevitably raise: (a) qualitative questions about the state of mind of the Director whether communicated to staff or not, and (b) legal and practical questions about the capacity of the Director to change her mind at any time until the period of one month from receipt of the request has expired.

[40] The reliance on the ordinary meaning of "decide" (to make up one's mind), on analysis, does not assist the submissions for Dr Amir. When has a person in fact made up their mind? It is not difficult to accept that, in ordinary usage, a person makes up their mind only once they manifest externally that their state of mind is committed to a particular position or course of action. Before that manifestation, can it be said that the person has "decided" anything? For so long as they have not manifested their settled state of mind about a matter by communicating their commitment to a position or a particular course of action, the person has not decided one way or another. They may have a strong predisposition one way or another, but the decision is made by the manifestation of the commitment to a position or a particular course of action.

[41] The fact that s 88A(1) requires the Director to "decide", s 88A(4) requires notice to be given of the decision, and ss 88A(5) and (7) provide that a failure to comply with the notice requirements does not affect the validity of the decision are relevant. The terms of s 88A(5) in particular ("[t]he notice must be given within 7 days after the decision is made") support the conclusion that the decision and the notice are separate and distinct, and that the former may pre-date the latter.

[42] This said, the better resolution of the potentially competing considerations, in my view, is to construe "decide" in s 88A(1) as meaning an externally manifested communication by the Director of an irrevocable commitment by her whether or not to undertake a review. This externally manifested communication of an irrevocable commitment by the Director might be to her staff or others (option (b)) or by the giving of notice as required by s 88A(4) (option (c)). Everything which occurs before either of these events does not involve the Director "making up" the Director's mind because such acts, of necessity, are not final and are not irrevocable. They are subject to change as and when the Director determines within the period of one month provided for the making of the decision.

[43] I recognise that extending the meaning of a "decision" to option (b) as described above goes further than the submissions for the Director and the Commonwealth would allow. The Director and the Commonwealth would confine the meaning of a "decision" for the purposes of s 88A(1) to a decision communicated by a notice as provided for in s 88A(4) of the Act. The reasons that I am persuaded that the concept might take a broader meaning are twofold. First, the terms of s 88A(4) suggest that a decision ordinarily will pre-date the giving of the notice. Second, and for example, assume the Director communicates to her staff on the last day of the month and in irrevocable terms that she had decided not to undertake a review and instructs her staff to prepare a notice to a person to that effect. As no notice will have been given within the period of one month, is that decision inoperative or ineffectual so that s 88A(3) operates so that the Director is

taken to have decided to undertake a review and thus bound to do so? In my view, the better answer to this question is "no". As a result, I consider that there is scope for a decision of the Director to be made (in the sense of being the subject of an externally manifested communication by the Director of an irrevocable commitment by her whether or not to undertake a review) whether or not that communication is by way of a notice under s 88A(4) of the Act. The issue will be one of fact in the particular circumstances.

[44] Within the statutory scheme the communication by the Director to her staff on 4 April 2014 involved an externally manifested communication by the Director but did not involve an irrevocable commitment by her whether or not to undertake a review. The commitment was not irrevocable because it was open to the Director to change her mind at least until she gave notice of her decision as required by s 88A(4) (and it is arguable that even a decision subject to notice under s 88A(4) is not irrevocable if the one month period referred to in s 88A(1) has not expired). Further, it is apparent from the terms of the letter of 16 April 2019 that the Director did not consider her communicated state of mind on 4 April 2019 to be irrevocable.

[45] While this resolution of the statutory provisions may not be perfect, it is less imperfect than the approach advocated for Dr Amir. Dr Amir's approach, as discussed, invites: (a) qualitative questions about the state of mind of the Director whether communicated to staff or not, and (b) legal and practical questions about the capacity of the Director to change her mind at any time until the period of one month from receipt of the request has expired. The approach which I prefer, subject to the deeming provision in s 88A(3), requires identification of an externally manifested communication by the Director of an irrevocable commitment by her whether or not to undertake a review. This constitutes the "decision". In this case, the best evidence of such a decision is the letter of 16 April 2019.

[46] Contrary to the submissions for Dr Amir, some of the cases to which the Director referred are relevant, albeit involving different statutory schemes and different issues. In particular, in *Semunigus v The Minister for Immigration & Multicultural Affairs* [1999] FCA 422 Finn J considered the meaning of "decision", saying:

> [19] For present purposes I am prepared to hold that the making of a decision involves both reaching a conclusion on a matter as a result of a mental process having been engaged in and translating that conclusion into a decision by an overt act of such character as, in the circumstances, gives finality to the conclusion - as precludes the conclusion being revisited by the decision-maker at his or her option before the decision is to be regarded as final.
>
> [20] What constitutes such an act can obviously vary with the setting in which the decision is made: it may be no more than a written notation of a conclusion on a departmental file; it may be publication of the conclusion in a particular forum, or communication of it to another; it may be performing a consequential or collateral act that presupposes the decision's having been made, etc.

[47] On appeal in *Semunigus v Minister for Immigration & Multicultural Affairs* [2000] FCA 240; (2000) 96 FCR 533 (*Semunigus FFC*) Spender, Higgins and Madgwick JJ each accepted Finn J's description of a "decision", at [11], [55], [75]

and [101]. Their Honours applied the description differently but Spender and Madgwick JJ stressed the need for irrevocable communication to constitute the making of the decision, at [12] and [103]. Higgins J took a different view focusing on the making of a decision as a matter of objective fact: [78].

[48] In *Minister for Immigration and Citizenship v SZQOY* [2012] FCAFC 131; (2012) 206 FCR 25 at [25]-[26] and [29] Buchanan J agreed with Finn J in *Semunigus* at [19] and with the judgment of Madgwick J in *Semunigus FFC* at [102]-[103] and Spender J at [12]. At [29] Buchanan J also disagreed with the view of Higgins J which involved a search for a decision as a matter of "objective fact". Justice Buchanan continued at [29]:

> In my respectful opinion the principles stated by Madgwick J and echoed by Spender J are a correct statement of the legal position. All three judges endorsed the statement of principle made by Finn J. That statement of principle incorporates a critical consideration. A decision maker must be precluded from revisiting the decision at his or her option before it is to be regarded as final in the relevant sense.

[49] In *SZQOY* Logan J, at [33], agreed with Buchanan J. Justice Barker, at [50], agreed with Buchanan and Logan JJ.

[50] In *SZRNY* at [24] and [25] Buchanan J again endorsed Finn J in *Semunigus* at [19] and Spender and Madgwick JJ in *Semunigus FFC*. Justices Griffiths and Mortimer at [94] also accepted the principle in *Semunigus*.

[51] The principle in *Semunigus* concerns the meaning of a "decision" generally. It gives that term a meaning which is consistent with its ordinary meaning and which is clear and capable of application. The focus is not on a decision-maker's mental state. It is on the external manifestation of that state of mind in some irrevocable and final manner. While this meaning will always yield to the particular statutory context, the context in the present case supports giving the words "decide" and "decision" in s 88A(1) and s 94(1)(a) and (b) this meaning.

[52] *National Home Doctor Service* is not authority to the contrary. In that case, the issue was whether a decision must be a valid decision or a decision in fact whether or not valid. The issue is different from that which arises in the present case.

[53] In the present case, the Director decided to review the provision of services by Dr Amir on 16 April 2019 as she informed Dr Amir on that date that she had so decided. The email the Director sent certain staff on 4 April 2019 did not constitute the Director deciding to review the provision of services by Dr Amir as, given the date of that email (the first day of the one month period in s 88A(1)), the state of mind of the Director communicated therein was not final and irrevocable. The Director was free to change her mind, as the terms of the letter of 16 April 2019 confirm. That is, it must be inferred from the communications that after 4 April 2019 the Director was free to change her mind and/or again to decide to undertake a review. Accordingly, the Director made no decision on 4 April 2019 for the purposes of s 88A(1) of the Act.

[54] There is a further basis to reject Dr Amir's claim. There is the internal email from the Director to certain of her staff on 4 April 2019 saying "I have reviewed

the referral and decided to conduct a review" and requesting that the necessary paperwork be prepared. There is also the letter of 16 April 2019 from the Director to Dr Amir saying "Accordingly, ***today I have decided*** to undertake a review into your provision of those services in accordance with the requirements of the Act. This letter constitutes written notice of that decision for the purposes of s 88A(4)(a) of the Act" (emphasis added).

[55] Dr Amir bears the onus of proof. While the relevant decision-maker is the Director, the Director is a party, and the Director has not given evidence, the only adverse inference which could be drawn against the Director is that she in fact decided to undertake the review on 4 April 2019. If that is so, the Director's email of 16 April 2019 remains to the effect that she also decided "today" (that is, on 16 April 2019) to undertake the review. The result is that within the prescribed time period of one month, the Director made two decisions to the same effect. Of those two decisions, only one was irrevocable and communicated to Dr Amir, the decision of 16 April 2019. As such, it is the relevant decision for the purposes of the statutory provisions.

[56] Alternatively, I am not satisfied that any *Jones v Dunkel* inference should be drawn against the Director. While all evidence is to be "weighed according to the proof which it was in the power of one side to have produced, and in the power of the other to have contradicted" (*Blatch v Archer* (1774) 1 Cowp 63; (1774) 98 ER 969), it is necessary to acknowledge that the Director is responsible for deciding about all reviews under s 88A(1). The power of delegation in s 131 of the Act is limited to the Minister, the Secretary or the Chief Executive Medicare. It would be unreasonable to infer that he Director was capable of recalling her state of mind about the Chief Executive Medicare's request in respect of Dr Amir over and above what is disclosed in the documents.

[57] The Director sent the email of 4 April 2019 about 20 minutes after receiving it in circumstances where the attachments to the email from the Chief Executive Medicare comprised 102 pages. When this is taken together with the facts that: (a) an internal email of 8 April 2019 between staff of the Director records information relevant to a decision whether or not to undertake a review of Dr Amir's provision of services, and (b) the letter from the Director to Dr Amir of 16 April 2019 is hand dated and expressly states that the Director had made the decision to undertake the review "today", I would not infer that the Director had in fact decided on 4 April 2019 to undertake the review.

[58] As submitted for the Director and the Commonwealth, the evidence taken as a whole supports the inference that the Director's mental processes about a review of Dr Amir's provision of services continued until 16 April 2019. It would not lightly be inferred that the Director misrepresented the fact in the letter to Dr Amir of 16 April 2019 that she had made the decision to undertake the review on that date. Taken with the other facts and circumstances, the inference that should be drawn is that the email of 4 April 2019 expressed a preliminary, even if strong view, of the Director, that she would be deciding subsequently to undertake a review. That is not a decision for the purposes of s 88A(1) of the Act.

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[64] The submissions advanced on behalf of Dr Amir fall into two parts. First, Dr Amir relies on the ordinary meaning of the word "decide" to seek to demonstrate that the primary judge erred in construing the relevant provisions. Secondly, Dr Amir contends that the primary judge erred in importing a requirement that a decision under s 88A(1) must be irrevocable when neither the Act nor the ordinary meaning of decision includes a requirement of irrevocability.

[65] As to the first, the construction for which Dr Amir contends attaches a meaning to "decision" that fixes on the Director's subjective state of mind, which Dr Amir submits is consistent, with the ordinary usage of the word. On the facts, Dr Amir contends that the 4 April 2019 decision made by the Director was communicated by the Director to her staff. Dr Amir relies on the communication not as a necessary requirement of the making of the decision but as objective evidence from which the decision in fact having been made may be inferred. Dr Amir submits that the Director's decision communicated in the 4 April 2019 email was clear and unequivocal, namely "I have reviewed the referral and decided to conduct a review". Dr Amir submits that many decisions in the ordinary use of that word are not communicated and are revocable. Dr Amir gives the example that one may decide to go the shops and then change one's mind.

[66] Dr Amir's appeal to the broad ordinary meaning of the term decision must be rejected. The ordinary meaning must necessarily yield to the relevant statutory context. In the present circumstances, the relevant decision functions within the statutory scheme as the trigger to start time running on the finite period within which the Director can perform her function in the first part of the review process. To seek to anchor the temporal guillotine of the Scheme, which carries real legal consequences, to the subjective state of mind of the particular office bearer without any requirement for a committed demonstrable manifestation of that state of mind is to divorce impermissibly the meaning of the term decision from its statutory context. For the purpose of s 88A(1), what is required, having regard to the statutory scheme, is a decision that constitutes, or at least purports to constitute, a performance of the decision-making function conferred by s 88A(1). The primary judge was correct to find that the words "decide" and "decision" in s 88A(1) and s 94(1) do not focus on the Director's mental state but rather on the external manifestation of that mental state in an irrevocable, or firm, way.

[67] The second aspect of Dr Amir's attack on the primary judge's construction of ss 88A and 94 is premised upon the contention that the primary judge construed a decision under s 88A as necessarily being irrevocable as a matter of law. The case below did not concern whether a decision under s 88A(1) could be revoked within the one-month time period specified by s 88A(3) and re-decided before that period expired. Dr Amir's case below was that the relevant and operative decision for the purpose of triggering the commencement of time running for s 94(1) was made on 4 April 2019. On appeal, Dr Amir submits that the primary judge erred in finding that the decision must be irrevocable because any decision made under s 88A(1) could always be revoked within the one month period specified by s 88A(3). Dr Amir submitted that there is nothing in the Act which expressly requires a "decision" to be irrevocable. Further, Dr Amir argues there are strong textual indictors that a "decision" does not have to have the quality of being irrevocable as

a matter of law. It is not necessary to rehearse Dr Amir's submissions in respect of the textual indicators relied upon in this respect because the underlying premise upon which he relies is flawed.

[68] Read in context, the primary judge's repeated use of the word "irrevocable" serves to emphasise that the manifestation of the Director's "decision" must have the requisite character of conclusiveness, commitment or finality. The converse is that the "decision" must not be tentative, preliminary or subject to change. The Director must have decided, or be committed to a course, and not be in a state of flux or tentativeness about that course. The primary judge's use of the descriptor "irrevocable" underscored that the decision required by s 88A must be of a firm, committed or final character: see J [42], [43], [44], [45] [47], [51], [53], [55].

[69] The primary judge's repeated references to "irrevocable" are used in connection with "commitment" (see J [40], [42], [43], [44], [45]) or with the clarity with which the Director's "state of mind" is manifested in the communication of the decision (see J [51], [53]). The reference at J [55] to "irrevocable" highlights that the primary judge's use of this word denotes that the decision is firm, that is, not subject to change. The primary judge considered Dr Amir's contention that the Director in fact decided to undertake the review on 4 April 2019 and concluded that even if that was so, the Director's email of 16 April 2019 remains to the effect that she also decided "today" (that is, on 16 April 2019) to undertake the review (at J [55]):

> The result is that within the prescribed time period of one month, the Director made two decisions to the same effect. Of those two decisions, only one was irrevocable and communicated to Dr Amir, the decision of 16 April 2019. As such, it is the relevant decision for the purposes of the statutory provisions.

[70] The submissions advanced on behalf of Dr Amir are premised on a contortion of the clear and plain reasoning of the primary judge and are rejected. Ground 1 must fail.

[71] By Ground 2, Dr Amir contends that the primary judge applied the wrong test or asked the wrong question when concluding that the Director did not "in fact" decide to review the Appellant's provision of services on 4 April 2019 and that her mental processes continued until 16 April 2019. Ground 2 depends on Dr Amir succeeding on his argument in relation to the construction of s 88A(1). Ground 2 therefore falls with Ground 1.

A 'decision' under this section is not amendable to judicial review. It is not a decision for the purposes of the *Administrative Decisions (Judicial Review) Act 1977* and a person under review cannot be said to be aggrieved by such a decision as they have no substantive rights affected by it, and so do not have standing to seek an order under section 39B of the *Judiciary Act 1903*. The Director is not obliged to provide procedural fairness in making a decision under section 88A.

Yoong v The Chief Executive Medicare [2021] FCA 701 —

> [110] … I would not have accepted that the Director is obliged to provide the practitioner with an opportunity to make submissions when deciding whether or not to undertake a review. The considerations against that position under s 86(1) apply analogously in respect of s 88A(2). In addition, ss 88A(3) to (7) tell against any implication of procedural fairness.
>
> …
>
> [161] A decision made by the Director under s 88A of the HI Act also lacks the quality of a final or operative determination of a substantive kind. A decision as to whether to undertake a review does not directly affect any right or obligation of a practitioner, but simply determines whether the Director will undertake a review. Any effect on a person's legal rights or obligations would be the result of separate decisions made by the Director following the conduct of a review. The Director's decision to undertake the review is not a decision under an enactment, and is no more than a step in the administrative process that may lead to a final or operative decision.
>
> …
>
> [173] Further, I do not accept that the Director's decision under s 88A of the HI Act affects a practitioner's rights, or is sufficiently connected with decisions that do affect rights. As in *Marles*, such a decision only means that an investigation is conducted, which may lead to no further consequence. It is not until and unless the Director uses her powers to compel production of information and documents, or the Director comes to make a decision in accordance with s 89C, that rights may be affected.
>
> [174] I consider that the decisions of the Chief Executive and the Director are not susceptible to certiorari.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2020] FCA 386 —

> [67] … Although there is no explicit statutory provision which requires the Director to invite the person the subject of the requested review to make submissions or give information as to whether or not the Director should undertake the review, I see no reason why the Director could not, in his or her discretion, extend an invitation to that effect (bearing in mind the 1 month time period within which the Director is required to make a decision whether or not to conduct the review) or, indeed, why (with or without an invitation) the person the subject of the request could not provide submissions or information to the Director before that time expired on the question whether or not the Director should undertake the requested review. I emphasise that I am ***not*** suggesting that these are procedural fairness requirements. Rather, they are discretionary.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [18] The decisions which s 89C(2) summarises as open to the Director to make are not merely procedural. Decisions to take no further action or to enter into an

> agreement bring the Pt VAA process to an end. Once made, they become the source of substantive rights. If not made, those substantive rights are denied to the practitioner. These features, in my view, give each the necessary quality of finality to make each of the decision options mentioned in s 89C(2) decisions to the ADJR Act applies.
>
> [19] It does not follow from this conclusion that the anterior decisions of the CEO under s 86 to request the Director to undertake the review of services and a decision of the Director under s 88A as to whether or not to undertake that review have that same quality. Neither such decision entails what Mason CJ in *ABT v Bond*, at 337, described as a "substantive determination". Each is wholly procedural. The administrative states of mind which inform the making of these decisions have no consequential binding effect whatsoever in respect of any later stage in the Pt VAA review processes.

88B Scope of Director's review

Once the Director decides to conduct a review of the provision of services, the Director may review any or all of the services provided by the person under review during the review period.

Prior to amendments made in 2002, the Federal Court held in *Pradhan v Holmes* [2001] FCA 1560 that the Director was limited in the review to the conduct specified in the 'investigative referral' (as it was then called) by the Health Insurance Commission (as it then was) under section 86. The 2002 amendments removed the reference to 'conduct' in section 86, and instead referred to a 'review of the provision of services'. Paragraph 88B(c) now expressly provides that the Director is not limited in the review by the reasons within the request for review.

It is not the Director's function to make findings of inappropriate practice, but to form a view as to whether the person may have engaged in inappropriate practice. While the test in section 91 is in the negative ('is satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review engaged in inappropriate practice'), the test in subsection 93(6) is in this positive form ('… it appears to the Director that the person under review may have engaged in inappropriate practice').

Carrick v Health Insurance Commission [2007] FCA 984 —

> [12] The role of the Director in the investigative process established by Part VAA is properly seen as a screening role. The Director on an investigative referral is to form a view as to whether there are sufficient grounds on which a Professional Services Review Committee could reasonably find that the person under review has engaged in inappropriate practice in connection with rendering or initiating the

> referred services. The Director is authorised to dismiss an investigative referral if satisfied that the Commission's belief that the person under review may have engaged in inappropriate practice cannot be substantiated (s 91). If the person under review is willing to acknowledge that his or her conduct the subject of the investigative referral constituted engaging in inappropriate practice, the Director and the person may enter into a written agreement pursuant to s 92 of the Act and the Director must then dismiss the referral. Alternatively, the Director may set up a Professional Services Review Committee and make an adjudicative referral to it of specified services (s 93). The specified services must be services particulars of which were contained in the investigative referral but need not include all of those services (s 93(7)). On such a referral the Committee may consider only those services specified in the referral (s 106H).
>
> [13] Importantly, the Director is not authorised to make a finding that the conduct of a person under review is conduct that the person's peers would find unacceptable. Only a Professional Services Review Committee is authorised to do that. As mentioned above, in this regard the Director cannot go beyond forming a view on whether a Professional Services Review Committee could reasonably find that the person had engaged in inappropriate practice.

Pradhan v Holmes [2001] FCA 1560

> [118] Apart from having the person under review put on notice by the s 86(4)(b) reasons – if not by prior non-statutory counselling – as to the form of conduct that has invited attention, the statutory procedural fairness scheme at this early investigative stage seems best described as provisional and preliminary. But its limitations do not disadvantage the person under review should an adjudicative referral be made given the far more explicit statutory requirements to be observed at that later stage. As has often been said of staged decision-making, in judging whether the requirements of natural justice are satisfied one must consider whether the decision-making process in its entirety entails procedural fairness: *Ainsworth v Criminal Justice Commission* [1992] HCA 10; (1992) 175 CLR 564 at 578.

In conducting a review, the Director is not required to consider a random sample of services consistent with section 106K or the *Health Insurance (Professional Services Review – Sampling Methodology) Determination 2017*. In *Soryal v Director of Professional Services Review* it was argued that the Director had erred in law in not examining a random sample consistent with those provisions.

Soryal v Director of Professional Services Review [2023] FCA 326 —

> [50] Correctly, the respondent submits that applicant's reliance on s 106K(1) is misguided as that section applies only to the PSR Committee's investigation, once referred; see *National Home Doctor Service Pty Ltd v Director of Professional Services Review* (2020) 279 FCR 338; (2020) 379 ALR 513; [2020] FCA 386 at [55]. Section 106K(1) provides:
>
> 106K Committee may have regard to samples of services

> (1) The **Committee *may***, in investigating the provision of services included in a particular class of the referred services, have regard only to a sample of the services included in the class.
>
> (emphasis added)

[51] Additionally, the applicant's reliance upon the *Health Insurance (Professional Services Review – Sampling Methodology) Determination 2017* (Cth) (Determination) in this case is unhelpful. The applicant cites s 6 of the Determination which specifies:

> 6 Purpose
>
> This Part specifies the content and form of a sampling methodology **that may be used by a Committee** in investigating the provision of services included in a particular class of referred services, where regard is to be had only to a sample of the services included in the class.
>
> (emphasis added)

[52] Further, s 3 of the Determination stipulates that the authority under which the Determination is made is in fact s 106K of the HI Act. It is difficult to see in these circumstances how the respondent has made an error pursuant to these provisions and the Determination which do not apply to the decision under review.

[53] In this case, which concerns a decision made by the Director to refer the applicant to the PSR Committee, s 88B applies to the Director. In particular, I note s 88B(a) and (b) which stipulate:

> 88B Scope of Director's review
>
> If the Director decides to undertake the review, he or she:
>
> (a) ***may*** **review any or all of the services provided by the person under review during the review period; and**
>
> (b) ***may*** **undertake the review in such manner as he or she thinks appropriate**; and
>
> ...
>
> (emphasis added)

[54] I note the applicant's submissions in its "Particulars as to Insufficient Patient Records and Non-Randomised Patient Records" regarding ss 93(7B), 98, 102, 105A. These provisions do not assist the applicant in its contention.

…

[81] Considering the legislation as a whole, notwithstanding that the respondent was only able to obtain a small portion of the records, I am satisfied that the respondent was entitled to make the determination that she did. I can see no error on behalf of the respondent in making the decision under s 93. It is the legislative role of the PSR Committee to conduct an investigation into the referred person.

…

> [84] The respondent's decision was not unreasonable. Although the respondent was only able to obtain, in the statutory timeframe, a small portion of records, for the reasons provided by the respondent this was sufficient to support a concern that the applicant may have engaged in inappropriate practice, so as to justify a referral for investigation; see for example NHDS at [120].
>
> [85] These grounds of review have no merit and are dismissed.

89 When Director must review

Section 89 requires the Director to conduct a review if the same person had been the subject of a previous request for review by the Chief Executive Medicare, and the Director had decided not to conduct a review in respect of the most recent such previous request.

89A Director may refer material to Chief Executive Medicare if certain offences or civil contraventions are suspected

If the Director thinks that material before him or her indicates that the person under review may have may committed an offence or contravention within the meaning of section 124B of the Act, the Director may send that material to the Chief Executive Medicare and may suspend the Director's review of the matter for such period as he or she thinks appropriate. This would enable the Chief Executive Medicare to investigate those offences or contraventions without the risk that further investigation by the Director or a Committee might disturb the Chief Executive Medicare's investigation. Usually the Director would liaise with the relevant delegate of the Chief Executive Medicare to determine whether any likely action by PSR would put the investigation or prosecution by the Chief Executive Medicare at risk before recommencing the review or setting up a Committee.

89B Power of Director to require the production of documents or the giving of information

Section 89B empowers the Director to give a notice in writing to the person under review, or any other person whom the Director believes to have possession, custody or control of, or to be able to obtain, relevant documents, to require the person to produce such relevant documents as are referred to in the notice, and, if the person does not have relevant access to the documents, to inform the Director of that fact, and identify the relevant person regarding access to those documents.

When a notice is taken to have been given

When and whether a person can be taken to have received a notice to produce can be affected by provisions of the *Acts Interpretations Act 1901*, the *Electronic Transactions Act 1999* and the *Evidence Act 1995*, which provide for certain presumptions. Those presumptions can be displaced by evidence of the event occurring at a particular date or time. For that reason, the Professional Services Review Agency keeps electronic copies of documents evidencing sending and receipt of its correspondence, as well as maintaining a postal register for documents sent by post.

Section 28A of the *Acts Interpretation Act 1901* provides that for the purposes of any Act that requires or permits a document to be served on a person, whether the expression 'serve', 'give' or 'send' or any other expression is used, then the document may be served:

> (a) on a natural person:
> (i) by delivering it to the person personally; or
> (ii) by leaving it at, or by sending it by pre-paid post to, the address of the place of residence or business of the person last known to the person serving the document; or
> (b) on a body corporate—by leaving it at, or sending it by pre-paid post to, the head office, a registered office or a principal office of the body corporate.

Section 29 of the *Acts Interpretation Act 1901* deems service by post to be effected by properly addressing, prepaying and posting the document as a letter and, unless the contrary is proved, to be effected at the time at which the letter would be delivered in the ordinary course of post.

Section 8 of the *Electronic Transactions Act 1999* provides that 'a transaction is not invalid because it took place wholly or partly by means of one or more electronic communications.' Section 5 of that Act defines a 'transaction' to include 'any statement, declaration, demand, notice or request'. Subsection 14(1) of that Act concerns when a document is taken to have been sent and provides:

> (1) For the purposes of a law of the Commonwealth, unless otherwise agreed between the originator and the addressee of an electronic communication, the time of dispatch of the electronic communication is:
> (a) the time when the electronic communication leaves an information system under the control of the originator or of the party who sent it on behalf of the originator; or

(b) if the electronic communication has not left an information system under the control of the originator or of the party who sent it on behalf of the originator--the time when the electronic communication is received by the addressee.

Section 14B of the *Electronic Transactions Act 1999* concerns when a document is taken to have been received and provides:

(1) For the purposes of a law of the Commonwealth, unless otherwise agreed between the originator and the addressee of an electronic communication:
(a) the time of receipt of the electronic communication is the time when the electronic communication becomes capable of being retrieved by the addressee at an electronic address designated by the addressee; or
(b) the time of receipt of the electronic communication at another electronic address of the addressee is the time when both:
(i) the electronic communication has become capable of being retrieved by the addressee at that address; and
(ii) the addressee has become aware that the electronic communication has been sent to that address.

(2) For the purposes of subsection (1), unless otherwise agreed between the originator and the addressee of the electronic communication, it is to be assumed that the electronic communication is capable of being retrieved by the addressee when it reaches the addressee's electronic address.

For the purposes of all proceedings before an Australian court, the *Evidence Act 1995* also contains deeming provisions regarding service of documents. Section 160 of that Act provides a postal rule, which states:

(1) It is presumed (unless evidence sufficient to raise doubt about the presumption is adduced) that a postal article sent by prepaid post addressed to a person at a specified address in Australia or in an external Territory was received at that address on the seventh working day after having been posted.

(2) …

(3) In this section:
"working day" means a day that is not:
(a) a Saturday or a Sunday; or
(b) a public holiday or a bank holiday in the place to which the postal article was addressed.

Section 163 of the *Evidence Act 1995* provides a presumption of when a letter has been sent from a Commonwealth agency. It states:

(1) A letter from a Commonwealth agency addressed to a person at a specified address is presumed (unless evidence sufficient to raise doubt about the presumption is adduced) to have been sent by prepaid post to that address on the

fifth business day after the date (if any) that, because of its placement on the letter or otherwise, purports to be the date on which the letter was prepared.

(2) In this section:
"business day" means a day that is not:
(a) a Saturday or a Sunday; or
(b) a public holiday or bank holiday in the place in which the letter was prepared.
"letter" means any form of written communication that is directed to a particular person or address, and includes:
(a) any standard postal article within the meaning of the *Australian Postal Corporation Act 1989*; and
(b) any envelope, packet, parcel, container or wrapper containing such a communication; and
(c) any unenclosed written communication that is directed to a particular person or address.

Validity of a notice to produce

A notice will not be invalid merely because compliance is burdensome, costly, and time-consuming. Nevertheless, such a notice needs to provide a reasonable time for compliance.

I-MED Radiology Network Limited v Director of Professional Services Review [2020] FCA 1645 —

> [68] In the course of submissions, I was taken to numerous authorities concerning the exercise, and validity of exercise, of information gathering or document production powers conferred by various statutes. Each of these ultimately turned on the terms of the notice requiring the giving of information or production of documents and the authority conferred by the statute concerned.
>
> [69] Insofar as there are any general principles, they may be gleaned from observations made by Bowen CJ in *Riley McKay Pty Ltd v Bannerman* [1977] FCA 7; (1977) 31 FLR 129; (1977) 15 ALR 561 (*Bannerman*), at 566, in relation to an information gathering notice given under s 155 of the then *Trade Practices Act 1974* (Cth). The power of requiring the giving of information or production of documents must be exercised for the statutory purpose for which it is given. Here, that purpose is as specified by s 89B(2) of the HIA, "For the purpose of undertaking a review". There is nothing on the evidence to suggest the possession of any purpose by the Director in giving these two notices other than the undertaking of a review in relation to the applicants' provision of services in respect of the Review Period. Within these confines, the only further requirement, flowing from the definition of "relevant documents" in s 89B(1) of the HIA, is that the documents sought be "relevant to the review".
>
> [70] Such a notice must also "specify the information sought with sufficient certainty to enable the recipient of the notice to know what is required of him":

Bannerman, at 566. To like effect is this statement, recently offered by Wigney J, together with a summary of authorities, in *Australian Securities and Investments Commission v Maxi EFX Global AU Pty Ltd* [2020] FCA 1263 (*Maxi EFX Global AU*), at [90], in relation to a cognate requirement under s 33(1) of the *Australian Securities and Investments Commission Act 2001* (Cth) to produce "specified books", "the documents which are required to be produced be identified in the notice with sufficient clarity and precision to enable the recipient to know what documents come within the terms of the notice and to form a view about what must be produced so as to comply with the notice". To the summary of authorities offered in *Maxi EFX Global AU*, but to no different effect, might be added *Australia and New Zealand Banking Group Ltd v Konza* [2012] FCAFC 127; (2012) 206 FCR 450, at [46] – [47].

[71] I-MED Radiology and I-MED NSW also advanced, in oral submissions other objections to the legality of the s 89B notices. It may well be that not all of the perceived deficiencies of clarity were expressly pleaded by them in their amended statement of claim. Most of the alleged deficiencies, for reasons already given in relation to those pleaded, were confected. In keeping with its use throughout Pt VAA, the s 89B notices adopt the correlative conjunction, "employed or otherwise engaged". That relieves I-MED Radiology, or as the case may be I-MED NSW, of whatever burden there is in determining whether, as a matter of law, it "employed" a particular practitioner. For any engagement short of, or different to, that to provide services is within the embrace of the production obligation as well.

[72] I rather doubt in any event that there could be any valid objection, on the basis of lack of clarity, to a requirement to produce the records of a recipient's "employees". Adverse though the consequences of non-compliance may be, that is not a licence for pedantry on the part of a recipient.

[73] Once the breadth of review permitted by s 88B upon the appearance of a possibility is understood, there was no requirement that the notices identify particular practitioners, be they Dr M or another practitioner mentioned in the evidence, Dr S (whose name is suppressed for like reasons) or otherwise. The Director was entitled to inquire who those practitioners were as an initial step in her review. That is one object of the s 89B notices. Subject to one possible qualification, flowing from the non-exhaustive nature of the definition of "details" for the purposes of the s 89B notices, that the documents sought were relevant is patent on a fair reading of the notices in light of that definition.

[74] As to that non-exhaustive quality, flowing from the use of the word, "includes", and by analogy with an observation made by Robertson J in *Binetter v Deputy Commissioner of Taxation (No 3)* [2012] FCA 704; (2012) 89 ATR 296 (*Binetter*), at [62], concerning a similar use of the word "including" in a notice, it means no more in context than that the recipient is also to produce any other document which shows which practitioners were employed or otherwise engaged to provide MBS rebateable services in connection with it during the Review Period.

[75] Another fallacy in the applicants' complaint about the notices, flowing from a failure to appreciate the breadth of review permitted by s 88B of the HIA and the ends to which such a review are directed, was the assertion of a need to detail

particular contraventions or instances of "inappropriate practice". What precedes a review is nothing more than the appearance of a possibility. The scope of the review is, as I have already highlighted, not limited to whatever has occasioned the appearance of that possibility. At the conclusion of the review, the actions which the Director may take are those specified in s 89C of the HIA (agreement under s 92 being excluded because those under review are not practitioners). At that time, the Director may come to identify with precision, and for the purposes of a referral to, and investigation by, a Committee, specified instances in which it is alleged that the person under review engaged in inappropriate practice in providing services: see s 93(1) of the HIA. It then becomes the remit of the Committee, not the Director, to investigate and report upon whether the person under review engaged in inappropriate practice in providing the services specified in that referral.

[76] A notice issued under statute to produce documents will not be invalid merely because compliance with it is burdensome and visits considerable compliance work and expense on its recipient: *Bannerman*, at 567. Invalidity on this basis might, however, be found if the time allowed for compliance were not reasonable, having regard to the nature and extent of the production obligation imposed.

[77] The applicants did not introduce evidence on this subject. That was because of, so they submitted, "the inherent difficulty of identifying the class of persons in respect of whom documents may need to be produced". That alleged "inherent difficulty" as to the class of persons, was, however, for reasons already given, grounded in a misunderstanding of s 88B(a). Contrary to the applicants' submission, what any other practitioner other than Dr M or Dr S has done or not is relevant to this review.

[78] The applicants made a deliberate, forensic choice not to introduce evidence of the burden entailed in compliance, having regard to the time for production specified in the s 89B notices. In some circumstances, it might be possible, having regard to the apparent breadth of production sought and the time allowed for that production, to conclude that, on any view and objectively, a notice to produce was invalid. Quite apart from violating the 14-day minimum period mentioned in s 89B(4) of the HIA, perhaps such a conclusion would have been open here if the notice had required production the following day. Here, each s 89B notice specified that, "The documents must be produced by no later than: 5pm, Friday 14 August 2020", in other words, not less than 30 days and more than double that 14 day, minimum period. Sometimes, a conclusion of unreasonableness, and hence invalidity, might flow from a consideration of the material before the person who issued the notice at the time when it was issued. The metes and bounds of that material is not in evidence here. In *Binetter*, at [82], and with reference to the power granted to the Commissioner of Taxation, under s 264 of the *Income Tax Assessment Act 1936* (Cth), to require a person to provide information and to produce documents, Robertson J made the following observations by reference to authority:

> The status of the objective test of reasonableness, on the basis of the decision in *DCT v Ganke* [1975] 1 NSWLR 252; (1975) 5 ATR 292; 25 FLR 98; 75 ATC 4097, was referred to by Jagot J in *Krok v FCT* [2009] FCA 1497; (2009)

> 77 ATR 897 at 907 [46]; [2009] FCA 1497; 2009 ATC 20-156 at 10,565 [46]. Her Honour noted a potential inconsistency between the approach in Perron Investments and the approach in *Holmes v DCT* (1988) 19 ATR 1173; 88 ATC 4328 and in the full court in *Wouters v DCT* (1988) 20 FCR 342; 19 ATR 1884; 88 ATC 4906; 84 ALR 577.
>
> It is not necessary in the present case to explore whether there is any inconsistency of the kind mentioned in the passage quoted, much less to endeavour to resolve it if there is. Suffice it to say, on the true construction of the s 89B notices on their face, I am not prepared to find that the time for compliance, considered objectively, was unreasonable in the sense referred to in *Minister for Immigration and Border Protection v SZVFW* [2018] HCA 30; (2018) 264 CLR 541, at [10], per Kiefel CJ and, at [82], per Nettle and Gordon JJ.

Limitations on the use of a compulsorily acquired document

If documents have been produced by compulsion, there will be an implied undertaking (sometimes called a 'Harman undertaking'[159]) that they not be used for any purpose other than that for which they have been produced.[160] A party may be released from that undertaking if there are special circumstances. If the Director had required the production of the documents, and they were then sought to be used for another purpose, it would be a matter for the Director to decide whether a release should be granted.

Ashby v Slipper (No. 2) [2016] FCA 550 —

> [10] When exercising the jurisdiction to release a party from the "implied undertaking", it has been said that a Court may do so only where "special circumstances" exist. The dispensing power "is not freely exercised": *Esso Australia Resources Ltd v Plowman* (1995) 183 CLR 10 at 37 per Brennan J. The need for "special circumstances" recognises the balance between reasons for imposing the constraint on material secured for use in proceedings and the reasons why a party may seek to free itself from that constraint. There must be a reason to release a party from the constraint initially imposed which seeks to balance – or at least take into account – the reasons for imposing the constraint in the first place. Reasons for initially imposing the constraint include a recognition that the Court's compulsory processes of obtaining information may have been employed to secure that information – in some cases from third parties – in order to facilitate the administration of justice between the parties to litigation. Reasons for relaxing the constraint frequently involve considerations going beyond the immediate interests of the parties to particular litigation (and those whose otherwise confidential materials have been subpoenaed) and involve the wider public interest, including

[159] Harman undertaking is named after the case, *Harman v Secretary of State for the Home Department* [1983] 1 AC 280.

[160] *Hearne v Street* [2008] HCA 36 at [96] and [106] to [107]; (2008) 235 CLR 125 at 154 to 155, and 158 to 159 per Hayne, Heydon and Crennan JJ.

the public interest in the administration of justice and the administration of the law more generally. In the present case, these considerations include the enforcement or administration of the criminal law.

[11] More recently, in *Liberty Funding Pty Ltd v Phoenix Capital Ltd* [2005] FCAFC 3, (2005) 218 ALR 283 at 289 to 290 Branson, Sundberg and Allsop JJ expressed the principles to be applied as follows:

> '[31] In order to be released from the implied undertaking it has been said that a party in the position of the appellants must show "special circumstances": see, for example, *Springfield Nominees Pty Ltd v Bridgelands Securities Ltd* [1992] FCA 472; (1992) 38 FCR 217. It is unnecessary to examine the authorities in this area in any detail. The parties were not in disagreement as to the legal principles. The notion of "special circumstances" does not require that some extraordinary factors must bear on the question before the discretion will be exercised. It is sufficient to say that, in all the circumstances, good reason must be shown why, contrary to the usual position, documents produced or information obtained in one piece of litigation should be used for the advantage of a party in another piece of litigation or for other non-litigious purposes. The discretion is a broad one and all the circumstances of the case must be examined. In *Springfield Nominees*, Wilcox J identified a number of considerations which may, depending upon the circumstances, be relevant to the exercise of the discretion. These were:
>
> - the nature of the document;
> - the circumstances under which the document came into existence;
> - the attitude of the author of the document and any prejudice the author may sustain;
> - whether the document pre-existed litigation or was created for that purpose and therefore expected to enter the public domain;
> - the nature of the information in the document (in particular whether it contains personal data or commercially sensitive information);
> - the circumstances in which the document came in to the hands of the applicant; and
> - most importantly of all, the likely contribution of the document to achieving justice in the other proceeding.'

This list of "considerations" is, obviously enough, not exhaustive: *Plate Glass Holdings Pty Ltd v Fraser Gordon Investments Pty Ltd* [2012] FCA 1487 at [27] per Flick J.

The High Court has described the receiver of information compulsorily obtained as having a duty of confidence in respect of that information even if the information is not otherwise confidential in nature.

Johns v Australian Securities Commission [1993] HCA 56 (per Brennan J)—

> [14] Information is intangible. Once obtained, it can be disseminated or used without being impaired, though dissemination or use may reduce its value or the

desire of those who do not have it to obtain it. Once disseminated, it can be disseminated more widely. A person to whom information is disclosed in response to an exercise of statutory power is thus in a position to disseminate or to use it in ways which are alien to the purpose for which the power was conferred. But when a power to require disclosure of information is conferred for a particular purpose, the extent of dissemination or use of the information disclosed must itself be limited by the purpose for which the power was conferred. In other words, the purpose for which a power to require disclosure of information is conferred limits the purpose for which the information disclosed can lawfully be disseminated or used. In *Marcel v Commissioner of Police* (1992) Ch 225, at p.234. The Vice-Chancellor's view in this respect was affirmed on appeal: see (1992) Ch, esp. at pp.261, 262.) Sir Nicolas Browne-Wilkinson VC said, in reference to a statutory power conferred on police to seize documents:

> "Powers conferred for one purpose cannot lawfully be used for other purposes without giving rise to an abuse of power. Hence, in the absence of express provision, the Act cannot be taken to have authorised the use and disclosure of seized documents for purposes other than police purposes."

And in *Morris v Director of the Serious Fraud Office* ((8) (1993) 3WLR 1, at p.7.), Sir Donald Nicholls VC said in reference to information acquired by exercise of statutory powers:

> "The compulsory powers of investigation exist to facilitate the discharge by the S.F.O. of its statutory investigative functions. The powers conferred by section 2 are exercisable only for the purposes of an investigation undersection 1. When information is obtained in exercise of those powers the S.F.O. may use the information for those purposes and purposes reasonably incidental thereto and such other purposes as may be authorised by statute, but not otherwise. Compulsory powers are not to be regarded as encroaching more upon the rights of individuals than is fairly and reasonably necessary to achieve the purpose for which the powers were created. That is to be taken as the intention of Parliament, unless the contrary is clearly apparent."

A statute which confers a power to obtain information for a purpose defines, expressly or impliedly, the purpose for which the information when obtained can be used or disclosed. The statute imposes on the person who obtains information in exercise of the power a duty not to disclose the information obtained except for that purpose. If it were otherwise, the definition of the particular purpose would impose no limit on the use or disclosure of the information. The person obtaining information in exercise of such a statutory power must therefore treat the information obtained as confidential whether or not the information is otherwise of a confidential nature. Where and so far as a duty of non-disclosure or non-use is imposed by the statute, the duty is closely analogous to a duty imposed by equity on a person who receives information of a confidential nature in circumstances importing a duty of confidence.

[15] A person who obtains information in exercise of the powers conferred by s.19 of the Act comes under a statutory duty of confidence with respect to the information thus obtained. It is therefore important to ascertain the purposes for which such information can be legitimately used or disclosed. In the first place, the

> power conferred by s.19 of the Act to require a person to appear for examination and to answer questions is conferred for the purpose of obtaining "information relevant to a matter that (the ASC) is investigating, or is to investigate, under Division 1" of Pt 3 of the Act. So the information acquired by conducting a s.19 examination may be used for the purposes of such an investigation. In addition, s.127(3) authorizes disclosure of otherwise confidential information by, inter alia, the members and staff members of the ASC for the purposes of performing the official functions of the person making the disclosure. As investigations are but some of the functions of the ASC (most of which are prescribed by Pt 2 of the Act) the Act contemplates that information acquired on examinations under s.19 may be used and disclosed for the purpose of the performance or exercise of any of the functions of the ASC. Then, certain purposes other than the performance of the functions of the ASC are approved by sub-ss.(2) and (4) of s.127. Information obtained in exercise of the powers conferred by s.19 may therefore be used or disclosed for the purpose of the performance of any of the functions of the ASC and for any of the purposes mentioned in sub-ss.(2) and (4) of s.127. But for no other purpose.

Particular provisions within Part VAA permit the Director to provide information that has been received by compulsion and on a confidential basis to third parties. For example, section 89A permits the Director to send material to the Chief Executive Medicare if the material indicates that the person under review may have committed a relevant offence or civil contravention within the meaning of section 124B; and section 106XA and 106XB require the Director to provide information and material to a relevant body where the Director, a Committee or the Determining Authority has formed the view that conduct by a practitioner has caused, is causing, or is likely to cause, a significant threat to the life or health of any person, or where a practitioner has failed to comply with professional standards.

Once a third party has received the information or material from the Director under a statutory disclosure provision, that third party is similarly under an obligation not to use it for any purpose other than the purpose for which it has been obtained.

Johns v Australian Securities Commission [1993] HCA 56 (per Brennan J)—

> [21] The confidentiality of the information contained in the Johns transcripts was thus amenable to protection by injunction in cases where its use or disclosure was not authorized by statute. But once the ASC, possessed of statutory authority to disclose the information to the Royal Commission, gave the transcripts to the Royal Commission, the confidentiality of the information could be protected by order against the Royal Commission only by enforcing an 'obligation of conscience arising from the circumstances in or through which the information was communicated or obtained'.

Documents acquired by the Director in one matter can be used by the Director in a different matter when they are used in the lawful exercise of the Director's statutory powers and functions.

La Mancha Africa S.A.R.L. v Commissioner of Taxation [2021] FCA 1564 —

> [7] It is important to bear in mind the nature of the Harman obligation. As the Full Court stated in *Rennie* at [29], the content of the Harman obligation is such that it recognises and is shaped by inconsistent legal obligations. The imposition of the obligation not to use documents or information compulsorily produced in a proceeding other than for the purposes of that proceeding is necessarily abrogated by a duty or compulsion imposed by law or statute to use the information for other purposes. Hence the Harman undertaking must yield to inconsistent statutory provisions and to the requirements of curial process in other litigation.

Subsection 88A(2) indicates that the Director may use information other than that obtained in the course of a particular review when exercising functions or duties under the Act. That provision contemplates that the Director may have already obtained 'other relevant information' relevant to the question of whether there is a possibility that the person has engaged in inappropriate practice. Such information may well have been obtained by the Director under compulsion when reviewing the conduct of other practitioners associated with or engaged by the person who the subject of the request. Once having decided to conduct a review, section 88B permits the Director to undertake it in such manner as he or she thinks appropriate, thus permitting the use of relevant information and material already obtained in other matters.

89C Director's action following review

Following a review, the Director must either dismiss the matter by deciding to take no further action under section 91, or give the person under review a written report setting out the reasons why no decision was made under section 91, and invite written submissions, within one month, about the action the Director should take in relation to the review.

The Director must then take into account any such submissions, and must:

- decide to take no further action under section 91; or
- enter into an agreement under section 92; or
- make a referral to a Committee under section 93.

The Director does not make findings of inappropriate practice.

Carrick v Health Insurance Commission [2007] FCA 984 —

> [12] The role of the Director in the investigative process established by Part VAA is properly seen as a screening role. The Director on an investigative referral is to form a view as to whether there are sufficient grounds on which a Professional Services Review Committee could reasonably find that the person under review has engaged in inappropriate practice in connection with rendering or initiating the referred services. The Director is authorised to dismiss an investigative referral if satisfied that the Commission's belief that the person under review may have engaged in inappropriate practice cannot be substantiated (s 91). If the person under review is willing to acknowledge that his or her conduct the subject of the investigative referral constituted engaging in inappropriate practice, the Director and the person may enter into a written agreement pursuant to s 92 of the Act and the Director must then dismiss the referral. Alternatively, the Director may set up a Professional Services Review Committee and make an adjudicative referral to it of specified services (s 93). The specified services must be services particulars of which were contained in the investigative referral but need not include all of those services (s 93(7)). On such a referral the Committee may consider only those services specified in the referral (s 106H).
>
> [13] Importantly, the Director is not authorised to make a finding that the conduct of a person under review is conduct that the person's peers would find unacceptable. Only a Professional Services Review Committee is authorised to do that. As mentioned above, in this regard the Director cannot go beyond forming a view on whether a Professional Services Review Committee could reasonably find that the person had engaged in inappropriate practice.

If the submissions from the person under review reveal a misunderstanding of the Director's concerns as expressed in the section 89C report, procedural fairness may require that Director restate those concerns more clearly so that the person under review has an adequate opportunity to address them.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2020] FCA 386 —

> [132] While it is relevant to take into account the different tiers of decision-making under the PSR Scheme, I consider that the Director has overstated the relevance of that matter in determining the content of procedural fairness requirements in tier 2. Different considerations may arise with a multi-staged decision making process which, unlike the legislative regime here, does not contain its own rich supply of procedural fairness requirements. It is also relevant to take into account the essentially investigative nature of tier 2 and that the person under review will have a right to be heard before the Committee if a referral is made under s 93. Of particular relevance and significance, however, is the Director's obligation under s 89C to make a decision under s 91(1) to take no further action in relation to the review, rather than enter into a s 92 agreement (which was not an option in the case of NHDS) or make a referral under s 93.

[133] The point is well illustrated by a decision of the Victorian Court of Appeal in *Byrne v Marles* [2008] VSCA 78; 27 VR 612, which the Court drew to the parties' attention. There, Nettle JA (with whom Dodds-Streeton JA and Coghlan AJA agreed) highlighted the difference between the circumstances in *Cornall v AB (A Solicitor)* [1995] VICSC 7; [1995] 1 VR 372 and the circumstances in 2004 after amendments were made to the State legislation regulating the legal profession in Victoria. His Honour made the following observations at [85] to [87], which are apposite to the position under the PSR Scheme (footnotes omitted and emphasis added):

> [85] Now, however, because the Commissioner is compelled by s 4.2.8 of the 2004 Act to give notice of the complaint to the solicitor as soon as practicable after receipt, and to make a preliminary decision whether to dismiss the complaint summarily before going further with the investigation, it appears to me that the statute evinces an intention that the Commissioner should give notice of a complaint to the solicitor more or less immediately after receipt, and then take into account anything about the complaint which the solicitor may wish to submit, before determining whether to dismiss the complaint summarily or to go on to investigate it further or to refer it to the Institute for investigation. Otherwise, why provide, as s 4.2.8 so clearly does provide, that the Commissioner must notify the solicitor of the complaint as soon as practicable after receipt?
>
> [86] As has been seen, the essence of the reasoning of the court in *Cornall v AB* was that, because the function of the Secretary under the 1958 legislation did not involve any more than satisfaction as to facts sufficient to form a prima facie case, there was little practical merit in providing the solicitor with an opportunity to make submissions or adduce facts. The solicitor's right to natural justice was said to be adequately protected by his right to be heard before the tribunal which would decide the charge. Now, however, the position under the 2004 Act appears to be such that the Commissioner has an independent obligation under s 4.2.10 to determine whether a complaint is to be dismissed summarily or not proceeded with further. If so, there is practical merit in providing the solicitor with an opportunity to make a submission or adduce facts to the Commissioner before the Commissioner determines that the complaint is a disciplinary complaint which needs be investigated. The right to be heard at that stage affords the solicitor an opportunity to head off the complaint *in limine*, by persuading the Commissioner not to treat it as a disciplinary complaint or to dismiss it or not proceed with it under s 4.2.10. And such a right to be heard is essentially different to any which the solicitor may later be accorded by the Institute or the Board.
>
> [87] In the result, it appears to me as a matter of statutory construction that the structure and operation of Part 4.2 imply an expectation that the Commissioner will give the solicitor a right to be heard at the outset before making the preliminary decision for which s 4.2.10 provides. The position is analogous to Ainsworth and Johns.

[134] These observations are directly pertinent to the proceeding here having regard to the terms and effect of s 89C(1) and with its particular reference to s 91. A right to be heard by the person under review affords that person an opportunity to persuade the Director to terminate the complaint at a relatively early stage. That

right is different from the rights which the person under the review who is the subject of a subsequent referral has before the Committee.

…

[141] It is important to bear in mind that there were three elements of "inappropriate practice" which the Director relied upon in making the s 93 referral, namely:
(a) knowingly, recklessly, negligently causing or permitting certain conduct;
(b) which included the conduct of one or more practitioners employed by NHDS; and
(c) the conduct constituted "inappropriate practice" as defined in s 82.

[142] Procedural fairness obliged the Director to provide NHDS with a reasonable opportunity to address those three elements, which required the Director to provide NHDS with appropriate particulars and/or information in respect of those three matters with reference to the 56 identified NHDS practitioners. There is an obvious connection between the provision of a s 89C report and the obligation of the Director to invite submissions as to the future course of action, as required by s 89C(1)(b)(ii). Having regard to the contents of the s 89C report, NHDS reasonably believed that the conduct of the other 15 NHDS practitioners formed an important part of the Director's decision not to terminate the review at that point and that their conduct would also be relevant in determining what future course of action the Director might take. That this was NHDS's belief is abundantly clear by the terms of its 30 May 2019 submissions (see [102] ff above).

[143] There is also a plain connection between the making of those submissions and the effect they may have on the Director's decision under s 93, as is emphasised by the explicit obligation on the Director under s 89C(2) to take into account those submissions in deciding whether or not to make a referral to a Committee.

[144] The Director effectively shifted the goal posts after receiving NHDS's submissions so as to bring to the forefront of the Director's further deliberations the conduct of 56 other NHDS practitioners. The Director took their conduct into account (as well as other matters, including the conduct of the other 15 NHDS practitioners), in referring the matter to the Committee. NHDS was given no notice of this significant change in the focal point of the review. The statutory requirements of procedural fairness under the PSR Scheme would be seriously compromised if the Director proceeded as she has done without giving NHDS proper notice and relevant information about the significant change in direction she had taken.

[145] As NHDS pointed out at [28] of its written submissions in the proceeding, disclosing that it is alleged, for example, that "the person knowingly permitted their employee Dr A to engage in such-and-such inappropriate practice says nothing as to whether Dr B engaged in that or some other inappropriate practice, whether this was knowingly permitted by the person, or whether Dr B was employed by them". This proposition is patently correct.

[146] As noted, the Director did not submit that the PSR Scheme in the HI Act constituted an exhaustive procedural code which precluded the implication of any additional requirements of procedural fairness. Nor would I have accepted any such submission. The richness of the statutory procedural requirements in the multi-stage

> process under the PSR Scheme are not exhaustive. In particular, the procedural fairness rights and obligations under tier three do not deny the need for procedural fairness at the tier two level. The Director has a statutory power under s 91 at that stage to terminate a review and not make a referral under s 93.

Each of the decision options referred to in subsection 89C(2) give rise to a right of judicial review under the *Administrative Decisions (Judicial Review) Act 1977*.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [18] The decisions which s 89C(2) summarises as open to the Director to make are not merely procedural. Decisions to take no further action or to enter into an agreement bring the Pt VAA process to an end. Once made, they become the source of substantive rights. If not made, those substantive rights are denied to the practitioner. These features, in my view, give each the necessary quality of finality to make each of the decision options mentioned in s 89C(2) decisions to the ADJR Act applies.

90 Director may consult on decisions

The Director may consult a panel member or any consultant or learned professional body that the Director considers appropriate to obtain assistance in making a decision on a review. Such panel member or consultant is protected from civil or criminal action for any statement made or information given in good faith to the Director in connection with such consultation. Any decision subsequently made by the Director may be informed by the advice of the consultant, but cannot displace the Director's responsibility for making the decision: it must be the Director's decision. The Director need not disclose the identity of the consultant to the person under review.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [34] In terms of explicit provision, s 90(1) of the HIA expressly authorised the Director (as the Director submitted), in order to obtain assistance in making her decision on a review, to consult one or both of the following, a "Panel member" or any consultant or learned professional body that the Director considered appropriate.
>
> [35] "Panel members" are medical practitioners appointed by the Minister to the Professional Services Review Panel, established by s 84 of the HIA, after consultation with the Australian Medical Association and such other consultation as ordained by or under that section. Panel members are charged with the performance of a number of functions under Pt VAA of the HIA. In relation to a review conducted by the Director, the apparent purpose of permitting the Director to consult with a Panel member is to afford the Director, if the Director chooses to take up the option, of having a professional sounding board who can, if occasion

requires, challenge any idiosyncratic thinking by the Director. Section 90 also authorises the Director to consult more widely but for like purposes.

[36] In this case, the Director took up an option offered by s 90 of the HIA so as to have the benefit of a review by a consultant, a general practitioner, of such of Dr Karmakar's medical records as were then available to the Director. There is neither evidence nor allegation in a ground of review of any resultant abrogation by the Director in favour of that general practitioner of her decision-making function. The decision was hers.

[37] It is true that the Director declined to reveal to Dr Karmakar's then lawyers the identity of the practitioner she had consulted, who had reviewed and at her request advised upon Dr Karmakar's records - see the Director's letter of 21 August 2017. Yet neither in s 90 nor elsewhere in the HIA is there any provision obliging the Director to reveal the name of any such consultant. In that same correspondence, the Director reiterated a statement already made in her s 89C(1)(b) report that the "consultant is an experienced and currently practising general practitioner".

[38] What the Director was obliged to do, by s 89C(1)(b) of the HIA, was to give Dr Karmakar a report setting out the reasons why she had at that point decided, pursuant to s 91, not to take no further action and extending to her an invitation to make written submissions, within 1 month, about the action the Director should take in relation to the review. By a letter dated 9 August 2017, which enclosed a report of that same date, the Director at least purported to comply with that obligation.

[39] In *Re Minister for Immigration and Multicultural Affairs and Indigenous Affairs; Ex parte Lam* [2003] HCA 6; (2003) 214 CLR 1, at 13 – 14, [37] – [38], Gleeson CJ observed that procedural fairness was concerned with whether there was any practical injustice. That observation was recently taken up by Kiefel CJ and Gageler, Keane and Gleeson JJ in *MZAPC v Minister for Immigration and Border Protection* (2021) 95 ALJR 441, at [46], who stated in their joint judgment:

> ... To say that a demonstration that the appellant had been deprived of the opportunity of a successful outcome is an aspect of proof of procedural unfairness is necessarily to accept that procedural unfairness is a matter of practical injustice, so that a demonstration of a bare or merely technical denial of procedural fairness alone is not sufficient to establish an entitlement to a new trial.

[40] Thus, the real question is whether, in the prevailing circumstances, Dr Karmakar has demonstrated that compliance by the Director with the obligation in s 89C(1)(b) of the HIA required that she be furnished by the Director with the particulars pleaded and, even if the obligation did entail that, whether that was productive of any practical injustice to her?

[41] In her report, the Director recited that, as a sequel to a request made of her by the CEO pursuant to s 86 of the HIA received on 17 March 2017, it appeared to her that "there was a possibility that you engaged in inappropriate practice in providing services during the review period". The Director then recited, and the fact is, that she had decided to undertake a review of Dr Karmakar's provision of services in

accordance with Div 3A of Pt VAA of the HIA and advised Dr Karmakar of this decision on 21 March 2017 in accordance with s 88A of the HIA. The Director then stated:

> [4] The review has focussed on a sample of services that you provided as Medicare Benefits Schedule (MBS) items.
>
> **Review**
>
> [5] Pursuant to section 88 of the [HIA], I asked Medicare to provide me with lists of patients to whom MBS item 597 (urgent attention after hours) 721 (GP management plans), 723 (team care arrangements) and 732 reviews of GP management plans or team care arrangements) 54 (long consultations), and 735 (multidisciplinary case conferences) services were provided by you during the review period.

[42] Having so done, the Director then recited in her report further particular steps which she had undertaken in her review, which included requiring the production of clinical records by the operators of medical practices where Dr Karmakar had practised. She then stated that these had been "examined in assessing whether or not there were grounds on which a Professional Services Review Committee (Committee) could reasonably find that you had engaged in 'inappropriate practice' as defined by the [HIA] in relation to any of those services". The Director recorded that, in "reviewing these records, I have had the benefit of advice from an experienced and currently practising consultant general practitioner who was engaged under [s 90 of the HIA]". The Director did not, in terms, quote from the contents of that advice. Rather, the Director afforded Dr Karmakar with her summary of a meeting which she had held with Dr Karmakar and her then lawyer in Brisbane on 1 August 2017, reciting the Director's concerns as then raised and responses made by Dr Karmakar.

[43] The Director then detailed in her report, at length, particular areas of concern adopting these headings:

- Clinical records (areas of concern as to adequacy were detailed);
- Urgent Attendance – After Hours (MBS item 597) (adequacy of records as to whether attendance was after hours and appropriateness of prescribed medication detailed);
- Chronic Disease Management (CDM) Services – GP Management Plan (GPMP) (MBS item 721), team care arrangement (TCA) (MBS item 723) and review of a GPMP or TCA (MBS item 732) (apparent use of "template" rather than individualised care plans and adequacy of records as to consistent practice of identification of the chronic disease, consultation with at least two collaborating health service providers and rational for ordering pathology tests;
- Professional attendance at consulting rooms of more than 25 minutes (MBS item 54) (absence of record supporting length of attendance detailed);
- Multidisciplinary Case Conferences (MBS item 735) (absence on occasion of record of such a conference detailed).

[44] The Director summarised at the conclusion of her report her various concerns in this way:

> [42] Following the review of your records and my meeting with you, I have concerns in relation to your rendering of MBS items 597, 721, 723, 732, 54 and 735 services during the review period.
>
> [43] My concerns include that:
> - the MBS requirements were not met for all items that you rendered;
> - you have billed items that were not clinically necessary;
> - your prescription of first line antibiotics may be inappropriate;
> - you have ordered pathology without clinical indication; and
> - your notes were an inadequate clinical record;

[45] The Director opined in her report, at [44], that "Inadequate documentation alone can be grounds for a Committee of your peers to find that you engaged in inappropriate practice." She then stated:

> [45] At this stage of my review, I am not satisfied that there are:
> - insufficient grounds on which a Committee could reasonably find that you had engaged in inappropriate practice in providing services during the review period; or
> - circumstances that would make a proper investigation by a Committee impossible.
>
> [46] Accordingly, I have not made a decision under section 91 of the [HIA] to take no further action in relation to the review.

[46] The acronym, "MBS", as the report indicated, and as used in these reasons for judgment, is a reference to what is generally termed the "Medicare Benefits Schedule", being the table of general medical services scheduled to regulations made from time to time under s 4 of the HIA, which set out the following:
(a) items of medical services (hence the reference to particular item numbers);
(b) the amount of fees applicable in respect of each item; and
(c) rules for interpretation of the table.

[47] After the later exchange, mentioned above, concerning Dr Karmakar's request for further information, Dr Karmakar sent to the Director a detailed response (including related, supporting annexures), dated 18 October 2017 but received by the Director on 6 November 2017, to the issues raised in the Director's report.

[48] By a letter dated 13 November 2017, the Director advised Dr Karmakar that she was not prepared to take no further action under s 91 of the HIA but rather that she had decided, pursuant to s 93 of the HIA, to refer the matter to the Committee. The Director stated:

> Notwithstanding your submissions, I remain of the view that your conduct in rendering the referred services may be considered inappropriate by a Committee of your peers and I am not prepared to take no further action in this review in accordance with section 91 of the *Health Insurance Act 1973* (Act).
>
> *I acknowledge your submission that there is documentation missing from the records obtained from Harbourtown Medical Centre but do not accept that this makes a proper investigation by a Committee impossible.*

> I have therefore decided to refer this matter to a Professional Services Review Committee (PSR) Committee under section 93 of the Act.
>
> [Emphasis added]

[49] One submission made by Dr Karmakar was that the Director's refusal to specify the name and qualifications of the practitioner she consulted under s 90 of the HIA was procedurally unfair, because it denied her the opportunity to make a submission as to the weight which ought to be afforded to the views expressed by that practitioner. As I understood it, the unfairness lay in an inability to ascertain whether that practitioner was, for example, known in the profession as an iconoclast, possessed of idiosyncratic views. As an abstract proposition, that submission may, in certain circumstances, have merit. But not, in my view, in the context of the scheme in Pt VAA of the HIA.

[50] Whether any consultation as envisaged by s 90 occurs at all is entirely a matter for the Director. If it does, the Director's obligation is not to disclose the assistance, if any, received or the author of any advice but rather, as s 89C(1)(b)(i) of the HIA dictates, to furnish the practitioner concerned with "a written report setting out the reasons why the Director has not made a decision under section 91". The reasons in that report must be those of the Director, not of such person or body, if any she may have chosen to consult for assistance. There is nothing to indicate that the reasons in the report were other than those of the Director. It is to that report containing those reasons that the practitioner is expressly afforded an opportunity by invitation to respond. If those reasons reflect idiosyncratic views within the profession, that will be apparent on the face of the report itself. It would, in my view, have been permissible for the Director, if she chose, to have quoted from any advice which she received under s 90 of the HIA, naming the author, and indicating that she agreed with that advice. But she was under no obligation either expressly by statute or by implication so to do. Indeed, it would be permissible for the Director to consult under s 90 but depart from any resultant advice to her if she had a different opinion. The s 90 process is intramural. The extramural aspect of this stage of the processes for which Pt VAA provides is the report containing the Director's reasons. The reasons which the Director furnished in her report were comprehensive. They conspicuously fulfilled her obligation to afford Dr Karmakar with an opportunity to engage with the critical issues that had not led the Director initially just to decide to take no further action under s 91 and which might persuade her to make a referral to a committee. They also enabled Dr Karmakar to address those same issues to the end of persuading the Director under s 91 that, taking her submission into account no further action ought to be undertaken.

[51] This is a case where no injustice, practical or otherwise, was visited upon Dr Karmakar by the Director. The Director discharged the procedural fairness duty imposed on her by s 89C(1)(b)(i) of the HIA.

Soryal v Director of Professional Services Review [2023] FCA 326 —

[61] The applicant submits that *Karmakar* is different from the present matter because:

> (a) The records relied upon had not been made available to Applicant at the meeting to discuss the matter with the Director on 27 July 2021;

(b) The Director's report does not raise all the issues that were adverse to the Applicant and these were not put to him.

(i) The Consultant alleged the 'business model was devoted purely to a screening protocol;

(ii) The Consultant stated that "the fact that the ancillary providers universally used the [person under review]'s provider number....conveys additional responsibility";

(iii) The Consultant stated that the statistical data defied belief;

(iv) The Consultant stated that he was confused or concerned about infection control;

(v) The Consultant specifically queried the rationale for treatments for fissure deals and sought that this be asked of the Applicant;

(vi) The Consultant specifically queried whether there were written guidelines for decision making – which is not required- and sought that this be asked of the Applicant;

(c) The Director's report raises issues that were not of concern to the Consultant which she took into consideration in the making of her decision;

(i) The Consultant was not critical of the records, but the Respondent mentioned inadequacies as part of her report and the interview with the Applicant;

(d) The Consultant's report was materially flawed and these flaws were not able to be addressed by the Applicant.

(i) The Consultant complained that he had not received all of the requisite records;

(ii) The Consultant complained that the records had not been obtained "from the [person under review] despite being requested" when this is incorrect as the [person under review] did not ever have access or control of the records 'invariable supplied by the [person under review]';

(iii) The Consultant's view on fissure sealants is not consistent with recognised Dental Practice.

(footnotes omitted)

[62] In contrast, as part of the respondent's submissions, the respondent's solicitors prepared a table comparing the critical issues relied on by the Director in her report, and instances where the applicant was put on notice of these issues and provided with an opportunity to respond.

[63] As Griffiths J noted in *National Home Doctor Service Pty Ltd v Director of Professional Services Review* (2020) 276 FCR 338; (2020) 379 ALR 513; [2020] FCA 386 at [66], "the statutory PSR Scheme is rich with procedural fairness requirements". Having regard to the reasons of Logan J in *Karmakar*, in my view, the applicant has failed to establish any procedural unfairness or practical injustice resulting from the redaction of the consultant's name and report. The fact that the Director has sought assistance from a consultant who has expressed various

opinions with which the applicant does not inherently mean that the Director has erred. As required under ss 88A(4) and 89C(1)(b) of the HI Act, the respondent was required to provide written reasons for her decision, which was complied with.

Re Raiz and Professional Services Review [2021] AATA 4360 —

[107] The Director may engage a consultant who belongs to the same profession as the person under review to provide expert advice when they are considering a referral to a Committee. In this matter, the Director spoke to potential consultants and directed staff to make the necessary arrangements to engage them.

[108] The PSR claimed that the names of the consultants are exempt from disclosure under s 47E(d) and s 47F.

[109] The PSR argued that it is necessary to keep the names of Consultants confidential otherwise consultants would be reluctant to assist the Director as it involves providing advice about another practitioner in their field. They contended that this would have a substantial adverse impact on the ability of the PSR to conduct its reviews and therefore qualifies as conditionally exempt information under s 47E(d).

[110] The PSR has instituted a policy not to reveal the name of consultants to combat the reluctance of consultants to assist the Director if the person under review is aware that they are helping. Therefore, as is their usual practice, the PSR informed the consultants contacted to assist the Director in Dr Raiz's review that their names and personal information would remain confidential.

[111] Mr Topperwien provided the following evidence as to the likely consequences of breaching this confidentiality policy:

> Based on my experience working at PSR and as Executive Officer, , I am of the view that there is a serious risk that if consultants' names were to be routinely released under the FOI Act, this could reasonably be expected to reinforce the reluctance of practitioners to act as consultants advising the Director in a review of one of their colleagues. This is a particularly sensitive issue where the relevant profession or specialty is a relatively small one. If consultants are reluctant to assist the Director, this would seriously affect the Director's ability to access a vital source of advice to assist in her review.
>
> ...
>
> If the Director is unable, or hampered in her ability, to engage the services of experienced practitioners in the same profession or specialty as the PUR, this could, or would, reasonably be expected to have a substantial adverse effect on the proper and efficient function of the operations of the PSR. This is because the Director would have to perform her functions without expert advice on the particular services she is reviewing and whether the PUR may have engaged in conduct that would be unacceptable to the general body of the relevant profession or specialty. This in turn would undermine the objects of the Scheme to protect patients and the community in general from the risks associated with inappropriate practice and to protect the Commonwealth from

having to meet the cost of services provided as a result of inappropriate practice.

[112] Dr Raiz stated that the PSR has made a 'mere assumption or allegation' that disclosure of the names of consultants would seriously impact the Director's ability to access consultants to assist the Director in her review. However, I have no reason to doubt Mr Topperwien's evidence based on his extensive experience that consultants often seek confirmation that they will be anonymous as a condition of offering their services. I note that the applicant did not require Mr Topperwien for cross-examination therefore I have no basis to challenge his evidence. Furthermore, it is understandable that in small professions where practitioners are likely to know one another, that one would not wish to engage in a review of their colleague without anonymity.

[113] Therefore, I find that if the names of consultants could be released through an FOI process, this would, or could, have the substantial adverse impact of limiting the number of consultants willing to assist the Director. If the Director no longer has access to a wide pool of consultants, this would significantly prejudice her ability to make informed decisions in the initial referral stage and would therefore fetter the functions of the PSR scheme.

[114] Therefore, I considered that this information relating to the Consultant's names is conditionally exempt under s 47E(d).

[115] I will not consider whether the names of the consultants are exempt from disclosure under s 47F as I have already found them exempt under s 47E(d).

Public Interest Test

[116] The only public interest in releasing the names of consultants would be to promote the objectives of the Act of transparency and accountability. Dr Raiz argued that releasing the names of the consultants may substantiate any possible claim he wishes to make that the PSR acted improperly during his investigation. However, there is no evidence of impropriety or basis for this claim.

[117] The PSR submitted that there are significant factors against disclosure of the consultants' names. As discussed earlier, such disclosure would disincentivise consultants to assist the Director in investigating matters. The PSR argues that it is in the public interest that the Director have a broad selection of consultants so that she is guided by the most appropriate experts to reach her views as to whether a practitioner should be investigated for malpractice.

[118] If the Director is fettered in her ability to make decisions at to which matters to refer, this could have a significant negative impact on the public. It would impede the efficacy of the PSR Scheme in protecting the public from both the risks of inappropriate practice and the risks of the Commonwealth having to meet the costs associated with Medicare-related malpractice.

[119] Dr Raiz submitted that as the HI Act never submitted that the names of consultants are confidential, the PSR should never have promised confidentiality. He further argued that the PSR's motivation to keep the consultants' names confidential is that the PSR will risk embarrassment if consultants discover that the

> Director made a baseless promise of confidentiality. Under paragraph 6.24 of the Guidelines, the decision maker must not take into account whether access to a document could result in embarrassment to the Commonwealth Government or a loss of confidence in the Commonwealth Government. Therefore, any embarrassment to the Director if the names of consultants were released against the PSR's stated policy is not relevant to my decision.
>
> [120] However, without considering this irrelevant factor of the PSR's reputation, there are significant factors contrary to the public interest if consultants' names could be released through FOI requests. There would be a substantial risk that many consultants would be reluctant to assist the Director in the future which would impede the effectiveness of the Director's investigation. There are few compelling reasons to disclose the information except that increased government transparency is generally a favourable outcome.
>
> [121] In these circumstances, the public interest factors against disclosure of the consultants' names outweigh the public interest factors in favour of disclosure of their names. Therefore, this information is conditionally exempt under s 47E(d).

91 Decision to take no further action

The Director may decide to take no further action in relation to a review if he or she is satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice in providing services during the review period.

Whether the Director should consider dismissal of a matter under s 91 was considered in the context of a request for review in relation to an 80/20 rule matter. The Court said that the Director would seldom be satisfied that insufficient grounds exists in such a case. This indicates that the nature of the Director's consideration following a review is whether or not there is a *prima facie* case of inappropriate practice.

Daniel v Health Insurance Commission [2003] FCA 772 —

> [20] In a practical sense, the applicant submits, the Director can respond to a referral in one of only three ways; by dismissing it, by entering into an agreement under s 92 or by referring the matter to a Committee for adjudication. A referral can only be dismissed where the Director "is satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice in connection with rendering or initiating the referred services": s 91. It could not be suggested that the Director should not have regard, in deciding whether he or she is so satisfied, to the requirement under s 106KA(1) to deem inappropriate practice to have occurred where a proscribed pattern of service exists. Where the "80/20" pattern appears on the face of the Commission's records, a Director could seldom be satisfied that there are "insufficient grounds" on which a Committee could reasonably make a finding of inappropriate practice,

> unless there is a strong prima facie case of exceptional circumstances as contemplated by s 106KA(2) which affect sufficient days to render inapplicable the 80/20 rule.

The phrases 'insufficient grounds' and 'reasonably find' indicate that a level of pragmatism is called for by the Director in considering the information and material following the Director's review and then deciding which of the three available choices should be made: namely, take no further action (s 91), enter into negotiations for an agreement (s 92), or make a referral to a Committee (s 93).

The Director may also decide to take no further action if circumstances exist that would make a proper investigation by a Committee impossible. Circumstances that may warrant such a decision include the total destruction of patient records through some unfortunate accident, the death of the person under review, removal of the person under review from Australia with little, if any, likelihood of their return.

In the latter circumstance, it may be open to the Director, prior to making such a decision, to inform the relevant registration authority in the country to which the person has moved that the person has failed to cooperate with an investigation into their conduct in providing professional services. The mere fact of informing the regulatory authority may encourage the person to return to Australia or at least engage with the PSR process from overseas. While under s 106ZPM of the Act, the Director may give a notice to the Chief Executive Medicare that medicare benefits or dental benefits are not payable in respect of services provided by the person under review while they continue to refuse to provide requested documents or information, such an sanction is ineffective if the person has no intention of ever providing such services. Persistent failure to cooperate and the lack of an effective enforcement mechanism may make a decision under section 91 inevitable. However, once a decision is made under s 91, that is the end of the review and the matter cannot be reopened. Additionally, any disqualification that may have operated under s 106ZPM would no longer operate. Consequently, the Director may decide not to take any action under any of sections 91, 92, or 93 while a disqualification remains in place and while there is a reasonable prospect that the person may return to Australia. It might be open to a person to seek an order from the Federal Court under the *Administrative Decisions (Judicial Review) Act 1977* (the AD(JR) Act)[161] or the

[161] Section 7 of the *Administrative Decisions (Judicial Review) Act 1977* provides:

(1) Where:

(a) a person has a duty to make a decision to which this Act applies;

(b) there is no law that prescribes a period within which the person is required to make that decision; and

Judiciary Act 1903, such as a declaration or a writ of mandamus, to require the Director to make a decision. Under the AD(JR) Act, the test has been held to be whether the delay was justified and not capricious, and at common law, the Court would have a discretion not to issue a writ of mandamus while ever the person unreasonably fails to cooperate with the PSR process.

Thornton v Repatriation Commission [1981] FCA 76 —

> The question is whether there are circumstances which a reasonable man might consider render this delay justified and not capricious.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2021] FCA 1381—

> [77] Consistently with cases such as *Thornton* and *ASP15*, the test of unreasonableness is whether "there are circumstances which a **reasonable man** might consider render this delay justified and not capricious" (emphasis added). It is notable that the test is expressed as requiring the objective assessment to be conducted through the prism of a reasonable person, as opposed to the Court itself. A broad analogy might be drawn with the test for apprehended bias. Thus, in applying the test of unreasonable delay, the reasonable person should be imputed with a knowledge of all relevant matters, including the statutory context within which the delay has occurred as well as all the relevant facts and circumstances.

The Director may make a decision under section 91 to take no further action in relation to a review at any time in the course of the Director's review.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2020] FCA 386 —

> [39] … There is no single point in time in which the Director may make a decision under s 91 to, in effect, terminate a review. It may be exercised from time to time within the tier 2 stage. Such a decision might be made, for example, as contemplated in s 89C(1)(a), at the point in time when the Director has conducted a review of the provision of services by a person. The Director could also make a

(c) the person has failed to make that decision;

a person who is aggrieved by the failure of the first-mentioned person to make the decision may apply to the Federal Court or the Federal Circuit Court for an order of review in respect of the failure to make the decision on the ground that there has been unreasonable delay in making the decision.

(2) Where:

(a) a person has a duty to make a decision to which this Act applies;

(b) a law prescribes a period within which the person is required to make that decision; and

(c) the person failed to make that decision before the expiration of that period;

a person who is aggrieved by the failure of the first-mentioned person to make the decision within that period may apply to the Federal Court or the Federal Circuit Court for an order of review in respect of the failure to make the decision within that period on the ground that the first-mentioned person has a duty to make the decision notwithstanding the expiration of that period.

decision under s 91 to take no further action after taking into account any written submissions received from the person under review as contemplated by s 89C(1)(b). This is made clear in the terms of s 89C(2).

92 Agreement entered into between Director and person under review

When the PSR Scheme was established in 1994 by the enactment of the *Health Insurance (Professional Services Review) Act 1994*, section 92 enabled the Director to enter into an agreement with a person under review, being a practitioner, to partially disqualify them from the MBS in respect of particular MBS services for a period of up to a year. Once such an agreement was entered into, the Director was required to notify the Health Insurance Commission and dismiss the referral. Disqualification was the only sanction that could be the subject of an agreement.

In practice, this provision was only occasionally used as it was not seen to be an appropriate outcome in most cases. Instead, cases were either dismissed or referred to a PSR Committee.

In 1999, the PSR Scheme was significantly revised in response to the March 1999 *Report of the Review Committee of the Professional Services Review Scheme*. The amending legislation replaced the Determining Officer (who had been a senior officer within the Department) with the Determining Authority. It also expanded the actions available to the Director in a s 92 agreement by including nearly all of the same sanctions that could be imposed by the Determining Authority, but added a requirement that an agreement could not come into force unless ratified by the Determining Authority.

Section 92 provides for the Director to enter into an agreement with a person under review in circumstances where the person acknowledges that they have engaged in inappropriate practice.

Subsection 92(2) sets out the range of sanctions (called 'actions') that can be imposed on a person under review by being included in agreement that has been entered into by the Director and the person under review and has been ratified by the Determining Authority. The actions that may be included in an agreement are:

- reprimand;
- counselling;

- repayment of medicare or dental benefits that had been paid (whether or not paid to the person under review) in respect of services rendered or initiated by the person, and in respect of which the person has acknowledged engaging in inappropriate practice;
- that any medicare benefit or dental benefit that would otherwise be payable for services in respect of services rendered or initiated by the person, and in respect of which the person has acknowledged engaging in inappropriate practice, cease to be payable;
- if the person under review is an employer or engager of practitioners (associated persons[162])—the person under review is to give specified classes of associated persons specified information about the appropriate provision of services, or that is relevant to preventing inappropriate practice in the provision of services;
- determine that the Minister's acceptance of an undertaking under section 21B or 22A of the Act is to be taken to be revoked for a midwife or a nurse practitioner, respectively;
- suspend the person under review's Part VII authority under the *National Health Act 1953* in relation to pharmaceutical benefits for a period of up to 3 years;
- disqualify the person under review in respect of providing specified services, specified classes of services, or any services at all for a period of up to 3 years (or 5 years if there has been a previous section 92 agreement or determination in relation to that person).

As subsection 82(1) excludes DVA treatment services from the general rule regarding inappropriate practice.[163] This means that as a person under review could not acknowledge inappropriate practice in connection with rendering or initiating DVA treatment services under the general inappropriate practice rule, repayment of benefits for such services could not be a specified action for the purposes of a section 92 agreement. The only action for the repayment of benefits in respect of DVA treatment services that can be included in a section 92 agreement is a repayment for services rendered as part of a 'prescribed pattern of services'.

If the Chief Executive Medicare forms the opinion that a person under review has failed to comply with an action in a ratified agreement, the Chief Executive Medicare may notify the Director and the Director may, under section 106ZPR, publish details

[162] 'Associated person' is defined in subsection 106U(5).

[163] That is, 'the conduct in connection with rendering or initiating services … is such that a Committee could reasonably conclude that … the conduct would be unacceptable to the general body of' the relevant profession or specialty.

of the person under review and the nature of the e conduct of the person under review in respect of which the person acknowledged under the agreement that the person engaged in inappropriate practice, and the actions specified in the agreement. Before doing so, the Chief Executive Medicare must give the person an opportunity to make submissions as to why such action should not be taken.

It is not a requirement that the Director enter into negotiations for a section 92 agreement, but is at the Director's discretion. Nevertheless, if a practitioner takes steps to enter into negotiations for an agreement, the Director must consider such a request and decide whether or not to do so.

Oreb v Willcock [2005] FCAFC 196 (per Lander J, with whom Black CJ and Wilcox J agreed) —

> [121] Next, the appellant contended that s 92 should be construed as imposing a 'positive duty to approach the doctor under investigation and offer to him or her the opportunity to negotiate for and enter into a section 92 agreement'. In my opinion, there is nothing in s 92 itself or in any of the other provisions of the Act which supports such a contention.
>
> …
>
> [124] Section 89 allows the Director to conduct the investigation in such a manner as he or she thinks appropriate.
>
> [125] As I have already indicated, as a result of that investigative referral, the Director might send the matter to the Commission if the Director thinks an offence might have been committed under s 124B (s 89A(1)), or summarily dismiss the investigative referral (s 91), or enter into an agreement between himself or herself and the person under review (s 92), or set up a Committee in accordance with Division 4 (s 93), or decide to take no action (s 93).
>
> [126] There is nothing in the language of the Act which requires the Director to offer to enter into an agreement with the person under review under s 92. Indeed, the fact that so many options are available to the Director is a good reason for thinking there is no positive obligation on the Director to offer the practitioner a s 92 agreement.
>
> [127] The Director is entitled to make that offer provided, of course, that the person under review is prepared to acknowledge that the conduct during the referral period constituted engaging in inappropriate practice and provided that the person under review is prepared to enter into an agreement which includes any one or more of the matters in s 92(2). That is one option available to the Director but is not something that the Director is required to do.
>
> [128] In any event, in this case, the Director did in his letter of 18 December 2001 provide the appellant with the information regarding the various outcomes which

might flow from the investigative referral, including the possibility of a s 92 agreement.

[129] There is nothing to support the contention that the Director failed to have regard to all of the options which were available to him after conducting his inquiry under s 89. He was not bound to appoint a Committee under s 93 but he was entitled so to do.

[130] The appellant's contentions must fail because the Director did put the option of a s 92 agreement to the appellant. In those circumstances, the appellant's contentions fail both on the construction of the Act and on the facts. In those circumstances, the appeal must fail.

Tisdall v Kelly [2005] FCA 365 —

[89] … By s 92(1)(a), it is a necessary part of an agreement that the person under review acknowledge engaging in inappropriate practice during the referral period. Without such an acknowledgement, there can be no agreement. A view held by the Director that the medical practitioner would have to acknowledge having engaged in inappropriate practice, before an agreement could be entered into, would appear to be correct. Unless the medical practitioner indicated a preparedness to make such acknowledgement, there would seem to be little point in engaging in negotiations about an agreement.

[90] Further, in the present case, there was no evidence that the Acting Director, who acted as the Director in dealing with the investigative referral, held the view alleged. In his letter of 20 January 2001, the Acting Director informed the applicant that the Acting Director had the option to enter into an agreement pursuant to s 92, but did not refer to the question of how negotiations might be initiated, or specifically to the need for preparedness to admit having engaged in inappropriate practice. The letter did not invite the applicant to address the point. None of these facts establishes that the Acting Director had any particular view.

[91] In the absence of evidence, counsel for the applicant sought to rely on a finding of fact made by Ryan J in *Daniel v Kelly*. The Acting Director was the first respondent in that case, as he is in the present case. At [27], Ryan J set out the contents of an affidavit of the first respondent, in which he apparently said that, before making the adjudicative referral in that case, he considered whether it might be an appropriate case to enter into agreement with Dr Daniel under s 92. He did not consider it was an appropriate case to enter into an agreement. He did not receive any indication that Dr Daniel wished to enter into an agreement under s 92. No submissions were made by Dr Daniel in that respect. It was a precondition of an agreement that the person acknowledge conduct constituting inappropriate practice. The first respondent received no indication that Dr Daniel was prepared to make such an admission. At [28], Ryan J found that this evidence made it clear that the first respondent regarded it as a prerequisite for the exercise of his discretion that the person under review be prepared to concede guilt of inappropriate practice or otherwise invite the first respondent to resort to s 92.

[92] Counsel in the present case sought to rely on that finding of fact, on the basis that the investigative and adjudicative referrals in respect of both Dr Daniel and the

present applicant were made on the same dates, so it is highly likely that the Acting Director's approach to each was uniform. If this were not possible, counsel for the applicant sought production of the affidavit from the Daniel case, and leave to rely on it.

[93] A finding of fact by a judge in one case is no precedent for another judge in another case. Even if the affidavit from the *Daniel* case were admitted into evidence in the present case, on the basis that it contained some kind of admission by the Acting Director as to his state of mind, with great respect to Ryan J, I am by no means sure that it would lead me to make the same finding of fact as his Honour made in *Daniel*. As I have already said, the Acting Director had no obligation to initiate negotiations for a s 92 agreement. The fact that he might have received no indication from the applicant that the applicant wished to enter into an agreement under s 92, or that the applicant made no submissions to that effect, does not mean that the Acting Director was of the view that he should refuse to consider a s 92 agreement unless the applicant proposed it. To say that it was a precondition of a s 92 agreement that the person under review acknowledge conduct constituting inappropriate practice was true in the sense that such an acknowledgement was an essential term of any agreement. In the absence of any indication that the applicant was prepared to make an admission of having engaged in inappropriate practice, there was no reason why the Acting Director should not take the view that he would not invite the making of such an admission. In any event, I do not regard it as necessary for me to pursue these factual issues, because the ground on which the applicant relied can be dealt with without making final decisions on them.

[94] The applicant contended that *Daniel v Kelly* and *Kelly v Daniel* establish that it is necessary for the Director to advise a medical practitioner of any view that the Director holds, that it is up to the medical practitioner to initiate negotiations, and to acknowledge having engaged in inappropriate practice, before the Director will consider the possibility of a s 92 agreement. The question is whether those authorities sustain that proposition. The reasoning of Ryan J was summarised by the Full Court in *Kelly v Daniel* at [62] – [64] as follows:

> 'The primary judge found as a fact that the Acting Director regarded it as a prerequisite for the exercise of his discretion for the person under investigation to be prepared to concede guilt of inappropriate practice or otherwise invite the Director to resort to s 92. That construction of the section found no support in the statute. A s 92 agreement, logically, had to be considered before the Director made a referral to the Committee. The willingness of a practitioner to enter such an agreement might legitimately inform that decision. However, nothing in Dr Daniel's submission to the Acting Director indicated a refusal to acknowledge inappropriate practice, or that it would have made it pointless to consider a s 92 agreement. Rather, the submission suggested that Dr Daniel had seen the error of his ways and had accepted the need for counselling and further professional education in relation to the future conduct of his practice.
>
> His Honour went on to say that had the Acting Director thought that a refusal by Dr Daniel to make an admission would preclude entry into a s 92 agreement, that matter should, as a matter of procedural fairness, have been put to him to allow him to comment upon it. Similarly, if the Acting Director had proposed to treat as relevant the fact that Dr Daniel had not himself suggested a s 92

agreement, he should have afforded him an opportunity to explain his silence on the point. His Honour referred to *Kioa v West* [1985] HCA 81; (1985) 159 CLR 550. It did not appear to have been put to Dr Daniel that a failure to show contrition, or specifically invite recourse to s 92, would exclude him from an agreement under that section. His Honour found, accordingly, that Dr Daniel was denied procedural fairness in relation to the exercise of the Director's discretion under s 92.

His Honour then set out relevant extracts from the adjudicative referral. He noted that the instrument was described as "a referral under s 106KA" and observed that this only tended to reinforce the conclusion that nothing more than cursory consideration was given to any issue beyond the 80/20 rule. This was despite the fact that Dr Daniel might have had a legitimate claim to an offer of a s 92 agreement, or some other favourable exercise of the Acting Director's discretion.'

[95] The reasoning of the Full Court is found at [104] – [106]:

'The final issue raised on the appeal was whether the Director had denied Dr Daniel procedural fairness by making the adjudicative referral without affording him an opportunity to enter into an agreement under s 92.

It is clear, as the primary judge concluded, that the Acting Director regarded it as a prerequisite for the exercise of his discretion for the person under investigation to be prepared to concede guilt of inappropriate practice or otherwise invite the Director to resort to s 92. Mrs Hampel submitted that, in the event that her primary submission regarding his limited role was rejected, the Acting Director acted correctly in approaching the section in that way.

We reject that submission. There is nothing in the language of the section to support that construction. Moreover, we agree with his Honour that if the Acting Director understood the section to operate in that way, he was under an obligation to afford Dr Daniel the opportunity to enter into such agreement. It follows that whether one characterises the Acting Director's approach to s 92 as involving a fundamental error of law going to jurisdiction, or whether it be characterised as a denial of procedural fairness, jurisdictional error has been demonstrated. The adjudicative referral could therefore have been set aside on this ground as well.'

[96] The last sentence of this passage indicates that what the Full Court said was *obiter*. I do not regard the Full Court as having established a principle that, in every case, if the Director understands s 92 to operate on the basis that it is a prerequisite for the exercise of the Director's discretion to enter into a s 92 agreement for the person under investigation to be prepared to concede guilt of inappropriate practice or to invite the Director to resort to s 92, the Director has an obligation to afford the person under investigation the opportunity to enter into such agreement. Procedural fairness depends upon the circumstances of each case. An absolute rule of such particularity would be arbitrary. It may be that Ryan J and the Full Court came to the conclusions that they did in the *Daniel* cases because Dr Daniel had had previous dealings with the Commission, which appeared to have resolved the issues about the manner in which he conducted his practice, so that there were particular circumstances that suggested that the Acting Director should have pursued the question of a s 92 agreement in a more positive manner. The reference to Dr Daniel

having seen the error of his ways, and being prepared to accept professional education, and to Dr Daniel's 'legitimate claim' to the offer of a s 92 agreement, tend to support this view. This is not to say that, in every case the Director is bound to present a medical practitioner whose conduct is under review with an explicit offer to enter into negotiations with a view to the making of such an agreement.

[97] In *Crowley v Holmes* [2004] FCA 521, Sundberg J dismissed an application for interlocutory relief in respect of an alleged denial of procedural fairness, in which reliance was placed upon *Daniel* as authority for the principle that the Director was obliged to inform a medical practitioner under investigation of his view as to how negotiations for a s 92 agreement should be initiated, and as to the need for an acknowledgement of engaging in inappropriate practice. His Honour found that there was no serious question to be tried. In addition, in *Oreb* at [174] – [202], Jacobson J rejected the view that there was a denial of procedural fairness in circumstances similar to those in the present case. Subsequently, in *Dimian v Health Insurance Commission* [2004] FCA 1615 at [45], *Selim v Lele* [2005] FCA 24 at [30] and *Lee v Kelly* at [29] – [41], Jacobson J has taken the same view. I respectfully adopt the reasoning in those cases.

[98] In the present case, the applicant knew that a s 92 agreement was an option. If he did not know it otherwise, he was so advised by the Director's letter dated 20 December 2001, informing him of the investigative referral and inviting him to make submissions as to why the Director should dismiss that referral, which letter accorded with s 88 of the Health Insurance Act. The applicant had legal advice at all times. His current solicitor has sworn an affidavit in which he says that he has received instructions from the applicant as to what he would have done if he had received notice from the Acting Director that the Acting Director would not consider entry into a s 92 agreement without an indication from the applicant that he was interested in entering into such agreement and a preparedness to admit inappropriate practice. He says that the applicant would have sought legal advice from his then solicitors and, on certain conditions, might have attempted to negotiate for an agreement. The applicant's current solicitor also details what advice he would have given to the applicant in those circumstances. The affidavit was admitted without objection and there was no cross-examination on it, but it is difficult to avoid the conclusion that there is a hefty element of hindsight in this evidence. There is no reason why the applicant could not have sought and received advice about his prospects of entering into a s 92 agreement. There is no reason why he could not have indicated to the Acting Director that he wished to negotiate in relation to such an agreement. To enter into such an agreement, the applicant would have had to be prepared to acknowledge that he had engaged in inappropriate practice. Instead, he chose to contest this issue. He could equally have chosen the negotiating path. Nothing that the Acting Director did or failed to do denied the applicant procedural fairness in this respect.

Dimian v Health Insurance Commission [2005] FCAFC 200 —

[33] The Director is not obliged to offer to enter into a s 92 agreement with a medical practitioner whose conduct is under review. Section 92 permits, but does not require, the Director to enter into such an agreement but only if the medical

practitioner acknowledges that the medical practitioner's conduct during the referral period constituted engaging in inappropriate practice.

Barnes v Director of Professional Services Review [2023] FCA 129 —

[71] I agree with the submission advanced by the Commonwealth that the Act prescribes particular points at which the Director is required to give notice of certain matters and submissions from a person under review. There is no suggestion that those requirements were not met. The applicant was on 23 February 2021 notified of the Director's decision to conduct a review. By letter dated 29 June 2021, the Director notified the applicant of the process to be followed, which was foreshadowed to include a meeting with the Director, an opportunity for the applicant to make written submissions and consideration of those written submissions. The Director informed the applicant that, after that, she would "make a decision to either take no further action, seek to enter into an agreement with you or refer the case to a PSR Committee". This accords with the contemplated steps in s 89C. The Director duly met with the applicant on 14 July 2021 and in her letter of 29 July 2021 she invited the applicant to make written submissions, indicating that she would consider them and do one or other of the three things prescribed in s 89C(2) of the Act.

[72] It was clear that following the receipt of the submissions the Director would make a decision under s 89C(2).

[73] In the applicant's written submissions of 6 September 2021 he said, "... he believes this is a matter which may be capable of resolution by entering into an Agreement pursuant to section 92 of the [Act]".

[74] The applicant contends that, by not meeting with him after this suggestion, the Director failed to afford him procedural fairness, because it is the nature of an agreement that the Director and practitioner discuss and agree on its terms. However, as the Court noted in *Dimian* at [33], the Director "is not obliged to offer to enter into a s 92 agreement with a medical practitioner whose conduct is under review", see also *Oreb* at [126]. Section 92 permits but does not require the Director to do so, and only permits this if the medical practitioner acknowledges that his or her conduct during the referral period constituted engaging in inappropriate practice.

[75] In the present case the applicant suggested that the Director ought to review and alter her findings. It would appear that the request was intended to be the commencement of a negotiation, which might have entailed discussing with the Director as to which of her criticisms would be dropped. Although the Director was free to engage in such negotiations, nothing in the structure or substance of Part 3A of the Act indicates that she was required to do so.

[76] In this regard the *obiter dicta* observations of Ryan J in *Daniel v Kelly* [2003] FCA 772; 200 ALR 379 at [27]-[29] do not assist the applicant. That case concerned a different version of the Act. The relevant finding was that the Acting Director incorrectly regarded it to be a prerequisite for the exercise of his discretion to discuss entry into a s 92 agreement that the practitioner under investigation first invite recourse to such an agreement and be prepared to concede guilt of

inappropriate practice before he could resort to a s 92 agreement. It was in that context that the court considered that there was a denial of procedural fairness.

[77] The present case is somewhat different. There is no evidence to suggest that the Director did not consider entry into a s 92 agreement, or that she considered a concession of culpability a prerequisite. Nor is the Director obliged by s 89C(2) to give reasons for entering into (or not entering into) an agreement. Furthermore, there is nothing in the language of the Act which requires the Director to offer to enter into an agreement under s 92: *Oreb* at [126].

[78] The applicant was offered an opportunity to make submissions, which he took. Thereafter it was open to the Director to determine which of the three courses available under s 89C to take. There is nothing in the Act, or the common law, to indicate that procedural fairness required the Director to give the applicant successive oral hearings, or to receive an early indication from the Director that she was not proposing to enter into an agreement. Procedural fairness does not require that the decision-maker disclose what she is minded to decide so that the parties may have a further opportunity to criticise her mental processes before she reaches a final decision; under s 92; Minister for Immigration and *Citizenship v SZGUR* [2011] HCA 1; 241 CLR 594 at [9] (French CJ and Kiefel J). In this regard the analogous observations made by Rangiah J in *Yoong* at [90] are apposite (emphasis in original):

> … where a decision-maker is positively required to give the person under review an opportunity to be heard as to whether a particular decision should be made, the PSR Scheme tends to make the requirement express, and does not leave it to implication. For example, ss 89C(1), 103(1)(g) and 106H(4) specify that the practitioner must be permitted to make submissions before the relevant decision is made. This is reinforced by s 80(11) which states that, "[p]rovision is made throughout the scheme for the person under review to make submissions before key decisions are made or final reports are given." The fact that s 86 of the HI Act does not expressly provide for a right to make submissions as to why the Chief Executive should not make a request to the Director, while not of itself determinative, strongly suggests that no obligation of procedural fairness is implied.

[79] Nor can the scope of any obligation to afford procedural fairness have been expanded by the statements made by the officers of the Agency that the director "would like to organise a teleconference with you to discuss the next steps in her review". There is no indication in these statements as to the purpose of the meeting.

[80] Finally, I do not accept that the statements in *Oreb* and *Dimian* to which I have referred are inapplicable in the current case. Although the practitioners under review in those cases had not expressed a willingness to enter into a s 92 agreement, the statements of principle in these cases are not limited to those factual circumstances but rather provide guidance to the approach in cases of this type.

[81] For these reasons I reject the application insofar as it relies on the first particular appended to ground 1.

[82] For completeness I should add that had the applicant been denied procedural fairness by not having a second opportunity to meet with the Director, I am not satisfied that the applicant has established that he would in any event have suffered any practical injustice. The request was couched tentatively as "perhaps" the Director "might" contact the applicant's solicitor after reading the submissions advanced. As I have noted, the applicant's submissions amounted to a rejection of a number of the conclusions expressed by the Director, and acceptance only of infelicities in record keeping. Having regard to the precondition in s 92(1)(a) that before entry into an agreement the practitioner must acknowledge inappropriate practice, I am not satisfied that the applicant has established that he has lost any opportunity to put any information or argument to the Director, or otherwise suffered any detriment that would amount to a practical injustice of the type contemplated in *Ex Parte Lam*, see, for instance, at [35]-[38] (Gleeson CJ); and [105] (McHugh and Gummow JJ).

…

[121] … Section 92(1) does, however, provide pre-conditions to the entry into an agreement. One is an acknowledgement from the person under review that the person engaged in inappropriate practice in connection with rendering services during the review period. Section 93 provides for the alternative of referral to a committee.

[122] As I have noted in Section 5 above, the Director is not obliged to offer an agreement under s 92; *Dimian*[164] at [33]; *Oreb*[165] at [126]. Nor, as I have found, did the Director owe a duty of procedural fairness to the applicant to discuss a possible s 92 agreement. Indeed, in the present case the applicant proffered a limited acknowledgement that he had engaged in inappropriate conduct. He did not acknowledge all of the allegations made. The preconditions for entry into an agreement were accordingly not met.

[123] Regardless of this point, there is nothing in the scheme of the Act to suggest that by referring the matter to the Committee the Director failed to have regard to a mandatory consideration or had regard to an irrelevant consideration; *BHL19*[166] at [133]. Nor may it otherwise be concluded that the outcome of the Director's decision was legally unreasonable. Whilst it may be that other decision makers in the same position might differ in their approach to negotiating agreements, it cannot be said that the decision not to do so falls outside the range of decision freedom afforded to the Director under the scheme of the Act; *BHL19* at [134]; *Li*[167] at [109] (Hayne, Kiefel and Bell JJ).

[124] Furthermore, I do not accept that the decision to refer the applicant to the committee was arbitrary or indicated a lack of regard for the purposes of s 89C(2) and s 92. No doubt one purpose of the scheme is to permit a practitioner and the Director to reach agreement as to specific action under s 92(2) and thereby, subject to ratification by the Determining Authority, circumvent a more protracted enquiry

[164] *Dimian v Health Insurance Commission* [2005] FCAFC 200
[165] *Oreb v Willcock* [2005] FCAFC 196; 146 FCR 237
[166] *BHL19 v Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs* [2020] FCAFC 94; 277 FCR 420
[167] *Minister for Immigration and Citizenship v Li* [2013] HCA 18; 249 CLR 332

> process. However, another purpose of the scheme, apparent from s 93 and the provisions concerning the conduct by a committee of its functions, is to enable the Director to engage the expertise of peers of a medical practitioner sitting in a committee to investigate further the conduct under review before recommending specific action. It was within the decisional freedom afforded to the Director to form the view that such a course was appropriate in the circumstances of the present case.

Subsection 92(4)(d) provides that if the Determining Authority ratifies an agreement, 'the Director must ensure that any action specified in the agreement under subsection (2) that is necessary to give effect to the agreement is taken.' The Director does this in respect of:

- Paragraph 92(2)(a), by sending a letter of reprimand; and
- Paragraphs 92(2)(b) to (g), by sending the agreement to the relevant area within the Department of Health responsible for implementing these actions.

The Director may enter into an agreement with a person under review that is a corporation. As section 92 requires the agreement to be in writing, it is necessary that the corporation's agreement be evidenced in that written agreement by the signatures of persons authorised under the Corporations Law to sign for the company. Subsection 127(1) , of the *Corporations Act 2001* provides:

> (1) A company may execute a document without using a common seal if the document is signed by:
> (a) 2 directors of the company; or
> (b) a director and a company secretary of the company; or
> (c) for a proprietary company that has a sole director—that director, if:
> (i) the director is also the sole company secretary; or
> (ii) the company does not have a company secretary.

92(6) — Director must not disclose communications to a panel member

In conducting negotiations for an agreement under section 92, the person under review must acknowledge that they engaged in inappropriate practice in connection with the provision of services. Consequently, a person under review might make certain acknowledgements when discussing the terms of a proposed agreement with the Director. It is sometimes suggested by lawyers representing persons under review that they might have a 'without prejudice' discussion with the Director in the course of such negotiations.

The 'without prejudice' privilege applies to negotiations that have the object of seeking to avoid litigation. It enables the parties to make statements that are not admissible in court.

That privilege cannot apply in the context of section 92 negotiations because the Director's power to enter into an agreement is statutory. The Director cannot ignore matters raised by a person under review when such matters are brought to the Director's attention and are relevant to the decision the Director might make in deciding whether to enter into an agreement or formulating the terms of such an agreement. The information and matters considered and taken into account by the Director should be discoverable in a judicial review application concerning such a decision.

Subsection 92(6), which provides that the Director is prevented from disclosing to a PSR panel member the content of any communications in relation to proposals for an agreement, gives the appropriate protection to the person under review should the negotiations fail and the matter be referred to a Committee. Consequently, there is no need for a 'without prejudice' privilege to apply to any discussions between the person under review and the Director.

93 Referral to a Committee

In deciding to make a referral to a Committee under section 93, the Director may rely on statistics that compare the person under review with all other practitioners of the same profession or specialty.

Tang v Holmes [1998] FCA 135 —

> It was contended that the statistics relied on by the Director are irrelevant because they fail to take into account the distinctions between the applicant's practice and that of other practitioners. In particular it was said that the statistics for all practitioners include a large number of part timers; they do not take account of practitioners who work seven days a week with virtually no holidays (as the applicant does); they do not provide a breakdown of services provided to particular ethnic and socio-economic groups (such as the applicant's exclusively Chinese patients); they provide no means to isolate the effect of hospital visits and medico-legal work which the applicant does not perform; and where there is a comparison between the applicant and busy full time practitioners, there is no "provision of the range which the comparison covers so as to determine whether or not [the applicant] is outside it".
>
> The question for the Director under s 93 is not whether the applicant has engaged in inappropriate practice, but whether the Director is satisfied that there are

insufficient grounds on which a Committee could reasonably find that the applicant has engaged in inappropriate practice. The Director's function is of a preliminary character designed to weed out cases in which there is no reasonable prospect of a finding of inappropriate practice, leaving for the Committees those in which there is a reasonable prospect of an affirmative finding. The function is to be understood in the light of the fact that, unlike a Committee, the Director lacks the power to require the provision of information and documents. The applicant may be able to persuade the Committee that his practice is so idiosyncratic, for the reasons he advances, that the statistics should be ignored. But in my view the statistics are relevant to the Director's function under s 93.

In *Artinian* a comparison of Dr Artinian's practice with that of other active general practitioners showed that he provided substantially more services in a year (23,706) than 99 per cent of all active general practitioners in Australia. The 99th percentile was 16,961. While general practitioners on average spent 39 hours per week in contact with patients (and worked 55 hours per week), Dr Artinian averaged 464 services per week with 70 hours of total patient contact per week, seeing an average of 6.5 patients per hour. It was contended for Dr Artinian that the Commission in referring his conduct to the Director, and the Director in acting under s 93, had taken into account irrelevant matters, namely Dr Artinian's statistical standing in comparison with other practitioners. Hill J rejected the contention. At 241-242 his Honour said:

> It seems to me almost unarguable that the commission was not entitled to take into account the statistical material in determining whether or not to refer Dr Artinian's conduct in connection with his rendering of services, to the director. The time spent by Dr Artinian, even if considered without reference to the time spent by other practitioners, would seem enough to raise questions for consideration. When, however, the time he spent is compared with time spent by other practitioners, the point is even more obvious. No doubt it is possible that there could be good explanations. But this is not to say that the statistical material would be irrelevant in considering the issue under s 86. …

There is absolutely no substance at all in the argument that reference cannot be made to the statistical material. Not only is that material relevant but it may also, in a particular case, be highly cogent of inappropriate conduct.

Although in the first of these paragraphs his Honour was dealing with the Commission rather than the Director, the argument that was rejected as having absolutely no substance was that neither the Commission nor the Director acting under s 93 was entitled to have regard to the statistics.

The Director may refer to a Committee services different from those investigated in the Director's review. Nevertheless, the person under review must have an opportunity, in responding to the section 89C report, to make submissions in relation to the services that might be referred to a Committee.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2020] FCA 386 —

> [41] NHDS did not contest the Director's submission [of written outline] that the effect of s 93(7B) and (7C) was that the services specified in a s 93 referral need not be the same services which were the subject of the Director's s 89C report and that additional services may be included. Page 3 of the Explanatory Memorandum to the related Bill to the 2002 Amendment Act which introduced those provisions provides some support for that view, whilst also drawing attention to the different position which exists under tier 3 (where the Committee is empowered to refer back to the Director a request to review the provision of services other than those services which were the subject of the s 93 referral, as to which see further [53] below).
>
> [42] Page 3 of the Explanatory Memorandum describes the main amendments as including the following (emphasis added):
>
> > replacing the current investigative referral process with a request from the Commission [now the Chief Executive Medicare] that the Director examine ***certain services*** rendered or initiated by a practitioner for which a Medicare benefit has been claimed (section 86). The purpose of the request is to initiate a process of further review and investigation into the conduct of the practitioner in connection with ***those services*** by the Director and, where the Director decides to make a referral to a PSR Committee, by that Committee. This process of investigation and inquiry can only examine ***the referred services during a specified period*** but is otherwise not limited in any way by the Commission's request or, where a referral has been made to a PSR Committee, by the Director's referral. In other words, both the Director and the PSR Committee may identify ***additional species of conduct arising from the referred services that may constitute inappropriate practice***. In addition, a Committee may refer back to the Director a request to review the provision of services, ***other than referred services*** during the specified period. [His Honour's emphasis]
> >
> > …
>
> [123] It was not legally unreasonable or irrational for the Director to switch the focus of her s 89C report (which relied partly on information relating to the 15 NHDS practitioners) to focus on 56 different NHDS practitioners in the s 93 referral (noting also that Medicare billing information in relation to these 56 practitioners was also taken into account by the Director). Although the evidence is scant, it appears that the reason for this switch of focus was because, when the s 93 referral decision was made, the Director had arrived at agreements under s 92 with 14 of those 15 practitioners, and the other was the subject of a separate referral to a Committee. The Director's subsequent focus on 56 other NHDS practitioners is appropriately understood as the selection by her of a sample of NHDS practitioners for review by the Committee in circumstances where the Director was satisfied, on the basis of all the information before her (including, but not limited to that specifically in relation to the other 15 NHDS practitioners) that NHDS practitioners generally may have engaged in inappropriate practice. But rather than refer all that conduct to the Committee, the Director chose a sample of 56 NHDS practitioners

> so as to limit the scope and burden of the referral. That is entirely reasonable and rational.

The Director does not need to decide that the person under review actually provided the services in question, it merely has to appear to the Director that the person under review may have engaged in inappropriate practice in providing the services. Whether the person under review provided the services is matter for investigation by the Committee.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [55] The Director's decision was conditioned upon what "appears" to her and upon her being "satisfied" as to a possibility. Provisions so cast leave no room for any litigation on the factual merits of the evaluation to which the s 82(1)(a) definition of "inappropriate practice" is directed: *Municipality of Bankstown v Fripp* [1919] HCA 41; (1919) 26 CLR 385, at 403, per Isaacs and Rich JJ. "Appears" and "satisfied" necessarily entail a particular state of mind being held. In this sense, subjectivity, as pleaded by Dr Karmakar, is present. However, the evidence, particularly her report, discloses that the end to which the Director turned her mind as to what "appears" to her or about which she was satisfied was the possibility that a committee established under Pt VAA could make a finding of "inappropriate practice", as defined. That is quite different to the "subjective comparison of [Dr Karmakar] with other (unnamed or unidentified) medical practitioners" as alleged by Dr Karmakar. The Director made no such comparison. The evidence of the decisions she made discloses that she turned her mind, as and when required, to the ordained subject of "inappropriate practice", as defined.

In order to make more certain the effect of *National Home Doctor Service Pty Ltd v Director of Professional Services Review* [2020] FCA 386 concerning the jurisdiction of the Director to make a referral, subsection 93(1A) was inserted[168] to provide as follows:

> (1A) This section applies if it appears to the Director that a person under review may have:
> (a) provided services during the review period; and
> (b) engaged in inappropriate practice in the provision of the services.

National Home Doctor Service Pty Ltd v Director of Professional Services Review [2020] FCA 386 —

> [164] NHDS contended that, having regard to the terms of s 93(1), it was a precondition to the Director's exercise of the power under that provision that the person under review is the person who provided the services specified in the referral. It emphasised that s 93(1) empowered the Director to set up a committee

[168] Schedule 1, item 19, *Health Legislation Amendment (Medicare Compliance and Other Measures) Act 2022*.

and make a referral "to investigate whether the person under review engaged in appropriate practice in providing the services specified in the referral" (emphasis added). It submitted that whether or not the person under review provided the services is not something which the Committee investigates; rather, its role is to investigate whether the provision of services was inappropriate practice. NHDS submitted that the "provides services precondition" was a jurisdictional fact which the Director had to determine and which the Court could determine for itself in a judicial review.

[165] NHDS submitted that it did not render or initiate the referred services; rather they were rendered by the 56 practitioners identified in the referral and the related s 93 report. NHDS emphasised that only practitioners may render services which attract Medicare benefits (see the definition of "service" in s 81(1), as well as the definition of "provides services" in s 81(2)).

[166] If it had been necessary to do so, I would have rejected NHDS's submissions on this matter for the following reasons.

[167] First, they are not supported by the text of s 93(1) (which is set out at [40] above). The power conferred upon the Director by that provision is a power to "make a referral... to investigate whether the person under review engaged in inappropriate practice in providing the services..." (emphasis added). I accept the Director's submission that the issue of whether the person under review provided the services specified in the referral is an aspect of the question that is referred for investigation to the Committee. It is not a jurisdictional fact in respect of the Director's power under that provision.

[168] Secondly, this view is supported by the surrounding context, with particular reference to the features of the PSR Scheme. The Director's s 93 referral power arises for determination prior to an investigation by the Committee, which investigation includes the provision of services by the person under review.

[169] Thirdly, I take into account the considerable inconvenience and disruption which would follow if the matter involved a jurisdictional fact. In particular, the person under review could delay and disrupt a statutory investigation at a relatively early stage of the review process, noting also that the issue would involve complex questions of both fact and law. These are the sorts of considerations which the Full Court had in mind when it made the observations that it did in *Grey* at [79].

[170] Fourthly, NHDS's position on this matter sits uncomfortably with the language of s 93(6)(a), which requires the Director to prepare a written report for the Committee, in respect of the services to which the referral relates, giving reasons why the Director "thinks" the person under review may have engaged in inappropriate practice in providing the services. The reference to "thinks" is scarcely consistent with the notion of the matter being a jurisdictional fact.

[171] For completeness, I should also say something briefly about NHDS's separate submission that it is a jurisdictional fact for the exercise of the Committee's powers that the person under review had provided the services specified in the referral. I accept the Director's submission that this matter is premature and should not be determined at this stage of the proceeding. The Committee is yet to exercise any

> power under Div 4. It is entirely unclear what attitude the Committee might adopt to this issue, if and when a valid referral is made to it.
>
> [172] As to NHDS's contention that it was a jurisdictional fact for the exercise of the Director's power to make a referral under s 93 that NHDS was the employer of the medical practitioners, I would have rejected that contention for similar reasons as those given above in respect of the "provides services precondition".
>
> [173] Insofar as NHDS contends that the issue of employment was also a jurisdictional fact for the exercise of the Committee's powers, I repeat and adopt what I said above in respect of the prematurity of that matter in circumstances where the Committee has yet to exercise any power.
>
> …
>
> [183] As to NHDS's claim that it was not open to the Director to conclude that there may be an employment relationship, I would have rejected that claim for the following reasons. First, having regard to the evidence which was before the Director (not including additional material which has been placed before the Court and which is not relevant for the purposes of this ground of review), there is no evidentiary basis for the claim. It was open to the Director to come to the tentative view which she did.
>
> [184] Secondly, I accept the Director's submission that the relevant question for her to determine under s 93 was not whether it was open on the material before her to find that the practitioners were employees. Rather, the relevant question for her was whether it was open for her to conclude on that material that they might be employees, or whether it might be open on material that might later be placed before the Committee for the Committee to form a final view on that issue.

In *Soryal v Director of Professional Services Review,* Collier J quoted with approval paragraphs [162] to [171] of the Judgment of Griffiths J in *National Home Doctor Service Pty Ltd v Director of Professional Services Review* [2020] FCA 386.

Soryal v Director of Professional Services Review [2023] FCA 326 —

> [73] Despite these observations being *obiter* only, his Honour's reasoning is persuasive. Further, it would seem that given the present tier of review of the applicant, it was sufficient for the purposes of the respondent's review that there was a basis for an appearance that the applicant had provided, rendered or initiated the services given that they were actually billed under his allocated Medicare Provider Number. It would be difficult to imagine a system whereby a holder of a Medicare Provider Number was absolved of all responsibility. I also note the respondent's submissions that matters concerning the legality and financial integrity of payments under the Medicare system have previously be held to fall within the definition of "inappropriate practice"; *Selia v Commonwealth of Australia* [2017] FCA 7.
>
> …

> [82] In addition, I note the comments produced in the Explanatory Memorandum for the Health Legislation (Professional Services Review) Amendment Bill 1993 (Cth) in relation to the definition of "inappropriate practice":
>
> > New Proposed Section 82 – Definitions of inappropriate practice
> >
> > Section 82 defines a new concept, to be known as "inappropriate practice" It encompasses the existing concepts of excessive rendering and excessive initiating but also introduces the concept of excessive prescribing. **In addition, it will allow a Committee to examine, where relevant, aspects of a practitioner's practice broader than purely the excessive servicing of patients. A Committee will have the capacity to consider the conduct of the person under review in his or her practice and determine whether that conduct is acceptable to the general body of his or her profession or speciality**.
> >
> > (emphasis added)
>
> [83] Finally, the applicant's submission that "Part VAA of the [HI Act] does not refer to [Medicare Provider Number]" is superfluous. Section 79A of the HI Act sets out the objective of the act as to "protect the integrity of the Commonwealth medicare benefits, dental benefits and pharmaceutical benefits programs. Items under the CDBS cannot be claimed without the provision of the relevant services, which could not be done without the applicant's Medicare Provider Number.

93(1) — The Director may set up a Committee and make a referral

A PSR Committee is not a corporation. It has no power to own property, employ staff, or enter into transactions. It has no legal personality.[169] Nevertheless, because it is established for a public purpose and is constituted by natural persons, namely a Chair and other members, it can be regarded as a 'Commonwealth officer' for the purposes of being a respondent to an action under section 75(v) of the *Constitution*.[170]

A consequence of lacking legal personality (other than being a 'Commonwealth officer' for the limited purpose of an action under s 75(v) of the *Constitution*) is that a Committee does not have constructive knowledge of any previous matters. Its functions and powers are limited to consideration of the particular case referred to it by the Director. However, Committee members bring with them, and are expected to apply, their expertise and experience.

In providing administrative support for Committees, the Professional Services Review Agency, keeps the records relating to their activities.

[169] *Church of Scientology v Woodward* [1982] HCA 78; (1982) 154 CLR 25 per Mason J (as he then was).
[170] *Re Minister for Immigration and Multicultural Affairs; Ex parte Epeabaka* [2001] HCA 23; 206 CLR 128 (per Gleeson CJ, McHugh, Gummow and Hayne JJ at para [19]).

The extent of the Committee's jurisdiction is determined by the services specified in the referral from the Director.

Health Insurance Commission v Grey [2002] FCAFC 130 —

> [188] … The terms of a referral, read in the context of any particulars contained in a notice of hearing, define the jurisdiction of the committee to inquire.

'the services specified in the referral'

In *Health Insurance Commission v Grey* [2002] FCAFC 130, it was argued that the Committee could not proceed to make findings in respect of the services rendered by Dr Grey because, even though Dr Grey had claimed the particular MBS item for those services that was the subject of the referral, the Committee had found, in fact, that Dr Grey had not met the requirements for that item number and so had not rendered the services that had been referred. The Court rejected that argument, and held that the Committee did not lose its jurisdiction to make findings in relation to those services merely because Dr Grey had misdescribed the services in claiming a medicare benefit.

Health Insurance Commission v Grey [2002] FCAFC 130 —

> [189] … It should not be forgotten that Dr Grey's claim, upheld by the primary Judge, was that the Committee had exceeded its jurisdiction when it continued its inquiry (originally valid as we have held) in circumstances where it emerged, in the course of the inquiry, that information previously provided to the Commission was incorrect in a material respect, viz. Dr Grey's description of the appropriate "Levels". As has been said, it may give rise to an estoppel against Dr Grey, or this may be a case of an impermissible attempt by Dr Grey to take advantage of his own default. But, on any analysis, the emergence of the truth, of a matter very much bound up, or interrelated, with the subject of the Referral could hardly operate to place that field of inquiry beyond the limits of the Committee's purview. Put differently, given the obvious importance in the legislative scheme of correct item description, it is impossible that an inquiry in that area could be beyond power. True, concerns about procedural fairness may conceivably arise, but that is not the present question. No report has yet been made by the Committee and Dr Grey has already been informed of the precise matters raised for his response.
>
> [190] In our opinion then, the Committee was not acting beyond its Referral when it inquired into the area of item misdescription. In other words, in our view, the Committee was entitled, in the course of its inquiry and in its draft report, to have regard to the components of the item described in the Medical Benefits Scheme.

A note inserted[171] at the end of subsection 93(1) makes clear that a Committee has jurisdiction to investigate the provision of services even if it turns out that the person under review did not actually provide them. The Note to the subsection provides as follows:

> Investigating whether the person under review engaged in inappropriate practice in providing the services may include investigating whether the services were provided by the person or another person.

93(6) — the Director's report to the Committee

While subsection 93(6) provides that the Director must attach the report to the referral, they need not be separate documents. What the provision requires is that the relevant information in both documents be provided together.

Pradhan v Holmes [2001] FCA 1560 —

> [89] … Giving a purposive construction to this provision, I do not consider that the attached Director's report should be considered any less a part of the adjudicative referral than is the Commission's s 86(4)(b) statement of reasons part of the investigative referral. Both the report and the statement of reasons necessarily require the identification of the conduct that may have constituted engaging in inappropriate practice. Both are to be provided to the person under review in informing him or her of the respective referral. Both in a practical sense are part of the composite of documentation that properly can be described as the investigative referral and the adjudicative referral respectively. Insofar as the language of s 93(6) is concerned, the use of the words "attached to" does not require generic differentiation between the referral and the report. It merely ensures that the information in the report is part of the material provided to the person under review. I do not consider that Parliament intended that the differing formulae of s 86(4)(b) ("[the referral must] ... set out the reasons") and s 93(6) ("the Director must ... attach the report to") were intended to have the dramatically different legal consequence as to what respectively constitutes the referral. Unsurprisingly, the Explanatory Memorandum for the proposed 1999 amendments described s 93(6) as providing that "an adjudicative referral ... must include a written report ..." (emphasis added). I would interpret "attach to" in this setting as meaning "attach to so as to become part of".

94 Director taken to have made a decision after 12 months

Section 94 has the effect that, unless a review is suspended and the Director has determined, in writing, that the period of 12 months referred to in subsection 94(1) is extended by a specified period (that is not longer than the period of suspension),

[171] Schedule 1, item 20, *Health Legislation Amendment (Medicare Compliance and Other Measures) Act 2022*.

the Director is deemed to have taken a decision at the end of that period to take no further action in relation to the review if the Director has not made a decision under section 91 to take no further action in relation to the review, or entered into an agreement with the person under section 92, or referred the provision of services to a Committee. The Federal Court has described this as 'the temporal guillotine of the Scheme': *Amir v Director of Professional Services Review* [2022] FCAFC 44 at [66].

The 12 month period commences after the Director decides to review the provision of services by the person under review.

Amir v Director of Professional Services Review [2022] FCAFC 44 —

> [64] The submissions advanced on behalf of Dr Amir fall into two parts. First, Dr Amir relies on the ordinary meaning of the word "decide" to seek to demonstrate that the primary judge erred in construing the relevant provisions. Secondly, Dr Amir contends that the primary judge erred in importing a requirement that a decision under s 88A(1) must be irrevocable when neither the Act nor the ordinary meaning of decision includes a requirement of irrevocability.
>
> [65] As to the first, the construction for which Dr Amir contends attaches a meaning to "decision" that fixes on the Director's subjective state of mind, which Dr Amir submits is consistent, with the ordinary usage of the word. On the facts, Dr Amir contends that the 4 April 2019 decision made by the Director was communicated by the Director to her staff. Dr Amir relies on the communication not as a necessary requirement of the making of the decision but as objective evidence from which the decision in fact having been made may be inferred. Dr Amir submits that the Director's decision communicated in the 4 April 2019 email was clear and unequivocal, namely "I have reviewed the referral and decided to conduct a review". Dr Amir submits that many decisions in the ordinary use of that word are not communicated and are revocable. Dr Amir gives the example that one may decide to go the shops and then change one's mind.
>
> [66] Dr Amir's appeal to the broad ordinary meaning of the term decision must be rejected. The ordinary meaning must necessarily yield to the relevant statutory context. In the present circumstances, the relevant decision functions within the statutory scheme as the trigger to start time running on the finite period within which the Director can perform her function in the first part of the review process. To seek to anchor the temporal guillotine of the Scheme, which carries real legal consequences, to the subjective state of mind of the particular office bearer without any requirement for a committed demonstrable manifestation of that state of mind is to divorce impermissibly the meaning of the term decision from its statutory context. For the purpose of s 88A(1), what is required, having regard to the statutory scheme, is a decision that constitutes, or at least purports to constitute, a performance of the decision-making function conferred by s 88A(1). The primary judge was correct to find that the words "decide" and "decision" in s 88A(1) and s 94(1) do not focus on the Director's mental state but rather on the external manifestation of that mental state in an irrevocable, or firm, way.

[67] The second aspect of Dr Amir's attack on the primary judge's construction of ss 88A and 94 is premised upon the contention that the primary judge construed a decision under s 88A as necessarily being irrevocable as a matter of law. The case below did not concern whether a decision under s 88A(1) could be revoked within the one-month time period specified by s 88A(3) and re-decided before that period expired. Dr Amir's case below was that the relevant and operative decision for the purpose of triggering the commencement of time running for s 94(1) was made on 4 April 2019. On appeal, Dr Amir submits that the primary judge erred in finding that the decision must be irrevocable because any decision made under s 88A(1) could always be revoked within the one month period specified by s 88A(3). Dr Amir submitted that there is nothing in the Act which expressly requires a "decision" to be irrevocable. Further, Dr Amir argues there are strong textual indictors that a "decision" does not have to have the quality of being irrevocable as a matter of law. It is not necessary to rehearse Dr Amir's submissions in respect of the textual indicators relied upon in this respect because the underlying premise upon which he relies is flawed.

[68] Read in context, the primary judge's repeated use of the word "irrevocable" serves to emphasise that the manifestation of the Director's "decision" must have the requisite character of conclusiveness, commitment or finality. The converse is that the "decision" must not be tentative, preliminary or subject to change. The Director must have decided, or be committed to a course, and not be in a state of flux or tentativeness about that course. The primary judge's use of the descriptor "irrevocable" underscored that the decision required by s 88A must be of a firm, committed or final character: see J [42], [43], [44], [45] [47], [51], [53], [55].

[69] The primary judge's repeated references to "irrevocable" are used in connection with "commitment" (see J [40], [42], [43], [44], [45]) or with the clarity with which the Director's "state of mind" is manifested in the communication of the decision (see J [51], [53]). The reference at J [55] to "irrevocable" highlights that the primary judge's use of this word denotes that the decision is firm, that is, not subject to change. The primary judge considered Dr Amir's contention that the Director in fact decided to undertake the review on 4 April 2019 and concluded that even if that was so, the Director's email of 16 April 2019 remains to the effect that she also decided "today" (that is, on 16 April 2019) to undertake the review (at J [55]):

> The result is that within the prescribed time period of one month, the Director made two decisions to the same effect. Of those two decisions, only one was irrevocable and communicated to Dr Amir, the decision of 16 April 2019. As such, it is the relevant decision for the purposes of the statutory provisions.

[70] The submissions advanced on behalf of Dr Amir are premised on a contortion of the clear and plain reasoning of the primary judge and are rejected. Ground 1 must fail.

[71] By Ground 2, Dr Amir contends that the primary judge applied the wrong test or asked the wrong question when concluding that the Director did not "in fact" decide to review the Appellant's provision of services on 4 April 2019 and that her mental processes continued until 16 April 2019. Ground 2 depends on Dr Amir succeeding on his argument in relation to the construction of s 88A(1). Ground 2 therefore falls with Ground 1.

A period of suspension of the 12 month period can occur if a person has failed to comply with a notice to produce issued under section 89B of the Act, or if an injunction or other court order has had effect in relation to the review.

Once one of the three events (dismissal under section 91, agreement under section 92 or referral to a Committee under section 93) has occurred, section 94 has no further function.

If a Court subsequently finds that an action of the Director purportedly taken under section 92 or 93 within the 12 month period was for some reason invalid, it is likely that section 94 would no longer operate because the relevant action had, in fact, been taken by the Director within the 12 month period.

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> **(i) Text**
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> [41] There is nothing in the express text in s 94(1)(b) which suggests that a referral for the purposes of that provision must be one which is valid in law, rather than a referral which has been made in actual fact, even if it is subsequently set aside on judicial review. As the Director pointed out, it is well-established that statutes do not invariably speak only to valid conduct (see, for example, *Plaintiff M174/2016 v Minister for Immigration and Border Protection* [2018] HCA 16; 264 CLR 217 at [39]- [52] per Gageler, Keane and Nettle JJ).
>
> [42] Secondly, it is significant that the subject of s 94(1)(b)(iii) is the taking of an actual step, namely the referral of the provision of services to a Committee. Contrary to NHDS's submission, I do not consider that much assistance is gained from the definition of "referral" in s 81. The term is defined there as meaning "a referral to a Committee under section 93". Section 93 deals with referrals to Committees. It provides that a referral involves setting up a Committee and making a referral to a Committee to investigate specified services. NHDS submitted that without the existence of a valid referral which establishes a Committee, there can be no "referral" as defined by s 81. There are at least two difficulties with that submission. The first is that a valid referral of itself does not establish a Committee. Rather, a Committee is a body which is set up by the Director under s 93(1) and to which the Director is empowered to make a referral under that provision. Thus a referral does not establish a Committee; instead a Committee is established by the Director exercising his or her power under s 93(1). Secondly, the submission simply begs the central question as to whether a "referral" means a referral which has been made as a matter of fact, as opposed to a referral which has been made in fact and is also valid in law.
>
> [43] Moreover, merely because a referral must be "to" a Committee, as specified in both ss 93(1) and 94(1)(b)(iii), does not assist NHDS's construction. It simply

indicates that there must actually be a decision in fact to refer the review of the provision of services to a Committee.

(ii) Context

[44] The statutory predecessor of s 94 is s 93C of the HI Act, which was inserted by the *Health Insurance Amendment (Professional Review) Act 1999* (Cth). In the second reading speech to the 1999 Bill, the Minister made the following general observations regarding the amendments:

> The changes contained in this bill have come in the wake of criticism of some aspects from the Federal Court. A review was undertaken by a committee chaired by the Australian Medical Association. The review confirmed the profession's and the government's continued support for a peer review based scheme. The amendments to the Act will enhance the administration of the scheme to ensure that the process is fairer and more transparent...

[45] NHDS submitted that the concerns underlying the insertion of time limits in the scheme appeared to relate to delays by the Director, as opposed to any delays created by persons under review. So much may be accepted. The legislation included several provisions which impose time limits within which particular steps had to be taken with the evident purpose of avoiding unreasonable delay. Thus, for example:

(a) if the Chief Executive Medicare requests the Director to review the provision of services during the period specified in the request, the period must fall within the 2 year period immediately preceding that request (s 86(2));

(b) where the Director has received a request from the Chief Executive Medicare to review the provision of services, the Director must within 1 month after receiving the request decide whether or not to undertake the review (s 88A(1)), and if no such decision is made within that period, the Director is taken to have decided, at the end of that 1 month period, to undertake the review (s 88A(3));

(c) following a review, the Director must either make a decision under s 91 to take no further action in relation to the review or, alternatively, provide the person under review with a written report which sets out the Director's reasons why a decision to take no further action has been taken and the person under review has 1 month to make written submissions to the Director as to the action which the Director should now take (s 89C(1)). Where such submissions are received, the Director must, as soon as practicable thereafter, decide which of the three options specified in s 89C(2) will be taken (s 89C(2));

(d) if the Director decides under s 91 to take no further action in relation to a review, written notice of that decision and a written report setting out the grounds for the decision must be given by the Director to the Chief Executive Medicare and the person under review within 7 days of that decision being made (s 91(2)); and

(e) time limits are also imposed upon other relevant decision-makers under the legislative scheme, including a duty on the Committee to whom a referral has been made to give a final report to the Determining Authority generally within 6 months

after the day on which the referral was received from the Director, subject to some express exceptions (s 106G(2)).

[46] It may be accepted that the primary purpose of such provisions is to encourage decision-makers, including the Director, to avoid unreasonable or unnecessary delays. The extent to which that purpose provides meaningful assistance in resolving the issue of statutory construction here may be somewhat limited. That is because, as pointed out by Mr Kennett SC (who appeared for the Director together with Mr Hume), the issue remains one of determining the extent to which the evident legislative purpose has been implemented with reference to the text. As Gleeson CJ observed in *Carr v State of Western Australia* [2007] HCA 47; 232 CLR 138 at [5], a purposive approach may be of little assistance where a statutory provision strikes a balance between competing interests and there is uncertainty as to how far the statutory provisions go in seeking to achieve the underlying purpose.

[47] Separately from that consideration, with specific reference to the proper construction of s 94 of the HI Act, there is nothing in the second reading speech or any other relevant extrinsic materials which indicates that the Parliament had in mind that referrals had to be legally valid, as opposed to simply having been made as a matter of fact.

[48] Fourthly, contrary to NHDS's submission, I do not consider that the task of construction is assisted by contrasting the use of the word "decision" in s 94(1)(b)(i) and the word "referred" in s 94(1)(b)(iii). The former usage appears to refer to a decision in fact, but that does not mean that the latter usage refers to a legally valid referral. Moreover, as the Director pointed out, in circumstances where there are three different steps identified in s 94(1)(b), any one of which has the effect of engaging the operation of the provision at the foot of s 94(1), it is most unlikely that the Parliament would intend one of those steps to pick up decisions in fact, while another operates only to pick up a valid decision. In oral address, Mr Kirk SC who appeared for NHDS, submitted that the term "decision" in s 94(1)(b)(i) should be construed as meaning a "valid decision". It is difficult to accept that submission, in circumstances where, as previously mentioned, the word "decision" is generally to be given its ordinary meaning as a decision which has been made in fact. I am not persuaded by NHDS's submission that that term should be given a different meaning when it appears in s 94(1)(b)(i).

[49] Fifthly, I respectfully consider that NHDS has overstated the significance of s 89C in construing s 94. Necessarily, of course, the task of statutory construction needs to take into account all relevant provisions of the HI Act and assume that, at least prima facie, those provisions are intended to give effect to harmonious goals. Section 89C is set out at [16] above. In short, NHDS's submission was that unless the term "referred" in s 94(1)(b)(iii) is read as "referred validly in law" and not merely as "referred in fact", the obligation imposed upon the Director to make a decision "as soon as practicable" as to which of the three specified options will be selected will not apply. NHDS submitted that this would seriously undermine the purpose of the 1999 amendments, of which s 89C is one, which was to incentivise the Director to act expeditiously.

[50] There are several reasons why I consider that this submission has little force. The submission is directed very much to the particular factual circumstances which

have occurred here and, in particular, is focused on the orders which were made in the First NHDS Judgment. NHDS's point is that if the Director's review remains on foot notwithstanding those orders there is no statutory timeframe for the Director to choose between the three options. There is a well-recognised danger, however, in seeking to construe a statutory provision with reference to a particular set of facts and not more broadly so as to accommodate a wider range of factual circumstances in which the provision operates. I respectfully agree with the following observations of Flick J in *DLJ18 v Minister for Home Affairs* [2019] FCAFC 236 at [6]:

> Any process of statutory construction is a process which stands separate and apart from the application of the statutory scheme to the facts of an individual case. It is only after the relevant statutory regime has been properly construed that it can thereafter be applied to the facts and circumstances of a particular case – including the facts in issue and the submissions advanced for consideration.

[51] The Full Court expressed the point in slightly different terms in *VOAW v Minister for Immigration & Multicultural & Indigenous Affairs* [2003] FCAFC 251 at [10], where Ryan, Lindgren and Sundberg JJ described the submissions made on the appeal on relevant issues of statutory construction as:

> ... [going] beyond a process of statutory construction. They require a remodelling of the legislation to deal with the specific fact situation thrown up by the appellant's case...

[52] In any event, I consider that NHDS has overstated the effect of the Court's orders in the First NHDS Judgment. Those orders set aside both the Director's decision to set up and refer to the PSR Committee the matters set out in Item 2 of the referral, as well as the Referral itself. As Mr Kennett SC pointed out, the orders did not go so far as to state, explicitly or implicitly, that the Director has not made a decision in fact to do the things the subject of those orders.

[53] Finally, acceptance of the Director's construction of s 94 does not mean that the Director has unlimited time to conduct the resumed review. Assuming (without deciding) that s 89C(2) has no application because of the events that have occurred, the resumed review would need to be conducted within a reasonable time, consistently with the common law principles which require statutory powers to be exercised within a reasonable time (see, for example, *Thornton v Repatriation Commission* [1981] FCA 71; (1981) 35 ALR 485 and *Plaintiff S297/2013 v Minister for Immigration and Border Protection* [2014] HCA 24; 255 CLR 179 at [37] per Crennan, Bell, Gageler and Keane JJ). For this reason, I do not accept NHDS's submission that the effect of accepting the Director's preferred construction of s 94 is to create a "dead zone" in respect of the timeframe for the conduct of the resumed review.

[54] It should be made clear, however, that I accept the Director's submission that it is unnecessary to express a final view in this proceeding as to the proper construction of s 89C.

[55] Sixthly, I accept the Director's submission that s 94(1) contains a "deeming provision" of a kind which is to be construed no more broadly than that which is

required to achieve its purpose (as suggested, for example, by Gageler J in *Wellington Capital Ltd v Australian Securities Investment Commission* [2014] HCA 43; 254 CLR 288 at [51]). His Honour's comments there were addressed to what was described as a "legal fiction". His Honour said that ordinarily "a legal fiction is not to be construed beyond that required to achieve the object of its incorporation". The importance of considering the purpose for which a statutory fiction is created was emphasised by Griffith CJ in *Muller v Dalgety & Co Ltd* [1909] HCA 67; 9 CLR 693 at 696. A distinction is to be drawn between two different types of "deeming provisions" as described by Windeyer J in *Hunter Douglas Australia Pty Ltd v Perma Blinds* [1970] HCA 63; 122 CLR 49 at 65. Some deeming provisions create a statutory fiction in the sense that the meaning of a concept is extended artificially to include something which would not otherwise be included in the concept. That is to be distinguished from a deeming provision which simply operates as a source of designation and does not involve any extension of meaning of the relevant concept. An example of that kind of deeming provision was identified by Windeyer J in *Hunter Douglas*, when he stated that a provision in the *Trade Marks Act 1955* (Cth) which provided that "... a trade mark shall be registered as of the date of the lodging of the application for registration, and that date shall be deemed... to be the date of registration" did not create a fictional date of registration, but rather did no more than designate what the date should be. The phrase at the foot of s 94(1) whereby the Director "is taken to have made a decision" at the end of the 12 month period is properly to be viewed as a statutory fiction because it operates to deem a decision to have been made at a point in time when no such decision was in fact made.

(iii) Purpose

[56] The parties were agreed that the evident purpose of s 94(1) is to encourage the Director, having decided to undertake a review, not to be dilatory in taking action of the kind referred to in s 94(1)(b). The Director is encouraged to act with all appropriate speed by s 94(1) providing that, if none of the three specified actions or steps in s 94(1)(b) has been taken at the end of the relevant 12 months period, the matter is removed from the Director's hands altogether. This is because it is deemed that a decision is made at the end of the 12 month period to take no further action in relation to the review.

[57] I accept the Director's contention that, accepting that this is the purpose of s 94(1), NHDS's preferred construction does not advance that purpose. That is because the purpose is sufficiently served by construing the provision as meaning that the Director must in fact make a decision within the 12 month period to avoid the future conduct of the matter being taken out of the Director's hands.

[58] Reference has been made above to other provisions in the HI Act which reinforce the fact that the evident purpose of s 94(1) is as described above. In addition to the examples set out above, the legislation contemplates the possibility that the conduct of a review may also be suspended because of events which are beyond the Director's control, which serves to underline the statutory purpose. For example, a review may be suspended under s 89A(2)(b) if there is material before the Director which indicates that the person under review may have committed a relevant criminal offence or civil contravention. A second situation where the Director is empowered to extend the 12 month period is where a review is

suspended because of an injunction or other court order (see s 94(2)(b)). It is worth emphasising that this provision had no application in the circumstances here because the restraining order made by the Court on 1 October 2019 did not have the effect of suspending the Director's review simply because that review had ended when the Director made the Referral decision. A third situation in which the Director may make a written determination to extend the 12 month period referred to in s 94(1)(b) is where a person fails to comply with the requirements of a notice given by the Director under s 89B(2) to produce documents which are relevant to a review. Section 94(2) empowers the Director to make a written determination that the period of 12 months referred to in s 94(1) is extended for no longer than the period for which a review is suspended.

[59] Finally, it is desirable to say something briefly about the question whether s 94 is distinguishable from s 500(6L) of the *Migration Act 1958* (Cth) (Migration Act), a matter which was the subject of detailed submissions by both parties. It should be emphasised at the outset, however, that there are well-known dangers and limitations in relying upon the construction of a similar phrase in another statutory context. As McHugh, Gummow and Heydon JJ stated in *McNamara (McGrath) v Consumer Trader and Tenancy Tribunal* [2005] HCA 55; 221 CLR 646 at [40]:

> ... It would be an error to treat what was said in construing one statute as necessarily controlling the construction of another; the judicial task in statutory construction differs from that in distilling the common law from past decisions [49].

Footnote [49] refers to *Ogden Industries Pty Ltd v Lucas* [1970] AC 113 at 127 (also reported at [1968] UKPCHCA 1; [1968] 118 CLR 32); and *Brennan v Comcare* [1994] FCA 360; 50 FCR 555 at 572.

[60] Section 500(6L) of the Migration Act relevantly provides:

> 500 Review of decision
> ...
> (6L) If:
> (a) an application is made to the Tribunal for a review of a decision under section 501 of this Act or a decision under subsection 501CA(4) of this Act not to revoke a decision to cancel a visa; and
> ...
> (c) the Tribunal has not made a decision under section 42A, 42B, 42C or 43 of the Administrative Appeals Tribunal Act 1975 in relation to the decision under review within the period of 84 days after the day on which the person was notified of the decision under review in accordance with subsection 501G(1);
> the Tribunal is taken, at the end of that period, to have made a decision under section 43 of the Administrative Appeals Tribunal Act 1975 to affirm the decision under review.

[61] Section 500(6L) has been construed as meaning that the provision has no further application in circumstances where a decision of the AAT has been quashed, even where the application for review is subsequently reinstated under s 42A(9) of the Migration Act (see *Somba v Minister for Home Affairs* [2019] FCAFC 150 at

> [38]; *Khalil v Minister for Home Affairs* [2019] FCAFC 151 at [63]- [64] and *Ikupu* at [2]-[7] per Jagot J).
>
> [62] The Director acknowledged that there are differences between s 500(6L) and s 94(1), including the different legislative contexts in which the provisions appear, and the different legislative policies underlying the provisions. In *Somba*, the policy underlying the time limit in s 500(6L) was said to be to prevent applicants from manipulating the review system in an attempt to delay deportation. The policy underlying s 94(1) is quite different (see [46] above). Moreover, although the term "decision" appears several times in s 94, including in s 94(1)(b)(i), it is notable that the two matters referred to in s 94(1)(b)(ii) and (iii) which also have the potential to trigger the deemed making of a decision to take no further action in relation to the review do not involve any express decision. One relates to the entry into an agreement while the other relates to referring services to a Committee. The jurisprudence concerning the meaning of the word "decision" in legislation such as the *Administrative Appeals Tribunal Act 1975* (Cth) (including the Full Court's decision in *Collector of Customs (NSW) v Brian Lawlor Automotive Pty Ltd* [1979] FCA 37; 41 FLR 338) has little, if any, relevance in this particular statutory context.
>
> [63] The same can be said regarding the construction of "decision" in *Plaintiff S157/2002 v Commonwealth* [2003] HCA 2; 211 CLR 476 where the constitutional underpinnings of judicial review by the High Court were prominent. It would be a strange outcome if, having regard to that jurisprudence, the word "decision" was construed in s 94(1)(b)(i) as meaning a decision which is valid in law, while s 94(1)(b)(ii) and (iii) merely referred to the fact of entering into an agreement or referring the provision of services to a Committee respectively.
>
> [64] In my view, these matters provide a sufficient basis for distinguishing between s 94(1) of the HI Act and s 500(6L) of the Migration Act. In expressing that view, I do not mean to suggest that comparing these two statutory provisions, which appear in very different statutory contexts, provides any meaningful assistance to the proper construction of s 94(1). The construction of that provision which I favour has nothing to do with the way in which Courts have construed s 500(6L).

The result might be different if the action were declared invalid because the Director had not been validly appointed, as no relevant action could be said to have been taken by a person who was, in fact, the Director: *Kutlu v Director of Professional Services Review* [2011] FCAFC 94.

> ***Kutlu v Director of Professional Services Review*** [2011] FCAFC 94 (per Rares and Katzmann JJ) —
>
> [35] In addition, the Committees on which the persons whose appointments are impugned served were not capable of exercising any functions or powers under the Act. That latter consequence also arises because none of the five medical practitioner applicants had given consent under s 96A for the Committees to proceed when one or more of their three members had not been validly appointed under ss 84(3) or 85(3): cf. *Tu* 57 NSWLR at 386 [21]. As Fullagar J pointed out in *Australian Communist Party v The Commonwealth* [1951] HCA 5; (1951) 83 CLR

> 1 at 258 a stream cannot rise higher than its source. Persons cannot exercise the powers of a Committee under the Act unless each of the members of that body, in fact, is and continues to be validly appointed.

While section 94 would no longer operate if the relevant action had, in fact, been taken by the Director within the 12 month period, there is an implied obligation on the Director to act within a reasonable time. A failure to act within a reasonable time is not a jurisdictional error such that it would render a subsequent decision invalid, but a failure to act within a reasonable time would be a basis for a person under review seeking an order of the Court in the nature of mandamus to require the Director to act. A significant delay might, in some circumstances, lead to the Director deciding that an investigation would be impossible, and dismiss the review under paragraph 91(1)(b).

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> [70] My reasons for concluding that breach of the Director's obligation to make a decision within a reasonable time does not result in a loss of jurisdiction under s 93(1) are as follows.
>
> [71] As the parties agreed, the issue falls to be determined with reference to ordinary principles of statutory construction, which requires appropriate consideration to be given to the text, context and purpose of the relevant statutory provisions.
>
> [72] Applying that approach, I make the following findings, which largely accord with the Director's submissions:
>
> (a) Nothing in the text of the Act explicitly stipulates that a referral decision must, on pain of invalidity, be made within a reasonable time. Rather, the critical question is whether the implied requirement for the Director to make a decision under s 93 within a reasonable period of time is accompanied by an additional statutory implication that the Director loses jurisdiction to make such a decision after a reasonable time has lapsed.
>
> (b) The absence of express text to that effect contrasts with the express provisions of the Act stipulating specific timeframes (e.g. one month, 12 months), following expiry of which statutory consequences follow: see, for example, ss 86(2), 88A(3), 94(1) and 106R(1) and (2).
>
> (c) I consider that there is no warrant to imply into the Act a condition to the effect that, upon the expiry of a reasonable time, jurisdiction to refer under s 93(1) is lost. Such an implication cannot be justified where the Parliament has chosen expressly to regulate the circumstances in which jurisdiction is lost by reason of delay in this heavily regulated statutory scheme, which includes not only s 94(1) but also other express provisions which make clear whether non-compliance with a time requirement produces invalidity (see, for example, ss 106G(5) and 106TA(2)). The applicant does not suggest that the express circumstances in s 94 apply here. I

accept the Director's submissions that the applicant's case is undermined by s 94(1), not assisted by it.

(d) I also accept the Director's submission that an improbable consequence of the applicant's proposition is that she could lose jurisdiction because, although the express 12 month timeframe in s 94(1) was not reached, a "reasonable time" had nevertheless expired. Such an unlikely outcome could scarcely have been intended. In its outline of written submissions in chief, the applicant contended that the outer boundary for a reasonable time in the circumstance of this case is 12 months from the date of the resumption of the review (see [47]). Accordingly, the applicant seemed to accept that, depending upon the facts and circumstances of a particular case, the "reasonable time" might be a period less than that outer boundary. This serves to highlight the force of the Director's submission that jurisdiction to make a referral is not lost simply because a "reasonable time" has lapsed. I do not accept that submission.

(e) Nor is there room for such an implication to be drawn in the face of the scheme of Div 3A of Pt 7AA, which allows for only three outcomes following a review. First, the Director may decide to take no further action under s 91, if satisfied of the matters set out in that section. (The Director may also be deemed to have made such a decision by force of s 94, but the *Second NHDS Judgment* [*National Home Doctor Service Pty Ltd v Director of Professional Services Review* [2020] FCA 1016] establishes that that provision does not apply here). Secondly, the Director may enter into an agreement with the person under review, of the kind referred to in s 92 (albeit that is the end of the matter only if the agreement is ratified (s 92A), and s 92 has no operation here because it applies only where the person under review is a "practitioner"). Thirdly, the Director may make a referral under s 93. I accept the Director's submission that the review cannot be left unresolved. The review can result in no further action being taken only if the Director decides (or is deemed to decide) upon that course in accordance with s 91.

(f) I accept the Director's submission that the statutory scheme here is quite different from the scheme described in *Calwell* at 573-574, where an officer was empowered to do something of his or her own motion upon the occurrence of some event (i.e. without a request or application), and the position may be that that thing can only be done within a reasonable time. The statutory regime here requires the Director to decide, one way or another, on a matter raised before her. Similarly, in *Plaintiff S297/2013 v Minister for Immigration and Border Protection* [2014] HCA 24; 255 CLR 179, the statutory process of decision-making was enlivened by the fact that a person had made a visa application. Here, the decision-making processes required of the Director are triggered by a request made by the Chief Executive Medicare. In such cases, I consider that the obligation to decide within a reasonable time is capable of being enforced by mandamus or an injunction. It is not to the point that NHDS itself had no interest in seeking any such relief in the present circumstances. It is inapt to describe the result of the Director's construction as leaving the timing of a referral under s 93 as entirely at the Director's discretion. The issue is one of statutory construction, which should not be driven by the facts and circumstances of any particular case, as emphasised in the *Second NHDS Judgment* at [50]. Here, outside the circumstances that the Parliament has expressly covered in s 94, I accept the Director's submission that there is no sensible reason

to infer a legislative intention that delay would dictate the substantive outcome of the review (by making s 93 unavailable).

(g) Nothing in the extrinsic materials indicates any contemplation by the Parliament that, upon expiry of a reasonable time, the Director would lose jurisdiction to make a referral decision.

(h) It may be accepted that the task of determining whether or not there should be implied into this statutory regime a condition to the effect that jurisdiction to make a decision under s 93 is lost where a reasonable time has passed necessarily requires consideration of all relevant provisions in the statutory scheme. However, I consider that the applicant has overstated the significance of statutory provisions whose purpose is to protect the interests of persons such as itself who are regulated by the statutory scheme. True it is that those provisions are not irrelevant to the task, but they should not be overstated. In particular, it is notable that the express object of Pt VAA of the Act, as stated in s 79A, focuses upon protecting the Commonwealth and the community from misuse of the Medicare scheme, as opposed to giving primacy to protecting the rights and interests of practitioners and others who benefit professionally from the Medicare scheme.

(i) Nor is there any reason of statutory purpose why the suggested implication should be made. It can be accepted that (as with most statutory schemes involving inquiry and decision-making) it is good policy to make decisions as soon as practicable. To make that observation does not, however, indicate whether there is also a statutory purpose that decisions not made within that time are a priori invalid. As stated in the *Second NHDS Judgment* at [46], there is always a question as to how far the Parliament has chosen to go in pursuing an identified purpose. I accept the Director's submission that the policy that decisions be made within a reasonable is sufficiently achieved by the power of the Director to take into account delay as a discretionary reason not to refer, and the potential for a person under review to obtain injunctive relief or mandamus to require the Director to fulfil any duty she has to act expeditiously (see *Project Blue Sky Inc v Australian Broadcasting Authority* [1998] HCA 28; 194 CLR 355 at [100] per McHugh, Gummow, Kirby and Hayne JJ). The potential availability of those remedies to compel the Director to make a decision within a reasonable time is inconsistent with the applicant's contention that the implied time limit must have a "hard edge" because otherwise the timing of a referral under s 93 would be left entirely to the discretion of the Director.

(j) I also accept the Director's contention that the applicant, at least in its written submissions, has elided two quite distinct legal propositions. At [30] of its written submissions in chief, the applicant suggested that the issue of "reasonable time" is an objective fact, presumably akin to a jurisdictional fact. However, at [32]-[33] of that outline, it introduced the quite distinct area of principle relating to the exercise of statutory discretionary powers. The legal and practical distinction between the two principles is reflected in the significance of the material before the decision-maker (which is generally irrelevant in the former case, and highly relevant in the latter case) and the standard of review (in the former, the matter is generally for the Court, whereas in the latter, matters are generally for the decision-maker subject to error). The importance of maintaining the distinction between jurisdictional facts and matters going to legal unreasonableness was emphasised by Gummow ACJ and

Kiefel J in *Minister for Immigration and Citizenship v SZMDS* [2010] HCA 16; 240 CLR 611 at [39] (in a passage referred to by French CJ in Li at [22]).

(k) I consider that there is some force in the Director's contention that the applicant's motive in attempting to grasp onto legal unreasonableness cases is presumably to attempt to bring itself within the general presumption that functions must not, on pain of invalidity, be exercised in a legally unreasonable way, in circumstances where every other textual and structural indication in the Act points against delay being jurisdictional. In my view, the label of "legal unreasonableness" is of minimal utility in the particular circumstances here. It provides limited guidance in determining whether, in the exercise of statutory construction, there is an implication that jurisdiction to make a decision under s 93 evaporates if the Director does not act within a reasonable time.

[73] I also accept that the Director's submission that the applicant's reliance on a line of authority which includes *NAIS* is a distraction. That line of authority is concerned with the circumstances in which delay by a judge or tribunal in giving judgment or a decision may evidence appealable error. Importantly, however, as Gleeson CJ explained at [5], "the ground of appellate intervention is the error, or the infirmity of the decision, not the delay itself". Here, the only basis on which the decision is impugned is delay, not error said to be caused or contributed to by delay.

…

[85] I also accept the Director's submission that there is no basis for discerning a prescriptive "12 month" rule from the "resumption" of a review (with "resumption" being a term of uncertain legal content). It is well settled that words should not be implied into a statute unless it is necessary and it is possible to "state with certainty" the words which would have been used (*Zanardo & Rodriquez Sales & Services Pty Ltd v Tolevski* [2013] NSWCA 449 at [21] per Leeming JA (with whom Beazley P and Tobias AJA agreed). Neither of these criteria is met in respect of NHDS's proposed "12 month from resumption" rule. Further, great caution is needed before drawing an implication in an Act which has already addressed a matter in detail: *Simon v Condran* [2013] NSWCA 388; 85 NSWLR 768 at [29] per Leeming JA (with whom Macfarlan JA and Sackville AJA agreed). The Act says so expressly when specific time limits (e.g. one month, 12 months) are intended. I accept the Director's submission that, as a matter of general principle, what is outside a "reasonable time" will turn on the circumstances of the particular case with due regard to the relevant statutory framework (see *Thornton* at 289, 290, 291, 292 and 294 per Fisher J).

95 Constitution of Committees

A Committee set up under section 93 must be constituted according to section 95. Essentially, a Committee must be constituted by members of the same profession as the practitioner who rendered or initiated the services to be investigated. Provided that the members of the Committee are from the same profession or specialty there can be no challenge to their appointment the Committee on the ground that they are not an appropriate 'peer'.

McFarlane v Batman [2000] FCA 1663 —

> [6] The only other issue that Dr McFarlane raised at the hearing was the contention that the members of the Professional Services Review Committee were inappropriately qualified to be able to form a reliable view of her professional conduct. Five medical practitioners constituted the Committee. The Committee was expanded beyond the normal size of a committee usually appointed to deal with such matters in so far as it included a specialist physician and a specialist pathologist. It is enough for this Court to say that whatever views Dr McFarlane may have about the professional competence of the members of that Committee to reach the determination they made, her challenges to the professional competence of the members of the Committee do not give rise to any error of law which invalidates the decision of the Tribunal, and it is the decision of the Tribunal alone which is before me for review.
>
> [7] There being no basis upon which, it seems to me, Dr McFarlane has attempted to identify invalidating error of law in the Tribunal's decision, the appeal will be dismissed.

Chandra v Webber [2010] FCA 705 —

> [62] Dr Chandra's challenge is without merit and must be rejected. The constitution of a Professional Services Review Committee is dealt with comprehensively by s 95 of the Act (see above at [12]). There can be no doubt that when this provision was formulated, careful regard was given to the attributes necessary for members of a Committee in order to facilitate the fair and efficient investigation of a referral. The extent of the experience or expertise of members of the Committee with the profession and/or the particular speciality of the practitioner whose conduct is under review is a matter expressly dealt with by s 95. By so doing, Parliament should be regarded as having specifically and comprehensively addressed its intent as to the extent of experience or familiarity with the speciality of the practitioner under review that a Committee should have in order to conduct its investigation fairly and efficiently.
>
> [63] In that respect, and in relation to an investigation of a practitioner who is a specialist in relation to a particular speciality, s 95 requires that the Chairperson of the Committee be a member of the same profession as that practitioner. The two other members of the Committee are also required to be members of the same profession, but they are additionally required to be specialists in relation to the same speciality as that of the practitioner whose conduct is the subject of the investigation: s 95(4).
>
> [64] It is not particularly surprising that when dealing with the constitution of a committee which is to investigate a practitioner with a particular speciality, not all of the members of the Committee are required to have that speciality. It was obviously intended that the presiding members, being Deputy Directors, would bring to the task their status as senior Panel members and also their experience of the conduct of investigations.
>
> [65] Mr Ham was appointed by the Director to be the Chairperson of the Committee. The only relevant qualifications required by s 95 were that he be a

> Deputy Director and a member of the same profession as Dr Chandra. There is no issue that Mr Ham held both of these attributes. In compliance with both s 95(2) and s 80(7), Mr Ham did belong to the profession relevant to the investigation. There is no basis for the construction of the Act for which Dr Chandra contends. The Director did not misconstrue the requirements of the Act in relation to the appointment of Mr Ham.
>
> [66] Dr Chandra is deemed by s 3D of the Act to be a specialist, and the Regulations identify his speciality as dermatology. Those matters are not in dispute. Nor is it in dispute that both Professor Cooper and Dr Paver are dermatologists. Dr Chandra's counsel accepted that the speciality of each of Professor Cooper, Dr Paver and Dr Chandra was dermatology, but contended that Dr Chandra had a "sub-speciality" in Mohs' surgery and that Professor Cooper and Mr Ham did not. Dr Chandra's proposition is that the provisions of the Act require that each member of the Committee have the same sub-speciality as that of the relevant practitioner.
>
> [67] I have already dealt with the fact that there is nothing in the Act, either expressly or impliedly, that requires the Chairperson (Mr Ham) to have the same speciality (let alone the same sub-speciality) as Dr Chandra. None of s 80(7), s 82(1)(c), or s 95 refer to sub-specialities. Each of those provisions uses the term "speciality" or "specialities". Both textually and by reference to the apparent purpose of the Act, the terms of the Act are clear and unequivocal. The speciality of Dr Chandra and Professor Cooper is the same. The appointment by the Director of Professor Cooper involved no misconstruction of the requirements of the Act and was perfectly consonant with those requirements.

Tisdall v Kelly [2005] FCA 365 —

> [22] By s 95(1), a PSR Committee consists of a Chairperson and two other panel members, appointed by the Director. By s 95(2), the Chairperson and the other panel members must be practitioners who belong to the profession in which the practitioner was practising when he or she rendered or initiated the referred services. In particular, by subs (5), if the practitioner was at that time a general practitioner, the other panel members must also be general practitioners.

Section 95 does not require the members of the Committee to be 'peers' in the sense that they have similar clinical or professional experience to that of the person under review. Instead, they are peers in the sense that they are of the same profession or specialty and have the experience and understanding to be able to decide whether particular conduct would be unacceptable to the general body of that profession or specialty.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [58] As to the first, the Committee's role was to investigate and then make findings in respect of the referred services. Those findings had to be whether or not Dr Karmakar had engaged in inappropriate practice, as defined, in respect of the referred services. As so defined, the Committee was required to make an evaluation

> by reference to its understanding (or at least that of a majority of the Committee) as to whether Dr Karmakar's conduct in connection with the rendering of those services would be unacceptable to the general body of general practitioners. To take up an expression favoured in Dr Karmakar's statement of claim, s 82 contains the "legislatively endorsed" standard. To take up another such expression, s 95 specifies what constitutes "peer review". The specified standard and review body is not unacceptability to the general body of general practitioners of Dr Karmakar's length of registration as determined by a committee comprised of such practitioners. Further, the required finding, one way or the other, is wholly evaluative by the Committee. There is no "objective standard". All that is necessary is that the Committee's evaluation be reasonable.
>
> …
>
> [64] It was put that Dr Karmakar's provision of the referred services had not been investigated by a committee of her peers. As I understood it, foundation for this submission was that she was a junior, general practitioner and ought therefore to have been investigated by a committee so comprised. That submission must be rejected. The constitution of the Committee was dictated by s 95 of the HIA. The Chairperson of the Committee had to be a Deputy Director. Given that Dr Karmakar was, during the review period, a general practitioner, the other members of the Committee had to be (and were) general practitioners: s 95(5) of the HIA. Neither explicitly nor implicitly did the HIA additionally require that those general practitioners be of the same number of years post-registration as Dr Karmakar.

Mitchelson v Health Insurance Commission (No. 3) [2007] FCA 1491 —

> [31] As to the composition of the Committee, the Director exercised a power conferred by the Act and constituted a committee made up of Dr Hirst, a medical practitioner and Deputy Director of Professional Services Review under the Act (s 85) and two general practitioners, Dr Marcela Cox and Dr Brian Morton appointed after consultation with the Australian Medical Association (s 84). There is no suggestion that there is a statutory obligation on the Director in exercising the power conferred by the Act in constituting a committee, to appoint a regional medical practitioner nor any want of power in constituting the committee as formed. There is no arguable denial of natural justice in these circumstances or a denial of procedural fairness made out (*Australian Broadcasting Tribunal v Bond* [1990] HCA 33; (1990) 170 CLR 321 at 365-368 per Deane J and *Plaintiff s 157/2002 v Commonwealth* (2003) 211 CLR 476 at 489-490, per Gleeson CJ). Mr Royds says that *Tisdall v Kelly* [2005] FCA 365 is authority for the proposition that a PSR Committee must include a medical practitioner from a regional area or a practitioner familiar with patients from the class or catchment from which the medical practitioner under review draws his or her patients. It seems to me that *Tisdall* is not authority for that proposition.

A PSR Committee is constituted as an expert body and does not need to rely on expert evidence to make findings in relation to matters in which the Committee has its own expertise. Its decisions are not subject to merits review but may be challenged for legal error. While a Court will not generally give a Committee's interpretation of statutory provisions (including the interpretation of MBS items) any

deference, where those provisions involve concepts within the committee's field of expertise, a Court will generally take its views into account. To the extent that any ground of judicial review raises the question of legal unreasonableness, irrationality or a no evidence ground that requires some analysis of the facts, a Court is likely to pay deference to the views of the committee given their expertise, particularly as it concerned the relevant specialty and including the use which could be made of statistics.

Kew v Director of Professional Services Review [2021] FCA 1607 —

> [52] First, as I have indicated, by enacting s 93 and Div 4 of Pt VAA, a regime was established whereby the Director could refer the conduct of a medical specialist to a committee comprising a Deputy Director chair from the medical profession and two panel members from the same specialty, thereby ensuring that the question whether a specialist had engaged in inappropriate conduct was investigated and determined by persons with an expert understanding of the issues involved. Such a panel was suited to answering the relevant question under s 82(1)(b).
>
> [53] Second, in the present context I am not of course engaged in any merits review. Fact finding was for the committee. Moreover, to the extent that any ground of review raises the question of legal unreasonableness, irrationality or a no evidence ground that requires some analysis of the facts, deference ought to be paid to the views of the committee given their expertise, particularly as it concerned the relevant specialty and including the use which could be made of statistics. I am not here concerned with what I would describe as jurisdictional fact finding in the strict sense.
>
> [54] The following observation in *Corporation of the City of Enfield v Development Assessment Commission* [2000] HCA 5; (2000) 199 CLR 135 at [47] per Gleeson CJ, Gummow, Kirby and Hayne JJ is apposite:
>
> > The weight to be given to the opinion of the tribunal in a particular case will depend upon the circumstances. These will include such matters as the field in which the tribunal operates, the criteria for appointment of its members, the materials upon which it acts in exercising its functions and the extent to which its decisions are supported by disclosed processes of reasoning...
>
> [55] And more specifically to the present context, in finding facts about the conduct of a peer practising in the same area of specialty, and forming the evaluative judgment required by s 82(1)(b), the expertise of the committee is of some significance as explained by Logan J in *Norouzi v The Director of the Professional Services Review Agency* [2020] FCA 1524 at [65]. The committee is not a lay tribunal that is necessarily reliant on the independent expert opinion of others in order to make findings of fact calling for expertise. It is constituted as a group of professional peers, charged with investigating whether there has been inappropriate practice and then making consequential findings against specified criteria. Each member of the committee brings to the deliberations their own knowledge and experience that qualified them for appointment. And in that context the committee

> was entitled to reach its own views on the basis of the professional training, knowledge and experience of its members, as to whether it would be reasonable to conclude that the relevant conduct would be unacceptable to the general body of specialists in this case.
>
> [56] Third, the committee was required to construe and apply various provisions of the Act and relevant sub-ordinate instruments. And in the present context that has raised several legal issues. Now generally speaking, I would not accord any deference to the committee's views on construction questions. Having said that, where the relevant instruments embody concepts within the committee's field of expertise, I have taken their views into account on construction questions, although their views cannot be dispositive.
>
> [57] Fourth and more generally, I have considered the committee's reasons bearing in mind the observations of Mortimer J in *Sevdalis v Director of Professional Services Review (No. 2)* [2016] FCA 433 at [132] to the effect that in reviewing the reasoning of the committee I should not over-scrutinise that reasoning, nor to parse it, nor to separate it from its context especially as the committee members are not qualified lawyers. Further, as Mortimer J explained, I should read the reasons fairly, in terms of reading them as a whole, including the 450 pages of appendices dealing with each of the case studies.

96 Challenging appointments to Committees

A person under review has the opportunity to challenge the appointment of Committee members within seven days of being notified of their appointment to a Committee. If a person under review fails to make such a challenge, they run the risk that a Court may refuse to entertain a subsequent challenge on the ground of apprehension of bias when it could have been made within that time period.

Artinian v Commonwealth [1997] FCA 1604 —

> … Finally, there are discretionary grounds which in any event, in my view, would disentitle the applicant to relief. As I already indicated, s96 of the Act provides a mechanism for Committee appointments to be challenged in a timely way if ostensible bias is alleged. The applicant made no attempt to avail himself of the procedure. There are good reasons why such a procedure should be availed of because it permits the question of ostensible bias to be determined before the Committee embarks upon the review entrusted to it.
>
> A challenge under s96 of the Act must be taken seven days after the person under review has received notice under s94. In the present case, not only did the applicant stand by and make no challenge under s96, but he has already participated in a hearing which, as has been indicated, occupied some 191 pages of transcript. He now seeks to obtain the assistance of this Court to obtain interlocutory injunctive relief when he has not availed himself of the statutory machinery which would have achieved the same result.

Crowley v Holmes [2003] FCAFC 189 (per Dowsett J, with which Finkelstein J agreed) —

> [33] Finally, I turn to the alleged perception of bias. For the sake of argument, I again assume (contrary to my actual view) that the additional material was not appropriate for consideration by the Committee in performing its function. In *Livesey v The New South Wales Bar Association* [1983] HCA 17; (1983) 151 CLR 288 at 293 - 294, the High Court observed:
>
> > " ... a judge should not sit to hear a case if in all the circumstances the parties or the public might entertain a reasonable apprehension that he might not bring an impartial and unprejudiced mind to the resolution of the question involved in it. ... Although statements of the principle commonly speak of 'suspicion of bias', we prefer to avoid the use of that phrase because it sometimes conveys unintended nuances of meaning."
>
> [34] In assessing the question, courts frequently speak of the "fair-minded and informed observer". See *Holmes v Mercado* at [63]. The question is whether such an observer might doubt the impartiality of the Committee because it knows that:
>
> - in 1993, 1995 and 1997 the Commission considered that the appellant had, or may have engaged in conduct in some way similar to that presently under review; and
>
> - from the beginning of 1997 until the end of the first quarter of 2001 the appellant had, according to some statistics, conducted his practice in a way which was consistent with the way in which he conducted it during the referral period.
>
> [35] As I have observed, in order to consider this submission, it is necessary to assume that the additional material had no legitimate bearing upon the matter in issue before the Committee. In that theoretical situation, I cannot see how anything in part 2 of section E could in any way prejudice the appellant. However, some people might conclude that a tribunal of fact could be inappropriately affected by knowledge of the material concerning prior conduct contained in section D. In this respect, it is important to note that the Committee is not selected at random off the street. As was observed in *Holmes v Mercado* at [62] and [63]:
>
> > "Even if we are wrong in holding that the material concerning prior counselling of Dr Mercado was not irrelevant to the task of the committee, we respectfully disagree with the view that the committee members' knowledge of that material leads to a reasonable apprehension of bias. The committee gave assurances to Dr Mercado, on a number of occasions, that it would restrict its findings to referred services ... .
> >
> > ...
> >
> > The argument put on behalf of Dr Mercado requires the Court to disregard or discount these assurances. The argument has to be, and is, that a fair-minded and informed observer would reasonably have such doubts about the willingness or ability of a lay (as distinct from a legally-trained) tribunal to honour these assurances as to continue to harbour apprehension of bias. We see no basis for that view. The committee comprises three members of the

> Professional Services Review Panel. Members of the Panel are appointed by the Minister after consultation with the Australian Medical Association (AMA): see s 84(3) of the Act. The committee's chairman is a Deputy Director of Professional Services Review appointed in consultation with the AMA: see s 95(1)(a) and (2). The three members were required to be, and no doubt were, medical practitioners during the review period. We see no reason to doubt that such people are as capable as lawyers of understanding the concept of putting out of their minds an irrelevant matter, when reaching conclusions on a matter of grave importance to a practitioner, and of doing so."

[36] I agree. A fair-minded observer would not perceive bias merely because the Committee knew of such previous dealings between the Commission and the appellant. The Committee would inevitably know that the investigative and adjudicative referrals leading to its own deliberations were, in effect, instigated as a result of the Commission having such concerns. That it had previously had similar concerns about other conduct could hardly take the matter any further. The appellant will no doubt have an opportunity to be heard on the matter. He will almost certainly receive assurances similar to those referred to in Holmes v Mercado. Our society relies upon courts and tribunals to determine factual matters by weighing evidence, often rejecting or discounting some of it. There is no justification for the view that a professional tribunal such as the Committee is unable or unwilling to set aside material which, for one reason or another, is not proper for its consideration. I am confident that a fair-minded observer would share that view.

[37] I should refer to one other matter. Section 96 of the Health Insurance Act conferred upon the appellant a statutory right to challenge the composition of the Committee, provided that he did so within seven days of receiving notice of the referral. He did not adopt that course. The result has been a substantial delay of the Committee's deliberations. I have assumed that I have power to consider the allegation of perception of bias in these proceedings, notwithstanding the appellant's failure to avail himself of the procedure prescribed in s 96.

Crowley v Holmes [2003] FCAFC 189 (per Madwick J)—

[1] I agree with Dowsett J's conclusions and with his reasoning.

[2] There is one aspect on which I should comment and that is his treatment, following *Holmes v Mercado*, of the ostensible bias issue. Were it not for the authority of that case and the fact that North J at first instance and now, on appeal, Dowsett and Finkelstein JJ have agreed with the approach there taken, I might well have viewed the matter differently. I quite agree that doctors are as capable as lawyers, including judges, of putting merely prejudicial matters from their minds. However modern psychology suggests, I believe, that people (whether or not they are judges, other lawyers or doctors) are actually not very good at doing that at all. It might therefore be more realistic to view more cautiously than was done in Holmes v Mercado people's (including doctors') ability to do so. Nevertheless, six judges of this court think differently and I do not feel that I would be justified in not following an earlier Full Court decision

Chandra v Webber [2010] FCA 705 —

> [73] There was no obligation upon the Director to provide the basis for his decision. Compliance with the requirements of s 96 required no more than a decision that the challenge was not justified and written notice of that decision to Dr Chandra: see s 96(3) and (6).

96A If Committee members are unavailable

If, before the Committee starts its investigation, a member of a Committee ceases to be a Panel member or, for any other reason, is unable to take part in the investigation, the Director may appoint another Panel member to the Committee as a replacement.

It will usually be the case that a Committee 'starts its investigation' upon holding a hearing at which evidence is taken by the Committee. While a Committee might have been provided with the referral, considered the Director's report, decided to hold a hearing (subsection 101(2)), and issued notices to produce (section 105A) and a notice of hearing (section 102), it does not have any evidence formally before it for the purposes of conducting an investigation until a hearing is commenced and evidence is taken. That is the starting point of its investigation.

Subsection 98(3) refers to the preliminary stage of the Committee process as an 'inquiry into the provision of the referred services', and provides that it may conduct that inquiry in any way it sees fit. There is a separate provision in similar terms in relation to its power to 'inform itself on any matter in any way it thinks appropriate' once a hearing is being conducted and the investigation has commenced (subsection 106(2)).

If the Committee has started its investigation and a member of the Committee ceases to be a Panel member or, for any other reason, is unable to take any further part in the investigation, the remaining members may constitute the Committee only if the person under review consents. If the person under review does not consent, the Director must set up another Committee under subsection 93(1).

Kutlu v Director of Professional Services Review [2011] FCAFC 94 (per Rares and Katzmann JJ) —

> [21] Section 96A provides a further important indication of the intention of the Parliament as to the consequences of a defect in the constitution of a Committee. That section contemplates that once a Committee has started its investigation and before it completes its final report, one of its members may cease to hold office or,

> "for any other reason" be unable to take any further part in an investigation or the preparation of reports. In such a case, the Parliament made clear, in s 96A(2), that the remaining Committee members could complete the investigation and prepare its reports but only with the express consent of the person whose conduct was the subject of review. If that consent were not given, s 96A(3) requires the Director to establish a new Committee.
>
> [22] In other words, s 96A evinces a legislative choice. It expressly stipulates that a Committee will have no power to proceed without the consent of the person under review where a Panel member ceases to be a Panel member or "for any other reason is unable" to take part in the investigation or preparation of reports by the Committee. This stands in contrast to the Commonwealth's assertion that invalidity was not an intended consequence of the Minister's failure to comply with the consultation process mandated by the Act in ss 84 and 85. That is because each of s 96A(2) and (3) creates a right for a person under review to grant or withhold consent to a Committee continuing to deal with his or her review where its constitution has changed since it embarked on the review process. The expiry or invalidity of a Panel member's appointment would be examples of why he or she was unable to continue as or be a member of a Committee. This is because he or she would "cease to be a Panel member" or would be unable to take any further part in the review process. Thus, s 96A(2) expressly contemplated that a person's term of appointment under ss 84 or 85 could expire before a Committee of which he or she was a member had completed its final report and that the consequence of this that the Parliament intended was invalidity, unless the person under review consented to the Committee continuing without that member. Another reason may be that the Panel member is temporarily unavailable. In such a case, a Committee could not proceed without such consent, as was held in respect of similar legislation in *Tu v University of New South Wales* [2003] NSWCA 170; (2003) 57 NSWLR 376 at 386 [21], 387 [24]-[25] and 388 [27] per Sheller JA with whom Beazley and Tobias JJA agreed.
>
> [23] The same consequence, invalidity, must follow even if the person under review found out after a Committee had published its final report that his or her consent had not been sought under s 96A(2) and (3), because those provisions make the consent a precondition of the Committee being able to continue its functions. There is no reason why a different result should follow in a case like the present where an important statutory precondition to the appointment of Panel members and Deputy Directors was not observed. The operation of s 96A(2) and (3) is an indication that the Parliament regarded the valid and proper constitution of a Committee as an essential and indispensible condition of any Committee's exercise of its functions under the Act.

The suggestion in this judgment that a Committee could not proceed without consent if a member were only temporarily unavailable was neither argued nor necessary for the result in the *Kutlu* case. Additionally, it is not supported by the NSW Court of Appeal case cited for the proposition. The case of *Tu v University of New South Wales* involved the substitution of the presiding member of the Tribunal without consent of a party, rather than the matter proceeding by a quorum of the remaining validly appointed members. Section 99 of the HI Act expressly permits

meetings of a Committee to proceed with a quorum of a majority of its members. Section 101 provides that hearings are held at meetings of a Committee. Under section 96A, consent is required if a member who is unavailable 'is unable to take *any further* part' in the investigation or preparation of the reports. The words 'any further' would be unnecessary if it were intended that a Committee could not proceed without consent where there was only a temporary unavailability of a Committee member.

97 Meetings

Once a Committee has been appointed, the chair must convene a meeting within the first 14 days. Although a failure to do so does not render invalid anything done by the Committee. At the first meeting, which is usually conducted by telephone, the Committee usually decides whether or not an investigation is warranted, which services it will investigate, and how it proposes to proceed.

Saint v Holmes [2008] FCA 987 —

> [136] In my view, the Act does not require the Committee to meet to perform the functions referred to by Dr Saint in the preceding paragraph. Section 160KD of the Act provides that the Committee "prepare a written draft report". Likewise, s 106L provides that after the expiry of the requisite period and after taking into account any submissions made in response to the draft report, the Committee must "prepare a final report". In neither of these sections is there any requirement that the Committee meet to prepare, or meet in relation to the preparation of, either of the reports. The Act does, however, deal with the convening of meetings. Section 97(1) of the Act requires that the chairperson must convene the first meeting of the Committee within 14 days after the appointment of the Committee members. The fact that the Act expressly identifies only one occasion when a meeting is required to be held, namely, the first meeting, but has not expressly provided for the holding of a meeting in relation to the preparation of either report, is indicative of a legislative intention that it is no absolute requirement for the Committee to meet to perform those functions. Whether meetings, other than the first meeting, are to be held depends on what is necessary for the efficient conduct of the affairs of the Committee (s 97(3)). By legislating for the preparation of the two reports as part of the function of the Committee, without also specifying that the Committee must meet in relation to the performance of this function, it is apparent that the legislature did not intend that the efficient conduct of the Committee's affairs mandated that the Committee meet to carry out this function.

98 Conduct of meetings

The Committee may regulate the proceedings of its meetings as it thinks fit. The meetings must be held in private. The Committee may, for the purposes of its inquiry into the provision of services specified in the referral, inform itself in any manner it thinks fit.

The Scheme establishes a staged process by which a Committee proceeds. There is an **'inquiry'** stage that may be followed by an **'investigation'** stage. Section 98 refers to an 'inquiry into the provision of the services specified in the referral'. Subsection 101(2) provides, in effect, that if following that inquiry 'it appears to the Committee that the person under review may have engaged in inappropriate practice in providing the referred services', it 'must hold a hearing'.

The investigation stage commences at the hearing, and subsection 106(2) provides an equivalent provision to subsection 98(2) in respect of how the Committee may inform itself in the investigation stage, but makes clear that, while it involves a 'hearing', the rules of evidence do not apply.

A Committee that has embarked on an inquiry into the services provided by the person under review has a duty to investigate if the inquiry raises issues of concern. But whether such a duty arises depends on the material before the Committee and what the Committee makes of that material. There may be material before the Committee in the inquiry stage that it disregards and does not take into evidence at the investigation stage because it is satisfied that such material does not raise issues of concern and is not relevant to the matters it chooses to investigate.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [69] Dr Karmakar alleged (but did not prove) that the Committee was provided with incomplete medical records to consider the purpose of the PSR Committee hearing. But she was furnished (via her then lawyers) with copies of such records as the Committee did obtain pursuant to notices issued by it under s 105A of the HIA before the Committee's first hearing. There is nothing in Pt VAA of the HIA which prevents a committee from undertaking its investigation if records are incomplete. Indeed, s 106KB contemplates that findings of inappropriate practice may be made even in cases where clinical records are either incomplete or missing altogether:
>
> > **106KB Generic findings of inappropriate practice**
> >
> > (1) This section applies in relation to services (the *relevant services*) in respect of which:
> > (a) there are no clinical or practice records or some or all of the clinical or practice records are missing, inadequate, illegible or otherwise incomprehensible; and

(b) the Committee is unable, because of the matters mentioned in paragraph (a), to make findings under section 106K or for the purposes of subsection 82(1A) or (1B).

(2) For the purpose of making a finding in respect of the relevant services, the Committee may use any information that it is able to obtain, including information supplied by the Chief Executive Medicare, contained in the report by the Director or given in evidence at hearings held by the Committee.

(3) If:
(a) the Committee is of the opinion, based on an evaluation by the Committee of the information obtained as mentioned in subsection (2), that the person under review has engaged in inappropriate practice in the provision of some or all of the relevant services; but
(b) the Committee is not able to identify or determine the number of particular services in the provision of which the person engaged in inappropriate practice; the Committee may nevertheless make a finding that the person engaged in inappropriate practice in the provision of some or all of the relevant services.

A committee is also empowered, by s 106GA of the HIA to notify the Director that "[it] is satisfied that circumstances exist that would make a proper investigation by the Committee impossible", detailing those circumstances. Conceivably, where there was no issue before a committee as to whether the practitioner concerned had kept adequate records, an absence or incompleteness of records might provide occasion for such satisfaction. But that is a matter for the value judgement of the committee concerned. This Committee evidently did not consider that such an impossibility existed.

[70] As it was, during the hearings conducted by the Committee, Dr Karmakar accepted that she had written the records which had been produced to the Committee. Contrary to a submission on her behalf that she was at the Committee's hearings, "examined and criticised for incomplete records", all that the transcripts disclose is that the Committee took her through records which had been produced to it and afforded her an opportunity to offer an explanation about the records. The Committee's final report, at [78], expressly stated that it agreed that the quality of the records to which Dr Karmakar was exposed in the Harbourtown practice was relatively poor and that she was of limited experience and "has borne [those facts] in mind" in making its findings. Dr Karmakar's account of her record keepings practices was taken into consideration by the Committee. Indeed the Committee did this on a record by record basis. The Committee accepted that certain records may not have been scanned but stated, at [59] – [60], that none of its findings turned on an absence of documentation that could have been scanned. All of this is apparent from the meticulous, individual consideration of, and related reasons given by the Committee in respect of, each of the permissibly randomly selected sample services provided by Dr Karmakar, as found in the tables which are annexed to and form part of the Committee's report.

[71] A variant of Dr Karmakar's allegation that she was provided with incomplete records by the Committee was an allegation that the Committee was subject to a "duty to inquire" and had failed to discharge that duty upon being informed by Dr Karmakar that the records were incomplete.

[72] It is not controversial that a committee constituted for the purposes of Pt VAA of the HIA is an inquisitorial body. A committee is charged with a duty of investigation into the provision of services specified in the Director's referral: see s 80(6) and s 93(1) of the HIA. At this general level of abstraction, there is a "duty to inquire".

[73] Detailed provision is made by Div 4 of Pt VAA of the HIA as to how such an investigation is to be undertaken and the powers exercisable by the Committee for that purpose. Those powers include a power to require the production of documents and the giving of information relevant to the referral: s 105A of the HIA. That production requirement power was exercised by the Committee prior to the first hearing day. Both in its draft and final reports the Committee addressed what to make of Dr Karmakar's claims about incompleteness of records.

[74] Dr Karmakar did not, and could not, on the evidence she adduced in the proceeding point to any obvious inquiry which the Committee might have made to remedy the incompleteness of records she claimed. The Committee had already made the obvious inquiry by exercising its power under s 105A of the HIA. It also had the benefit (as had Dr Karmakar) of the results of the inquiries earlier made by the Director.

[75] Some care must be taken in relation to the use of the expression "duty to inquire" in relation either to a ground of review found in s 5 of the ADJR Act or as a foundation for jurisdictional error. In *Minister for Immigration and Citizenship v SZIAI* [2009] HCA 39; (2009) 83 ALJR 1123 (*SZIAI*), at [20], French CJ, Gummow, Hayne, Crennan, Kiefel and Bell JJ stated:

> The failure of an administrative decision-maker to make inquiry into factual matters which can readily be determined and are of critical significance to a decision made under statutory authority, has sometimes been said to support characterisation of the decision as an exercise of power so unreasonable that no reasonable person would have so exercised it.

[76] Later their Honours allowed, at [25], with respect to an administrative decision-making tribunal, the core function of which was to conduct a review of a primary administrative decision:

> It may be that a failure to make an obvious inquiry about a critical fact, the existence of which is easily ascertained, could, in some circumstances, supply a sufficient link to the outcome to constitute a failure to review. If so, such a failure could give rise to jurisdictional error by constructive failure to exercise jurisdiction.
> [Footnote references omitted]

[77] Thus, as Gummow J noted in *Minister for Immigration and Citizenship v SZGUR* [2011] HCA 1; (2011) 241 CLR 594, at [78], the High Court left open in *SZIAI* whether a failure to make an obvious inquiry as to a critical fact might give rise to jurisdictional error. That question remains unresolved at ultimate appellate level.

[78] That, in singular circumstances, a failure to make such an inquiry might expose a failure to discharge statutory function or demonstrate that final conclusions

reached in an inquiry were unreasonable finds support in observations made by Wilcox J in *Prasad v Minister for Immigration and Ethnic Affairs* (1985) 6 FCR 155, at 167 – 170, which is something of a root authority for that proposition. Other authorities collected by Kenny J in *Minister for Immigration and Citizenship v Le* [2007] FCA 1318; (2007) 164 FCR 151, at [65] – [67], might also be said to support such a proposition. The difficulty for Dr Karmakar is that the Committee did make the obvious inquiry about the critical facts relevant to its investigation in respect of the referred services. Having so done, it made its findings taking into account, to the extent that it accepted her account, her claims about incompleteness of her records.

[79] It was also put that Dr Karmakar had not been interrogated by the Committee about "probative evidence". In relation to such an expression also, some care needs to be taken. That is because a committee is not bound by the rules of evidence: s 106(2) of the HIA. Necessarily therefore, where the word "evidence" is used in Div 4 of Pt VAA, it is not used in the sense of evidence which would be admissible in the exercise of judicial power by a court. To conceive of "evidence" in that sense is to commit the error of borrowing "from the universe of discourse which has civil litigation as its subject": *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259, at 282. The hearing transcripts disclose that the Committee asked questions of Dr Karmakar by reference, *inter alia*, to records in respect of the referred services which were before the Committee. In an administrative investigation such as the Committee was duty bound to conduct, those records were "evidence". What to make of them was a matter for the Committee, taking into account, *inter alia*, such responses as Dr Karmakar chose to make either at the hearing by evidence or submission or afterwards by submission. The Committee's final report discloses that it did this. There is no merit in this particular submission.

99 Other procedural matters relating to meetings

The chair presides at all meetings (including hearings) of a PSR Committee at which the chair is present. If the chair is not present, those members who are present are to elect one of their number to preside.

The quorum for a meeting is a majority of members of the Committee, and any question arising at a meeting is decided by a majority of votes of those members present and voting. The presiding member does not have a casting vote, but only a deliberative vote.

If there is an equality of votes, the question is taken to be unresolved and the presiding member may direct that the question is to be reconsidered at a time and place that he or she fixes.

Tisdall v Health Insurance Commission [2002] FCA 97 —

> [12] … Questions arising at meetings of the Committee are decided by a majority of votes of the Committee members present and voting; the Committee member presiding does not have a casting vote (s 99(5)).

101 Hearings

101(1) — a Committee may, at any meeting, hold a hearing

While a hearing is a 'meeting' of the Committee for the purposes of the Act, it is not an informal chat between professional colleagues but is a serious occasion in which evidence is given under oath or affirmation, and documents are produced.

Traill v McRae [2002] FCAFC 235 —

> [66] It was put to us that Dr Traill was, in effect, led to believe that the hearing was capable of characterisation as an informal professional exchange. Counsel submitted that it was no more than 'a chat around the table between doctors over a year's practice'; that the informality and tone of the hearing was such as to foster the making of 'casual' remarks by Dr Traill which were said to have been ultimately (and implicitly, unfairly) held against him; and that this air of informality contributed to a fatal lack of focus in the way the hearing was conducted. In the light of the history of the matter up to 1 October 1997 and the manner in which the hearing was introduced we do not think that prior to or on that date Dr Traill could have been under any misapprehension about the seriousness of the inquiry or about the central matter the subject of the inquiry to which we have referred. The fact that Dr Traill was under no such misapprehension is reflected in the detailed letter of 26 September 1997 that he produced at the hearing. It should be noted that Dr Traill did not seek, by affidavit or oral evidence before us, to establish that he did not understand the nature of the hearing before the Committee; that he had not understood what the Committee intended to do; or that by the way the hearing was conducted he had been lulled into a belief that what was occurring was somehow neither serious nor an occasion warranting his close attention and considered evidence.

101(2) — when a Committee must hold a hearing

The Committee is required to hold a hearing if it appears to the Committee that the person under review may have engaged in inappropriate practice in providing the referred services.

Tisdall v Health Insurance Commission [2002] FCA 97 —

> [87] … The Committee is obliged to conduct an inquiry if, after considering the matters which comprised the subject of the referral, it considers that the person

> under review may have engaged in relevant inappropriate practice. This contemplates that the Committee would have given some prior consideration to the concerns expressed before a hearing is convened and formed a tentative view.

The expression of concerns by Committee members at a hearing

It is the usual practice at hearings for Committee members to question the person under review regarding the person's conduct in connection with the provision of particular services, and if a member has a concern regarding that conduct, which might lead to a finding of inappropriate practice, the member will express that as a 'preliminary' or 'initial' concern and ask the person under review for a response to it. On occasion, the expression of such concerns has led to allegations of pre-judgment or bias. Nevertheless, this practice of raising genuine concerns has been endorsed by the Federal Court. It gives the practitioner an opportunity to answer the concern, or deny it, to produce further evidence, or to persuade the Committee that it is not such as to warrant a finding of inappropriate practice.

Hamor v Commonwealth [2020] FCA 1748 —

> [62] A concern is typically something less than a preconception, prejudgment or predisposition. For example, a concern on the part of the Committee that arrangements between Dr Hamor and HSS may not have been in the best interests of his patients may be described as an ethical concern. Such a concern might cause a fair-minded lay person reasonably to expect the Committee to approach its task with scepticism or suspicion that Dr Hamor may have engaged in inappropriate practice in the provision of services affected by the arrangements. Provided that the concern was genuine and well founded, it is unlikely that such a person could reasonably conclude that the Committee might have lacked impartiality on the basis of that ethical concern.
>
> [63] As explained below, I am not persuaded that a hypothetical fair-minded lay observer with knowledge of the material objective facts might reasonably apprehend that the Committee might not have brought an impartial mind to the decision before it concerning Dr Hamor.
>
> …
>
> [114] A fair-minded lay person would understand that the hearing was an occasion for the Committee to investigate, among other things, what facts were relevant to the provision of the relevant services. A fair-minded lay person would also appreciate that, by expressing concerns, the Committee gave Dr Hamor an opportunity to address them, including by submitting that they were irrelevant. Thus, the hypothetical fair-minded lay person would not be concerned about the impartiality of the Committee based on the concerns identified above, particularly where they were expressed as "concerns" and were followed by an opportunity for Dr Hamor to make submissions on the draft report.
>
> …

> [141] The portions of the transcript identified by Dr Hamor do not suggest an inappropriate or unfairly challenging style of questioning by the Committee, or that the repeated expression of concerns was not genuine.
>
> [142] The transcript of the hearing indicates that the Committee was seeking to discharge its role conscientiously by investigating Dr Hamor's provision of services in the wider context of the overall treatment of the relevant patients, as well as by giving detailed attention to Dr Hamor's provision of services to the sample cases. The transcript indicates that Dr Hamor was given many opportunities to comment on the relevance or correctness of the Committee's concerns over a two day hearing, which could not reasonably be considered to indicate the formation of any inappropriate fixed or final view. Subsequently, Dr Hamor was given an opportunity to make written submissions and to respond to the preliminary findings in the Committee's draft report.

An inordinate delay in conducting Committee proceedings may be grounds for the Federal Court granting a permanent stay of proceedings.

Freeman v McKenzie [1988] FCA 308 —

> [37] Weighing these factors as best I can, in exercise of my judicial discretion, I have reached the clear conclusion that these proceedings should be put to rest. However fair-minded the committee might try to be, and however closely its further proceedings might be monitored by the Court, the risk of substantial injustice to the applicant has, I believe, become too great.
>
> [38] It was inevitable that months would be taken in preparing for an inquiry such as this. In this case a number of honest errors were made which were successfully challenged by the applicant, and these added considerably to the time taken. The applicant also mounted an unsuccessful challenge to the Court which took up about twelve months in 1984-85.
>
> [39] All these delays, although worrying, can be accepted as being within the bounds of reason. Certainly the applicant cannot make capital out of his own unsuccessful court action - and he has not attempted to do so.
>
> [40] The remaining five years of inadequately explained delays are, however, quite unacceptable in proceedings as serious as these from the applicant's viewpoint. Both in fairness to the particular applicant, and as a mark of the Court's determination to see that proceedings which it is called on to oversee are conducted justly, these proceedings must be permanently stayed.

102 Notice of hearings

The purpose of holding a hearing is to investigate whether the person under review engaged in inappropriate practice in providing the services specified in the referral.

At the stage of giving notice of a hearing, the Committee will have conducted an inquiry, as referred to in section 98, into the provision of the referred services. It will have read the referral and may have informed itself in relation to some matters arising from the referral. The Committee is likely to have some idea of the direction its investigation might take, but it usually has not made any detailed analysis of patient records or other material that might be put into evidence at the hearing. Committee members might have formulated some questions to ask, but are usually not in a position to formulate concerns regarding the conduct of the person under review in connection with the provision of the referred services.

In this context it is important to note the effect of subsection 106H(3), which provides that the Committee's investigation of the referred services is not limited by the reasons given in the Director's report to the Committee under paragraph 93(6)(a) or anything else in that report, or the reasons given in any request under section 86 or 106J or anything else in such a request.

The hearing is the principal means by which a Committee conducts its investigation. It seeks to identify and understand the conduct of the person under review in connection with providing the referred services by questioning the person about the context in which the services were provided in light of the clinical records and other material taken into evidence.

102(3) — particulars of the referred services

The 'particulars of the referred services to which the hearing relates' must be specified in the notice of hearing. This does not mean that the Notice must particularise any conduct that might amount to inappropriate practice, but it must identify the services that are the subject of the investigation to which the hearing relates. This may be done by making reference to 'the matters referred to in the referral' to the Committee. Section 81 defines 'referred services' as 'the services specified in the referral made to the Committee under section 93'. A copy of the referral must be given to the person under review within 7 days after the referral was made (subsection 93(7)).

While the Director may have referred to a Committee a number of different classes of services provided by the person under review in the review period, it is open to the Committee, after its initial inquiry into the referred services, to limit the scope of its investigation to a smaller set of services within those referred services. Consequently, the requirement for the notice of hearing to identify the particulars

of the referred services to which the hearing relates ensures that the person under review is clearly on notice of the scope of the Committee's investigation in that hearing, and need not concern themselves with any other of the referred services that are not particularised in that notice.

Health Insurance Commission v Grey [2002] FCAFC 130 —

> [188] … The terms of a referral, read in the context of any particulars contained in a notice of hearing, define the jurisdiction of the committee to inquire.

The particularisation required by the subsection is much narrower than was previously required by the section. Prior to amendments in 2002, the subsection referred to 'particulars of the ***matter*** to which the hearing relates'. *Traill v McRae* [2002] FCAFC 235, *Health Insurance Commission v Grey* [2002] FCAFC 130 and *Tisdall v Health Insurance Commission* [2002] FCA 97 referred to this earlier provision.

Traill v McRae [2002] FCAFC 235 —

> [42] After considering the referral, it appeared to the Committee that Dr Traill may have engaged in inappropriate practice and so the Committee was obliged to hold a hearing: subs 101(2) of the Act. On 10 September 1997, in compliance with s 102 of the Act, the Committee sent Dr Traill a notice of hearing to be held on 1 October 1997. (In submissions, for reasons that are not clear, counsel for Dr Traill referred to the notice as a `purported' notice.) Subsection 102(3) of the Act required that that notice give `particulars of the matter to which the hearing relates'. The notice gave the following particulars:
>
> > This referral concerns your conduct in relation to whether you have engaged in inappropriate practice as defined by the Health Insurance Act 1973 in connection with the rendering of those services described below.
> >
> > *As detailed in the referral, for the purposes of section 87 of the Act, the referral relates to all services rendered by you during the referral period, from your practice locations in the State of Victoria*. [Emphasis added.]
>
> Thus, the particulars given under subs 102(3) were the matters `detailed in the referral'.
>
> [43] The notice required Dr Traill to appear at the hearing and give evidence to the Committee and to produce documents referred to in a schedule and in the various attachments to the schedule. The Committee was empowered by s 104 of the Act to require Dr Traill to attend a hearing, produce documents and give evidence.
>
> [44] The letter of 10 September 1997, enclosing the notice of hearing, invited Dr Traill to provide the Committee with the following information:
>
> - your curriculum vitae, including particulars of your experience in the profession;
> - a brief description of your practice, its clientele and any special professional interests relevant to your practice; and

- any additional material you believe may be relevant to the matter now before the Committee.

[45] The letter also outlined the procedure to be undertaken at the hearing. The letter indicated that the documents called for in schedule 1 of the notice (referred to in [43] above, and to which reference is made in [47] to [55] below) and the documents summonsed from the two medical centres at which Dr Traill carried on practice (Kingsbury and Mill Park) would be `tendered into evidence'. Dr Traill was provided with copies of those summonses. The following was also stated in the letter:

> You will be asked to provide details of your professional training and experience. Among other things, the Committee will be interested in:
>
> - your practice arrangements, ie type of practice/patients, staffing, financial & clerical arrangements;
> - your *high volume of rendered services, particularly level B consultations*;
> - absences from the practice, including holidays; and
> - your understanding of your professional responsibilities under the Medicare programme. [Emphasis added.]
>
> The Committee will also seek your views of the referral and the matters the HIC took into consideration in forming its view that your *conduct in connection with the rendering of level B consultations may constitute inappropriate practice*. [Emphasis in original.]
>
> …
>
> Would you please advise me if you are to be accompanied at the hearing and if so, by whom and in what capacity (legal, medical, other adviser or friend). If you intend to have evidence given by witnesses other than yourself, notice of that intention (and the names and nature of the proposed testimony) must be given to me as a matter of urgency and no later than 72 hours prior to the hearing.
>
> In closing, I would like to assure you that the Committee will endeavour to conduct this inquiry in a fair manner without undue formality. It is intended that proceedings be more in the form of a professional discussion.

[46] Stopping at this point, and before coming to schedule 1 to the notice, there cannot have been the slightest doubt in the mind of Dr Traill (who had been in possession of the referral since March 1997), or any reasonable practitioner in his place, that the primary subject of the Committee's inquiry was its concerns (being the concerns previously expressed to him by the Commission) as to the number of patients Dr Traill was seeing and the number of services he was undertaking, especially Item 23 (level B), and as to whether he could be providing an appropriate level of clinical input (that is, appropriate medical treatment) to his patients, given the number of patients he was seeing. These concerns had been explained to him in 1994 and 1995. In 1994, he had been able to allay the concerns, partly no doubt because of his expressed expectation, at that time, that he would treat fewer patients in the future (see [19] above). In 1995 he had told the Commission that he understood the concerns (see [22] above). The concerns were again made clear in

the referral, as was the professional foundation for them. It is wrong to describe, as counsel for Dr Traill did, the concerns in the referral as being of `obscure generality'. It may be that by investigating the circumstances of particular patients and their treatment from Dr Traill's practice the Committee's concerns would be heightened or reduced, or given more specific exemplification; but the nature of the perceived problem was, and had been for some time, put squarely and clearly to Dr Traill.

Tisdall v Health Insurance Commission [2002] FCA 97 —

WERE PARTICULARS FURNISHED WHICH SATISFIED SECTION 102?

[64] It is submitted for the applicant that the particulars given in the notice of hearing were not within s 102 of the Act in that they did not give the required particulars.

[65] Section 102(3) requires that the notice must give particulars of the matter to which the hearing relates. This "matter" is that referred to in s 86, as outlined above. In considering whether the particulars are within the notice it is necessary to determine the "matter" to which the hearing relates.

[66] It should be borne in mind that prior to the giving of particulars there has previously been a referral which had outlined in general terms the content of the concerns. The hearing particulars given in the present case specify the period and place during which and where the services were provided. The particulars in Schedule 2 to the notice of hearing inform the practitioner that the hearing concerns his conduct in relation to services rendered during the referral period. The notice of hearing incorporates the terms of the Referral comprising 295 pages in that it states that the hearing has arisen upon consideration of matters which are the subject of the Referral by the Commission to the Director of the Committee in accordance with s 93 of the Act and makes specific reference to the inquiry being in respect of inappropriate practice in connection with the rendering of the "referred services". Attached to the notice of hearing and Schedule is an extensive list specifying patients' names and addresses, their date of birth and the date of the service, in random selection order. The pages of detail are headed "Medicare, 100 Randomly Selected Services Rendered to Patients of Dr Tisdall P/N O24956 During 1 January 1996 to 31 December 1996 having Item 23 - Report in Random Selection Order". Dr Tisdall was therefore on notice of all the specific services proposed to be inquired into.

[67] The concern expressed related to Level B (MBS item 23), set out earlier in [26] above.

[68] The particulars update the Referral in relation to the concerns of the Committee. These are expressed to be, as at the date of the notice of hearing, (31 March 1999), whether the practitioner was able to provide an appropriate level of clinical input into the services rendered during the referral period with particular reference to the rendering of the services covered by item 23 and whether the services that were rendered during the period were clinically relevant in so far as they are necessary for the appropriate treatment of the patient to whom they were rendered. It should be noted that the particulars narrow the field for inquiry to

services rendered during the referral period as opposed to the Referral which related to both the rendering and the initiating of services. The particulars also state that further concerns might emerge during the hearing and that the practitioner will be made aware of any other concerns that arise and be given an adequate opportunity to address them.

[69] The expression "matter" is one of broad and general content which can cover a wide range of considerations. The breadth of the expression in the present context is reinforced by the requirement that the matter is one to which the hearing "relates". The word "relates" is also one of broad meaning. The concept of clinical input is a wide one. Accordingly, having regard to the above considerations I am of opinion that the particulars furnished with the notice of hearing were appropriate and sufficient to meet the requirements of s 102(3) of the Act.

WAS THE CONDUCT INVESTIGATED WITHIN THE REFERRAL AND PARTICULARS?

[70] The submission of the applicant is that in its inquiry, the Committee went outside the terms of the Referral and the particulars. Specifically, the applicant contends that the Referral and particulars do not cover the following matters in respect of which the investigation was constructed and findings made:

- the quality of service;
- the necessity of the service;
- the appropriateness of diagnosis or treatment;
- the competence of the applicant as a medical practitioner or the extent of his knowledge or expertise;
- the sufficiency of the applicant's records;
- any questions as to whether or not the applicant provided a service or part of a service at all;
- the length of time spent by the applicant in providing the service.

[71] The applicant submits that the Committee investigated matters that were beyond its jurisdiction and which were therefore irrelevant, being the subjects referred to above, and made findings as to those matters against the applicant upon which it relied in concluding that the applicant had engaged in inappropriate practice. A related submission is that, in pursuing the above matters, the Committee identified wrong issues and therefore acted outside jurisdiction.

[72] To support the above submissions the applicant referred to the decision in *Grey v Health Insurance Commission* [2001] FCA 1257 where Finkelstein J decided that, in the circumstances of that case, having regard to the terms of the particular referral and the particulars, the Committee had inquired into matters which were not the subject of the inquiry. That decision is subject to an appeal to the Full Court.

[73] After referring to the report of the Committee, the hearing and several particular services, his Honour said at [27] and [29]:

> "The subject matter of the inquiry before the Committee is confined to whether Dr Grey had engaged in inappropriate practice by failing to provide appropriate treatment to his patients. The Committee is not charged with the responsibility

> of considering whether Dr Grey had rendered medical services that were not necessary for the care of a patient (sometimes known as over-servicing), whether Dr Grey had charged for services that he did not in fact provide, or whether Dr Grey had engaged in inappropriate practice by failing to keep proper records. It seems clear that, in inquiring into these matters, the Committee is going beyond its reference.
> ...
>
> In this case, the Commission has identified as its areas of concern the high volume of services rendered by Dr Grey, and the possibility that with such a large workload he may not be able to provide proper medical treatment to his patients. That is the only subject matter of the referral, and the only issue which the Committee has jurisdiction to determine. The Committee is not entitled to delve into any other aspect of Dr Grey's conduct that might constitute inappropriate practice. Of course, **other aspects of Dr Grey's conduct may require investigation if they have a bearing on the matter that is within the Committee's jurisdiction. But those matters can only be examined, if at all, as an incident of the main inquiry, and not as a separate subject**. ..." (Emphasis added)

[74] The conclusion of his Honour, as is evident from the above paragraphs, was that the Committee in that case, had embarked on an investigation of rendering unnecessary medical services, charging for services not provided, and failing to keep proper records, not as matters which were incidental to a consideration of the matter referred for investigation, but as giving rise to inappropriate conduct in their own right. His Honour recognised that the Committee might look into those aspects of the practitioner's conduct which could have a bearing on the matter which is within the Committee's jurisdiction but only as an incident of the main inquiry and not as a separate hearing of inappropriate conduct.

[75] In the present case Counsel for the Commission submits that the inquiries were within the terms of the reference, which was broader than that in the *Grey* case and, in addition, the consideration of recording keeping, rendering necessary services and charging for work which had not been carried out were incidental and appropriate to consider when addressing the question posed. Alternatively, Counsel submits that *Grey* was wrong in law. In view of the difference of the facts in this case it is not necessary for me to express an opinion on this. Counsel for the Commission points out that in the present case the Commission did not find that charges had been made in respect of any item or circumstances where no work had been carried out.

[76] In this case the Referral extended beyond the referral in *Grey* in so far as the concerns in that case expressed related only to the high volume of rendered services. In *Grey*, the referral did not express concern as to any of the services being rendered or initiated which were not reasonably necessary. The *Grey* referral did not refer to any concern by the Commission that the high rate of prescription of drugs might be excessive. In the present case these concerns were spelt out as being the reasons as to why the practitioner's conduct in connection with the rendering of medical services may constitute inappropriate practice. The Commission submits that the inquiries made in the present case were appropriate to determine whether the conduct of the applicant was within the language and substance of the particulars. It submits that inquiry into the quality and quantity of the services and the level of

> prescriptions was proper and reasonably incidental to enable the Committee to perform its function in making a determination as to the appropriateness of the conduct. The investigations made were incidents of the main inquiry and were not themselves independent inquiries into behaviour and non-performance in their own right. In the present case, for reasons given, I consider that the inquiries made did not travel beyond the Referral or the particulars and that the inquiries were sufficiently related to the principle function of the Committee.
>
> [77] Both the Referral and the particulars make reference to the notion of "clinical input". This is a wide, undefined expression capable of including quantity, quality and the need for, or appropriateness, of the service in respect of which a claim is made. So long as there is this nexus with the subject matter of the inquiry it is open, in my view, for the Committee to make inquiry into these matters.

102(4) — the notice may require the person under review to appear

A Committee cannot require a person under review to attend a hearing that the Committee knows the person cannot attend. To do so would be a breach of procedural fairness and any consequences flowing from non-attendance would be liable to be set aside by a Court.

> ***Minister for Immigration and Citizenship v Li*** [2013] HCA 18 per Hayne, Kiefel, and Bell JJ—
>
> > [61] Section 360(1) requires that the invitation be meaningful, in the sense that it must provide the applicant for review with a real chance to present his or her case. Scheduling a hearing on a date which, to the Tribunal's knowledge, would not permit the applicant to have sufficiently recovered from an incapacity to attend would not fulfil the duty imposed by s 360(1). The invitation would be an empty gesture and any decision made following the hearing would be liable to be set aside. Not only would the conduct of the Tribunal, judged by the standard set by s 357A(3), be regarded as unfair, but, relevantly, other consequences would follow because the action of the Tribunal would also amount to a failure or refusal to comply with a statutory duty in the conduct of its review. The decision could not stand and the Tribunal would be required to consider it afresh after complying with that duty.

In *Bellamy v Professional Services Review Committee No. 345*, the person under review sought judicial review of a requirement that she attend a hearing of the Committee on the appointed day. She had been given notice of the hearing at some time between 8 and 15 August 2006 for a hearing date of 22 September 2006. Two days before the hearing she advised the Committee that she had a commitment to speak at a conference on the morning of 22 September 2006. The Committee refused to postpone the hearing. An urgent application to the Federal Court was heard and judgment delivered on 21 September 2006.

Bellamy v Professional Services Review Committee No. 345 [2006] FCA 1283—

> [10] No reason whatsoever is advanced as to why it would be unjust for the Review Committee to proceed with the hearing at the appointed time in circumstances where the applicant has had over a month's notice of the intended hearing time. In my opinion, the application has no merit and should be dismissed with costs.

102(5) — an executive officer of a body corporate required to appear and give evidence

If the person under review is a body corporate, the Committee may require the body to cause an executive officer of the body to appear and give evidence. Subsection 81(1) defines an 'executive officer' as follows:

> ***executive officer*** of a body corporate means a person, by whatever name called and whether or not a director of the body, who is concerned in, or takes part in, the management of the body.

103 Rights of persons under review at hearings

Section 103 sets out the rights of a person under review at Committee hearings. They have the right to be accompanied by a lawyer or another adviser, and may call witnesses to give evidence (other than evidence as to their character – but may produce written statements as to their character), may question witnesses, may address the Committee on questions of law arising during the hearing, and after the conclusion of the taking of evidence, make a final address to the Committee on questions of law, the conduct of the hearing, and the merits of the matters to which the hearing relates.

A lawyer accompanying the person under review may give advice to the person, may address the Committee on questions of law arising during the hearing, and may, in addition to the person under review, make a final address to the Committee on questions of law, the conduct of the hearing, and the merits of the matters to which the hearing relates.

A non-lawyer adviser accompanying a person under review may advise the person, and may make a final address to the Committee. However, only one or other of the lawyer or non-lawyer adviser may make such a final address, not both of them.

Formerly, section 103 expressly provided that a lawyer attending a hearing as an adviser to a person under review was not permitted to question a witness at the hearing. That exclusion no longer appears in the Act, and while a legal practitioner

has a limited role in a hearing, Committees have permitted lawyers representing persons under review to question witnesses on behalf of the person under review.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

> [156] The applicant was represented at all of the hearings by Mr Davey who was the author of all of the submissions made to the Committee. I do not accept that it is irrelevant to a consideration of the procedural fairness issue that the applicant was legally represented throughout the process. While it is true that s 103(3) describes the role of the lawyer at a hearing, none of the transcript in evidence suggests that the Committee sought to restrain Mr Davey in raising issues and he was given an opportunity to provide oral submissions on 7 April 2016 or written submissions after the close of the hearing, and he in fact provided extensive written submissions on 22 April 2016 and again in June 2016 in response to an invitation from the Committee to address some issues.
>
> …
>
> [162] As mentioned, it is difficult to understand why Mr Davey did not, in the cross examination of Ms Martin, explore the issues which arose out of Ms Martin's evidence during her relatively brief appearance at the hearing (for example, what a manned mobile after-hours telephone coverage meant, when the doctors took leave and the timeframe in which the doctors would see the applicant's patients). Ms Martin had her records available to her on line while she was giving evidence so that it was open to ask these questions by reference to the days during which the prescribed pattern of services occurred. If the exercise of finding answers from the records would have been too time consuming in the context of the hearing, it was open to Mr Davey to ask the questions and for the Committee to allow time for Ms Martin to marshal answers and respond in writing after the hearing. Indeed, the available hearing date of 8 April 2016 might have been utilised to allow her to give evidence. There is no reason to think that the Committee would not have allowed this.
>
> [163] I do not accept the applicant's submission that it is "unlikely" that the Committee would have countenanced the admission of evidence from witnesses addressing Ms Martin's evidence had Mr Davey made the request for it to do so. It was within the discretion of the Committee to determine the procedure for the conduct of the hearings and it had foreshadowed that there may be other hearing dates if need be. Given the way that the Committee conducted the proceedings, including allowing indulgence on time to make the 23 March 2016 submissions and the presiding member's remark on 7 April 2016 that the Committee did not intend further sitting days "at this time", in my view it would have been open to Mr Davey to seek an opportunity to address these issues by seeking to re-open the hearing to call witnesses or submit evidence before the draft report was issued. It would also have been open for him to request the Committee to seek further evidence from Ms Martin to address his concern about the perceived "gaps" in her evidence.

Romeo v Asher [1991] FCA 201; 100 ALR 515; 29 FCR 343 (per Morling and Neaves JJ) —

> [22] The requirements of procedural fairness will, however, often extend beyond the specific requirements of the statute. What is necessary for a Committee to do in order to satisfy those requirements in any individual case will, of course, depend upon the particular circumstances of that case. It may generally be accepted, however, that a Committee will fail to satisfy those requirements if, having regard to the manner in which the hearing is conducted, a Court is satisfied, upon a perusal of the Committee's report, that it has made findings adverse to a practitioner on factual matters of which it can be said, upon a fair examination of what has occurred, that the practitioner has had no real notice, that his attention was not specifically directed to those matters at the hearing and that he has, in consequence, had no real opportunity to comment.

Grey v Health Insurance Commission [2001] FCA 1257 —

> [31] I propose first to deal with the waiver point. Once there was a doubt whether bias could be waived: *Goktas v Government Insurance Office of NSW* (1993) 31 NSWLR 684, 687. That doubt has now been dispelled by the High Court in *Vakauta v Kelly* [1989] HCA 44; (1989) 167 CLR 568. The rule is that where a party is aware of his right to object to a decision-maker determining a matter on account of bias, that right will be waived if the party acquiesces in the decision-maker continuing to deal with the matter: see generally *R v Byles; Ex parte Hollidge* (1912) 108 LT 270; [1913] All ER 430; *Corrigan v Irish Land Commission* (1977) IR 317; *R v Magistrates' Court at Lilydale; Ex parte Ciccone* [1973] VicRp 10; [1973] VR 122; *Vakauta v Kelly* (1988) 13 NSWLR 502, 528 et seq. That is not to suggest that there must be an express objection requiring the Committee to withdraw. In *Vakauta v Kelly* Toohey J said (at 587): "It may be enough that counsel make clear that objection is taken to what the judge has said, by reason of the way in which the remarks will be viewed. It will then be for the judge to determine what course to adopt, in particular whether to stand down from the case."
>
> [32] It was submitted that Dr Grey's position should be viewed differently because he was not entitled to be represented by a lawyer and was therefore at a presumed disadvantage. I do not agree. Although s 103(1) denies to a practitioner the right to be represented before the Committee by a lawyer, the section permits the practitioner to be accompanied by a lawyer or another adviser. The section contemplates that if a practitioner brings his lawyer, the lawyer may give legal advice to the client during the course of the hearing. That is sufficient, in my opinion, to deny the suggestion that a practitioner is at any disadvantage, at least as regards making a complaint about bias.
>
> [33] What is the position with regard to Dr Grey? On each day of the hearing he was accompanied by a solicitor. If the solicitor thought that, by its behaviour, the Committee had overstepped the mark, he could have advised his client to object. Apparently no such advice was given. Moreover, neither Dr Grey nor his solicitor wrote to the Committee raising the issue of bias. If a letter of complaint had been written shortly after the hearing, it is unlikely that there would be waiver. It was only when Dr Grey received the draft report that bias was raised. By then it was too late to make the complaint. It is not appropriate for a person to wait and see if his case may succeed before raising an objection on this ground.

[34] In the result, Dr Grey has waived any right he may have had to object to the Committee on account of apprehended bias. Because I have reached this conclusion it is not necessary for me to consider whether the conduct complained of would permit a finding of apprehended bias.

[Note: *Grey* was overturned on appeal, but not in relation to this aspect.]

Thoo v Professional Services Committee No 446 [2008] FCA 830 —

[35] According to the transcript, the hearing before the Committee on 3 February 2006 commenced at 9.07 am. Present were the three members of the Committee (including the Chairman); the Committee Secretary; a member of the Committee Secretariat; the Committee's legal adviser; Dr Thoo; and a transcriber from Auscript Australasia Pty Ltd.

[36] The Chairperson made some introductory remarks and invited Dr Thoo to make an application for a short adjournment at "any time" and for "any reason", including for the purpose of "obtaining legal advice".

[37] Dr Thoo said that he was consulting his lawyers and thought that the hearing had to be adjourned until they decided whether the hearing should continue or whether they should write to Medicare or whether they take the matter to court. By "they" Dr Thoo was referring to his lawyers. Dr Thoo added that he thought that until he had the legal advice from his solicitors, the hearing should be adjourned. The Chairperson asked Dr Thoo whether he was saying that he was unwilling to proceed at that time and he replied that he was unwilling. The Chairperson then said that the Committee would have a short adjournment while the Chairperson took advice. The Chairperson asked Dr Thoo to wait outside for a few minutes. Apparently Dr Thoo went outside at 9.11 am and the hearing resumed at 9.25 am. There is no evidence of what happened during the intervening 14 minutes but I infer that the members of the Committee discussed Dr Thoo's application for an adjournment among themselves and with the Committee's legal adviser.

[38] On the resumption of the hearing, the Chairperson informed Dr Thoo that the Committee had considered his request for an adjournment. The Chairperson referred Dr Thoo to a letter dated 10 November 2005 which Dr Thoo had written to the Committee in which he had stated:

> I would like this legal matter referred to a barristor [sic] for a legal opinion. Until this legal matter is resolved it is not appropriate to attend for review on Nov 18, 2005.

[39] The Chairperson next quoted from the Committee Secretary's reply to Dr Thoo of 15 November 2005 to the effect that as the Committee was not in a position to provide Dr Thoo with legal advice, it suggested that he seek his own legal advice on the issues he had raised. The Committee Secretary had also pointed out in her letter that Dr Thoo was entitled, subject to any reasonable limitations or restrictions imposed by the Committee, to be accompanied at the hearing by a lawyer or other adviser. The Chairperson then said:

> Now, I can't see or the Committee can't see that the argument has changed at all so that we intend to continue with the hearing today.

[40] In substance, at this point the Chairperson was indicating that as far as could be seen, Dr Thoo was raising at the hearing on 3 February 2006 the matters that he had raised twelve weeks earlier in his letter of 10 November 2005. It will be noted that Dr Thoo had in fact appeared unrepresented at the second hearing date of 18 November 2005, notwithstanding the exchange of letters between him and the Committee Secretary a few days earlier to which I have referred above.

[41] Dr Thoo did not acquiesce in the Chairperson's statement and the following exchange ensued:

> DR THOO: Okay. The legal matter – I sought an opinion so I think I have grounds, okay, for not continuing because I will get the solicitor to either write to Medicare or write to you or he will decide whether to challenge the thing in court or he decide to continue on and then challenge subsequently in court because in your letter the reason for referral is due to other reasons. In the Health Insurance Act if you have a reason you have to give me the reason and then for me to reply and go through. But in your reasons is I breached 80 20, which I didn't, and statistics are provided which are fraudulent statistics and no court of law will uphold any fraudulent statistics. So, such that I want it to be adjourned until my lawyer get in contact with you which is reasonable under the Health Insurance Act.
> THE CHAIRPERSON: Dr Thoo, you've had 11 weeks from the time you got the last letter to seek this legal advice and you've given us no communication whatever from that date. Now, what is your explanation for that?
> DR THOO: That is a holiday period and I thought that I am busy with other legal matters, okay? So I couldn't get into too many of these things because I am suing a body corp for damages. I've got a top solicitor, David Le Page, and so now I am getting this solicitor so he can get back to you. So, I don't think we should proceed.
> THE CHAIRPERSON: When did you discuss this matter with your solicitor?
> DR THOO: I contracted recently, okay? But I will have to get more details on it and so we get back to you.
> THE CHAIRPERSON: What does "recently" mean?
> DR THOO: The last couple of days.
> THE CHAIRPERSON: Right. So, you've had 11 weeks and two days before the hearing you decided that - - -
> DR THOO: Because this is a matter that in any of this thing I shouldn't prejudice my legal rights. So, what I suggest to you, that is a matter that you cannot rush into anything but I think that this should be adjourned to appropriate date when we get back to you.
> THE CHAIRPERSON: All right. Well, we will adjourn the hearing for ten minutes and we will consider your submission.
> DR THOO: Okay, yes.
> THE CHAIRPERSON: Thank you.

[42] There followed a second adjournment, apparently from 9.30 am to 9.40 am. Upon the resumption, the Chairperson read to Dr Thoo:

- an extract from a letter from the Committee Secretary to Dr Thoo dated 30 March 2005;

- an extract from a Notice of Hearing signed by the Chairperson for and on behalf of the Committee dated 19 July 2005, which had been enclosed in a letter sent to Dr Thoo from the Committee Secretary dated 20 July 2005;
- section 106KA(7) of the Act; and
- the Committee's report dated 31 August 2005 to the effect that the Committee did not intend to inquire into whether there had been a prescribed pattern of services, and that the hearing in fact related to the question of whether Dr Thoo had engaged in inappropriate practice as defined in the Act in respect of MBS Item 23 and MBS Item 36 services during the review period of 1 January 2003 to 31 December 2003 inclusive, because he may not have provided adequate clinical input into the services and because he may not have satisfied the requirements of the relevant MBS descriptors.

[43] The Chairperson said that the Committee intended to go ahead. After further resistance by Dr Thoo, the Chairperson said that Dr Thoo's options appeared to be to stay and go through the process or leave the hearing. The Chairperson said that if Dr Thoo chose to leave, the Committee would go through the process in his absence. Dr Thoo said he decided to leave because he did not think his legal rights should be disadvantaged. The Chairperson said that Dr Thoo had previously had plenty of time to get legal representation. Dr Thoo said that he would not proceed on that day.

[44] There was a third adjournment, apparently from 9.51 am to 9.52 am after which the Chairperson said that the Committee had taken legal advice. The Chairperson read part of s 104 of the Act to the effect that a committee might proceed with the hearing even if the person under review failed to appear, or appeared but refused or failed to give evidence or to answer a question. Dr Thoo asserted that that provision applied only if he stubbornly refused to cooperate. He asserted that he was "happy to cooperate" but because it was a legal problem, the hearing should be postponed. Finally, the Chairperson repeated that Dr Thoo had had ample time to obtain legal advice by the time of the hearing on 3 February 2006. The Chairperson said "good morning" to Dr Thoo at 9.53 am which was apparently the time when Dr Thoo departed.

[45] The transcript does not reveal what happened subsequently on 3 February 2006.

Dr Thoo's submissions and the legislation

[46] In his affidavit Dr Thoo states that on the occasion of each adjournment, he was ushered from the hearing room, the doors of which were closed behind him. I do not think anything turns on this. The same consequences would follow whether that course was followed or the Committee and the legal adviser departed the hearing room, leaving Dr Thoo in it.

[47] Counsel for Dr Thoo points out, in addition to relying on the facts revealed by the transcript, that English was not his client's first language and that it must have been obvious to the Committee that Dr Thoo was at a disadvantage. Again, I do not think that in the circumstances anything turns on this.

> [48] At one point I thought that counsel's submission was that the Committee had no power to proceed with a hearing in the absence of Dr Thoo, that is to say, that there was no power, under any circumstances and for any reason, to refuse an application for an adjournment. I would reject any such submission. The Chairperson does have power to adjourn a hearing from time to time as he or she thinks fit (see s 106(4) of the Act), but this does not signify that the Chairperson is required to grant any adjournment that is requested. Indeed, the Chairperson has a discretion in respect of the procedure for conducting the hearing (see s 106(1) of the Act).
>
> [49] Section 103 of the Act sets out certain rights of persons under review at hearings. They include a right to attend the hearing. The Committee accorded Dr Thoo that right.
>
> [50] Section 103 also includes a right to be accompanied by a lawyer at the hearing. Although the Committee refused to adjourn the hearing of 3 February 2006 when requested by Dr Thoo to do so on that date, I do not think that this amounts to denying Dr Thoo his right to be accompanied at the hearing on that date. Dr Thoo had been given notice of the hearing date and of his right to legal representation at that hearing. Dr Thoo chose to appear unrepresented.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [67] Dr Karmakar also alleged that the processes of the Committee entailed a denial of natural justice, because she was not legally represented at the hearing which she attended. There is no substance in this allegation. As the active party respondents submitted, the absence of legal representation was a matter of choice by her. The HIA does not mandate that a committee can only conduct a hearing if the practitioner concerned is legally represented. Rather, the HIA authorises a practitioner to be legally represented and delineates the role which that legal representative may undertake at a hearing: s 103 of the HIA.
>
> [68] An alternative way in which Dr Karmakar put her allegation that she was denied natural justice was that she had neither received prior notice nor disclosure of material relating to the processes of the Committee. In respect of this allegation, too, there is no substance. The evidence establishes that the prior notice of hearing requirements specified in s 102 of the HIA were observed. Dr Karmakar attended the hearings concerned. It also establishes that prior to the Committee's hearings, Dr Karmakar's then lawyers and, on behalf of the Committee, the Department of Health's Professional Services Review Agency corresponded about the hearing arrangements, the MBS items to be examined, the clinical records to be referred to, the ability of witnesses to give evidence and the rights afforded to Dr Karmakar in respect of a hearing. It also discloses that inquiries Dr Karmakar made personally, whether in the course of a hearing or otherwise, were substantively answered by or on behalf of the Committee. Yet further, it discloses that the Committee observed the requirements of s 106KE of the HIA in relation to the furnishing to Dr Karmakar of a draft of its report for such submissions, if any, as she may care to make.

Legal assistance often can be obtained through the practitioner's professional indemnity insurer. Practitioners usually have an obligation, under the terms of their

professional indemnity insurance contract, to inform their insurer of reviews or investigations concerning them. They are not obliged to use the legal assistance that might be offered them by their insurer. Neither the PSR nor a PSR Committee have any obligation to provide legal assistance or to ensure that a person under review has such assistance: *Nguyen v Minister for Immigration & Multicultural Affairs* [2000] FCA 1265. Nevertheless, the Director of PSR and PSR Committees actively encourage persons under review to seek such assistance at the earliest stage of any review or investigation.

103A Rights of executive officer of body corporate at hearings

Section 103A contains similar rights to section 103 but in respect of an executive officer of a body corporate who may be compelled to appear at a hearing (see section 102). If the executive officer is unable to answer a question asked of them by a Committee member, subsection 103A(2) permits the executive officer to call, and put the question to, a witness, and if the witness answers the question, the executive officer is taken to have answered that question for the purposes of Part VAA of the Act.

104 Consequences of failing to appear, give evidence or answer a question when required

If a notice under section 102 requires a person under review to appear at the hearing and give evidence to the Committee and the person either fails to appear or appears but refuses or fails to give evidence or to answer a question that the person is asked by a Committee member in the course of the hearing, the Committee may notify the Director of the person's failure. Under section 105, the Director must fully disqualify the person under review from the medicare benefits program and notify the Chief Executive Medicare of that disqualification.

While the person under review must answer a question when required, the section does not require the person to give a responsive or meaningful answer to a question.

Hill v Holmes [1999] FCA 760 —

> [34] The word "fails" may have a number of meanings depending upon its context. It can mean simply an omission or the fact that something does not happen, that is to say mere non-fulfilment; it can also mean that something has not happened

because of an element of culpability or responsibility. In *Ingram v Ingram* [1938] NSWStRp 25; (1938) 38 SR (NSW) 407, Jordan CJ pointed out that the word "fail" may have at least three possible meanings. His Honour said at 410:

> "... where it is provided by statute that certain consequences shall follow if a person fails to do something which is directed to be done, the meaning of the word 'fail' depends upon the context in which it is found. In some contexts it may mean simply the omission to do the thing in question, irrespectively of any reason which may have existed for his not doing it. ... In other cases it may mean an omission to do the thing by reason of some carelessness or delinquency on his part, but not omission caused by impossibility for which the person in question is not responsible ... In other cases, it may mean omission to do the thing, but so that omission caused by impossibility arising from some causes is included and from others is excluded ..."

[35] As Kirby P (who dissented on the point of construction before the Court) pointed out in *CBS Productions Pty Ltd v O'Neill* (1985) 1 NSWLR 601 at 609:

> "There are doubtless several other combinations of circumstances which do or do not attract the verb to fail ...
>
> Scrutiny of judicial observations on the word 'fails' (or relevant variants of the verb 'to fail') discloses, as one would expect, differing meanings attributed to the word in differing contexts. In some contexts, the courts have been at pains to confine the word to circumstances evincing default or moral blame on the part of the person alleged to have failed ...
>
> On the other hand, an equally lengthy catalogue of cases can be assembled to illustrate the applicability of the words to circumstance where there is absolutely no suggestion of delinquency on the part of the person alleged to have failed, but simply an omission on that person's part to do something required or expected."

Although these observations were made in the context of construing an agreement between two parties they are equally applicable to a context of construing a statutory provision. There are numerous cases where the expression "fails" or "failure" has been construed but those cases are of little assistance because the relevant statutory provisions and contexts are quite different from the present circumstances. The Director relied on *R v Hulme* (1870) LR 5 QB 377 at 385 where the relevant statute entitled a witness called before an enquiry into electoral corruption to a certificate protecting the witness from prosecution where the "witness shall answer every question relating to the matter aforesaid." The Court held that this provision obliged the witness to give true answers. However that statutory context is sufficiently far removed from the present context to be of little assistance in the present circumstances.

[36] The relevant expression to be construed is not simply "fails", but "fails to comply with the requirements of the notice under paragraph 104(2)(b)". This contemplates two requirements in respect of which there may be a failure:
(a) to appear at the hearing and give evidence to the Committee;
(b) to appear at the hearing and produce documents referred to in the notice.

The failure in respect of the production of documents is easier to identify – the documents are produced or they are not produced. There are no intermediate shades of meaning. The requirement in par 104(1)(b) is therefore a requirement to appear at the hearing and physically produce the documents. No consideration needs to be given to the nature or content of the documents. They only have to answer the description set out in the notice.

[37] The similarity in language in par (a) and par (b) in subs 104(1) suggests that what is contemplated is that the person under review is to turn up at the hearing (that is, appear) and carry out the acts required by the notice, that is to say go through the act of producing the documents or go through the act of being questioned and articulating answers to the questions.

[38] The first passage in the Second Reading Speech to which I have referred in par 20 of these reasons is more consistent with the construction of the critical provisions in s 104 and s 105 of the Act that the reference to a failure to give evidence and a failure to answer a question is a reference to not giving any evidence or any answer at all rather than a reference to a circumstance which includes the giving of a non-responsive or non-meaningful answer.

[39] However s 105(6) makes it clear that a failure to comply with the requirements of a notice under s 104(2)(b) can occur after the person under review has entered upon the procedure of answering questions because it includes within such a failure a failure to answer a question asked in the course of giving evidence.

[40] The expression fails to "give evidence" in par 104(1)(a) (brought about through subs 105(1) and subs 104(3)) and the expression "failing to answer a question" in s 104(5) and s 105(6) contemplate a situation where there is no response at all from the person under review, either because the person has not appeared at the hearing and been sworn or made an affirmation or has not given any answer to a particular question where the person under review has turned up at the hearing and has been questioned.

[41] In my opinion, the expression "appear at the hearing and give evidence to the Committee" in par 104(1)(a) is to be construed as a reference to turning up at the hearing and going through the procedure of giving evidence rather than as a reference to giving responsive and meaningful answers to the Committee. Support for this construction can be found in par 104(2)(a) which provides that if there is a failure to comply with the notice to appear at the hearing and give evidence the Committee may fix a date for another hearing at which "the evidence of the person under review is to be taken" (emphasis added). The reference to "is to be taken" contemplates that the person under review has either not given any evidence at all or has not answered a particular question. Section 104(5) includes failing to answer a question within the expression failing to comply with the requirements of the notice.

[42] Support for the conclusion I have reached is also found in s 105. Section 105(1) provides that if the person under review fails to comply with the requirements of the notice under s 104(2)(b) then the Committee may proceed with the hearing "in the absence of the person under review" and if the person under review is a

practitioner the Chairperson must notify the Director of the failure to comply. This provision therefore contemplates that the failure to comply with the requirements of the notice has occurred because the person under review is absent. The person under review is not absent where he or she has turned up at the hearing, taken an oath or made an affirmation and entered into the procedure of being asked, and giving answers to, questions put by the Committee. The "absence of the person under review" in par 105(1)(a) occurs because of the failure to comply with the requirements of the notice under par 104(2)(b). That failure is to comply with such requirements of the notice being the requirements referred to in s 104(1) which is either or both of, appearing at the hearing and giving evidence or appearing at the hearing and producing documents required to be produced.

[43] Further, subs 105(2) renders subs 105(1) inapplicable where, before the hearing referred to in s 104(2), the person under review notifies the Committee that he or she has a medical condition preventing him or her from complying with the requirements. Again, this provision contemplates that the requirement is one to turn up at the hearing and give evidence or produce documents as the case may be. This construction is not consistent with the proposition that a requirement of the notice is to give evidence in the sense of giving responsive and meaningful answers to questions put by the Committee.

[44] Although subs 105(6) provides that the reference to a failure to appear at the hearing and give evidence in subs 105(1) includes a reference to failing to answer a particular question I consider that this provision is a reference to giving no answer at all to a question put to the person under review rather than failing to give a responsive or meaningful answer to a question. This construction is supported by the exception to subs 105(6) contained in subs 105(7) where the person under review refuses to answer the question, which is not answered for the purposes of subs 105(6), on the ground of self-incrimination. Such a situation contemplates no answer at all to the question. Although there is a change in terminology between subs 105(6) and subs 105(7) from "failing to answer" to "refuses to answer", I do not consider that this change leads to a different conclusion as to the proper construction of subs 105(6). In particular it does not lead to a conclusion that subs 105(6) includes in a failure to answer an answer to a question which is non-responsive to the question put.

[45] The Director submitted that the contrast between "failing to answer a question" in subs 105(6) and "refuse or fail to answer a question" put by a Committee member in par 106E(1)(b) was telling as the meaning of "fail" may be affected by its association with "refuse". Subsection 106E(7) provides that s 106E does not apply to the person under review. But even if one considers this juxtaposition of expressions, it does not assist in determining the proper construction of s 104 and s 105 as "refuse" in the context of subs 106E(1) is consistent with the fact of not being sworn or not making an affirmation and not producing the documents required to be produced. It gives no colour or flavour to "fail" inconsistent with the construction I have preferred in the context of s 104 and s 105.

[46] In determining which is the preferable construction to give to the expressions fails to "give evidence" and "failing to answer a question" it is helpful to consider the consequences of the failure. It leads, through par 105(1)(b) and par 105(3)(a)

inexorably to an immediate disqualification and an immediate inability of the medical practitioner's patients to obtain Medicare benefits in respect of the services supplied by the medical practitioner thereafter. Where the Committee gives to the Determining Officer a report with a recommendation for disqualification of the practitioner (subs 106L(3)) and the Determining Officer directs that the practitioner be fully disqualified (s 106T and s 106U), that disqualification is subject to review by a Professional Services Review Tribunal (ss 114, 115 and 116). However where the full disqualification is made by the Director under subs 105(3) there is no appeal or review procedure provided in respect of the disqualification. It would be surprising if the legislature intended a review procedure in the case of a disqualification brought about by a result of a determination after a substantive hearing yet denied any appeal or such a review procedure where there was a disqualification because there was an issue whether a person under review had given a responsive or meaningful answer to a question put by the Committee.

[47] It may be said that there is an avenue for the person under review to have the full disqualification by the Director lifted or revoked by complying with the requirement to "give evidence" or "answer a question" as the case may be: subs 105(4) and (5). Such an avenue is easily understood if the requirement was either to attend the hearing and commence to answer questions, which the person under review failed to do, or was to answer a question to which the person under review had given no answer at all. In such circumstances the failure to comply with the requirement would be quite clear – there was either no commencement of the process of answering questions or there was no answer at all to a particular question.

[48] However the position would not be as clear cut where there had been an answer to a question which the Committee considered was non-responsive or was not meaningful. If the person under review maintained that his or her answer was responsive and meaningful the issue could not be resolved by any appeal or review procedure. It is unlikely that the legislature intended such draconic consequences to follow the failure to give evidence or the failure to answer a question where the person under review contended that he or she had given a responsive or meaningful answer to the question. However such draconic consequences are understandable where there has been either no appearance at the hearing and a commencement of the procedure of answering questions or no response at all to a particular question.

[49] The Director submitted that if one bears in mind the purpose of s 105 it was apparent that a non-responsive answer to a question was a failure to answer the question for the purposes of s 105. It was said that if the peer investigation and review process provided by the Act was to be effective, with the Committee examining and reaching findings on inappropriate practices, the answers of the practitioner under review must be responsive and meaningful. The Director referred to the passage in the Second Reading Speech to which I have earlier referred in par [20] of these reasons. I accept that the provision for full disqualification in s 105 reflects the view that:

> "a practitioner whose conduct in the rendering or initiating of publicly funded services is open to question should be required to participate in a professionally oriented process of review."

> Such participation occurs when the practitioner attends the hearing, produces any documents required to be produced, swears an oath or makes an affirmation and enters into the procedure of being questioned by the Committee and articulates answers to those questions. The reference to participating in the process of review in the Second Reading Speech takes as its reference point the earlier reference to a practitioner refusing to attend a hearing or to produce documents when required to appear before a Committee. I do not consider that the reference to the passage in the Second Reading Speech relied on by the Director requires me to reach a different conclusion having regard to my analysis and construction of the relevant statutory provisions.

104(3) — Committee may proceed in the absence of the person under review

A Committee may proceed with the hearing in the absence of the person under review if that person failed to appear at the hearing or appears but refuses of fails to give evidence or answer the question.

Alternatively, the Committee may propose to hold another hearing following giving a further notice to the person under review.

Thoo v Professional Services Committee No 446 [2008] FCA 830 —

> [51] Section 104(3) makes it clear that a committee may, in any case, proceed with a hearing despite s 103 even though the person under review fails to appear or appears but fails to give evidence or to answer a question. Dr Thoo appeared but indicated that he would not give evidence or answer questions because his legal objection had not been resolved. The Committee was entitled to proceed with the hearing after Dr Thoo left. The question remains, however, whether the Committee failed to accord procedural fairness to Dr Thoo in exercising its statutory power to proceed with the hearing in the circumstances that prevailed.
>
> **The authorities**
>
> [52] The refusal of an adjournment may amount to a denial of procedural fairness if it is likely to deny a party a reasonable opportunity to present his or her case (*Minister for Immigration and Multicultural Affairs v Bhardwaj* (2002) 209 CLR 597 at [40] per Gaudron and Gummow JJ (*Bhardwaj*); *Touma v Saparas* [2000] NSWCA 11 at [27]). The procedure that will satisfy the demands of procedural fairness may differ in order "to meet the particular exigencies of the case" (*Kioa v West* [1985] HCA 81; (1985) 159 CLR 550 at 615 per Brennan J). As I stated in *Ali v Minister for Immigration and Multicultural and Indigenous Affairs* [2005] FCA 1415; (2005) 41 AAR 410 at [27]:
>
> > Ultimately, each complaint of a failure to accord procedural fairness by reason of the refusal of an adjournment turns on its own facts. Whether an adjournment should be granted is a matter within the discretion of the trial

Judge (or Tribunal), to be resolved according to the overall requirements of justice in the particular circumstances [citation omitted].

Consideration of the second ground of review

[53] In my view, Dr Thoo had a reasonable opportunity to present his case to the Committee and the Committee's refusal to grant the adjournment did not amount to a denial of procedural fairness.

[54] The Committee gave its reasons for refusing the adjournment, namely, that the reason given by Dr Thoo for the adjournment reflected a concern that he had ventilated with the Committee over a long period of time. He did not give any reason why he had not sought legal advice on the matter until a couple of days prior to 3 February 2006. No lawyer accompanied him on that date. He did not have anything in writing from his solicitor supporting his objection to the appointment and procedure of the Committee.

[55] Dr Thoo had known from the time he received the letter dated 30 March 2005 from the Committee Secretary that the Committee was investigating his conduct in connection with his provision of MBS Item 23 and MBS Item 36 services. The first date of hearing was 31 August 2005. It was not until 10 November 2005, just eight days before the second hearing date, that Dr Thoo, for the first time, asserted that he believed that the Committee was inappropriately set up and invalid. His complaint in his letter of that date appears to have been that the Committee's authority was limited by reference to the allegation that he had engaged in a prescribed pattern of services by breaching the 80/20 rule. That letter also stated that he would like the matter referred to a barrister, and that it was not appropriate for him to attend the review on 18 November 2005 (see [38] above).

[56] Notwithstanding his letter, Dr Thoo did in fact attend and participate in the hearing on 18 November 2005. He conceded that he did not seek legal advice until two days prior to the hearing on 3 February 2006.

[57] In the circumstances, I do not think that Dr Thoo was denied procedural fairness by the Committee's decision to refuse his adjournment and continue the hearing in his absence. I note, though do not rely on, the fact that Dr Thoo's solicitors were afforded the subsequent opportunity to make submissions in respect of Dr Thoo's complaints (see [16] above).

[58] I also reject counsel for Dr Thoo's criticism of the Committee because it adjourned the hearing on several occasions to confer with a legal adviser in Dr Thoo's absence and did not inform Dr Thoo of what had transpired in the course of that conferral. In my view, such a situation is no different to judges taking a short adjournment to confer. The Chairperson had a discretion to adjourn the proceedings pursuant to s 106(4) of the Act. The Committee was apparently provided with legal advice, and it was not incumbent on the Committee to disclose the content of the discussion it had with its legal advisers to Dr Thoo.

[59] In my view, there is no substance in the second ground of review relied on by Dr Thoo.

104(4) — Subsequent appearance, giving evidence, and answering questions at a hearing

If a person who has been fully disqualified subsequently appears at a hearing, gives evidence as required, and answers every question asked by a Committee member in the course of the hearing, then, the Committee must inform the Director of that fact, and the Director must revoke the disqualification and give the Chief Executive Medicare notice of the revocation (subsection 105(2)).

104(5) — Medical examination indicating person under review has a medical condition preventing appearing and giving evidence

If a person under review notifies the Committee that they have a medical condition preventing them from appearing and giving evidence or answering questions, and they then undergo a medical examination as reasonably required by the Committee, and if the results of hat medical examination indicate that the person is so prevented, then subsection 104(2) and paragraph 104(3)(a) do not apply to them.

The Committee has a discretion as to whether the person is required to undergo medical examination, and the Committee need not do so, but may, in accordance with subsection 104(3), either:

- propose to hold another hearing (under paragraph 104(3)(b)) at a time when the person under review is no longer afflicted by their medical condition to the extent that they cannot give evidence or answer questions, or
- proceed with the hearing in the absence of the person under review (under paragraph 104(3)(a)).

While paragraph 104(5)(b) speaks of 'reasonable requirements', the Committee cannot compel a person under view to undergo a medical examination.[172] If the Committee makes reasonable arrangements for the person under review to be medically examined, and the person refuses or fails to attend and be examined, the Committee can still proceed, instead, in accordance with subsection 104(3). The phrase, 'reasonable requirements', concerns the reasonableness of the particular

[172] See the discussion on the 'principle of legality' in *Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs v LPSP* [2023] FCAFC 24. While that case concerns the general powers of the Administrative Appeals Tribunal to make directions rather than a specific power to arrange for a medical examination, similar principles apply where the HI Act gives the Committee a choice of procedure, and does not preclude the Committee from proceeding in the absence of the person under review.

arrangements for the medical examination that the Committee proposes to the person under review.

104(6) — Refusal to answer on the ground that the answer may tend to incriminate

Subsection 104(6) permits a person under review to refuse to answer a question on the ground that the answer may tend to incriminate him or her and if the Committee believes that the answer might tend to do so. This privilege has its origins in the common law.

Pyneboard Pty Ltd v Trade Practices Commission [1983] HCA 9; (1983) 152 CLR 328 (per Murphy J) —

> [7] … The privilege against compulsory self-incrimination is part of the common law of human rights. It is based on the desire to protect personal freedom and human dignity. These social values justify the impediment the privilege presents to judicial or other investigation. It protects the innocent as well as the guilty from the indignity and invasion of privacy which occurs in compulsory self-incrimination; it is society's acceptance of the inviolability of the human personality. In the widest sense it prohibits compulsory admission of criminality, that is, infamy, even where there is no prospect of punishment, because, for example, of a pardon, of the expiration of the time limited for prosecution. In a narrow sense, it is privilege against exposure to jeopardy of criminal prosecution, and is available only where there is a real danger of prosecution and conviction. The privilege developed in England out of concern for lack of due process in Star Chamber and criminal proceedings. It was introduced into the constitutions of several of the American States following the 1788 Revolution, and entrenched in the federal Bill of Rights.

In considering whether the Committee believes that the answer might tend to incriminate the person, it is not necessary that the answer itself would indicate that the person is guilty of an offence, but merely that the answer might contribute to an action being brought against the person for a criminal offence, or would imperil the person by raising the possibility of conviction of a criminal offence. This requires consideration of whether information may tend to prove the commission of an offence, as well as the likelihood, or risk, of steps being taken to prosecute that offence.

Hillier v Martin (No 10) [2022] FCA 166 —

> [15] It is accepted at common law that privilege against self-incrimination entitles a person to refuse to answer any question, or produce any document, if the answer to the question or the production of a document would tend to incriminate that

person: *Pyneboard Pty Ltd v Trade Practices Commission* [1983] HCA 9; (1983) 152 CLR 328 at 335.

[16] This proposition is well adopted and was recently cited by the Full Court in *Meneses v Directed Electronics OE Pty Ltd* [2019] FCAFC 190; 373 ALR 624; 140 ACSR 340, where their Honours, Moshinsky, Wheelahan and Abraham JJ, gave the following observations based on long-standing authority at [85] and [86]:

> The privilege of an individual against self-incrimination is a deeply entrenched common law right not to answer questions or produce documents or things where there would be a tendency to expose the individual to a criminal charge: *Griffin v Pantzer* at [43] (Allsop J, citing: *R v Associated Northern Collieries* (1910) 11 CLR 738; *Sorby*; *Pyneboard Pty Ltd v Trade Practices Commission* [1983] HCA 9; (1983) 152 CLR 328 (*Pyneboard*); *Reid v Howard* (1995) 184 CLR 1; and *Caltex*) ...
>
> ...
>
> The privilege against self-incrimination protects an individual not only from self-incrimination directly under a compulsory process, but also from making a disclosure that may lead to incrimination or to the discovery of real evidence of an incriminating character: [*Sorby v Commonwealth* [1983] HCA 10; (1983) 152 CLR 281; 46 ALR 237; 57 ALJR 248] at CLR 310; ALR 259 per Mason, Wilson and Dawson JJ. Thus, the risk of exposure to criminal sanctions may be indirect: *Reid v Howard* at CLR 7; ALR 612 per Deane J.

[17] A valid claim for the privilege against self-incrimination can be made out if the claimant can establish that the act of providing information or documents would give rise to a "real and appreciable" risk of prosecution: *Rio Tinto Zinc Corporation v Westinghouse Electric Corporation* [1978] AC 547 at 574; [1978] 1 All ER 434 at 457; *Rank Film Distributors Ltd v Video Information Centre* [1982] AC 380 at 392; [1981] 2 All ER 76; *Sorby v Commonwealth* [1983] HCA 10; (1983) 152 CLR 281 at 290; [1983] HCA 10; 46 ALR 237 at 242.

[18] In *Deputy Commissioner of Taxation v Shi* [2021] HCA 22; 392 ALR 1 (*Shi*), Gordon J (with whom Kiefel CJ, Gageler and Gleeson JJ agreed) held that to make out a claim of privilege against self-incrimination, while a claimant does not need to reveal the alleged incriminatory material, they must make sufficient disclosure to make it reasonably apparent that the material is capable of being incriminating. Gordon J held at [30]:

> What will be necessary to establish whether the information may tend to prove the commission of an offence will vary from case to case. The privilege may be claimed without requiring the person to explain fully how disclosure of the information would bring about the incriminating effect. To require the relevant person to go further would in at least some circumstances annihilate the protection that the section is designed to provide. However, the mere statement by the relevant person that they believe that disclosure of information will tend to incriminate them will rarely be sufficient to protect them from complying with the disclosure order, and it will not do so when other circumstances are

> such as to induce the court to believe that disclosure of that information will not really have that tendency.
>
> [19] Further, the claimant must demonstrate in any event that there is a real and appreciable risk of a prosecution; as Gordon J's explained at [34]:
>
> > In assessing whether there are reasonable grounds for the objection, the court must assess whether there is a 'real and appreciable risk' of prosecution if the relevant information is disclosed. The gist of the privilege is that disclosure of the information 'would tend to expose the claimant to the apprehended consequence'. The 'reasonable grounds' enquiry requires the court to assess, having regard to the circumstances of the case and the nature of the information which the relevant person is required to disclose, whether there are reasonable grounds to apprehend danger to them from being compelled to disclose the information. This requires consideration of whether information may tend to prove the commission of an offence, as well as the likelihood, or risk, of steps being taken to prosecute that offence. There must be some material upon which the court can be satisfied of these matters. The court is not limited to information in the privilege affidavit or any other material filed by the relevant person.

If a person under review makes use of this provision, the Committee cannot use such refusal as establishing the truth of the matters put to the person in the relevant question.

This provision does not apply to a witness before the Committee who is not the person under review—see subsection 106E(3).

105 Disqualification for failing to appear, give evidence or answer a question when required

If a person under review who is a practitioner fails to appear, give evidence or answer a question that they have been required to answer, without reasonable excuse, and the Committee notifies the Director of that fact, the Director must fully disqualify the person under review, and give the Chief Executive Medicare written notice of the disqualification.

Hill v Holmes [1999] FCA 760 —

> [28] In order for the applicant to succeed in setting aside the full disqualification it is necessary for the applicant to set aside the decision of the Chairperson of the Committee to notify the Director of the applicant's failure to comply with the requirements of the notice under par 104(2)(b). The attack on the Director's decision to disqualify fully the applicant is based on the grounds that there was no evidence or other material to justify the making of the decision which was contrary

> to law. However, the Director was bound under par 105(3)(a) to disqualify fully the applicant after receiving a notice under par 105(1)(b). There is no doubt that the Director received such a notice and, therefore, it cannot be said that there was no evidence or other material to justify the Director's decision. The letter of the Chairperson constitutes such evidence and having been notified that the applicant had failed to comply with the requirements of the notice it was not contrary to s 105 for the Director to disqualify fully the applicant.

If the person under review has been disqualified under section 105, the Committee may proceed in the person's absence. However, the person may request the Committee to hold another hearing, which the Committee must do as soon as practicable after the request is made, but that request must be made no later than one month after the day on which a copy of a draft report is given to the person under subsection 106KD(3).

105A Power of a Committee to require the production of documents or the giving of information

Committees use notices to produce documents to obtain documents including the clinical records of the patients to whom services were claimed to have been provided. While certain State and Territory legislation may prohibit the release of patient information without the consent of the patients, those laws do not apply in relation to a notice to produce issued by a PSR Committee.

Hill v Howe [1991] FCA 297 —

> [24] The main thrust of the applicant's argument is that by virtue of the provisions of subsection 28(2) of the *Evidence Act 1958* (Victoria) she is in effect prohibited without the consent of her patients from producing the documents sought. Subsection 28(2) provides:
>
> > No physician or surgeon shall without the consent of his patient divulge in any civil suit action or proceeding or an investigation by a Complaints Investigator under the *Accident Compensation Act 1985* any information which he has acquired in attending the patient and which was necessary to enable him to prescribe or act for the patient.
>
> [25] Counsel argued that the committee hearing was "a proceeding" within the meaning of the subsection, albeit that it was a proceeding before a tribunal established under Commonwealth legislation. His argument was that unless Commonwealth legislation expressly excludes the application of State legislation the State legislation will apply in relation to a proceeding conducted in Victoria particularly as the corresponding Commonwealth legislation (*Evidence Act 1905* (Commonwealth)) does not attempt to govern the proceedings and does not deal in any way with the question of medical privilege. On this basis it is said that there is

no inconsistency between the State law and any law of the Commonwealth to which the provisions of section 109 of the Australian *Constitution* would apply.

[26] In addition to the express provisions of the *Evidence Act* (Victoria) the applicant seeks to rely upon a claimed medical professional privilege analogous to legal professional privilege. The argument is supported by reference to the Code of Ethnics of the Australian Medical Association, the Hippocratic Oath and other like sources. However appropriate it might be for the effective conduct of medical practice and the general enhancement of the relationship between medical practitioners and their patients, the fact of the matter is that, in the absence of any specific statutory provision, there is no Australian authority to support the claim to medical professional privilege. On this issue counsel for the respondents referred to the statement in *Cross on Evidence*, 4th Edition at paragraph 25325 where it is asserted that judicial authority is uniformly against the existence of any privilege attaching to communications between doctors and their patients. No attempt was made to contradict this proposition.

[27] Even assuming for present purposes that the *Evidence Act* (Victoria) is capable of applying in relation to the proceedings of the committee (an assumption which I believe lacks any foundation), there is nevertheless an obvious inconsistency between the provisions of the *Health Insurance Act*, and in particular section 96, and those of subsection 28(2) of the *Evidence Act*.

[28] The *Health Insurance Act* is an act providing for payments by way of medical benefits and payments for hospital services and for other purposes. It is not suggested that it is beyond the constitutional competence of the Australian Parliament. It is clearly incidental to any law which provides for the payment of benefits for the rendering of medical services that provision be made to deal in an appropriate way with the rendering of excessive services. In the scheme of the Act, the method adopted for dealing with cases in which it is thought there may be an occasion of excessive services being rendered is to provide for a committee to conduct a hearing into the matter and for the committee to report its opinion to the relevant minister and where appropriate to make recommendations in respect of certain specified matters. To facilitate the conduct of a hearing provision is made in subsection 96(1) for the summoning of "a relevant person" (being the practitioner who is thought may have rendered excessive services or an officer of a body corporate which may have done so) and for requiring such person to produce documents. There can be no other conclusion but that Parliament has contemplated that in the context of a hearing into a suspected case of excessive servicing by a medical practitioner, the committee shall have the power to compel the production of the practitioner's records relating to the patients to whom medical services have been rendered. The object of the Commonwealth law being to compel the production of a doctor's medical records, it must clearly be inconsistent with a State law which purports to restrict the production of such documents. There is in my view a direct collision between the Commonwealth and the State laws. The legislative purpose of subsection 96(1) would be entirely frustrated if subsection 28(2) applied. It is not to the point that absent the production of medical records, a committee may nevertheless seek evidence from other sources. The relevant point is that in aid of the function conferred upon the committee Parliament has

specifically made provision for a procedure to facilitate the production of medical records. By any relevant test, the provisions of section 109 of the Constitution apply. The provisions of the Health Insurance Act prevail so as to render invalid any application that subsection 28(2) of the *Evidence Act* (Victoria) may otherwise have had in relation to the hearing.

[29] In my opinion, the decision or the conduct of the committee (however it may be described) whereby it insisted that the applicant was under an obligation to produce the documents is not susceptible to review for the reason that the documents in question record information which the applicant has acquired in her capacity as a medical practitioner in attending her patients.

Validity of a notice to produce

A notice will not be invalid merely because compliance is burdensome, costly, and time-consuming. Nevertheless, such a notice needs to provide a reasonable time for compliance.

I-MED Radiology Network Limited v Director of Professional Services Review [2020] FCA 1645 —

[68] In the course of submissions, I was taken to numerous authorities concerning the exercise, and validity of exercise, of information gathering or document production powers conferred by various statutes. Each of these ultimately turned on the terms of the notice requiring the giving of information or production of documents and the authority conferred by the statute concerned.

[69] Insofar as there are any general principles, they may be gleaned from observations made by Bowen CJ in *Riley McKay Pty Ltd v Bannerman* [1909] ArgusLawRp 55; (1977) 15 ALR 561 (*Bannerman*), at 566, in relation to an information gathering notice given under s 155 of the then *Trade Practices Act 1974* (Cth). The power of requiring the giving of information or production of documents must be exercised for the statutory purpose for which it is given. Here, that purpose is as specified by s 89B(2) of the HIA, "For the purpose of undertaking a review". There is nothing on the evidence to suggest the possession of any purpose by the Director in giving these two notices other than the undertaking of a review in relation to the applicants' provision of services in respect of the Review Period. Within these confines, the only further requirement, flowing from the definition of "relevant documents" in s 89B(1) of the HIA, is that the documents sought be "relevant to the review".

[70] Such a notice must also "specify the information sought with sufficient certainty to enable the recipient of the notice to know what is required of him": Bannerman, at 566. To like effect is this statement, recently offered by Wigney J, together with a summary of authorities, in *Australian Securities and Investments Commission v Maxi EFX Global AU Pty Ltd* [2020] FCA 1263 (Maxi EFX Global AU), at [90], in relation to a cognate requirement under s 33(1) of the *Australian Securities and Investments Commission Act 2001* (Cth) to produce "specified

books", "the documents which are required to be produced be identified in the notice with sufficient clarity and precision to enable the recipient to know what documents come within the terms of the notice and to form a view about what must be produced so as to comply with the notice". To the summary of authorities offered in *Maxi EFX Global AU*, but to no different effect, might be added *Australia and New Zealand Banking Group Ltd v Konza* [2012] FCAFC 127; (2012) 206 FCR 450, at [46] – [47].

[71] I-MED Radiology and I-MED NSW also advanced, in oral submissions other objections to the legality of the s 89B notices. It may well be that not all of the perceived deficiencies of clarity were expressly pleaded by them in their amended statement of claim. Most of the alleged deficiencies, for reasons already given in relation to those pleaded, were confected. In keeping with its use throughout Pt VAA, the s 89B notices adopt the correlative conjunction, "employed or otherwise engaged". That relieves I-MED Radiology, or as the case may be I-MED NSW, of whatever burden there is in determining whether, as a matter of law, it "employed" a particular practitioner. For any engagement short of, or different to, that to provide services is within the embrace of the production obligation as well.

[72]I rather doubt in any event that there could be any valid objection, on the basis of lack of clarity, to a requirement to produce the records of a recipient's "employees". Adverse though the consequences of non-compliance may be, that is not a licence for pedantry on the part of a recipient.

[73] Once the breadth of review permitted by s 88B upon the appearance of a possibility is understood, there was no requirement that the notices identify particular practitioners, be they Dr M or another practitioner mentioned in the evidence, Dr S (whose name is suppressed for like reasons) or otherwise. The Director was entitled to inquire who those practitioners were as an initial step in her review. That is one object of the s 89B notices. Subject to one possible qualification, flowing from the non-exhaustive nature of the definition of "details" for the purposes of the s 89B notices, that the documents sought were relevant is patent on a fair reading of the notices in light of that definition.

[74] As to that non-exhaustive quality, flowing from the use of the word, "includes", and by analogy with an observation made by Robertson J in *Binetter v Deputy Commissioner of Taxation (No 3)* [2012] FCA 704; (2012) 89 ATR 296 (*Binetter*), at [62], concerning a similar use of the word "including" in a notice, it means no more in context than that the recipient is also to produce any other document which shows which practitioners were employed or otherwise engaged to provide MBS rebateable services in connection with it during the Review Period.

[75] Another fallacy in the applicants' complaint about the notices, flowing from a failure to appreciate the breadth of review permitted by s 88B of the HIA and the ends to which such a review are directed, was the assertion of a need to detail particular contraventions or instances of "inappropriate practice". What precedes a review is nothing more than the appearance of a possibility. The scope of the review is, as I have already highlighted, not limited to whatever has occasioned the appearance of that possibility. At the conclusion of the review, the actions which

the Director may take are those specified in s 89C of the HIA (agreement under s 92 being excluded because those under review are not practitioners). At that time, the Director may come to identify with precision, and for the purposes of a referral to, and investigation by, a Committee, specified instances in which it is alleged that the person under review engaged in inappropriate practice in providing services: see s 93(1) of the HIA. It then becomes the remit of the Committee, not the Director, to investigate and report upon whether the person under review engaged in inappropriate practice in providing the services specified in that referral.

[76] A notice issued under statute to produce documents will not be invalid merely because compliance with it is burdensome and visits considerable compliance work and expense on its recipient: *Bannerman*, at 567. Invalidity on this basis might, however, be found if the time allowed for compliance were not reasonable, having regard to the nature and extent of the production obligation imposed.

[77] The applicants did not introduce evidence on this subject. That was because of, so they submitted, "the inherent difficulty of identifying the class of persons in respect of whom documents may need to be produced". That alleged "inherent difficulty" as to the class of persons, was, however, for reasons already given, grounded in a misunderstanding of s 88B(a). Contrary to the applicants' submission, what any other practitioner other than Dr M or Dr S has done or not is relevant to this review.

[78] The applicants made a deliberate, forensic choice not to introduce evidence of the burden entailed in compliance, having regard to the time for production specified in the s 89B notices. In some circumstances, it might be possible, having regard to the apparent breadth of production sought and the time allowed for that production, to conclude that, on any view and objectively, a notice to produce was invalid. Quite apart from violating the 14-day minimum period mentioned in s 89B(4) of the HIA, perhaps such a conclusion would have been open here if the notice had required production the following day. Here, each s 89B notice specified that, "The documents must be produced by no later than: 5pm, Friday 14 August 2020", in other words, not less than 30 days and more than double that 14 day, minimum period. Sometimes, a conclusion of unreasonableness, and hence invalidity, might flow from a consideration of the material before the person who issued the notice at the time when it was issued. The metes and bounds of that material is not in evidence here. In *Binetter*, at [82], and with reference to the power granted to the Commissioner of Taxation, under s 264 of the *Income Tax Assessment Act 1936* (Cth), to require a person to provide information and to produce documents, Robertson J made the following observations by reference to authority:

> The status of the objective test of reasonableness, on the basis of the decision in *DCT v Ganke* [1975] 1 NSWLR 252; (1975) 5 ATR 292; 25 FLR 98; 75 ATC 4097, was referred to by Jagot J in *Krok v FCT* [2009] FCA 1497; (2009) 77 ATR 897 at 907 [46]; [2009] FCA 1497; 2009 ATC 20-156 at 10,565 [46]. Her Honour noted a potential inconsistency between the approach in Perron Investments and the approach in *Holmes v DCT* (1988) 19 ATR 1173; 88 ATC 4328 and in the full court in *Wouters v DCT* (1988) 20 FCR 342; 19 ATR 1884; 88 ATC 4906; 84 ALR 577.

> It is not necessary in the present case to explore whether there is any inconsistency of the kind mentioned in the passage quoted, much less to endeavour to resolve it if there is. Suffice it to say, on the true construction of the s 89B notices on their face, I am not prepared to find that the time for compliance, considered objectively, was unreasonable in the sense referred to in *Minister for Immigration and Border Protection v SZVFW* [2018] HCA 30; (2018) 264 CLR 541, at [10], per Kiefel CJ and, at [82], per Nettle and Gordon JJ.

Limitations on the use of a compulsorily acquired document

If documents have been produced by compulsion, there will be an implied undertaking (sometimes called a 'Harman undertaking'[173]) that they not be used for any purpose other than that for which they have been produced.[174] A party may be released from that undertaking if there are special circumstances. Where a Committee had required the production of the documents sought to be used by a party for another purpose, it would for that Committee to decide whether a release should be granted.

Ashby v Slipper (No. 2) [2016] FCA 550 —

> [10] When exercising the jurisdiction to release a party from the "implied undertaking", it has been said that a Court may do so only where "special circumstances" exist. The dispensing power "is not freely exercised": *Esso Australia Resources Ltd v Plowman* (1995) 183 CLR 10 at 37 per Brennan J. The need for "special circumstances" recognises the balance between reasons for imposing the constraint on material secured for use in proceedings and the reasons why a party may seek to free itself from that constraint. There must be a reason to release a party from the constraint initially imposed which seeks to balance – or at least take into account – the reasons for imposing the constraint in the first place. Reasons for initially imposing the constraint include a recognition that the Court's compulsory processes of obtaining information may have been employed to secure that information – in some cases from third parties – in order to facilitate the administration of justice between the parties to litigation. Reasons for relaxing the constraint frequently involve considerations going beyond the immediate interests of the parties to particular litigation (and those whose otherwise confidential materials have been subpoenaed) and involve the wider public interest, including the public interest in the administration of justice and the administration of the law more generally. In the present case, these considerations include the enforcement or administration of the criminal law.

[173] Harman undertaking is named after the case, *Harman v Secretary of State for the Home Department* [1983] 1 AC 280.

[174] *Hearne v Street* [2008] HCA 36 at [96] and [106] to [107]; (2008) 235 CLR 125 at 154 to 155, and 158 to 159 per Hayne, Heydon and Crennan JJ.

[11] More recently, in *Liberty Funding Pty Ltd v Phoenix Capital Ltd* [2005] FCAFC 3, (2005) 218 ALR 283 at 289 to 290 Branson, Sundberg and Allsop JJ expressed the principles to be applied as follows:

> '[31] In order to be released from the implied undertaking it has been said that a party in the position of the appellants must show "special circumstances": see, for example, *Springfield Nominees Pty Ltd v Bridgelands Securities Ltd* [1992] FCA 472; (1992) 38 FCR 217. It is unnecessary to examine the authorities in this area in any detail. The parties were not in disagreement as to the legal principles. The notion of "special circumstances" does not require that some extraordinary factors must bear on the question before the discretion will be exercised. It is sufficient to say that, in all the circumstances, good reason must be shown why, contrary to the usual position, documents produced or information obtained in one piece of litigation should be used for the advantage of a party in another piece of litigation or for other non-litigious purposes. The discretion is a broad one and all the circumstances of the case must be examined. In *Springfield Nominees*, Wilcox J identified a number of considerations which may, depending upon the circumstances, be relevant to the exercise of the discretion. These were:
>
> - the nature of the document;
> - the circumstances under which the document came into existence;
> - the attitude of the author of the document and any prejudice the author may sustain;
> - whether the document pre-existed litigation or was created for that purpose and therefore expected to enter the public domain;
> - the nature of the information in the document (in particular whether it contains personal data or commercially sensitive information);
> - the circumstances in which the document came in to the hands of the applicant; and
> - most importantly of all, the likely contribution of the document to achieving justice in the other proceeding.'

This list of "considerations" is, obviously enough, not exhaustive: *Plate Glass Holdings Pty Ltd v Fraser Gordon Investments Pty Ltd* [2012] FCA 1487 at [27] per Flick J.

106 Conduct of hearings

The hearing is the principal means by which a Committee conducts its investigation. Prior to commencing a hearing, the Committee conducts an 'inquiry'.[175] The inquiry may involve issuing notices to produce documents to obtain clinical records and other material to assist it in deciding how it may proceed and how it might conduct

[175] Subsection 98(2) provides that 'the Committee may, for the purposes of its inquiry into the provision of the services specified in the referral, inform itself in any manner it thinks fit'. This is a parallel provision to subsection 106(2), which applies in relation to a Committee's hearing and investigation process.

its investigation. The investigation phase of the Committee process starts with the commencement of the hearing.

At the hearing, the Committee seeks to identify and understand the conduct of the person under review in connection with providing the referred services by questioning the person about the context in which the services were provided in light of the clinical records and other material taken into evidence.

The procedure for the conduct of the hearing is within the discretion of the presiding member of the Committee. The Committee is not bound by the rules of evidence but may inform itself in any way it thinks appropriate.[176]

Typically, a Committee will consider 30 services for each MBS item under investigation. In the hearing it will examine the person under review by reference to the clinical records that have been obtained for each patient to whom each of the services were rendered or initiated. The person under review is given the opportunity to explain the clinical records to the Committee as well as why the service was necessary for the treatment of the patient and how the entry for the service demonstrates that the requirements of the MBS item were satisfied.

Generally, if after examining the person under review in respect of a service, a Committee member has a concern regarding the person's conduct that might lead to a finding of inappropriate practice, the member will express that concern and give the person an opportunity to respond. If the person under review wishes to produce other evidence or call witnesses, they will be given a reasonable opportunity so to do.

106(1) — procedure for conducting a hearing

The procedure by which a Committee conducts a hearing is within the discretion of the presiding Committee member.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

> [163] I do not accept the applicant's submission that it is "unlikely" that the Committee would have countenanced the admission of evidence from witnesses addressing Ms Martin's evidence had Mr Davey made the request for it to do so. It was within the discretion of the Committee to determine the procedure for the conduct of the hearings and it had foreshadowed that there may be other hearing dates if need be. Given the way that the Committee conducted the proceedings,

[176] Subsection 106(2).

> including allowing indulgence on time to make the 23 March 2016 submissions and the presiding member's remark on 7 April 2016 that the Committee did not intend further sitting days "at this time", in my view it would have been open to Mr Davey to seek an opportunity to address these issues by seeking to re-open the hearing to call witnesses or submit evidence before the draft report was issued. It would also have been open for him to request the Committee to seek further evidence from Ms Martin to address his concern about the perceived "gaps" in her evidence.
>
> [164] It would undoubtedly have been a better and preferable process if the Committee had obtained a thorough proof of evidence from Ms Martin by reference to the Blackwater Health Care Centre's records and provided it to the applicant before the hearing on 7 April 2016 and, if necessary, also deferred the hearing for a time to enable it to do so.
>
> [165] Nonetheless, having regard to all of the matters identified above, in my view there was not a want of procedural fairness to the applicant in the Committee's failure to give him express notice that it might make the finding it did in the draft report, in its failure to invite him on 7 April 2016 to call further witnesses or the fact that Ms Martin's evidence was more extensive than the 1 April 2016 email suggested in relation to the availability after hours of a mobile telephone contact manned by a doctor.
>
> [166] Having regard to the foregoing, it is not necessary for me to make a finding as to whether the applicant could have adduced evidence or for the Committee to have convened a hearing after it issued the draft report. The fact that 106KD(3) makes express provision for the practitioner to be given an opportunity to provide written submissions would indicate that that is the approach contemplated by Parliament to be adopted in the interest of the efficient conduct of an investigation. However, there are potentially serious disciplinary consequences from an adverse finding and there is no express limitation on the Committee's powers to hold a hearing under s 106 so it may be that it is not necessary to infer from the existence of s 106KD(3) that the Committee could not receive more evidence had it been asked to do so. It is relevant that it was not asked to do so.

106(2) — not bound by rules of evidence but may inform itself in any way it thinks appropriate

While the Committee is not bound by the rules of evidence and may inform itself on any matter in any way it thinks appropriate. Nevertheless, it still must act judicially. That is, the Committee must ensure that the process is both lawful and fair.

Tisdall v Webber [2011] FCAFC 76 —

> [24] It follows from a consideration of the scheme adopted by the Act that, in the exercise of the adjudicative power (s 93 and Division 4 of the Act) to consider and make findings as to whether Dr Tisdall's conduct in rendering services specified in the referral under s 93(7) constituted engaging in inappropriate practice by reason of engaging in a pattern of prescribed services for the purposes of s 106KA, the Committee must act judicially. It must act according to the principles established

> in *Avon Downs Pty Ltd v Federal Commissioner of Taxation* [1949] HCA 26; (1949) 78 CLR 353 at 360 per Dixon J; *The King v Connell and Another; Ex parte Hetton Bellbird Colliers Ltd* [1944] HCA 42; (1944) 69 CLR 407 at 429-432 per Latham CJ; *Craig v South Australia* [1995] HCA 58; (1995) 184 CLR 163 at 179 per the Court; and *Minister for Immigration and Multicultural Affairs v Yusuf* [2001] HCA 30; (2001) 206 CLR 323 at 351 at [82] per McHugh, Gummow and Hayne JJ. Provisions such as s 98(3) and s 106(2) of the Act are generally regarded as facultative and in some senses free a decision-maker from the constraints applicable to courts of law although, notwithstanding those freedoms from constraint (in a limited sense), the administrative decision-maker must nevertheless act judicially.

While the Committee is not bound by the rules of evidence, those rules cannot be totally ignored.

R v War Pensions Entitlement Appeal Tribunal, ex parte Bott [1933] HCA 30; (1933) 50 CLR 228 (per Evatt J) —

> Some stress has been laid by the present respondents upon the provision that the Tribunal is not, in the hearing of appeals, "bound by any rules of evidence." Neither it is. But this does not mean that all rules of evidence may be ignored as of no account. After all, they represent the attempt made, through many generations, to evolve a method of inquiry best calculated to prevent error and elicit truth. No tribunal can, without grave danger of injustice, set them on one side and resort to methods of inquiry which necessarily advantage one party and necessarily disadvantage the opposing party.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [79] It was also put that Dr Karmakar had not been interrogated by the Committee about "probative evidence". In relation to such an expression also, some care needs to be taken. That is because a committee is not bound by the rules of evidence: s 106(2) of the HIA. Necessarily therefore, where the word "evidence" is used in Div 4 of Pt VAA, it is not used in the sense of evidence which would be admissible in the exercise of judicial power by a court. To conceive of "evidence" in that sense is to commit the error of borrowing "from the universe of discourse which has civil litigation as its subject": *Minister for Immigration and Ethnic Affairs v Wu Shan Liang* (1996) 185 CLR 259, at 282. The hearing transcripts disclose that the Committee asked questions of Dr Karmakar by reference, *inter alia*, to records in respect of the referred services which were before the Committee. In an administrative investigation such as the Committee was duty bound to conduct, those records were "evidence". What to make of them was a matter for the Committee, taking into account, *inter alia*, such responses as Dr Karmakar chose to make either at the hearing by evidence or submission or afterwards by submission. The Committee's final report discloses that it did this. There is no merit in this particular submission.

Crowley v Holmes [2003] FCAFC 189 —

[26] It is primarily for the Committee to identify the material on which it should rely. The Health Insurance Act provides for inclusion in the adjudicative referral of material supplied by the Commission to the Director. The additional material was so supplied. While the information in section D may itself be too imprecise to be of any use, the Committee might infer that the Committee's concerns on earlier occasions suggest that the appellant's prior conduct could be relevant to the referral and choose to inquire further as to that conduct. The Full Court (Wilcox, Merkel and Weinberg JJ) observed in *Holmes v Mercado* [2000] FCA 1848; (2000) 111 FCR 160 at [57] - [59]:

> "[57] ... It is important for committees and tribunals undertaking statutory reviews in respect of the provision of professional services to confine their findings to the period of time and the work locations specified in the relevant Commission reference. However, evidence about events that occur outside those work locations and period of time may bear on the matter under review. This is, perhaps, particularly a possibility in relation to a concept as imprecise as "inappropriate practice", as defined in s 82(1)(a) of the Health Insurance Act. It will be recalled this definition makes the question whether particular conduct is "inappropriate practice" depend on the committee's perception as to whether the conduct "would be unacceptable to the general body of practitioners". That must depend upon the whole of the circumstances surrounding the conduct.
>
> [58] ... A person under review might justify the provision of an unusually high number of services by reference to the paucity of other practitioners in his or her local area. The practitioner might claim it is better for him or her to work extremely long hours than to leave patients unattended. This attitude might be thought acceptable, even laudable, in the first year. But it might wear a different complexion if it is shown that the practitioner has previously acknowledged that the long hours made it impossible for him or her to provide adequate patient care; and even more so if it is shown that the practitioner neglected a reasonable opportunity to take in a partner or employee.
>
> [59] Leaving aside that example, it is a commonplace of human behaviour that particular conduct will be tolerated on its first occurrence but considered unacceptable if repeated, especially if repeated after counselling or an appropriate warning. That statement is true of professional behaviour, as much as in any other sphere."

[27] I agree.

[28] The appellant's concern regarding section D appears to be similar to that experienced in connection with "similar fact" evidence in criminal cases, that is evidence of prior conduct of the accused, including prior criminal conduct, similar in some way to the conduct which is the subject of the relevant charge. It is important to realize that such evidence is not necessarily inadmissible. See *S v The Queen* [1989] HCA 66; (1989) 168 CLR 266 and *B v The Queen* [1992] HCA 68; (1992) 175 CLR 599. Once it is conceded that even in a criminal trial with a jury, similar fact evidence may be received, provided that the proper conditions for admissibility are shown, there can be little justification for the assertion that

material is necessarily inappropriate for the Committee's consideration, merely because it is of that kind. The Committee might treat with some respect the views of the High Court and other courts concerning the dangers of such evidence, but it is not bound by the rules of evidence. It is entitled to determine in a particular case whether prior conduct of a similar kind is relevant to the question which it is addressing and whether it is worthy of weight in that regard. It is for the Committee, not this Court, to determine the material which will be received and acted upon. To deprive the Committee of a possible line of inquiry would be to usurp its function. It was appropriate for the Director to inform the Committee that the appellant had previously come to the attention of the Commission for possibly similar conduct. It was for the Committee to decide whether or not to investigate such matters and to give them such weight as was appropriate.

[29] It is true that pursuant to s 106H the Committee may "make findings" only concerning services which are the subject of the referral. However that is a jurisdictional limitation upon the subject matter of the inquiry, not a limitation upon the material which the Committee may treat as relevant to its task. Undoubtedly, the appellant will be heard as to the relevance and weight of the additional material and invited to explain or contradict it. It cannot be said at this stage that evidence of the appellant's prior professional conduct is necessarily irrelevant to the Committee's consideration of this matter.

Yung v Adams [1997] FCA 1400 —

As can be seen therefore, although the process undertaken by a Professional Services Review Committee is essentially investigative and the Committee does not in itself make an order of a disciplinary nature, the principles of natural justice apply so that, except in a simple case where the ambit of the investigation and the subject matter of possible findings are defined by the reference which has initiated the inquiry, the Committee should at some stage make it clear to the medical practitioner whose affairs are under investigation what are the possible findings which are the subject of the investigation and what are the grounds on which those findings might be made. The medical practitioner should be given a fair opportunity to explain why those findings should not be made.

In a complex case such as the present, where 17,331 services were the subject of the referral, it would be very desirable that, at some stage, the issues and the grounds being investigated should be formulated in writing so that there be no misunderstanding about them. The formulation of such matters in writing would also be useful to give a structure to the investigation and so avoid problems such as those which arose in *Freeman's* case.

Section 102 of the Act provides that the notice of hearing "must give particulars of the matter to which the hearing relates." However, compliance with that requirement does not end the responsibility of the Committee to provide information in the nature of particulars. At the beginning of the inquiry, the Committee may well not have formulated likely or possible findings or the grounds upon which they might be made. As the inquiry proceeds, the Committee should give such further particulars or information of a like nature as is necessary to make

> it clear to the medical practitioner what are the matters to which he or she should respond.

Adams v Yung [1998] FCA 506 —

> As has been seen, it is common ground between the parties that a person under review was entitled to the protection of the rules of natural justice. In my opinion, it is both explicit and implicit in the Act, properly construed, that before the Committee the practitioner will be treated fairly in the natural justice sense: the procedures laid down in the statute are clearly designed to achieve a fair treatment of the practitioner, consistently with the need to protect the public interest in the proper discharge of the practitioner's professional responsibilities to patients. Moreover, in assessing whether a person under review has been fairly treated, it will no doubt be borne in mind that in some cases, at least, the exact details of the facts to be examined will, to some extent, lie within the knowledge of the practitioner, and would not be known to the Commission, and not even be readily available, in detail, to the Commission or to the Committee. In the present context, it could hardly be seriously supposed that fairness required that the detail of the treatment of each of some 17,000 patients be scrutinised.

The Committee may adjourn the hearing from time to time to obtain advice from its legal advisers. It has no obligation to inform the person under review of the advice given by the legal advisers.

Thoo v Professional Services Committee No 446 [2008] FCA 830 —

> [58] I also reject counsel for Dr Thoo's criticism of the Committee because it adjourned the hearing on several occasions to confer with a legal adviser in Dr Thoo's absence and did not inform Dr Thoo of what had transpired in the course of that conferral. In my view, such a situation is no different to judges taking a short adjournment to confer. The Chairperson had a discretion to adjourn the proceedings pursuant to s 106(4) of the Act. The Committee was apparently provided with legal advice, and it was not incumbent on the Committee to disclose the content of the discussion it had with its legal advisers to Dr Thoo.
>
> [59] In my view, there is no substance in the second ground of review relied on by Dr Thoo.

A Court will not readily intervene while a Committee is still in the process of investigating the referred services.

Romeo v Asher [1991] FCA 201; 100 ALR 515; 29 FCR 343 (per Morling and Neaves JJ) —

> [24] … While this Court has a general supervisory role under the *Administrative Decisions (Judicial Review) Act 1977* in relation to the conduct of inquiries for which the Health Insurance Act provides, the Court will not, unless compelling circumstances are shown, examine the material before a Committee at any particular stage of a hearing which it is conducting in order to determine, in the abstract, whether, if a particular finding is made, the making of that finding may

> vitiate the Committee's report because of an absence of procedural fairness. It is only after the findings of the Committee are known that such an inquiry can profitably be undertaken. We do not think that this view of the Court's function is inconsistent with what was said by the High Court in *Annetts v McCann* (supra). In that case the coroner had declined to hear any submissions from counsel appearing for the parents of the deceased and, in such circumstances, it was thought appropriate that the Court should intervene before the coroner proceeded to make findings of fact. In the circumstances of the present case, the Court would not, we think, be justified in assuming that the Committee will proceed to make findings upon any matter of which the appellants have not had adequate notice. That is to say we do not think the conclusion can yet be reached that the Committee has denied the appellants their undoubted right to natural justice.

Kitchen v Director of Professional Services Review [2019] FCA 1978 —

> [13] In considering whether there is a *prima facie* case of denial of procedural fairness, it is relevant that a substantial part of the Committee's role is to investigate whether the person under review has engaged in inappropriate practice and that such an investigation is likely to proceed in stages. As Davies J observed in *Yung* at 458, particulars do have to be provided "at some stage" before the preliminary report is provided. However, it is far from clear that that stage has been reached. The investigation is ongoing.

Onus and standard of proof

As Committee proceedings are administrative and inquisitorial, there is no legal onus of proof on any party before the Committee.

Minister for Health v Thomson (1985) 8 FCR 213, [1985] FCA 208 (per Fox J)—

> I do not think it useful, and it may be misleading, to talk in terms of onus of proof in relation to proceedings such as those with which the Committee was concerned. The Committee was one of inquiry, and it was inquiring into the services charged by one doctor. It was obliged to find the facts, so far as it could do so, concerning those services. There were not multiple parties to the inquiry. The process at the hearing was one in which documentary evidence was formally laid before it by its Secretary and thereafter Dr Thomson gave evidence and was questioned at length by members of the Committee. No other evidence was called. To talk of onus of proof, in its legal sense, is in my view inappropriate.

Nevertheless, there may be practical evidential onus on a person under review if there is evidence before a Committee suggesting a finding of inappropriate practice.

The civil standard of proof applies in proceedings before a Committee. That is, the Committee must be reasonably satisfied, or satisfied on the balance of probabilities, as to its findings. A Committee must form its views and make its findings on the

evidence and material before it, having regard to the seriousness of the matter and the nature and consequences of its findings.

Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd (1992) 67 ALJR 170, [1992] HCA 66 (per Mason CJ, Brennan, Deane, and Gaudron JJ) —

> [2] The ordinary standard of proof required of a party who bears the onus in civil litigation in this country is proof on the balance of probabilities. That remains so even where the matter to be proved involves criminal conduct or fraud.[177] On the other hand, the strength of the evidence necessary to establish a fact or facts on the balance of probabilities may vary according to the nature of what it is sought to prove. Thus, authoritative statements have often been made to the effect that clear[178] or cogent[179] or strict[180] proof is necessary "where so serious a matter as fraud is to be found".[181] Statements to that effect should not, however, be understood as directed to the standard of proof. Rather, they should be understood as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct[182] and a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct. As Dixon J commented in *Briginshaw v Briginshaw*:[183]
>
> > "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved ...".
>
> clear and cogent evidence to prove matters of the gravity of fraud or crime are, even when understood as not directed to the standard of proof, likely to be unhelpful and even misleading. In our view, it was so in the present case.

Mitchelson v Health Insurance Commission (No. 3) *[*2007] FCA 1491 —

> [49] The committee must act reasonably. In order to be satisfied that Dr Mitchelson engaged in 'inappropriate practice' the committee needs to reach a state of affirmative satisfaction of the foundation factual matters giving rise to that conclusion to a standard of 'reasonable satisfaction'. A member, acting reasonably, will not be so satisfied 'independently of the nature and consequence of the fact or

[177] See, e.g., *Hocking v Bell* [1945] HCA 16; (1945) 71 CLR 430, at p 500; *Rejfek v McElroy* [1965] HCA 46; (1965) 112 CLR 517, at pp 519-521.
[178] *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336, at p 362; *Helton v Allen* [1940] HCA 20; (1940) 63 CLR 691, at p 701; *Hocking v Bell* [1944] NSWStRp 31; (1944) 44 SR (N.S.W.) 468, at p 477 (affirmed in *Hocking v Bell* (1945) 71 CLR, at pp 464, 500); *Rejfek v McElroy* (1965) 112 CLR, at p 521; *Wentworth v Rogers (No.5)* (1986) 6 NSWLR 534, at p 539.
[179] *Rejfek v McElroy* (1965) 112 CLR, at p 521.
[180] *Jonesco v Beard* (1930) AC 298, at p 300; *Briginshaw v Briginshaw* (1938) 60 CLR, at p 362; *Helton v Allen* (1940) 63 CLR, at p 711; *Hocking v Bell* (1944) 44 SR (N.S.W.), at p 478 (affirmed in *Hocking v Bell* (1945) 71 CLR, at pp 464, 500); *Wentworth v Rogers (No.5)* (1986) 6 NSWLR, at p 538.
[181] *Rejfek v McElroy* (1965) 112 CLR, at p 521.
[182] See, e.g., *Motchall v Massoud* [1926] ArgusLawRp 22; (1926) VLR 273, at p 276.
[183] (1938) 60 CLR, at p 362; and see, also, *Helton v Allen* (1940) 63 CLR, at p 711.

facts to be proved' (*Briginshaw*, per Dixon J at 362). The seriousness of the allegation or the gravity of the consequences flowing from a particular finding must necessarily affect the judgment made by each committee member as to whether the particular issue has been established to that member's reasonable satisfaction. As Sir Owen Dixon observed, reasonable satisfaction should not be reached by 'inexact proofs, indefinite testimony or indirect inferences' (p, 362). Plainly enough, the nature of the issue before the tribunal 'necessarily affects the process by which reasonable satisfaction is attained' (Dixon J per 363).

Butler v Fourth Medical Services Review Tribunal [1997] FCA 773 —

Thus, the weight of authority is against describing the process before administrative tribunals, such as the Tribunal, in terms of the onus of proof. This concept applies to an adversarial contest in a court. The term is used to identify the obligations on the party responsible for proving a case. The concept does not apply readily where there is no adversarial contest. Thus, in the present situation, the Minister does not participate in the proceedings before the Committee and the Committee may inform itself in such manner as it thinks fit (s 92). If there is a review, the Tribunal must consider the evidence before the Committee. It does not usually hear further evidence. The Minister may or may not be represented at the Tribunal hearing (s 117(2)). In the proceedings before the Committee and the Tribunal, the statute defines the issue to be determined. The Committee or Tribunal may determine the issue when it achieves a state of positive satisfaction on the issue. In this case, the Tribunal required that it be positively persuaded that the services rendered were not reasonably necessary. In my view, this was the proper approach.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

[109] Unsurprisingly, having regard to the language of s 106KA(2), in *Tisdall v Webber* at [108], Buchanan J accepted that Dr Tisdall bore the onus of persuading the Committee that there was an "absence" of service available to his patients which affected his own provision of services, relying on *Oreb v Willcock* at [204]-[205], [208] and [223]. The language of s 82(1B) is not express as to onus; the question is whether, on the evidence before it, a Committee could reasonably conclude that on the day that the practitioner rendered or initiated more than 80 services exceptional circumstances existed that affected the rendering or initiating of those services.

[110] Section 82(1B) was introduced into the Health Insurance Act by s 3 and cl 3 of Sch 2 of the *Health Insurance Amendment (Professional Services Review) Act 2012* (Cth) and s 106KA was repealed. The Explanatory Statement to the Bill is not helpful in relation to the interpretation of s 82(1B): see pp 15-16 which discusses these changes. Relevantly the second reading speech on 9 May 2012 provides as follows:

> The bill also includes a number of provisions that strengthen the Professional Services Review's capacity to protect the integrity of Medicare, improve the operations of the scheme, and respond to the recommendations of a review of the scheme in 2007.
>
> ...

> The bill includes amendments to improve the protection of the public under the Professional Services Review.
>
> ...
>
> The quality of patient care can be placed at risk if practitioners undertake unreasonably high numbers of services. In 1999, medical professional groups agreed that 80 or more unreferred attendances on 20 or more days in a 12-month period constituted inappropriate practice.
>
> This bill clarifies in legislation that a practitioner who performs this number of services is automatically deemed by the legislation to have practised inappropriately, unless they can provide evidence that exceptional circumstances existed.

[111] At [64] of the draft and final report, the Committee correctly identified the test in s 82(1B). At [65]-[66] the Committee also referred to the interaction of s 82(1B) and reg 11.

[112] It is clear from the language of s 82(1A), and as explained in the second reading speech, that Parliament has determined that the prima facie position is that a practitioner engages in inappropriate practice if he or she renders more than 80 professional attendances on more than 20 days. Parliament relied for that view on the position taken by medical professional groups in 1999 based on the risk posed to patients by the provision of unreasonably high numbers of services. In that context, s 82(1B) poses the question of whether the Committee could reasonably conclude that, on a day on which the practitioner rendered more than 80 professional attendances, exceptional circumstances existed that affected the rendering or initiating of the services. The second reading speech recognises the practical reality that it is for the practitioner who claims it to do enough to show that exceptional circumstances existed on the relevant days so that the Committee could reasonably conclude that exceptional circumstances existed on those days.

[113] In those circumstances, it is my view that the Committee was correct when it said at new [15] that "while there is no legal onus of proof in Committee proceedings, once a prescribed pattern of services has been found to exist there is a practical or evidentiary onus on Dr Nithianantha to establish that there was an absence of alternative medical services for his patients". That is so, notwithstanding the fact that the Committee's processes are inquisitional in nature, as submitted by Dr Lucy.

Edelsten v Minister of State for Health [1998] FCA 1112 —

> In those circumstances, whilst it is true that the Committee's functions were inquisitorial, the legislation erected the attainment of a positive degree of satisfaction or formation of an affirmative opinion that excessive services had been rendered to a particular patient as a condition of making one of the recommendations set out in paragraphs (c), (ca), (e) and (f) of s 105(2). It may be inapt to say that the Committee sustained an onus of proof in an evidentiary sense but unless it reached the requisite degree of satisfaction it could not make one of those recommendations; see *Minister for Health v Thomson* [1985] FCA 208; (1985) 8 FCR 213 where Beaumont J noted, at 223:

> Generally speaking, concepts of onus of proof used in adversary proceedings are inapplicable in administrative proceedings in the social security area: see *McDonald v Director-General of Social Security* [1984] FCA 57; (1984) 1 FCR 354. However, where, as here, a breach of discipline, or something analogous is alleged, the onus of proving such a breach lies upon the accuser. The general position is explained by Professor Enid Campbell in "Principles of Evidence and Administrative Tribunals" published in Campbell and Waller (ed), *Well and Truly Tried*, (1982), p 53:

There may be legal burdens of proof to be discharged in administrative proceedings just as much as there are legal burdens of proof in purely judicial proceedings. Sometimes the incidence of the burden of proof is spelled out by legislation, but more often than not it is simply implied in the nature of the proceedings. If, for example, entitlement to grant of a licence or benefit depends on proof that certain qualifications have been met, the burden of proving the relevant facts going to qualifications must fall upon the applicant. Similarly where the issue to be decided is whether circumstances have arisen which would justify cancellation or suspension of a licence, or a finding that a breach of discipline had occurred, the onus of proving that these circumstances have arisen would devolve on the accuser. This would be so notwithstanding that the accuser was also, of necessity, the person or body having authority to adjudicate.

In the same case Wilcox J observed, at 226:

> The Committee was required to conduct an inquiry in relation to particular, specified, services. It was required to report its finding in relation to each service. In any case in which it was not able to reach a conclusion it was required to say so. Only if and to the extent that, the Committee positively found any particular service or services to be "not reasonably necessary" was it entitled to recommend disciplinary or recovery action under s 104.

In my view, this was not a case where, as Dr Edelsten apparently argued, because the individual patients had not been called to give evidence, an inference could be drawn that their evidence would not have assisted in tending to establish excessive servicing. The real utility of *Jones v Dunkel* in the present case lies in the principle enunciated by Dixon CJ who, quoting from an earlier judgment of the High Court, observed [1959] HCA 8; (1959) 101 CLR 298 at 304:

> In an action of negligence for death or personal injuries the plaintiff must fail unless he offers evidence supporting some positive inference implying negligence and it must be an inference which arises as an affirmative conclusion from the circumstances proved in evidence and one which they establish to the reasonable satisfaction of a judicial mind. It is true that "you need only circumstances raising a more probable inference in favour of what is alleged". But "they must do more than give rise to conflicting inferences of equal degree of probability so that the choice between them is mere matter of conjecture". These phrases are taken from an unreported judgment of this Court in *Bradshaw v McEwans Pty Ltd* (Unreported, delivered 27th April 1951) which is referred to in *Holloway v McFeeters* ((1956) [1956] HCA 25; 94 CLR 470) by Williams, Webb and Taylor JJ. The passage continues: "All that is necessary is that according to the course of common experience the more

> probable inference from the circumstances that sufficiently appear by evidence or admission, left unexplained, should be that the injury arose from the defendant's negligence. By more probable is meant no more than that upon a balance of probabilities such an inference might reasonably be considered to have some greater degree of likelihood." ((1956) 94 CLR at pp 480, 481) But the law which this passage attempts to explain does not authorise a court to choose between guesses, where the possibilities are not unlimited, on the ground that one guess seems more likely than another or the others. The facts proved must form a reasonable basis for a definite conclusion affirmatively drawn of the truth of which the tribunal of fact may reasonably be satisfied.

In the present case, as I have endeavoured to explain, the facts found by the Committee on inquiry had to form a reasonable basis for a definite conclusion affirmatively drawn that services rendered by Dr Edelsten to a particular patient had not been reasonably necessary for the adequate medical care of that patient. Evidence of a purely statistical kind e.g. that a specific service would be reasonably necessary for only 10% of a typical cross-section of patients and that patient A was one of a population all of whom had received that service would not form a reasonable basis for affirmatively concluding that the service had not been reasonably necessary for patient A. The problem is illuminated by Sir Richard Eggleston's illustration in his seminal article 'Probabilities and Proof' [1963] MelbULawRw 21; (1963) 4 MULR 180 at 183:

> Let us suppose that B is known to have tossed a coin. The fact in issue is whether it was heads or tails. It is proposed to prove that prior to the toss in question, B had tossed eleven heads in succession and it is said that the odds against tossing twelve heads in succession are 4,095 to 1, and that accordingly proof of the result of the previous tosses will show the improbability of a head turning up on the twelfth toss. The evidence would, however, be inadmissible. The probability of a head on the twelfth throw is still only .5. To prove that B had already tossed eleven heads in succession would merely show that he had already achieved a performance against which the odds were 2,047 to 1, or of which the probability was .511, and would not throw any light on the probability or improbability of his having thrown a head on the twelfth toss.
>
> On the other hand, if the question was whether B had tossed a head in any throw on that day, evidence of the number of tosses would be relevant, since the more tosses he had, the greater would be the probability of his having tossed a head on at least one occasion.

For these reasons, I consider that the Tribunal erred in concluding that the failure to call evidence from individual patients was both wise and proper. It is unhelpful to ask whether that failure involved a breach of the Committee's duty to inquire into a matter but, without evidence of that kind and, given that no clinical notes were available, the Committee could not have formed a definite conclusion, that, in the absence of some exculpatory explanation, Dr Edelsten had rendered excessive services for a particular patient. I have already indicated the ways in which evidence from the patient, despite imperfections of recollection and lack of medical expertise, could provide the basis for the formation of the requisite definite conclusion.

After noting that the Committee had been composed of medical experts, the Tribunal, at p 31 concluded this part of its reasons as follows:

> In the particular circumstances of this inquiry, where the "best evidence" was lacking, the importance of the Committee's using its own expertise to inform itself and enable it to carry out its statutory remit of assessing the state of the evidence in order to arrive at its findings on the question of excessive servicing is even more prominent than would normally have been the case. The Tribunal considers, therefore, that the application of its expertise by the Committee was a crucial and wholly legitimate evidentiary and evaluative source by which to inform itself in the circumstances of this particular inquiry.
>
> In summary, therefore, the Tribunal's conclusion is that the "no evidence" ground has not been made out. In particular, it does not regard the present situation as being on all fours with that described by Pincus J in *Taylor v Minister for Health* [1989] FCA 391; (1989) 23 FCR 53 because, unlike the scenario described by his Honour in that case, this is not a situation in which "no evidence whatever" (Ibid, 59) was available on the issue of over-servicing. On the contrary, there was a good deal of evidence, the sources of which have already been discussed in detail, that enabled the Committee to draw inferences as to whether particular services were or were not reasonably necessary and, in accordance with s 104 of the Act, to express the opinion that Dr Edelsten had rendered excessive services.
>
> It is true that those evidentiary sources were not the "best evidence". The Tribunal, however, has concluded that there is nothing in the Act that requires a MSCI to cease its inquiry where a practitioner's clinical notes are not available to it and where, moreover, that practitioner refuses or is not able to assist it in its inquiry (this case being clearly one of refusal as opposed to inability to assist). Indeed, such indicia as the words of the Act provide are against that position and the policy arguments even more strongly so.
>
> Such judicial authority as there is deals mainly with the issue of using "generic" evidence, especially statistical data showing a practitioner's pattern of servicing, in the context of a MSCI's initial decision to conduct an inquiry pursuant to s 94 of the Act. It does not, with a single exception, specifically address the problem this MSCI faced when actually conducting its hearing into the matter of possible over-servicing by Dr Edelsten. That single exception is an observation by Pincus J in *Taylor's* case that "[w]here there is *general* or particular evidence *relevant to the question* [whether a practitioner has rendered excessive services] ... the question of legal onus becomes irrelevant". (23 FCR 59: emphasis supplied)
>
> The Tribunal has concluded that his Honour's observation countenances the legal propriety, for the purposes of an inquiry conducted pursuant to s 94, of a MSCI arriving at an opinion that a practitioner has been guilty of over-servicing which is based on general evidence alone because it lacks the kind of particularised evidence that the practitioner's clinical notes and other testimony would otherwise have provided. That is what the Committee did here. It was entirely legitimate in the circumstances for it to have adopted such an approach. The sole question remaining for this Tribunal, therefore, is whether, on the

> basis of that evidence, it would have arrived at the same findings as the Committee. Accordingly it now turns to this the final question in the review.

I infer that the Tribunal's reference to the "best evidence" was to evidence from clinical notes or the individual patients to whom those notes related. That is to misstate the "best evidence rule" which has been defined as follows in *Cross on Evidence* 4th Australian Edition p 78:

> "Primary evidence" is that which does not, by its very nature, suggest that better evidence may be available; "secondary evidence" is that which, by its very nature, does suggest that better evidence may be available. The original of a document is primary evidence, a copy secondary evidence, of its contents. The distinction is now mainly of importance in connection with documents, because their contents must, as a general rule, be proved by production of the original, but it used to be of much greater significance on account of the "best evidence" rule which occupied a prominent place in books on the law of evidence in the eighteenth and early nineteenth centuries.

The deficiency in the evidence related to services rendered to each "patient concerned" which has been identified above is not supplied by "secondary" or other evidence derived by the Committee's drawing on its own expertise to inform itself. That expertise could legitimately provide a basis only for concluding, for example, what proportion of a typical cross-section of patients with possible cardiac disorders might require echocardiograms. It could throw no light on the need of a particular "patient concerned" for such a procedure. I therefore disagree with the Tribunal's conclusion that there was "a good deal of evidence ... that enabled the Committee to draw inferences as to whether particular services were or were not reasonably necessary" (emphasis added). It is true that Pincus J's observations in *Taylor v Minister for Health* [1989] FCA 391; (1989) 23 FCR 53 at 59 contemplated that "general or particular evidence" might make irrelevant the question of legal onus of proof. His Honour there said:

> It is my view that if no evidence whatever were available from which an inference might be able to be drawn as to whether particular services were necessary, it might not be legally possible for the committee to express "the opinion that a practitioner has rendered excessive services" within the meaning of s 104. In such a case it would be reasonable to say that the practitioner had succeeded because of the onus of proof. Where there is general or particular evidence relevant to the question, however, it appears to me to follow from Thomson's case that the question of legal onus becomes irrelevant.

However, the difficulty with the present case is that what the Tribunal regarded as general or "generic" evidence did not of itself permit an inference to be drawn about the reasonableness or otherwise of a service rendered to a particular patient. The concentration required by the statutory scheme on the services rendered to "the patient concerned" did not permit a conclusion adverse to the practitioner to be based solely on general evidence of the kind which was before the Committee in the present case. I am reinforced in this conclusion by the enactment, after the Committee's hearing related to Dr Edelsten, of Act No 22 of 1994 which permitted the referral to a Committee under a new s 87(1) of the question whether a person had engaged in "inappropriate practice" in relation to one or both of the following:

(a) specified services;

(b) services rendered or initiated by a practitioner that are one or more of the following:

(i) services of a specified class;

(ii) services provided to a specified class of persons;

(iii) services provided within a specified location.

In respect of such a referral, the Committee was empowered by s 106H to base its findings wholly or partly on its findings on [the practitioner's] conduct in connection with a sample of those services". That new legislative scheme, I consider, permitted a finding solely based on general evidence and statistical samples which was not available under the Act as in force when the Committee inquired into Dr Edelsten's conduct which ordained a concentration on whether services were or were not reasonably necessary for the adequate medical care of the patient concerned. This is borne out by the Second Reading Speech on the Bill for the Act which inserted the 1994 amendments. In the course of that speech as recorded in Hansard for 30 September 1993 at p 1556 it was said:

> A major factor in the inability to impose penalties commensurate with the extent of a practitioner's overservicing is the current lack of power to make decisions on the extent of overservicing on the *basis of generalised evidence*. At present judgments about overservicing can only be made *on the basis of individual services*, that is, recovery of benefits and the imposition of penalties can only be made in respect of each service separately determined to have been excessive.
>
> ...
>
> A significant change in the bill is the replacement of the concept of excessive servicing with one of inappropriate practice. Whereas excessive servicing is currently defined as the rendering or initiation of services not reasonably necessary for the adequate care of the patient, the concept of inappropriate practice goes further. It covers a practitioner engaging in conduct in connection with the rendering or initiating of services that is unacceptable to his or her professional colleagues generally. (Emphasis added.)

I have already indicated why, in my view, the fact that clinical records were not available did not require the Committee to cease its inquiry directed to whether excessive services had been rendered to each patient concerned. The Committee's confining itself to general evidence of a statistical or "epidemiological" kind and to inferences drawn by expert medical witnesses from that evidence, precluded it from effectively completing its inquiry into any identified "patient concerned". This conclusion is enough to uphold the general contentions which have been advanced on behalf of the applicant.

Kew v Director of Professional Services Review [2021] FCA 1607 —

[145] Sixth, notwithstanding how the committee expressed itself at [175], Dr Kew was not required to establish the positive proposition that what she had done was acceptable to her peers. She did not carry the onus. Moreover, s 82(1)(b) required the committee to consider whether her conduct would be unacceptable. But on a review of the reasons as a whole, I am satisfied that the committee did not reverse any onus.

Use of statistical evidence

It is often the case that practitioners come to the attention of the Chief Executive Medicare because of an analysis of the statistical data concerning patterns of billing. The fact that a practitioner might be a statistical outlier in billing patterns is often one of the reasons given for requesting the Director to review their provision of services. A practitioner is usually given an opportunity to explain their billing and mode of practice to a Departmental Medical Officer before a decision is made whether to recommend to a delegate of the Chief Executive Medicare to make a request of the Director of PSR to review the matter.

Once the Director commences a review, or a matter has been referred to a Committee, statistical information is usually of little probative value because both the Director and the Committee are usually more concerned with the specific conduct of the person under review in respect of particular identified services rather than how their billing compares to a particular practitioner cohort.

Artinian v Commonwealth [1996] FCA 1903 —

> [36] On behalf of the applicant it is submitted that the Commission in referring to the Director and the Director in acting under s93 of the Act, took into account irrelevant matters being Dr Artinian's statistical standing in comparison to other practitioners.
>
> [37] So far as emerges in the material before me, it is clear that Dr Artinian came to the notice of the Commission, at least in recent times, as a result of "service patterns in his profile". When Dr Artinian's practice was compared with the practices of other active general practitioners in Australia, it was noticed that Dr Artinian provided substantially more services in a year (23,706) than 99% of all active general practitioners in Australia. The 99 percentile was in fact 16,961. While general practitioners on average spent 39 hours per week in contact with patients (and worked 55 hours per week), Dr Artinian it would seem averaged 464 services per week with 70 hours of total patient contact per week, seeing an average of 6.5 patients per hour. These and other figures might well lead to the conclusion either that Dr Artinian would be so exhausted from seeing a large number of patients as not to give his patients appropriate medical attention or alternatively was misstating the number of patients he had personally seen or the time in which he spent with them.
>
> [38] An interview was ultimately held between Dr Artinian and medical advisers at which certain Provider summary statistics were discussed and the concerns of the Commission that the volume of patients being treated was inappropriate was made clear to Dr Artinian.
>
> [39] The submission, as I understand it, is that the Commission or the Director, as the case may be, were not entitled to take into account these statistics. There is some suggestion in the submission that statistics were the only matters taken into account

and that the record of interview and a subsequent recommendation by Dr Whitby, a general practice consultant, recommending that it was appropriate that Dr Artinian be referred to the Director of Professional Services Review, were not taken into account. Factually, there is no support for that submission.

[40] It seems to me almost unarguable that the Commission was not entitled to take into account the statistical material in determining whether or not to refer Dr Artinian's conduct in connection with his rendering of services, to the Director. The time spent by Dr Artinian, even if considered without reference to the time spent by other practitioners, would seem enough to raise questions for consideration. When, however, the time he spent is compared with time spent by other practitioners, the point is even more obvious. No doubt it is possible that there could be good explanations. But this is not to say that the statistical material would be irrelevant in considering the issue under s86.

[41] It is interesting to note that in Dr Edelsten's case a statistical analysis was undertaken of Medicare claims arising out of Dr Edelsten's practice as compared to other practitioners and that the Full Court did not regard this material as in any way irrelevant. Indeed, the Court referred to the "unusual patterns of practice" and the disparity which the results of Dr Edelsten's practice had in comparison with that of others (see at 61). In considering a submission that reference to the statistical material was reference to impermissible considerations, Northrop and Lockhart JJ said "The submission is untenable". Their Honours continued (at 71):

> "In our opinion Dr Nearhos, when exercising his powers under reg 3(2)(b) on behalf of the Commission; Dr Dash, as delegate of the Minister, when referring the matters concerning Dr Edelsten to the Committee under s82; and the Committee, when exercising its powers under s94 of the Health Insurance Act, are not limited to a consideration of the services rendered to a particular patient with respect to specifically defined symptoms, disease or injury. If there is a pattern of services rendered by Dr Edelsten to a large number of patients which is unusual in relation to the pattern of services which it is considered are likely to be provided by the average general practitioner during the same or substantially the same period in a similar location, that is a legitimate matter to consider in deciding whether there may be evidence of the rendering of excessive services."

[42] Their Honours made reference as well to the decision of *Freeman v McCubbery* (1985) 5 FCR 367, a decision of Northrop J subsequently upheld on appeal as clear authority against the argument of counsel for the appellant.

[43] In my view the present submission is equally untenable. There is absolutely no substance at all in the argument that reference cannot be made to the statistical material. Not only is that material relevant but it may also, in a particular case, be highly cogent of inappropriate conduct.

Tankey v Adams [1999] FCA 683 —

[73] Dr Tankey objected to the use of the statistics derived from a mathematical formula to determine the time he spent with patients. In *Artinian v Commonwealth & Ors* [1996] 43 ALD 235 at 242, Justice Hill stated that:

> "There is absolutely no substance at all in the argument that reference cannot be made to the statistical material. Not only is that material relevant but it may also, in a particular case, be highly cogent of inappropriate conduct."
>
> [74] It is of course always necessary to guard against the use of statistics in an unthinking fashion or to become enslaved by them. I have detected no sign that the Committee or the Tribunal did so here. The statistics were used as guides or indicators to be put with other more direct evidence. There was nothing impermissible in this process.

In *Kew v Director of Professional Services Review*, it was argued that the Committee should not have found that Dr Kew's conduct in co-billing items 104 or 105 with a diagnostic imaging service would be unacceptable to the general body of radiologists because there were statistical data that demonstrated that many other radiologists also co-billed these items to a similar extent. The Court rejected that argument, indicating that statistics were unlikely to trump the detailed analysis the Committee had made of the sampled cases, the Committee was not obliged to take the statistics into account, and it was not required to investigate the circumstances behind those statistics. While the Committee appropriately took into account the usual variances of practice and differences of opinion within the specialty, it was not required to base its assessment of the opinion of the general body by reference to one member, or a part of, the general body of radiologists.

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> [136] Now as to the statistical material, Dr Kew's submissions to the committee were to the effect that a majority of radiologists billed items 104 or 105 in association with a diagnostic imaging item and item 18222 was rendered in association with item 104 or 105 in almost A% of cases and item 18216 was rendered in association with item 104 or 105, B% of the time. Therefore, so it was said, the committee could not be satisfied that Dr Kew's peers would consider the conduct unacceptable.
>
> [137] But whether co-billing was justified or not depended on the facts of each case.
>
> [138] In my view, the committee appropriately disposed of Dr Kew's argument without error (at [156] and [175]). I have already set out [156]. Let me set out [175]:
>
> > Both the Submissions and the submissions on the Draft Report relied on data provided to Dr Kew by the Committee (via the Department of Health) which reflected how many radiologists in Australia co-billed certain diagnostic procedure and consultation items during the Review Period. The Committee considers the statistical information to be of limited use in its task as it has not had an opportunity to investigate the systems of work of other radiologists. It does not follow that simply because many other radiologists have a similar billing profile to Dr Kew, or that certain MBS items such as 104 and 105 are regularly billed with procedures such as MBS item 18222, that Dr Kew's

particular practice in billing these services would be deemed acceptable by her peers. The Committee's review of the Referred Services is not based on statistics but is conducted with the benefit of the records and Dr Kew's evidence about particular services.

[139] In my view the committee was entitled so to proceed.

[140] First, its approach was, if I might say so, transparently rational. Statistics are one thing, and they were considered by the committee. But they could not or at least did not trump the committee's more detailed consideration. I also note here that the label "statistics" may over-state what was really being provided, which was in essence summarised aggregate data.

[141] Second, of course the committee was not bound to take the statistics into consideration. But it did consider them as part of the matrix of material before them.

[142] Third, I reject the suggestion that the committee was obliged to go away and investigate the particular circumstances behind the underlying data.

[143] Fourth, I have little difficulty with the committee's analysis in [150] addressed in context to the expression "the general body of specialists". Perhaps the reference to "singular threshold" is a little infelicitous. No matter. All that the committee was saying was that the hypothetical views of "one member, or a part of, the general body of radiologists" was not the relevant lens, although of course they could be taken into account. And as they say. "the usual variances of practice and differences of opinion" are relevant.

[144] Fifth, if one appreciates the point that I have just made, then the committee's observations at [153] are both consistent and unremarkable. Moreover, the latter part of [153] is grounded in the factual reality of the precise circumstances before them concerning Dr Kew's conduct and what the records reflected or otherwise.

[145] Sixth, notwithstanding how the committee expressed itself at [175], Dr Kew was not required to establish the positive proposition that what she had done was acceptable to her peers. She did not carry the onus. Moreover, s 82(1)(b) required the committee to consider whether her conduct would be unacceptable. But on a review of the reasons as a whole, I am satisfied that the committee did not reverse any onus.

[146] Seventh, there was no positive other evidence of peer practice before the committee apart from the statistics. But then there did not need to be given the direct evidence of Dr Kew's conduct, the legal requirements and the fact that the members of the committee had relevant specialist expertise.

[147] Eighth, for all one knows in terms of the statistics, where other specialists were charging both fees they may have been doing so where there was meaningful consultation. But in Dr Kew's specific case the committee concluded otherwise.

Use of patient surveys and support of specialist colleagues

A Committee cannot disregard material that is relevant to issues it has to consider, but it is a matter for the Committee as to what weight is to be given to that information.

Tankey v Adams [1999] FCA 683 —

> [112] The reasons for the Referral were in relation to the number of services rendered per day by Dr Tankey. It also stated that "Dr Tankey's referral letters lack adequate clinical information". To deal with that allegation, letters from eighteen specialist colleagues were presented (the letters). The Committee commented:
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> > Dr Tankey submitted letters of support from a number of specialist colleagues. The Committee would not accept that those specialists are cognisant of all the facts of the referral and what was elucidated at the hearing regarding the mode of practice of Dr Tankey. It would accept that the referrals to those consultants would have been medically appropriate. However, with regard to the question posed by the HIC Referral, the Committee can give but little weight to such testimonials.
>
> [113] Even if, as was suggested during the proceedings in this Court, specialists generally pay little attention to referrals from GPs, the tone of the letters was generally positive as to the appellant's practice. On one view these letters were testimonials, on another they were direct evidence of the adequacy of Dr Tankey's referral letters. The test to be applied is that fixed by the standards of the body of GPs as revealed by the evidence. The examination of the appellant's practice according to standards set by GPs so established does not render inadmissible the comments made by his specialist colleagues, for at least two reasons, one, because these specialists may have previously been GPs themselves, and secondly, because they deal with GPs all the time.
>
> [114] As I read them, the quality of Dr Tankey's referrals varied, some being singularly uninformative, while others had more information. It cannot be said that referring doctors must inform specialists of every factor of a patient's case. It is also open to the specialists to ask the GP for more details or to ask the patients for additional information, including the medication they are taking, the results of the exercise being dependent on the different levels of competency of patients.
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> [115] As to the patient surveys, the Committee stated:
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> > Dr Tankey provided survey forms completed by his patients which demonstrated their satisfaction with his practice. However, the evidence given by the three general practitioners was that patient surveys are not a strong indicator of what the profession would regard as acceptable medical practice. The Committee would agree with that view.
>
> [116] The answers given to more than 100 patient questionnaires were an attempt by Dr Tankey to compile a general view of his patients of the service and quality of care provided to them at his practice. Despite the opinion of the expert witnesses at the Committee's hearing that patient surveys are not a reliable indication of the

> objective acceptability of a doctor's practice, I am of the opinion that patient satisfaction, particularly in an increasingly litigious area, would certainly be some evidence of the type of service provided by a practitioner, even allowing for the high level of trust often placed in doctors by patients. Furthermore, when one of the major allegations against a practitioner is that because he is seeing a vast number of patients, he could only be giving a few minutes is given to each, several patients' responses that the doctor was not too curt or rushed, inattentive or incomplete may be of some relevance. Out of a relatively large number of patients surveyed, it might be expected that at least a handful would have been dissatisfied with the doctor's service, which was not the case. Of course if some were dissatisfied, they may not have completed the questionnaire or their replies might simply not have been produced. But these possibilities raise a question of weight, not relevance or admissibility.

Tisdall v Health Insurance Commission [2002] FCA 97 —

> [95] … The Committee is not bound to accept the additional evidence but it must consider it. There is cogency in the respondent's submission that the deponents were for the most part specialists and not general practitioners. The Committee could not be confident as to the extent to which they were appraised of all relevant circumstances or as to what had transpired at the earlier hearing. A number of them had furnished letters and material to the Committee prior to the Draft Report. In these circumstances, the weight to be given to this material was a matter of evaluation for the Committee and it is not one for this Court. Even where the material is uncontradicted, there remains a question of evaluation as to its importance and weight in balancing the countervailing considerations and this is for the Committee and not the Court on review.

Use of members' own expertise

The members of a PSR Committee are entitled to use their experience and expertise in their decision-making.

Minister for Health v Thomson (1985) 8 FCR 213, [1985] FCA 208 (per Beaumont J)—

> The respondent further argues that the Committee denied him natural justice by using its own experience and expertise to determine an appropriate frequency of visitation. Although the Committee acknowledged that it did use its own experience and expertise in coming to its conclusions, it does not follow that any breach of the rules of natural justice thereby occurred. By virtue of the provisions of s.80(2), only medical practitioners may be appointed to the Committee and it is only reasonable to assume that the respondent was at all material times on notice that the members of the Committee would be likely to make use of their own expertise and experience in such matters (see *Rex v City of Westminster Assessment Committee; Ex parte Grosvenor House (Park Lane) Limited* (1941) 1 KB 53 at p.69; cf *Keller v Drainage Tribunal and Montague* [1980] VicRp 43; (1980) VR 449 at p.453).

Tisdall v Health Insurance Commission [2002] FCA 97 —

[96] It is of course a well-settled principle of administrative law that where a tribunal obtains specific material or information on which it relies to reach its decision without disclosing that material to the party adversely affected, there may be a breach of the requirement of procedural fairness. The circumstances that the tribunal is not bound by the laws of evidence and can obtain such information as it considers appropriate exclude the duty to disclose the material: see *R v Metropolitan Fair Rents Board; Ex parte Canestra* [1961] VicRp 16; [1961] VR 89 at 91-93 and authorities there cited.

[97] The extent to which an expert tribunal can use its own expert knowledge was considered by Stephen J *in Spurling v Development Underwriting (Vic) Pty Limited* [1973] VicRp 1; [1973] VR 1 at 9-10. That case involved a challenge to a decision of an expert town planning body. His Honour considered that there was little clear authority on the obligation of expert tribunals to disclose their own accumulated store of experience as distinct from specific sources of information such as reports of inspectors, personal inspections, and the like. At 10 his Honour said:

> " ... I say only that I would adopt the view ... that where only general expert knowledge of an expert tribunal is in question there need not be disclosure of that expert knowledge to parties in order for the hearing to be fair in the sense of complying both with the requirements of natural justice and with the terms of ...the Town and Country Planning Act – 'the experience of an expert tribunal such as this, is part of its equipment for determining the case': *R v City of Westminister Assessment Committee* [1941] 1 KB 53, per du Parcq LJ at p 69 ...
>
> I would not myself have concluded that non-disclosure of the sort of experience referred to in the Tribunal's reasons (if interpreted as referring to the experience of the Tribunal itself) involved any breach of ... the Act or of the requirements of natural justice."

[98] These statements were *obiter* because His Honour, in fact, formed the view that the Tribunal was relying on the evidence and not its own expert knowledge and experience. The reasoning nevertheless provides some useful guidance as to an appropriate approach.

[99] In these passages his Honour draws a distinction between the ***general*** experience and expertise used to evaluate material before the expert Tribunal, in contrast to the obtaining of ***specific material*** or facts which are then relied on by the expert Tribunal to reach a decision. In the former case, the better view seems to be that disclosure is not required but in the latter case where there are specific sources of information or particular, specific, experience called into play, disclosure may be necessary. The generalised nature of the experience of the members of the Tribunal in that case is set out in the judgment. By ***particular information*** or ***exposure*** I am referring to some matter, thing, observation or knowledge which would not be apparent to a party as part of the general expertise or experience of a member. For example, in a town planning case, independent personal knowledge of the activities carried out at a particular site where a question of "existing use" is in contest could amount to ***particular*** specific relevant knowledge of which the parties may normally be unaware. If such knowledge were reflected in the decision

without first alerting the parties there could be a breach of procedural fairness requirements.

[100] The observations of Stephen J were applied by Batt J in *Roads Corporation v Dacakis* [1995] VicRp 70; [1995] 2 VR 508 at 529-530. In that case it was not necessary for his Honour to consider the question as to the use of general expert knowledge because in his view the Tribunal had not used its expertise to supplant or contradict the evidence. However, he said that if he had concluded that such knowledge had been used then it must have been specifically referable to the land in question and therefore was not within the realm of general expert knowledge so that disclosure should have been made. That is in sharp contrast to the circumstances in the present case, where there is no indication whatsoever that the Committee had used its expertise to contradict evidence apart from speculation.

[101] There is a useful statement of principle by Street CJ in *Kalil v Bray* [1977] 1 NSWLR 256 where his Honour, with whose reasoning Moffit P and Glass JA agreed, said in relation to an expert disciplinary tribunal under the *Veterinary Surgeons Act 1923* (NSW), at 261:

> "The tribunal is in truth an expert panel, and as such it needs no expert evidence on matters within its particular field of expertise, that is to say, the field of veterinary science. Its function is to determine in the light of factual evidence, with or without supplementation by expert evidence, the proper veterinary conclusion to be drawn from such objective facts as may be established by the evidence, bearing in mind at all times that its function is essentially, as its name imports, disciplinary. It provides a veterinary surgeon facing a charge with a forum constituted in the majority by his professional peers and supplemented, in the interests of natural justice, with judicial chairmanship."

[102] At 262 his Honour continued:

> "The purpose of setting up the tribunal, with its membership drawn from the ranks of veterinary surgeons, is to enable it to do the very thing that either a Bench of justices or a jury may not do, that is to say, to draw upon its own expert resources to resolve such questions of expert science as might emerge from the objective, or lay facts proved in evidence before it. In doing so it will, no doubt, give due weight to such expert evidence, if any, as may be placed before it. But the ultimate responsibility for forming an expert view upon which the disciplinary powers will be exercised or withheld is with the tribunal itself. This is a responsibility to be discharged by drawing upon its own internal resources of knowledge of veterinary science."

[103] Of course, the Committee in the present case is ***not a disciplinary*** body but its findings are of a serious nature which could have a substantial impact on the livelihood of a practitioner under investigation. The approach taken by Street CJ are apposite to the present case. [emphasis in original]

…

[105] The duty of disclosure by an expert tribunal is discussed and examined in detail in Aronson and Dyer, *Judicial Review of Administrative Action*, 2nd ed. at 419-425 and the cases there cited. They say at 425:

> "The difference between identifying critical issues to be addressed, and disclosing mental processes and proposed conclusions, is one of degree only. But it would appear to be a significant distinction nevertheless."

I agree with this observation. It is normally sufficient to identify central issues to the parties affected and it is not usually necessary to explain or disclose the thinking process.

Tisdall v Webber [2011] FCAFC 76 —

> [24] It follows from a consideration of the scheme adopted by the Act that, in the exercise of the adjudicative power (s 93 and Division 4 of the Act) to consider and make findings as to whether Dr Tisdall's conduct in rendering services specified in the referral under s 93(7) constituted engaging in inappropriate practice by reason of engaging in a pattern of prescribed services for the purposes of s 106KA, the Committee must act judicially. It must act according to the principles established in *Avon Downs Pty Ltd v Federal Commissioner of Taxation* [1949] HCA 26; (1949) 78 CLR 353 at 360 per Dixon J; *The King v Connell and Another; Ex parte Hetton Bellbird Colliers Ltd* [1944] HCA 42; (1944) 69 CLR 407 at 429-432 per Latham CJ; *Craig v South Australia* [1995] HCA 58; (1995) 184 CLR 163 at 179 per the Court; and *Minister for Immigration and Multicultural Affairs v Yusuf* [2001] HCA 30; (2001) 206 CLR 323 at 351 at [82] per McHugh, Gummow and Hayne JJ. Provisions such as s 98(3) and s 106(2) of the Act are generally regarded as facultative and in some senses free a decision-maker from the constraints applicable to courts of law although, notwithstanding those freedoms from constraint (in a limited sense), the administrative decision-maker must nevertheless act judicially.
>
> …
>
> [86] Although the Committee members are entitled to consider and undertake their adjudicative function concerning the statutory factors against the background of their own professional experience as general practitioners especially having regard to s 95 of the Act which requires the Committee to be comprised of general practitioners in a case where a general practitioner is the person under review, the Committee members are not entitled to make findings of fact informing its state of non-satisfaction of those statutory factors based upon assumptions of likely capacity and likely disposition to see patients, unsupported by actual evidence, or simply based upon inferences drawn from statistics which do not reveal facts about the reasons for statistical rates of attendance.
>
> [87] This is especially so when the consequences for a citizen of findings made on such a footing is that the citizen might be deprived either for a time or entirely of an entitlement to earn an income from undertaking the provision of services.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

> [193] I also reject the applicant's argument that, having regard to the existence of debate about the time at which entitlement to MBS item 597 arises, it was not open to the Committee to make the finding it did concerning the applicant's conduct in making the claims he did under MBS item 597. While Dr Nithianantha put into evidence an opinion that had been obtained by someone (it is not clear that it was

the applicant) from the Provider Services Branch of the Department of Human Services which supported his reading of MBS item 597 (see [38(6)] above), the Committee rejected that advice on the basis that it was not correct. Dr Nithianantha could not have relied on that advice because it was obtained after the review period (at [60]-[62] of the final report). There was no other evidence of the debate. In any event, as noted in *Sevdalis* FCAFC at [21], the Committee is a peer review body. Under s 95(5) of the Health Insurance Act, where the person under review is a general practitioner, the members of the Committee must also be general practitioners. The Committee was in a position to form a view of whether the claims made by the applicant under MBS item 597 would be unacceptable to the general body of members of that profession having regard to their (in my view correct) interpretation of that item and reg 2.15.1, notwithstanding that some practitioners may have had a different view.

Norouzi v Director of Professional Services Review Agency [2020] FCA 1524 —

[65] A committee is not a lay tribunal, entirely reliant on the presence of expert opinion from others in order to make findings of fact calling for expertise. It is constituted as a group of professional peers, charged with investigating whether there has been inappropriate practice and then making consequential findings against specified criteria. It is expected that members of a committee will "bring to his deliberations that knowledge and experience which qualified him for appointment": *Reece v Webber* (2011) 192 FCR 254, at [50]; see also *Selia v Commonwealth of Australia* [2017] FCA 7, at [104], per Perry J.

…

[72] The whole point of the committee system for which Pt VAA provides is that a committee is entitled to reach its own views, on the basis of the professional training, knowledge and experience of its members, as to whether it would be "reasonable to conclude" that the conduct would be "unacceptable to the general body of [in this case medical practitioners]". The latter, and nothing else, is the material test. I respectfully agree with an observation made by Farrell J in *Nithianantha v Commonwealth of Australia* [2018] FCA 2063, at [193], that conduct may be "unacceptable to the general body of medical practitioners", "notwithstanding that some practitioners may have had a different view". Equally, it is possible to envisage cases where it would be reasonable for a committee to conclude the general body of medical practitioners might allow that there is more than one clinical approach open in relation to the rendering of a particular service. As it is, for just the reasons it gave, this committee was not obliged to reach such a conclusion in the present case.

Raising allegation of bias after the hearing

Allegations of bias or apprehended bias should be made as soon as practicable that it becomes a concern for the person affected. A significant delay may amount to waiver of the right to challenge on that basis.

Grey v Health Insurance Commission [2001] FCA 1257 —

[31] I propose first to deal with the waiver point. Once there was a doubt whether bias could be waived: *Goktas v Government Insurance Office of NSW* (1993) 31 NSWLR 684, 687. That doubt has now been dispelled by the High Court in *Vakauta v Kelly* [1989] HCA 44; (1989) 167 CLR 568. The rule is that where a party is aware of his right to object to a decision-maker determining a matter on account of bias, that right will be waived if the party acquiesces in the decision-maker continuing to deal with the matter: see generally *R v Byles; Ex parte Hollidge* (1912) 108 LT 270; [1913] All ER 430; *Corrigan v Irish Land Commission* (1977) IR 317; *R v Magistrates' Court at Lilydale; Ex parte Ciccone* [1973] VicRp 10; [1973] VR 122; *Vakauta v Kelly* (1988) 13 NSWLR 502, 528 et seq. That is not to suggest that there must be an express objection requiring the Committee to withdraw. In *Vakauta v Kelly* Toohey J said (at 587): "It may be enough that counsel make clear that objection is taken to what the judge has said, by reason of the way in which the remarks will be viewed. It will then be for the judge to determine what course to adopt, in particular whether to stand down from the case."

[32] It was submitted that Dr Grey's position should be viewed differently because he was not entitled to be represented by a lawyer and was therefore at a presumed disadvantage. I do not agree. Although s 103(1) denies to a practitioner the right to be represented before the Committee by a lawyer, the section permits the practitioner to be accompanied by a lawyer or another adviser. The section contemplates that if a practitioner brings his lawyer, the lawyer may give legal advice to the client during the course of the hearing. That is sufficient, in my opinion, to deny the suggestion that a practitioner is at any disadvantage, at least as regards making a complaint about bias.

[33] What is the position with regard to Dr Grey? On each day of the hearing he was accompanied by a solicitor. If the solicitor thought that, by its behaviour, the Committee had overstepped the mark, he could have advised his client to object. Apparently no such advice was given. Moreover, neither Dr Grey nor his solicitor wrote to the Committee raising the issue of bias. If a letter of complaint had been written shortly after the hearing, it is unlikely that there would be waiver. It was only when Dr Grey received the draft report that bias was raised. By then it was too late to make the complaint. It is not appropriate for a person to wait and see if his case may succeed before raising an objection on this ground.

[34] In the result, Dr Grey has waived any right he may have had to object to the Committee on account of apprehended bias. Because I have reached this conclusion it is not necessary for me to consider whether the conduct complained of would permit a finding of apprehended bias.

[Note: this case was overturned on appeal, but not in relation to this aspect.]

Nature of the proceedings – questioning by Committee members

A Committee hearing is an investigatory or inquisitorial proceeding and not adversarial. The Committee has no 'case' to put and is not a 'prosecutor' or 'contradictor' to the person under review. As such, the Committee is conducting an inquiry and is not an adversarial cross-examiner of the person under review. As an inquisitor, the Committee must be fair, and not engage in the tactics of a cross-examiner who might seek to damage the testimony of a witness by means that are sometimes confrontational and aggressive. The High Court considered a similar role in the context of the Refugee Review Tribunal.

Re Ruddock (in his capacity as Minister for Immigration and Multicultural Affairs); Ex parte Applicant S154/2002 [2003] HCA 60 (per Gummow and Heydon JJ, with whom Gleeson CJ agreed) —

> On occasion the submissions advanced for the prosecutrix were couched in the language of a contention that the rule in *Browne v Dunn* had not been complied with. Where a complaint is made about the failure of a questioner to put to a person giving oral answers a particular question, it is natural for a lawyer's mind to turn to the rule in *Browne v Dunn*. In essence, and subject to numerous qualifications and exceptions, that rule requires the cross-examiner of a witness in adversarial litigation to put to that witness the nature of the case on which the cross-examiner's client proposes to rely in contradiction of that witness.
>
> However, the rule has no application to proceedings in the tribunal. Section 420(2) of the Act states:
>
> > The Tribunal, in reviewing a decision:
> > (a) is not bound by technicalities, legal forms or rules of evidence; and
> > (b) must act according to substantial justice and the merits of the case.
>
> The purpose of a provision such as s 420(2) is to free bodies such as the tribunal from certain constraints otherwise applicable in courts of law which the legislature regards as inappropriate. Further, as was emphasised in *Minister for Immigration and Ethnic Affairs v Wu Shan Liang*, administrative decision-making is of a different nature from decisions to be made on civil litigation conducted under common law procedures. There, the court has to decide where, on the balance of probabilities, the truth lies as between the evidence the parties to the litigation have considered it in their respective interests to adduce at trial.
>
> Accordingly, the rule in *Browne v Dunn* has no application to proceedings in the tribunal. Those proceedings are not adversarial, but inquisitorial; the tribunal is not in the position of a contradictor of the case being advanced by the applicant. The tribunal member conducting the inquiry is not an adversarial cross-examiner, but an inquisitor obliged to be fair. The tribunal member has no "client", and has no "case" to put against the applicant. Cross-examiners must not only comply with *Browne v Dunn* by putting their client's cases to the witnesses; if they want to be as sure as possible of success, they have to damage the testimony of the witnesses

> by means which are sometimes confrontational and aggressive, namely means of a kind which an inquisitorial tribunal member could not employ without running a risk of bias being inferred. Here, on the other hand, it was for the prosecutrix to advance whatever evidence or argument she wished to advance, and for the tribunal to decide whether her claim had been made out; it was not part of the function of the tribunal to seek to damage the credibility of the prosecutrix's story in the manner a cross-examiner might seek to damage the credibility of a witness being cross-examined in adversarial litigation.

106A Evidence at hearings

The Committee may take evidence at a hearing on oath or affirmation. The hearing is the opportunity for evidence to be given to a Committee. A Committee does not have access to any information provided to the Director unless it is given to the Committee by the Director as part of the referral under section 93, or unless person under review provides it to the Committee or the Committee expressly requires it to be provided to it as part of its investigation. Any such material or information is put into evidence at a hearing.

Reece v Webber [2011] FCAFC 33 —

> [74] … The forum in which a medical practitioner is afforded the opportunity to adduce "evidence" is at the "hearing" conducted by the Committee prior to the preparation of its "draft report". Thereafter the only express entitlement afforded to a medical practitioner is to make "written submissions suggesting changes to the draft report": s 106KD(3).

While, as noted in *Reece v Webber*, the Act does not expressly provide for the taking of evidence after the Draft Report has been given, it has been suggested that circumstances might require a reopening of a hearing in order to take further evidence.

Nithianantha v Commonwealth of Australia [2018] FCA 2063 —

> [163] I do not accept the applicant's submission that it is "unlikely" that the Committee would have countenanced the admission of evidence from witnesses addressing Ms Martin's evidence had Mr Davey made the request for it to do so. It was within the discretion of the Committee to determine the procedure for the conduct of the hearings and it had foreshadowed that there may be other hearing dates if need be. Given the way that the Committee conducted the proceedings, including allowing indulgence on time to make the 23 March 2016 submissions and the presiding member's remark on 7 April 2016 that the Committee did not intend further sitting days "at this time", in my view it would have been open to Mr Davey to seek an opportunity to address these issues by seeking to re-open the hearing to call witnesses or submit evidence before the draft report was issued. It would also

have been open for him to request the Committee to seek further evidence from Ms Martin to address his concern about the perceived "gaps" in her evidence.

[164] It would undoubtedly have been a better and preferable process if the Committee had obtained a thorough proof of evidence from Ms Martin by reference to the Blackwater Health Care Centre's records and provided it to the applicant before the hearing on 7 April 2016 and, if necessary, also deferred the hearing for a time to enable it to do so.

[165] Nonetheless, having regard to all of the matters identified above, in my view there was not a want of procedural fairness to the applicant in the Committee's failure to give him express notice that it might make the finding it did in the draft report, in its failure to invite him on 7 April 2016 to call further witnesses or the fact that Ms Martin's evidence was more extensive than the 1 April 2016 email suggested in relation to the availability after hours of a mobile telephone contact manned by a doctor.

[166] Having regard to the foregoing, it is not necessary for me to make a finding as to whether the applicant could have adduced evidence or for the Committee to have convened a hearing after it issued the draft report. The fact that 106KD(3) makes express provision for the practitioner to be given an opportunity to provide written submissions would indicate that that is the approach contemplated by Parliament to be adopted in the interest of the efficient conduct of an investigation. However, there are potentially serious disciplinary consequences from an adverse finding and there is no express limitation on the Committee's powers to hold a hearing under s 106 so it may be that it is not necessary to infer from the existence of s 106KD(3) that the Committee could not receive more evidence had it been asked to do so. It is relevant that it was not asked to do so.

106A(2) — Administering an oath or affirmation

Subsection 106A(2) provides that any Committee member may administer an oath or affirmation. In practice, at Committee hearings, oaths and affirmations are administered on behalf of the Committee members by officers assisting the Committee. The PSR's internal guide to Oaths and Affirmations states:

Oaths and Affirmations: A Guide for the Professional Services Review

What do we use oaths and affirmations for?

The two main advantages of taking evidence by oath or affirmation in a PSR Committee hearing are:

- it emphasises to the witness the importance of telling the truth and being accurate in what they say to the Committee; and
- it enables a prosecution for perjury if the evidence given is willfully false.

What does the legislation say?

The *Health Insurance Act 1973* (Cth) contains specific provisions enabling prosecutions for perjury in the context of PSR hearings:

- s 106A(1) states that evidence at a hearing may be taken on oath or affirmation
- s 106E(1) provides that it may be an offence to refuse or fail to be sworn or to make an affirmation
- s 106E(2) provides it may be an offence to give a false or misleading answer to a question during a hearing

The HI Act makes it clear that the PSR Committees are not bound by the rules of evidence (s 106(2)), however PSR Committees aspire to best practice, and can look to federal legislation for guidance on the appropriate form of oath or affirmation to use.

Relevantly, Division 2 of the *Evidence Act 1995* (Cth) (Evidence Act)requires that a witness in a proceeding must take either an oath or an affirmation before giving evidence in accordance with the appropriate form set out in the Schedule to the Evidence Act (Appendix 1), or in a similar form. The Schedule to the Evidence Act provides an appropriate form of an oath or the affirmation for witnesses at PSR Committee hearings and should be used unless it is inappropriate to do so.

Practical steps for PSR

In the lead up to a Committee, the Case Manager will contact the witnesses legal representative (or the witness, if self-represented or being summonsed by the Committee) to ask what the preferred form of oath or affirmation will be.

This will ensure that PSR can prepare the appropriate wording and, if necessary, the appropriate holy text. PSR will seek to accommodate reasonable requests as to the form of oath a witness requests to take. Staff should also take to the hearing the Evidence Act Schedule in the event a witnesses changes their mind on the day as to the form of oath or affirmation they would like to provide.

There is no difference in probative quality between evidence given on affirmation or on oath. It is important that witnesses be made to feel comfortable about taking an affirmation as against an oath. They should be offered their options in a non-judgmental way.

If may be that a witness requests the use of an interpreter. In such cases the Committee should use the interpreters oath or affirmation (as appropriate) set out in the Schedule to the Evidence Act.

At the Committee hearing, PSR staff can check the wording of the oath with the PUR if practical.

How can this be inclusive for non-religious people and people of non-Christian faiths?

It is important that the Committee process is respectful and inclusive of people of all faiths, and non-religious people in the oaths and affirmations process. The primary way that this is done is through the option of either an oath or an affirmation, which generally does accommodate for most preferences.

For people of non-Christian faiths, the person may replace "almighty God" in the wording the attached Schedule with the name of a God recognised by their religion.

In the Inquiry into Oaths and Affirmations with Reference to the Multicultural Community held by the Victorian Law Reform Commission in 2002 there were several alternate oaths suggested by members of various religious communities. These have been included below, and provide an alternative form of oath, in a similar form to that provided in the Schedule to the Evidence Act, and would be appropriate to use at a Committee.

Islam: I swear in the name of God, Allah, that the evidence I shall give will be the truth, the whole truth and nothing but the truth and God, Allah, be my witness to what I am saying.

Buddhist: In accordance with Buddhist precept of truthful speech and mindful of the consequences of false speech, I, (name), do solemnly, sincerely and truly declare the evidence I shall give will be the truth, the whole truth and nothing but the truth.

It may be appropriate to confirm with the witnesses whether these forms of oaths would be acceptable to them prior to the hearing.

The use of religious texts?

Under section 24 of the Evidence Act it is not necessary that a religious text be used in taking an oath. That said, many people still prefer to swear on a physical religious text.

When the Case Manager clarifies the practitioner's choice of oath or affirmation and an oath is opted for, the Case Manager should clarify the appropriate religious text to be used (if any), and if the practitioner would like to provide their own text or if the text is to be supplied by PSR. PSR should seek to accommodate reasonable requests in this regard.

Where the practitioner is Christian, the Bible may be used when taking an oath.

Where the practitioner is Jewish, it is likely that the oath will be taken on an Old Testament or a Torah.

Where the practitioner is Muslim, the oath may be taken on the Koran. Islam has specific rules about who can touch the Koran, so if it is being used and supplied by PSR, it should be carried in its cover at all times, and staff should follow the below procedure for administering an oath upon the Koran:

1. Hand the witness the Koran (in its cover).

2. Ask the witness to remove the Koran from its cover.

3. Ask the witness if he/she recognises the book as a true copy of the Holy Koran.

4. Administer the oath.

5. Ask the witness to return the Koran to its cover

What if the witness is remote or virtual?

If the witness is giving their evidence remotely they are still required to give an oath or affirmation. In this case, they are still able to follow the steps outlined above, with the choice between oath and affirmation still available to them. If the witness chooses to take an oath, they can be invited to make use of a holy book, however it is not necessary.

106B Summons to give evidence etc.

A Committee member may, by instrument in writing, summon a person (other than the person under review) to appear at a hearing to give evidence and to produce such documents, if any, as are referred to in the summons.

106C Allowances for witnesses at hearings

Section 9 of the *Health Insurance (Professional Services Review Scheme) Regulations 2019* prescribes, for the purposes of section 106C of the Act, the allowances for expenses in respect of attendance by a person summoned to appear as a witness at a hearing before a Committee.

For a witness attending because of the witness' professional, scientific or other special skill or knowledge, the amount of attendance allowance is equal to the witness' actual fees for preparing to give evidence and of attending to give evidence.

Other witnesses are to be paid any actual salary, wages, or fees lost by their attendance at the hearing up to a maximum of $527 a day.

In addition, a witness is entitled to be paid a travel allowance, being a reasonable amount determined in relation to the witness by the Committee, for transport to and from the hearing, and for meals and accommodation.

106D Failure to attend

If a person served with a summons fails to appear or fails to continue to appear until excused or released from further attendance by a Committee member, without reasonable excuse, they are liable to a penalty of up to 20 penalty units. The offence is one of strict liability, which means that the person is liable even if their failure to attend or continue to attend without reasonable excuse was not intentional, reckless, or negligent.

106E Refusal to be sworn or to answer questions

A person appearing as a witness at a hearing, whether summoned to appear or not, must not refuse or fail to be sworn or to make an affirmation, or refuse or fail to answer a question that he or she is required by a Committee member to answer, or refuse or fail to produce a document that he or she is required under the Act to produce. This section does not apply to the person under review.[184]

The section does not require the person under review give a responsive or meaningful answer to a question.

Hill v Holmes [1999] FCA 760 —

> [12] The hearing commenced on 8 April 1999. The applicant had not produced the documents referred to in the notice of hearing to the secretary of the Committee and at the hearing the applicant was asked whether she had the documents. The applicant informed the Committee that she did not have the documents, that she did not own the notes relating to the patients and that she had tried to get access to them. The applicant said that the clinic in which she worked during the referral period was owned by a company called AMS Health Services Pty Ltd which owned the medical records and that they were not in her power or possession or custody and that she was not able to bring them. The hearing was adjourned to a date to be fixed.
>
> [13] On 16 April 1999 the Committee gave the applicant notice pursuant to par 104(2)(b) of the Act that there would be a further hearing on 18 and 19 May 1999 and the applicant was required by the notice to "Appear at the hearing ... and give evidence to the Committee" and produce certain specified documents.
>
> [14] The applicant had written to the director of AMS Health Services Pty Ltd on 10 March 1999 requesting the medical histories of the patients referred to in the notice of hearing so that they could be produced to the Committee. By letter dated 12 March 1999 that request was denied. The letter was signed by Alicia Clifford as director, Alicia Clifford being the daughter of the applicant. On 13 April 1999 the Committee gave a written notice to Alicia Clifford as director and secretary of AMS Health Services Pty Ltd pursuant to s 105A of the Act requiring her to produce patient records by 22 April 1999. It appears that the notice could not be served personally on Alicia Clifford and the documents were not produced.
>
> [15] The adjourned hearing resumed on 18 May 1999. The applicant appeared accompanied by her husband. The applicant made an affirmation to tell the truth and the members of the Committee commenced questioning the applicant. The transcript of the hearing from this point until the hearing was adjourned occupies approximately forty-eight pages. I do not propose to set out all the questions directed by the Committee or the applicant's responses to the Committee's questions. However, it is fair to say that on a number of occasions the applicant did not answer directly or responsively the questions which were put to her. The

[184] Subsection 106E(6)

Committee asked the applicant whether she had brought the documents the Committee had requested at the earlier hearing. The applicant had not brought the documents as she said they were not in her possession, power or custody. The Committee then asked the applicant questions about a patient whom the Committee identified as the applicant's most frequently serviced patient. According to the Committee this patient had received 490 services from the applicant in one year. The Committee sought by questions to ascertain the applicant's diagnosis for the patient and what the patient's medical condition was during the referral period. The applicant did not answer these questions in a manner which the Committee found satisfactory. For example the following sequence occurred (transcript 12-13):

> DR EDWARDS: Dr Hill, what we are asking you is: a woman you have seen 11/2 times every day for a year, we are asking what her diagnosis is? What is wrong with this woman?
> DR HILL: She is a lady who has many conditions.
> DR EDWARDS: Which are?
> DR HILL: Again, it is not possible to answer that for any particular time, Dr Edwards.
> DR EDWARDS: I am not asking for any particular time, I am asking you what is wrong with this woman? What are her major diagnosis? I am not asking about any particular day.
> DR HILL: You are asking for the whole of 1996, are you not?
> DR EDWARDS: We have said that. What was wrong with her during 1996? During the referral period, what was wrong with her?
> DR HILL: [The patient] has specifically asked me not to divulge any of her medical information.
> DR EDWARDS: I think you are obliged to, Dr Hill. That is the law.
> DR HILL: Then, Dr Edwards, to the best of my ability to recall, in the absence of the medical history, I am unable to give you accurately the required information and to give inaccurate information puts me in great jeopardy. I have taken an affirmation that I will tell the truth. Now, if I am unable to tell exactly and truthfully, I must not tell.
> DR EDWARDS: Dr Hill, I find it incomprehensible that a woman you saw 11/2 times every day for a year, you are unable to tell me what her major diagnosis are. I find that incomprehensible and unacceptable, I am sorry.
> DR HILL: I can only tell you, Dr Edwards, that her condition was very variable. I am not able to specify what was wrong on any particular time or even over a period of a year.
> DR EDWARDS: I cannot believe that, I am afraid, and I think you are being obstructive to this committee.
> DR HILL: No, I am not being obstructive. I have to take into account that I am under affirmation. I have to take into account what the legislation says is to happen to me if I give wrong or misleading information and in the absence of the notes, I am sorry, I am unable to give you accurate information which is what you are asking for. So I am caught.
> DR EDWARDS: Are you telling me that you do not know what is wrong with this woman?
> DR HILL: I am telling you that she has multiple problems and I am telling you, Dr Edwards, that I am unable to accurately when I am under affirmation give those answers.

> DR EDWARDS: Well, I am sorry, I find that unacceptable, Dr Hill, and I cannot believe you."

At page 26 the following exchange occurred:

> DR BANKS: Dr Hill, I think it is reasonable to ask what general medical conditions this woman does suffer from? It is a very different question from asking somebody who they saw on December 12th, this is a person who has been seen 490 times in a year. When one sees a patient fairly frequently, far far fewer times than 490 times a year most doctors would have some recall of the condition or conditions this patient suffers?
> DR HILL: All I can say, Dr Banks, is that over a number of years the conditions have varied. If I give you an answer I cannot be sure that it applies to 1996 and I am not prepared to give an incorrect answer because I am under that affirmation which the committee insisted I be under."

At page 29 of the transcript the Chairperson is recorded as saying:

> "Well, it is clear to me, Dr Hill, that you are obstructing this process and you are not answering our questions either in general or specific terms. Let us go on to the next patient ..."

[16] In general terms the applicant was unwilling to answer directly questions as to the medical condition of the patient who had been the subject of 490 services by the applicant in the referral year. The second patient about whom the applicant was questioned had received 254 services from the applicant during the referral period but the applicant was unable to remember anything about his clinical condition.

[17] After the applicant was questioned about the second patient the Chairperson said (Transcript 37):

> "I believe you have refused to answer questions and I believe that you are not being truthful when you say you cannot remember any clinical details about patients that you have seen on a daily basis and sometimes more frequently than a daily basis; I just cannot believe that."

Shortly thereafter the Chairperson said (Transcript 40):

> "I believe you are obstructing this committee and you are not answering our questions and you are not being cooperative and I think the only way possibly to get around this is to summon your patients and to get them to appear and to ask them, under oath, questions about those consultations and I think that is something that we may well consider doing.
>
> I would also like to remind you that under section 105 of the Act I have got the power to notify the Director of Professional Services Review of these events today and that you have been uncooperative and refused to answer our questions, in my opinion, and if I do that he must act upon that and must fully disqualify you from that point forth from any Medicare repayments to any of your patients."

[18] Towards the end of the hearing the Chairperson said (Transcript 50):

> "Dr Hill, it is our opinion as a committee that you have obstructed the course of this committee hearing by refusing to answer questions and by telling us that you have not remembered even the broadest details of your patients medical histories, which we find impossible to believe. You have refused to give us the information that we have wanted about cases and made it impossible to discuss them with you. You have also refused to give general information about your practice. I think going into an explanation of the background of your practice is not going to be helpful at this stage."

Thereafter the Chairperson also said (Transcript 53):

> "You have told us that you have no memory of things for which clearly we feel as a GP or a medical practitioner you should have a memory for, and you have refused to co-operate."

The Chairperson concluded (Transcript 54):

> "... I feel compelled to notify the Director of the Professional Services Review of the fact that you have not co-operated with this committee and I am going to leave the matter in his hands. So I would like to call this committee meeting to a close."

The hearing was adjourned indefinitely shortly afterwards.

[19] On the following day, 19 May 1999, the Chairperson wrote to the Director with reference to the hearing in relation to the applicant. The letter commenced:

> "As Chairperson of Professional Services Review Committee No. 102 and, pursuant to section 105(1)(b) of the Health Insurance Act 1973 (`Act'), I am required to notify you that, subsequent to the Notice issued on 16 April 1999 under section 104(2)(b), Dr Hill has, in the Committee's opinion, failed to comply with the requirements of this Notice."

The letter set out the events which had occurred since the Committee had been constituted. The letter then continued:

> The Committee found itself frustrated in its ability to carry on the inquiry. Despite repeatedly attempting to question Dr Hill about the most general issues Dr Hill refused to give any meaningful answers to questions about these patients' clinical conditions. The Committee formed the view, based on its own experience in general practice, that if Dr Hill had seen these patients on the numbers of occasions indicated in the HIC referral it was not credible that she was unable to recall any details of their clinical conditions without reference to the medical records. The Committee believed Dr Hill was deliberately avoiding giving any evidence which would assist the Committee in determining whether or not she had engaged in inappropriate practice in connection with the referred services.
>
> ...
>
> Because Dr Hill would not answer questions about any patient seen by her in 1996, the Committee concluded that she was not complying with the requirements of the s.104(2)(b) notice, namely that she appear and give evidence to the Committee. The Committee told Dr Hill that it would advise

the Director of Professional Services Review of her failure to comply with the notice and indicated what the consequences of the notification would be. The Committee than adjourned the hearing indefinitely.".

…

[25] The applicant submitted that the notices given to the applicant required her to give evidence and that she had in fact given evidence. The applicant submitted that the requirement of the notice in accordance with par 104(2)(b) was to "appear at the hearing and give evidence" to the Committee, that it was not to the point that the answers may not have been meaningful and that the fact that the applicant had answered questions meant that the basis for the decision to disqualify the applicant could not stand.

[26] The applicant submitted that a deliberate non-responsive answer is not a failure to give evidence to the Committee or a failure to answer a question for the purposes of s 105(6). It may be, said the applicant, that such a circumstance may be an obstruction or hindrance of the Committee giving rise to a contravention of s 106EA of the Act which prohibits a person from obstructing or hindering the Committee in the performance of its functions. However it was said that there was a fundamental difference between failing to attend and give evidence (par 104(1)(a) and subs 105(1)), failing to answer a question asked by the Committee (subs 104(6) and subs 105(6)) and refusing to answer a question on the ground that the answer might tend to incriminate (par 105(7)(a)) on the one hand and answering a question in an obstructive and evasive manner or giving a deliberate non-responsive answer on the other hand. The applicant did not accept that such was the situation in the present case.

[27] The Director submitted that in substance the applicant had failed to give evidence because her evidence was not responsive to the questions put to her. It was submitted that there was no attempt by the applicant to engage with the questions put to her and that her evasive answers should be considered to be a failure to answer the questions. It was submitted that the applicant was playing with the Committee and constantly evading the questions put to her and that one could not look at any particular question in isolation. It was said that the Chairperson's finding that the applicant had failed to comply with the requirements of the notice was open on the evidence before the Committee and that "failing to answer a question" for the purposes of s 105(6) meant failing to give a responsive answer. Put shortly, a non-responsive or non-meaningful answer was a failure to answer the question within s 105(6).

Reasoning

[28] In order for the applicant to succeed in setting aside the full disqualification it is necessary for the applicant to set aside the decision of the Chairperson of the Committee to notify the Director of the applicant's failure to comply with the requirements of the notice under par 104(2)(b). The attack on the Director's decision to disqualify fully the applicant is based on the grounds that there was no evidence or other material to justify the making of the decision which was contrary to law. However, the Director was bound under par 105(3)(a) to disqualify fully the applicant after receiving a notice under par 105(1)(b). There is no doubt that the

Director received such a notice and, therefore, it cannot be said that there was no evidence or other material to justify the Director's decision. The letter of the Chairperson constitutes such evidence and having been notified that the applicant had failed to comply with the requirements of the notice it was not contrary to s 105 for the Director to disqualify fully the applicant.

[29] Whether the decision of the Chairperson to give the notice can be set aside is more complex. It is apparent from the Chairperson's letter that she and the Committee had formed the view that the applicant had refused to give any meaningful answers to questions put to her, had obstructed the Committee in the manner in which she had responded to the questions put to her and had not co-operated with the Committee. If the proper construction of subs 105(1) and par 104(1)(a) is that the requirement in the notice to appear at the hearing and give evidence to the Committee was a requirement not simply to turn up at the hearing, be sworn or make an affirmation and respond to questions put to her but to give responsive answers to the questions put to her then it cannot be said that there was no evidence or other material to justify the Chairperson's decision. (I refer to par 104(1)(a) as subs 104(3) provides that a notice given under par 104(2)(b) may contain the requirements included under subs 104(1) in the first notice).

[30] I am satisfied that the responses by the applicant to the questions put to her by the Committee (to some of which I have referred in par 15 of these reasons) were such that it was open to the members of the Committee to conclude that the applicant had not given responsive or meaningful answers to the questions put to her and was deliberately avoiding giving any evidence which would assist the Committee reaching a determination. On the basis of this construction of subs 105(1) and par 104(1)(a), subs 105(1) entitled the Chairperson to give the notification to the Director.

[31] However, if the proper construction of the requirement in par 104(1)(a) is that the person under review is required to turn up at the hearing, be sworn or make an affirmation and then answer questions put to her in the sense of articulating answers without regard being given to the content or responsiveness of the answers then there was no evidence or other material to justify the Chairperson's decision to give the notification to the Director. Each question put to the applicant by members of the Committee was responded to by the applicant in the sense that she articulated and uttered an answer albeit an answer the Committee found, with some justification, unsatisfactory. In such circumstances the Chairperson's decision was contrary to law because not only did the applicant turn up at the hearing and make an affirmation but she also gave answers to each question put to her in the sense that she articulated and uttered a response to each question put to her.

[32] Although the members of the Committee took the view (which was open to them) that the applicant had not given responsive or meaningful answers to their questions and that such circumstances constituted a refusal to answer questions and a failure to "give evidence" for the purposes of par 104(1)(a) and subs 104(2) it is still necessary to determine whether such circumstances, as a matter of statutory construction, constitute a failure to "give evidence" for the purposes of par 104(1)(a) and subs 104(2) or a failure to "answer a question" for the purposes of subs 105(5).

[33] Subdivision B of Div 4 of Pt VAA of the Act which contains provisions relating to proceedings of Professional Services Review Committees recognises that in certain circumstances there will be a failure to give evidence – par 104(1)(a) and subs 104(2), a failure to answer a question – subs 104(5) and subs 105(6), a refusal or a failure to answer a question – par 106E(1)(b) and that there may be an obstruction, hindrance or disruption of the committee – s 106EA. This different use of language in each section makes it all the more important to consider the context in which the failure to give evidence and the failure to answer a question will arise.

[34] The word "fails" may have a number of meanings depending upon its context. It can mean simply an omission or the fact that something does not happen, that is to say mere non-fulfilment; it can also mean that something has not happened because of an element of culpability or responsibility. In *Ingram v Ingram* [1938] NSWStRp 25; (1938) 38 SR (NSW) 407, Jordan CJ pointed out that the word "fail" may have at least three possible meanings. His Honour said at 410:

> "... where it is provided by statute that certain consequences shall follow if a person fails to do something which is directed to be done, the meaning of the word `fail' depends upon the context in which it is found. In some contexts it may mean simply the omission to do the thing in question, irrespectively of any reason which may have existed for his not doing it. ... In other cases it may mean an omission to do the thing by reason of some carelessness or delinquency on his part, but not omission caused by impossibility for which the person in question is not responsible ... In other cases, it may mean omission to do the thing, but so that omission caused by impossibility arising from some causes is included and from others is excluded ..."

[35] As Kirby P (who dissented on the point of construction before the Court) pointed out in *CBS Productions Pty Ltd v O'Neill* (1985) 1 NSWLR 601 at 609:

> "There are doubtless several other combinations of circumstances which do or do not attract the verb to fail ...
>
> Scrutiny of judicial observations on the word `fails' (or relevant variants of the verb `to fail') discloses, as one would expect, differing meanings attributed to the word in differing contexts. In some contexts, the courts have been at pains to confine the word to circumstances evincing default or moral blame on the part of the person alleged to have failed ...
>
> On the other hand, an equally lengthy catalogue of cases can be assembled to illustrate the applicability of the words to circumstance where there is absolutely no suggestion of delinquency on the part of the person alleged to have failed, but simply an omission on that person's part to do something required or expected."

Although these observations were made in the context of construing an agreement between two parties they are equally applicable to a context of construing a statutory provision. There are numerous cases where the expression "fails" or "failure" has been construed but those cases are of little assistance because the relevant statutory provisions and contexts are quite different from the present circumstances. The Director relied on *R v Hulme* (1870) LR 5 QB 377 at 385 where the relevant statute entitled a witness called before an enquiry into electoral

corruption to a certificate protecting the witness from prosecution where the "witness shall answer every question relating to the matter aforesaid." The Court held that this provision obliged the witness to give true answers. However that statutory context is sufficiently far removed from the present context to be of little assistance in the present circumstances.

[36] The relevant expression to be construed is not simply "fails", but "fails to comply with the requirements of the notice under paragraph 104(2)(b)". This contemplates two requirements in respect of which there may be a failure:
(a) to appear at the hearing and give evidence to the Committee;
(b) to appear at the hearing and produce documents referred to in the notice.

The failure in respect of the production of documents is easier to identify - the documents are produced or they are not produced. There are no intermediate shades of meaning. The requirement in par 104(1)(b) is therefore a requirement to appear at the hearing and physically produce the documents. No consideration needs to be given to the nature or content of the documents. They only have to answer the description set out in the notice.

[37] The similarity in language in par (a) and par (b) in subs 104(1) suggests that what is contemplated is that the person under review is to turn up at the hearing (that is, appear) and carry out the acts required by the notice, that is to say go through the act of producing the documents or go through the act of being questioned and articulating answers to the questions.

[38] The first passage in the Second Reading Speech to which I have referred in par 20 of these reasons is more consistent with the construction of the critical provisions in s 104 and s 105 of the Act that the reference to a failure to give evidence and a failure to answer a question is a reference to not giving any evidence or any answer at all rather than a reference to a circumstance which includes the giving of a non-responsive or non-meaningful answer.

[39] However s 105(6) makes it clear that a failure to comply with the requirements of a notice under s 104(2)(b) can occur after the person under review has entered upon the procedure of answering questions because it includes within such a failure a failure to answer a question asked in the course of giving evidence.

[40] The expression fails to "give evidence" in par 104(1)(a) (brought about through subs 105(1) and subs 104(3)) and the expression "failing to answer a question" in s 104(5) and s 105(6) contemplate a situation where there is no response at all from the person under review, either because the person has not appeared at the hearing and been sworn or made an affirmation or has not given any answer to a particular question where the person under review has turned up at the hearing and has been questioned.

[41] In my opinion, the expression "appear at the hearing and give evidence to the Committee" in par 104(1)(a) is to be construed as a reference to turning up at the hearing and going through the procedure of giving evidence rather than as a reference to giving responsive and meaningful answers to the Committee. Support for this construction can be found in par 104(2)(a) which provides that if there is a failure to comply with the notice to appear at the hearing and give evidence the

Committee may fix a date for another hearing at which "the evidence of the person under review is to be taken" (emphasis added). The reference to "is to be taken" contemplates that the person under review has either not given any evidence at all or has not answered a particular question. Section 104(5) includes failing to answer a question within the expression failing to comply with the requirements of the notice.

[42] Support for the conclusion I have reached is also found in s 105. Section 105(1) provides that if the person under review fails to comply with the requirements of the notice under s 104(2)(b) then the Committee may proceed with the hearing "in the absence of the person under review" and if the person under review is a practitioner the Chairperson must notify the Director of the failure to comply. This provision therefore contemplates that the failure to comply with the requirements of the notice has occurred because the person under review is absent. The person under review is not absent where he or she has turned up at the hearing, taken an oath or made an affirmation and entered into the procedure of being asked, and giving answers to, questions put by the Committee. The "absence of the person under review" in par 105(1)(a) occurs because of the failure to comply with the requirements of the notice under par 104(2)(b). That failure is to comply with such requirements of the notice being the requirements referred to in s 104(1) which is either or both of, appearing at the hearing and giving evidence or appearing at the hearing and producing documents required to be produced.

[43] Further, subs 105(2) renders subs 105(1) inapplicable where, before the hearing referred to in s 104(2), the person under review notifies the Committee that he or she has a medical condition preventing him or her from complying with the requirements. Again, this provision contemplates that the requirement is one to turn up at the hearing and give evidence or produce documents as the case may be. This construction is not consistent with the proposition that a requirement of the notice is to give evidence in the sense of giving responsive and meaningful answers to questions put by the Committee.

[44] Although subs 105(6) provides that the reference to a failure to appear at the hearing and give evidence in subs 105(1) includes a reference to failing to answer a particular question I consider that this provision is a reference to giving no answer at all to a question put to the person under review rather than failing to give a responsive or meaningful answer to a question. This construction is supported by the exception to subs 105(6) contained in subs 105(7) where the person under review refuses to answer the question, which is not answered for the purposes of subs 105(6), on the ground of self-incrimination. Such a situation contemplates no answer at all to the question. Although there is a change in terminology between subs 105(6) and subs 105(7) from "failing to answer" to "refuses to answer", I do not consider that this change leads to a different conclusion as to the proper construction of subs 105(6). In particular it does not lead to a conclusion that subs 105(6) includes in a failure to answer an answer to a question which is non-responsive to the question put.

[45] The Director submitted that the contrast between "failing to answer a question" in subs 105(6) and "refuse or fail to answer a question" put by a Committee member in par 106E(1)(b) was telling as the meaning of "fail" may be affected by its association with "refuse". Subsection 106E(7) provides that s 106E does not apply

to the person under review. But even if one considers this juxtaposition of expressions, it does not assist in determining the proper construction of s 104 and s 105 as "refuse" in the context of subs 106E(1) is consistent with the fact of not being sworn or not making an affirmation and not producing the documents required to be produced. It gives no colour or flavour to "fail" inconsistent with the construction I have preferred in the context of s 104 and s 105.

[46] In determining which is the preferable construction to give to the expressions fails to "give evidence" and "failing to answer a question" it is helpful to consider the consequences of the failure. It leads, through par 105(1)(b) and par 105(3)(a) inexorably to an immediate disqualification and an immediate inability of the medical practitioner's patients to obtain Medicare benefits in respect of the services supplied by the medical practitioner thereafter. Where the Committee gives to the Determining Officer a report with a recommendation for disqualification of the practitioner (subs 106L(3)) and the Determining Officer directs that the practitioner be fully disqualified (s 106T and s 106U), that disqualification is subject to review by a Professional Services Review Tribunal (ss 114, 115 and 116). However where the full disqualification is made by the Director under subs 105(3) there is no appeal or review procedure provided in respect of the disqualification. It would be surprising if the legislature intended a review procedure in the case of a disqualification brought about by a result of a determination after a substantive hearing yet denied any appeal or such a review procedure where there was a disqualification because there was an issue whether a person under review had given a responsive or meaningful answer to a question put by the Committee.

[47] It may be said that there is an avenue for the person under review to have the full disqualification by the Director lifted or revoked by complying with the requirement to "give evidence" or "answer a question" as the case may be: subs 105(4) and (5). Such an avenue is easily understood if the requirement was either to attend the hearing and commence to answer questions, which the person under review failed to do, or was to answer a question to which the person under review had given no answer at all. In such circumstances the failure to comply with the requirement would be quite clear – there was either no commencement of the process of answering questions or there was no answer at all to a particular question.

[48] However the position would not be as clear cut where there had been an answer to a question which the Committee considered was non-responsive or was not meaningful. If the person under review maintained that his or her answer was responsive and meaningful the issue could not be resolved by any appeal or review procedure. It is unlikely that the legislature intended such draconic consequences to follow the failure to give evidence or the failure to answer a question where the person under review contended that he or she had given a responsive or meaningful answer to the question. However such draconic consequences are understandable where there has been either no appearance at the hearing and a commencement of the procedure of answering questions or no response at all to a particular question.

[49] The Director submitted that if one bears in mind the purpose of s 105 it was apparent that a non-responsive answer to a question was a failure to answer the question for the purposes of s 105. It was said that if the peer investigation and review process provided by the Act was to be effective, with the Committee examining and reaching findings on inappropriate practices, the answers of the

practitioner under review must be responsive and meaningful. The Director referred to the passage in the Second Reading Speech to which I have earlier referred in par 20 of these reasons. I accept that the provision for full disqualification in s 105 reflects the view that:

> "a practitioner whose conduct in the rendering or initiating of publicly funded services is open to question should be required to participate in a professionally oriented process of review."

Such participation occurs when the practitioner attends the hearing, produces any documents required to be produced, swears an oath or makes an affirmation and enters into the procedure of being questioned by the Committee and articulates answers to those questions. The reference to participating in the process of review in the Second Reading Speech takes as its reference point the earlier reference to a practitioner refusing to attend a hearing or to produce documents when required to appear before a Committee. I do not consider that the reference to the passage in the Second Reading Speech relied on by the Director requires me to reach a different conclusion having regard to my analysis and construction of the relevant statutory provisions.

[50] Section 106EA which makes it an offence to obstruct or hinder the Committee or to disrupt a Committee hearing is of little assistance in determining the proper construction of s 104 and s 105. It was introduced into the Act by the *Health Insurance Amendment Act (No 1) 1997* (Cth) which was almost four years after s 104 and s 105 was enacted. The Explanatory Memorandum for the bill for that Act makes it clear that the section was added because:

> "Experience to date has shown that the current provisions are likely to be inadequate in dealing with disruptions and threats against Committee members."

Conclusion

[51] I have reached the conclusion that as the applicant articulated answers to the questions put to her by the members of the Committee there was no evidence or other material to justify the decision that the applicant had failed to give evidence or had failed to answer a question asked by the Committee for the purposes of par 104(2)(b) and the Chairperson was not entitled by subs 105(1) to give the Director the notice which she gave in her letter of 19 May 1999. The Chairperson's decision must be set aside as a consequence of which the Director's decision to disqualify fully the applicant and the disqualification must be set aside.

Coward v Stapleton [1953] HCA 48; (1953) 90 CLR 573—

[6] Then it was said that the only duty of the appellant under s. 68 was to answer the questions put to him, and that even if he gave untrue answers he could not be convicted of refusing to answer. It was pointed out that s. 68, unlike r. 103, does not distinguish between answering questions and answering them to the satisfaction of the court. The order under appeal, however, convicts the appellant, not of failing to answer to the satisfaction of the judge, but of refusing to answer. As no question was put to the appellant which he in terms refused to answer, or in respect of which

> he remained mute, the order must mean that the learned judge considered that some of his purported answers not only were untrue but were so plainly absurd as to convey an intention not to give any real answers to the questions to which they related. That, in effect, is what his Honour said. "A substantial part of the answers I have referred to", he observed, "represented, in my opinion, a shuffling and a fantastic attempt to conceal the truth about the bankrupt's dealings, perhaps I should say, more correctly, manipulations, with vast amounts of money". And he ordered the appellant to be detained in prison until he should make to the satisfaction of the court "proper answers" to the questions.
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> [7] It is only in a strictly limited class of cases that a witness can properly be convicted of refusing to answer a question which he has purported to answer. A disbelief on the part of the court in the truth of the purported answer is not, without more, a sufficient foundation for such a conviction. The words used, considered in their setting and in the light of the demeanour of the witness, must show that in fact the witness is declining to make any reply which can be properly called an answer to the question. There must be a manifestation in some form of an intention on the part of the witness not to give a real answer. It is essential not to lose sight of the sharp distinction that exists between a false answer and no answer at all. Of course a purported answer may be so palpably false as to indicate that the witness is merely fobbing off the question. His attitude in the box may show that he is simply trifling with the court and is making no serious attempt to give an answer that is worth calling an answer. In such cases it may well be right to say that the witness refuses to answer the question, but it cannot be too clearly recognized that the remedy for giving answers which are false is normally a prosecution for perjury or false swearing, and not a summary committal for contempt. Such a committal can be justified only by a specific finding of an evinced intention to leave a question or questions unanswered, or by a finding of contempt in some other defined respect.
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> …
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> [9] … While it is clear enough that a refusal to answer may be inferred from the giving of what purports to be an answer, the power to commit summarily for a refusal so inferred is a power attended by obvious dangers, and extreme caution is required in its exercise. Not only does the charge place the liberty of the individual in jeopardy in proceedings of a summary character which do not surround him with all the safeguards of a jury trial; but the issue whether statements offered as answers not only are false but imply a refusal to answer may well depend upon considerations of degree, which may strike different minds in different ways. The court, especially when it has itself preferred the charge, must be alert to see that it withholds judgment on the issue until it has considered everything which the witness may fairly wish to urge in his defence.

Under subsection 106E(3) a person (other than the person under review[185]) appearing as a witness is not excused from answering a question or producing a document on the ground that the answer or production of the document may

[185] See subsection 104(6), which permits the person under review to refuse to answer a question on the ground that it might tend to incriminate them, and if the Committee believes the answer might tend to do so.

incriminate the person. However, an answer given or document produced and any information given under such compulsion is not admissible in evidence against the person in any criminal proceedings.

Hamilton v Oades [1989] HCA 21; (1989) 166 CLR 486 (per Mason CJ)—

> [16] Of course the section gives no protection to the witness against the use in criminal proceedings of derivative evidence, that is, evidence which is obtained from other sources in consequence of answers given by the witness in his examination. It would be difficult for Parliament to provide for specific protection against derivative use of such answers given by a witness. Immunity from derivative use tends to be ineffective by reason of the problem of proving that other evidence is derivative: *Sorby* [*v The Commonwealth* (1983) 152 CLR 281], at p 312. But in any case, by enacting s. 541 [of the *Companies (New South Wales) Code*] without providing such specific protection, Parliament has made its legislative judgment that such action is not required and has limited specific protection to the possible consequences of direct use in evidence of the answers of the witness, thereby guarding against the possibility that the witness will convict himself out of his own mouth – the principal matter to which the privilege is directed. Thus the legislative resolution of the competition between public and private interest is to provide for a compulsory examination and to give specific protection in relation to the principal matter covered by the privilege but not otherwise, except in so far as a judge, in the exercise of a wide statutory discretion, may see fit in the particular circumstances of a case to give directions as to the matters to be inquired into.

106EA Contempt of Committee

A person must not obstruct or hinder the Committee or a Committee member in the performance of the functions of the Committee or disrupt a hearing before the Committee.

Anderson v XLVII [2014] FCA 1089 —

> [73] In my opinion, the power of the Parliament to provide for punishment of contempts of executive processes can properly be regarded as an incident of the substantive powers granted to it, or as granted by the incidental power in s 51(xxix) of the *Constitution*. It is a means by which the Parliament may ensure respect for, and compliance with, executive processes.

106F Protection of Committee members, representatives and witnesses at hearings

A Committee member has, in the performance of their duties, the same protection and immunity as a Justice of the High Court. A person appearing on behalf of another person at a hearing has the same protection as a barrister has in appearing for a party in proceedings in the High Court. A person appearing as a witness has the same protection, and subject to the same liabilities, as a witness appearing before the High Court. An action or proceeding, whether civil or criminal, does not lie against a person who, without giving evidence at a hearing, gives a document to the Committee in his or her capacity as a consultant to the Committee.

Saint v Holmes [2008] FCA 987 —

> [55] Counsel for the respondents also submitted that evidence such as the communications between Ms Horler, the Secretary of the Committee, and the members of the Committee about drafting the reports, drafts of the reports and documents prepared by Dr Saint derived from these documents, was inadmissible because it was advanced to show the means whereby the Committee made its decision, with a view to impugning of the lawfulness of the decision of the Committee. The respondents contended that each of the members of the Committee enjoys judicial immunity by reason of s 106F(1) of the Act. This section provides that each member of the Committee has, in the performance of his or her duties, the same protection and immunity as a Justice of the High Court. It follows, said the respondents, that it is not open to the applicant to seek to advance evidence of the means whereby the Committee members came to their decision, because the immunity is an absolute immunity and if the Committee members had to answer allegations about how they came to their decision, they would lose the immunity. Dr Saint argued that the judicial immunity would only preclude from admission into evidence documents or other evidence which exposes the actual thought processes of the Committee.
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> [56] In the case of *Herijanto v Refugee Review Tribunal* [2000] HCA 16; (2000) 170 ALR 379, Gaudron J held that the entire general protection and immunity of a Justice of the High Court is conferred on a member of the Refugee Review Tribunal by s 435(1) of the *Migration Act 1959* (Cth). This immunity was described by Gaudron J at 383 as:
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> > … immunity from disclosing any aspect of the decision-making process.
>
> [57] In *Herijanto v Refugee Review Tribunal (No 2)* [2000] HCA 21; (2000) 170 ALR 575 (*Herijanto (No 2)*), the plaintiffs in that case were seeking to undermine a statement made by the Tribunal in its reasons for rejecting a visa application, that it had considered certain specified documents stored in a computer database before making a decision. Gaudron J refused to permit discovery of records which would indicate access by members of the Tribunal to the Tribunal's database at 577, at [9]-[10]:

> So far as the plaintiffs seek discovery to ascertain whether the individual members concerned with their review applications gained access to the Pt B documents stored in computer databases, they seek to achieve indirectly what they cannot achieve directly by means of interrogatories. The protection afforded to individual members of the tribunal by s 435(1) of the Act would be illusory if, although they could not be compelled to disclose their decision-making processes, those processes could be revealed by analysis of computer records. In my view, the protection and privilege conferred by s 435(1) of the Act extends not merely to disclosure by the individual member concerned, but the revelation, by whatever means, of any aspect of his or her decision-making process. This seems to have been the basis for the decision in *Zanatta v McCleary*. In that case the evidence of counsel was not admissible to prove an out of court statement by a judge as to his decision-making process. And it may also be the rationale for the decision of the Privy Council in *Ramlochan v R* in which it was held that a defendant in criminal proceedings was not entitled to production of the notes of the judge who presided at a his previous trial. (Emphasis added. Footnotes omitted.)

[58] In my view, evidence which exposes or purports to expose the means whereby the Committee came to its decision, is inadmissible for the purpose of impugning the decision of the Committee. This is because if evidence was admitted for that purpose the absolute immunity of the Committee from having to answer as to how they came to their decision, would be lost. I do not accept that the preclusion is limited to the class of evidence contended for by Dr Saint. Such a limitation is inconsistent with the width of the preclusion described by Gaudron J as "any aspect" of the decision-making process. Further, it is significant that in *Herijanto (No 2)* the plaintiffs were not seeking access to documents and information disclosing the thought processes of the Tribunal, but discovery of the documents which the Tribunal had accessed before making its decision. Gaudron J refused discovery on the basis that the preclusion extended to "any aspect" of the decision making process.

[59] It follows that I do not accept into evidence any of the documents including the documents compiled by Dr Saint from the derived information or any other evidence, on which Dr Saint sought to rely to expose the process whereby the Committee made its decision, for the purpose of impugning the Committee's decision …

Re Saint and Director of Professional Services Review [2006] AATA 929 —

> [40] As regards para (b) of s 36(1) of the FOI Act, the respondent submitted that disclosure of Document 52 (and, indeed, all of the other abovementioned documents in issue), would be contrary to the public interest on the following grounds:
>
> - Section 106ZR of the *Health Insurance Act 1973* makes it a criminal offence for a person to disclose to another person any of the deliberations or findings of a Professional Services Review Committee or any information or evidence given to a Professional Services Review Committee in the course of its deliberations, unless the disclosure is required or permitted under the

Health Insurance Act or is necessary in connection with the performance of the first-mentioned person's functions or duties under that Act. The existence of this section clearly indicates that the legislature does not regard disclosure of Committee deliberations to be in the public interest. Part VAA provides for the person under review to be furnished only with a copy of the Committee's draft report (and subsequently with a copy of the Committee's final report).

- The notes of members of an adjudicative body made in relation to matters on which they are statutorily bound to reach a reasoned finding in a draft report on which the person under review is given a legal entitlement to comment should not be disclosed. The Health Insurance Act specifically provides for the draft report alone of the PSR Committee to be provided to the person under review for comment. Members of a Committee would be severely inhibited in their task if their hearing notes or preliminary drafts or parts of a draft report or correspondence passing between the Committee Secretary and members as to how findings in the draft report should be formulated were disclosed.
- Members of Professional Services Review Committees have, in the performance of their duties, the same protection and immunity as a Justice of the High Court: see s 106F(1) of the Health Insurance Act. It would be contrary to the public interest if the immunity of Committee members from disclosing any aspect of their decision-making process – an immunity which is "required to ensure freedom of thought and independence of judgment" – were rendered illusory by that process being disclosed by other means such as disclosure under the FOI Act: see *Herijanto v Refugee Review Tribunal* [2000] HCA 16; (2000) 170 ALR 379 at 383; *Herijanto v Refugee Review Tribunal (No 2)* [2000] HCA 21; (2000) 170 ALR 575 at 576, 577.

[41] The Tribunal accepts the respondent's submission.

Phan v Kelly [2007] FCA 269 —

[61] In the course of the hearing and the reading of evidence, there were objections to certain material prepared by Professor Nicholls concerning material said to have been before the Committee. The principal objection taken by the Applicant was that to allow such evidence would be contrary to the principle of 'judicial immunity,' as discussed in the judgments of Gaudron J in *Herijanto v Refugee Review Tribunal* [2000] HCA 16; (2000) 170 ALR 379 and *Herijanto v Refugee Review Tribunal (No 2)* (2000) 170 ALR 575. Those decisions were concerned with the operation of s 435(1) of the *Migration Act 1958* (Cth), which confers on members of the Refugee Review Tribunal ("RRT") the same protection and immunity as a member of the Administrative Appeals Tribunal. In the present case, s 106F(1) of the Act gives to Committee members in the performance of their duties the same protection and immunity as that given to a Justice of the High Court.

[62] The case of *Herijanto* concerned a plaintiff who had administered interrogatories to an individual member of the RRT in relation to the conduct and role of that member in the processing of the plaintiff's application. By way of illustration of the nature of several of the interrogatories, the member was asked to give details as to the time and date when a specific view was reached and over what

period of time the plaintiff's application was considered before the member came to a conclusion. One question concerned the physical location of the member during the consideration of the plaintiff's application.

[63] Her Honour held that the entire general protection and immunity of a Justice of the High Court is conferred on a member of the RRT by s 435(1), and that this immunity extends to the disclosure of any aspect of the decision-making process. In her Honour's view, the purpose of such a provision was to provide freedom of thought and independence of judgment. Her Honour found no difficulty with the proposition that, in appropriate cases, a judge may be required to disclose 'the record' on which the judge has acted. However, in her Honour's view, the production of additional material beyond the record could breach immunity: *Herijanto v Refugee Review Tribunal* [2000] HCA 16; (2000) 170 ALR 379 at 383.

[64] In respect of several of the interrogatories at issue in *Herijanto*, her Honour found that answers would not disclose the decision-making process and therefore these were permitted. However, where Gaudron J considered that the nature of the interrogatories sought compulsory disclosure of aspects of the decision-making process, her Honour held that they constituted a contravention of s 435(1). The offending interrogatories were consequently set aside by her Honour.

[65] In the later *Herijanto* decision, her Honour held that the protection conferred by s 435(1) extended not merely to disclosure by the individual member concerned, but the revelation, by whatever means, of any aspect of their decision-making process. It was also noted by her Honour that whether or not the privilege extended to the revelation, by whatever means, of the decision-making processes of individual members, it would not be right to order discovery to enable the plaintiffs to do indirectly what they could not do directly. Accordingly, her Honour refused the discovery application: *Herijanto v Refugee Review Tribunal (No 2)* (2000)170 ALR 575.

[66] In *Mathews v Health Insurance Commission (No. 1)* [2005] FCA 1061, Edmonds J refused an application for discovery of the file of the Committee. In that case, the Applicant submitted that the file should be disclosed on the basis that an affidavit of the Manager of the Committee Unit indicated that the Manager had reviewed the Committee file and certain statements in the affidavit were made in consequence of that review. Referring to the principles articulated by Gaudron J in the *Herijanto* cases, his Honour rejected the application for discovery of the Committee file.

[67] In the present case, the Committee has not opposed the disclosure of the material provided in Professor Nicholl's report in respect of which the Applicant makes the objection based on judicial immunity. In my view, there are two considerations which lead me to reject the submissions of the Applicant as to the application of judicial immunity in this case.

[68] The first is that the advice of Professor Nicholls and the circumstances surrounding the provision of his report have not been shown to be a part of or an aspect of the decision-making process of the Committee or any individual member. The certification by Professor Nicholls and matters relating to it were directed to

the provision of advice as to whether a statistical method was valid and could be used by the Committee. In other words, the advice of Professor Nicholls provided a basis, factum or tool of analysis in respect of which the Committee was free to act if it so chose. The Committee was able to accept a methodology approved by him as being in accordance with the required procedures, but his certification of the relevant methodology could not be said to be part of the Committee's 'decision-making process' in the sense articulated by Gaudron J in the *Herijanto* decisions.

[69] The second consideration is that Professor Nicholls cannot be considered to be a member or agent of the Committee. I do not agree with Applicant's contention that the principle of judicial immunity operates to prevent Professor Nicholls from providing copies of his report to the Court because he is effectively the Committee's agent. Professor Nicholls is an independent expert consultant of the Committee, and accordingly the evidence which is objected to is not within the immunity conferred by s 106F.

[70] In addition, I do not consider that s 129 of the *Evidence Act 1995* (Cth) takes the matter further or is of any assistance to the Applicant. I do not need to decide whether the immunity can be waived in a manner similar to the way in which, for example, legal professional privilege can be waived, having regard to the public interest element that is concerned with the grant of judicial immunity. I note that Division 3 of Part 3.10 of the Evidence Act in which s 129 appears is entitled "Evidence Excluded in the Public Interest." Clearly, the evidence given by Professor Nicholls in this case is an expression of his own independent advice.

[71] As a consequence of my ruling in the course of the hearing on the judicial immunity objection, counsel for the Applicant indicated that he might seek discovery of other documents in the Committee file on the basis that there had been a "waiver" of the privilege by the Commission, and that the Applicant was therefore entitled to see the whole of the file and not just simply the letter of advice from Professor Nicholls. However, this course was not pressed by the Applicant.

Mathews v Health Insurance Commission (No. 1) [2005] FCA 1061 —

[14] … as the respondent's counsel submitted, having regard to the terms of sub-s106F(1) of the Act which provides:

> "A Committee member has, in the performance of his or her duties, the same protection and immunity as a Justice of the High Court".

and the reasons for judgment of Gaudron J in *Herijanto v Refugee Review Tribunal (No.2)*; *Muin v Refugee Review Tribunal (No.2)*; *Lie v Refugee Review Tribunal (No.2)* [2000] HCA 21; (2000) 170 ALR 575 in considering an application for further discovery of various documents relating to the computer system of the Refugee Review Tribunal, and its computer records, in the context of the provisions of sub-s435(1) of the *Migration Act 1955* (Cth) which, save for the substitution of the words 'Administrative Appeals Tribunal' for 'High Court' is in the same terms as sub-s106F(1) of the Act, the applicant's application for further discovery in terms of access to the Committee's file must be rejected. Her Honour said:

> "[9] ...The protection afforded to individual members of the Tribunal by s 435(1) of the Act would be illusory if, although they could not be compelled to disclose their decision-making processes, those processes could be revealed by analysis of computer records.
>
> [10] In my view, the protection and privilege conferred by s 435(1) of the Act extends not merely to disclosure by the individual member concerned, but the revelation, by whatever means, of any aspect of his or her decision-making process. ...
>
> [11] Whether or not the privilege conferred by s 435(1) of the Act extends to the revelation, by whatever means, of the decision-making processes of individual members of the Tribunal, it would not be right, in my view, to order discovery to enable the plaintiffs to do indirectly what they cannot do directly. Accordingly, in each case, the application for further discovery is dismissed with costs."

Re Raiz and Professional Services Review [2021] AATA 4360 —

> **Committee Investigation (s 47C and s 47E(d))**
>
> [77] The PSR claims immunity under s 47C and s 47E(d) in respect of documents that contain information relating to the deliberations of the Committee in its investigation into the services provided by Dr Raiz during the review period. The documents in dispute in this category are 82 to 84, 92 to 96, 98, 99, 105 to 107, 112, 114, 115, 134, 175 to 178, 243 to 245, 249, 250, 258 to 269, 276, 282 and 307 in the Schedule.
>
> [78] Section 47E(d) provides:
>
> > **47E Public interest conditional exemptions—certain operations of agencies**
> >
> > A document is conditionally exempt if its disclosure under this Act would, or could reasonably be expected to, do any of the following:
> > ...
> > (d) have a substantial adverse effect on the proper and efficient conduct of the operations of an agency.
>
> [79] The Guidelines provide guidance on the interpretation of the words 'would' and 'could' in s 47E(d) at paragraph 5.17:
>
> > The use of the word 'could' in this qualification is less stringent than 'would', and requires analysis of the reasonable expectation rather than certainty of an event effect or damage occurring. It may be a reasonable expectation that an effect has occurred, is presently occurring, or could occur in the future.
>
> [80] The Guidelines further advise on the meaning of 'substantial adverse effect' at paragraph 5.20:
>
> > The term 'substantial adverse effect' broadly means 'an adverse effect which is sufficiently serious or significant to cause concern to a properly concerned

> reasonable person' [see *Re Thies and Department of Aviation* [1986] AATA 141 [24]). The word 'substantial', taken in the context of substantial loss or damage, has been interpreted as 'loss or damage that is, in the circumstances, real or of substance and not insubstantial or nominal' [*Tillmanns Butcheries Pty Ltd v Australasian Meat Employees Union & Ors* [1979] FCA 85; (1979) 27 ALR 367 383].

[81] The phrase 'could reasonably be expected' requires more than a mere assumption or allegation that damage may occur. The Guidelines provide at paragraph 6.103:

> The particulars of the predicted effect should be identified during the decision making process, including whether the effect could reasonably be expected to occur. Where the conditional exemption is relied upon, the relevant particulars and reasons should form part of the decision maker's statement of reasons, if they can be included without disclosing exempt material...

[82] The PSR describes each of the documents to which they claim s 47C and s 47E(d) exemptions in the Schedule as documents containing information that records, or is in relation to, the Committee's deliberations.

[83] Upon Dr Raiz's review application, the PSR further reviewed the documents related to the Committee investigations and provided to Dr Raiz additional information that they deemed merely administrative in nature.

[84] The PSR submits that disclosure of the documents relating to the Committee investigation would disclose deliberative matter in the nature of, or relating to, opinion, advice or recommendation obtained, prepared or recorded, or consultation or deliberation that has taken place in the course of, or for the purposes of, the deliberative processes of the Committee's function of investigating Dr Raiz. They further submit that the documents were created for or by the Committee for its sole function to investigate whether Dr Raiz had engaged in inappropriate practice. They submit that none of the redacted information is 'purely factual matter' as any factual material that has been redacted is integral to the deliberative content and purpose of the documents such that it is impractical to excise it.

[85] Some of the documents relate to requests by the Committee for data related to the Medical Benefits Scheme (MBS). Mr Topperwien provides an explanation of these data requests as follows:

> As part of their investigation, PSR Committees need to consider relevant MBS data and make decisions on what MBS items to investigate. A Committee can choose to investigate a random sample of services which then enables it to apply the sampling methodology under s 106K of the HI Act.
>
> It is usual practice for a Committee to instruct PSR staff at a Committee meeting regarding which items it wants to consider. PSR staff are then responsible for taking all the steps required to enable such consideration and deliberation to occur, including obtaining on behalf of the Committee additional data where required by the Committee.

> The staff of the Committee, and the Committee, may have questions about the particular data from the 'owner' of the data (the Department of Health and previously the Department of Human Services). If so the staff of the Committee are tasked with dealing with the issues on behalf of the Committee.
>
> To undertake its investigation following the Raiz referral, the Committee, in accordance with usual practice, required data about the MBS items specified in the referral from the Director. The Committee directed staff at a Committee meeting to obtain the data in accordance with its decisions. Staff took the necessary steps to obtain and collate the data, on behalf of the Committee.

[86] Dr Raiz submits that requests for data are not inherently deliberative as they do not involve a process of weighing up or considering competing arguments. Therefore, he argues that the MBS data is best categorised as 'purely factual material' and not conditionally exempt. Further, Dr Raiz argues that instructions to staff about which MBS data to review occurs after a deliberative process but is a purely administrative matter in itself. Similarly, Dr Raiz submits that questions from the staff to the 'owners' of the data do not involve a deliberative process.

[87] I reject Dr Raiz's arguments that this material is not deliberative material. I refer to paragraph 6.67 of the Guidelines that states that material that is gathered as a basis for intended deliberations may be deliberative matter. It is clear from Mr Topperwien's evidence that MBS data must be considered as a part of a PSR Committee investigation and further that the Committee must deliberate as to which MBS items to investigate. It is not relevant that the instructions to retrieve certain data technically occurs after the deliberative process as these instructions would reveal the outcomes of deliberations regarding which data to request. Therefore, disclosure of the contents of the requests for data, the data itself, and the staffs' interactions with the 'owners' of the data would all reveal information directly related to deliberations and necessary for the Committee's continuous deliberations.

[88] In any event, the PSR submits that the information relating to the Committee investigations is also conditionally exempt under s 47E(d) because disclosure of the documents would, or could, reasonably be expected to have a substantial adverse effect on the proper and efficient conduct of the operations of the PSR.

[89] The PSR contends that ss 106ZR and 106F of the HI Act which protect against disclosure of Committee deliberations evince parliament's intention that information related to Committee investigations are protected from public disclosure. The PSR submits that if information that reveals Committee deliberations could be uncovered through the FOI process, this would defeat the purpose of these protections.

[90] The PSR submits that this would have a substantial adverse effect on Committee operations as it would limit freedom of thought and independence of judgement which is the purpose of such an immunity provision.

[91] Mr Topperwien deposes to the potential harm to the agency's operations if the documents regarding the Committee's deliberations were disclosed:

> I am concerned, as the Executive Officer of the PSR, that members of a Committee would be severely inhibited in their task if the correspondence on issues about the data that the Committee has requested as part of their deliberative processes were disclosed to the PUR, and that is particularly the case in Dr Raiz's matter as the Committee's investigation is ongoing.
>
> Disclosure of the documents dealing with collection and interpretation of data by PSR staff to ensure the Committee has relevant and correct data for the purposes of its investigation would disclose matters relating to deliberation that has taken place by PSR staff discussed with the Committee in the course of and for the purposes of the deliberative processes of the Committee.

[92] In *Herijanto v Refugee Review Tribunal* [2000] HCA 21; (2000) 170 ALR 575 at 577 [9]- [11], Gaudron J considered the immunity provision that applied to members of the Migration Review Tribunal which was in the same terms as s 106F(1) of the HI Act:

> ...The protection afforded to individual members of the Tribunal by s 435(1) of the Act would be illusory if, although they could not be compelled to disclose their decision-making processes, those processes could be revealed by analysis of computer records.
>
> In my view, the protection and privilege conferred by s 435(1) of the Act extends not merely to disclosure by the individual member concerned, but the revelation, by whatever means, of any aspect of his or her decision-making process
>
> ...
>
> Whether or not the privilege conferred by s 435(1) of the Act extends to the revelation, by whatever means, of the decision-making processes of individual members of the Tribunal, it would not be right, in my view, to order discovery to enable the plaintiffs to do indirectly what they cannot do directly.

[93] Dr Raiz argues that the PSR employs too wide a definition of ss 106F(1) and 106ZR of the HI Act and that requests for data and other information regarding the Committee process do not reveal deliberations that attract immunity. I reject these arguments for the reasons identified above that the redacted information does reveal deliberations for which s 106ZR of the HI Act specifically protects.

[94] There is no general rule that information is not disclosable under the Act if it is attached to an immunity provision in a particular statute. However, if the immunity provision is necessary for the proper functioning of the agency and for decision makers to freely make decisions, there may be a substantial adverse effect if the expected immunity is not upheld.

[95] I accept the PSR's argument that there could be a serious and material negative impact on the PSR's operations if the deliberations of the Committee were disclosed to Dr Raiz. Sections 106F(1) and 106ZR of the HI Act evince parliament's intention that the protections in the PSR Scheme allow Committee members to openly discuss and consider whether a practitioner has engaged in inappropriate practice. If Committee members know that their private deliberations would be available to the person under review, even whilst a review process was

ongoing, I consider that this could severely limit their willingness to openly engage in the review process and deliberate on sensitive and controversial matters.

[96] Therefore, the materials related to the Committee investigations are conditionally exempt under ss 47C and 47E(d).

Public Interest Test

[97] The main factor in favour of disclosing the materials relating to the Committee investigations is promoting the Act by revealing the reasons for the agency's decisions and enhancing scrutiny of the PSR's operations.

[98] Dr Raiz further submits that disclosure would inform debate on a matter of public importance and allow access to his personal information.

[99] I have reviewed the documents and I find that although the Committee investigation documents may incidentally contain some of Dr Raiz's personal information, they are predominantly documents of the Committee, dealing with its investigation. I also do not accept that disclosure would inform public debate in any meaningful sense. The documents relate specifically to Dr Raiz's investigation and they do not reveal any matters that would be of serious concern to a substantial section of the public or raise any issues of public interest about the functions of the PSR scheme. Therefore, I find that the only factor in favour of disclosure is to promote the objects of the Act including by increasing scrutiny of the government's activities and transparency.

[100] The PSR argues that disclosure is against the public interest. They submit that s 106ZR of the HI Act that makes it a criminal offence to disclose deliberations of the Committee is evidence of the legislature's intent that disclosure of information about Committee investigations is against the public interest.

[101] In *Muin v Refugee Review Tribunal* [2002] HCA 30; (2002) 190 ALR 601, Callinan J discussed the equivalent immunity provision for Members of the Refugee Review Tribunal at 669, [299]:

> The entire, general, protective immunity of a Justice of the High Court is conferred on the member of the [Migration Review] Tribunal by s 435 of the Act [163]. The rationale for immunity from compulsory disclosure is the assurance that judges should be free in thought and independent in judgment. That rationale naturally extends to an immunity from disclosing any or all aspects of the decision-making process itself.

[102] Dr Raiz submits that disclosing information about the Committee investigation would not affect the free thought and independence of the Committee although he did not provide clear submissions as to why he held this view.

[103] I am satisfied that there is a public interest in the information surrounding the Committee investigation remaining confidential. This is particularly the case whilst the investigations are still on foot. If the Committee members are aware that a person under review may have access to their deliberations and the information they

> seek in relation to their deliberations, this may fetter their ability to freely seek out information and explore different possible findings without concern of alerting the person under review. The HI Act has implemented statutory immunities for Committee members to ensure the proper functioning of the review scheme and that Committee members may effectively conduct reviews.
>
> [104] At this time, with the review ongoing, I consider it against the best interest of the public for the Committee investigation documents to be disclosed. The Act's general principles of transparency that favour disclosure are outweighed by the real possibility that Committee members will not be able to fully investigate persons under review if they can no longer rely on the confidentiality of their deliberative materials. This would have negative effects on the PSR process and may impede on the agency's important function to protect the public from inappropriate use of public Medicare funding.
>
> [105] I conclude that the materials related to the Committee investigations are exempt from disclosure under ss 47C and 47E(d).

In *Winters v Fogarty* [2017] FCA 51 the Federal Court discussed a similar provision in s 53C of the *Federal Court of Australia Act 1976* relating to the immunity conferred on mediators. In that case, Justice Bromberg held that '[118] … In my view, the protection and immunity conferred upon a mediator by s 53C precludes the curial examination of the conduct of the mediator for the purpose of determining whether a finding ought to be made that the conduct constituted a civil wrong. In other words, whether a mediator engaged in civil unlawfulness in the course of mediating anything referred under s 53A is, in my view, not a justiciable issue.' He then explained the basis for his view as follows:

> ***Winters v Fogarty*** [2017] FCA 51 —
>
> [121] As Beazley P (with whom McColl JA and Tobias AJA agreed) said at [72] of *O'Shane v Harbour Radio Pty Ltd* [2013] NSWCA 315; (2013) 85 NSWLR 698:
>
> > The principle of judicial immunity is of ancient origin, extending from the time of Lord Coke. In *R v Skinner* [1763] EngR 29; (1772) 98 ER 529, Lord Mansfield (at 530) stated the principle in terms that "neither party, witness, counsel, jury, or Judge can be put to answer, civilly or criminally, for words spoken in office." The principle was applied in *Scott v Stansfield* (1868) 3 LR Ex 220, which involved an action for slander brought by a disgruntled litigant against a County Court judge. Kelly CB referred (at 223) to the general proposition that "no action will lie against a judge for any acts done or words spoken in his judicial capacity in a court of justice."
>
> [122] The most recent High Court authority on judicial immunity is *Fingleton v The Queen* [2005] HCA 34; (2005) 227 CLR 166. Diane Fingleton was the Chief Magistrate of Queensland. She was accused and convicted of unlawful retaliation against a witness arising out of certain administrative conduct in which the Chief

Magistrate was engaged. Section 30 of the *Criminal Code* (Qld) provided that "judicial officers" were not criminally responsible for anything done in the exercise of judicial functions. Section 21A of the *Magistrates Act 1991* (Qld) provided that a magistrate has, in performing an administrative function, the same immunity as a magistrate in a judicial proceeding. The High Court unanimously upheld the appeal on the ground that the appellant was immune from prosecution.

[123] After referring (at [36]) to the general principle stated by Lord Denning MR in *Sirros v Moore* [1975] QB 118, Gleeson CJ (with whom McHugh J, Gummow and Heydon JJ, and Hayne J relevantly agreed) explained the policy underlying judicial immunity (emphasis added, footnotes omitted):

> [38] This immunity from civil liability is conferred by the common law, not as a perquisite of judicial office for the private advantage of judges, but for the protection of judicial independence in the public interest. It is the right of citizens that there be available for the resolution of civil disputes between citizen and citizen, or between citizen and government, and for the administration of criminal justice, an independent judiciary whose members can be assumed with confidence to exercise authority without fear or favour. As O'Connor J, speaking for the Supreme Court of the United States, said in *Forrester v White*, that Court on a number of occasions has "emphasised that the nature of the adjudicative function requires a judge frequently to disappoint some of the most intense and ungovernable desires that people can have." She said that "[i]f judges were personally liable for erroneous decisions, the resulting avalanche of suits ... would provide powerful incentives for judges to avoid rendering decisions likely to provoke such suits."
>
> [39] This does not mean that judges are unaccountable. Judges are required, subject to closely confined exceptions, to work in public, and to give reasons for their decisions. Their decisions routinely are subject to appellate review, which also is conducted openly. The ultimate sanction for judicial misconduct is removal from office upon an address of Parliament. However, the public interest in maintaining the independence of the judiciary requires security, not only against the possibility of interference and influence by governments, but also against retaliation by persons or interests disappointed or displeased by judicial decisions.

[124] In a separate judgment, Kirby J emphasized that the purpose of the immunity was to forestall "curial examination" of the exercise of judicial functions (at [176]) (emphasis added, footnotes omitted):

> Secondly, the purpose of the immunities provided by the cited provisions of the Queensland statute law is to forestall, in the cases to which they apply, the very kind of proceedings that occurred in this instance, involving as they did curial examinations of the exercise of functions and powers which the statutory provisions aimed to remove from such accountability, and do so for important principles of public policy supportive of judicial independence. It would defeat the expression and policy of the legislation and be wholly inappropriate to introduce an obligation in every case to examine all the facts so as to provide the characterisation of the "true nature" of what was done or omitted to be done

> by the judicial officer as within or outside the exercise of that officer's functions. To require this would be to undermine the achievement of the purpose of the immunity. It would render it ineffective in practice and would be contrary to the obvious object of the Queensland Parliament in enacting the provisions as it did.

[125] At [188]–[189], Kirby J elaborated and said this (emphasis added, footnotes omitted):

> [188] Judicial independence from external pressure from litigants and others is one of the legal immunities that can be fully justified. It is supported by reference not only to legal authority but also to legal principle and policy, including considerations of the protection of human rights and fundamental freedoms and the functions of the judiciary in securing those ends. Such immunity is an essential precondition to the rule of law. The independence of judicial officers comes at a price. It is a price that our society has long been prepared to pay. That price is the immunity provided by law. The Queensland Parliament has enacted, and also extended, that immunity. It protects the public interest, not just the interests of individual judicial officers.
>
> [189] The Supreme Court of the United States explained the rationale for this immunity. Speaking of constitutional and common law principles akin to those which in Australia preceded the Queensland laws, that Court said in *Pierson v Ray*:
>
> > "Few doctrines were more solidly established at common law than the immunity of judges from liability for damages for acts committed within their judicial jurisdiction, as this Court recognized when it adopted the doctrine, in *Bradley v Fisher*. This immunity applies even when the judge is accused of acting maliciously and corruptly, and it 'is not for the protection or benefit of a malicious or corrupt judge, but for the benefit of the public, whose interest it is that the judges should be at liberty to exercise their functions with independence and without fear of consequences' ... *[A judge's] errors may be corrected on appeal, but he should not have to fear that unsatisfied litigants may hound him with litigation charging malice or corruption. Imposing such a burden on judges would contribute not to principled and fearless decision-making but to intimidation*."

[126] In *Rajski v Powell* (1987) 11 NSWLR 522, a claim for damages was made against a judge of the Supreme Court of New South Wales for allegedly wrongful acts committed in the abuse of his powers, and against the Attorney-General of New South Wales in vicarious liability. The allegedly wrongful acts of the judge related to the purported exercise of his jurisdiction as a judge of the Supreme Court. The Court of Appeal unanimously summarily dismissed the proceeding. In relation to the judicial immunity, Kirby P said at 527–528 (emphasis added):

> It is a fundamental principle of our law that a judge of a superior court is immune from civil liability for acts done in the exercise of his judicial function or capacity. Such immunity rests, as it has been said, upon considerations of public policy. Its object is not to protect judges as individuals but to protect the interests of society. *The purpose of the rule is to preserve the integrity, independence and resolve of the judiciary and to ensure that justice may be*

> *administered by such judges in the courts, independently and on the basis of their unbiased opinion — not influenced by any apprehension of personal consequences*.

[127] *Wentworth* concerned the taxing of costs by a Taxing Officer, in the exercise of the jurisdiction of the court. On the basis that the underlying rationale for the judicial immunity applied equally to a master or registrar exercising the court's jurisdiction or performing judicial functions, Fitzgerald JA (with whom Heydon JA and Davies AJA agreed) found (at [58]–[59]) that the immunity also so applied. Fitzgerald JA relevantly explained the rationale of the immunity as follows at [24] (emphasis added):

> ... Judicial immunity is an essential corollary of judicial independence, which requires that judges be free to administer justice free from not merely the risk of personal liability *but also the burden of resisting the claims and allegations of disaffected litigants*. The protection which judicial immunity is intended to provide to those who perform the controversial but essential function of adjudicating disputes would be denied them if the ambit and operation of the doctrine were open for debate.

[128] At [260] Heydon J cited the following passage from the judgment of Channell J in *Bottomley v Broughan* [1908] 1 KB 584 at 587–586 which is also instructive (emphasis added):

> ... absolute privilege ... is [not] a very accurate expression, and I am sure that calling it a 'privilege' is sometimes misleading. Privilege means, in the ordinary way, a private right. Now there is no private right of a judge ... to be malicious. ... The real doctrine of what is called 'absolute privilege' is that in the public interest it is not desirable to inquire whether the words or acts of certain persons are malicious or not. It is not that there is any privilege to be malicious, but that, so far as it is a privilege of the individual — I should call it rather a right of the public — *the privilege is to be exempt from all inquiry as to malice; that he should not be liable to have his conduct inquired into to see whether it is malicious or not — the reason being that it is desirable that persons who occupy certain positions as judges ... should be perfectly free and independent, and, to secure their independence, that their acts and words should not be brought before tribunals for inquiry into them merely on the allegation that they are malicious*.

[129] A second rationale for the judicial immunity is the need for the finality of litigation. That rationale is expressed in *D'Orta-Ekenaike v Victoria Legal Aid* [2005] HCA 12; (2005) 223 CLR 1 and repeated in *Forge v Australian Securities and Investments Commission* [2006] HCA 44; (2006) 228 CLR 45 at [75] (Gummow, Hayne and Crennan JJ) as well as O'Shane at [78] (Beazley P). *D'Orta-Ekenaike* concerned the advocate's immunity rather than judicial immunity, however, in discussing the basis for the advocate's immunity (at [31]–[47]), Gleeson CJ, Gummow, Hayne and Heydon JJ considered the rationale for the judicial immunity, noting that it was also founded in the need for the finality of litigation (at [40]). At [42] their Honours said this (emphasis added, footnotes omitted):

> In *R v Skinner*, Lord Mansfield said that "neither party, witness, counsel, jury, or Judge, can be put to answer, civilly or criminally, for words spoken in office". Of that immunity it has been said in *Mann v O'Neill* that it responds to two related considerations, "to assist full and free access to independent courts for the impartial quelling of controversies, without fear of the consequences" and "the avoidance of the reagitation by discontented parties of decided cases after the entry of final judgment" other than by appellate processes. That view of the matter reflects the consideration that what is at stake is the public interest in "the effective performance" of its function by the judicial branch of government.

[130] Many of the cases to which I have referred are cases in which a judge was personally sued and, in those authorities, the judicial immunity is sometimes referred to as an "immunity from suit" (see for instance *O'Shane* at [187]). However, I do not think that "suit" was necessarily intended to be used in the narrow sense of a proceeding brought against the judge personally (but cf. *Towney* at [59]). In Nguyen, Gleeson CJ, Gaudron, McHugh, Gummow, Hayne and Callinan JJ, (at [30]) referred to the immunity as an "immunity from suit" but applied the judicial immunity in a case in which judicial officers were not sued personally but where their conduct was impugned in proceedings seeking prerogative relief against the courts in which those judges sat. By reference to the judicial immunity, their Honours at [29] spoke of "the notion that either a judicial officer, or a court, may be subject to legal redress" as being problematic. At [80] Kirby J spoke of the immunity as an "immunity from personal suit or other proceedings". That the operation of the judicial immunity is not confined to proceedings where the holder of the immunity is personally sued is also apparent from *Herijanto v Refugee Review Tribunal* [2000] HCA 16; 170 ALR 379 ("*Herijanto (No 1)*") and *Herijanto v Refugee Review Tribunal (No 2)* [2000] HCA 21; 170 ALR 575 ("*Herijanto (No 2)*").

[131] *Herijanto (No 1)* concerned the claims of a number of claimants for protection visas that various members of the Refugee Review Tribunal had failed to comply with procedural fairness requirements under the *Migration Act 1958* (Cth). The claimants sought relief in the High Court under s 75(v) of the Constitution. They served interrogatories upon the members of the Refugee Review Tribunal whose decisions they sought to impugn. An application was made to set aside those interrogatories. The basis for that application was that the Tribunal member enjoyed the same immunity as that of a Justice of a High Court and that the immunity precluded examination of the material read by member in reaching his or her decision. At [13]–[16] of *Herijanto (No 1)*, Gaudron J set out the principles governing the scrutiny of the exercise of judicial power concluding that any aspect of the record that betrays a decision-maker's decision-making process is protected by the immunity (footnotes omitted):

> [13] It has been settled law since Knowles' Trial that judges cannot be compelled to answer as to the manner in which they have exercised their judicial powers. In *Hennessy v Broken Hill Pty Co Ltd*, the immunity was said to be such that judges cannot be compelled "to testify as to matters in which they have been judicially engaged". However, it was also pointed out in that

> case that "their evidence has been received upon matters which did not involve the exercise of their judicial discretions and powers".
>
> [14] In *MacKeigan v Hickman*, the Supreme Court of Canada held that judges could not be compelled to disclose what affidavit evidence had been received when that did not clearly appear from the record. However, Wilson J, in dissent on this point, would have held that they might be asked "what as a factual matter comprised the final record for purposes of their decision".
>
> [15] In *MacKeigan*, the immunity of judges from compulsory disclosure was rested on the principle of judicial independence. In *Sirros v Moore*, a case concerned with immunity from civil suit, Lord Denning MR suggested that the reason underlying that immunity was to ensure that judges "may be free in thought and independent in judgment". That, in my view, is also the true basis of the immunity from compulsory disclosure. And on that basis, I see no reason why a judge might not be compelled to disclose the record upon which he or she has acted. However, that is subject to the qualification that disclosure of the record cannot be compelled if it would also reveal some aspect of the decision-making process, as may well have been the case in *MacKeigan*.
>
> [16] There is no difficulty in saying that, in an appropriate case, judges may be compelled to disclose the record on which they have acted. In the context of the judicial process, "the record" bears a clear meaning. The same is not necessarily true in the context of administrative decisions. Thus, it is preferable to identify what is within the immunity, rather than that which is outside it. And in my view, the immunity is immunity from disclosing any aspect of the decision-making process. That is what is required to ensure freedom of thought and independence of judgment. And that approach is entirely consistent with what was said in *Hennessy*.

[132] Her Honour confirmed her conclusion in *Herijanto (No 2)* at [10] and extended the principle to the revelation by any other means (ie evidence from a source other than the decision-maker) of the decision-maker's decision-making process. Other authorities are to the same effect. After reviewing relevant authorities from the UK (*Warren v Warren* [1997] QB 488, citing *Duke of Buccleuch v Metropolitan Board of Works* (1872) LR 5 HL 418), New Zealand, Canada (*MacKeigan v Hickman* [1989] 2 RCS 796) and Australia (*Hennessy v Broken Hill Proprietary Company Limited* [1926] HCA 32; (1926) 38 CLR 342; *Zanetta v McClearly* [1976] 1 NSWLR 230; *Herijanto (No 1)*), Gilbert J in *Deliu v New Zealand District Court* [2016] NZHC 2806 concluded (at [31]):

> Although the authorities have developed in response to widely differing factual scenarios, the underlying rationale for the immunity is to preserve the independence of the judiciary. There is a consistent line of authority tracing its origins to cases decided in the seventeenth century establishing that Judges cannot be compelled to give evidence relating to their performance of their judicial functions.

[133] It is not necessary for me to try and chart the outer perimeter of the judicial immunity. It is sufficient to say that many if not most of the ills, burdens, pressures, apprehensions and influences likely to afflict a judge when personally sued would

also be present when a judge is faced with a curial examination of the judge's exercise of his or judicial function for the purpose of determining whether that exercise constituted civil unlawfulness. Exposure to a finding of unlawful conduct would entail a heavy burden upon a judge, irrespective of whether a financial impact was also in prospect because the judge had been sued personally. Such an exposure to curial examination of a judge's exercise of the judicial function would also provide a significant capacity for disgruntled litigants to hound the judge through collateral attacks which re-litigate the matter from which the disgruntlement arose. Exposure of that kind is sufficiently corrosive of the principled and fearless functioning of a judge as to warrant its preclusion. Whilst there is no authority to which I was referred (or that my researches have revealed) which is directly on point, the rationale for the judicial immunity, as expressed and applied by the authorities to which I have referred, strongly supports the proposition that the judicial immunity extends to prohibiting the curial examination of the conduct of a judge exercising judicial functions for the purpose of determining whether that conduct constituted civil unlawfulness.

[134] There are obvious differences between the functions of a judge and that of a mediator. Those differences must have been readily apparent to the drafter of s 53C; as must have been apparent the differences between the functions of a mediator and those of an arbitrator upon whom s 53C also confers the same immunity. The provision can only be sensibly read as intending to provide the same protection and immunity in relation to the performance of the functions of an arbitrator or those of a mediator as a judge has in the performance of the functions of a judge. That the functions of a judge are different and that the reasons that may support the need for those functions to be protected may be different, does not appear to be a consideration which is accommodated by the text of s 53C. The provision seems to me to be founded upon the idea that whatever protections judges have in relation to the exercise of their functions is to be conferred upon arbitrators and upon mediators in the exercise of their respective functions.

[135] If it be the case that the underlying rationale for the functions of a mediator were intended as a guiding consideration, to my mind, the need for a mediator to perform his or her functions without fear or favour is an important consideration which, of itself, provides a policy justification for conferring an immunity upon a mediator. For similar reasons as those applicable to the judicial immunity, an immunity from being personally sued would not of itself protect the principled and fearless functioning of a mediator. I would also observe that, if an immunity from being personally sued was the only protection intended to have been conferred, s 53C could readily have said so and limited protection of that kind could have been provided without reference to the judicial immunity. Parliament had more in mind and its reference to the judicial immunity has effectively said so.

[136] It necessarily follows from my conclusion about the scope of the immunity conferred upon the mediator by s 53C, that the accessorial liability claims do not disclose a reasonable cause of action. If the Court is precluded from examining the conduct of the mediator and from making a finding that the mediator's conduct contravened the DDA, no finding of a contravention by the first, second and third respondents as accessories is available and the claims of accessorial liability must fail. It follows that the accessorial liability claims (VID 114 [114]–[133]) must be

> struck out and, in the circumstances, it would be futile to grant Ms Winters any leave to re-plead those claims.
>
> [137] In coming to this view, I have taken into account the principle, observed by Kirby J in *Fingleton* at [168], that immunities such as that conferred by s 53C which "derogate from an individual's ordinary legal obligations to others, and to the community, on a footing of full equality before the law" should, where possible, be confined. I consider this principle to be outweighed, however, by the countervailing principle and policy underlying the judicial immunity, as applied to mediators by virtue of s 53C, to which I have adverted.

106GA Notification by Director or Committee that proper investigation is impossible

The Director may give notice to the Committee, or the Committee may give notice to the Director, that a proper investigation by the Committee is impossible. If such notice is given, Division 4 of Part VAA ceases to have effect in relation to the Committee. This effectively puts an end to the Committee's inquiry or investigation.

It is the impossibility of undertaking a 'proper investigation', rather than simply 'an investigation', that is the subject of this section. The expression 'proper investigation' indicates not only that the Committee would be able to undertake the procedural steps required to conduct the investigation, but that having regard to all of the circumstances of the case it would be able to make a genuine and appropriate assessment of whether or not the person under review engaged in inappropriate practice.

The Explanatory Memorandum to the Health Insurance Amendment (Professional Services Review) Bill 2012, which was the Bill for the Act that inserted this section stated:

> Circumstances may arise when it becomes impossible for the Professional Services Review Committee to conduct a proper investigation or for the Determining Authority to make a Determination in relation to the person under review, for example when the person under review dies or is permanently incapacitated.

106H Committee findings, scope of investigation etc.

A Committee is limited to making findings only in respect of the referred services. The 'referred services' are those services referred to the Committee by the Director in the referral made under section 93.

'the referred services'

Health Insurance Commission v Grey [2002] FCAFC 130 —

> [186] We reject the arguments advanced by the notice of contention. In our view, the primary Judge correctly held (at [16]) that the Referral properly raised the possibility that by rendering so many services Dr Grey could not provide an appropriate level of "clinical input". Implicit in this expression of the Commission's concern was acceptance, albeit a necessarily provisional acceptance at that stage, of the accuracy of Dr Grey's numbers and of the classification of the services in terms of appropriate levels. If it were to turn out that Dr Grey had wrongly described (and thus misrepresented, even by an innocent mistake) an item, it could hardly follow that the Referral was thereby invalidated from the beginning. Dr Grey would be estopped from relying on his misrepresentation. Another answer would be that Dr Grey would be seeking, impermissibly, to take advantage from his own default (see, e.g. *Akbarali v Brent London Borough Council* [1983] 2 AC 309 at 344).
>
> …
>
> [189] … It should not be forgotten that Dr Grey's claim, upheld by the primary Judge, was that the Committee had exceeded its jurisdiction when it continued its inquiry (originally valid as we have held) in circumstances where it emerged, in the course of the inquiry, that information previously provided to the Commission was incorrect in a material respect, viz. Dr Grey's description of the appropriate "Levels". As has been said, it may give rise to an estoppel against Dr Grey, or this may be a case of an impermissible attempt by Dr Grey to take advantage of his own default. But, on any analysis, the emergence of the truth, of a matter very much bound up, or interrelated, with the subject of the Referral could hardly operate to place that field of inquiry beyond the limits of the Committee's purview. Put differently, given the obvious importance in the legislative scheme of correct item description, it is impossible that an inquiry in that area could be beyond power. True, concerns about procedural fairness may conceivably arise, but that is not the present question. No report has yet been made by the Committee and Dr Grey has already been informed of the precise matters raised for his response.
>
> [190] In our opinion then, the Committee was not acting beyond its Referral when it inquired into the area of item misdescription. In other words, in our view, the Committee was entitled, in the course of its inquiry and in its draft report, to have regard to the components of the item described in the Medical Benefits Scheme.

While a Committee must restrict its findings to the referred services, its investigation may involve consideration of matters outside the review period in order to ascertain the whole of the circumstances surrounding the conduct in question.

Holmes v Mercado [2000] FCA 1848 —

> [57] … It is important for committees and tribunals undertaking statutory reviews in respect of the provision of professional services to confine their findings to the period of time and the work locations specified in the relevant Commission reference. However, evidence about events that occur outside those work locations

> and period of time may bear on the matter under review. This is, perhaps, particularly a possibility in relation to a concept as imprecise as "inappropriate practice", as defined in s 82(1)(a) of the Health Insurance Act. It will be recalled this definition makes the question whether particular conduct is "inappropriate practice" depend on the committee's perception as to whether the conduct "would be unacceptable to the general body of practitioners". That must depend upon the whole of the circumstances surrounding the conduct.

106K Committee may have regard to samples of services

Section 106K permits a Committee to have regard to a sample of services within a class of services. Subsection (2) enables the Committee to extrapolate findings of inappropriate practice made in respect of the sample, to the entire class of services provided the sampling methodology in the Ministerial instrument made under subsection (3) has been complied with, or the Committee has been advised, in accordance with subsection (4), by an accredited statistician that another sampling methodology that has been applied is statistically valid.

Under a previous Sampling Determination (the *Health Insurance (Professional Services Review—Sampling Methodology) Determination 2000 (No. 1)*), sections 6 and 8 of that Determination provided:

> **6 Preliminary random sample**
>
> In having regard, under subsection 106K(1) of the Act, only to a sample of the services included in a particular class of referred services, a Committee must ensure that the sample (the preliminary random sample) is a random sample.
>
> **8 Exploratory sample**
>
> In making a finding based on statistical sampling, the Committee must:
> (a) examine a sample, preferably of 30 or more services (but not less than 25 services) (the exploratory sample), randomly drawn from the preliminary random sample; and
> (b) determine whether or not each of those services constitutes inappropriate practice.

That Determination was the subject of litigation in *Phan v Kelly* and *Mathews v Kelly* (see below). Subsequent Sampling Determinations have not had the requirement of a preliminary sample and an exploratory sample. Instead, the Committee must have a regard to a sample of no fewer than 25 provided services randomly drawn from a class of referred services being investigated.

Tankey v Adams [1999] FCA 683 —

> [103] … Here there was sampling, but I cannot see how its criteria apply to a case of the servicing of too many people in a day. A day cannot be a "class": s 87(1). In a volume case sampling cannot refer to any relevant criterion. Thus it seems to me that the sampling rules do not greatly assist in the resolution of the particular allegations brought against Dr Tankey about the number of services rendered. There are many cases in which a patient would come to see a practitioner where the time taken for a consultation would be very small, such as where a decision is made to send a patient straight to hospital by ambulance or where a patient has a simple non-recurring problem such as a headache or the 'flu or where only a prescription was needed. Unless the Committee undertook to look at each situation separately, it would simply be unable to make a finding that Dr Tankey could not have given the appropriate level of clinical input generally.
>
> [104] These observations do not, however, apply to a judgment on adequacy and quality of service over the year in question based on the overall statistical facts. Where fairness might demand that a practitioner not be too highly penalised on the basis of severely limited examples or statistics said to justify a finding arising merely from number of services, the servicing of an excessively high number of patients is not to be tolerated because of the logistical difficulty of investigating a doctor's practice. During the referral period in this case, there were 24,231 level B consultations such that proportionately there were only a small number of short consultations including those for work certificates and repeat prescriptions, for which Dr Tankey suggested he received many requests and which he said he often took home and wrote outside ordinary practice hours. In my opinion, this fact alone justified the Committee's findings.

106K(4) — use a sampling methodology not specified in the determination

Phan v Kelly [2007] FCA 269 —

> [58] The decision of the Committee was further contested by the Applicant on the basis that Dr Phan was unable to make any submission regarding the advice given by Professor Nicholls as Dr Phan was not notified that any such advice had been given. In my opinion, the Committee was not required by s 106K(4) to disclose the advice from Professor Nicholls. Under s 106K(4), it is open to the Committee to use any particular sampling methodology provided that the sampling methodology is the subject of the requisite advice prepared by a statistician qualified according to the section. The Committee is entitled to obtain the required advice at any stage of the decision-making process up to the time of the decision. There is no restraint on the changing of method, provided that the Committee makes use of a methodology that satisfies the requirements of s 106K(4).

Mathews v Kelly [2006] FCA 195 —

> [58] … It is said that the Committee had regard to 30 services of Dr Mathews in each relevant MBS Item class of service purportedly as an 'exploratory sample' within the meaning of that expression in s 8(a) of the Sampling Determination. It is

further said that the Committee failed to examine samples 'randomly drawn from the preliminary random sample' within the meaning of that expression in s 8(a) of the Sampling Determination. The Committee, it is said, merely examined the first 30 services on lists of the first 40 services taken from the HIC lists. They were not, therefore, 'randomly drawn from the preliminary random sample[s]'.

[59] There is no doubt that the Committee examined the first 30 services on lists of the first 40 services taken from the HIC lists. To be completely accurate, the Committee did not examine service nos. 6, 8 and 9 for MBS item 23 owing to lack of records maintained by Dr Mathews but it examined the remainder of the first 30 services as well as nos. 31, 32 and 33; it did not examine service nos. 18 and 24 for MBS item 24 owing to lack of records maintained by Dr Mathews but it examined the remainder of the first 30 services as well as nos. 31 and 32; and it did not examine service nos. 5 and 9 for MBS item 193 owing to lack of records maintained by Dr Mathews but it examined the remainder of the first 30 services as well as nos. 31 and 32.

[60] Professor D F Nicholls from the School of Finance and Applied Statistics at the Australian National University, Australian Capital Territory, gave evidence on behalf of the respondents. In relation to this fourth allegation of error, his report recorded the following:

> 'While the Determination states that the exploratory sample should be "randomly" drawn from the preliminary sample, from a statistical point of view to state that it should be randomly drawn from a random sample is redundant. The preliminary random sample is a sample randomly drawn from the total number of services rendered for each class of services. Consequently any sample chosen from the preliminary random sample will itself be a random sample (of the total number of services of the item class under review). The exploratory sample of 30 services, for each of items 23, 24 and 193 will themselves be random samples from each of their respective items. ...

As has been argued above, the preliminary samples for each of the three items have been confirmed by the HIC to be random. Any subset of services chosen from a preliminary random sample will itself be a sample of random services from the total number of services of each item under investigation.' (Emphasis)

[61] Dr M J Stevenson from the School of Business, Faculty of Economics and Business at the University of Sydney, New South Wales, gave evidence on behalf of Dr Mathews. In response to Professor Nicholls, Dr Stevenson said:

> 'Had the Committee, in following section 6 of the Determination, ensured that the preliminary random sample was a random sample and, in doing so by independently selecting a sample of 99 records randomly from a sampling frame of 8,947 records then, it might be argued from a statistical point of view that to insist the exploratory sample of 30 be further selected randomly is redundant. In this case, the exploratory sample of 30 would be random irrespective of how the smaller sample of 30 records comprising the exploratory sample were selected from the preliminary random sample of 99.' (Emphasis)

[62] However, with respect to both Professor Nicholls and Dr Stevenson, the issue raised by this allegation of error is not whether the first 30 (record available) services of each relevant item of service is a random sample of the total number of services of each relevant item of service specified in the referral, but whether the first 30 (record available) services of each relevant item of service are 'randomly drawn from the preliminary random sample'. One has only to put the issue in those terms to realise that what the Committee examined as 'exploratory samples' is infected with error.

[63] The fact that the first 30 (record available) services of each relevant item of service is a random sample of the total number of services of each relevant item of service specified in the referral by reason that it is a sub-set of services chosen from a preliminary random sample which, by definition, is a random sample, is not to the point. Unless those first 30 (record available) services of each relevant item of service is randomly drawn from the preliminary random sample, it is not an 'exploratory sample' for the purposes of the Sampling Determination: s 8(a).

[64] Relevantly, the *Oxford English Dictionary* meaning of the word 'random' provides:

> 'b. Statistics. Governed by or involving equal chances for each of the actual or hypothetical members of a population; also, produced or obtained by a random process (and therefore completely unpredictable in detail);'
>
> Under the same heading 'Statistics', the phrase 'random sample' is defined to mean –
>
> 'A sample drawn at random from a population, each member of it having an equal or other specified chance of inclusion.'

[65] The selection by the Director of the first 40 services from each of the HIC lists would, on the theses of Professor Nicholls and Dr Stevenson, constitute random samples themselves of the total number of services of each item under review. However, that selection was not itself 'randomly drawn from the preliminary random sample'. To say otherwise is to fly in the face of the dictionary meaning of the word 'random' referred to at [64], supra, and to read the phrase 'randomly drawn from the preliminary random sample' as if the word 'randomly' had no work to do; or to read the phrase as if the word 'randomly' was not there.

[66] The same observations can be made of the examination by the Committee of the first 30 (record available) services of each list of the first 40 services from each of the HIC lists. They may also be random samples as sub-sets of sub-sets of random samples (the preliminary random samples) but they do not qualify as being 'randomly drawn from the preliminary random sample[s]'. Indeed, on the evidence, the Committee never had before it the preliminary random sample of each item of service under review, that is, the HIC lists, from which to randomly draw the exploratory samples; it only ever had before it the first 40 services in those lists.

[67] The question which arises is whether this error invalidates the Committee's finding at [2] of its Final Report, namely, that the conduct of Dr Mathews in connection with rendering MBS Item 23, 24 and 193 services that were the subject of Adjudicative Referral 223 was, in the Committee's opinion, unacceptable to the

general body of general practitioners and constituted inappropriate practice as defined in s 82 of the Act. In my view it does and for the following reasons:

1. The importance of complying with the sampling methodology in the Sampling Determination is borne out by all the provisions of s 106K of the Act, but in particular the deeming operation of subs 106K(2) and the fact that the Committee is, by subs 106K(4), prohibited from using a sampling methodology that is not specified in a determination made under subs 106K(3), unless it is ordered by a statistician accredited by the Statistical Society of Australia that the sampling methodology is statistically valid.

2. The opening words of s 8 of the Sampling Determination make it clear that its requirements are mandatory: 'In making a finding based on statistical sampling, the Committee must ...'.

3. In *Project Blue Sky Inc v Australian Broadcasting Authority* [1998] HCA 28; (1998) 194 CLR 355, the majority rejected (at 389 – 391, [92] – [93]) the traditional distinction between 'mandatory' and 'directory' requirements, saying that: '[a] better test for determining the issue of validity is to ask whether it was a purpose of the legislation that an act done in breach of the provision should be invalid'. In determining the purpose of the legislation, regard has to be had to 'the language of the relevant provision and the scope and object of the whole statute'.

4. Nevertheless, having regard to the mandatory terms of s 8 of the Sampling Determination and its importance in the process of statistical sampling upon which the Committee's finding is ultimately made, I am of the view that it is a purpose of the Sampling Determination that a finding made in reliance on an act done in breach of s 8 of the Sampling Determination is an invalid finding: See *SAAP v Minister for Immigration & Multicultural & Indigenous Affairs* (2005) 215 ALR 162 per McHugh J at [72] – [73]; per Hayne J at [205].

[68] Paragraph (j) contains the fifth allegation of error. It is said that the Committee examined 30 services in each MBS item of service under review from a list of 40 services provided to the Committee by the Director and that the examined services had already been examined by the Director or by servants, officers or agents on his behalf and had been found to be deficient or sufficiently deficient in relevant respects and adverse to Dr Mathews such as to cause the Director to set up a Committee and refer the matter to it by way of Adjudicative Referral pursuant to s 93 of the Act. It follows, it is said, that the purported 'exploratory sample' in the hands of the Committee could no longer be considered (if it ever was) a sample 'randomly drawn from the preliminary random sample' within the meaning of s 8 of the Sampling Determination.

[69] In view of my finding in relation to the fourth allegation of error, it is unnecessary to reach a concluded view on this allegation. Counsel for Dr Mathews put his case on this fifth allegation of error as being 'where fairness meets statistics'. Whether or not the Director's prior examination of the first 30 (record available) services on the list of 40 services provided by the Director to the Committee does lead to the result contended for, namely, non-compliance with the requirements of s 8(a) of the Sampling Determination, it is clear, in my view, that had the Committee undertaken its task according to the terms of s 8(a) of the Sampling Determination

and randomly drawn, from the preliminary random sample, 30 services of each item of service under review, the likelihood of all 30 services of each item of service under review being a service which the Director had already examined is negligible. That, of itself, might suggest that this fifth allegation of error in the sampling process should be upheld.

Mitchelson v Health Insurance Commission (No. 3) [2007] FCA 1491 —

[45] The statutory role of the committee is investigative. It makes findings to be relied upon by the Authority in making draft and final determinations containing one or more of the directions contemplated by s 106U which include repayment to the Commonwealth of the whole or part of a medical benefit paid for a service or class of services where inappropriate practice has been found and suspension for a period and/or disqualification for a period from the provision of services to which medical benefits relate. The *Briginshaw* point seems to be that in relying on the composition and size of the sample selected and in failing to consult with patients, the proof of matters going to 'inappropriate practice' was inexact and failed to attain the standard of proof a committee acting reasonably in the conduct of its proceedings ought to adopt having regard to the gravity of the possible s 106U directions.

[46] The statute expressly provides that the committee in discharging its investigative function may 'have regard only to a sample of the services' in a class of services where reliance on a sample is for the very purpose of testing 'inappropriate practice' leading to findings likely to lead to one or more of the serious s 106U directions by the Authority.

[47] The sampling methodology adopted by the committee might be that contained in a ministerial determination specifying the content and form of sampling methodologies that may be used (s 106K(3)); or a nonspecified methodology 'if but only if' shown on advice to the committee to be statistically valid, by an accredited statistician.

[48] Since the Committee has acted in conformity with the Act by having regard only to a sample within the statutory constraints upon the methodology to be used (and no contention to the contrary is made) the question is whether any *Briginshaw* principle is engaged. Should the Committee have selected a method of fact finding other than by sampling the services?

[49] The committee must act reasonably. In order to be satisfied that Dr Mitchelson engaged in 'inappropriate practice' the committee needs to reach a state of affirmative satisfaction of the foundation factual matters giving rise to that conclusion to a standard of 'reasonable satisfaction'. A member, acting reasonably, will not be so satisfied 'independently of the nature and consequence of the fact or facts to be proved' (*Briginshaw*, per Dixon J at 362). The seriousness of the allegation or the gravity of the consequences flowing from a particular finding must necessarily affect the judgment made by each committee member as to whether the particular issue has been established to that member's reasonable satisfaction. As Sir Owen Dixon observed, reasonable satisfaction should not be reached by 'inexact proofs, indefinite testimony or indirect inferences' (p, 362). Plainly

enough, the nature of the issue before the tribunal 'necessarily affects the process by which reasonable satisfaction is attained' (Dixon J per 363).

[50] The proposed amended application simply asserts a conclusion of reliance upon inexact proof and thus, inferentially, a failure on the part of committee members to be reasonably satisfied of the relevant matters. The difficulty with that bald conclusionary assertion is that the Committee acted in conformity with the Act in circumstances where the sampling methodology was the subject of advice from an expert, Professor Nicholls, of statistical validity. Prima facie the Committee acted reasonably in conducting its investigation. No attempt has been made by Dr Mitchelson to isolate the process of reasoning in respect of any of the various sample services and demonstrate any failure on the part of the Committee. There is no reference to factual material from which 'inferences' were drawn incorrectly nor reference to 'indefinite testimony' or 'inexactness' in any of the analyses of the sample services.

[51] As a result, the proposed amended application fails to identify a ground of challenge supported by material facts going to a ground of challenge.

In a sample of services considered by a Committee in its investigation, it does not matter that some or all of those services were the same services that were considered by the Director.

Carrick v Health Insurance Commission [2007] FCA 984 —

[70] The Director, by a written notice given under s 89B(2) of the Act, required Dr Carrick to produce to him original patient records for the first 40 patients listed on the random sample of 98 patient services provided to the Director by the Commission. The Director engaged Dr Heap to review the 40 medical records provided by Dr Carrick. Dr Heap reported that he did not believe that it was justified for Dr Carrick to charge any of the 40 patients for an MBS item 30487 service. The Director also obtained data which showed that Australia wide 7,800 claims were made for MBS item 30487 services during the referral period and that Dr Carrick provided 4,073 of these services. The next highest provider claimed 876 MBS item 30487 services.

[71] Having concluded that Dr Carrick may have engaged in inappropriate practice as defined by s 82 of the Act, the Director decided to make the Adjudicative Referral. It appears that the Director provided to the Committee the names of the first 40 patients listed on the random sample of 98 patient services provided to him by the Commission together with the patient records for those patients as provided by Dr Carrick. That is, the Director provided to the Committee the same medical records that he had earlier provided to Dr Heap.

[72] The Committee considered Dr Carrick's conduct in respect of the first 30 services on the list of 40 services that had been considered by Dr Heap. At [19] of the Final Report the Committee stated that it:

'considered Dr Carrick's conduct in respect of the 30 services contained in the final random sample (drawn from a preliminary random sample of 98 taken

> from a total of 4062 MBS item 30487 services provided in association with one or more gastrointestinal endoscopic procedural items by Dr Carrick during the review period) which were examined during the hearing.' (footnote omitted)

[73] The Committee found that Dr Carrick's conduct would be unacceptable to the general body of medical practitioners in connection with 28 of the 30 MBS item 30487 services examined by it. It concluded that in this circumstance the Determination authorised it to extrapolate its findings to the overall class of services in the manner prescribed by s 11 of the Determination.

[74] The first error claimed to affect the methodology adopted by the Committee was that it failed to 'ensure' that the preliminary random sample was a random sample as required by s 6 of the Determination. Dr Carrick submitted that s 6 required the Committee itself to undertake a random sampling procedure.

[75] A submission to the same effect was 'rejected out of hand' by Edmonds J in *Mathews v Health Insurance Commission* [2006] FCA 195; (2006) 90 ALD 49 at [40]. It is appropriate for me to follow the approach adopted by his Honour unless I am satisfied that his Honour was in error. I am not so satisfied. Indeed, in my respectful view, his Honour was plainly correct.

[76] The sampling methodology prescribed by the Determination assumes an understanding of, and facility with, statistics. It is unlikely that the Minister intended that Committee members, rather than appropriately qualified statisticians, should undertake important statistical procedures. The obligation on a Committee to 'ensure' that the preliminary random sample is a random sample may, in my view, be met by the Committee satisfying itself that the preliminary random sample has been generated as a random sample by an appropriately qualified person. Nothing in the evidence establishes that the Committee did not take that step in this case.

[77] I am not persuaded that it was necessary for the Committee to be given the full preliminary sample in the order of its original random selection, as argued by Dr Maxwell Stevenson, an expert statistician whose affidavit evidence was adduced by Dr Carrick. The responsibility of the Committee under s 106K and the Determination was not to engage in 'sound audit practice', to use Dr Stevenson's expression, but rather to ensure that s 6 of the Determination was complied with.

[78] In any event, I see no reason to conclude that the Determination, considered in the context of the Act and s 106K in particular, discloses an intention that, where a preliminary random sample is in fact random, the findings of a Committee should be rendered invalid because the Committee itself failed to 'ensure' that the preliminary random sample was random (*Project Blue Sky Inc v Australian Broadcasting Authority* [1998] HCA 28; (1998) 194 CLR 355).

[79] The second error claimed to affect the methodology adopted by the Committee was that the preliminary random sample was not a random sample in the hands of the Committee because it had already been the subject of consideration by the Director. This argument was rejected by Tamberlin J in *Phan* [2007] FCA 269 at [52]. His Honour there observed:

> 'In my view, the sample used in the present case was in accordance with the requirements of the Act. The evidence is that the Commission drew a preliminary random sample and that the Director required the production of records which he examined. He concluded, for the reasons given by him in his Report, that it would be appropriate for him to refer the matter to a Committee. In examining the material and completing his Report, the Director did not decide that there was inappropriate conduct. That determination was left for the Committee to make following a hearing and having regard to the evidence adduced at that hearing. It is not correct to suggest that the Director had found that the samples had ***in fact*** given rise to inappropriate conduct. The fact that the Director examined and considered the records and forwarded them to the Committee does not affect their randomness when they were considered afresh by the Committee. The sample items retained their character as random samples and were not skewed or biased so that the Committee's decision should be considered invalid.' (emphasis in original)

[80] Again, I should follow the approach adopted by his Honour unless I am satisfied that his Honour was in error. I am not so satisfied. Indeed, in my respectful view, his Honour was correct.

[81] The report of Dr Stevenson, parts of which I received by way of submission (O 10 r 1(2)(j) of the *Federal Court Rules*), assumed a requirement for the conclusions arrived at by the Committee to be 'truly independent of those of the Director'. Dr Carrick argued that were this not the case, the conclusions would otherwise be 'unfair'. It is, of course, the case that a Professional Services Review Committee is obliged to make its own finding in respect of the conduct of the person under review; that is, a finding as to whether the conduct constituted engaging in inappropriate practice. However, as I understand the report of Dr Stevenson, he takes the view that, at least where a Committee places reliance on s 106K of the Act, the findings of the Committee must be arrived at by reference to samples of services not previously considered by the Director. Additionally Dr Stevenson places reliance on the notion of 'data snooping' in suggesting that the preliminary random sample did not satisfy the requirements of s 7 of the Determination. Data snooping can occur when a given set of data is used more than once for the purpose of inference.

[82] The question of whether the findings of the Committee were required to be arrived at by reference to samples of services not previously considered by the Director is to be answered by reference to the Act. References to sound audit practice and notions of fairness are of only limited assistance in this regard. Section 93(6) of the Act provides that where the Director makes an adjudicative referral the Director must prepare and attach to the adjudicative referral:

> 'a written report to the Committee, in respect of the services to which the referral relates, giving the reasons why the Director thinks that conduct by the person under review in connection with rendering or initiating the services may have constituted engaging in inappropriate practice'.

This statutory requirement suggests against any legislative intention that the conclusions arrived at by the Committee are to be arrived at by reference to evidence independent of that considered by the Director.

[83] It is also significant in this regard that the Director is not authorised to make a finding that a person has engaged in inappropriate practice. Rather the role of the Director under Part VAA of the Act is as outlined in [12] above. A function of the Director under the scheme established by Part VAA is to ensure that only matters where the Committee could reasonably find that the person under review has engaged in inappropriate practice are referred to a Professional Services Review Committee.

[84] I conclude that the conclusions arrived at by the Committee are not required to be 'truly independent of those of the Director' in the way assumed by Dr Stevenson.

[85] I accept the evidence of Professor Nicholls that the notion of data snooping has no application in the context of the sampling methodology prescribed by the Determination. Even if it did, the Committee did not use any data more than once. The Committee was not required by the Determination to examine any sample other than the exploratory sample of 30 services. As the Act does not, in my view, require the conclusions of the Director to be arrived at by reference to evidence independent of that considered by the Committee, the fact that the Director had earlier given consideration to the same 30 services as part of his sample of 40 services is, I conclude, irrelevant.

[86] The third and fourth errors claimed to affect the methodology adopted by the Committee are related. The third alleged error was that:

> 'The Committee should have not accepted or taken into account the various medical records of the applicant that the Director had delivered to it with or as part of the Adjudicative Referral as it adversely affected the sampling determination process under the Act and the Sampling Determination itself and it affected the independence and partiality of the Committee as a whole, afflicting the Committee with an apprehension of bias in undertaking the sampling determination process'.

[87] The fourth alleged error was that the exploratory sample of 30 patient services considered by the Committee were not, in the hands of the Committee, a sample 'randomly drawn from the preliminary random sample' as required by s 8(a) of the Determination because they formed part of the pool of 40 patient services examined by Dr Heap as a consultant to the Director.

[88] The submissions in support of both the third and fourth claimed errors assumed a requirement for the conclusions of the Committee to be arrived at independently of those of the Director in the sense of not being supported by reference to the same sample of patient services. For the reasons given above, I do not accept that the Act imposes such a requirement.

[89] The final error claimed to affect the methodology adopted by the Committee was that the Committee failed to examine a random sample drawn from the preliminary random sample as required by s 8 of the Determination because the preliminary random sample was not before the Committee. The above proposition involves a non sequitur. Nothing in s 8 requires the Committee itself to draw the exploratory sample from the preliminary random sample. Section 8 requires the Committee to 'examine a sample ... (the exploratory sample), randomly drawn from the preliminary random sample'. If the submissions based on the Director's

previous review of the random sample of 40 patient services are put to one side, nothing in the evidence suggests that the exploratory sample examined by the Committee was not randomly drawn from the preliminary random sample. As indicated above, I do not consider that the Director's previous consideration of the 40 patient services affects this position.

106KC Notification by Committee to Director of matters of concern to profession

If, in the course of its investigation, a Committee becomes aware of any matter that it considers to be of concern to the profession of which the practitioner who rendered the services is a member, the Committee must notify the Director in writing of that matter so that it can be considered by the Chief Executive Medicare or another appropriate authority or body.

This is a separate and potentially broader power of referral to that provided for in section 106XA and 106XB, which concern patient safety and professional conduct concerns regarding the conduct of the practitioner.

106KD Preparation of draft report

The draft report of a Committee provides the person under review with an opportunity to see what findings the Committee is likely to make and to make submissions and suggestions for changes.

Reece v Webber [2011] FCAFC 33 —

> [53] The purposes served by the preparation of a draft and final report must also be borne in mind. One purpose served by a draft report is to properly put to a medical practitioner whose conduct is in question the basis upon which a Committee may be proceeding so that he can thereafter make a "submission". Whether the very professional background that qualified a Committee member for appointment to the panel from which Committee members are drawn influences the "provisional findings" that have been reached will be thereby disclosed for comment. One purpose served by the final report is to properly inform the "Determining Authority" of the views of the Committee as to whether a medical practitioner has engaged in "inappropriate practice".
>
> …
>
> [74] … The forum in which a medical practitioner is afforded the opportunity to adduce "evidence" is at the "hearing" conducted by the Committee prior to the preparation of its "draft report". Thereafter the only express entitlement afforded to a medical practitioner is to make "written submissions suggesting changes to the draft report": s 106KD(3).

Saint v Holmes [2008] FCA 987 —

> [136] In my view, the Act does not require the Committee to meet to perform the functions referred to by Dr Saint in the preceding paragraph. Section 160KD of the Act provides that the Committee "prepare a written draft report". Likewise, s 106L provides that after the expiry of the requisite period and after taking into account any submissions made in response to the draft report, the Committee must "prepare a final report". In neither of these sections is there any requirement that the Committee meet to prepare, or meet in relation to the preparation of, either of the reports. The Act does, however, deal with the convening of meetings. Section 97(1) of the Act requires that the chairperson must convene the first meeting of the Committee within 14 days after the appointment of the Committee members. The fact that the Act expressly identifies only one occasion when a meeting is required to be held, namely, the first meeting, but has not expressly provided for the holding of a meeting in relation to the preparation of either report, is indicative of a legislative intention that it is no absolute requirement for the Committee to meet to perform those functions. Whether meetings, other than the first meeting, are to be held depends on what is necessary for the efficient conduct of the affairs of the Committee (s 97(3)). By legislating for the preparation of the two reports as part of the function of the Committee, without also specifying that the Committee must meet in relation to the performance of this function, it is apparent that the legislature did not intend that the efficient conduct of the Committee's affairs mandated that the Committee meet to carry out this function.

The draft report is not reviewable under the AD(JR) Act as it has no impact on rights and is not a reviewable decision because it is neither final nor operative, nor is it substantive in character.

Mathews v Health Insurance Commission [2006] FCA 195 —

> [11] Ground 3 is as follows:
>
> > '[The Committee's] preparation of the Draft Report involved a breach of the rules of natural justice (s 39B of the Judiciary Act, and s 5(1)(a) of the ADJR Act) and/or the procedures that were required by law to be observed in connection with [the Committee's] preparation of the Report were not observed (ADJR Act ss 5(1)(b) and 6(1)(e), or s 5(1)(e)) in that [the Committee] breached s 106KD(3) of the Act. [The Committee] failed to set out in the Draft Report:
> > (a) Its proposed findings on material questions of fact; and
> > (b) Refer to the [evidence] upon which the proposed findings were based (*Acts Interpretation Act 1901* (Cth), s 25D); and/or
> > (c) Its reasoning processing or sufficient reasons for it making the preliminary conclusions;
> > so as to allow [Dr Mathews] to respond at all or in a meaningful fashion.'
>
> [12] The Application contains the following particular in support of this ground of review:

> 'Nowhere in the body of the report, nor the appendices, does [the Committee] employ a chain of reasoning analysing the evidence, leading from what did, may have, or did not occur in connection with the provision of the services under review, to findings of inappropriate practice, so as to expose a process of reasoning at all or one sufficient to allow [Dr Mathews] to respond or respond meaningfully, as was intended under the Act.'

[13] There are a number of difficulties with this ground of review. First, while the Application seeks to review the decision, conduct or action of the Committee in preparing the Draft Report, it does not state that Dr Mathews is aggrieved by the Draft Report. It asserts that he is aggrieved by the Final Report because it exposes him to sanction by the Determining Authority under Part VAA of the Act, however, it could not be suggested that he is aggrieved by the Draft Report on that basis: See s 106KD of the Act; cf., s 106KL. Moreover, the Application does not contain any prayer for relief in respect of the Draft Report.

[14] Second, the Draft Report has no impact on rights and is not a reviewable decision because it is neither final nor operative, nor is it substantive in character: *Australian Broadcasting Tribunal v Bond* [1990] HCA 33; (1990) 170 CLR 321. The preparation of the Draft Report is not reviewable as 'conduct' engaged in for the purposes of making a decision in circumstances where it is superseded by a final and operative decision that is reviewable, that is, the Committee's Final Report: *Minister for Immigration & Multicultural Affairs v Ozmanian* [1996] FCA 1017; (1996) 71 FCR 1.

[15] Third, at the time when the Draft Report was prepared, the Act contained no statutory requirement that it contain reasons. Subsection 106KD(1A), which provides that 'a draft report must set out the reasons for the preliminary findings' did not come into force until 1 January 2003. It does not apply to the present case – see Item 118(1) Schedule 1, *Health Insurance Amended (Professional Services Review and Other Matters) Act 2002* (Cth). Section 25D of the *Acts Interpretation Act 1901* (Cth), which operates only where there is such a statutory requirement, did not apply to the Draft Report. Dr Mathews' contention to the contrary was rejected in *Dimian v Health Insurance Commission* [2004] FCA 1615 at [78] – [80] per Jacobson J. I agree with his Honour's view.

[16] In any event, this ground cannot be sustained because the Draft Report does contain reasons …

106KD(2) — Recommendation of full or part disqualification

Subsection 106KD(2) provides that if the person under review is a practitioner the draft report may, with the practitioner's consent, include recommendations for the practitioner to be fully or partly disqualified, and about the nature and period of the disqualification. In *Freeman v Health Insurance Commission*, lawyers for the person under review wrote to the Committee indicating that they were unable to show that exceptional circumstances existed on any of the days in relation to a prescribed pattern of services, acknowledged that the Committee would be bound to find

inappropriate practice on that basis, and suggested to the Committee that it make a recommendation in relation to a period of disqualification in its Draft Report.

The Committee's lawyer wrote to the practitioner's lawyers indicating that the Committee would acceded to that request, and recommended a period of full disqualification for a period of not more than 2 years and 9 months. The practitioner responded with a signed consent stating, 'After receiving legal advice I do not oppose the recommendation that I be fully disqualified from Medicare arrangements for a period of 2 years and 9 months'. After receiving the Committee's Final Report, which also contained this recommendation, the Determining Authority made a Draft Determination including that period of disqualification as well as other sanctions including repayment of $225 377.50.

In the Federal Court it was argued that he ought to have been given an opportunity, by the Determining Authority, to present his case concerning 'exceptional circumstances' because he had not presented that case before the Committee since he was not aware that the Determining Authority might make directions which went beyond the Committee's recommendations. The Court rejected these submissions.

> ***Freeman v Health Insurance Commission*** [2004] FCAFC 335 (per Kiefel J, as she then was, with whom Marshall J generally agreed)—
>
> > [45] The Determining Authority did what it could when it received the appellant's complaint. It called for submissions from him and there is no reason to doubt that it took them into account. It knew that he contended that no additional penalties or sanctions should be made beyond those recommended by the Committee but it was of the view that the case for repayment of benefits was a strong one and the penalty necessary.
> >
> > [46] The Determining Authority could not however undertake the task that the appellant contends it was obliged to do, namely to hear his case relating to exceptional circumstances. In the Scheme of the Act that role is given to the Committee. It is charged with the duty to make a finding as to whether there has been inappropriate practice. In that process it considers what the person under review puts forward as constituting exceptional circumstances. The Determining Authority's role is to consider the sanctions and penalties to be imposed, by one or more of the directions referred to in s 106U. It does so if the Committee's final report contains a majority or a unanimous finding of inappropriate practice. There is no provision which permits the Determining Authority to itself make that finding or to revisit the question of whether there has been inappropriate practice except so far as is relevant to the question of penalty. The Authority is obliged, by s 106T, to make a draft determination and to do so within one month of being given the report. It must then proceed to a final determination. It has no power to remit the matter where such a finding has been made.

[47] The requirements of procedural fairness are determined by reference to the statutory framework within which the decision is made. In *National Companies and Securities Commission v News Corporation Ltd* [1984] HCA 29; (1984) 156 CLR 296 at 326 Brennan J said:

> 'The terms of the statute which creates the function, the nature of the function and the administrative framework in which the statute requires the function to be performed are material factors in determining what must be done to satisfy the requirements of natural justice ...'.

[48] It does not seem possible to hold that the Determining Authority should have offered the opportunity of which the appellant speaks if it is not in a position to do so. The Determining Authority had no authority to deal with the appellant's case on exceptional circumstances. It may have taken his submissions in that regard into account in determining penalty, but the appellant did not provide any such submissions. Steps might have been undertaken to restrain the Authority making a decision, whilst the Committee's finding was sought to be reviewed, but they were not.

[49] There is another aspect of the appellant's case concerning procedural fairness which has relevance to the Determining Authority and may have had relevance to the Committee if its decision had been the subject of application for review. It concerns the nature of the mistake which led to the appellant foregoing his right to defend and the cause of that mistake. Neither the Determining Authority nor the Committee played any part in the wrong assumption made by the appellant and his legal advisers. Indeed the Committee had alerted him to the existence of other sanctions under section 106U(1) and advised that its power of recommendation did not extend to all of them.

[50] There is maybe a divergence in the approaches taken by the English courts and the High Court of Australia on the question whether there needs to be something approaching personal responsibility for the unfairness in question, on the part of the decision-maker, before orders would be made affecting the decision. In *Al-Mehdawi v Secretary of State for the Home Department* [1990] 1 AC 876 ('*Al-Mehdawi*') the appellant failed to receive notice of the hearing of his appeal due to his solicitors' mistake and his appeal was dismissed. The House of Lords did not consider that there was a breach of natural justice. To recognise a breach as arising from the fault of persons other than the decision-maker was considered likely to undermine the finality of decisions (at 885, 889 and 894). However in *R v Criminal Injuries Compensation Board, Ex parte A* [1999] UKHL 21; [1999] 2 AC 330 ('*Ex parte A*') a breach was found where police officers had failed to give the Criminal Injuries Compensation Board a police medical report which supported the applicant's case in circumstances where the applicant had been told that she could not ask for police statements. Lord Slynn (at 345) said that it was sufficient if, objectively, there was unfairness. The decision in *Al-Mehdawi* was not discussed, perhaps because it was thought that Ex parte A turned on its own special facts.

[51] Sackville J has observed that *Ex parte A* has not been greeted with 'unalloyed enthusiasm' by the High Court: *O'Sullivan v Repatriation Commission* [2003] FCA 387; 74 ALD 407 at [52]. In *Re Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Applicants S134/2002* [2003] HCA 1; (2003) 195 ALR

1 at 10, *Ex parte A* was distinguished. Although the majority of the High Court found it unnecessary to decide the questions examined in *Ex parte A*, they expressed doubts whether the case would be decided upon procedural fairness grounds in Australia. Rather the ground in s 5(1)(b) of the *Administrative Decisions (Judicial Review) Act 1977* (Cth), which refers to the non-observance of procedures required by law to be observed, might be invoked.

[52] In the context of administrative decision-making there would not appear to be support in Australia for the view that problems which arise in the conduct of the case of the person to be the subject of the decision, through their mistaken view or that of their legal advisers, could amount to procedural unfairness. There would seem to be strong policy grounds why this should not be the case. And it may be that the position formerly stated in England with respect to a mistake of this nature still maintains.

Freeman v Health Insurance Commission [2004] FCAFC 335 (per Downes J)—

[65] The following appears in the letter dated 7 September 2001 from the solicitors representing the Professional Services Review Committee in reply to the letter dated 4 September 2001 from the appellant's junior barrister stating that the appellant "would not object to disqualification from participation in the scheme of a period of two years and six months":

> "Fourth, although section 106KD(2) of the *Health Insurance Act 1973* provides for a Committee recommendation as to a period of disqualification, it makes no provision for any recommendation in relation to other sanctions envisaged under section 106U(1) of the *Health Insurance Act 1973*. Nor does the Determining Authority appear to be bound by such a recommendation".

[66] This communication seems to me to be fatal to the second ground however it is put. To the extent to which denial of procedural fairness is relied upon it cannot be said that the necessary element of unfairness was present (*Minister for Immigration and Multicultural and Indigenous Affairs; Ex parte Lam* (2003) 214 CLR 1; *NAFF of 2002 v Minister for Immigration and Multicultural and Indigenous Affairs* [2004] HCA 62). To the extent to which failing to consider and rule on the appellants submission is relied upon there was no obligation to consider and rule on it and, if there was, relief would be refused in the exercise of discretion.

[67] In addition, I agree with Kiefel J's reasons relating to Ground 2 although it does not seem to me that it is necessary to refer to the cases relating to unfairness caused by the conduct of third parties. Here there was no unfairness for which any of the relevant investigating or adjudicating persons or bodies was responsible even if some of them might have been regarded as third parties.

106L Final report of Committee

The final report of a Committee must contain the findings of the Committee and its members regarding inappropriate practice of the person under review. The Committee need not meet to prepare its report, but may do so as it sees fit.

Saint v Holmes [2008] FCA 987 —

> [136] In my view, the Act does not require the Committee to meet to perform the functions referred to by Dr Saint in the preceding paragraph. Section 106KD of the Act provides that the Committee "prepare a written draft report". Likewise, s 106L provides that after the expiry of the requisite period and after taking into account any submissions made in response to the draft report, the Committee must "prepare a final report". In neither of these sections is there any requirement that the Committee meet to prepare, or meet in relation to the preparation of, either of the reports. The Act does, however, deal with the convening of meetings. Section 97(1) of the Act requires that the chairperson must convene the first meeting of the Committee within 14 days after the appointment of the Committee members. The fact that the Act expressly identifies only one occasion when a meeting is required to be held, namely, the first meeting, but has not expressly provided for the holding of a meeting in relation to the preparation of either report, is indicative of a legislative intention that it is no absolute requirement for the Committee to meet to perform those functions. Whether meetings, other than the first meeting, are to be held depends on what is necessary for the efficient conduct of the affairs of the Committee (s 97(3)). By legislating for the preparation of the two reports as part of the function of the Committee, without also specifying that the Committee must meet in relation to the performance of this function, it is apparent that the legislature did not intend that the efficient conduct of the Committee's affairs mandated that the Committee meet to carry out this function.

The Committee does not need to give reasons in its Final Report as to why it did, or did not, accept submissions or other information provided to the Committee in response to its Draft report. Nevertheless, the usual practice of Committees is to respond to such submissions in their Final Reports.

Reece v Webber [2011] FCAFC 33 —

> [71] Section 106L, directed as it is to the contents of a final report, does not impose any requirement to provide "reasons" – as opposed to "findings". Section 106KD does incorporate a requirement to provide "reasons": s 106KD(1A). And the reference to "findings" in both provisions may well be confined to a finding "in respect of the relevant service" or a finding as to "inappropriate practice" as opposed to a more generally expressed requirement to provide "findings of fact". It may be that it was for this reason that Counsel for the Applicant did not seek to place reliance upon s 25D of the *Acts Interpretation Act 1901* (Cth) as a further basis upon which the Final Report could be challenged. Nor was any submission directed to any failure to comply with s 106KD(1A).
>
> [72] Nevertheless, it remains important that the Committee expose the factual basis upon which it was proposing to proceed in its Draft Report and the "findings" upon which its Final Report is founded. Notwithstanding differences in statutory language, the requirements imposed in the present statutory context to provide "findings" and "reasons" remain important elements of the procedural protection afforded by the legislature to the medical practitioner, albeit at different stages in the deliberations of the Committee. Those requirements have "important work" to

do both insofar as the medical practitioner and the Determining Authority are concerned.

…

[74] … The forum in which a medical practitioner is afforded the opportunity to adduce "evidence" is at the "hearing" conducted by the Committee prior to the preparation of its "draft report". Thereafter the only express entitlement afforded to a medical practitioner is to make "written submissions suggesting changes to the draft report": s 106KD(3). Section 106L(1A) provides for the course to be pursued by the Committee "if the person under review has been given a notice under subsection 106KD(3) inviting submissions on changes to the draft report". But such a distinction need not be further pursued.

…

[77] It is unquestionably the case that it would have been far preferable for the Committee in its Final Report to have referred to the submissions made on behalf of Dr Reece and to the competing views of the medical practitioners there referred to. It would also have been far preferable for the Committee to have explained why it adhered to its own views previously expressed in its Draft Report that Dr Reece had engaged in "inappropriate practice".

[78] But its failure to refer to this "specific evidence" and its failure to make express "findings" as to whether such evidence was or was not in accordance with generally accepted medical practice does not lead to a conclusion that this "specific evidence" was not also taken into account. Section 106L does not require the Committee to refer to the evidence or "specific evidence" upon which its "findings" were based or to refer to "submissions" that may have been made. Nor does s 106L impose any requirement to make "findings" in respect to "specific evidence" or "submissions" which may have been advanced on behalf of a practitioner. No contrary construction of s 106L was advanced on behalf of the Applicant.

[79] Such a conclusion, it is considered, is consistent with the statutory scheme set forth in Division 4 of Part VAA of the Health Insurance Act. Any different conclusion would impose upon the Committee a requirement "to refer" in its Final Report to the evidence upon which its findings of fact are based and possibly "to refer" to submissions made and a requirement to expressly state why specific evidence or submissions have not led it to make "findings" different to those in fact made. Any different conclusion or construction of Division 4 of Part VAA would only encourage a course whereby medical practitioners may seek to scour the "evidence" or "submissions" advanced before a Committee with a view to discerning some "evidence" or "submissions" that have not been expressly referred to. However desirable it may be for a Committee to do so, such requirements have not been imposed upon the Committee by the legislature. A failure to refer to the "expert medical opinions" advanced on behalf of Dr Reece, and to make "findings" in respect to those opinions, may well place the Determining Authority in a position where it is not as informed as it otherwise may have been. But such difficulties are of no immediate significance.

Tisdall v Blazow [2005] FCAFC 190 —

> [33] The draft report of the Committee, which was adopted by the Tribunal after the Tribunal's independent consideration, gave notice to the applicant of the issues of concern to the Committee and upon which it ultimately decided adversely to the applicant in relation to the 14 cases relied upon by the applicant in this proceeding. Procedural fairness required the applicant to be told of these issues in order to give him the opportunity to respond.
>
> [34] The specialists' affidavits addressed these issues which had been flagged by the Committee. It was not a requirement of procedural fairness in the circumstances of this case that the Committee articulate to the applicant the reasons why it was not persuaded by the specialist's affidavits. As the Full Court said in *Commissioner for Australian Capital Territory State Revenue v Alphaone Pty Ltd* [1994] FCA 1074; (1994) 49 FCR 576 at 591–2:
>
> > Where the exercise of a statutory power attracts the requirement for procedural fairness, a person likely to be affected by the decision is entitled to put information and submissions to the decision-maker in support of an outcome that supports his or her interests. That entitlement extends to the right to rebut or qualify by further information, and comment by way of submission, upon adverse material from other sources which is put before the decision-maker. It also extends to require the decision-maker to identify to the person affected any issue critical to the decision which is not apparent from its nature or the terms of the statute under which it is made. The decision-maker is required to advise of any adverse conclusion which has been arrived at which would not obviously be open on the known material. Subject to these qualifications however, a decision-maker is not obliged to expose his or her mental processes or provisional views to comment before making the decision in question.
>
> See also *Applicant M189 of 2002 v Minister for Immigration and Multicultural and Indigenous Affairs* [2004] FCAFC 131; and *MZWBW v Minister for Immigration and Multicultural and Indigenous Affairs* [2005] FCAFC 94.

The final report of a Committee may contain observations on matters related to its investigation but not necessarily affecting its findings concerning inappropriate practice of the person under review.

Sinha v Asher [1989] FCA 167 —

> [16] … It is a commonplace event for administrative tribunals or investigating committees to make observations upon matters arising out of their investigations about which they are not required to make findings. So long as those observations fairly arise, do not purport to be definitive findings and are relevant to the general scope and purpose of the legislation under which the tribunal or committee operates, I see no objection about that course. Obiter remarks, whether made by administrative bodies or judges, are made for what they may be worth and in an endeavour to be helpful to the parties or to advance the public interest. If the Committee does express the doubts which it has foreshadowed, no interest of the applicant will be directly affected. No legal right will be infringed.

Retnaraja v Morauta [1999] FCA 80 —

> [41] In *Sinja v Asher* [1989] FCA 167; (1989) 22 FCR 423 Wilcox J considered the former provisions of the Act which provided for the investigation of excessive servicing by a Medical Services Committee of Inquiry. His Honour held that the duty of the Committee in relation to its Report was limited to the question of excessive servicing which had been referred for inquiry. However, that did not preclude the Committee from stating its view that doubts had arisen as to whether the particular services were rendered even though it had no power to make any determination in relation to that question. …
>
> [42] In my opinion the "other problems" discussed by the Committee in this case did fairly arise. In the course of expressing its concerns, the Committee made comments about the quality of aspects of Dr Retnaraja's practice management, and his professional skills. In a sense these could be described as findings of fact, but, especially having regard to the fact that the Committee noted that it was not making any findings on the problems it identified, I think the better construction of the Report is that the Committee was merely expressing its opinions on the problems, and was not purporting to make definitive findings on any of those matters.

On judicial review of a Final Report of a Committee, it is not open to the Court to review the merits of the Committee's findings.

Joseph v Health Insurance Commission [2005] FCA 1042 —

> The Committee, which was composed of expert members, was required to consider randomly selected samples of home visits made by the applicant. The applicant could not recall, and had made no record of, most of these home visits. He was thus unable to (or at least, did not) provide the Committee with any information that would undermine the inference that the Committee considered to be open in the circumstances; that is, the inference that the home visits were undertaken as a matter of routine rather than because they were medically necessary. While it may be the case, as the applicant argued, that frequent and regular home visits to the chronically ill, or the severely ill, may be warranted, it is not for the Court to review on the merits the judgment made by the Committee, on the information available to it, following its consideration of the randomly selected sample of MBS item 59 services.

A challenge to a Final Report of a Committee by way of judicial review may be dismissed if it is not brought within a reasonable time. Subsection 106L(3) provides for a minimum of one month from when the Final Report is given to the person under review to when it can be provided to the Determining Authority. This period allows for the 28 day time limit in making an application under the *Administrative Decisions (Judicial Review) Act 1977*.

Bham v The Determining Authority [2006] FCA 589 —

[60] The relief which the applicant seeks against the Committee in his proposed amended application for review is to set aside the determination of the Committee. As the Committee has discharged its statutory function the prerogative relief against the Committee would be by way of certiorari. As mentioned above, the applicant appears to have proceeded on the assumption that it would be necessary to obtain an extension of time in order seek relief by way of certiorari. There is, however, no provision in the Federal Court Rules which in terms imposes any time restriction for the bringing of any application for relief by way of certiorari. It may be arguable that the time limits imposed by the High Court Rules for the commencement of an application for the issue of a writ of certiorari, apply by reason of s 38(2) of the *Federal Court of Australia Act 1976* (Cth), but no submission was made to me to that effect, and I do not propose to decide this application on that basis.

[61] I decline to make an order for the joinder of the members of the Committee and the Director. I do so by applying, by analogy, the principle that a court will not usually exercise its discretion to allow an amendment to join a person as a party to an application who has a good defence under a period of limitation (see, *Bridge Shipping Pty Ltd v Grand Shipping SA* [1991] HCA 45; (1991) 173 CLR 231 at 236).

[62] In *Re Commonwealth of Australia; Ex parte Marks* [2000] HCA 67; (2000) 177 ALR 491 at 496:

> 'An applicant's inability to obtain favourable legal advice is not a ground for extending the time for seeking mandamus or the ancillary writ of certiorari. Upon the expiry of the time for the issue of a constitutional writ against a decision or judgment, the respondent has a vested right to retain the judgment or decision. Its rights should not be dependant on whether the applicant can at some future time obtain a favourable legal opinion that he or she has an arguable case. In addition, the efficacy of public acts, decisions and judgments cannot be the hostage of an applicant's search for favourable legal advice.'

[63] Although those remarks were addressed specifically in relation to the time limits for obtaining prerogative relief under the High Court Rules, the observations have wider applicability in relation to public acts and are germane to the facts of this case.

[64] Delay and acquiescence have been described as defences available to a respondent in relation to relief sought by way of certiorari in the sense that a court may, in the exercise of its discretion, refuse relief on those grounds. In assessing whether there has been an unwarranted delay, such as would equate with a limitation defence, it is significant that s 106L(3) of the Act provides that the Committee is to deliver its final report to the respondent no earlier than one month after the date that a copy of its final report is delivered to the person under review. This period equates with the prescribed period for bringing an application for review under the ADJR Act and is an indication of legislative intent as to the time within which applications for review of the Committee's final report should be brought (see the observations of Branson J in *Joseph v Health Insurance Commission* [2005] FCA 1042 at [6]).

[65] When assessed by reference to that one month period, a delay of 14 months, in all the circumstances of this case, amounts to an unwarranted delay which would, in the exercise of the Court's discretion, lead to the refusal of relief. The proposed respondents have, in my view, a good defence, and I would, therefore, decline to order that they be joined as parties to the application.

Norouzi v Director of Professional Services Review Agency [2020] FCA 1524 —

[27] The giving of the committee's report to Dr Norouzi was required by s 106L(3)(a) of the HIA. That provision also required the committee to give a copy of its final report to the Director. Thereafter, s 106L(3)(b) of the HIA required that there be a pause of at least one month by providing that the committee was to "give the final report to the Determining Authority not earlier than 1 month after the day on which a copy of the report is given to the person under review".

[28] The HIA does not expressly state, either in the description in s 80 of the "main features" of the scheme or otherwise, that the purpose of this one month pause is to enable the person under review, here Dr Norouzi, to institute an application for review under the ADJR Act (or the Judiciary Act) of the committee's decision within the time provided by that Act. However, when regard is had to s 106TB of the HIA, that to me does seem to be the purpose of the one month specification in s 106L(3)(b).

[29] By s 106SA of the HIA, the Determining Authority is obliged to "give the person under review a written invitation to make written submissions to the Authority, having regard to the Committee's final report and any information given by the Director under section 106S, about the directions the Authority should make in the draft determination relating to the person". In the ordinary course of events, that invitation must be given within one month after the Determining Authority has been given the committee's final report: s 106SA(3) of the HIA. However, that period for the doing of that act is one of those which s 106TB terms an "original action period".

[30] Section 106TB expressly contemplates that the doing of an act such as the extending of a Determining Authority's invitation within a related original action period might be prevented by an injunction or other court order. Implicit in s 106TB is the proposition that the jurisdiction of a court of competent jurisdiction might have been invoked so as, presently materially, to challenge the final report (decision) of the committee and that such a court might be persuaded that progression of the statutory processes ordained by Pt VAA of the HIA should be stayed, pending the hearing and determination on its merits of the court challenge. One way in which the decision of a committee might be challenged in a court of competent jurisdiction is by an application made under the ADJR Act within the time prescribed by that Act. In turn, a court seized with such an application might stay the operation of a committee decision under review by an order made pursuant to s 15 of the ADJR Act. Another means of challenge is, of course, by way of an application under s 39B of the Judiciary Act.

[31] This feature of Pt VAA was relevantly highlighted by the Determining Authority and the committee in opposing the granting of an extension of time.

[32] There are other indications within Pt VAA of the HIA that Parliament contemplated that reasonable expedition would attend the scheme's processes. At the very outset of the processes, if the Director decides to review the provision of services by a person, the Director cannot, without consequence, leave that decision unactioned. If, before the end of the period of 12 months after making the decision, the Director has not either referred the matter to a committee, reached an agreement with a practitioner or decided to take no further action, the effect of s 94(1) of the HIA is "the Director is taken to have made a decision at the end of that period to take no further action in relation to the review".

[33] Although s 106G(5) of the HIA provides in respect of a committee that, "Failure to give the final report to the Determining Authority within the period of 6 months, or that period as extended, does not affect the validity of that report", s 106G nonetheless makes elaborate provision in relation to what is at least an aspirational, timely completion of a committee's function. Inbuilt into the completion of a committee's function is the allowance of an opportunity to a person under review to make submissions suggesting changes to a draft report of the committee but a one month time period attends that opportunity: s 106KD(3) of the HIA.

[34] All of the various time limits specified in Pt VAA which attend processes which occur prior to the giving of the committee's report to the Determining Authority can be seen to balance reasonable expedition with procedural fairness to a person under review and also to manifest the desirability of closure in respect of the review of the provision of a service and the contingency that there may be a repayment obligation in respect of the benefit paid or other consequences in respect of the provision of that service.

[35] Another evident purpose in the various specified time limits is that there be reasonable proximity between any review and the provision of the service concerned. At the very outset of the Pt VAA processes, in relation to the request by the Chief Executive Medicare to the Director to review provision of services, s 86(2) of the HIA ordains that, "The period specified in the request must fall within the 2 year period immediately preceding the request".

[36] In *Lucic v Nolan*, at 416, Fitzgerald J, having observed in respect of public administration decisions that it seemed a "broadly accurate" feature of the ADJR Act that there was "a legislative intention that certain standards are to be observed in respect of such decisions and actions", stated:

> [That] is not the only public interest to be served. Other matters of proper public concern which are readily identifiable as relevant to the review of administrative acts and decisions include the need for finality in disputes, the efficient use of public resources, the appropriate allocation and expenditure of public funds …

[37] In my view, such public interest considerations loom large in the present case and tell against the granting of an extension of time.

[38] The review period with which the committee was concerned covered the period from 1 September 2016 to 31 August 2017 inclusive (Review Period). Were the

committee's decision to be quashed, under s 16 of the ADJR Act if an extension were granted (or quashed by certiorari in aid of relief under s 39B akin to a constitutional writ), in excess of four years would have elapsed since the commencement of the period within which the provision of particular services under claimed item numbers occurred.

[39] The Court could not, on judicial review, reach any conclusions of its own as to whether inappropriate practice had occurred in substitution for those of the committee. Depending upon the basis of quashing, the submissions of the parties, and the pleaded review grounds including alleged denial of natural justice, a remitter to the committee as presently constituted may not be apt were Dr Norouzi to succeed in his application. It might be necessary to remit the matter to the Director to set up a different committee under s 93(1) of the HIA. The HIA provides for ad hoc, bespoke committees drawn from a panel of practitioners (some of whom are additionally appointed as Deputy Directors of Professional Services Review – see Division 2 of Pt VAA). Dr Norouzi would have to be offered an opportunity to challenge the appointments to any reconstituted committee: s 96, HIA.

[40] In any event, even if the matter were apt for remitter to the existing, respondent committee, there is, in light of the experience offered by the progress of committee proceedings to date in this matter, at least a realistic contingency that committee deliberations on remitter might not be finalised this year.

[41] Were the committee's decision to be set aside, it would necessarily follow that the Determining Authority's decision would also have to be set aside.

[42] Under the scheme, the provision of the committee's final report is not just a condition precedent to the processes and decision of the Determining Authority. The Determining Authority's decision is informed by that committee report, as well as any submissions which the person under review cares to make in response to an invitation: s 106SA(1) of the HIA. Even if it were otherwise valid, a decision of the Determining Authority could not stand if the committee's decision were quashed. All of the expenditure of public funds entailed in the deliberations of the Determining Authority to reach that decision would necessarily be set at nought if the committee's decision were set aside.

[43] A decision of the committee to issue a final report, as in the present case, is not unexaminable on judicial review. However, when an application under the ADJR Act is not made within the time prescribed or when the court's jurisdiction under s 39B of the Judiciary Act is not invoked within a reasonable time after such a decision, those engaged in the administration of the HIA are entitled to assume that this particular phase of the staged processes ordained by Pt VAA of that Act is a closed chapter. I accept the submission made on behalf of the committee and the Determining Authority that it is antithetical to the integrity of the scheme for an extension of time to be granted to challenge a committee's decision after a lengthy delay. Having regard to the ordained progression of a review by a committee, an unexplained, six month delay in the institution of a challenge may readily be classified as such a lengthy delay.

[44] Apart from the wasting of the expenditure of public funds (and the related time of professionally qualified persons) relating to the Determining Authority's

> decision, other public administration consequences flowing from a lengthy delay can be envisaged in the ordinary course of public administration according to law. As a matter of constitutional law, expenditures under the HIA must be paid by parliamentary appropriation from Commonwealth Consolidated Revenue: s 81 and s 83 of the *Constitution*. The Minister and those advising him for this purpose would be entitled to assume, when preparing budget estimates for parliamentary consideration of expenditure likely to be incurred in the administration of the HIA, that no provision need be made for the contingency of a fresh review, perhaps by a differently constituted committee. Similarly, the Director would be entitled to assume that those members of the panel who constituted the committee in the present case can be redeployed if needs be to another committee and that there is no need to make provision for the contingency that other panel members might have to be found to replace them in the event that it was necessary again to undertake the review. Such panel members, too, could be deployed to other tasks if needs be. There was no direct evidence of such consequences. The point of mentioning them is to highlight that public administration is neither static nor able to draw upon an inexhaustible supply of human and financial resources. It is inherently likely that there will be an opportunity cost in public administration by permitting, after a lengthy delay, challenges on judicial review to administrative decisions hitherto, for good reason, entitled to be regarded as final.
>
> [45] Of course, in a personal sense, neither the members of the committee, the Determining Authority nor the Director might suffer prejudice by the granting of an extension of time to Dr Norouzi but that says nothing about the impact on an efficient use of public resources, a consideration highlighted by Fitzgerald J in *Lucic v Nolan*.

106N Committee may refer material to Chief Executive Medicare if certain offences or civil contraventions are suspected

If a Committee thinks that material before it indicates that the person under review may have may committed an offence or contravention within the meaning of section 124B of the Act, the Committee may send that material to the Chief Executive Medicare and may suspend its consideration of the referral for such period as it thinks appropriate. This would enable the Chief Executive Medicare to investigate those offences or contraventions without the risk that further investigation by Committee might disturb the Chief Executive Medicare's investigation. Usually the staff assisting the Committee would liaise with the relevant delegate of the Chief Executive Medicare to determine whether any likely action by the Committee would put the investigation or prosecution by the Chief Executive Medicare at risk before continuing the review.

106Q The Determining Authority

The Determining Authority makes decisions whether or not to ratify agreements entered into by a practitioner and the Director,[186] and makes draft[187] and final determinations[188] setting out the sanctions to be imposed on persons under review consequent upon the findings of a Committee.[189] Its members are appointed by the Minister following consultation with the relevant professional bodies.[190]

The Determining Authority is 'established' by section 106Q. It is a 'body' established under an Act and is thus an 'agency' for the purposes of the *Privacy Act 1988*, but is not an 'agency' for the purposes of the *Freedom of Information Act 1982* (FOI Act) because it performs functions connected with a prescribed authority (namely, the Professional Services Review, which is a body established under an Act as a 'statutory agency' for the purposes of the *Public Service Act 1999*): see subsection 6(2), FOI Act.

The Determining Authority is not a corporation. It has no power to own property, employ staff, or enter into transactions. It has no legal personality. Nevertheless, because it is established for a public purpose and are constituted by natural persons, namely a Chair and other members, it can be regarded as a 'Commonwealth officer' for the purposes of being a respondent to an action under section 75(v) of the *Constitution*.

A consequence of lacking legal personality (other than being a 'Commonwealth officer' for the limited purpose of an action under s. 75(v) of the *Constitution*) is that the Determining Authority has no constructive knowledge of any previous matters. Its functions and powers are limited to consideration of particular cases. However, members bring with them, and are expected to apply, their expertise and experience.

While the Determining Authority has a continuing existence, it is separately constituted for the purpose of performing its functions and exercising its powers in particular matters depending on the profession of the person under review. As it does not perform any functions or exercise any powers apart from its consideration of particular cases, it, as a body, exists in a similar manner to the Panel, as a repository of members from whom the decision-maker is formed depending on the

[186] Section 106R of the Act.
[187] Section 106T of the Act.
[188] Section 106TA of the Act.
[189] Section 106U of the Act.
[190] Section 106ZPB of the Act.

profession of the person under review. It does not possess any material except for the purpose of the particular matter it is considering, and so cannot have access to, or have a 'memory' of, any previous matter. Consequently, in order for the Authority to have regard to a previous ratified section 92 agreement or determination of the Authority in relation to a particular person under review, it must obtain that information from the Director or from some other proper source (such as the person under review).

In providing administrative support for the Determining Authority, the Professional Services Review keeps the records relating to the Determining Authority's activities.

Brief History of the PSR sanction process

The 1994 scheme

The *Health Insurance (Professional Services Review) Amendment Act 1994* amended the *Health Insurance Act 1973*, with effect from 1 July 1994, to create:

- the office of the **Director of Professional Services Review**;
- the **Professional Services Review Panel**, from which **Professional Services Review Committees** were selected; and
- the office of **Determining Officer**, being a public servant within the Department of Health, appointed by the Minister to determine the sanctions (called 'determinations') arising from Final Reports of Committees.

Under the 1994 scheme, the Director could enter into a '**written arrangement**' with the person under review to partially disqualify the practitioner for a period of up to 12 months in respect of one or more of the following:

- provision of specified services (being the services specified in the referral to the Director from the Health Insurance Commission), or provision of services other than specified services;
- provision of services to a specified class of persons, or provision of services to persons other than persons included in a specified class of persons;
- provision of services within a specified location, or provision of services otherwise than within a specified location.

A written arrangement came into effect upon being entered into, and the Director was required to notify the Health Insurance Commission as soon as the disqualification had occurred. There was no provision for an arrangement to include

full disqualification or any repayment of medicare benefits. Given the limited sanctions that could be imposed in an arrangement, it was not often used.[191]

PSR Committees considered whether the practitioner had engaged in inappropriate practice in relation to specified services or services of a specified class. While Committees utilised sampling, it was a complex process, and there were successful legal challenges to its application. In 1997 a Committee's capacity to use sampling was removed from the Act.[192]

Committees' Final Reports, together with the transcript of proceedings and other relevant documents, were sent to the Determining Officer for determining the sanctions. The Determining Officer would give the person under review an opportunity to comment on a **Draft Determination** before issuing the **Final Determination**.

If a person under review was dissatisfied with the Final Determination of the Determining Officer, he or she could request a review by a **Professional Services Review Tribunal**. The Tribunal's task was to review the Final Determination by reference only to the existing material, and in the light of any addresses made to it on that material. Nevertheless, the Tribunal was not confined to accepting the Committee's findings. Where a Final Determination on its face would not be justified by a Committee's finding, it was open for the Tribunal to take a different view from the Committee and set aside the Determining Officer's Final Determination.[193]

If a practitioner had two effective Final Determinations, he or she had to be referred to a **Medicare Participation Review Committee**, which could disqualify the practitioner from participation in Medicare for up to 5 years.

The 1999 scheme

In July 1998, the Minister for Health appointed a Committee to review the 1994 Scheme. The Review Committee reported to the Minister in March 1999, and stated:

> 'The Review Committee noted the ANAO report findings and the need for the level of benefit recovered from a practitioner to be commensurate with the level of over servicing actually engaged in. There is also a strong need to

[191] *The Report of the Review Committee of the Professional Services Review Scheme*, at page 28, indicates that it had been used on only 5 occasions.
[192] *Health Insurance Amendment Act (No. 1) 1997*.
[193] See *Adams v Yung* [1998] FCA 506 per Burchett and Hill JJ.

satisfy community perceptions that the level of sanction imposed matches the level of inappropriate practice.

The Review Committee noted the views of the AMA and the Commonwealth, and agreed that substantial periods of suspension from Medicare and the recovery of medicare benefits were appropriate for practitioners found to have rendered high volumes of services per day.'[194]

The Review Committee recommended a number of changes, including:

- the application of a simpler statute-based sampling methodology for classes of services;
- inappropriate practice be deemed to occur if the practitioner engaged in a '**prescribed pattern of services**' (the so-called '**80/20 rule**'), unless exceptional circumstances were demonstrated;
- the keeping of adequate and contemporaneous records be a legislative requirement;
- replacing the Determining Officer with a 'Determining Panel';
- enabling the Director to enter into '**written agreements**' that could include full or partial disqualification and the repayment of benefits, but that, given the extended range of sanctions that could be included, agreements should be ratified by the Determining Panel before coming into force;
- the Minister should have the authority to make guidelines for the assistance of the Determining Panel;
- PSR Tribunals be removed from the scheme.

The Government accepted the Committee's recommendations and amended the legislation. The proposed 'Determining Panel' was instead named the '**Determining Authority**'. The written agreements became known as '**section 92 agreements**'.

The 2002 amendments

Following a Federal Court decision relating to the nature and scope of referrals to a Committee,[195] the legislation was amended to clarify and strengthen the scheme that had been enacted in 1999. The main amendments were:

- a new objects clause;
- replacing the investigative referral process with a request from the Commission that the Director examine certain services rendered or initiated by a practitioner for which a medicare benefit has been claimed. The

[194] *The Report of the Review Committee of the Professional Services Review Scheme*, at page 23.
[195] *Pradhan v Holmes* [2001] FCA 1560

amendments enabled both the Director and the PSR Committee to identify additional types of conduct arising from the referred services that may constitute inappropriate practice;

- enhancing procedural fairness at various stages of the Scheme, including an opportunity to make submissions in respect of appropriate directions before the Determining Authority makes a Draft Determination. This was to be in addition to the already existing opportunity a person under review had to comment on the Draft Determination.

The 2012 amendments

In 2012, the legislation was amended[196] to require the Chief Executive Medicare to refer a practitioner to the Director as soon as practicable after becoming aware that the practitioner had engaged in a prescribed pattern of services. The amendments enabled the Director to determine, for the purposes of entering into a section 92 agreement, whether or not exceptional circumstances applied. Previously, that was only a matter that a Committee could determine.

The amendments also abolished referrals to a Medicare Participation Review Committee, and in their place, the Determining Authority was permitted to disqualify a practitioner for up to 5 years if there had been a previous section 92 agreement or Final Determination.

106S Director may give Determining Authority information

The Director is given a single opportunity to provide information to the Determining Authority that the Director considers is relevant to the Authority's making of its draft and final determinations, and must not do so after it has made its draft determination. Such information must also be given to the person under review. The Determining Authority is required to consider that information in making its draft determination or final determination.

The type of information often given by the Director to the Determining Authority includes information regarding previous occasions on which the Determining Authority has ratified a section 92 agreement or a final determination has come into force in respect of the person under review. Information may also be provided that would assist the determining authority in setting an appropriate repayment amount under paragraph 106U(1)(cb) by reference to subsection 106U(1A), namely what was

[196] *Health Insurance Amendment (Professional Services Review) Act 2012*.

the lowest rate that was payable for any of the services included in each of the relevant classes services.

Li v Determining Authority [2022] FCA 1448 —

> [68] The applicant submitted that the Authority took into account an irrelevant consideration (see ss 5(1)(e); 5(2)(a) of the ADJR Act), or otherwise misdirected itself or misunderstood its statutory task, when making the repayment and disqualification directions, by taking into account the:
> (a) Director's statements of concerns, dated 3 October 2019, purportedly under s 106S of the Act, referred to at [29]–[31] above; and
> (b) Committee's statement of concerns dated 2 March 2021 referred to at [38]–[41] above.
>
> [69] To successfully impugn the Authority's decision on the basis that it took into account an irrelevant consideration, the applicant must prove (i) that the Authority took into account, in fact, each of the Director's and the Committee's statements of concern; (ii) that those considerations were irrelevant considerations in that by taking them into account for a particular use or purpose, it was impermissible under the applicable statutory provisions; and (iii) that those applicable statutory provisions have the effect that taking the statements of concern into account will result in invalidity: *Love v Victoria* [2009] VSC 215 at [191]; see also *Duffy v Da Rin* [2014] NSWCA 270; 87 NSWLR 495 at [53].
>
> [70] However, relevantly, it is noted that the applicant's grounds of review are more expansive and include a purported misdirection from or misunderstanding of its statutory task. The bases for both grounds were intertwined and will be dealt with together.
>
> [71] It is clear that the Authority "had regard to" the Director's and the Committee's statements of concerns made pursuant to ss 106XA and 106XB of the Act. At FD[9], identifying the material relied upon, the Authority refers to having "regard to", inter alia, the letter from the Director dated 19 November 2021 providing additional information under s 106S of the Act. The letter, extracted in full at [49] above, included the following statements and attachments:
>
> - I sent a written statement of concerns about Dr Li to the Australian Health Practitioners Regulation Agency (AHPRA) under sections 106XA and 106XB of the Act on 3 October 2019 during my review of Dr Li's provision of services. A copy of this AHPRA referral is enclosed.
> - I sent a written statement of concerns about Dr Li, which I received from the Committee, to AHPRA under sections 106XA and 106XB of the Act on 3 March 2021. A copy of this AHPRA referral is enclosed.
>
> [72] The Authority also notes at FD[8] that it relied on the Committee's Final Report (which annexed the Committee's statement of concerns).
>
> [73] The Authority, thereafter, only refers to the fact of these statements of concern, in response to the applicant's submission about them at FD[56]–[57]. The applicant

relies on FD[57]. It is worthwhile noting that this paragraph appears in the part of the Final Determination which addresses the applicant's submissions, and with respect to a specific submission made by the applicant which is extracted at [60] above. For completeness, the preceding paragraph of the Final Determination is also relevant, and both paragraphs are extracted as follows:

> [56] More generally, Dr Li submits that the Determining Authority may have inadvertently taken into account the Director's and the Committee's statements of concerns about significant threats to the life or health of Dr Li's patients and a failure to comply with professional standards, under sections 106XA and 106XB of the Act. Dr Li refers to section 106UAA of the Act, which makes clear that the Determining Authority must not take into account any statements of concerns the Determining Authority might prepare under those provisions.
>
> [57] The Determining Authority has not prepared any such statement of concerns in relation to Dr Li. Accordingly, section 106UAA does not apply. The Determining Authority also notes that in arriving at its findings of inappropriate practice, the Committee expressly disregarded the opinion which formed the basis of its statement of concerns, as it was required to do under section 106M of the Act. Equally, the Director notified the Determining Authority of the statements of concerns she provided to the Australian Health Practitioners Regulation Agency, under section 106S of the Act. ***The Determining Authority is required to take that information into account***. (Emphasis added).

[74] The gravamen of the applicant's submission regarding why, by operation of the legislative scheme, if the Authority did take into account the statements of concerns they constituted "irrelevant considerations", was by reason of the preclusions that apply under ss 93(1), (8), (9), 106M(3) and 106UAA of the Act. These preclusions were said to reveal why the Authority was not able, purportedly under s 106S, to take them into account.

[75] The applicant contends that the effect of the final sentence in FD[57] is that the Authority did take into account the Director's and the Committee's statements of concerns which, rather than being entitled to under s 106S, was prohibited because it may be inferred from the subject-matter, scope and purpose of the Act that there is an implied limitation on the factors to which the Authority may lawfully have regard to when imposing directions pursuant to ss 106TA(1) and 106U(1) of the Act: see *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* [1986] HCA 40; 162 CLR 24 at 40.

[76] Sections 93(9), 106M(3) and 106UAA provide that the Director, Committee and Authority respectively are to disregard, for the purpose of them undertaking certain statutory tasks, opinions they have formed in statements of concern that the person under review caused a significant threat to the life or health of a person or failed to comply with professional standards when exercising their respective functions. …

[77] The applicant submits that those "concerns" are matters which are to be referred by the Director, Committee or Authority to State and Territory regulatory bodies for their consideration such that it is "implicit" from these provisions that the legislature intended that the Authority is not to have regard to an opinion

expressed in a Director's or Committee's statement of concerns made under ss 106XA or 106XB, when making its determinations.

[78] It follows, according to the applicant, that on its proper construction, s 106S of the Act does not authorise the Director to provide a statement of concerns to the Authority. Further, those statements are not something which is "relevant" to the Authority making its draft or final determination (having regard to ss 93(9), 106M(3) and 106UAA) and its directions pursuant to s 106U.

[79] The applicant contends that in its Final Determination, the Authority rejected the applicant's submission that it was not permitted to take into account the statements of concern by it saying it was "required to take that information into account": FD[57]. Those statements of concern, on the applicant's submission, were highly prejudicial, akin to taking into account a charge as opposed to a conviction and, whilst the Authority did not explain the effect of taking into account those statements, it did so "expressly" such that when "examining an open-textured discretion" it may be inferred that the prejudicial matters were taken into account such that the error was material because it deprived the applicant of a realistic possibility of a different outcome.

[80] At hearing, the applicant expanded on this submission, with the aid of the reasoning in *Adams v Yung* [1998] FCA 506; 83 FCR 248 at 298, submitting that by reason of the Authority taking those statements into account, it was taking into account the applicant's conduct "at large" rather than the confined conduct required under the Act.

[81] For the following reasons, I reject the applicant's submission that the statements of concern constituted an "irrelevant consideration" or that the Authority misdirected itself or misunderstood its task when making the Final Determination.

[82] To make out the "irrelevant consideration" ground of review, the impugned consideration is ordinarily described as needing to be forbidden or prohibited with reference to the canonical principle elucidated by Mason J in *Peko-Wallsend* at 39–40. However, this statement of principle needs to be understood with a degree of flexibility, which Mason J had recognised later in his Honour's reasoning, at 41 (see *Duffy* at [52]), about which Basten JA opined expansively in *Duffy* at [53]:

> This analysis was incomplete in that it did not address the weight given to permissible considerations and any possible flexibility with respect to impermissible considerations. The significance of these omissions is that "considerations" have different qualities which are not recognised by a simple classification as permissible, mandatory or prohibited. To identify a lion and a deer as wild animals and place them together in a zoo is unlikely to provide a satisfactory outcome (at least for the deer). Two considerations may each be relevant, but may pull in opposite directions. A particular consideration may be relevant to one aspect of the reasoning process, but not to other aspects. For example, in sentencing an offender a prior criminal record is relevant, but may only be used to diminish a plea for leniency, not to increase an otherwise appropriate sentence for the particular offence. Thus a consideration which is relevant for a specific purpose or in respect of a particular issue only may be

> impermissibly used for a different purpose or with respect to another issue. Such misuse could constitute an error of law.

[83] In *Duffy*, the Court of Appeal ultimately found that the relevant Tribunal had erred in its conclusion as to Mr Duffy's place of living by determining whether the connections with one town outweighed the connections with the other town, or were so substantial so as to prevent the other town constituting a place of living. Justice Basten stated, at [57], that this finding by the Tribunal "was not the exercise required by the statute. The use to which the factors, while not irrelevant for all purposes, were put by the Tribunal indicates that it misdirected itself as to the precise question it was required to determine".

[84] The alleged "prohibition" in the present case is said to arise, by implication, from a consideration of certain parts of the legislative scheme. As to the first basis for such an implication, being by reason of the restrictions imposed by ss 93(9), 106M(3) and 106UAA of the Act, a consideration of the statutory scheme and its history reveals the following, as submitted by the applicant:

> [15] When Part VAA was introduced into the Act in 1994, a committee was required to make a referral to a State or Territory regulatory authority, providing a statement of its concerns, if it considered that "material before it indicates that action should be taken against the person under review in order to lessen a serious and imminent threat to the life or health of any person" (Act, s 106P(1) (as it then stood)). However, this did not affect the Committee's consideration of the referral (Act, s 106P(2)).
>
> [16] The professional services review scheme was reviewed in 1999 and it was recommended by a review committee that the Director, a committee and what was then the Determining Panel all be given a power to make referrals to regulatory bodies. The *Health Insurance Amendment (Professional Services Review) Act 1999* (Cth) introduced new provisions expanding on the existing referral powers. It was specified, however, in the amended provisions, that the Director (s 93(9)), a committee (s 106M(3)) and the Determining Authority (s 106UAA) were "to disregard" any opinion each formed for the purposes of making a statement of concerns to be sent to a regulatory body.
>
> [17] Following the 1999 amendments, Part VAA of the Act provides for the Director, a committee and the Determining Authority to make a statement of concern to be sent to regulators if the decision-maker forms the opinion that the conduct by a person has caused a significant threat to the life or health of any other person (s 106XA) or that a practitioner has failed to comply with professional standards (s 106XB). (Footnotes omitted.)

[85] The applicant referred in his submissions to Recommendation 32 of the *Report of the Review Committee to the Professional Services Review Scheme* – March 1999. That report, at pp. 32–33, described why there was an expansion in the circumstances by which, at "any stage of the process", there could be a referral to a State or Territory body as follows:

> PSRCs [Committees] have identified various professional issues in relation to clinical competence and performance; aberrant professional behaviour or beliefs; lack of meaningful continuing medical education; physical or mental

> impairment; and substance abuse. Organisational issues that can affect patient safety, such as equipment and staffing deficiencies, are also sometimes evident.
>
> These issues are relevant for professional practice but, in light of the Federal Court's decision in *Adams v Yung*, are not necessarily relevant to the issue of inappropriate practice relating to the provision of services that attract a Medicare benefit.
>
> Currently PSRCs must refer concerns about possible serious threats to the life or health of persons to State/Territory registration bodies. Matters relating to a practitioner's compliance with professional standards (for example, compliance with conditions for vocational registration) can only be referred by the DO [Determining Officer] to other bodies such as a General Practice Recognition Eligibility Committee and a Specialist Recognition Advisory Committee.
>
> The Review recommends that with the creation of a consolidated PSR Agency, the legislation be amended so that the DPSR [Director], PSRCs and the DP [Determining Panel] can, at any stage of the process, refer concerns relating to significant threats to the life or health of persons to State/Territory registration bodies, and refer matters relating to the practitioner's compliance with professional standards to relevant bodies.

[86] In his further written submissions, the applicant contended that:

> The legislature introduced the injunction to each Part VAA decision-maker that he, she or it "must disregard any opinion formed" in making a statement of concerns in the 1999 Amending Act (in the new ss 93(9), 106M(3) and 106UAA). It may be inferred that it did so in light of *Adams v Yung* so as to help ensure that the Part VAA decision-makers did not take into account irrelevant material, or deny a practitioner natural justice.

[87] The applicant correctly identified the confines of what constitutes "inappropriate practice" for the purposes of the Act, which by contrast does not include "professional issues" of the kind identified in the Report: They are the remit of the appropriate State or Territory body and as recognised under the National Law.

[88] The chronology of events revealed above that there is likely to be an interplay between the parallel regimes in operation (with different powers and responsibilities) at a State or Territory and a Federal level. The Act contemplates and facilitates the same. There is a delineation between the kinds of professional matters that are dealt with under this Act and under the State and Territory regimes as is clear from the legislative history referred to above, the extrinsic material and the terms of the Act. The Act makes clear, as submitted by the applicant, that it is concerned with "inappropriate practice", defined in s 82, which arises from the practitioner's conduct "in connection with rendering or initiating services" which are defined in s 81 of the Act …

[89] Necessarily, by these definitions, together with its stated object under s 79A (extracted above at [9]) the scope of this Act is to deal with "inappropriate practice" and is confined.

[90] However, the Act contemplates and makes specific provision for the referral of "professional issues" to other regulatory bodies under Division 5A of Part VAA (the relevant provisions are extracted at [76] above). In order to facilitate the same, the Authority or Committee is required, pursuant to s 106XA, "in the course of the performance of functions or the exercise of powers under this Part", to give the Director a written statement of its concerns which leads to a referral, if it forms the view that any of the conduct by the person under review caused, or was likely to cause, a significant threat to the life or health of any other person. Similarly, the Authority or Committee is required to give to the Director a written statement of its concerns regarding its opinion that the practitioner has failed to comply with professional standards: s 106XB. The Director is then required, by reason of "receiving" statements in either circumstance, to send the statement and material to a State or Territory body that is responsible for the administration of health services or the protection of public health and safety, as well as any other "appropriate person or body: ss 106XA(2), 106XB(2).

[91] Similarly if the Director forms his or her own opinion of a similar kind, he or she must: (a) prepare a written statement of his or her concerns; and (b) attach to the statement the material or copies of the material on which his or her opinion is based; and (c) send the statement and material to the State or Territory body that is responsible for the administration of health services or the protection of public health and safety, as well as any other "appropriate person or body": ss 106XA(3), 106XB(2).

[92] If the Authority, in the course of considering a report by the Committee, forms its own opinion that any of the conduct falls within the criteria under s 106UAA(1)(a) (significant threat to life or health) or under s 106UAA(1)(b) (failure to comply with professional standards), it must disregard those matters when making its draft or final determination (extracted at [20] above).

[93] Such statements of concerns (precipitating a prompt for the Director) and the Director's referrals can be made at any time. The fact of these referrals then may precipitate a course of events, under the National Law, as occurred in the case of the applicant, leading to disciplinary proceedings and measures of the kind that occurred in this case, such as a hearing related to an inquiry or an appeal under s 150 of the National Law (see s 11 of Sch 5D of the National Law), conditional registration and supervision.

[94] What is clear here is that the Authority did not prepare any such statement of concerns itself (as required under s 106UAA if those concerns had arisen): The Authority states that it "has not" done so explicitly at FD[57]. Given that it is compelled by the mandatory statutory command of ss 106XA(1) and 106XB(1) to provide a "written statement of its concerns" if it held those views, there was no submission made to the effect that the Authority held those views when making its draft or final determination.

[95] What the Authority was aware of, which it identified at FD[57], was: (a) the Committee having previously held those views and disregarding them, as it identified; and (b) that the Director had notified AHPRA of her concerns as required under s 106XA(3): AHPRA being an "appropriate person or body" for the purpose

of s 106XA(4): reg 10(2)(c) of the *Health Insurance (Professional Services Review Scheme) Regulations 2019* (Cth).

[96] Given this distinction, there was no suggestion that the Authority had its own present concerns (for which it was excluded from taking into account when making its determination). What, then, must be made of the fact that it was aware of the Committee and Director having those concerns in the past? There is a clear distinction between the two. Whilst, on one view, the Authority being aware of these past concerns might be prejudicial to an applicant, the fact that the Authority does not hold that view itself now is particularly relevant.

[97] Importantly, as submitted by the Commonwealth, it must be remembered that the Authority was necessarily, by statutory command, aware of the fact of both the Director's and the Committee's statements of concerns, by operation of ss 106L(3) and 106M, regardless of being provided with them by the Director under a s 106S Notice.

[98] …

[99] Accordingly, by operation of s 106L(3) the Committee was required to provide a copy of its Final Report to the Authority and by operation of s 106M(2)(b), the Committee was required in its Final Report to state whether it had formed the relevant opinion precipitating a statement of concerns and set out the terms of the statement of concerns. It is uncontroversial that in this case, consistent with the requirements of the Act, the Committee included both its written statement to the Director (as required under ss 106XA and 106XB) and also its statement of concerns (at Appendix 10 of the Final Report).

[100] The Committee's Final Report includes reference to the Director's referral to the Committee on 31 October 2019 where the Committee was asked to investigate whether the applicant had engaged in inappropriate practice. The Director's referral included, as required under s 93(8), the statement of concerns that the Director had formed regarding significant threat to life or health (s 93(8)(a)) and failure to comply with professional standards (s 93(8)(b)). Whilst the Committee did not attach the Director's referral (and the Director's statement of concerns) to its report, the Committee specifically referred, at [85] in its Final Report, to the fact of the Director having included in her referral to AHPRA, her statement of concerns under ss 106XA and 106XB, having been raised by the applicant in his submission to the Committee. Paragraph [85] of the Final Report was as follows:

> The written submissions concluded by suggesting that the release of the Committee's report to the Determining Authority would be resisted because "PSR is estopped from imposing a further penalty on this person under review". This was said to be based on the fact of the Director's referral of a statement of concerns concerning Dr Li to the Australian Health Practitioner's Regulation Agency (AHPRA) under section 106XA and 106XB of the Act dated 3 October 2019. This was also provided to the Committee as Appendix 1 to the Director's report to the Committee attached to the Referral." The submissions advise that as a consequence of this referral under sections 106XA and 106XB, action was taken as a result of the "AHPRA enquiry [sic]" to

> impose conditions on Dr Li's registration based on a finding that his performance was unsatisfactory. (Footnotes omitted).

[101] Sections 106L(3) and 106M(2)(b) reveal that it was ordinary and envisaged, that each of the relevant actors – the Director, Committee and the Authority – be appraised of the fact of the other holding those concerns.

[102] Furthermore, the legislation's permissive provisions by which each actor has knowledge of the fact of the Committee and Director previously holding these views is consistent with the legislation's protective objects (s 79A), its referral powers as between the Director, the Committee and the Authority (ss 80(4), 80(10), 93, 106L), and then the referral powers from the Director to the State and Territory bodies (ss 106XA, 106XB) and what the Authority is required to consider for the purpose of making directions under s 106U. The scheme facilitates the funnelling of information such that the Authority understands what precipitated the other professional disciplinary processes (outside its remit).

[103] Consistent with the same, they were the very matters the applicant wanted the Authority to be appraised of. On one view, the fact that the Authority was aware of AHPRA being notified, is something that may assist the applicant rather than be prejudicial to him. It is consistent with the applicant's submission that he has been the subject of review and protective measures by other health regulatory bodies such that there is not the need for the Authority to impose its own regime. This was clear from the content of the applicant's own submissions both before the Committee (see [84]–[87] of the Committee's Final Report) and those to the Authority. Paragraph [87] of the Committee's Final Report was as follows:

> Action resulting from a review by another regulatory body under a different statutory regime is no impediment to investigation and action being taken by the Committee under the Act even where the genesis of the AHPRA review was a referral by the Director in respect of similar broad subject matter. The legislation under which the AHPRA review was conducted involves different protective objectives, methods, powers and focus to those under the Act. It is difficult to see how these circumstances might be suggested to operate as an estoppel or bar based on the legal concept of double jeopardy, which commonly understood as "prosecution twice for the same offence," for the reasons outlined and where the action by Medicare to refer Dr Li to PSR occurred before the Director's referral to AHPRA. (Footnotes omitted).

[104] Notably, the applicant provided the Director's statement of concerns as part of the documents annexed to his first submissions. It appears entirely understandable, in the context of his submission, that it was the first Annexure to his submission because it is the first chronological step that precipitated the State-based professional services review, for which he claimed he should not be "sanctioned twice" (detailed at [122] of his 1 March 2022 submissions and where he refers to it at [124]–[125]):

> [124] The complaint by the Director of the PSR dated 3 October 2019 appears as Annexure A to these submissions.
>
> [125] Dr Li unaware of the action taken by the Director of the PSR in lodging the complaint to AHPRA provided submissions as a consequence of the

interview with the Director conducted on 21 August 2019. Dr Li's response dated 23 October 2019 appears as Annexure B.

[105] The applicant did not say in his first submission to the Authority, contrary to his submission later and in this Court, that the Director's and the Committee's statement of concerns should not have been before the Authority and was only referred to in his submission to the Authority because of the fact that the Authority's invitation for submissions referred to the documents provided under s 106S which included the "statement of concerns". As referred to above at [103], the applicant had already raised the fact of the concurrent processes including the Director's referral to the Committee (and the existence of the Director's statement of concerns) in his submissions to the Committee (which was before the Authority).

[106] It is clear from the content of the applicant's submissions that the Authority's consideration of the applicant's parallel disciplinary procedural history appear to be accepted by the applicant, as being relevant considerations for the purposes of the Authority's determination. By extension, it appears ordinary, and consistent with the legislative scheme, that the Authority would be appraised of the steps taken by the Director and Committee which led to those processes. They complete the picture.

[107] To the extent that the applicant submitted that by taking into account the statements of concerns the Authority was in effect considering the applicant's conduct "at large" beyond that which fell within the Act's confines of "inappropriate practice" (as described at [88] above) with reference to the reasoning in Adams v Yung, I do not accept that submission. The circumstances in Adams v Yung were very different. In that case, the error of law comprised the Committee's failure to afford procedural fairness to Dr Yung by taking into account issues with Dr Yung's practice which were not raised in the referral to the Committee (see at 291) and accordingly Dr Yung was not given an opportunity to address those other issues. Justices Burchett and Hill found that the Committee had "failed to confine itself to the very reference which was before it" and by not undertaking proper sampling of Dr Yung's services, it "also failed to consider the issue in that reference which related to conduct in respect of the referred services by only considering the one day which it did": at 298. By contrast, in the present case, the applicant himself provided the Authority with the Director's statement of concerns in his 1 March 2022 submissions and then addressed, in his 16 May 2022 submissions, his concerns with the provision of the statements of concerns to the Authority.

[108] Furthermore, it appears clear from the Authority's reasoning and the manner in which the statements were provided (as contained in the context of the Director's letter containing the documents for the purpose of s 106S) that the Authority was considering the fact of the statements of concern rather than taking into account possible conduct "at large" beyond its remit.

[109] Similarly, the applicant's contention is not persuasive when one considers that there may be, as there was here, an overlap between the "inappropriate practice" as found under this Act and the "conduct" which the Council had dealt with. Indeed, the applicant submitted, at [129] of his 1 March 2022 submissions, that those medical professionals who conducted the hearing on 4 February 2020, "could be classed as 'a general body of general practitioners' [for] the purposes of

the health insurance act": No doubt a reference to the applicable test for "inappropriate practice" under s 82(1) of the Act. The applicant went on to then refer, in detail, to the conditions which were imposed on him as part of the Council's process, …

[110] The applicant's inclusion of this information was to support his submission as to why there was no need for the Authority to impose its own form of directions of those contained in s 106U.

[111] The applicant, again, impressed upon the Authority that there was a significant overlap between the two regimes when he described the consequences that the "[State] PSR investigations" had on "his practice methods and processes with respect to MBS item billing" (at [141]–[149] of 1 March 2022 submissions).

[112] I do not accept the applicant's submission that he only referred to the fact of what was occurring at the other regulatory levels because of the fact that the Authority was aware of it. The central gravamen of his submission was that there was no need for the Authority to enter the fray because of what was happening at a State level, including his ongoing supervision and further training. Even if this were not the case, it makes no difference to the Court's consideration of how the legislative scheme worked.

[113] The issue is what was the "purpose" or "use" of the statement of concerns. It appears, in the context of the legislative scheme, and as elucidated in the Authority's reasons of its Final Determination, that their provision was for the purpose of and their use to complete the regulatory history. It may be that if it were established that it were provided for another "purpose" or "use" it may be impermissible, if it were contrary to other specific statutory commands under the Act. However, this was not the case here.

[114] There is nothing in the terms, nor by implication, of those provisions, which leads to a reading down (as required on the applicant's submission) of the terms of s 106S.

[115] Section 106S provides:

> **106S Director may give Determining Authority information**
>
> (1) The Director may give the Determining Authority any information that the Director considers is relevant to the Authority making its draft determination or final determination in accordance with section 106U.
>
> (2) The Director may give information to the Determining Authority under subsection (1) on one occasion only.
>
> (2A) The Director must not give information to the Determining Authority under subsection (1) after the Authority has made its draft determination in accordance with section 106U.
>
> (3) If the Director gives the Determining Authority information under subsection (1) at a particular time, the Director must also give the information to the person under review at that time.

(4) The Determining Authority must consider the information in making its draft determination or final determination in accordance with section 106U.

[116] Section 106S of the Act is cast in broad terms and contains no fetter of the kind identified in ss 93(9), 106M(3) and 106UAA. On a consideration of its terms, together with taking into account all those matters above, there is nothing to suggest the form of implied limitation nor prohibition for which the applicant contends. This is particularly so, given the legislation, by operation of ss 106L(3) and 106M ensured the Authority was aware of the Director's and Committee's statements of concern regardless of them being provided by the Director under a s 106S Notice.

[117] Whilst unnecessary to aid any construction of the section, the drafting history of s 106S confirms why there should be no such implied limitation or prohibition in the circumstances. The Commonwealth noted that s 106S was repealed and substituted in 2002 and then amended in 2012. As a consequence of the 2002 amendment, the provision was as follows:

106S Director may give Determining Authority information

(1) The Director may give the Determining Authority any information that the Director considers is relevant to the Authority making its draft determination or final determination in accordance with section 106U.

(2) The information must be given no later than the day on which the Committee's final report is given to the Determining Authority under subsection 106L(3).

(3) If the Director gives the Determining Authority information under subsection (1) at a particular time, the Director must also give the information to the person under review at that time.

(4) The Determining Authority must consider the information in making its draft determination or final determination in accordance with section 106U.

[118] The Explanatory Memorandum to the Health Insurance Amendment (Professional Services Review and Other Matters) Bill 2002 (Cth) noted, that "[e]xamples of information which might be relevant are the nature and circumstances of any previous conduct of the person that has resulted in a criminal conviction or ***disciplinary action (by a registering or licensing body)***, responses to any counselling, ratification of a section 92 agreement, a final determination that has taken effect, and any particular needs of the locality in which the person under review practices" (emphasis added).

[119] In 2012, s 106S(2) was repealed and replaced by a new s 106S(2) and s 106S(2A) which extended the time by which the Director could pass on information and required that the Director provide the information on "one occasion" only. The Explanatory Memorandum to the Health Insurance Amendment (Professional Services Review) Bill 2012 (Cth) stated that the amendments were "necessary" for the following reasons.

This amendment is necessary because there is no other provision under which the Director may pass information to the Determining Authority even though instances have arisen when the Director has acquired case-relevant information

> after the date upon which the Determining Authority had received the Professional Services Review Committee's final report. In such instances, the Director was unable to pass the information to the Determining Authority.
>
> The information the Director may provide to the Determining Authority may be to the advantage of the person under review, for example, if the practitioner has taken demonstrable steps to address the conduct under review in relation to the provision of services. However, the information provided may not be to the person's advantage, for example, if it demonstrates that the person has persisted with conduct relevant to the review.
>
> New subsections 106S(2) and 106S(2A) prevent the Director from giving information more than once and from giving information after the Authority has made its draft determination. These limitations ensure that the person under review has adequate opportunities to make submissions in relation to the information given, which affords natural justice to the person under review (refer to new section 106SA at item 36).

[120] Again, it is clear from the 2012 Explanatory Memorandum that there will necessarily be information provided to the Authority regarding the practitioner's conduct, during the review processes, including "demonstrable steps to address the conduct" which may be to the "advantage" of the person under review as well against them if they have "persisted with conduct relevant to the review".

[121] The fact that the Director can only provide the Authority with relevant information once is important. I accept the submission of the Commonwealth that the Director provided information about the applicant's past involvement in the PSR process, which enlivened the scope for directions under s 106U(3)(a). In that context, it was relevant for the Authority to be aware of the broader regulatory activity with respect to the applicant. The Director, had provided under s 106S, an MBS item payment summary and the 2009 s 92 agreement (the full list extracted at [49] above). Notably, the fact of the statement of concerns having been made by both the Director and the Committee was already before the Authority, having been cited in the Committee's Final Report (as it was required to under s 106M(2)(b) and s 106L(3)(b), as considered in more detail at [97] –[101] above).

[122] Accordingly for the reasons identified above, I do not accept that the Authority engaged in error by taking into account the statements of concern. I do not accept that by doing so, it took into account an irrelevant consideration, misdirected itself or misunderstood its task when making the impugned directions.

106SA Authority to invite submissions before making a draft determination

The Determining Authority must give the person under review a written invitation to make written submissions to the Authority about the directions the Authority should make in its draft determination.

The Authority has no power to take evidence or conduct a hearing. It can only receive submissions. Similar provisions were considered in *Determining Officer v Lusink* [1998] FCA 63, which related to the previous scheme, under which a Professional Services Review Tribunal could review the decision of the Determining Officer to impose particular sanctions. The Court, in that case, held that the Tribunal could not receive further evidence. The Determining Authority's role is even more restricted than that of the former Tribunal. Unlike the Tribunal, the Determining Authority has no power to make findings regarding any facts found by a Committee.

Determining Officer v Lusink [1998] FCA 63 —

> The second respondent, Dr Demirtzoglou, is a registered general practitioner. On 31 August 1995 Dr Demirtzoglou's conduct was referred by the Health Insurance Commission to the Director of Professional Services Review pursuant to s 86 of the Act. On 22 September the Director of Professional Services Review, pursuant to s 93, set up a Professional Services Review Committee to consider whether Dr Demirtzoglou had engaged in inappropriate practice. On 14 February 1996 the Committee, pursuant to s 106L, reported that it had found that Dr Demirtzoglou had engaged in inappropriate practice. On 5 September the applicant, the Determining Officer, made a draft determination under s 106S. I have not seen the draft determination, but it was common ground that it directed that Dr Demirtzoglou be counselled, that he repay the Commonwealth $150,266 being an amount equivalent to the Medicare benefits paid for a percentage of the inappropriate services rendered by him during the period of the referral, that he be disqualified for six months in respect of the provision of certain services in the General Medical Services Table, and that he be fully disqualified for three months. In response to the draft determination Dr Demirtzoglou made a written submission on 22 September. I have not seen the submission. On 26 November the Determining Officer made a final determination under s 106T. The directions in the final determination are the same as those in the draft determination, though the Determining Officer's reasons differ from those in the draft in that they take into account Dr Demirtzoglou's submission. In his summary of Dr Demirtzoglou's submission the Determining Officer said:
>
> The submissions focussed on and took issue with a number of findings of the Committee, but provided little or no material that went directly to the question of the appropriate determination for me to make under section 160U of the Act.
>
> He then noted two examples:
>
> > 'Dr Demirtzoglou submitted that he has no control over the fact that a large number of patients come back to him. That lack of control would not in my view justify the patterns of practice that concerned the Committee and there was no indication of change.
> >
> > Dr Demirtzoglou submitted that he has not dealt with Pethidine addicted patients since those considered by the Committee. If he intends to deal with

> those patients in the future, the submissions do not explain what new measures he would be taking to ensure the inappropriate practice is not repeated.'

Under the heading "Reasons" the Determining Officer set out details of the inappropriate practice found by the Committee, and continued:

> 'Dr Demirtzoglou submitted that a six month disqualification would destroy his practice, his patients' sense of credibility and commitment on his part. To be disqualified would be devastating for him both professionally and morally. The feelings expressed in these submissions can be understood, and I have taken them into account but I was required to view them in the context of my statutory function.
>
> The submissions did not lead me to consider that the inappropriate practice that had occurred with respect to the referred services was of any less serious concern than that indicated to me by the Committee's report and that the amount of Medicare benefit to be repaid should be reduced or otherwise changed. The submissions tended to confirm rather than dispel my view of the seriousness of the inappropriate practice formed after reading the Committee's report.'

The Determining Officer then gave six examples of this tendency.

On 20 December Dr Demirtzoglou requested that the determination be reviewed by a Tribunal. The grounds upon which the request was made are that the Determining Officer erred in concluding that Dr Demirtzoglou had engaged in inappropriate practice, that the findings on material questions of fact are erroneous, and that the directions made are harsh, excessive and oppressive, and not commensurate with the facts found.

On 30 June 1997 a Tribunal consisting of the three persons described as the first respondent commenced a review of the determination. At the close of counsel for Dr Demirtzoglou's address, the Tribunal called on the Determining Officer to produce the draft determination and the written submission. Counsel for the Determining Officer declined to produce the documents. The Tribunal then directed the Determining Officer to produce them, and adjourned the review to permit him to obtain a ruling from this Court as to whether he is obliged to produce them. In its reasons for the direction the Tribunal said:

> '[The Tribunal's] job is to look at what the Determining Officer has done, and to right anything which is considered ... incorrect, or any decision which was considered to be incorrect. We believe that we are unable to fulfil this duty unless we have all documentation at hand.'

THE ARGUMENT AGAINST PRODUCTION

The Determining Officer declined to produce the draft determination and the submission on the ground that s 115(1) lists the documents that are to be forwarded to the Tribunal, the listed documents are those to which s 119(1)(a) requires the Tribunal to have regard in coming to its conclusion on the review, and neither the draft determination nor the submission appears in the list. In particular, because of

the definition of "determination" in s 107, the draft determination does not fall within par (d).

Reliance was placed on the decision of the Full Court in *Minister for Health v Thomson* [1985] FCA 208; (1985) 8 FCR 213 in which it was held that a Tribunal does not have power to admit new evidence. Fox J at 218-219 said that the clear implication from s 119 was that the Tribunal is not intended to accept new evidence. At 226-227 Wilcox J dealt with the matter at greater length. His Honour noted that the provisions empowering Committees to obtain information, including by evidence on oath or affirmation, have no counterparts in relation to Tribunals, and that s 121, unlike s 103(3) , makes no reference to the protection of witnesses in proceedings before the Tribunal, though the sections are otherwise in the same form. His Honour also referred to ss 115 and 119(1)(a), and noted that there was no reference to further evidence in either provision. The Tribunal's task, he said, "is to review the case by reference only to the existing material, and in the light of any addresses made to it on that material". The other member of the Court, Beaumont J, did not decide whether the Tribunal could receive new evidence.

In *McIntosh v Minister for Health* (1987) 17 FCR 463 at 464 Davies J treated Thomson as establishing that s 119(1)(a) requires the review to be undertaken "on the papers before the Review Tribunal, namely in accordance with the request for a review, having regard to the grounds set out in the request and to the documents forwarded by the Minister with the request", and precludes the Tribunal receiving "additional evidence". In *Yung v Adams* (unreported, 11 December 1997) Davies J refused to allow *Thomson* to be reopened, saying that it bound him, and that ss 115(1) and 119(1) "are quite explicit and preclude the Tribunal from having regard to material other than that specified in the sections". Although his Honour uses the word "material", it is apparent from the context that he is referring to "new evidence". Counsel for the Determining Officer did not dispute this, but submitted that while the documents in question here were not "new in the usual sense", Wilcox J's reasoning in Thomson is based on the fact that s 115 is exhaustive of the documents that are to be before the Tribunal, and the draft determination and the submission do not fall within the section.

On the basis of these submissions the Determining Officer seeks a declaration that the Tribunal is not entitled to receive and take into account any material in addition to that provided for by ss 115 and 119, an order that the Tribunal recommence and complete the hearing without calling for production of the draft determination and the submission, and an order setting aside the decision requiring their production and remitting the matter to the Tribunal to be determined according to law. The application is made in reliance on s 39B of the Judiciary Act 1903 and the *Administrative Decisions (Judicial Review) Act 1977*.

THE ARGUMENT FOR PRODUCTION

Counsel for Dr Demirtzoglou submitted that there is an implied power in the Tribunal to receive any material which was before the Committee or the Determining Officer, in order to complete the papers. In the alternative, it was submitted that the draft determination and the submission fall within s 115(1)(d).

Both are referred to in the final determination, and are incorporated by reference into it. The first submission was based on s 119(1)(b)(ii), which empowers the Tribunal, inter alia, to set aside the final determination and make any other determination that the Determining Officer is empowered to make under s 106T. Section 106S(1) requires the Determining Officer to make a draft determination in accordance with s 160U. A copy must be given to the person under review, who must be invited to make a written submission "suggesting changes to the draft determination". The argument was that since the Tribunal stands in the shoes of the Determining Officer, and in particular can make any determination the Officer could have made under s 106T, the Tribunal must be entitled to have before it any submissions that have been made by the person under review suggesting changes to the draft determination, and the draft determination itself. Only then will it stand in the shoes of the Determining Officer.

THE NATURE OF A S 119 REVIEW

The review contemplated by s 119(1) is a review on the merits. The ambit of the review is however qualified by the fact that it is conducted "on the papers", that is to say upon the request for review and the documents forwarded to the Tribunal under s 115(1), in the light of any submissions made during the proceedings.

In *McIntosh*, in reviewing a Committee's decision, the Tribunal had confined itself to enquiring whether on any reasonable view of the evidence the Committee's decision could be supported. It had eschewed making up its own mind on the evidence before it. Davies J held that the Tribunal was wrong to adopt this judicial review approach. His Honour said, at 467-468:

A Medical Services Review Tribunal has a much wider function than that. Although it is limited to a consideration of the documentary material forwarded to it by the Minister, a Review Tribunal has the duty ... itself to exercise the function which the Minister himself performed, namely to determine whether or not to accept the recommendation made by the Committee of Inquiry. It does not exercise the function of review on a point of law, it exercises the function of review on the papers. Save that the Review Tribunal was limited to reviewing the documentary material, taking into account the addresses made to it, it was entitled itself to reconsider any matter contained in the report and recommendation of the Committee of Inquiry.

In *Tiong v Minister for Community Services and Health* (1990) 93 ALR 308 at 312 Davies J, with whom Spender J agreed, approved the primary judge's description of the Tribunal's function, which was "to determine whether, on the evidence before the committee, its conclusions are factually correct". The other member of the Full Court, Burchett J, said the Tribunal's function was "to review the actual decision on the merits, though upon evidence restricted to that which had been before the committee": at 321-322. In Yung Davies J said that the changes in the legislation since Thomson and McIntosh were decided had not altered the role of the Tribunal, which is to "consider the whole matter for itself and to do so on the papers". Its duty is "to review the matter for itself and independently to arrive at its own conclusions".

THE PRESENT REVIEW

Dr Demirtzoglou will seek to persuade the Tribunal that the finding that he had engaged in inappropriate practice is wrong. If he fails so to persuade the Tribunal, he will contend that the sanctions imposed are excessive. Dr Demirtzoglou is entitled to appear in person or by a representative. He can put to the Tribunal any submissions that bear on the issues before it. He may choose to repeat the whole or part of the written submission he made to the Determining Officer, he may supplement it, or he may craft an entirely new submission. But a full opportunity will be afforded him to attack the final determination, which is the only determination that has legal effect and is susceptible of review. Since the Tribunal's task is to come to its own conclusion on inappropriate practice and sanctions in the light of the documents forwarded by the Minister and any address made to it during the proceedings, I do not think it correct to say, as the Tribunal did, that it cannot perform its task without having Dr Demirtzoglou`s submission to the Determining Officer and the draft determination. The submission was directed to a draft determination which has been superseded by the final determination.

In any event, in the face of the clear words of ss 115 and 119, I do not consider it possible to imply a power in the Tribunal to receive material in addition to that contemplated by those provisions. The fact that they deal only with the final determination suggests to me an express legislative intention to exclude the draft determination from the Tribunal's consideration. Such an intention should not surprise, for the draft has been superseded by the final determination. I do not accept the argument that s 119(1)(b)(ii) requires that the Tribunal be in possession of all the material that was before the Determining Officer. That overstates the effect of the provision. Section 119(1) must be read as a whole, and par (a) is inconsistent with such a construction of par (b)(ii). Nor do I think it possible to treat the final determination in s 115(1)(d) as including the draft determination and the submission simply because they are referred to in the final determination. The matter was not explored before me, but my own researches have not disclosed any general doctrine of incorporation by reference that will achieve the result for which Dr Demirtzoglou contended. Under the doctrine of incorporation by reference that applies to wills, a testator may incorporate into a duly executed will the terms of an informal document, so long as the document is in existence at the time of execution of the will, the will refers to it as an existing document, and clearly identifies it. See *Allen v Maddock* [1858] EngR 379; (1858) 11 Moo PC 427. But so far as I have been able to discover, that doctrine is peculiar to wills, and is not a particular instance of a principle of general application.

106T Draft determination

The Determining Authority must, after taking into account any submissions made by the person under review, make a draft determination in accordance with section 106U relating to the person, and give copied of that draft determination to the person and to the Director.

Selia v Commonwealth of Australia [2017] FCA 7 —

[131] A consideration of the Review Scheme in Part VAA makes it clear that the Determining Authority is bound by a PSR Committee's finding of inappropriate practice made pursuant to ss 106H(1) in its Final Report under s 106L with respect to the referred services. The statutory task of the Determining Authority is not to revisit those findings, but to make a determination which contains one or more of the directions in s 106U consequential upon the finding of inappropriate practice by the PSR Committee. Before it can make a final determination, the Determining Authority is also bound under s 106TA to take "into account any submissions made by the person" under s 106T(3) suggesting changes to any directions contained in the draft determination within a set timeframe. As such, it is plain that those submissions constitute a relevant consideration in a jurisdictional sense: *Minister for Aboriginal Affairs v Peko-Wallsend Ltd* [1986] HCA 40; (1986) 162 CLR 24 at 39-42 (Mason J), 56 (Brennan J); *Minister for Immigration and Multicultural Affairs v Yusuf* [2001] HCA 30; (2001) 206 CLR 323 (Yusuf) at 338 [37]- 339 [39] (Gaudron J), 351 [82] (McHugh, Gummow and Hayne JJ, Gleeson CJ agreeing).

…

[134] The question whether the Determining Authority must have regard to the PSR Committee's reasons for making a finding of inappropriate practice in a Final Report is more complicated. Those reasons in this case were set out in appendices to its Final Report. There is an obligation on the Committee to give reasons for its proposed findings in the Draft Committee Report under s 106KD(1A), to which the practitioner must be given an opportunity to respond under s 106H(4). Those reasons in turn must set out the findings on material questions of fact in accordance with s 25D of the Interpretation Act (see the legislative note to s 106H(4)). The duty to give reasons in the context of the Draft Report is therefore an aspect of the statutorily prescribed rules of procedural fairness under the Act. However, there is no requirement under the Act for the PSR Committee to give reasons for a finding of inappropriate practice made in the Final Report (although I assume for present purposes that there would be an obligation if a request were made under s 13 of the ADJR Act). This reflects the fact that, by virtue of s 106L(1B) of the Act, no finding of inappropriate practice can be made by a PSR Committee unless the finding and the reasons were included in the Draft Report under s 106KD (see ss 106H(4) and (5) and 106KD(1A)). That notwithstanding, contemporaneous reasons were in fact given by the PSR Committee in appendices to its Final Report (in line with good administrative practice).

[135] No party argued (rightly in my view) that it was irrelevant in a jurisdictional sense for the Determining Authority to have regard to the reasons of the PSR Committee when making its findings. However, there being no obligation under the Act to give reasons for the findings in the PSR Committee's Final Report, it may be doubted whether there is an obligation upon the Determining Authority to take such reasons as may be given by the PSR Committee into account, subject to one caveat. The caveat is that the Determining Authority must have regard to the reasons insofar as they are the subject of submissions by the applicant to the Determining Authority under s 106T(3) which must, as I have said, be taken into account. In this case, the findings allegedly not taken into account were set out in the submissions and therefore the Determining Authority was required to have regard to them. In any event, I have assumed for the purposes of determining this

ground of review that an obligation existed to have regard to the PSR Committee's reasons in the Final Report *per se*.

[136] In my view, the applicant has not established that the Determining Authority failed to have regard to relevant considerations.

[137] First, as the applicant submits, in its reasons the PSR Committee expressly "did not find" that Dr Selia had provided an inadequate level of clinical input, kept records deficient in essential clinical information, or provided services that were not clinically necessary for some or all of the services investigated with respect to the three MBS items the subject of the pre-billing findings (the Non-Findings).

[138] Secondly, as the applicant also submits, in commenting on the draft determination he made submissions to the Determining Authority relying upon (and quoting) the Non-Findings by the PSR Committee. In particular, he submitted that the findings of inappropriate practice were "not the usual type" of inappropriate practice, that "the findings of the Committee were that Dr Selia had performed the great majority of those services appropriately, they were clinically necessary and relevant and importantly, his records were all adequate" and that "for the Determining Authority to suggest that the level of inappropriate practice is serious or, of a very high proportion belies the actual factual findings of the Committee and is erroneous except in so far as it relates to pre-billing."

[139] That said, however, the Determining Authority plainly had regard to the substance of those submissions (and therefore to the Non-Findings of the PSR Committee upon which the applicant relied) contrary to the inference which the applicant asks this Court to draw.

[140] First the Determining Authority states among other things that it had regard to the Report of the PSR Committee and the submissions made on behalf of Dr Selia under s 106SA of the Act and s 106T(3) (noting expressly that the latter submissions relied on the information in the earlier submission). Consistently with this, under the heading "Background and Findings of Fact", the Determining Authority referred to the findings of inappropriate practice, summarised the PSR Committee's reasons, and noted that its findings are set out in the Final Report and detailed reasons in the appendices to the Final Report.

[141] Secondly, the Determining Authority extensively summarised both sets of Dr Selia's submissions in its reasons. In the course of so doing, the Determining Authority expressly noted the submission that:

> In relation to pre-billing:
>
> Save for the issue of pre-billing the great majority of services examined by the Committee were found to have been appropriate – on all fronts

[142] Thirdly, under the subheading "Preliminary" under the heading "Reasons for Final Determination", the Determining Authority stated that, among other things it "has considered the submissions made on behalf of Dr Selia ..."

[143] Fourthly, as the Commonwealth submits, it cannot be inferred that the Determining Authority failed to have regard to the submissions and the Non-

Findings because the Determining Authority failed expressly to address them in the operative part of its reasons. To the contrary, it is apparent that it considered all of the applicant's submissions but focused in the operative part of its reasons upon those which it considered the most significant. In so doing, it implicitly rejected Dr Selia's submissions based in part on the Non-Findings that the proportion of inappropriate practice should not be regarded as "very high". Thus, in addition to the passages already referred to in which the Determining Authority explained that it had had regard to the applicant's submissions, the Determining Authority said in the context of making findings in relation to the direction generally:

> [36] Although the Determining Authority has set out above some of the submissions made on behalf of Dr Selia and provided details of consideration, it has read and considered all of the submissions and other documents provided on behalf of Dr Selia.
>
> [37] The very high proportion of inappropriate practice was noted by the Determining Authority and was a factor which was given some weight in the decision-making process.

[144] It follows that no inference can be drawn from the Determining Authority's failure specifically to address the weight to be given to the PSR Committee's Non-Findings in the exercise of discretion as to the directions to be made under s 106U. This is particularly so in circumstances where the Determining Authority had no duty to give reasons in the first place and, therefore, no duty to provide reasons that complied with statutory requirements on the basis of which it could be inferred that any matter not mentioned was not considered to be material: cf *Yusuf* at 346 [69]. An inference that the Determining Authority did not have regard to a matter by reference to reasons which it was not required to set out should not lightly be drawn: see by analogy, *Minister for Immigration and Citizenship v SZGUR* [2011] HCA 1; (2011) 241 CLR 594 at 617 [70] (Gummow J (with whose reasons Heydon and Crennan JJ agreed)).

106TA Final determination

The Determining Authority must, after taking into account any submissions made by the person under review, make a final determination in accordance with section 106U relating to the person.

Sevdalis v Director of Professional Services Review [2017] FCAFC 9 —

> [31] It is true, as her Honour said at [149], that it is not possible to identify from the reasons why there was not more sympathy for Dr Sevdalis' situation, and it is also true, as her Honour found at [143], that what is missing from the reasons is any substantive examination of why it made the directions it did in preference to the directions Dr Sevdalis had contended would be appropriate, but the reasons of the Determining Authority explain the determination it made and the reasons for making it. The Determining Authority read, took into account, and engaged with the submissions which had been made but decided within its jurisdiction to impose a heavier sanction than Dr Sevdalis submitted was proportionate. The Determining Authority explained its reasons for that decision although it did not in terms spell

out why and how its reasons involved a rejection of the submissions Dr Sevdalis had made.

…

[33] *Soliman* was a case in which the Full Court found jurisdictional error in the reasons by a Tribunal which had not considered a matter that was centrally relevant to its decision. The Tribunal in that case, like the Determining Authority but unlike the decisionmaker in *Quinn*, was not obliged by statute to give reasons. It did give reasons for its decision, however, and in those reasons the Full Court found that the Tribunal had failed to address a submission that was centrally relevant to the decision being made. The Court said at [53] that the failure to address a submission in reasons where facts and reasons have been provided, albeit that there is no statutory requirement to provide either reasons or findings of fact, may found a conclusion that the submission had not been considered or addressed. The Court then said at [55]-[57]:

> [55] Even in the absence of a statutory requirement to provide findings or reasons, a failure to address a submission centrally relevant to the decision being made may similarly found a basis for concluding that that submission has not been taken into account. Such a failure may be exposed in reasons voluntarily provided. And a failure to take into account such a submission may constitute jurisdictional error: cf *WAFP v Minister for Immigration and Multicultural and Indigenous Affairs* [2003] FCAFC 319. Lee, Carr and Tamberlin JJ there concluded:
>
> > [21]However, in our view, the failure by the RRT to refer to the interview of 10 September 1997 and to take it into account in considering whether the appellant departed illegally did amount to an error of law, because it constituted a failure to have regard to relevant material, which is so fundamental that it goes to jurisdiction: see Minister for Immigration and Multicultural Affairs v Yusuf [2001] HCA 30; (2001) 206 CLR 323 per McHugh, Gummow and Hayne JJ at [82].
>
> [56] In the present proceeding it is concluded that the failure to refer to the submissions relating to mitigating circumstances and the reasonableness of the decision of the Acting Vice-Chancellor is properly to be characterised as a failure on the part of the Vice President to resolve, in accordance with law, the application that had been made.
>
> [57] Just as reasons for an administrative decision should not be read with an eye keenly attuned to discerning error (*Minister for Immigration and Ethnic Affairs v Wu Shan Liang* [1996] HCA 6; (1996) 185 CLR 259 at 271-272 per Brennan CJ, Toohey, McHugh and Gummow JJ), eyes should not be so blinkered as to avoid discerning an absence of reasons or reasons devoid of any consideration of a submission central to a party's case. Two factors, in particular, dictate the conclusion that the reasons of the Vice President fail to give any real consideration to the submissions advanced on behalf of Dr Soliman as to mitigating circumstances, namely:
>
> > the fact that the findings and reasons provided were written by an experienced, senior member of Fair Work Australia with legal qualifications and a person who had the considerable benefit of written submissions filed

> by experienced legal practitioners: *Endeavour Coal Pty Ltd v Association of Professional Engineers, Scientists and Managers, Australia* [2012] FCA 764; (2012) 206 FCR 576 at [36]; *Yum! Restaurants Australia Pty Ltd v Fair Work Australia Full Bench* (2012) 205 FCR 306 at [37] per Lander, Flick and Jagot JJ;
>
> > and, irrespective of any consideration being given to the qualifications and experience of the person who prepared those findings and reasons:
> >
> > > the fact that any reading of the findings and reasons of the Vice President disclose no real attempt to engage with the submissions being advanced on behalf of Dr Soliman.
> >
> > The submissions advanced on behalf of Dr Soliman as to mitigating circumstances were not considered by the Vice President. The decision of the Full Bench gives no greater consideration to those submissions. Both the decision of the Vice President and the decision of the Full Bench, it is concluded, should be quashed.
>
> In that case the Court found that the decision-maker's references to the relevant submissions had only been their restatement (see [39]) but that they had not been considered by the decisionmaker (see [57]). The same conclusion cannot be reached in respect of the Determining Authority's reasons for not adopting submissions by Dr Sevdalis for a lesser sanction. The Determining Authority set out the substance of the submissions in its own words in [7] quoted above and explained in detail at [51]-[59] quoted above why it decided to impose the disqualification it imposed.

While it is probably desirable, it is not necessary that the same members constitute the Determining Authority for making both the draft determination and the final determination.

Lee v Maskell-Knight [2004] FCAFC 2 (per Hill and Marshall JJ) —

> [30] The first submission raised is that, as a matter of interpretation of Division 5 of Part VAA of the Act, the person who as Determining Officer makes the final determination in accordance with s 106T of the Act must be the same person as makes the draft determination under s 160S of the Act, acting then also in the capacity as the Determining Officer. It is submitted that the legislative intention is that the function of making both the draft and final determinations is one that must be performed personally and by the same person. In consequence, it is submitted, the final determination was invalid and a fortiori there would be nothing for the Tribunal to review.
>
> [31] Section 106Q of the Act deals with the appointment of the Determining Officer. Qualification for appointment is the holding of an office or appointment under the *Public Service Act 1922* (Cth). The contemplation which appears clearly from s 106Q(2) is that the instrument of appointment of the Determining Officer might refer not to a person by name but to a person as the holder "for the time being of a particular office or appointment". While s106Q is not determinative of the submission, the fact that an appointment might refer to a person holding a particular office "for the time being" rather suggests that there would be likely to be changes

in the identity of the Determining Officer as changes occurred in the particular office specified in the appointment.

[32] The question whether a function such as the making of a final determination is required to be carried out by the same person as carried out another function, for example the making of a draft report, must clearly be decided having regard not only to the nature of the relevant functions to be performed but also to the consequences of administrative convenience or inconvenience, as well as such implications as arise from the terms of the statute itself and its context.

[33] The argument that both functions should be performed by the one person gains some support from the fact that the legislation contemplates that after the draft determination has been made, the final terms of the determination will take into account such written submissions as the person under review may make. So it can be said that what is involved in Division 5 is a process which commences with the making of a draft determination and proceeds thereafter through a decision making process where the Determining Officer reconsiders the draft in the light of any submissions that the doctor may make. It is submitted that the legislative intention was not that some person who did not make the draft determination be permitted to make the final determination.

[34] A consequence of acceptance of this submission would be that any change in the Determining Officer after the presentation of a draft determination would require the whole process to begin again. It is difficult, however, to see that the legislation in fact envisages that the process recommence when regard is had to the specific time limits which are set out in the Division. So, for example, the Committee is required under s 106L to report to the Determining Officer, giving its findings as to whether the person under review has engaged in inappropriate practice. The Determining Officer is obliged under s 106R(1) to give a copy of the report to the person under review seven days after the Determining Officer has been given the Committee's report under s 106L.

[35] The Determining Officer is required to make a draft determination giving a copy of that draft to the person under review 14 days after receipt of the Committee's report: s 106S(1)(b). The time limits for making submissions then run from the day on which the person under review receives the draft determination. Further, the final determination is required to be made by the Determining Officer within 35 days after that officer has received the Committee's report.

[36] It is specified that failure to comply with these time limits does not affect validity. However, the time limits appear to have been calculated on the premise that there is no break in them which could be brought about by changes in the office of Determining Officer. If the change in the Determining Officer had the consequence as submitted that there had to be a new draft determination following a change in the person appointed as Determining Officer, then it might be expected that the legislature would set alternative time limits in Division 5, capable of being complied with.

[37] Put simply, Division 5 does not seem to contemplate that there could be more than one draft determination but rather that the draft determination is to be made

> once only and within 14 days after the Determining Officer receives the Committee's report.
>
> [38] In summary, the question whether the Act requires both the power to make a draft determination and the power to make a final determination to be exercised by the same person, being the person who is the Determining Officer, must depend upon the nature of the power and all the circumstances of the case. Further in determining the answer to the question, regard may properly be taken of the practicalities of administration: cf the somewhat different contextual question of delegation of statutory powers, *O'Reilly v Commissioners of the State Bank of Victoria* [1983] HCA 47; (1983) 153 CLR 1 per Gibbs CJ, and the cases there referred to.
>
> [39] The first submission on behalf of Dr Lee should not, in our view, be accepted.

If the Federal Court sets aside or quashes part of a Final Determination, on remittal, the Determining Authority is not required to provide a further Draft Determination.

Norouzi v Determining Authority [2023] FCA 35 —

> [20] First, the applicant was provided with a draft determination, in accordance with s 106T of the HIA, on 28 February 2020, in addition to the Committee's final report. That draft determination also clearly outlined the Committee's intention to direct that the applicant repay $459,555.55, consisting of the Medicare benefits that were paid for the MBS item 597 and 599 services in connection with which the applicant was found to have engaged in inappropriate practice, less the amount he voluntarily repaid. As the second respondent submitted, this was a "worst case scenario" in respect of which the applicant had been on notice since 28 February 2020.
>
> [21] Second, as the Full Court explained in *Lee* at [37], the first respondent was not obliged to provide the applicant with additional draft determinations for his comment. This is the case unless a determination is quashed in its entirety. It was not the case in this proceeding: Logan J only quashed the part of the direction referable to the applicant's repayment of Medicare benefits.
>
> [22] Third, I am satisfied that the applicant was not denied procedural fairness in respect of the making of the repayment direction. The applicant was afforded the opportunity to, and did in fact make, submissions to the first respondent prior to the making of the repayment direction. The submission of the applicant that "[i]n providing an invitation to give a written submission within one month, the Authority engendered a legitimate expectation in the Applicant that the Authority would give his submission due consideration and publish a Draft Determination to him for comment..." is unpersuasive. There is no evidence before the Court, or any basis on which the Court can infer, that the first respondent did not take into account the applicant's later submissions in making the repayment determination.
>
> [23] Fourth, and in any event, for a breach of procedural fairness to constitute error, it must give rise to practical injustice, namely a denial of the opportunity to make submissions and that denial being material to the decision that is made: *SZBEL*. The applicant was given the opportunity to make submissions referable to the repayment

> direction, which he did on 11 January 2021. It follows that the applicant was not denied procedural fairness in this respect.

In making a final determination, the Determining Authority is under no duty to make any inquiries.

Joseph v Health Insurance Commission [2005] FCA 1042 —

> [78] I am not satisfied that the applicant has established that there was any consideration that in the circumstances the Authority was bound to take into account that it did not take into account. I reject the submission that the Authority was under a duty to make inquiries as to whether the applicant, an educated man with the benefit of legal representation, was likely to, or could, practice again. If the applicant had wanted to place information before the Authority on this issue, he was free to do so. The applicant placed reliance on *Azzi v Minister for Immigration & Multicultural Affairs* [2002] FCA 24; (2002) 120 FCR 48 in which Allsop J reviewed the authorities on the duty of an administrative decision-maker to institute enquiries. Nothing in the authorities reviewed by his Honour at [101]-[113] provides support for the applicant's submission.

In making a final determination, the Determining Authority does not require evidence concerning matters within the professional expertise of its members.

Hamor v Determining Authority [2023] FCA 267 —

> [101] … I am not persuaded that specific evidence was necessary to establish that other practitioners were likely to be available, in circumstances where:
>
> (1) the Authority, as constituted, included medical practitioners and in particular a practitioner within the same profession as the applicant. As such, the Authority was entitled to draw upon its own expertise and the Court would not lightly find that it acted unreasonably in doing so: see *Selia* at [104] …
>
> …
>
> [126] The applicant submitted, in summary, that the Authority:
>
> …
>
> (2) found, without evidence, that the ongoing treatment of a patient to whom an item 12250 service was provided is for the sleep physician to manage and relied upon this finding when rejecting the applicant's submission that the Authority should take into account the benefits patients gained from the applicant's services. I disagree. As noted above, the Authority, as constituted, included medical practitioners and in particular a practitioner within the same profession as the applicant and as such, the Authority was entitled to draw upon its own expertise and the Court would not lightly find that it acted unreasonably in doing so: see *Selia* at [104].

In making a final determination, the Determining Authority is not bound to accept the submissions made by a person under review.

Hamor v Determining Authority [2023] FCA 267 —

> [114] … whilst it may be accepted that the applicant had made submissions that: (1) he had carefully considered the Committee's comments and findings, and had taken advice; (2) he had made significant changes and was completely compliant with the item descriptor as amended, the Authority did not (and was not bound to) accept those submissions.

106U Content of draft and final determinations

Section 106U sets out the range of sanctions (called 'directions') that can be imposed on a person under review by being included in a Determination by the Determining Authority following its consideration of a Committee's Final Report. At least one of these directions must be specified in the Determination. The directions that may be specified in a Determination are:

- reprimand;
- counselling;
- that any medicare benefit or dental benefit that would otherwise be payable for a service in the provision of which the person is stated in a report under section 106L to have engaged in inappropriate practice cease to be payable;
- repayment of medicare or dental benefits that had been paid (whether or not paid to the person under review) in respect of services rendered or initiated by the person under review or an associated person, in respect of which the person under review has been found to have engaged in inappropriate practice; [197]
- determine that the Minister's acceptance of an undertaking under section 21B or 22A of the Act is to be taken to be revoked for a midwife or a nurse practitioner, respectively;
- suspend the person under review's Part VII authority under the *National Health Act 1953* in relation to pharmaceutical benefits for a period of up to 3 years;
- disqualify the person under review in respect of providing specified services, specified classes of services, or any services at all for a period of up to 3 years (or 5 years if there has been a previous section 92 agreement or determination in relation to that person).

Subparagraph 106U(1)(da)(ii) limits the scope of directions for the repayment of benefits that can be imposed on a person under review in respect of DVA treatment services by excluding amounts paid for DVA treatment services where the

[197] An associated person is defined in the section as a person employed or otherwise engaged by the person under review.

Committee's Report made findings based on random sampling and subsequent extrapolation to classes of services (subsection 106K(2)) or generic findings of inappropriate practice (subsection 106KE(3)).[198] The only direction for the repayment of benefits in respect of DVA treatment services that can be included in a Determination under section 106U is a repayment for services rendered as part of a 'prescribed pattern of services'.

Prior to enacting current paragraphs 106U(1)(c), (ca) and (cb), paragraph 106U(1)(c) provided:

> (c) that the person under review repay to the Commonwealth an amount equivalent to any medicare benefit payable for inappropriate services (whether or not the medicare benefit was paid to the person), and that any medicare benefit that would otherwise be payable for those services cease to be payable.

This provision was discussed in *Retnaraja v Morauta* [1999] FCA 80.

Retnaraja v Morauta [1999] FCA 80 —

> [81] The obvious purpose of such a direction is to enable the recovery of Medicare benefit which should not have been paid, and to prevent payment where Medicare benefit is not rightly due.
>
> [82] The expression "inappropriate service" is defined in s 106U(5) to mean a service in connection with which the person under review is stated in a Committee's Report under s 106L to have engaged in inappropriate practice.
>
> [83] "Service" has the meaning given to it in s 81(1) and relevantly means a service for which Medicare benefit was payable. A reference to a "service" is therefore a reference to a specific service and in the definition of "inappropriate service" carries that meaning. In the present case the Committee has not sought to quantify by reference to a number of services, or a percentage of all services in a category, the number of services which were inappropriately charged or for which there was no medical justification.
>
> [84] In determining whether a practitioner has engaged in inappropriate practice within the meaning of s 82(1) the Committee is concerned with the practitioner's conduct in connection with the rendering or initiation of services. As discussed above, it is not necessary in that context for the Committee to identify particular services rendered to an identified patient, or a number of services rendered to an identified patient. The power in s 106U(1)(c) is a power to direct repayment of Medicare benefit paid for "inappropriate services", not a general power to direct repayment of all Medicare benefits paid for services of a particular category in a case where the Committee finds that the practitioner has engaged in inappropriate practice in relation to the provision of some services in that category. In my opinion it is a prerequisite to the exercise of the power under s 106U(1)(c) to identify by

[198] Subparagraph 106(1)(da)(ii).

number, or by a percentage of a total, services which constitute the "inappropriate services".

[85] This identification provides the starting point for the calculation of Medicare benefits which should not have been paid.

[86] In the present case no findings made by the Committee in its Report enabled this identification to occur for the purpose of quantifying Medicare benefit that was wrongly paid.

[87] Where a Committee follows a sampling process and bases general findings about a practitioner's conduct on the findings in the sample, the nature and extent of the sample may in the circumstances of the case justify a finding by the Committee that, as a matter of probability, a particular percentage of services rendered in a particular category of service were not medically justified, or were charged at one rate rather than another. A finding of this kind would enable the necessary quantification of wrongly paid benefit for the purpose of s 106U(1)(c). In this case, however, the Committee did not make such a finding.

[88] I do not have a sufficient understanding of the material that was before the Committee to ascertain whether it might have supported findings that certain percentages of services in each of the categories attracted wrong payments of benefit. Statistical evidence that the number of services rendered in each category greatly exceeded the expected norm could not alone establish the extent of benefits that were wrongly paid. But whether there was other material as well that might have led to such a finding is now beside the point. The quantification of services in respect of which Medicare benefits were wrongly paid was not a topic of investigation before the Committee. It was not a topic on which Dr Retnaraja was given an opportunity to respond. In these circumstances it was not open to the Determining Officer, or the Tribunal, to review the material and endeavour to make findings that would enable the quantification of wrongly paid benefit.

[89] In my opinion the reasoning process adopted by the Determining Officer to arrive at the direction to repay $55,115.90 was not open. Apart from the consideration of procedural fairness just mentioned, the provisions of s 106U(1)(c) do not authorise the Determining Officer to direct repayment of the whole, or a discretionary part of the whole, of the Medicare benefit paid for a category of service rendered in a referral period where only some of those services are found to be inappropriate. In the present case the Determining Officer directed repayment of only a percentage of all benefits paid for four categories of service, but the reduction from 100 per cent was not made in an attempt to distinguish between services that were appropriate and those which were not, or between payments of benefit rightfully made and payments wrongly made. Rather, the reduction was justified on other grounds which proceeded, on the wrong assumption that s 106U(1)(c) authorised a direction in the discretion of the Determining Officer to repay up to the total sum of $157,816.15.

[90] For these reasons I consider that the direction for repayment was not authorised by s 106U(1)(c) as that section stood at the time of the Final Determination.

The Determining Authority may determine that the person under review repay benefits even though some or all of those benefits were not received by them.

Hamor v Determining Authority [2023] FCA 267 —

> [135] That is, the sub-section operates by reference to the amounts paid by the Commonwealth "whether or not to the person under review" and contemplates repayment, by the person under review, of the whole or part of the total of Medicare benefits paid in connection with services found to have been provided by the person under review as part of an inappropriate practice.
>
> [136] The second matter relied upon by the applicant is his submission that the relevant question is whether the repayment direction is appropriate to protect the integrity of that program, having regard to the circumstances of the case; and the Authority did not address that question and instead (at [34(c)]) focussed upon whether the applicant's provision of services caused Commonwealth expenditure. Contrary to the applicant's submission a fair reading of the Final Determination reveals that the Authority considered this very question.
>
> [137] In any event, s 79A(b) of the Act specifically identifies that part of the object of Pt VAA of the Act is the protection of the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice.
>
> [138] For the same reasons, I reject the applicant's submission that the protection of the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice is not an object of Pt VAA of the Act.
>
> [139] The third matter relied upon by the applicant is his submission that it was open to the Authority to conclude that the integrity of the scheme could be achieved by directions requiring the applicant to pay back moneys he actually and personally received for services provided as a result of inappropriate practice, had it considered this; and instead the repayment direction required the applicant to "*repay*" moneys, not only moneys he actually received but also the remainder of the moneys paid by the Commonwealth. This submission invites merit review. Whether the integrity of the scheme could have been achieved by a direction that the applicant repay only the moneys he had received was a matter squarely within the decisional freedom of the Authority. It decided that a full repayment was appropriate and that decision was well open to it, particularly in view of the wording of ss 79A(b) and 106U(1)(cb) of the Act discussed above.

On a number of occasions, the Federal Court has been asked to decide whether the amount that a person under review has been ordered to pay has been legally unreasonable.

Joseph v Health Insurance Commission [2005] FCA 1042 —

> [80] The applicant argued that the cumulative effect of the elements of the determination of the Authority was so severe as to be unreasonable in the sense

identified in *Associated Provincial Picture Houses Ltd v Wednesbury Corporation* [1947] EWCA Civ 1; [1948] 1 KB 223.

[81] The applicant submitted to the Court, as he had submitted to the Authority, that his principal 'sin' related to deficiencies in record-keeping. The Authority rejected this submission, noting that the Committee's report included examples of inappropriate practice of an extremely serious nature. It also noted that poor record-keeping has the potential to impact adversely on patient care.

[82] The seriousness of the conduct of the applicant found to constitute inappropriate practice was a matter for the assessment of the Authority. The aspect of its determination that the applicant finds particularly severe is the direction that he repay Medicare benefits in the amount of $297 999.47. The applicant is not in a position to practice medicine again. It seems reasonable to assume that he now derives less income than he did while he practised medicine.

[83] The matters drawn to the Court's attention by the applicant concerning the severity of the Authority's determination are factors that it was appropriate for the Authority to assess. Nothing suggests that the Authority did not have regard to them. The amount of $267 999.47 is $67 000 less than the amount of Medicare benefits directed to be repaid in the Authority's draft determination. Nothing placed before this Court suggests that the determination of the Authority was so severe that the Authority must have been influenced by factors extraneous to the task that it was required to perform or that its determination was otherwise so unreasonable that it cannot have resulted from a proper exercise by the Authority of its statutory role.

Sevdalis v Director of Professional Services Review [2016] FCA 433 —

[81] It is necessary to say something at a general level about the function of the Determining Authority. The legislative scheme allocates to the Committee the fact finding functions in reviewing and investigating a practitioner. There is no scope for the Determining Authority to proceed on the basis of different, additional or inconsistent factual findings to those made by the Committee. Nor is there any scope for the Determining Authority to depart from the characterisation of a practitioner's conduct by the Committee as "inappropriate practice", or to decide that there should be no consequence at all for the practitioner flowing from the Committee's report. The terms of s 106U make it clear that the Determining Authority must impose some kind of consequence or sanction on a practitioner who has been found by a Committee to have engaged in inappropriate practice.

[82] The Determining Authority's function is to examine the material before the Committee and its findings, together with any submissions made by the practitioner, and form its own opinion about what, within the range of options set out in s 106U, is the appropriate sanction or consequence for that practitioner in the particular circumstances of the inappropriate practice identified. The opinion formed by the Determining Authority and implemented through the directions given under s 106U must be consistent with the purposes of Pt VAA as set out in s 79A, as well as (at a minimum) being rational, legally reasonable and based on probative material: *Minister for Immigration and Citizenship v Li* [2013] HCA 18; 249 CLR 332 at [24]- [30] (French CJ), [64]-[76] (Hayne, Kiefel and Bell JJ), [88]-

[92], [105]-[113] (Gageler J); *Minister for Immigration and Citizenship v SZMDS* [2010] HCA 16; 240 CLR 611 at [124] (Crennan and Bell JJ); *FTZK v Minister for Immigration and Border Protection* [2014] HCA 26; 88 ALJR 754 at [16] (French CJ and Gageler J), [31] (Hayne J), [96] (Crennan and Bell JJ).

…

Whether the Determining Authority made directions which were punitive and not protective (grounds 7, 8 and 9)

[135] These grounds challenge the Determining Authority's decision, rather than the Committee's report. One of the grounds (ground 9) was not the subject of any oral submissions, and both parties relied on their written submissions. The applicant's contention in ground 9 is that the Determining Authority went beyond simply taking into account the fact that Dr Sevdalis was the subject of a previous final determination in 2004, in which sanctions were imposed on him. Instead, the Determining Authority's reasons indicate it sought to punish the applicant again for that conduct. The applicant relies on the following passage from the Determining Authority's reasons:

> The Determining Authority is of the view that inappropriate conduct can place patients at risk and that the directions in this determination are proportionate to the inappropriate conduct found by the Committee and also the previous conduct of Dr Sevdalis as set out in the previous final determination. Any possible adverse consequences to the patients of Dr Sevdalis of a disqualification may be managed by Dr Sevdalis' patients for the period of the disqualification.

[136] This passage could have been expressed differently by the Determining Authority. On its face, it could be seen as having the effect for which the applicant contends. However, in my opinion in this passage the Determining Authority is reflecting on the protective purpose of Pt VAA, and on its sanctions power in particular. In doing so, it was open to the Determining Authority to take into account that this was not the first time Dr Sevdalis had been sanctioned under the Health Insurance Act, thus increasing the need for further specific deterrence, and a longer period of disqualification in order to reduce the risk he might engage in similar conduct in the future. In this passage the Determining Authority did so expressly on the basis of its view about a possible risk to patients, and this aspect of its reasoning was not challenged by the applicant on judicial review.

[137] Ground 9 is not made out.

[138] Grounds 7 and 8 challenge the cumulative imposition of sanctions by the Determining Authority under each and every relevant category available to it in s 106U(1). Counsel for the applicant referred to the "devastating" impact the direction to repay $453,656.75 would have on Dr Sevdalis, as well as the lengthy period of disqualification entirely from receiving medicare benefits. Counsel emphasised that none of the contraventions related to general consultations (item 23) and there was no need for the Determining Authority to remove Dr Sevdalis' entitlement to medicare benefits for general consultations, when all the impugned services had been of other kinds.

[139] Although at times during oral argument counsel for Dr Sevdalis disclaimed this, it seems to me the challenge involved in these grounds was based on an absence of reasoning by the Determining Authority as to why it had imposed the directions it had.

[140] The applicant submitted the Determining Authority "never considered why a full disqualification from the MBS was necessary to satisfy the protective purpose of the scheme", in circumstances where the Applicant had provided detailed submissions explaining a change in circumstances between the review period and the future. He contended his case had "some extraordinary mitigating circumstances", but there was no analysis or assessment of the future risk of inappropriate practice by the Determining Authority in its reasons.

[141] He also submitted that the Determining Authority "never considered" why a partial disqualification (from receiving medicare benefits in respect of certain item numbers) was not sufficient to satisfy the protective purposes of the scheme. It is important to recognise that the Committee did not review all services provided by the applicant during the review period, but only those under certain item numbers (such as off-site, after hours and care plans). Preventing the applicant from providing services under those item numbers, by limiting him to standard consultations only (item 23), could have neutralised any concern about his misuse of those item numbers in the future. Relying on *Quinn v Law Institute of Victoria Limited* [2007] VSCA 122; 27 VAR 1, the applicant submitted the Determining Authority was bound to consider this, but it did not.

[142] The submission that the Determining Authority "never considered" why a full disqualification was appropriate and a partial disqualification was inappropriate, particularly given the tragic personal circumstances experienced by Dr Sevdalis and outlined to the Determining Authority, is put too high. The Determining Authority's reasons make it plain the Determining Authority was aware of, and took into account, those circumstances. Similarly, it cannot be said the Determining Authority "never considered" why a partial disqualification would not satisfy the scheme's protective purpose. This was Dr Sevdalis' submission and the Determining Authority took that submission into account.

[143] What is missing from the Determining Authority's reasons, however, is any substantive examination of why it made the directions it did, in preference to the directions Dr Sevdalis contended would be appropriate (or any other directions for that matter). Its reasons are largely conclusory.

[144] Such an approach can be criticised as less than best practice – it does not inform Dr Sevdalis, as the affected practitioner, why his submissions were so roundly rejected, nor does it inform a reviewing court as to why the Determining Authority reached the conclusions it did. Both are left to piece together a few observations made earlier in the Determining Authority's reasons (such as those at [23]-[29] of its reasons) and infer that these were the matters the Determining Authority then decided weighed strongly in favour of full disqualification (and full repayment.

[145] Nevertheless, such a criticism of the way the Determining Authority has expressed its reasoning process is not the same as a conclusion that it misunderstood

its task and was intent on punishing Dr Sevdalis, rather than making directions it was satisfied would give effect to the protective purposes of the legislative scheme. While in parts of its reasons, it is critical of Dr Sevdalis, those criticisms are generally couched in the context of the Determining Authority explaining why the shortfalls in Dr Sevdalis's behaviour may pose a risk to patients. An example is [28] of its reasons:

> The importance of clinical records in the management of patient care should not be understated. The inadequacies of Dr Sevdalis' clinical records adversely affect his ability (and the ability of other practitioners) to provide effective and adequate care to his patients. The Committee's finding is indicative of the importance and value that the profession places on clinical records.

[146] In *Trade Practices Commission v CSR Ltd* [1990] FCA 521; [1991] ATPR 41-076, French J (as his Honour then was) made the following observations regarding the distinction between punishment imposed for breaches of the criminal law and civil penalties imposed for statutory contraventions that are not criminal offences:

> Punishment for breaches of the criminal law traditionally involves three elements: deterrence, both general and individual, retribution and rehabilitation. Neither retribution nor rehabilitation, within the sense of the Old and New Testament moralities that imbue much of our criminal law, have any part to play in economic regulation of the kind contemplated by Pt. IV [of the *Trade Practices Act 1974* Cth)]. ... The principal, and I think probably the only, object of the penalties imposed by s.76 is to attempt to put a price on contravention that is sufficiently high to deter repetition by the contravenor and by others who might be tempted to contravene the Act.

[147] His Honour's comments were recently cited with approval by a plurality of the High Court in *Commonwealth v Director, Fair Work Building Industry Inspectorate* [2015] HCA 46; 90 ALJR 113 at [55], with their Honours going on to state at [59] that "civil penalties are not retributive, but like most other civil remedies essentially deterrent or compensatory and therefore protective".

[148] Those cases deal with statutory contexts that differ from the Professional Services Review Scheme provided for by Pt VAA of the Health Insurance Act, but they demonstrate that civil sanctions may be imposed for purposes that include general and specific deterrence without necessarily straying into retribution, which is better seen as the province of criminal punishment. That those principles apply in the context of the Scheme can be seen from decisions such as *Mukherjee v Medicare Participation Review Committee* [2010] FCA 233; 114 ALD 148, in which Cowdroy J said that sanctions under an earlier version of the Scheme were "primarily intended to ensure the integrity of the Scheme's operation and [are] not to be seen as a form of penalty or punishment simpliciter" (at [27]) but could "include an element of deterrence" (at [31]).

[149] I am not satisfied that it would be correct to characterise the Determining Authority's reasoning as punitive. Further, although this language does not appear in the Determining Authority's reasons, in my opinion the Determining Authority was conscious of a need to deter both Dr Sevdalis and other medical practitioners

from engaging in what it clearly regarded as significantly poor record keeping of attendances on patients, and poor clinical practice in terms of how Dr Sevdalis carried out his responsibilities as a medical practitioner. That it was not more sympathetic to Dr Sevdalis's own personal situation may reflect one of the attributes of peer review. No doubt many medical practitioners know what it is like to balance a very demanding and responsible profession with life experiences. It may be that some peer reviewers are less sympathetic than might be expected to practitioners who are unable to maintain that balance. Whatever the case, it is not possible to identify from the reasons why there was not more sympathy for Dr Sevdalis's situation. But the fact there was less sympathy than other minds might have brought to the decision is not a legal error. The issue was within the judgment and discretion of the Determining Authority.

The Determining Authority's repayment direction (grounds 7.1.2, 10 and 11)

[150] These grounds concern the way the Determining Authority calculated the amount the applicant would be directed to repay. It is true, as the applicant submitted, that the terms of s 106U gives the Determining Authority a discretion as to the amount a practitioner should be required to repay, and it need not be the entire amount of the medicare benefits paid for services the Committee has found were the subject of inappropriate practice.

[151] The applicant did not challenge the use by the Committee of the sampling regime available to it under s 106K. His submissions before the Court emphasised that the sample size was small: 3.1% of item 37 services; 1.8% of item 597 services; 1.8% of item 5043 services; and around 9% for item 721 services (although only four of the latter services were examined because the remaining 24 in the sample were subject to a concession by Dr Sevdalis). That may be, but in the absence of any challenge to the methodology the sample size is no evidence of legal error.

[152] Accepting that his is a challenge to an exercise of discretion by the Determining Authority, the applicant's contention focuses on the failure by the Determining Authority to examine each of the sampled services (i.e. all 27 or 28 in each class) and to consider whether, in relation to each of those examined services, it was appropriate to require a full repayment depending on the problems identified. For example, it was submitted that, in the case of items 37 and 5043, the Determining Authority could have required repayment by Dr Sevdalis of only the additional amount payable for each home visit over the amount payable for a standard consult – in other words, that since Dr Sevdalis delivered treatment during an attendance, he should be allowed to retain that portion of the medicare benefit for that attendance that would have been payable had it occurred in his consulting rooms. The applicant submitted this approach was especially significant for the item 721 services in relation to management plans: if the management plans prepared by Dr Sevdalis were deficient only in limited areas (given the concession by Dr Sevdalis about two aspects of the plans was accepted by the Committee), then repayment should not be of the whole benefit paid because the patient otherwise derived a benefit and the service was otherwise performed.

[153] All of these submissions may be persuasive submissions to the repository of the exercise of the discretion. I do not accept that the repository's response to them in this case indicates any legal error.

[154] The legal error relied on by the applicant is the failure to take into account a relevant consideration, and the matters which I have set out at [152] above are said by the applicant to be the kinds of considerations the Determining Authority was required to take into account.

[155] That submission conflates a matter which the Act expressly or impliedly requires that a decision maker take into account with evidence before a decision maker which the decision maker has not, or has not sufficiently, dealt with in her or his reasoning: see *Telstra Corporation Ltd v Seven Cable Television Pty Ltd* [2000] FCA 1160; 102 FCR 517 at [131]- [136] per Beaumont, Moore and Gyles JJ; *Rezaei v Minister for Immigration and Multicultural Affairs* [2001] FCA 1294 at [57] per Allsop J; *Paul v Minister for Immigration and Multicultural Affairs* [2001] FCA 1196; 113 FCR 396 at [78]- [79] per Allsop J (with whom Heerey J agreed).

[156] Insofar as the applicant identifies the consideration as "the question whether the applicant ought to be required to repay all amounts paid in respect of item 721 services", in my opinion the reasons of the Determining Authority do disclose that it considered this at a general level, even though its reasons do not record any submissions by Dr Sevdalis about the item 721 services in particular, nor do the reasons address the specific repayment of the amounts for these services. The Determining Authority said at [47]:

> In balancing the inappropriate practice that was found by the Committee with that submission and those other factors mentioned above, the Determining Authority considers that a direction requiring repayment of the whole of the Medicare benefits that were paid for the proportion of the services is indicated in the circumstances.

[157] Again, this reasoning is almost entirely conclusory and does little to enlighten the reader at anything but the most general level. Reasons of that kind are far from best practice, as I have noted, but in the present case I see no legal error of the kind asserted by the applicant arising from them.

[158] More critically, the power of the Determining Authority to require repayment stems, in this case, from the terms of s 106U(cb)(ii), which relates to a class of services. I have extracted that provision at [51] above.

[159] Given that this provision applies where there has been sampling as authorised by s 106K, its terms authorise the Determining Authority to impose a repayment direction for a "class" of services. In this case, that meant the Determining Authority was authorised to impose a repayment direction for the class of item 37 services, for the class of item 597 services, for the class of item 5043 services, and for the class of item 721 services. That is what it did. The applicant's submission that in doing so it needed to consider whether each and every service needed to be repaid by a close analysis of the circumstances of each sampled service is not supported by the authorising provisions.

Sevdalis v Director of Professional Services Review [2017] FCAFC 9 —

[38] Dr Sevdalis was not entitled to be paid any Medicare benefits by the Commonwealth in respect of services the subject of his inappropriate practice. The object of the Professional Services Review Scheme as stated in s 79A was "to protect the integrity of the Commonwealth Medicare benefits" and to "protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice". The Committee had proceeded by reference to the sampling scheme permitted by s 106K which the Determining Authority had taken into account in its final determination. At [23] the Determining Authority said:

> The Determining Authority considers that the inappropriate practice disclosed in the Report is of a serious nature. The finding of inappropriate practice has been made by reference to inadequate clinical input, a failure to meet MBS requirements for each service, and clinical records lacking in essential clinical information. All of these are matters of significant concern to the Determining Authority.

It had before it the statement of concerns produced by the Committee under the Act where a Committee concludes that a doctor is causing or is likely to cause a significant threat to the life or health of patients. The Committee's statement of concerns outlined features of Dr Sevdalis' treatment of his patients in relation to the examined services where the Committee concluded that there was a likelihood that the treatment would cause significant threat to the health of his patients.

[39] Her Honour was correct to reject the submission by Dr Sevdalis that in determining what repayment direction to make the Determining Authority was obliged to consider separately each and every individual service which had been the subject of the Committee's adverse findings. The Act imposed no such obligation either pursuant to s 106U(1)(cb) or otherwise. The power of the Determining Authority to require repayment in this case stemmed, as her Honour correctly found, to be from the terms of s 160U(1)(cb)(ii). That provision entitled it to require the making of repayment directions in respect of "a class of services". The Committee's findings were authorised by s 80(9) to be based upon samples of services and s 80(10) contemplated that the Determining Authority would decide what action to take if a Committee found that a person under review had engaged in inappropriate practice based upon the report from the Committee. The Determining Authority had regard to the appellant's submission that he should only be directed to make a partial repayment of the Medicare benefits in issue but decided, nonetheless, to direct Dr Sevdalis to repay the whole of the Medicare benefits received by him as it was open to do.

Norouzi v Director of Professional Services Review Agency [2020] FCA 1524 —

[103] If it were the case that any service tainted in any way by a committee finding of inappropriate practice had to be repaid in full, there would have been no point to the inclusion as an alternative in s 106U(1)(cb) of "in part". As was observed in Wong, at [215], there is in Pt VAA a very large conception of what constitutes inappropriate practice. Some provision of services yielding a finding of inappropriate practice will be the result of findings such as made by the committee in *Sevdalis v Director of Professional Services Review (No 2)*; others will be the

result of findings such as those made by the committee in the present case. As to a requirement for repayment, there is no "one size fits all" sequel in the subsequent decision by a Determining Authority. That decision must, inherently, be specific to the particular findings of the committee. And by express provision in s 106U(1)(cb) of the HIA, that necessarily includes the contingency of requiring part payment on the basis of those findings. In this case, and with all due respect, the Determining Authority has conspicuously failed to appreciate this in circumstances where it was expressly asked to address that subject.

[104] The repayment obligation which can be required pursuant to s 106U(1)(cb) of the HIA is responsive to the object of protecting the revenue of the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice. It is not penal. That part payment is a contingency surely recognises that the result of inappropriate practice as found by a committee in some cases may require something less than repayment of the whole in order to protect the revenue of the Commonwealth. The object is certainly not enrichment of the Commonwealth in a manner inconsistent with the findings of a committee. In contrast, a decision under s 106U(1)(a) to impose a reprimand is obviously penal. In truth, s 106U provides for some penal and some protective decisions by a Determining Authority.

[105] It by no means follows from the foregoing that each of the propositions put forward on behalf of Dr Norouzi offers a basis for deciding part payment only is apt. Those propositions are qualitatively different. For example, there is nothing in law which would make it follow from a committee finding that a service was rendered, and the point that, in law, and consistently with the basis of that finding, a scheduled item number, albeit not that claimed, was applicable, such that there was always an amount that, if correctly claimed, was payable, that there ought to be a further reduction of any part payment on the basis of an intramural arrangement between Dr Norouzi and House Call Doctor service. Further and fundamentally, the evaluation of such propositions is a matter for the Determining Authority, not for the Court.

Health Care Complaints Commission v Do [2014] NSWCA 307 (per Meagher JA) —

[35] The objective of protecting the health and safety of the public is not confined to protecting the patients or potential patients of a particular practitioner from the continuing risk of his or her malpractice or incompetence. It includes protecting the public from the similar misconduct or incompetence of other practitioners and upholding public confidence in the standards of the profession. That objective is achieved by setting and maintaining those standards and, where appropriate, by cancelling the registration of practitioners who are not competent or otherwise not fit to practise, including those who have been guilty of serious misconduct. Denouncing such misconduct operates both as a deterrent to the individual concerned, as well as to the general body of practitioners. It also maintains public confidence by signalling that those whose conduct does not meet the required standards will not be permitted to practise.

Peverill v Backstrom [1994] FCA 1135 [this case refers to a predecessor body to the Determining Authority under the former scheme] —

> [102] The Committee had a discretion within the framework of the statutory prescriptions. Although the applicant contends that the Committee's recommendations were unreasonable, he was quite unable, and I have been unable, to identify where or how the discretion miscarried. As has been seen, the Committee was composed of experts who were the applicant's peers. The 653 excessive services it identified were performed under a system custom-built by the applicant to secure himself an income that on the Committee's findings was unjustified and exploited the funds made available to Medicare from the earnings of ordinary Australians. It noted that he had been unjustifiably enriched by these services in the sum of almost $12,000. On any view the Committee's findings were a serious even devastating condemnation of him. I can see no basis for describing the recommendations as to penalty as an improper exercise of powers because they were so unreasonable that no reasonable decision-maker could have made them. On the contrary, I should have thought that they were in the circumstances lenient to a fault. But that is not a decision for me.

Peverill v Backstrom [1994] FCA 1565 —

> [66] The fourth point evokes *Wednesbury* unreasonableness. The submission also is put in terms that the sanction imposed on Dr Peverill is "disproportionately severe". However, as Dawson J has explained in *Cunliffe v Commonwealth of Australia* [1994] HCA 44; (1994) 124 ALR 120 at 177, the notion of proportionality has its origin in European systems with a different basic structure for administrative review to that which has developed in common law countries. See also Boyron "Proportionality in English Administrative Law: A Faulty Translation?", (1992) 12 Ox JLS 237. The fourth point is best approached as turning upon the *Wednesbury* doctrine as devised in England and developed in Australia.

Traill v McRae [2002] FCAFC 235 —

> [204] … a direction made by a Determining Officer under s 106U, that the person under review be reprimanded, repay benefits or be disqualified, is not imposed as a punishment. Such a direction flows from a finding that the person has engaged in inappropriate practice in connection with rendering or initiating some or all of the referred services and is, as Davies J said in *Yung v Adams*, supra at 472, 'imposed with a view to protecting patients and the Commonwealth against abuse of the system'. The Full Court which, by majority, allowed an appeal in part did not comment on this passage. Thus, although the person under review can be said to be subjected to something in the nature of disciplinary sanctions, the legislative regime is protective rather than punitive: cf *Bar Association (NSW) v Evatt* [1968] HCA 20; (1968) 117 CLR 177, 183; and *Peverill v Backstrom* (1994) 54 FCR 410, 429, per curiam.
>
> …
>
> [211] In our opinion, subss 106U(3) and (4) of the Act were concerned with past history as a condition of present fitness. The amendment of those provisions by items 21 and 22 of schedule 1 to the Amendment Act 1997 did not attract the

principle stated in *Maxwell v Murphy*, supra. This can be seen from the structure of the Act itself. The Act required the Director either to dismiss a referral made by the Commission pursuant to subs 86(1) or to set up a Committee to consider whether the practitioner had engaged in 'inappropriate practice' as defined in subs 82(1) (see ss 89 and 93). The Committee was required to give a report to the Determining Officer setting out its findings as to whether the practitioner's conduct in connection with rendering or initiating the referred services was, in the Committee's opinion, 'unacceptable to the general body of the members of the specialty [including general practice] in which the practitioner was practising at the time' (subs 81(2) and s 106L). If the report contained a finding that the practitioner had engaged in 'inappropriate practice in connection with rendering or initiating some or all of the referred services', the Determining Officer had to make a final determination under s 106U (ss 106S and 106T). The determination had to contain one or more of a number of specified directions including directions for a reprimand, counselling, repayment of an amount equivalent to Medicare benefits paid for inappropriate services, disqualification in respect of particular services or full disqualification (s 106U). The final determination took effect twenty-eight days after the person under review received a copy or upon the completion of the appeal process (s 106V).

[212] The Determining Officer was therefore required to determine, by reference to conduct in connection with the rendering of the referred services, whether the practitioner should be disqualified and, if so, for what term. In short, any disqualification operated prospectively and was founded on past conduct by the practitioner. The amendment increasing the period of prospective disqualification that could be imposed did not affect the applicant's rights or liabilities in the sense required by *Maxwell v Murphy*, supra. The amendment operated prospectively, albeit by reference to the practitioner's past conduct. There is therefore no reason not to give effect to the amending legislation in accordance with its terms.

[213] It follows that in the absence of legislation providing to the contrary, the amendments to subss 106U(3) and (4), effected by items 21 and 22 in schedule 1 to the Amendment Act 1997, applied to referrals which had not been resolved before the amending legislation commenced. In a case where the Committee had reported under s 106L to the Determining Officer adversely to the practitioner, the referral would not be resolved until a final determination was made by the Determining Officer pursuant to s 106U of the Act. The significance of s 4 of the Amendment Act 1997 is that Parliament did not specifically provide that items 21 and 22 should not apply to matters referred before the Amendment Act 1997 commenced. The absence of any reference to items 21 and 22 in s 4 of the Amendment Act 1997 confirms the intent of Parliament that the longer periods of disqualification should apply to referrals not finally resolved before the Amendment Act 1997 came into force.

[214] We should add that the protective rather than the punitive nature of the sanctions specified in subss 106U(3) and (4) is a further reason for concluding that the legislation should be construed as providing for a prospective period of disqualification founded on past conduct. As we have noted, independently of provisions such as par 8(d) of the Interpretation Act, courts are reluctant so to construe legislation which amends criminal penalties. The difference would seem to be this. Criminal penalties are meant, amongst other things, to deter those who

would otherwise be tempted to breach the criminal law. It is difficult to see how penalties can deter if they are not in force at the time the relevant conduct takes place. Measures such as disqualification of practitioners who engage in 'inappropriate practice' are designed principally to protect the public, rather than to deter (although it would be unrealistic to deny that the measures have some deterrent effect). Moreover, to the extent that the presumption against the 'retrospective' operation of legislation rests on the injustice of denying the reasonable expectation of citizens who rely on the law at any given time (cf *Palmer* and *Sampford*, op cit at 233), it is not reasonable for a practitioner to engage in 'inappropriate practice' in the expectation that the period of disqualification to which he or she might be subject cannot thereafter be changed by Parliament.

[215] In our opinion, the Tribunal did not err in concluding that the maximum periods of disqualification that the Determining Officer could impose on the applicant were those provided for in subss 106U(3) and (4) as amended by the Amendment Act 1997.

Pradhan v Holmes [2001] FCA 1560 —

[109] It is a matter of no little significance that the PSR scheme is a disciplinary one that can lead to significant sanctions being imposed upon a practitioner who has been found to have engaged in inappropriate practice: s 106U; *Adams v Yung*, above, at 294; on disciplinary proceedings see generally Forbes, *Disciplinary Tribunals* (2nd Ed, 1996). The 1999 scheme, much more so than the 1994 scheme, evidences a heightened legislative appreciation of the implications of this in the significantly enhanced procedural fairness safeguards introduced in the 1999 amendments. Those safeguards are now part of the skeletal structure of the PSR scheme and are, as will be seen, useful for the light they throw on the proper construction of the referral processes of the scheme itself.

Tisdall v Kelly [2005] FCA 365 —

[58] To the extent to which the Determining Authority will have to judge the degree of culpability of the applicant, when it comes to deal with the question of directions pursuant to s 106U of the Health Insurance Act, it will have before it the entire report of PSRC 325. It is obvious that the Determining Authority will have regard to the specific finding of PSRC 325 that the applicant engaged in inappropriate practice on 35 days during the referral period. I cannot imagine that the Determining Authority would act on the basis that the applicant had engaged in inappropriate practice on 66, or 63, days, in the light of PSRC 325's reasoning.

Selia v Commonwealth of Australia [2017] FCA 7 —

[149] In line with the principles earlier set out, the starting point in addressing the unreasonableness argument with respect to the repayment direction is the language and objects of s 106U(1) pursuant to which the repayment direction was made. That section provides that a determination must contain one or more of the directions set out in the provision. These include, relevantly to the repayment direction against Dr Selia, subs (cb) which reads:

> if any medicare benefits for a class of services:

(i) that were rendered or initiated by the person under review, by an employee of the person under review, or by an employee of a body corporate of which the person under review is an officer; and
(ii) in connection with the rendering or initiation of which, or of a proportion of which, the person under review or such an employee is stated in a report under section 106L, based on a finding made under subsection 106K(2), to have engaged in inappropriate practice;
have been paid (whether or not to the person under review)—that the person under review repay to the Commonwealth the whole or a part of the medicare benefits that were paid for the services or that proportion of the services, as the case may be;

[150] It will be recalled that other directions which may be made in the exercise of discretion under s 106U include a reprimand, a direction requiring the practitioner undertake counselling, a direction that a Medicare benefit otherwise payable cease to be payable, or partial or full disqualification from practice.

[151] The purpose of a direction under s 106U must be read in light of the object of Part VAA set out in s 79A of the Act to protect the integrity of the Medicare benefits scheme and, in so doing, to protect, relevantly under s 79A(b), the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice. Given the object of Part VAA and that inappropriate practice is not limited to clinical matters, there is nothing in the text of s 106U(cb) that limits the power to direct the repayment of benefits wrongfully paid to circumstances where the services were clinically unnecessary, were not provided to a clinically appropriate standard, or were not performed at all.

[152] Consistently with this, deterrence may be a relevant factor taken into account in the exercise of discretion under s 106U including whether to make a direction under subs (cb), as Mortimer J held in *Sevdalis*.

[153] In *Sevdalis*, it was submitted by the medical practitioner that the Determining Authority had made directions under s 106U of the Act disqualifying the practitioner from practice and requiring repayment which were punitive. Justice Mortimer accepted that the purpose of making directions under s 106U is protective and not to impose a punishment for contravening the standard set by s 82 (*Sevdalis* at [145]). While Mortimer J rejected the practitioner's submission at [149] on the basis that it would not be correct to characterise the Determining Authority's reasons for making the directions as punitive, her Honour accepted (rightly in my view) that deterrence as opposed to punishment could be an element taken into account in the exercise of the discretion. Specifically, Mortimer J explained that:

> [146] In *Trade Practices Commission v CSR Ltd* [1990] FCA 521; [1991] ATPR 41-076, French J (as his Honour then was) made the following observations regarding the distinction between punishment imposed for breaches of the criminal law and civil penalties imposed for statutory contraventions that are not criminal offences:
>
> > Punishment for breaches of the criminal law traditionally involves three elements: deterrence, both general and individual, retribution and rehabilitation. Neither retribution nor rehabilitation, within the sense of the

> Old and New Testament moralities that imbue much of our criminal law, have any part to play in economic regulation of the kind contemplated by Pt. IV [of the *Trade Practices Act 1974* Cth)]. ... The principal, and I think probably the only, object of the penalties imposed by s.76 is to attempt to put a price on contravention that is sufficiently high to deter repetition by the contravenor and by others who might be tempted to contravene the Act.

> [147] His Honour's comments were recently cited with approval by a plurality of the High Court in *Commonwealth v Director, Fair Work Building Industry Inspectorate* [2015] HCA 46; 90 ALJR 113 at [55], with their Honours going on to state at [59] that "civil penalties are not retributive, but like most other civil remedies essentially deterrent or compensatory and therefore protective".

> [148] Those cases deal with statutory contexts that differ from the Professional Services Review Scheme provided for by Pt VAA of the Health Insurance Act, but they demonstrate that civil sanctions may be imposed for purposes that include general and specific deterrence without necessarily straying into retribution, which is better seen as the province of criminal punishment. That those principles apply in the context of the Scheme can be seen from decisions such as *Mukherjee v Medicare Participation Review Committee* [2010] FCA 233; 114 ALD 148, in which Cowdroy J said that sanctions under an earlier version of the Scheme were "primarily intended to ensure the integrity of the Scheme's operation and [are] not to be seen as a form of penalty or punishment simpliciter" (at [27]) but could "include an element of deterrence" (at [31]).

[154] It follows that I accept the Commonwealth's submission that repayment directions under s 106U are not limited to inappropriate clinical practices. Rather, there is no reason why practices found to be inappropriate which seek to abuse the Medicare benefits scheme in other respects posing a risk to the integrity of the scheme (such as claiming the benefit by one designated number rather than another, failing to keep proper records, or pre-billing) cannot be the subject of a repayment order. Even if that risk has not in the individual case been realised in terms of a quantifiable loss to the Commonwealth or otherwise, deterrence may be a factor warranting a repayment of all or part of the benefits. As the counsel for the Commonwealth submitted:

> ...we say what happened here falls squarely within the aim of protecting the integrity of the program. I mean, there are rules as to what you can do. Those rules haven't been followed. It has been shown that that would be found to be unacceptable to the requisite standard by peers. And your Honour will recall the findings that it's not clear what had been repaid. The Commonwealth in the position of having to go through and work out what has been provided or not, whether things have been repaid or not, when; I mean, one really is fairly and squarely within the whole ambit of protection of the integrity of the program...

…

[158] The applicant contended that it was unreasonable for the Determining Authority to observe that Dr Selia had engaged in a "very high proportion of inappropriate practice" in circumstances where the inappropriateness derived only from one aspect of the service, namely, its billing. However, as the Commonwealth submitted, that finding does no more than reflect the PSR Committee's finding of

inappropriate practice in connection with 74% of the MBS item 85011 services and 100% in relation to the three remaining MBS item services.

[159] The applicant also submitted that it was unreasonable for the Determining Authority to make a repayment direction in respect of services that were provided and were clinically appropriate, and in circumstances where he had paid out money to third parties for equipment in connection with the rendering of those services. Underlying this submission is the proposition that if Dr Selia had billed the services after they had been provided, there would have been no question as to his entitlement to the payment of benefits for the provision of those services. Added to this, the applicant submitted that he had understood the practice of pre-billing to be acceptable and that Dr Dalton's inspection had confirmed this belief.

[160] I do not accept those submissions and consider that the applicant has not demonstrated that the decision of the Determining Authority to make the repayment direction was legally unreasonable, even though the amount of the repayment direction is substantial and may be regarded as harsh.

[161] First, the Determining Authority found at [40] of its reasons that it was not satisfied that the Commonwealth should have to bear the cost of services in respect of which Dr Selia has been found to have engaged in inappropriate practice. That view reflects the protective purpose intended to be served by directions under s 106U as explained above. Relevant to this finding among other things was what the Determining Authority considered to be the "serious nature" of the inappropriate practice disclosed in the PSR Committee's final report, and specifically that the pre-billing of services was "a matter of significant professional concern" (at [21] and [22] respectively). The Determining Authority's findings in this regard align with the findings by the PSR Committee in its reasons that the general body of dentists would regard pre-billing as "a gross departure" from the standard expected of dentists in claiming Medicare benefits (at [42]). In this regard, the Determining Authority specifically noted that the PSR Committee considered pre-billing by itself constituted inappropriate practice and observed that the practice is inconsistent with the Act and reflected in the commentary in the Medicare Benefits Schedule Dental Services during the review period (at [23]). Furthermore, the Determining Authority found at [38] that:

> The Determining Authority considers that the practitioner bears responsibility for ensuring that clinical input is adequate, avoiding billing practices that are inconsistent with the Act, meeting the requirements of these MBS services, and keeping adequate and contemporaneous records detailing sufficient clinical information. In this regard, the Determining Authority notes the Committee's finding that Dr Selia should have familiarised himself with the requirements for billing the Commonwealth (both generally and with respect to specific MBS items) prior to making claims.

[162] Secondly, the applicant submitted that it was disproportionate for the pre-billing to be given such prominence "[b]ecause it's an administrative practice engaged in by the dentistry practice". However, that submission ignores the PSR Committee's finding that post-service billing was a legal requirement, not merely an administrative nicety, and a matter bearing upon the lawfulness and financial integrity of the Medicare scheme (at [70]). As the PSR Committee found, there is

no entitlement under the Act to payment of a Medicare benefit until a service is rendered. No issue was taken with that finding. Accordingly, Dr Selia had no entitlement as a matter of law to the benefits which he claimed and was paid with respect to the services in connection with which the findings of inappropriate practice were made.

[163] Against this, Dr Selia submits that the purpose of a direction under s 106U is limited to that identified by von Doussa J in *Retnaraja v Morauta* [1999] FCA 80; (1999) 93 FCR 397 (*Retnaraja*) at 418 [81], namely "to enable the recovery of Medicare benefit which should not have been paid, and to prevent payment where Medicare benefit is not rightly due." Relying upon this passage, the applicant submits that the fact that the services were subsequently provided meant that the wrongful payment of the benefit in each case was effectively 'cured' such that they became "rightly due" and that, therefore, a direction that they be repaid was unreasonable. However, no provisions of the Act are pointed to by which the wrongful payment of the benefit is 'cured'. Furthermore, the submission ignores the different wording of s 106U(1)(cb) as it stood before the amendment by the *Health Insurance Amendment Act (No 1) 1997* (Cth) and as considered in *Retnaraja*. The provision then provided for a determination to contain a direction:

> (c) that the person under review repay to the Commonwealth an amount equivalent to any medicare benefit payable for inappropriate services (whether or not the medicare benefit was paid to the person), and that any medicare benefit that would otherwise be payable for those services cease to be payable.

[164] Moreover, in *Retnaraja* the repayment direction was found to be wrong in law in circumstances where among other things, it directed repayment of a percentage of all benefits paid for four categories of services, but the reduction from 100% was not based upon any distinction between those services that were appropriate and those which were not, or between payments of benefit rightfully paid and those wrongfully paid (*Retnaraja* at 419 [89]). That is not the present case where the percentage of benefits directed to be partially repaid equated to the percentage of inappropriate practice undertaken in connection with the referred MBS item services, utilising using the sampling provisions of Part VAA. Thus, given that there was no issue that there had been sampling as authorised by s 106K, the Determining Authority was authorised to impose a repayment direction for the class of the item 85011, 85615, 85661 and 85672 services.

[165] Dr Selia also relied on s 129AC which provides that where, as a result of the making of a false or misleading statement, an amount is paid purportedly by way of benefit in excess of the amount that should have been paid, the amount of the excess (and only the amount of the excess) is recoverable as a debt due to the Commonwealth. However, the section with respect does not assist the applicant's argument. Section 129AC is in different terms from s 106U and achieves different ends, it is not in Part VAA and therefore the objects in s 79A do not apply to its construction, and in any event it does not overcome the difficulty that no provision "curing" the wrongful payment on provision of the pre-billed services has been identified. Further, under s 129AEA an administrative penalty may be paid in addition to the recovery of the amount under s 129AC where certain criteria are met.

[166] Thirdly, the applicant relies upon the finding by the Determining Authority at [26] that it gave "little weight" to Dr Selia's submission that he was entitled to rely on what was described as the implicit endorsement by Dr Dalton of Dr Selia's pre-billing practice. In this regard, counsel for the applicant submitted that "it's inconceivable... that he didn't see the client's billing practices. It's inconceivable because that's what Medicare is about..." However, the finding by the Determining Authority that it gave "little weight" to Dr Selia's submission at [26] was based upon its finding at [25] as to the findings made by the PSR Committee:

> The Determining Authority noted that it had been submitted to the Committee that Dr Dalton had examined three patient records and recorded that "All treatment plans were fully set out and signed by the patient". The Committee also noted that '[t]he Committee does not know what particular records were shown to Dr Dalton and does not know whether or not Dr Dalton appreciated that patients were pre-billed."

[167] Furthermore, the Determining Authority found that "[t]he Committee was unequivocal in its view that pre-billing, in the circumstances in which Dr Selia pre-billed patients, constituted inappropriate practice" (at [27]). The findings by the Determining Authority as to what the PSR Committee found and why, were therefore open to it; indeed, it is difficult to see how issue could be taken with the Determining Authority's findings in this regard. The applicant's submission ultimately, therefore, seeks impermissibly to take issue with the merits of the PSR Committee's findings and fails to grapple with the fact that it was not open to the Determining Authority to revisit the PSR Committee's findings.

[168] Fourthly, the applicant submitted that it was unreasonable for the Determining Authority to make a repayment direction when he had made payments to third-party providers for equipment for some of the services. In his submission to the Determining Authority, Dr Selia submitted that he had incurred fees in the vicinity of $240,000 in relation to laboratory fees, and for the costs of implants, crowns and models. The applicant did not however point to evidence before the Determining Authority in support of that amount but rather submitted in this application that support for that amount should be inferred on the following basis:

> For three of the four categories, it involves the insertion or implanting of teeth, and my client doesn't make teeth implants. That is not – it's not part of his practice ... So in all of the categories of the second and third and fourth categories of MBS items in the MBS list – not the oral examination one but all of the others – your Honour can find that he had to make payments to outsider providers to make the teeth that he implanted.

[169] The reasons of the Determining Authority must be fairly read bearing in mind that that they were written by decision-makers who are not legally trained. As Mortimer J said in *Sevdalis* at [132], "'[f]airness' in this context includes reading the reasoning as a whole, because it is only by doing so that a reviewing court can gain a balanced appreciation of how the decision maker understood and applied the statutory concepts." In this regard, the applicant's submission among other things overlooks the fact that, fairly read, the Determining Authority did take this consideration into account in adjusting the amount of the repayment notwithstanding the absence of evidence verifying the precise amount claimed. The

Determining Authority specifically noted at [42] "the nature of dental practice, which required Dr Selia to make payments directly to third party providers of items such as models, bridges and implants." When the structure of the reasoning is considered, it is apparent that that factor was then taken into account by the Determining Authority in determining that a direction on repayment should be made for part only of the Medicare benefit paid for the proportion of those services in connection with which Dr Selia engaged in inappropriate practice and in setting the percentage at 60% (at [45] and [46]): see further at [172] below.

[170] In the fifth place, the applicant submitted that the Determining Authority failed to take into account his submission that he had made repayments in an amount of approximately $200,000 to Medicare for services ultimately not provided or where the patient did not return within a reasonable timeframe for completion of the proposed treatment. In response, the Commonwealth submitted that the $200,000 figure was not limited to repaying amounts relating to services the subject of the PSR Committee's findings of inappropriate practice, referring to the broader concerns initially raised with Dr Selia which ultimately led to the referral under s 93: see above at [22] – [25]. Thus, it is possible that part only of the amount which was said to have been repaid related to the services which were the subject of the findings by the PSR Committee. However, the short point (also made by the Commonwealth) is that the Determining Authority expressly took into account Dr Selia's repayments to Medicare where they had been substantiated by evidence but that, despite being invited to give evidence of further repayments in the Draft Determination, Dr Selia had provided no further information in his submissions on the Draft Determination (at [42]-[43]).

[171] The applicant also submitted that he did not obtain any monetary advantage from pre-billing "except that he got the money a little bit earlier". However, there was no evidence to that effect. Indeed, it is difficult to reconcile that submission with the submission that the monies were used to purchase equipment from third parties in relation to the services subsequently rendered.

[172] Finally, as I have mentioned the Determining Authority did not require repayment of 100% of the amount of the Medicare benefit paid to Dr Selia for the proportion of services in connection with which he was found to have engaged in inappropriate practice, but only 60% of that amount. That figure of 60% was neither inexplicable nor baseless. Rather, it is apparent that, in deciding upon that percentage, the Determining Authority took account of various mitigating factors on which Dr Selia relied including his financial position, his repayments to Medicare and the changes which he made to his practice in light of the PSR Committee's findings, as well as such matters as the seriousness of the findings of inappropriate practice (at [46]). That process is not one susceptible to a precise mathematical calculation, as counsel for the applicant accepted in oral submissions. Rather, fairly read, the Determining Authority reached the figure of 60% by weighing the different factors in an evaluative process akin to the process of intuitive synthesis in sentencing in criminal law, as the Commonwealth submitted.

[173] It follows that neither individually nor cumulatively do the matters relied upon by the applicant demonstrate that the Determining Authority's decision to make the repayment direction lacks an intelligible foundation or is otherwise irrational or arbitrary so as to make good the contention that it is legally

unreasonable. While reasonable minds might differ as to the direction that might have been appropriate, the decision by the Determining Authority to make the repayment directions here fell within the range of possible lawful outcomes of the exercise of the discretion in s 106U and was not obviously disproportionate or unjust in the circumstances.

Li v Determining Authority [2022] FCA 1448 —

[130] The applicant submitted that the Authority misdirected itself as to its statutory task by starting from a position that it should make the repayment direction and then ask itself whether the applicant had justified a "reduction in the amount repayable" (at FD[67]). The applicant submits that this effectively placed an onus on the applicant to justify a different amount, which was not required by s 106U(1)(cb) and refers to FD[67] in this regard:

> The Determining Authority is not satisfied that Dr Li has outlined sufficient mitigating factors, or shown substantial insight into the deficiencies identified with his practice, to warrant any reduction in the amount repayable. ...

[131] The applicant contended that the Authority's broad discretion as to directions it may impose under s 106U do not *require* it to make a repayment direction, but rather it is an "open-ended discretion" that does not warrant starting with a presumption that a person has to "repay everything". Accordingly, the applicant argued that by "imposing a policy that a full repayment direction was to be imposed unless the applicant could justify a reduction, the Authority fettered its own discretion and misdirected itself."

[132] The applicant submitted that the proper approach was for the Authority to examine the whole of the circumstances, including all the matters raised in the applicant's submissions, and then having considered all the circumstances, consider what might be an appropriate repayment direction, if any, and to determine what is appropriate for particular MBS item numbers, which it purportedly did not do.

[133] The applicant further submitted that the Authority ought to have informed its decision as to whether to make a repayment direction by reference to the Committee's different reasoning for each MBS item for which inappropriate practice had been found and the applicant's submissions to the Authority (which related to the specific circumstances of each MBS item for which inappropriate practice had been found). Rather, the applicant submitted that the Authority misdirected itself by asking whether the amount repayable should be reduced from the full amount of the Medicare benefits paid for items in respect of which inappropriate practice had been found, notwithstanding that no amount was repayable (and accordingly no amount could be "reduced") until the Authority made a repayment direction.

[134] The applicant, at hearing, referred to *Norouzi v The Director of the Professional Services Review Agency* [2020] FCA 1524, a case where Logan J found that the Authority had not recognised that it was open to it to make a partial repayment direction (see pleadings of that case at [85]). The applicant referred to *Norouzi* at [103], where Logan J found:

> As to a requirement for repayment, there is no "one size fits all" sequel in the subsequent decision by a Determining Authority. That decision must, inherently, be specific to the particular findings of the committee. And by express provision in s 106U(1)(cb) of the HIA, that necessarily includes the contingency of requiring part payment on the basis of those findings. In this case, and with all due respect, the Determining Authority has conspicuously failed to appreciate this in circumstances where it was expressly asked to address that subject.

[135] Justice Logan further observed as to the purpose of s 106U(1)(cb) at [104]:

> The repayment obligation which can be required pursuant to s 106U(1)(cb) of the HIA is responsive to the object of protecting the revenue of the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice. It is not penal. That part payment is a contingency surely recognises that the result of inappropriate practice as found by a committee in some cases may require something less than repayment of the whole in order to protect the revenue of the Commonwealth. The object is certainly not enrichment of the Commonwealth in a manner inconsistent with the findings of a committee. In contrast, a decision under s 106U(1)(a) to impose a reprimand is obviously penal. In truth, s 106U provides for some penal and some protective decisions by a Determining Authority.

[136] The applicant submitted that "in this case the Determining Authority has recognised that it can require part payment, but its error has been in only partially departing from the position it took in *Norouzi* by still starting from the basis that full repayment is required and then effectively requiring the applicant to justify why that's not so".

[137] *First*, contrary to the submission of the applicant, the Authority did not start from the presumption that the applicant had to "repay everything". It is clear from the Authority's reasons, consistent with what the applicant contends it should do, that it understood it had an "open-ended discretion". This is clear from the Authority's reasoning: At FD[62], the Authority notes:

> The Determining Authority notes that in exercising its discretion under section 106U of the Act, it may direct that all, or part, or none of the amounts paid for services found to constitute inappropriate practice be repaid.

[138] The Authority then considered the applicant's differing positions over time as to what he submitted would comprise the "appropriate" repayment amount, at FD[63], as follows:

> In his original submissions, Dr Li submitted that it would be appropriate that he be directed to repay $49,443 relating to services found to constitute inappropriate practice. In his further submissions, Dr Li submits that it would be appropriate that he be directed to repay $320,000. The Determining Authority appreciates that this represents a substantial change in Dr Li's position, following his consideration of the draft determination.

[139] The Authority then responded to these differing positions and stated, at FD[64], that it was:

> [U]ltimately not persuaded that it would be appropriate in the circumstances to seek repayment of something less than of the full costs incurred by the Commonwealth in connection with services found to constitute inappropriate practice.
>
> [140] The Authority's reasons identify the basis for why it considered, despite acknowledging its discretion to direct all, or part, or none, of the amounts paid for services (at FD[62]), that full repayment should occur.

[141] *Secondly*, the Authority provided, in clear terms, the basis for its view that inappropriate practice had occurred in the provision of all the services: This is clear from the Authority's reasoning at FD[65]–[66], extracted as follows:

> [65] For the reasons outlined above, the Determining Authority is satisfied that the Committee's findings reflect a serious degree of inappropriate practice. The Determining Authority acknowledges that Dr Li provided the services examined by Committee during the Review Period, but the Committee's Report highlights that the services did not meet the relevant MBS requirements, for a number of different reasons. The Committee found that Dr Li's record-keeping was universally inadequate, in the sense that in every case where findings of inappropriate practice were made, Dr Li's record-keeping was unsatisfactory. However, contrary to Dr Li's submissions, the Committee's findings go well beyond his poor record-keeping.
>
> [66] The Committee often found that there was no clinical indication for many of the services performed and they did not meet relevant MBS requirements. As noted above, the Determining Authority is particularly concerned about the extremely high proportion of MBS item 23 and 36 services found to constitute inappropriate practice. On occasion, the Committee found that Dr Li's clinical input into services was also inadequate.

[142] *Thirdly*, to the extent that the Authority refers at FD[67] to not being "satisfied" that the applicant had "outlined sufficient mitigating factors" warranting any reduction, this reasoning does not equate to the Authority requiring that the applicant bear the onus of justifying an amount less than the full amount, when the reasoning is understood in the entire context from FD[62] onwards.

[143] This reading is fortified by a consideration of the whole of FD[67], which is extracted as follows:

> The Determining Authority is not satisfied that Dr Li has outlined sufficient mitigating factors, or shown substantial insight into the deficiencies identified with his practice, to warrant any reduction in the amount repayable. ***While Dr Li provided the services in a very basic sense, they did not meet the relevant requirements to justify relevant payment. The Determining Authority must have regard to compliance with relevant MBS requirements in discharging it obligation to protect the integrity of the Medicare scheme***. (Emphasis added.)

[144] The Authority's consideration of the purported mitigating factors and the applicant's insight are highly relevant to its considering what comprise appropriate directions in light of the protective nature of the regime as well as its consideration

of the appropriate directions necessary to deter the applicant in future. As noted by Perry J in *Selia v Commonwealth of Australia* [2017] FCA 7, when exercising a power under s 106U deterrence may be a relevant factor that can be taken into account in the exercise of the discretion: at [152]; see also *Sevdalis v Director of Professional Services Review (No 2)* [2016] FCA 433 at [148].

[145] The Authority expands its reasoning at FD[68] as to its concern regarding the applicant's lack of insight, in the following way:

> As noted above, Dr Li submits that any repayment direction should be proportionate in relation to 'civil harm' which has allegedly occurred. He submits that no civil harm has been caused by his conduct. The Determining Authority is not satisfied that this submission is reflective of any substantial insight by Dr Li into the deficiencies identified in his practice in the review period. Dr Li's submission suggests that, it is only if his patients were harmed in some way that a full repayment direction may be appropriate. The Determining Authority rejects that submission. It accepts that harm to patients is a relevant factor, in terms of assessing risk to patients and the community from inappropriate practice. However, it does not follow that a lack of 'civil harm' is a sufficient basis to conclude that a full repayment may not be warranted in the circumstances.

[146] It then, at FD[69], articulated the necessity for full repayment on the bases both that the "repayment direction appropriately reflects the benefits paid for the services found to constitute inappropriate practice" (being all of them given its reasoning at FD[65] and FD[67]) and "as well as deterring Dr Li and other practitioners from engaging in similar inappropriate practice into the future".

[147] In any event, even if I am wrong in concluding that the Authority did not start from the position that there ought to be full repayment where a finding of inappropriate practice is made with respect to Medicare services, I accept the submission, in the alternative, from the Commonwealth that starting from a point of full repayment "is entirely consistent with the objective in [s] 79A". The direction to repay, in "whole", the Medicare benefits for items ***for which*** inappropriate practice had been found, was one of two options if making a repayment direction under s 106U(1)(cb). Whilst it is not mandated to start from a point of full repayment, it was open to the Authority do so.

[148] It follows that I find that the Authority did not misdirect itself as to its statutory task when determining whether it should make the repayment direction. Given this conclusion, there is no need for me to determine the issue of the purported materiality of the purported error. However, for completeness, I make the following observations in relation to materiality.

[149] The applicant repeated his submissions already made with respect to ground 1, and also submitted that ground 2 was a material error "because it was capable of affecting the quantum of any repayment direction" thereby depriving the applicant "of a realistic possibility of a different outcome".

[150] In support of this submission, the applicant contended that the Authority had failed to look at all the circumstances, namely that the applicant had reduced his gross billing of Medicare by 60 percent, he no longer performs complex procedures

> such as flats and grafts and in relation to particular MBS item numbers he had a reasonable and honest belief that the way he billed was correct for various reasons. I do not accept this submission.
>
> [151] Again, the Authority's Final Determination must be read as a whole. It is clear, contrary to the applicant's submission, that the Authority did take into account the changes the applicant had made to his practice arrangements. Specific reference is made to the same at FD[30] and to the notation by the Committee that the applicant had been "generally receptive to its concerns and admitted many deficiencies in his record-keeping and billing" as well as having "expressed a willingness to continue to improve where necessary". Whilst the Authority does not go into the detail of all of the forms of new arrangements, there is an explicit acknowledgement of the same in this part of the reasoning and again at FD[46]. Regarding the applicant's purported "reasonable and honest belief" that his billing practices were correct for various reasons, specific reference is made to the same at FD[44(c)].
>
> [152] For these reasons, I do not accept if any error were established, if could have realistically affected the result.

If a person under review has had a final determination or a section 92 agreement previously take effect, the Determining Authority may impose a disqualification period of up to 5 years instead of up to 3 years. Prior to this provision coming into effect, if a person under review had a previous final determination or agreement come into effect, after the Determining Authority's final determination came into effect, they were referred to the Medicare Participation Review Committee, which had the power to impose a further disqualification period. A person under review who was dissatisfied with that Committee's decision could apply to the Administrative Appeals Tribunal for review, which then stood in the shoes of the Committee for the purposes of reviewing its decision. In *Re Alekozoglou and Medicare Participation Review Committee*, the Tribunal discussed the factors that it took into account in deciding whether a further disqualification period should apply and in varying the decision of the Committee (the only variation was the date from which the disqualification would commence).

Re Alekozoglou and Medicare Participation Review Committee [2012] AATA 937 —

> [53] The preferable decision in a matter such as this must be determined by the consideration of the facts of the particular matter. We set out in the following paragraphs the matters we have taken into account in reaching our decision.
>
> **The repeated instances of inappropriate practice by Dr Alekozoglou**
>
> [54] On three occasions between September 1997 and June 2011 it has been determined that Dr Alekozoglou has engaged in "inappropriate practice" as defined in the Act. We acknowledge that the nature of the inappropriate practice has varied

but there is some similarity in the findings which indicates that difficulties have continued to arise by reason of the manner in which Dr Alekozoglou conducts his practice. It indicates also that these difficulties have not been adequately addressed.

[55] In 1997 the inappropriate practice included the high volume of services "resulting in a workload which would not allow [Dr Alekozoglou] as a general practitioner, to provide appropriate clinical input." In 2009 the conduct included the provision of Item 723 "in circumstances which did not meet the MBS item descriptor." The Committee noted that:

> The report of the advisor who reviewed Dr Alekozoglou's program acknowledged his work ethic but expressed concern that his level of total services, chronic disease management services and attendances at residential aged care facilities may not allow sufficient time for appropriate clinical input."

[56] In 2011 Dr Alekozoglou agreed that again he had engaged in further inappropriate practice, again in part relating to his provision of services under Item 723. The specified practice included "failing to satisfy the minimum clinical content of MBS item 723 services. The Team Care Arrangement Plan only involved one other allied health provider."

[57] This is the third occasion on which a finding of inappropriate practice has been made against Dr Alekozoglou. There have been ongoing concerns raised as to the contribution to this made by his very high workload. In addition, on two occasions the inappropriate practice has involved the provision of services, mainly to aged patients, under Item 723.

Dr Alekozoglou's failure to address his lack of understanding of Item 723

[58] In January 2009 Dr Alekozoglou agreed that he had provided services not in accordance with the requirements of Item 723 during the period between 1 September 2006 and 31 August 2007. In May 2011 he agreed that this practice had been repeated between 1 March 2009 and 28 February 2011. Despite this, Dr Alekozoglou claimed that he did not understand the requirements of Item 723 until he had discussions with officers of Medicare in November 2011.

[59] Dr Alekozoglou admitted that when he signed the agreement in 2009, and at the time he was disqualified, he did not read the descriptor of Item 723.

[60] Further Dr Alekozoglou gave evidence that indicated that even at the time of the hearing of this application (1 November 2012) he did not understand the requirements of the Item and that he had recently prepared Team Care Arrangements which did not comply with the descriptor of the Item.

[61] Dr Alekozoglou's attitude to the need for his being conversant with the requirements of a Medicare Item under which he has claimed substantial payments of public money does him no credit whatsoever. His attitude was cavalier and contemptuous of the system in which he has chosen to participate. Clearly he is an intelligent man and yet he offered no reason for his failure to understand the requirements of the Item and his continued lack of effort to reach an understanding of them. He has been offered assistance to do so and has failed to take advantage of the assistance.

Dr Alekozoglou's attitude to his claiming payment for services not properly provided

[62] We are satisfied that Dr Alekozoglou has been required to repay a total of $241,157.36 as a result of the three separate final determinations. He does not dispute that these repayments were appropriate. Nevertheless on the basis of Dr Alekozoglou's evidence and the fact that he has been required to refund amounts received on three separate occasions, we are satisfied that he does not appreciate the need for care in claiming the payment of public funds. His comment, when questioned, that "it's only money" was indicative of his attitude.

Dr Alekozoglou's failure to address his workload

[63] On several occasions during the hearing comments were made as to Dr Alekozoglou's work-ethic and this has been acknowledged by the various Committees. However it is not appropriate that the standard of patient care being provided is compromised by Dr Alekozoglou's taking on more patients than he can manage properly resulting in his inability to give proper clinical input into their care. This concern was expressly raised with Dr Alekozoglou in 1997 and again in 2009.

[64] Dr Alekozoglou has agreed that on occasions he has not properly prepared Team Care Arrangements and that on occasions he has not had the necessary discussions with allied health professionals when plans were being prepared. On this basis we are satisfied that some of his patients did not receive the benefits which should have flowed from properly prepared plans and properly conducted discussions with appropriate allied health professionals.

[65] In 1997 the Determining Officer took into account that Dr Alekozoglou had employed another doctor to assist him in his practice. This employment lasted for approximately two months and, apart from employing occasional locums, Dr Alekozoglou has not employed another practitioner to assist him.

Dr Alekozoglou's attitude to the operation of the Scheme

[66] On the basis of Dr Alekozoglou's evidence we are satisfied that he does not regard the requirements of the Medicare benefits scheme with the degree of seriousness as is reasonably expected of a general practitioner who has opted to be part of the scheme.

[67] Dr Alekozoglou does not now recall what it was in his conduct which led to his disqualification in 1997, even though the conduct referred to at the time included the high volume of services rendered, and the Determining Officer expressing concern as to Dr Alekozoglou's ability to give appropriate clinical input to patient care by reason of his workload. The reasons given by the Determining Officer referred to "inappropriate practice of a most serious nature..."

[68] In January 2009 Dr Alekozoglou signed an agreement in which he acknowledged that he had engaged in inappropriate practice in that he provided Item 723 services in circumstances which did not meet the Item descriptor. Dr Alekozoglou now says that at the time he did not understand what was required by

that Item. Further he says that he did not read the agreement at the time he signed it and that he did not understand at that time what it was alleged that he had done wrongly. Dr Alekozoglou had met with the Director of Professional Services Review in November 2008, at which time the Director explained to him the shortcomings in the manner in which claims under Item 723 had been made. Notwithstanding this advice Dr Alekozoglou has continued to prepare team care plans which do not comply with Item 723.

[69] The attitude of Dr Alekozoglou to the requirements of the scheme and his conduct of his practice up to the time of the hearing of this application causes us to be satisfied that Dr Alekozoglou does not appreciate his obligations which arise from his participation in the scheme and that unless he does understand his obligations it is likely that he will continue to engage in inappropriate practice.

Dr Alekozoglou's continued provision of a high volume of services to a large number of patients

[70] Despite being warned as to the risk of his continuing to provide medical services to a large number of patients, many of whom are elderly and who need special attention, Dr Alekozoglou gave evidence that he sees about 50 patients per day at his clinic, about five per day at various aged care facilities and reviews one care plan per day. This is in addition to the administrative work required in running his practice. Dr Alekozoglou does not claim on Medicare for all of the services rendered by him in an effort to avoid further investigation of his practice. This means that Medicare records do not accurately reflect the extent of the services he has rendered. Dr Alekozoglou was in the 99th percentile of practitioners so far as services rendered during the period of the last review.

[71] While Dr Alekozoglou continues to service such a high volume of patients, many of whom are elderly, there is a substantial risk that he will not provide proper care of those patients and that he will continue to claim payment for services not properly supplied should he continue to participate in the Medicare scheme. It is necessary to take action to protect Dr Alekozoglou's patients and future patients from the provision of services which do not comply with the requirements of the scheme. Patients are entitled to expect that services they receive are of the standard required. This is particularly so in relation to the preparation of Team Care Arrangements.

The need to protect public funds from claims for inappropriate practices

[72] As previously mentioned, Dr Alekozoglou has been required to repay to the Commonwealth $241,157.36, being an amount determined to be payments he received for services rendered inappropriately. This amount is the total of three re-payments required of Dr Alekozoglou:

- $168,054.10 after the investigation in 1997;
- $30,000.00 after the investigation in 2006-2007;
- $43,103.26 after the investigation in 2009-2010.

[73] Dr Alekozoglou was not entitled to these funds. He did not properly render the services for which he claimed and the public purse was deprived of these funds for some years until they were repaid. Dr Alekozoglou does not appear to appreciate

the seriousness of his actions in this regard in view of his comment that "it's only money."[55] Furthermore, based on the information he provided to patients who provided statements on his behalf[56], we are satisfied that Dr Alekozoglou regarded these repayments as fines rather than repayments of funds to which he was not entitled. Dr Alekozoglou says that he now understands the true nature of the repayments he was required to make.

Need for public education

[74] It is necessary that appropriate action be taken in respect of the practices of Dr Alekozoglou to bring to the attention of other general practitioners and members of the public the seriousness of a medical practitioner engaging in inappropriate practice.

Potential dislocation of Dr Alekozoglou's practice and the consequent effect on his patients

[75] We accept the evidence of Dr Alekozoglou that should he be disqualified from claiming payment for services rendered under the scheme it will have an adverse effect on many of his patients who will be forced to seek medical assistance elsewhere. This will be particularly disruptive for patients in aged care facilities who often will be unable to seek alternative assistance easily.

[76] On the basis of the evidence of Mr Thomson we are satisfied that that there are at least 10 Greek-speaking general practitioners practising within six kilometres of Dr Alekozoglou's practice. We are satisfied that alternative services are reasonably available to Dr Alekozoglou's patients. We take into account also the evidence of Dr Alekozoglou that on a previous occasion on which he was disqualified there was no unreasonable difficulties caused to his patients. For the reasons already stated the patient statements do not assist us in reaching a conclusion in this regard.

CONCLUSION

[77] Having considered all of the evidence we have concluded that any difficulties which may arise from Dr Alekozoglou's being fully disqualified for a period are far outweighed by the various considerations in favour of such action and we decide that a period of full disqualification is appropriate in this case.

[78] In view of Dr Alekozoglou's history of repeated inappropriate practice over a long period and his reluctance to take meaningful steps to remedy the situation, a significant period of disqualification is appropriate. This will be in addition to the period of disqualification already served by Dr Alekozoglou. However we do take into account that many of Dr Alekozoglou's patients are elderly and some are resident in aged care facilities. It will be likely to be more difficult for these patients to obtain alternative care. Had it not been for this particular aspect of Dr Alekozoglou's practice we would have given consideration to a longer period of disqualification. We consider that the period of disqualification of three months imposed by the Medicare Participation Review Committee is appropriate.

[79] The reviewable decision of the Medicare Participation Review Committee made 16 March 2012 is varied to read as follows:

> Pursuant to section 124FAA of the *Health Insurance Act 1973* (Cth) Dr Ioakim Alekozoglou Medical Practitioner who practises at 138 Melville Road, Brunswick West Victoria is fully disqualified for a period of three (3) months, such period of disqualification to commence on 14 March 2013.

It has been argued that section 106U is unconstitutional in that it purports to confer the judicial power of the Commonwealth on the Determining Authority. These arguments have been rejected by the Full Court of the Federal Court. *Tankey v Adams* and *Health Insurance Commission v Grey* concerned an earlier iteration of the PSR scheme and the Constitutional challenge was against the Professional Services Review Tribunal. Under that scheme once a PSR Committee had found inappropriate practice, the matter was referred to a Determining Officer who made a determination under section 106U. The person under review could request the Minister to refer that decision to a Professional Services Review Tribunal for review. While these two cases concerned the previous version of the PSR scheme, their application to the current PSR Scheme was endorsed by the Full Federal Court in *Selim v Lele*. The question was abandoned in the High Court on appeal in *Wong's case* (which was an appeal to the High Court from *Selim v Lele*).

Tankey v Adams [2000] FCA 1089 —

> [23] In our view, contrary to the argument advanced on behalf of the appellant, the Tribunal was not concerned with the ascertainment of legal rights and obligations. It is true that s 106U contemplated that the Determining Officer might make a direction for repayment to the Commonwealth of an amount equivalent to any medicare benefit paid for inappropriate services (s 106U(c)) or for payment of an amount in addition to that payable under s 106U(c). However, the making of a direction of that kind was not predicated on the ascertainment of any existing liability in the practitioner. The liability, in the sense of a debt due to the Commonwealth, arose on the making of the determination. Similar observations apply to directions under s 106U(f) and (g) effecting a revocation or suspension of the authority to prescribe a pharmaceutical benefit or a partial or total disqualification from the provision of services.
>
> [24] Another consideration which militates against regarding the power conferred on the Tribunal as judicial is that the Tribunal was required to review a determination of the Determining Officer based on a report by a Committee that a practitioner had engaged in "inappropriate practice" as defined in s 82(1). That is not a phrase which has any parallel with "traditional judicial concepts" as Windeyer J called them in *The Queen v Trade Practices Tribunal; Ex parte Tasmanian Breweries Pty Ltd* [1970] HCA 8; (1970) 123 CLR 361 at 399. Rather, it is a concept which depends for its application on peer review which is, of its nature, a delegated administrative function of government rather than the exercise of judicial power; see also *Reg v Spicer; Ex parte Australian Builders' Labourers' Federation* [1957] HCA 81; (1957) 100 CLR 277 per Kitto J at 305. This impression is reinforced, first, by the fact that an examination of a practitioner's conduct could only be initiated by reference from the Health Insurance Commission. It was, in no

sense, able to be initiated in vindication of a private or individual right; see *Tasmanian Breweries* (supra at 402).

[25] In the second place, the debt to the Commonwealth which came into existence upon the giving of a direction under s 106U(1)(c) was not directly enforceable by the Director or the Tribunal. It had to be sued for in a court of competent jurisdiction. By contrast, the facility to make a determination which is immediately binding or conclusive between the parties is a characteristic aspect of judicial power. Thus, in *Brandy v Human Rights and Equal Opportunity Commission* [1995] HCA 10; (1995) 183 CLR 245, it was observed in the joint judgment of Deane, Dawson, Gaudron and McHugh JJ at 268-269:

> "However, there is one aspect of judicial power which may serve to characterise a function as judicial when it is otherwise equivocal. That is the enforceability of decisions given in the exercise of judicial power. In Waterside Workers' Federation of Australia v J W Alexander Ltd [(1918) [1918] HCA 56; 25 CLR 434 at 451], Barton J said:
>
> "It is important to observe that the judicial power includes with the decision and the pronouncement of judgment the power to carry that judgment into effect between the contending parties. Whether the power of enforcement is essential to be conferred or not, when it is conferred as part of the whole the judicial power is undeniably complete."

And in *Federal Commissioner of Taxation v Munro* [(1926) [1926] HCA 58; 38 CLR 153 at 176], Isaacs J pointed out that the concept of judicial power includes enforcement: the capacity to give a decision enforceable by execution. It was this characteristic of judicial power which was emphasised by Latham CJ in *Rola Co (Australia) Pty Ltd v The Commonwealth* [(1944) [1944] HCA 17; 69 CLR 185 at 198-199]. He pointed to the fact that in *Huddart, Parker & Co Pty Ltd v Moorehead* Griffith CJ referred not only to the giving of a binding and authoritative decision as being indicative of the exercise of judicial power, but also spoke of such a decision being given by a tribunal "called upon to take action". Thus, Latham CJ pointed out, where a tribunal is able to give a binding and authoritative decision and is able to take action so as to enforce that decision, "all the attributes of judicial power are plainly present" [*Rola Co (Australia) Pty Ltd v The Commonwealth* (supra, at 199)].

[26] In *Attorney-General (Cth) v Breckler* (1999) 197 CLR 83 at 109-112, the High Court referred to *Tasmanian Breweries* when holding that a decision of the tribunal established under the *Superannuation (Resolution of Complaints) Act 1993* (Cth) reviewing a decision of a trustee of a regulated superannuation fund did not create a new charter by reference to which the existence of the rights or obligations of the parties to the complaint were to be decided between those persons or classes of persons. There was not, as there was in Brandy, a mechanism of registration whereby a non-binding administrative determination was converted into a binding, authoritative and curially enforceable determination. Rather, in *Breckler*, the trustees became obliged to observe determinations of the tribunal by force of a variation to the trust deed and the status of the superannuation scheme as a regulated scheme. Moreover, determinations of the tribunal were not immune from collateral attack in properly constituted curial proceedings.

[27] A related indication of the absence of judicial power is that the armoury of directions which might be made under s 106U in consequence of a determination includes directions for reprimand and counselling which are foreign to the exercise of judicial power, even for the punishment of criminal offences. It is true that all of the directions available under s 106U(1) have a disciplinary flavour but that does not entail that they could only be given in the exercise of judicial power. Even a power to impose a fine, if exercisable as part of a disciplinary scheme applicable to members of a identifiable class by virtue of their relationship with the Commonwealth, is not inherently judicial. Thus, it was observed in the joint judgment of the High Court in *The Queen v White; Ex parte Byrnes* [1963] HCA 58; (1963) 109 CLR 665 at 669-671:

> "If as a result of s. 55(1) and s. 55(3)(d)(1) [of the Public Service Act] the section were construed as enabling the tribunal to impose a fine which was recoverable at law by any lawful means, that would explain the view insisted upon by the applicant that the section invades the realm of the judicial power of the Commonwealth but we do not think that the provisions of the Act should be so construed. We think that the so-called fine is nothing but a mulct to be deducted from salary or pay and we think that the provisions of s. 55, in spite of the heading of Div 6, "Offences", should be interpreted as wholly concerned with breaches of discipline and disciplinary measures concerned only with the Service. Division 6 is, of course, limited to the Service and we are not here dealing with a law having general operation over all the members of the community. We are dealing with the regulation of what is, no doubt, a very large body of people with respect to their work for and their relations with the Commonwealth Crown. The expressions used in sub-s. (1) of s. 55 relate of course to conduct which is treated as open to considerable objection on what may be Service grounds but it should be kept steadily in mind that the so-called punishment must be determined by officers acting under the provisions of the subsequent sub-sections of s. 55. Again, when par. (d) of sub-s. (3) is examined, it is seen that no inconsiderable portion of the disciplinary measures which it authorizes relates simply to status, conditions or other relations in the Service. The Appeal Board is mentioned in the proviso to sub-s. (3) and further dealt with in sub-ss. (4), (5), (6), (6A), (7), (8), (9), (9A), (10) and (11).

As has already appeared, we think that Div 6 of Pt. III of the Act relating to offences is part of the law regulating the relationship between the Commonwealth and its servants; it is a law with very special application. Section 55, in creating so-called "offences" and providing for their "punishment", does no more than define what is misconduct on the part of a public servant warranting disciplinary action on behalf of the Commonwealth and the disciplinary penalties that may be imposed or recommended for such misconduct; it does not create offences punishable as crimes. The formalities prescribed in ss. 55, sub-ss. (3), (5) and (7), and 57, 58 and 60 (which counsel for the applicant described as "judicial trappings") are directed to safeguarding public servants from possible official injustice in the determinations whether there has been departure from the "code" established by s. 55(1) and, if so, what punishment should be imposed. The establishment of these safeguards does not indicate that an officer whose conduct is being investigated is being tried for a criminal offence; indeed in the Act a clear distinction is drawn between criminal offences committed by public servants (s. 62) and breaches of the disciplinary code established by s. 55(1)."

[28] Similar views were expressed by Davies J in *Yung v Adams* (1998) 80 FCR 453 at 472 about the directions which can be given under s 106U of the Act. His Honour there said:

> "In *Clyne v Bar Association (NSW)* [1960] HCA 40; (1960) 104 CLR 186 the High Court pointed out (at 201-202) that, although disbarment is sometimes referred to as "the penalty of disbarment", it was in no sense punitive in character. In the course of their reasons, Dixon CJ, McTiernan, Fullagar, Menzies and Windeyer JJ referred to the fact that, in one of the proceedings brought in the Supreme Court of New South Wales against Mr Clyne on a charge of unprofessional conduct, the charges had been withdrawn on his giving an undertaking (at 202) "to abide by the recognised standards which should govern the conduct of members of the profession". Similarly, in *Bar Association (NSW) v Evatt* [1968] HCA 20; (1968) 117 CLR 177 Barwick CJ, Kitto, Taylor, Menzies and Owen JJ said (at 183-184) that:
>
> > "The power of the Court to discipline a barrister is, however, entirely protective, and, notwithstanding that its exercise may involve a great deprivation to the person disciplined, there is no element of punishment involved."
>
> Their Honours went on to say (at 184):
>
> > "The respondent's failure to understand the error of his ways of itself demonstrates his unfitness to belong to a profession where, in practice, the client must depend upon the standards as well as the skill of his professional adviser."
>
> As those cases show, directions under s 106U with respect to a reprimand, counselling, the repayment of benefits and disqualification are not imposed as a punishment. They are imposed with a view to protecting patients and the Commonwealth against abuse of the system."

[29] For these reasons, we have concluded that the learned primary Judge was plainly right when he concluded that the Tribunal, when reviewing a Determining Officer's final determination and directions given under s 106U, was not exercising judicial power.

Health Insurance Commission v Grey [2002] FCAFC 130 —

[75] On behalf of Dr Grey, it is submitted that the authority vested by Parts VAA and VA of the Act in the Committee (under s 93), the Determining Officer (under s 106Q) and the Tribunal (under s 108) respectively, was judicial power purportedly vested in a non-judicial body, contrary to s 71 of the Constitution; and that, accordingly, the enactment of s 94 - s 106F, and of s 106M - 121, was beyond the Commonwealth's legislative power.

[76] Specifically, Dr Grey contends:

- Parts VAA and VA of the Act create a tiered scheme by which judicial power is invested in the decision-makers thereby appointed as follows:-

(a) The first level of decision-making involves a Committee set up under s 93 as the tribunal of fact, and the Determining Officer appointed under s 106Q, as the tribunal imposing the penalty.
(b) It is important that in the entire process of review (as it is called) under Parts VAA and VA, the practitioner has but one opportunity only to have a full hearing on the merits before a decision affecting him is made.
(c) At the least, a finding by a Committee that the practitioner has engaged in "inappropriate practice", is a finding that the practitioner has been guilty of engaging in conduct which would be unacceptable to the general body of general practitioners (s 82(1)(a)) which requires that he be reprimanded and/or counselled (s 106U(1)(a) and (b)). But, upon the making of that finding, much more serious penalties may be imposed, which require the practitioner to pay to the Commonwealth a substantial amount and/or (for all practical purposes) which may destroy his medical practice by disqualifying him from the provision of services under the Act. The finding alone must damage his professional standing and reputation, whether or not it is communicated outside the walls of the Commission.

- The creation by the Parliament of a scheme, whereby a finding may be made against a medical practitioner that he has engaged in "inappropriate practice", and whereby one or more decisions must be made in reliance upon that finding, including decisions of serious, enduring and adverse consequences, is a grant, to the person or persons concerned, of judicial power. This must be so, regardless of whether the bodies or persons making findings of fact are other than the persons making decisions upon those findings. That one of the decision-makers in this scheme does not make the decisions upon penalty is irrelevant to the question of whether or not there has been an impermissible grant of judicial power under the Professional Services Review Scheme.

- The decision of the Full Court in *Tankey v Adams*, above, rejecting a more limited constitutional challenge, that the power conferred on the Tribunal under Part VA is an impermissible grant of judicial power, is plainly wrong and ought not to be followed. Alternatively, the decision in that case must be distinguished as applying only to questions related to the duties and functions of the Tribunal, when considered in isolation from the overall scope and intent of the Professional Services Review Scheme created by Part VA.

(b) Conclusions on the cross-appeal

[77] We cannot accept that either Part VAA (i.e. the Committee and Determining Officer) or Part VA is invalid on any of the grounds suggested. Moreover, in our respectful opinion, *Tankey* was plainly a correct decision, applying as it did a well-settled course of authority in the High Court.

[78] A similar argument was recently rejected by Tamberlin J in *Tisdall v Health Insurance Commission* [2000] FCA 97. His Honour said (at [128] - [130]):

"This was not argued before me because it was agreed that I am bound by the Full Court decision in *Tankey v Adams* [2000] FCA 1089 which held that a Committee established under the Health Insurance Act was not exercising judicial, as opposed to administrative power. In my view, this conclusion is correct and it is binding on me.

> Having regard to the well-settled principles as to what constitutes an exercise of the judicial power of the Commonwealth, set out in detail in *Tankey*, there is no exercise of judicial power by the Committee in this matter.
>
> The Committee Report does not amount to a decision which will affect rights or obligations. It makes a finding as to the character of certain specified conduct. Further action on the Report will depend on the decision of the Determining Officer, which is subject to review and thereafter to appeal to the Court. The Committee has no power to enforce its determinations. It simply makes a finding on conduct measured against the practice of the general body of practitioners. It may give rise to circumstances which might, if other action were taken, affect the practitioner but this is not sufficient to constitute an exercise of the judicial power of the Commonwealth."

[79] We respectfully agree.

[80] In the present connection, it will be convenient to consider collectively the respective positions of the Committee, the Determining Officer and the Tribunal under the statutory Scheme.

[81] As has been mentioned, the ultimate statutory function of the Committee is that, upon duly making its inquiry, it "must give to the Determining Officer a written report setting out its findings on whether, in its opinion, the person under review engaged in inappropriate practice in connection with the referred services" (s 106L(1)); the ultimate statutory function of the Determining Officer is, after making and giving a draft, to make a determination containing one, or more, directions (s 160U(1)).

[82] The Tribunal's ultimate statutory function is, upon review, to affirm or set aside (etc.) the determination (s 119(1)).

[83] In *Tankey*, as has been noted, the Full Court (Ryan, O'Connor and Weinberg JJ) rejected an argument that the Tribunal was a repository of judicial power. In our opinion, their Honours were correct in their decision, for the reasons they gave, which we will explain below. Moreover, as Finkelstein J held here, the position of the Committee is at least analogous to that of the Tribunal for present purposes.

[84] In *Tankey*, the Full Court relied (at [19]) upon frequently cited observations of the High Court in the *Re Ranger Uranium Mines Pty Limited; Ex parte Federated Miscellaneous Workers' Union of Australia* [1987] HCA 63; (1987) 163 CLR 656 (at 665 - 666) for the proposition that -

> "... the fact that [a body - there the Tribunal] was involved in the determination of facts and the application of concepts like `inappropriate practice' which have been defined by statute, does not entail that the [body] was exercising judicial power. It is necessary ... to identify the purpose for which the [body] has been required to exercise its power of inquiry and determination".

[85] In our view, these remarks, although directed at the Tribunal's position, are also apposite in the case of the Committee and the Determining Officer.

[86] The Full Court in *Tankey* went on (at [21]) to cite other frequently cited observations of the High Court in this area in *Precision Data Holdings Limited v Wills* (1991) 173 CLR 167 at 188 - 189, that is to say, that functions may be classified as either judicial or administrative "according to ***the way in which*** they are to be exercised" (emphasis added). Thus, "if the ***ultimate*** decision may be determined ***not merely by the application of legal principles to ascertained facts but by consideration of policy also***, then the determination does not proceed from an exercise of judicial power" (emphasis added).

[87] The Full Court in *Tankey* proceeded (at [23]) to hold that the Tribunal "was not concerned with the ascertainment of legal rights and obligations". Whilst acknowledging the Determining Officer's statutory power to direct repayment (s 106U), the Full Court observed that such a direction "was not predicated upon the ascertainment of any existing liability in the practitioner".

[88] We agree with these observations, which are expressly applicable in the case of the Tribunal and the Determining Officer, and implicitly extend to the analogous situation of a Committee in this context.

[89] The Full Court in *Tankey* went on to say (at [24]):

> "Another consideration which militates against regarding the power conferred on the Tribunal as judicial is that the Tribunal was required to review a determination of the Determining Officer based on a report by a Committee that a practitioner had engaged in `inappropriate practice' as defined in s 82(1). That is not a phrase which has any parallel with `traditional judicial concepts' as Windeyer J called them in *The Queen v Trade Practices Tribunal; Ex parte Tasmanian Breweries Pty Ltd* [1970] HCA 8; (1970) 123 CLR 361 at 399. Rather, it is a ***concept which depends for its application on peer review which is, of its nature, a delegated administrative function of government rather than the exercise of judicial power***; see also *Reg v Spicer; Ex parte Australian Builders' Labourers' Federation* [1957] HCA 81; (1957) 100 CLR 277 per Kitto J at 305. This impression is reinforced, first, by the fact that an examination of a practitioner's conduct could only be initiated by reference from the Health Insurance Commission. It was, in no sense, able to be initiated in vindication of a private or individual right; see *Tasmanian Breweries* (supra at 402)." (Emphasis added)

[90] We agree. It follows, in our view, that the Committee was not exercising judicial power.

[91] So far as concerns the functions of the Director and the Tribunal under the statutory scheme, the Full Court in *Tankey* went on to say (at [25]), in a passage with which we also agree, that -

> "... the debt to the Commonwealth which came into existence upon the giving of a direction under s 106U(1)(c) was not directly enforceable by the Director or the Tribunal. It had to be sued for in a court of competent jurisdiction. By contrast, the facility to make a determination which is immediately binding or conclusive between the parties is a characteristic aspect of judicial power."

[92] Their Honours added (at [27]):

> "A related indication of the absence of judicial power is that the armoury of directions which might be made under s 106U in consequence of a determination includes directions for reprimand and counselling which are foreign to the exercise of judicial power, even for the punishment of criminal offences. It is true that all of the directions available under s 106U(1) have a disciplinary flavour but that does not entail that they could only be given in the exercise of judicial power. Even a power to impose a fine, if exercisable as part of a disciplinary scheme applicable to members of a identifiable class by virtue of their relationship with the Commonwealth, is not inherently judicial."

[93] Again, we concur.

[94] It follows, in our opinion, that none of the functions exercised under Part VAA or part VA involved the exercise of judicial power. Accordingly, the cross-appeal must be dismissed.

Hill v Keith [2002] FCAFC 7 —

[4] The legislative scheme in Parts VAA and VA of the Act is set out in detail in our reasons for decision in *Health Insurance Commission v Grey* [2002] FCAFC 130 ("*Grey*") and we will not repeat that exposition. The contention that the Committee, the Determining Officer and the Tribunal exercise the judicial power of the Commonwealth contrary to s 71 of the *Constitution* was rejected in *Grey* as it had been by an earlier Full Court decision in *Tankey v Adams* [2000] FCA 1089; (2000) 104 FCR 152 ("*Tankey*"). Mr Shand QC, who appeared for the appellant, described this as a formidable body of authority, but said that the appellant "desires to pursue the appeal in order to preserve her rights". Before us the appellant deployed essentially the same arguments as those that had been advanced in *Grey*. They followed the form of the written submissions that had been filed, and since they are on the Court file and the submissions did not depart from them, we need not attempt to summarise those submissions.

[5] In *Grey* the Court dealt in detail with the arguments comparable with those advanced by Mr Shand, rejecting all of them. We do not propose to repeat here what we have so recently written in *Grey*. We incorporate here by reference what we said there. The appellant has not convinced us that *Grey* and *Tankey* are clearly wrong, and accordingly we should follow those decisions. See *Transurban City Link Ltd v Allan* [1999] FCA 1723; (1999) 95 FCR 553 at 560. It follows that the sole ground of appeal fails and the appeal must be dismissed with costs.

Selim v Lele [2008] FCAFC 13 —

The judicial power of the Commonwealth

[51] In *Tankey v Adams* [2000] FCA 1089; (2000) 104 FCR 152 a Full Court of this Court (Ryan, O'Connor and Weinberg JJ) rejected an argument that s 106U of the Act impermissibly confers the judicial power of the Commonwealth upon a body other than a Ch III court. The Court was then considering the Act as it was prior to the 1999 amendments, when the Determining Officer made the determination under s 106U, with the Professional Services Review Tribunal having the power to review that decision. Counsel for the doctors conceded that the amendments to the Act

were not such as to cast any doubt on the applicability of *Tankey* [2000] FCA 1089; (2000) 104 FCR 152 to Pt VAA as it was in force during the period relevant for these cases. Rather, the doctors' argument was that the decision in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152 should be reconsidered in light of what the High Court said in *Rich v Australian Securities and Investments Commission* [2004] HCA 42; (2004) 220 CLR 129.

[52] One of the reasons for the Full Court's decision in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152 was its characterisation of the Determining Officer's power under s 106U as protective, as opposed to punitive. In *Rich* (2004) 220 CLR 129 the High Court did cast doubt upon the validity of this distinction, albeit in the context of considering whether exposure to the penalties that the Australian Securities and Investments Commission (ASIC) can impose enlivens a privilege against the obligation to make discovery in civil proceedings. The Court was not concerned with an issue of the judicial power. This is not to deny the relevance of the High Court's observations to what was decided in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152, but the characterisation of the power as protective and not punitive was only one of many relevant factors considered by the Full Court. In *Health Insurance Commission v Grey* [2002] FCAFC 130; (2002) 120 FCR 470 another Full Court (Beaumont, Sundberg and Allsop JJ) rejected an argument that the Act impermissibly vested the judicial power of the Commonwealth in PSR Committees, and in doing so summarised the Court's decision in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152 in these terms (at 478):

> The Full Court held that the Tribunal was exercising administrative power, so that Ch III was not applicable. A number of factors led to that conclusion. First, the Tribunal was not concerned with the ascertainment of legal rights and obligations. Secondly, the Full Court said, the determination whether a practitioner had engaged in "inappropriate practice" is not a traditional inquiry: "[I]t is a concept which depends for its application on peer review which is, of its nature, a delegated administrative function of government rather than the exercise of judicial power": *Tankey v Adams* at 162. Thirdly, the Full Court drew attention to the fact that any determination by the Tribunal was not directly enforceable by it.

[53] As can be seen, several factors informed the Full Court's decision in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152, and the characterisation of the power as "protective" was a relatively minor element which was not seen to warrant a mention in *Grey* [2002] FCAFC 130; (2002) 120 FCR 470 in that Full Court's summary of the earlier case. The recent decision of the High Court in *Attorney-General (Cth) v Alinta Ltd* [2008] HCA 2 where the court considered the constitutional validity of the powers and functions of the Takeovers Panel casts no doubt upon the Full Court decision in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152. In determining whether the Panel was exercising judicial power such that the authorising legislation would be inconsistent with Ch III, the Court was careful to emphasise that "no single combination of necessary or sufficient factors identified what is judicial power": at [93] per Hayne J; and see also at [5]-[7] per Gleeson CJ, at [9] per Gummow J, at [34]-[48] per Kirby J, at [105] per Heydon J and at [151] per Crennan and Kiefel JJ.

[54] It was said on behalf of the doctors that this Court should decline to follow *Tankey* [2000] FCA 1089; (2000) 104 FCR 152. An intermediate court of appeal will, as a matter of practice, determine for itself whether it will treat itself as bound by its previous decisions or, if not, the extent to which it will feel itself free to depart from those decisions: *Nguyen v Nguyen* [1990] HCA 9; (1990) 169 CLR 245 at 268 (per Dawson, Toohey and McHugh JJ). If it adopts the practice that it is free to depart from an earlier decision "it should do so cautiously and only when compelled to the conclusion that the earlier decision is wrong": *Nguyen v Nguyen* at 269. This Court has determined that it is free to depart from its earlier decisions: *Chamberlain v The Queen (No 2)* [1983] FCA 78; (1983) 72 FLR 1; *Transurban City Link Ltd v Allan* [1999] FCA 1723; (1999) 95 FCR 553 at 560-1. In *Chamberlain* [1983] FCA 78; (1983) 72 FLR 1 at 8-9, the Court said that it would "normally follow an earlier decision unless convinced that it is wrong." Put another way, whilst this Court is not strictly bound by its previous decisions, this Court will only decline to follow a previous decision of the Court if it is satisfied that that decision is plainly wrong and to continue to follow that decision would perpetuate error: *New Zealand v Moloney* [2006] FCAFC 143; (2006) 154 FCR 250 at [133]- [137].

[55] The primary contention advanced by the doctors that s 106U was invalid because it purports to confer the judicial power of the Commonwealth on persons who have not been appointed pursuant to s 72 of the Constitution was rejected in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152. It was reagitated in *Grey* [2002] FCAFC 130; (2002) 120 FCR 470 and, for the separate reasons given by that Court, rejected again. Whilst this Court has adopted for itself a practice whereby in circumstances mentioned it is free to decline to follow a previous decision, it is almost inconceivable as a matter of practice that this Court would be satisfied that two closely reasoned decisions of the Court on the same point reaching the same conclusion were plainly wrong. This Bench should, for those reasons, follow this Court's two previous decisions.

[56] In any event, we are not satisfied that the two decisions which the applicants and appellant ask this Court not to follow are plainly wrong. Indeed, we are satisfied that those decisions are plainly right for the reasons relied upon subject to the caveat that the distinction between protective and punitive legislation may not be a relevant consideration. That being the case, this Court should follow the decision in *Tankey* [2000] FCA 1089; (2000) 104 FCR 152 and the subsequent decision in *Grey* [2002] FCAFC 130; (2002) 120 FCR 470. Any declaration that those decisions are wrong must now be for the High Court: *Transurban* [1999] FCA 1723; (1999) 95 FCR 553 at 560.

106U(1A) — limit on direction for repayment for a class of services

Subsection 106U(1A) limits the amount the determining authority can direct to be repaid under paragraph 106U(1)(cb) for a class of services by reference to 'the lowest rate that was payable for any of the services included in the class'. In so doing, the subsection deems an amount to have been paid, rather than requiring it to consider the actual amount that was paid.

Notably, the subsection does not refer to the lowest 'amount' that was paid, but rather refers to a 'rate', and it refers to what 'was payable' rather than what 'was paid'. It does not require ascertaining the lowest amount paid for any service in the class of services, but requires knowledge of the lowest 'rate that was *payable*' for any service in the class.

This is determined by considering the fees and rules within the relevant regulations that were in force from time to time during the review period, and the circumstances in which the practitioner provided their services. For some MBS items, there is a lower rate payable if a service is provided in a hospital than if it is provided in a private practice. For other items, there is a multiple services rule that applies where certain services are provided in association with each other. It is necessary for the determining authority to have regard to the circumstances in which the practitioner provided the relevant class of services during the review period to decide whether any of those rules applied to services in the class of services under consideration, and to know what was the lowest rate at which such services in each class 'was payable'.

A practitioner could not benefit by seeking to artificially lower the 'rate payable' by charging a nominal amount for one service in each class of services each year so that if the determining authority were to impose a sanction, only that nominal amount would be applied across the entire class of services. That is because the subsection does not refer to the 'lowest amount paid' for any of the services, but the 'lowest rate payable' for any of the services. The 'rate payable' is the rate set out by legislation and applicable to *any* services in the class as affected by the circumstances in which the services were provided by that practitioner (such as in-hospital services or application of a multiple services rule). To read the subsection as to allow such a practice would be to defeat a significant purpose of the scheme—to protect the Commonwealth from having to meet the cost of services provided as a result of inappropriate practice (paragraph 79A(b)).

106V When final determinations take effect

The final determination takes effect on the 35th day after the day on which the Determining Authority gave a copy of it to the person under review. However, if a proceeding is instituted in a court in respect of the final determination, the determination takes effect, subject to any order of the court, on one of various dates as specified in the section after the action has been finalised.

The section operates as an automatic stay of a final determination as soon as an action has commenced, even if the originating application to the Court is inadequate.

Mitchelson v Health Insurance Commission (No. 3) [2007] FCA 1491 —

> [12] Section 106V(1) provides that a final determination takes effect on the 35th day after the day on which the Determining Authority gives a copy of the determination to the person under review subject to s 106V(2) which provides:
>
> > (2) If, before the 35th day, a proceeding is instituted in a court in respect of the final determination, the determination takes effect at the end of the prescribed number of days after:
> > (a) the day on which the court gives its decision; or
> > (b) if an appeal is instituted against the decision but the appeal is withdrawn or discontinued – the day on which the appeal is withdrawn or discontinued; or
> > (c) if an appeal is instituted against the decision and the appeal is decided – the day on which a court gives its decision on the appeal or, if there are further appeals, on the ultimate appeal.
>
> [13] The term 'prescribed number of days' means in relation to a proceeding (including an appellate proceeding) in a court other than the High Court – 35 days.
>
> [14] The provisions of the Act establishing a scheme for the review and investigation of the provision of services by a person to determine whether that person has engaged in inappropriate practice fall within Part VAA the object of which is to protect the integrity of the Commonwealth medicare benefits and pharmaceutical benefits programmes and, in doing so: (a) protect patients and the community in general from the risks associated with inappropriate practice; and (b) protect the Commonwealth from having to meet the costs of services provided as a result of inappropriate practice (s 79A).
>
> [15] The Act and particularly Part VAA has been described as 'public protective' legislation which should not be narrowly interpreted as the legislation has as its object the 'protection of the public' (*Health Insurance Commission and Ors v Grey* [2002] FCAFC 130; (2002) 120 FCR 470 [173] and [179]).
>
> [16] This is the third occasion on which the applicant's proposal to amend his proceeding has come before the Court. The applicant initially sought to challenge the decision of the Authority by filing the Notice of Appeal of 8 May 2007. The grounds raised were these:
>
> > 4.1 The applicant appeals against the findings of the Determining Authority of 5 April 2007 on the following grounds:
> >
> > 4.2 As a matter of law erred in reaching the conclusion that they did in fact make.
> >
> > 4.3 As a matter of law the conclusions reached was in error by failing to take into account relevant considerations.
> >
> > 4.4 As a matter of law erred in failing to take into account relevant considerations.

4.5 As a matter of law the penalty that was imposed was manifestly excessive.

[17] Sections 11(1)(c) and 11(3)(a) required Dr Mitchelson file an application for an order of review not later than 28 days after receipt by him of a decision setting out findings on material questions of fact, references to the evidence supporting those findings and reasons for the decision. Dr Mitchelson was served with the decision material on Wednesday 11 April, 2007 by courier delivery to Karen O'Mullane, a legal representative from United Medical Protection now known as Avant Mutual Group Limited. Ms O'Mullane represented Dr Mitchelson before the PSR Committee. Mr Royds is informed by Dr Mitchelson and swears to a belief that the material was received by Dr Mitchelson on 15 April 2007. Accordingly, the 28 days provided for by the ADJR Act expired on either 9 May 2007 or 13 May 2007. The Notice of Appeal filed on 8 May 2007 was within time although entirely devoid of any proper formulation of the grounds of review or any material facts in support of those grounds.

[18] The question of an amendment first arose at a Directions Hearing conducted on 12 July 2007, it became clear that Dr Mitchelson proposed to file an Amended Notice of Appeal and accordingly the Court ordered that an Amended Notice of Appeal be filed by Monday 30 July 2007. The directions of 12 July 2007 provided Dr Mitchelson with a further 18 days beyond 12 July to properly formulate an Amended Application for an order of review setting out properly identified grounds in support of an order having regard to s 5 of the ADJR Act and the material facts (properly particularised) in support of the contended grounds. By 30 July 2007, 106 days had elapsed since Dr Mitchelson had, on his evidence, received the decision material yet no application beyond that formulated as the 'Notice of Appeal' had been filed. During this period Dr Mitchelson had the benefit of s 106V(2) preventing the determination of the Authority taking effect. The applicant failed to comply with the direction order made on 12 July 2007.

[19] The matter was to be relisted for further directions on 6 August 2007 on the footing that by that date, an amended document would have been filed by Mr Royds on behalf of Dr Mitchelson. That directions date was vacated. On 3 August 2007, the respondents filed the present Notice of Motion returnable on Tuesday 28 August 2007. On Friday 24 August, 2007 Dr Mitchelson filed the amended application. On the hearing of the respondent's motion, Mr Royds again sought leave to amend the Notice of Appeal. This time in terms of the amended application filed on 24 August 2007. Mr Royds said it was clear that the Notice of Appeal would need to be amended; it was filed in circumstances of urgency, it misdescribes the true character of the initiating document; the document is in substance an application for an order of review; and leave ought to be granted to amend the document in terms of the amended application.

[20] On 28 August, the court refused leave to amend the Notice of Appeal in terms of the amended application and made a direction that 'the applicant in the proceedings file and serve an Application supported by appropriate material for leave to amend the document described as the 'Notice of Appeal' filed on 8 May 2007 so as to properly formulate having regard to identified grounds and particulars of those grounds, an Application for an Order of Review of an identified decision for the purposes of the ADJR Act' (Mitchelson [23]). By 28 August, the second time the question arose, 134 days had elapsed since Dr Mitchelson had received the

decision material. Plainly enough, within that time, Dr Mitchelson ought to have been able to formulate precise grounds of challenge to the Authority's decision and the material facts in support of those grounds especially having regard to the statutory stay effected by s 106V(2) of the Act. The Court further directed that the application for leave to amend the Notice of Appeal would be listed and heard on Tuesday 18 September 2007 at 10.15 am. When the matter came on for hearing on 18 September, the applicant relied upon a notice of motion filed on 12 September which simply sought leave to amend in terms of the same document filed on 24 August 2007. Dr Mitchelson has made no effort to reformulate the amended application to either identify with any precision the grounds of challenge or the material facts giving content and expression to those grounds. Shortly prior to Tuesday 18 September, Mr Royds sought approval to appear and argue the application for leave by telephone. Mr Royds then provided a mobile telephone number to the Court as the appropriate contact telephone number. Mr Moloney appeared in Court for the respondents.

[21] Although an application in such a manner by a lawyer for a party seeking leave to amend a document such as the inadequate 'Notice of Appeal' in the context of a decision of the importance to Dr Mitchelson of the Authority's decision is unsatisfactory, ultimately the matter is one for Mr Royds against the background of the earlier Orders made in the proceeding which have not been met and the perceived strength of the argument for leave. If the material filed in support of the application is clear, precise and compelling, an election to seek and obtain approval to support the application by attendance before the Court by telephone or mobile network telephone attendance, might be thought to be cost efficient since Mr Royds practices in Cairns. However, Mr Royds did not file any reformulation of the earlier amended application and by 18 September, 156 days had elapsed since Dr Mitchelson had received the decision material with a continuing statutory stay of the Authority's directions.

[22] Dr Mitchelson and Mr Royds have had more than enough time beyond the statutory 28 days prescribed by the ADJR Act to file a proper document.

[23] The statutory period of 28 days is not intended by the Act to operate simply as a holding or 'peg in the ground' period. Plainly enough, a party might file a document within a 28 day period which for a number of perfectly sensible reasons requires amendment or perhaps comprehensive amendment. In this case, slightly over 5 months have now elapsed since Dr Mitchelson received the decision material and the applicant has failed to comply with two Orders of the Court.

[24] Having regard to the objects of the Act, the protective nature of the legislation, the failure to comply with Orders and the long delay in attempting to formulate a proper application, I am prima facie inclined to exercise the discretion against granting leave.

…

[60] The question of a proposed amendment to the applicant's initiating document has been before the Court on three occasions; 12 July 2007, 28 August 2007 and 18 September 2007. The foundation document filed on 8 May 2007 was so inadequate that the proposed amended application is in truth the first attempt to formulate an

> ADJR ground of challenge supported by any facts. The amended application seems to be the best the applicant can say after 156 days (and two court orders) of reflection on the PSR Committee's findings having elected to make no oral submissions at the conclusion of the hearing nor written submissions notwithstanding the invitation by the committee chair to do both. During this period (over 5 months from receipt by Dr Mitchelson of the decision material) Dr Mitchelson has had the benefit of the statutory stay upon the Authority's directions taking effect and the consequent fulfilment of the statutory objective of protecting the public interest.
>
> [61] I am satisfied that the claims made by the applicant as formulated by the proposed amended application cannot succeed and are bound to fail in the sense identified by Bennett J in *Spotwire Pty Ltd v Visa International Services Inc* [2003] FCA 762; (2003) ATPR 41-949 at 47, 410. Accordingly, it would be futile to grant leave to amend in terms of the proposed document. I refuse leave to amend and dismiss the applicant's notice of motion filed on 12 September 2007.

For the purposes of bankruptcy law, a direction to repay medicare benefits is a contingent liability to the Commonwealth upon the making of the final determination, but it does not crystalise as such until the final determination becomes effective in accordance with section 106V.

Health Insurance Commission v Trustee in Bankruptcy of the Estate of Ioakim Alekozoglou [2003] FCA 848 —

> [51] I accept the submission of senior counsel for the HIC that an obligation must be a recognisable one created by law and must not be some amorphous vulnerability to a possible debt. I also accept that the obligation in this case arose from the final determination. As at the date of the final determination, a contingent liability existed in Dr Alekozoglou to the HIC for a debt in the amount specified in the final determination, made on 5 September 1997. That obligation crystallised when the final determination became effective on 9 October 1997.

In commencing action against a PSR entity, the individual members should not be named, rather the name of the entity or office should be named as the respondent to the action.

Commonwealth v Sex Discrimination Commissioner & Ors [1998] FCA 1607 —

> However, Sex Discrimination Commissioner is the name of an office created by s 96 of the Act. The holder of that office from time to time has not been created a corporation sole. The office itself is not a legal personality. It is presumably for this reason that proceedings against the Commissioner have on occasions in the past been commenced using the name of a particular holder of the office (see, for example, *Harris v Bryce* [1993] FCA 115; (1993) 41 FCR 388). However, for the reasons expanded upon by Moffitt P in *Kerr v Commissioner of Police* [1977] 2 NSWLR 721, difficulties can arise if the holder for the time being of a statutory office is individually named in legal proceedings in which orders are sought which

> are intended to bind a subsequent holder of the office. In the case of proceedings under the ADJR Act such difficulties would seem to be obviated by s 17 of the ADJR Act. I am aware, however, of no comparable provision which would have application to a proceeding under s 39B of the Judiciary Act. There is the further consideration, as Moffitt P pointed out in *Kerr v Commission of Police*, that the joining in proceedings of an office holder by name has the undesirable feature of suggesting personal involvement of the office holder with the parties in contest in the proceeding. In *Kerr v Commissioner of Police*, at 725, Moffitt P concluded that, on an application for an order in the nature of mandamus, subject to an exception not here relevant, "it is inappropriate, productive of problems and wrong" to join members of a tribunal by name or to join the holder of an office by his or her name. In my view, it would have been similarly inappropriate in this case for the Acting Sex Discrimination Commissioner to have been personally named as a party to this proceeding brought under the ADJR Act and pursuant to s 39B of the Judiciary Act. Section 17 of the ADJR Act will have the effect that any order of the Court under s 16 of the ADJR Act made against the Commissioner will bind the person for the time being holding or performing the duties of that office. In this respect s 17 would seem to be declaratory of the common law (*Kerr v Commissioner of Police*). In my view, it is similarly the case that any order made against the Commissioner in reliance of s 39B of the Judiciary Act will also bind the person for the time being holding or performing the duties of that office.

This case has been applied in *O'Halloran v Wood* [2004] FCA 544 and *Giddings v Australian Information Commissioner* [2017] FCA 677.

In *R v Australian Broadcasting Tribunal; ex parte Hardiman* (1980) 144 CLR 13 at 35-36, the High Court said that when a tribunal is a party to proceedings, 'the usual course is for a tribunal to submit to such order as the court may make' rather than take an active role in the litigation. In *Fagan v Crimes Compensation Tribunal* (1982) 150 CLR 666, Brennan J (as he then was) referred to circumstances in which a tribunal might be represented by Counsel.

Fagan v Crimes Compensation Tribunal [1982] HCA 49 (per Brennan J)—

> [13] In this case the Tribunal appeared by counsel as respondent to contest the appellant's case. Where curial proceedings arise out of a matter which is contested between parties appearing before a tribunal, it is not ordinarily appropriate for the tribunal to appear to contest the curial proceedings brought by one of the parties before it (*R v Australian Broadcasting Tribunal; Ex parte Hardiman* [1980] HCA 13; (1980) 144 CLR 13, at pp 35-36). But where the proceedings before the tribunal are not inter partes, and where the Attorney-General cannot or does not intervene to represent the public interest (cf. *Corporate Affairs Commission v Bradley* (1974) 1 NSWLR 391) and neither a law officer nor a public official is heard by the court (cf. *R v Cook; Ex parte Twigg* [1980] HCA 36; (1980) 147 CLR 15), it may be desirable that the tribunal should appear by counsel to make such submissions as it thinks calculated to assist the court and, in an appropriate case, to argue against the applicant's case. That is what was done in this case. Here, the Tribunal's function was to determine whether and to what extent a claimant was entitled under statute

to a payment out of public moneys. Though the Tribunal was bound to act impartially, it was in a sense the guardian of the moneys appropriated by Parliament to answer the proper claims for compensation under the Act. In proceedings to review its decision, the Tribunal properly represents the public purse, and it was right that the Tribunal should appear by counsel as a party to respond substantially to the application. It follows that the Tribunal should then be treated as an ordinary party in the matter of costs. Therefore I would make an order awarding the applicant his costs against the Tribunal both here and in the Supreme Court.

Ho v Professional Services Review Committee No 295 [2007] FCA 388 —

[108] However, I am more troubled about the question raised late in the argument that each of the committees has been the active respondent in the proceedings. Each of the committees submitted that there was no other respondent who had a right of appearance and that the committees were the only proper respondents in proceedings brought for judicial review of their decisions.

[109] I do not consider this to be a correct view. There is no doubt each of the committees is a proper and necessary party to such proceedings. After all, it is their decision which is challenged. If the Court were to make an order, it must make one in favour of or against the members of the committee whose decision is the subject of the proceedings for judicial review.

[110] The members of the tribunal are the relevant officers of the Commonwealth for the purposes of the proceedings and it is necessary that they be joined as parties to the proceedings: *SAAP v Minister for Immigration and Multicultural and Indigenous Affairs* (2005) 215 ALR 162 at 173 [43] per McHugh J, 185-186 [91] per Gummow J, 199 [153] per Kirby J, 204 [180] per Hayne J. Here, the tribunal took what the High Court said in *The Queen v Australian Broadcasting Tribunal; Ex Parte Hardiman* [1980] HCA 13; (1980) 144 CLR 13 at 35-36 was an unusual course of contesting the doctors' case for relief by presenting a substantive argument. Gibbs, Stephen, Mason, Aickin and Wilson JJ said:

> 'In cases of this kind the usual course is for a tribunal to submit to such order as the court may make. The course which was adopted by the Tribunal in this Court is not one which we would wish to encourage. If a tribunal becomes a protagonist in this Court there is the risk that by so doing it endangers the impartiality which it is expected to maintain in subsequent proceedings which may take place if and when relief is granted. The presentation of a case in this Court by a tribunal should be regarded as exceptional and, where it occurs should, in general, be limited to submissions going to the powers and procedures of the Tribunal.'

[111] The third respondent, now known as the Medicare Australia CEO, in a case like the present has an interest in defending the conduct of proceedings by a committee established under the Act. Such proceedings are initiated by a reference from the Medicare Australia CEO under s 86(1) and a final determination made by the determining authority is conveyed to the Medicare Australia CEO pursuant to s 106W. If for some reason in proceedings it is not appropriate to join the Medicare Australia CEO as the intended active respondent, the proper respondent must be the Minister administering the Health Insurance Act 1973 (Cth) for the time being. He

> or she is the officer of the Commonwealth who has the immediate interest in ensuring the due administration of legislation for which he or she is responsible under administrative arrangements and s 64 of the Constitution of the Commonwealth.
>
> [112] It is not satisfactory that the decision of a committee can be challenged, including on the basis that there is an apprehension of bias alleged against them, and have to defend themselves actively in proceedings of this kind, for the reasons given in *Hardiman* 144 CLR at 35-36. Moreover, the fact that each committee has defended its own interpretation of the legislation and their dismissal of the doctors' cases would suggest to a fair-minded lay person that they will find it difficult entirely to put out of their mind the approach which the Court in proceedings such as this finds to be erroneous if they were to come to reapply themselves to the task. Not everyone, especially a body which has actively defended themselves in contested litigation, would be able to approach the task anew, unaffected by the forensic demonstration of their previous error of approach. Moreover, there is no reason here not to order them to pay the doctors' costs. A fair-minded lay person would be entitled to think that the committees here would not have the equanimity of Sir Winston Churchill, who said:
>
> > 'In the course of my life, I have often had to eat my own words, and I must confess that I have always found it a wholesome diet.'
>
> [113] That is not to suggest any adverse view about the members of either of the two committees. There is no reason to doubt that they would try to apply the law as the Court has declared it. But it is unsatisfactory that having actively sought to uphold a view of the law and their conclusions adverse to the doctors, the same committees should then be called upon to reconsider the matter.
>
> [114] The second aspect of procedural fairness or natural justice is that a person should not be a judge in his or her own cause. Here, each committee has acted as a protagonist in this Court in their own cause and they now suggest they should be returned to the position of being a judge, in the sense of a lay tribunal charged with functions of administrative decision-making, in the same cause. That is an unsatisfactory outcome which should not occur unless it is necessary under the legislation: see *Laws v Australian Broadcasting Tribunal* [1990] HCA 31; (1990) 170 CLR 70 at 81-82 per Mason CJ and Brennan J, 96 per Deane J.

The two PSR Committees involved in the litigation in that case appealed the decision to the Full Court and were successful in arguing that they had not made an error of law. In consequence, the Full Court set aside the order of the Court at first instance. The Full Court noted the comments that had been made regarding the *Hardiman* principle.

Willcock v Do [2008] FCAFC 15 —

> [62] Dr Ho and Dr Do contended before the primary judge that, because the Committees focussed on practice management as a substantive answer to their reliance on exceptional circumstances, each Committee demonstrated an

> inflexibility of approach that would entitle a hypothetical fair minded lay person, properly informed as to the nature of the proceeding or process, reasonably to apprehend that each Committee might not have brought an impartial mind to making the decision. However, because his Honour considered that each Committee made an error of law in the approach adopted, he was not satisfied that an apprehension of bias would be perceived by the hypothetical fair minded lay person. There is no ground of appeal relating to that conclusion.
>
> [63] However, his Honour drew attention to the fact that the Committees took what his Honour characterised as the unusual course of contesting the case for relief by presenting a substantive argument (see *The Queen v Australian Broadcasting Tribunal; Ex parte Hardiman* [1980] HCA 13; (1980) 144 CLR 13 at 35-36). His Honour referred to the fact that other appellants may have been more appropriate parties to present substantive arguments. His Honour considered that the fact that each Committee had defended its own interpretation of the legislation and the dismissal of reliance upon exceptional circumstances would suggest to a fair minded lay person that the members of the Committee would find it difficult to put out of their mind entirely the approach that his Honour found to be erroneous, if they were to come to reapply to themselves to the task. Accordingly, his Honour made orders that the members of the Committees be prohibited from further constituting a Professional Services Review Committee in relation to Dr Ho and Dr Do.
>
> …
>
> > [78] Both appeals should be upheld. The orders made by the primary judge should be set aside. In lieu thereof, there should be orders that each proceeding be dismissed and that the relevant applicant pay the respondents' costs. The appellants' costs of the appeal should be paid by the respective respondents to the appeals.

It is now common for the Commonwealth to be named as a respondent to proceedings involving a PSR Committee or Determining Authority, and for the Director of PSR or the PSR Agency to give instructions regarding the litigation on behalf of the Commonwealth.

In a matter in which the Determining Authority had issued a final determination disqualifying the person under review for a period of time, an application for judicial review was made to the Federal Court a short time after the final determination had come into effect. In an interlocutory order, the Court granted a stay of the implementation of the final determination, and to preserve the effect of the time period of the disqualification should the final determination be upheld, made the following order, which took advantage of the 35 day period specified in section 106V in which, if litigation is commenced within 35 days of the final determination being made, it is not taken to have effect until the end of that litigation:[199]

[199] *Li v Determining Authority*, NSD 593 of 2022, Order of Bromwich J, 10 August 2022.

The following directions made in the Final Determination by the first respondent concerning the applicant dated 28 June 2022 be stayed pursuant to s 15(1)(b) of the *Administrative Decisions (Judicial Review) Act 1977* (Cth):
(a) The direction at paragraph 82 that the applicant repay $433,488.52; and
(b) The direction at paragraph 83 that the applicant be fully disqualified from rendering MBS item services for 18 months,
such that, unless set aside, that Final Determination takes effect as set out in s 106V(2) of the *Health Insurance Act 1973* (Cth) as though this proceeding had been commenced within 35 days of 28 June 2022.

106XA Significant threat to life or health

If in the performance of their functions or exercise of their powers a Committee or the Determining Authority form the opinion that conduct by a practitioner has caused, is causing, or is likely to cause, a significant threat to life or health of any other person, it must give the Director a written statement of the concerns, together with the material, or copies of the material, on which its opinion is based (subsection 106XA(1)).

If the Director receives such a statement and material, the Director must send the statement and material to a State or Territory body responsible for the administration of health services or the protection of public health and safety in the State or Territory in which the conduct occurred. The Director must also send the statement and material to each appropriate person or body for the person as specified in the *Health Insurance (Professional Services Review Scheme) Regulations 2019*, which has the power to take action against the person (subsection 106XA(2)).

The Director also has the duty to prepare such a statement and attach relevant material and send it to the relevant bodies if the Director forms such an opinion in the course of performance of the Director's functions or the exercise of power (subsection 106XA(3)).

This duty of referral applies not only in respect of the person under review, but any other practitioner who comes to the attention of the Director, a Committee, or the Determining Authority in the performance of their functions or exercise of their powers.

Under section 93(8), if the Director sent a statement and material under section 106XA regarding the conduct of the person under review, the Director must include a statement to the effect that the Director formed the relevant opinion and set out the terms of the statement sent to the relevant person or body. Subsection 93(9)

requires the Director disregard any opinion formed under section 106XA when making a referral to a Committee under subsection 93(1).

Similarly, under section 106M, if a Committee sent a statement of concerns to the Director under section 106XA, it must mention it in its draft report (if the referral was made before the draft report was finalised) and the final report, and must include the terms of the statement in that report. Under subsection 106M(3), the Committee must disregard any opinion formed under subsection 106XA(1) when making findings for the purposes of its draft and final reports.

106XB Non-compliance by a practitioner with professional standards

Section 106XB, subsections 93(8) and (9), and section 106M operate in the same manner as section 106XA but in relation to the formation of an opinion that a practitioner (not necessarily the person under review) has failed to comply with professional standards.

Examples of conduct that have resulted in referrals under section 106XB are:

- Egregiously poor record keeping;
- Charging extraordinarily high fees for services;
- Failing to cooperate with a PSR review or investigation;
- Attempting to mislead the Director or a Committee by producing false or misleading records or information.

106ZPL Director to arrange for the provision of services

As Committees and the Determining Authority have no power to enter into contracts or engage staff, it is the duty of the Director, under section 106ZPL, to provide staff, resources and services for those PSR entities in order to enable them to perform their functions and exercise their powers.

Subsections 106ZPL(2) and (3) place limits on the particular persons the Director may provide to a Committee or the Determining Authority to perform particular types of services if those persons have provided particular types of services for another of the PSR entities (the Director, the Committee, or the Determining Authority) in respect of the same matter.

There is no restriction on staff who provide clerical or administrative services to a PSR entity. Those staff may provide those types of services to any of the PSR entities for the same matter. But a person who provided either legal services, investigative services, or advice by a practitioner, may not provide those same services to another PSR entity in the same matter (though they may provide clerical or administrative services).

Re Raiz and Professional Services Review [2021] AATA 4360 —

> [124] The PSR has set out the documents that they claim attract legal professional privilege in the Schedule. Broadly these documents relate to:
> (a) The judicial review litigation brought by Dr Raiz in the Federal Court including documents 129 and 172; and
> (b) The PSR's investigation of Dr Raiz including communications regarding the Committee Review.
>
> [125] The Guidelines explain at paragraph 5.131 that communications from in-house lawyers are not always privileged. Factors that assist to determine whether a legal adviser-client relationship exists include whether a legal advisor is acting in their capacity as a professional legal advisor, whether the advice is independent, whether the dominant purpose test applies and whether the information is treated as confidential.
>
> [126] The dominant purpose test provides that legal professional privilege only attaches to documents that were brought into existence for the dominant purpose of giving or receiving legal advice or for use in actual or anticipated litigation.[11] Dr Raiz has queried whether all the documents that the PSR has claimed privilege comply with the dominant purpose test.
>
> [127] Mr Topperwien provides the following evidence:
>
> > Many of the documents to which legal professional privilege applies are emails between PSR's legal advisers, including myself, who were responsible for managing the litigation brought by Dr Raiz. These documents are identified in the Schedule with the lawyers involved also identified in the description of particular documents.
> >
> > ...
> >
> > PSR's lawyers are often called on to undertake tasks that do not involve giving legal advice or to managing litigation. This is because PSR is a small agency and at times work is required to be done by whomever has availability at the time and where a senior person is required to undertake a task that work often falls on the senior lawyers.
> >
> > Given that practice within PSR, and because I have a dual role as Executive Officer and lawyer, I have carefully reviewed each of the internal documents to ascertain that legal professional privilege applies to the document.

> I confirm that legal professional privilege has been claimed only for documents that contain communications between a PSR lawyer, acting in his or her capacity as an in-house legal adviser to the PSR, either to the Director, a Committee or a staff member performing administrative or secretarial roles in assisting the Committee, and where I have confirmed that the communication is for the dominant purpose of seeking or providing legal advice, or for use in connection with the judicial proceedings brought by Dr Raiz in respect of the Amending Instrument.
>
> [128] Mr Topperwien confirms that the documents are held in a secure password protected system and treated confidentially.
>
> [129] Having reviewed the documents in dispute, I confirm that these documents attract legal professional privilege and are for the dominant purpose of providing legal advice. I am guided by Mr Topperwien's knowledge of the legal matters and roles of lawyers in the PSR in his position as General Counsel of the PSR. I note that upon Dr Raiz's FOI request, Mr Topperwien reviewed all the documents that the PSR had claimed privilege over and released further documents where he determined that staff were not acting in their capacities as legal advisors. I am satisfied that the remainder of documents that the PSR have claimed privilege involve documents for use in the judicial review proceedings brought by Dr Raiz or to provide legal advice about the PSR's review of Dr Raiz's medical practices. These communications are confidential and relate to independent legal advice provided by the in-house lawyers at the PSR.
>
> [130] Therefore, I find that the documents relating to legal advice are exempt from disclosure under s 42.

It is likely that this obligation on the Director not to arrange for a person to provide those services to a PSR entity when they have provided them to another PSR entity is an 'imperfect obligation' in the sense that it is not judiciable except to the extent that a court might interfere if the person is still providing those services to the PSR entity in breach of the section. In such a case, the Court could make an order requiring the person to step aside and cease providing the relevant type of services to the entity currently employing their services. But after the PSR entity has finished its statutory task the fact that a person's services might have been provided to an entity in breach of the section would not give rise to a cause of action that would invalidate any decisions or actions taken by the PSR entity.

In *AVN20 v Federal Circuit Court of Australia*, Kenny J found that breach of s 91X of the *Migration Act 1958*, which prohibited the naming of an applicant for a protection visa, did not give rise to jurisdictional error, with the consequence that a Court's judgment was not rendered invalid merely because of an inadvertent breach of s 91X.

AVN20 v Federal Circuit Court of Australia [2020] FCA 584 —

> [109] This is not the occasion to examine in detail the complexities of a duty of imperfect obligation. It suffices to say the concept of a duty of imperfect obligation is known in diverse areas of the law. It is, for example, not uncommon for Commonwealth and State legislatures to impose a "duty" on a public office holder or corporation to take or not to take certain action, even though the duty is not enforceable in the courts: compare *Yarmirr v Australian Telecommunications Corporation* (1990) 96 ALR 739 at 749-750 and *Environment East Gippsland Inc v VicForests* [2010] VSC 335; 30 VR 1 at [304]-[311]. Such a duty has been described as a duty of imperfect obligation: see, for example, *Environment East Gippsland* at [305]. A duty of imperfect obligation is recognised in many other contexts: see, for example, *Re New World Alliance Pty Limited; Sycotex Pty Ltd v Baseler (No 2)* [1994] FCA 1117; (1994) 51 FCR 425 at 445; *Glennan v Commissioner of Taxation* [2003] HCA 31; 198 ALR 250 at [13]; *Bromby v Offenders' Review Board* (1990) 51 A Crim R 249 at 255-256; *Adler v District Court of New South Wales* (1990) 19 NSWLR 317 at 330-332 (Kirby A-CJ, Mahoney JA agreeing at 340-344); *Attorney-General (Qld) (Ex rel Nye) v Cathedral Church of Brisbane* [1977] HCA 15; 136 CLR 353 at 371; and HAJ Ford and WA Lee, *Principles of the Law of Trusts* (Thomson Reuters, 2016) at [5.12110]; cf. *The King v The Governor of the State of South Australia* [1907] HCA 31; 4 CLR 1497 at 1511; *Werrin v Commonwealth* [1938] HCA 3; 59 CLR 150 at 168 (Dixon J).

Nevertheless, the Director of PSR takes the obligations imposed by the Act seriously and makes every attempt through practical procedural and systemic measures within the PSR Agency to avoid the risk of inadvertent breach of the duties imposed by the section.

106ZPM Failure of a person to produce documents or give information

If a person under review intentionally refuses or fails to comply with a notice to produce issued by the Director under subsection 89B(2) or by a Committee under 105A(2), subsection 106ZPM(1) provides that a medicare or dental benefit is not payable in respect of a service rendered or initiated by the person under review, or by a practitioner employed or otherwise engaged by the person under review.

If the Director considers that subsection 106ZPM has that effect, that is the Director has formed the view that the person has intentionally refused or failed to comply, the Director must give a notice to that effect to the person and to the Chief Executive Medicare.

In *I-MED Radiology Network Limited v Director of PSR* [2020] FCA 1645, Logan J considered that subsection 106ZPM was not a self-executing provision, and that it only came into effect upon the Director also forming the view that a medicare or dental benefit is not payable.

I-MED Radiology Network Limited v Director of Professional Services Review [2020] FCA 1645 —

> [79] Neither applicant produced documents by the time specified but there was a reason for that. These proceedings were instituted on the following Monday, 17 August 2020 in order to test the validity of the notices. After initially being mentioned on 18 August 2020, the applicants' application for interlocutory injunctive relief was adjourned to 21 August 2020. On that day, and apart from making orders directed to an expeditious hearing of the substantive application, the Court made the following interlocutory orders:
>
> 10. The review of services of each of the applicants commenced on 15 July 2020 are suspended until the hearing and determination of this proceeding.
>
> 11. The first respondent must not give notice under subsections 106ZPM(2) or (3) of the [HIA] in respect of the applicants while the review of services of each of the applicants is suspended pursuant to Order 10.
>
> 12. The second respondent be restrained from taking any steps pursuant to or consequent upon the decision to issue the notices to produce dated 15 July 2020 by the first respondent, until the hearing and determination of this proceeding or further order of the Court.
>
> [sic]
>
> [80] The obvious concern of the applicants, reflected and addressed in these interlocutory orders, was to avoid the disqualification for which s 106ZPM of the HIA provides. Read in isolation, s 106ZPM(1) might be thought to suggest that there is a self-executing quality about any such disqualification in the event that the two objects of the conditional clause are met. One of these is that the person to whom the notice is directed, "intentionally refuses or fails to comply with the requirement within the period specified in the notice". Delving further into s 106ZPM, one sees that this is not so. Having regard to ss 106ZPM(2), (3) and (4), it is only if, additionally, the Director considers that s 106ZPM(1) prevents medicare benefits from being payable in respect of services rendered or initiated by the applicants and gives a notice to that effect to the that they are then taken, at that time, to be fully disqualified for the purposes of s 19D of the HIA. Section 19B is concerned with the disqualification of practitioners and the prevention of payment of medicare benefits to them or on their behalf. It is not necessary for the purposes of the present case to consider the interface between such a disqualification and bodies corporate such as the applicants, neither of which is a "practitioner". Whatever effect that may be, the administrative progression of the s 106ZPM process is presently stayed by the interlocutory orders.
>
> [81] There is nothing in the evidence to suggest that either I-MED Radiology or I-MED NSW approached the question of complying with the respective s 89B notices

> other than in good faith and on the basis that they ought only to be required to produce documents according to law, nothing more but equally nothing less. As it transpires, and for the reasons given above, their understanding that the notices were invalid was misplaced. It is in the nature of the finality of judicial decision-making that the absence of merit in the asserted grounds of invalidity has a clarity in hindsight that it may well not have had in prospect. By virtue of s 106ZPM(2), it is, however, for the Director, not me, to form a view ("considers") as to the operation of s 106ZPM(1) (in effect, as to the applicants' intention in relation to the failure to comply).
>
> [82] At present, the interlocutory injunctions will expire on the determination of this proceeding. It seems to me that the interests of justice in the circumstances are best served by continuing those injunctions for a further 30 days from the date of the judgment. That will allow the parties time to consider these reasons for judgment, accommodate the period for the institution of any appeal and also allow the originally contemplated period for production in the event that the applicants are disposed now to produce what has been required. I note that the Director is given certain powers under s 94 of the HIA to extend the 12 month period upon the expiry of which a deemed no further action decision can arise. The existence of those powers means that the Director, if so disposed, can address any concern she might have, arising from this litigation and the injunctions, as to any untoward such deeming.

Subsection 106ZPM(4) provides that once the Director gives the subsection 106ZPM(2) notice to the person, the person is taken to be 'fully disqualified' from that time for the purposes of section 19D of the Act, and is a 'disqualified practitioner' for the purposes of sections 20B to 20E of the *Dental Benefits Act 2008*.

Section 19D provides that the Minister may direct a practitioner who is fully disqualified not to render professional services for which a medicare benefit is not payable unless before rendering such a service a notice is given to the person to whom the service is intended to be rendered setting the particulars of the disqualification and explaining the effects of that disqualification. A practitioner who refuses or fails to comply with such a direction commits an offence of strict liability punishable by a fine. It is a defence that the practitioner has a reasonable excuse.

106ZPN Failing to produce documents or give information—offences and civil penalties

If a person under review other than a practitioner intentionally refuses or fails to comply with a notice to produce, they commit a civil offence, attracting 30 penalty units.

If a body corporate refuse or fails to comply with a notice, it commits a civil offence, attracting 30 penalty units, for every day that it fails to comply.

106ZPNA Failing to produce documents or give information—court orders for bodies corporate

If the Director is satisfied that a body corporate has refused or failed to comply with a requirement to produce a document or give information, the Director may, by writing, certify the failure to the Federal Court. If the Director does so, the Federal Court may inquire into the case and may order the body corporate to comply with the requirement as specified in the order.

106ZPR Publication of particulars of reports and determinations

Section 106ZPR permits the Director to publish details relating to the outcome of certain cases, which otherwise would not be permitted due to the secrecy obligations in sections 106ZR and 130 and in the *Privacy Act 1988*. Enabling such publication is an important element of the Scheme in that it provides both general and specific deterrence for practitioners to engage in inappropriate practice. The Director publishes such details on the PSR website.

While the Director is permitted to publish the name and address or practitioners for whom a final determination has come into effect, the Director does not always do so. A publication policy, available on the PSR website, sets out the matters the Director will take into account before publishing identifying details of a practitioner or person under review.

Sevdalis v Director of Professional Services Review [2016] FCA 32 —

> [8] I accept that the purpose of the prohibition in s 106ZR is to protect the privacy and confidentiality of patients whose records, clinical attendances and other details may be revealed and discussed during the investigation and decision-making process undertaken by a Professional Services Review Committee and the Determining Authority under Part VAA of the Health Insurance Act. It seems to me that the provision is also designed to ensure that personal matters relating to the practitioner under investigation are not the subject of dissemination or publication, although the Director of Professional Services Review may cause the findings of a Committee and the directions given by the Determining Authority to be published: s 106ZPR(1). In many Part VAA investigations and decisions, not only may there be great detail about the clinical treatment of individual patients, but the personal circumstances of the medical practitioner concerned are likely also to be the subject of evidence, discussion and findings. That was indeed the case in the report and

decision concerning Dr Sevdalis. While the Health Insurance Act reveals a legislative intention that the public interest in knowing of contraventions of the Act by medical practitioners be served by the publication to which I have referred, a provision such as s 106ZR indicates that the details which gave rise to the contraventions are not intended to be available for public review.

106ZR Disclosure of Committee deliberations etc.

It is an offence to disclose to another person any deliberations or findings of a Committee or any information or evidence given to the Committee in the course of its deliberations, unless such disclosure is required or permitted under the Act or the *Dental Benefits Act 2008* or is necessary in connection with the performance or functions of the discloser's functions or duties under either of those Acts.

Re Saint and Director of Professional Services Review [2006] AATA 929 —

[40] As regards para (b) of s 36(1) of the FOI Act, the respondent submitted that disclosure of Document 52 (and, indeed, all of the other abovementioned documents in issue), would be contrary to the public interest on the following grounds:

- Section 106ZR of the *Health Insurance Act 1973* makes it a criminal offence for a person to disclose to another person any of the deliberations or findings of a Professional Services Review Committee or any information or evidence given to a Professional Services Review Committee in the course of its deliberations, unless the disclosure is required or permitted under the Health Insurance Act or is necessary in connection with the performance of the first-mentioned person's functions or duties under that Act. The existence of this section clearly indicates that the legislature does not regard disclosure of Committee deliberations to be in the public interest. Part VAA provides for the person under review to be furnished only with a copy of the Committee's draft report (and subsequently with a copy of the Committee's final report).
- The notes of members of an adjudicative body made in relation to matters on which they are statutorily bound to reach a reasoned finding in a draft report on which the person under review is given a legal entitlement to comment should not be disclosed. The Health Insurance Act specifically provides for the draft report alone of the PSR Committee to be provided to the person under review for comment. Members of a Committee would be severely inhibited in their task if their hearing notes or preliminary drafts or parts of a draft report or correspondence passing between the Committee Secretary and members as to how findings in the draft report should be formulated were disclosed.
- Members of Professional Services Review Committees have, in the performance of their duties, the same protection and immunity as a Justice of the High Court: see s 106F(1) of the Health Insurance Act. It would be contrary to the public interest if the immunity of Committee members from disclosing any aspect of their decision-making process – an immunity which is "required to ensure freedom of thought and independence of judgment" – were rendered illusory by that process being disclosed by other means such as disclosure

> under the FOI Act: see *Herijanto v Refugee Review Tribunal* [2000] HCA 16; (2000) 170 ALR 379 at 383; *Herijanto v Refugee Review Tribunal (No 2)* [2000] HCA 21; (2000) 170 ALR 575 at 576, 577.
>
> [41] The Tribunal accepts the respondent's submission.

It has been held that 'another person' in section 106ZR does not include a Court.

Sevdalis v Director of Professional Services Review [2016] FCA 32 —

> [8] I accept that the purpose of the prohibition in s 106ZR is to protect the privacy and confidentiality of patients whose records, clinical attendances and other details may be revealed and discussed during the investigation and decision-making process undertaken by a Professional Services Review Committee and the Determining Authority under Part VAA of the Health Insurance Act. It seems to me that the provision is also designed to ensure that personal matters relating to the practitioner under investigation are not the subject of dissemination or publication, although the Director of Professional Services Review may cause the findings of a Committee and the directions given by the Determining Authority to be published: s 106ZPR(1). In many Part VAA investigations and decisions, not only may there be great detail about the clinical treatment of individual patients, but the personal circumstances of the medical practitioner concerned are likely also to be the subject of evidence, discussion and findings. That was indeed the case in the report and decision concerning Dr Sevdalis. While the Health Insurance Act reveals a legislative intention that the public interest in knowing of contraventions of the Act by medical practitioners be served by the publication to which I have referred, a provision such as s 106ZR indicates that the details which gave rise to the contraventions are not intended to be available for public review.
>
> [9] There is authority for the proposition that in provisions similar to s 106ZR the word "person" should not be construed as including a Court: see *Kizon v Palmer* (1997) 72 FCR 409 at 430-431 (Lindgren J, with whom Jenkinson and Kiefel JJ agreed). I accept that approach is applicable to s 106ZR. Accordingly, disclosure of the documents in paragraph [3] above to the Court, for the purposes of advancing, and responding to, the judicial review application does not contravene s 106ZR.
>
> [10] There is also authority, in a different statutory context, for the proposition that an exception of the kind found in s 106ZR(1) ("or is necessary in connection..." etc) should receive a very wide interpretation, such as to encompass the production of necessary documents in judicial proceedings where the officer's or body's decision is under review: see *Commissioner of Taxation v Nestle Australia Ltd* [1986] FCA 368; (1986) 12 FCR 257 at 261-262. I accept that is also a construction which should be applied to s 106ZR.

Section 106ZR does not preclude a person under review providing information or evidence given to the Committee to a potential witness, as this section is subject to the Act, and section 103 of the Act provides that the person under review is entitled to call witnesses to give evidence.

Adams v Yung [1998] FCA 506 —

On behalf of Dr Adams, any finding of lack of procedural fairness by the Committee in this regard is now challenged. In order to consider the argument in its context, reference should be made to the following circumstances.

- By letter dated 21 July 1995, the Committee provided Dr Yung's solicitor with a number of documents including the records of some of the patients seen on 29 November 1994.
- By facsimile letter to the Committee dated 25 July 1995, Dr Yung's solicitor said that a summons had been issued to Dr Gooley to produce "the balance of the... records for patients seen by Dr Yung on 29 November 1994", as the expert retained on behalf of Dr Yung required access to them.
- The Committee replied to the facsimile on the same day, stating, inter alia:

  "As previously advised, the hearing will resume at 9am on Thursday 27 July 1995. After the formal resumption, the committee will receive the clinical records into evidence (from Dr Brett Gooley, for services rendered by Dr Yung on 29 November 1994) and will then adjourn the proceedings until approximately 10.30am.

  On resumption, Dr Yung will be questioned on any issues that arise from these documents and on other matters relevant to the referral. Dr Yung will be given every opportunity to address the committee on all relevant issues.

  It is not considered that procedural fairness in these circumstances requires that the documents be made available to Dr Yung for the purposes of making them available to a potential expert witness prior to the resumed hearing."
- There was a short hearing on 27 July 1995, when the documents mentioned were taken into evidence. At the conclusion of this hearing, the Committee permitted Dr Yung, if he wished, to put in a report from an expert dealing with these records.

As has been noted, the solicitors for Dr Yung made a written submission to the Committee dated 8 August 1995. It was a nine page document which it is not practicable to summarise here. Some of it has already been picked up in the sections of the Report mentioned above. The submission did, however, attempt to deal with the points raised in the Referral, including the opinion of Dr Gordon. However, the submission was expressed in general, argumentative terms. It did not mention any of the records of patients seen on 29 November 1994.

In my opinion, none of the foregoing primary facts could be seriously disputed. If (and the position is not clear) his Honour inferred that, in this connection, the Committee did not afford Dr Yung natural justice, then I would not, with respect, concur that such an inference should be drawn from the entire history of this aspect of the Committee's process. In my view, Dr Yung was treated procedurally fairly in this respect. He was squarely informed that the Committee proposed to look at the records of 29 November 1994. He was then given fourteen days to make a written submission on this, and other matters. This process gave him a fair

opportunity to persuade the Committee that his conduct in this regard was not "inappropriate practice".

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

[86] Dr Karmakar also submitted that, if valid, s 106ZR of the HIA had operated so as to deny her a reasonable opportunity to present her case before the Committee. Put another way, she submitted that the inevitable consequence of the operation of that section was to deny a practitioner the opportunity of a fair hearing.

[87] Section 106ZR of the HIA provides:

> **106ZR Disclosure of Committee deliberations etc.**
> (1) A person must not disclose to another person:
> (a) any of the deliberations or findings of a Committee; or
> (b) any information or evidence given to the Committee in the course of its deliberations;
> unless the disclosure is required or permitted under this Act or the *Dental Benefits Act 2008* or is necessary in connection with the performance of the first-mentioned person's functions or duties under this Act or the *Dental Benefits Act 2008*.
> *Penalty: Imprisonment for 12 months.*
>
> (3) This section does not prevent a person from making a disclosure:
> (a) to a lawyer for the purpose of obtaining legal advice or representation relating to a matter involving the deliberations or findings of the Committee; or
> (b) if the person is a lawyer—for the purpose of complying with a legal duty of disclosure arising from his or her professional relationship with a client.
>
> (4) In this section:
> *lawyer* means a barrister or solicitor.

[88] Section 106ZR must, as the active party respondents correctly submitted, be construed in the context of Pt VAA. Part of that context is s 103(1)(c), which, in respect of a hearing by a committee, permits the practitioner "to call witnesses to give evidence (other than evidence as to his or her character)" and s 103(1)(d), which permits the practitioner "to produce written statements as to his or her character". Contrary to a submission made by Dr Karmakar, it would be disharmonious with the scheme in Pt VAA in respect of investigation by a committee to construe s 106ZR as inhibiting the practitioner from making such disclosures as were necessary to witnesses to give evidence as permitted by s 103(1)(c) or to give statements as permitted by s 103(1)(d) of the HIA. In my view, such disclosures are, in terms of s 106ZR(1) of the HIA, "required or permitted under this Act". Self-evidently from the proceedings of the Committee, s 106ZR did not in fact prevent Dr Karmakar from gathering statements from patients and other health professionals which were tendered on her behalf or from obtaining as part of the response she made, a report from Dr Turnbull. Her doing so was, for the reasons just given, lawful. Section 106ZR did not operate to deny her procedural fairness in the course of the Committee's investigation.

The Federal Court rejected a challenge to the constitutionality of section 106ZR on the ground that it was inconsistent with the implied protection of political communication.

Karmakar v Minister for Health (No 2) [2021] FCA 916 —

> [90] Dr Karmakar submitted that it was beyond the legislative competence of the Parliament to enact s 106ZR because:
> (a) it unreasonably burdens political communication as it prohibits and regulates an inherently political communication; and
> (b) goes well beyond the purpose for which it was designed because, among other things, it unfairly prevents persons under review from defending themselves by discussing the process and the evidence.
>
> [91] The active party respondents submitted, correctly, that the freedom concerned is not a personal right but rather a restriction on legislative power. They also submitted that Dr Karmakar's challenge to the validity of s 106ZR lacked any practical utility, because she had not sought to engage in any communication of political or governmental nature concerning Pt VAA of the HIA. In relation to a confidentiality provision, which, for the apparent purposes mentioned below, has a chilling effect in relation to communications, there is a certain self-fulfilling or "bootstraps" quality about that submission. As was pointed out in behalf of Dr Karmakar, an absence of desire to engage in such communications was never put to her in cross-examination. Further, the evidence disclosed that Dr Karmakar had made her own inquiries about possible problems in the Pt VAA regime, including approaching contributors to a 2011 Senate Inquiry. She had also sought, via a freedom of information application, information from the Professional Services Review agency established under Pt VAA information regarding internal processes. She obviously has a grievance about the operation of the Pt VAA regime and desires to air that grievance via public discussion. I do not doubt that either that grievance or that desire are held in good faith. I do not therefore accept that the relief she seeks about s 106ZR lacks practical utility.
>
> [92] Yet another submission made by the active party respondents, relying upon *Comcare v Banerji* (2019) 267 CLR 373 (*Comcare v Banerji*), was that s 106ZR did not impose a burden on freedom of political communication because only one group relevantly, medical practitioners, was affected by it. However, as was correctly put on behalf of Dr Karmakar, this submission mischaracterises the nature of the effect of s 106ZR. The section is not directed just to medical practitioners, but to any person who discloses information subject to the restriction.
>
> [93] Recently, in *LibertyWorks Inc v Commonwealth* (2021) 95 ALJR 490 (*LibertyWorks*), Steward J, at [249], opined that, "it is arguable that the implied freedom does not exist"; compare Kiefel CJ, Keane and Gleeson JJ, who stated, at [44], "The constitutional basis for the implication in the Constitution of a freedom of communication on matters of politics and government is well settled."
>
> [94] The active party respondents made no submission that the implied freedom did not exist. Rather, their submissions accepted that it did but put that s 106ZR did not transgress that implied freedom. Whether there should be reconsideration of

whether any such implied freedom exists is a matter for the High Court. As the judgments in the cases cited below demonstrate, there are authorities aplenty after the root authority, *Lange v Australian Broadcasting Corporation* [1997] HCA 25; (1997) 189 CLR 520 (*Lange*), where reference is made to the existence of such an implied freedom. Especially given that its existence is accepted in this case, I consider that I am obliged to proceed on the basis that the implied freedom does exist.

[95] Proceeding on this basis, there is no difference between the parties as to issues which fall for determination:
(a) The first (and perhaps only) issue flows from an identification of the purpose which the statute (s 106ZR in particular) seeks to achieve. The purpose will be legitimate only if it is compatible with the constitutionally prescribed system of representative government: *McCloy v New South Wales* [2015] HCA 34; (2015) 257 CLR 178, at [31] (*McCloy*).
(b) Even if the statute is compatible, the next issue is whether it is proportionate to the achievement of that purpose. Only if the statute is proportionate will a burdensome effect on the freedom be justified. To be proportionate, the statute must be a rational, response to a perceived mischief: *Clubb v Edwards* [2019] HCA 11; (2019) 267 CLR 171 (*Clubb v Edwards*), at [66] – [70]; *McCloy*, at [68].
(c) The final issue as to the validity of a statute effecting a burden on the freedom is whether the burden is "undue" having regard to its purpose: Lange at 569, 575. It will be "undue" if it is not a proportionate response to its purpose. That is to be ascertained by a "structured method of proportionality analysis": *LibertyWorks* at [48]; *McCloy*, at [2], [79]; see also *Brown v Tasmania* [2017] HCA 43; (2017) 261 CLR 328, at [123] – [127], [278]; *Unions NSW v New South Wales* [2019] HCA 1; (2019) 264 CLR 595, at [42], [110], [161] – [167]; *Clubb v Edwards*, at [96] – [102], [270] – [275], [491] – [501]; and *Comcare v Banerji*, at [38] – [42], [202] – [206].

[96] The evident purpose of s 106ZR of the HIA is the preservation, subject to the exceptions specified in the section itself and as otherwise permitted by that Act, of the deliberations and findings of a committee and information or evidence given to a committee in the course of its deliberations. Even if the enactment of s 106ZR and, for that matter, Pt VAA of the HIA in its entirety are not directly authorised by s 51(xxiiiA) of the *Constitution* itself, they would be authorised by the incidental power conferred by s 51(xxxix) of the *Constitution*. The establishment of a regime for ensuring that the medical services for which benefits are paid from consolidated revenue are not rendered via "inappropriate practice" as defined is surely incidental to a law providing for the payment from that source of such benefits.

[97] Within that regime, one end served by the confidentiality purpose of s 106ZR is, in my view, to preserve, at the committee stage, the professional reputation of the practitioner concerned. For reasons already given, when s 106ZR is read in the context of Pt VAA and s 103 in particular, it does not inhibit that practitioner's ability to make a case before a committee that there should be no finding of "inappropriate practice". Another end served by the confidentiality purpose of s 106ZR is the privacy of the patients to whom the services have been rendered by the practitioner under review. In this regard, s 106ZR complements the requirement in s 98(2) that a committee hearing be in private and a more general secrecy

provision, s 130, applicable to persons performing functions or exercising powers under the HIA.

[98] At various stages in the processes for which Pt VAA provides, there are limited circumstances in which disclosures can be made to nominated persons or agencies about the practitioner concerned. For example, were the Director to have thought that, in relation to services provided by her during the review period Dr Karmakar had committed a "relevant offence" or a "relevant civil contravention" (each as defined by s 124B), s 89A authorised her to send the material or a copy of the material concerned to the CEO, together with a statement of the matters that she thought may have constituted the offence or contravention. A similar disclosure authorisation is found at the committee stage: s 106N. Via such means, the name of the practitioner concerned might become known in the course of a consequential criminal or civil penalty proceeding. Other disclosures via a committee might permissibly occur if they from an opinion that conduct by a person under review has caused, is causing, or is likely to cause, a significant threat to the life or health of any other person (s 106XA) or has failed to comply with professional standards (s 106XB).

[99] In general, however, it is only if a case proceeds to the Determining Authority stage and a determination is made that the identity of the practitioner and related findings and determination are revealed via a publication made by the Director, as authorised by s 106ZPR of the HIA:

> **106ZPR Publication of particulars of reports and determinations**
>
> (1) When a final determination of the Determining Authority has come into effect, the Director may cause to be published, in such way as he or she thinks most appropriate, particulars of:
> (a) the name and address of the person under review; and
> (b) the profession or specialty of the person under review; and
> (c) the nature of the conduct of the person under review in respect of which the Committee found that the person had engaged in inappropriate practice; and
> (d) the directions contained in the determination under subsection 106U(1).
>
> (3) No action or other proceeding may be brought for defamation in respect of the publication of matters in accordance with subsection (1).

Thus, the Pt VAA regime itself contemplates that the general public, and thus the medical profession, will, inter alia, gain via this means an understanding of conduct which has been found to be "inappropriate practice".

[100] In *APLA Ltd v Legal Services Commissioner (NSW)* [2005] HCA 44; (2005) 224 CLR 322 (*APLA v Legal Services Commissioner*), at [27], Gleeson CJ and Heydon J pithily observed the meaning of the expression, "freedom of communication about government or political matters" is "imprecise". They considered that the source of the requirement for such a freedom, ss 7, 24 and 64 and s 128 of the *Constitution*, threw light on its content.

[101] The active party respondents submitted that an analogy was to be drawn between the inhibition found in s 106ZR of the HIA and the professional advertising

inhibition which, in *APLA v Legal Services Commissioner*, was found not to transgress the implied freedom, because it was not a communication about government or political matters. Of course it might be said that, these days, the business of federal government is broad and the merits and performance of any regime providing for expenditure from consolidated revenue may constitute a government or political matter. Dr Karmakar put as much.

[102] The present focus is just upon s 106ZR. That section does not prevent any communication about the regime in Pt VAA itself and its fairness or otherwise to practitioners of the processes for which it provides. The regime itself is a matter of public record.

[103] Section 106ZQ of the HIA mandates that the Director must prepare and give to the Minister under s 46 of the *Public Governance, Performance and Accountability Act 2013* (Cth) an annual report concerning the operation of Pt VAA. Via that means, the annual report must be tabled in Parliament by the Minister and becomes a public document. At a general level of abstraction, nothing in s 106ZR prevents communications about the merits or otherwise of the operation of Pt VAA as revealed by that annual report. The inhibition in s 106ZR is only at the committee stage in respect of a particular case. Dr Karmakar is now the subject of a determination by the Determining Authority. Section 106ZR is not aimed at preventing her from disclosing this or that she considers that the process ordained by Pt VAA is unfair. The section would not, for example, prevent her from promoting the reform of the present regime for examining and finding whether there has been "inappropriate practice" is unfair or from advocating that the definition of "inappropriate practice" should be reformed so as expressly to take account of the knowledge, training and experience of the practitioner concerned.

[104] *APLA v Legal Services Commissioner* is useful for its highlighting the imprecision in the expression and a need to understand the purposes of the impugned provision and exactly what it does or does not inhibit or restrict. However, beyond that, error can lie in analogy. When the purposes of s 106ZR and what it does or doesn't inhibit or restrict are understood, there is nothing about it which is incompatible with the requirements of responsible and representative government as found in the Constitution. In my view, the challenge to its validity fails.

Part VB – Medicare Participation Review Committees

Part VB of the Act provides for Medicare Participation Review Committees. Chairpersons are appointed by the Minister under section 124C, and must be legal practitioners. Under section 124D, if a practitioner has been convicted of a relevant offence or pecuniary penalty order, the Minister must give to the Chairperson a notice in writing setting out details of the conviction or order and give a copy of the notice to the practitioner. Under section 124E, upon receiving such a notice the Chairperson must establish a Medicare Participation Review Committee.

A Chairperson must also establish a Committee upon receipt of a notification under subsection 23DL(4) concerning an approved pathology practitioner or approved pathology authority. A notice may be given under subsection 23DL(4) if the Minister has reasonable grounds for believing that a person who is or was an approved pathology practitioner or approved pathology authority has breached an undertaking given by the person for the purposes of section 23DC or 23DF of the Act.

124F Determinations in relation to relevant offences and relevant civil contraventions

Under section 124F a Committee must make a determination in relation to the practitioner in respect of the commission of the relevant offence or civil contravention, that:

- no action be taken
- it should counsel the practitioner
- it should reprimand the practitioner
- the practitioner be disqualified in respect of one or more professional services
- the practitioner be fully disqualified, or
- any other practitioner who is employed or engaged under a contract for services by the practitioner is taken to be disqualified while so employed or so engaged.

In making the determination, the Committee must have regard to the nature of, and the circumstances concerning the commission of the relevant offence or civil contravention, and must comply with any Ministerial guidelines in force under section 124H.

Mukherjee v Medicare Participation Review Committee [2010] FCA 233 —

> [27] It is the function of the MPRC to identify those practitioners who have demonstrated that their conduct in the Medicare Scheme should be reviewed: see *Re Markey and Minister for Human Services and Health and Another* [1996] AATA 668 at [16]. The disqualification awarded to such person is primarily intended to ensure the integrity of the Scheme's operation and it is not to be seen as a form of penalty or punishment simpliciter: see *Re Dixit and Minister for Health and Aged Care* [2001] AATA 452 at [23]. In *Minister for Human Services and Health v Haddad and Another* (1995) 58 FCR 378, the Full Court at 385 said:

> It is important to keep in mind that the Act is not directed to questions of professional misconduct as such but rather to ensuring the effective operation and administration of the Medical Benefits and Hospital Services Insurance Scheme constituted and regulated by the Act.

The Tribunal, in assessing the appropriate sanction, was not however under an obligation to specifically state the purposes of the Act in its decision. The Tribunal was required to assess the sanction in regard to the relevant considerations as included in the Act. Purposes of the Act are not statements of the relevant considerations that a decision-maker is required to state in their reasons. Such considerations are found within the text of s124F. The Court therefore rejects this submission. …

[37] The appellant alleges that the Tribunal Member 'impermissibly substituted herself as an expert witness and informed herself at [20] as to the respondent's "awareness" having regard to his psychiatric illnesses during the periods of the commission of the "relevant offences"'. It is submitted that the Tribunal Member was therefore obliged to warn the appellant 'that she proposed to take such action'.

[38] The Tribunal had before it evidence that the appellant had pleaded guilty to breaches of 63 offences against s 128B(1) of the Act (set out in [4] above). One of the essential elements of each offence is knowledge on the part of an accused that the proscribed conduct took place knowingly. Such was clearly established in Haddad at 385 where the Full Court said at [E]:

> Under s 128B, on the other hand, the prohibition is on a person making or authorising the making of a statement if the person knows that the statement is false or misleading in a material particular and is capable of being used in connection with a claim for a benefit under the Act.

[39] The appellant pleaded guilty to all charges brought against him and he was convicted of each charge. For the purpose of s 124F(3)(a)(i), the MPRC (and the Tribunal) was obliged to consider the nature of, and circumstances concerning the commission of each relevant offence. It was therefore obliged to consider the fact that the appellant had pleaded guilty before the Burwood Local Court to charges involving the false making of claims. By the appellant's plea of guilty, he thereby must be taken to have acknowledged that he committed the offences 'knowingly' and therefore had 'awareness' of the criminality of his actions Further, the Tribunal, in view of the decisions referred to below, could not decide to the contrary.

[40] In *Minister for Immigration and Multicultural Affairs v SRT* [1999] FCA 1197; (1999) 91 FCR 234 the Full Court considered the circumstances of SRT, a respondent who had been convicted of manslaughter in the Supreme Court of New South Wales who sought to challenge his deportation before the Administrative Appeals Tribunal. The Full Court considered whether the Tribunal could go behind the conviction. At [46] the Full Court stated:

> While it stands, the conviction and sentence must be conclusive, so far at least as concerns a tribunal reviewing a decision that takes the conviction and sentence as its starting point. Serious practical questions would arise if the position were otherwise. The tribunal could arrive at its own decision as to that

> matter, what sentence his offence merited. It would be doing so on material gathered and considered at what could be a long time after the trial. Accepted trial procedures would be absent. The Crown would not be a party: cf *Minister for Immigration and Ethnic Affairs v Gungor* at 445-446 per Fox J.
>
> [41] See also Branson J in *Minister for Immigration and Multicultural Affairs v Ali* [2000] FCA 1385; (2000) 106 FCR 313 where her Honour said at [41]:
>
> > First, it seems to me to be clear beyond argument that the administrative decision-maker is entitled to receive evidence of a conviction and sentence and to treat it as probative of the factual matters upon which the conviction and sentence were necessarily based (Spackman, Daniele, Gungor and SRT).
>
> [42] In view of the above authorities the Tribunal was entitled to conclude, on the basis of his pleas of guilty, that the appellant was aware of the conduct.

The Committee cannot take into account any previous offence or contravention that is not a 'relevant offence' or 'relevant civil contravention'.

> ***Minister of Community Services and Health & Medicare Participation and Review Committee v Thoo*** [1988] FCA 54 (per Davies and Wilcox JJ) —
>
> [10] In our opinion, it would be inconsistent with the intent and object of these provisions for an MPRC, and on review the Administrative Appeals Tribunal, to take into account as relevant an offence of which the subject practitioner has been convicted or found guilty but which is not a relevant offence as defined or an offence that would have been a relevant offence as defined if it had occurred after the commencement of the new provisions.
>
> [11] An MPRC is not a court of law which, in imposing a penalty for an offence, may take into account any prior convictions which appear to it to have a relevance. An MPRC has a statutory function, that specified in s.124F(1), namely to "make a determination in relation to the practitioner in respect of the commission by the practitioner of any relevant offence that is the subject of the notice under s.124D ...". If these words stood on their own, the MPRC would be restricted to making a determination in relation to the particular relevant offence or offences before it and it would not be concerned with other offences, whether relevant offences as defined or not. The ambit of matters falling for consideration in respect of that determination is extended by the provisions of s.124F(3) which requires the MPRC to take into account each other relevant offence of which the practitioner has been found guilty or has been convicted and each other like offence that would have been a relevant offence if the finding or conviction had occurred after the commencement of the new provisions. The ambit of the MPRC's consideration is thus established by the provisions of s.124F(1) and (3). Offences which are not relevant offences or which would not, if they had occurred at a later point of time, have been relevant offences are not within that ambit. The Guidelines correctly recognise this point and likewise limit the consideration of the MPRC to relevant offences and to offences that would have been relevant if they had occurred after the commencement of the new provisions.

[12] In the present case, the MPRC held that the prior convictions in 1976 were "special circumstances" within the meaning of that term in Clause 8 of the Guidelines, thereby entitling the MPRC not to give effect to the presumptions specified in Clause 8. Yet, a circumstance may not be a special circumstance within Clause 8 unless it is a circumstance which is a relevant circumstance, having regard to other provisions of the Guidelines, particularly Clauses 3, 6 and 7 thereof. The Administrative Appeals Tribunal posed the question whether as a matter of law, the earlier convictions were not a relevant and therefore not a special circumstance. The Administrative Appeals Tribunal later stated:

> "We have come to the conclusion that it was not open to the MPRC to take into account convictions some 7 to 8 years prior to the occurrences forming the basis of the charges leading to the current proceedings pursuant to clause 3 of the Guidelines or as special circumstances, which we consider to be circumstances relating to 'relevant offences' as defined in the Act and Guidelines."

It is not entirely clear whether the Tribunal was expressing the view that, as a matter of fact, not of law, the 1976 convictions were not relevant to the matters which the Tribunal had to consider.

[13] However, as the matter has been argued, we express our view that, as a matter of law, the 1976 convictions were not within the ambit of the matters that it was relevant to the Administrative Appeals Tribunal to take into account.

[14] That is not to say that prior criminal behaviour may not, in a particular case, be admissible in evidence and properly taken into account as bearing upon the nature and circumstances of a relevant offence, though the effect of Clause 5 of the Guidelines, which provides that an MPRC may not review the decision of the Court in relation to a relevant offence, and of Clause 6(a)(v), which requires an MPRC take into account the reasons for decision and other statements made by the Court in relation to its consideration of the relevant offence, must be kept in mind. Those considerations do not arise in the present case as the Administrative Appeals Tribunal took the view that the 1976 convictions were unrelated to and threw no light upon the relevant offences, with which the Tribunal was concerned.

[15] In our opinion, the Administrative Appeals Tribunal was correct in excluding from its consideration Dr Thoo's 1976 convictions, which were convictions for offences which were not and would not, if they had occurred at a later point in time, have been relevant offences.

Minister of Community Services and Health & Medicare Participation and Review Committee v Thoo [1988] FCA 54 (per Burchett J) —

[36] But it is not necessary to accept the majority's restrictive view of "special circumstances" under clause 8, in order to support their denial of the proposition that the two convictions in 1976 were available to be considered against Dr. Thoo. The Act and the Guidelines confer a broad power to take account of matters within the scope of the inquiry undertaken. The scope of the inquiry is to be ascertained from the Act and Guidelines - and particularly s.124F. Nowhere in these is there

any suggestion that a conviction which does not relate either to a relevant offence or to the equivalent of a relevant offence (s.124F(3)(a)(ii), clauses 6(b), 8(c)(ii) of the Guidelines) is to be taken into account against the practitioner. The very description "relevant offence", though the subject of definition, is pregnant with meaning. It is not just the equivalent of a neutral expression such as "prescribed offence", which might have been used - it designates those offences the legislature regarded as relevant, and does so not the less because the peculiarities of drafting phraseology have led to the awkward existence of offences I have called equivalent to relevant offences. A feature of the legislation which should not be overlooked is that it is intended to be administered by committees in a fairly informal manner; they are hardly likely to have had thrust upon them the extremely difficult task of drawing a line between immaterial convictions and those having some more or less remote bearing on their inquiry. Parliament drew the line.

[37] If confirmation is needed, it is to be found in clause 5 of the Guidelines. That clause forbids a committee to review the decision of the court in relation to a relevant offence. It would be odd if the committee could not review the convictions which are at the centre of its inquiry, but could review peripheral convictions. The only reasonable explanation is that peripheral convictions were not contemplated as being before a committee.

[38] A conviction which is not relevant cannot constitute a special circumstance. …

Health Insurance Commission v G and M Nicholas Pty Ltd [2004] FCAFC 236 (per Emmett and Selway JJ) —

[32] In his reasons, the President found that no person with authority had been refused permission to enter Medtest's premises and that no person attended at the entrance and asked to be permitted to enter. His Honour observed that there may be some room for a finding, in a particular case, that there has been a constructive refusal of entry, just as the law of contract recognises anticipatory breach. However, his Honour considered that such a refusal would need to be very clear and that the problem with the present case was that there was not 'a sufficient degree of clarity'.

[33] His Honour accepted the evidence of Mr Garry Nicholas, a director of Medtest, and its laboratory manager, that if the persons authorised by the Chief Medical Officer had in fact arrived at Medtest's premises on 18 April 2002 and asked to be admitted, he would have permitted them to enter.

[34] His Honour accepted that Mr Fenton-Menzies had said to Ms Blacker in their conversation late on 17 April 2002 that, if Medtest acted inconsistently with the 23DF Undertaking, statutory consequences might flow. However, his Honour observed that, in saying so, Mr Fenton-Menzies had just referred to the differing views that he and Ms Blacker took. His Honour found that that conversation could not reasonably be understood as a notice of such formality as to give rise to a breach of the 23DF Undertaking, either constructive, or actual. His Honour considered that a reasonable person in the position of Ms Blacker, conscious that the application to the Tribunal to direct an inspection had failed, would not construe the conversation

with Mr Fenton-Menzies as a formal demand under the 23DF Undertaking, notwithstanding the reference to statutory consequences.

[35] His Honour noted that it was common ground that NATA accreditation was the basis for accreditation as a laboratory under the Act. Counsel for the Commission had observed that NATA had 'canonical status as the independent accreditation authority'. His Honour accepted that it may be that NATA is 'technically acting differently when it is assessing for its own accreditation than when it is advising the Minister or her delegate'. However, his Honour considered that, whatever was to happen on 18 April 2002, it was always to be an assessment by NATA, whether it was technically described as an assessment for NATA's own accreditation, from which would follow accreditation by the Minister's delegate, or whether the assessment was a special assessment for the Minister's delegate alone.

[36] His Honour concluded that what was proposed for 18 April 2002 was not within the 23DF Undertaking. His Honour's reasons were, first, that it was a voluntary assessment. Medtest had lost accreditation in respect of its laboratory and, unless the Tribunal intervened under s 41 of the Act, Medtest was not accredited. If it did not want to permit a NATA inspection, that was its right. While the consequence may have been the loss of its ability to provide services with Medicare benefits, that was its problem, not the Commission's. Medtest had no obligation to permit inspection. Secondly, his Honour concluded that what was proposed was an assessment, not a mere inspection. Eight distinguished medical experts were to attend, who would have wanted to discuss practices and procedures in some detail. Had the Commission proposed an inspection by one local expert, it would not have needed to know in advance whether entry would be permitted. The need to know in advance was necessary only because the assessment was by eight distinguished experts, some of whom had to travel from interstate. By that independent reasoning, his Honour found that there was no breach of the 23DF Undertaking.

ERROR OF LAW

[37] The Commission contended that the President's decision involved an error of law in that, in the light of the evidence and the President's findings, the only conclusion open to the President, as a matter of law, was that there was a breach of the 23DF Undertaking. Alternatively, the Commission contended that his Honour erred in applying the criterion of how a reasonable person in the position of Ms Blacker might react to the statements made by Mr Fenton-Menzies.

REASONING

[38] As the President found, there was no actual failure to comply with the 23DF Undertaking. Medtest had only undertaken to permit a person who was authorised and produced evidence of being so authorised to enter and inspect its laboratory. At no time did any member of the assessment team produce evidence of being authorised by the Chief Commonwealth Medical Officer to enter and inspect Medtest's laboratory. While the members of the assessment team were in fact authorised by the Chief Commonwealth Medical Officer, they did not satisfy the second requirement by producing evidence of being so authorised.

[39] The most that could be said is that, on 17 April 2002, Medtest, by its solicitor, Ms Blacker, made it clear to the Minister, and her delegates, that, even if a person who was authorised produced evidence of being so authorised, Medtest would not permit that person to enter and inspect its laboratory on 18 April 2002. However, and notwithstanding what Medtest had informed the Minister, his Honour found that, had those prerequisites actually been satisfied, in the events that would happen, Medtest would have permitted any such person to enter and inspect its laboratory.

[40] The reason why Ms Blacker, on behalf of Medtest, indicated that Medtest would not permit the inspection is that Medtest was taking a stance that, on the proper construction of the 23DF Undertaking, Medtest only bound itself to permit a person to enter and inspect its laboratory upon receiving reasonable notice. The President concluded that was an erroneous view of the meaning of the undertaking. There was no challenge to that conclusion.

[41] However it was not disputed that the stance that was taken by Medtest was taken in good faith and, apparently, on the basis of its legal advice. There was no finding by his Honour that Medtest was taking the stance that, whether it was right or wrong about its understanding of the 23DF Undertaking, Medtest would not comply with it. Nor is there any evidence that the Minister or her delegates or agents understood that the reason for Medtest's position was other than as stated by Ms Blacker to Mr Fenton-Menzies on 17 April 2002.

[42] If the contractual analogy be apt, it is not an anticipatory breach of contract, constituting repudiation, to take a stance as to the construction of the contract, albeit an erroneous stance, so long as there is no intimation that the contract will not be performed according to its proper construction, provided the relevant provision is not at "the root" of the contract such that the anticipated failure to perform (for whatever reason) can only be viewed as a repudiation: see GEC Marconi Systems Pty Ltd v BHP Information Technology Pty Ltd [2003] FCA 50; (2003) 128 FCR 1 at 492-493; cf. Federal Commerce & Navigation Co Ltd v Molena Alpha Inc [1979] AC 757 at 778-779 and see Lombok Pty Ltd v Supetina Pty Ltd (1987) 14 FCR 226 at 243-245. Any qualification in relation to 'the root' of the contract would not seem to be applicable in the circumstances of this case.

[43] On the other hand, it may be that the contractual analogy is not entirely apt. Within this statutory and regulatory framework, a better view may be that it was implicit within the 23DF Undertaking made by Medtest that it also gave an undertaking to continue to stand ready and be prepared throughout the term of the 23DF Undertaking to comply with the undertaking and each provision of it. On this approach, a statement by Medtest indicating that it would not comply with the 23DF Undertaking, or any part of it, would breach that implicit undertaking and would provide a proper basis for action under ss 23DL and 124E of the Act. As with the contract analogy, on this approach also the issue that needs to be determined is whether the statement made on behalf of Medtest can be understood as a breach of that implicit undertaking. Was Medtest saying that it was no longer prepared to comply with its undertaking? Or was it, on the other hand, saying that it would comply (whatever the undertaking was), but disputed the meaning of the undertaking?

> [44] Unless the statutory scheme is interpreted analogously to the law of contract, or unless some further requirement is implied in the 23DF Undertaking, it is difficult to understand how it could be said that Medtest breached the 23DF Undertaking. As already noted, no-one produced to Medtest, evidence of being authorised by the Chief Commonwealth Medical Officer to enter and inspect Medtest's laboratory as required by the terms of the undertaking.
>
> [45] In our view, it was open to the President, on the material before him, to reach the conclusion reached by him; that there was no breach of the 23DF Undertaking by Medtest. Ms Blacker was not evincing an intention on the part of Medtest no longer to be bound by the 23DF Undertaking or any aspect of it. She was asserting, albeit erroneously, that Medtest was not bound to permit any of the authorised persons to enter and inspect its laboratory on the following day because reasonable notice had not been given. Medtest had always indicated that it would permit entry and inspection, albeit six days after the date proposed. Ms Blacker explained, in her conversation with Mr Fenton-Menzies, why it was appropriate for Medtest to say no to the request to inspect on the following day.
>
> [46] In referring to how a reasonable person, in the position of Ms Blacker, might construe the statements made by Mr Fenton-Menzies, his Honour was doing no more than making an observation as to the meaning of the statements made and whether they led to the conclusion that Ms Blacker's statements amounted to a repudiation of the 23DF Undertaking in the light of Mr Fenton-Menzies' statements. That process of reasoning did not involve an irrelevant consideration, as the Commission contended. In any event, we are of the view that, on the facts as found or that are not in dispute, the conclusion reached by the President was correct.

Part VC—Quality assurance confidentiality

The object of Part VC of the Act (comprising sections 124V to 124ZC) is to encourage quality assurance activities in connection with the provision of certain health services. For the purpose of achieving that object, this Part contains provisions that prohibit the disclosure of information that became known solely as a result of those activities, and prohibits the production to a court of a document that was brought into existence solely for the purpose of those activities. It also protects certain persons engaging in those activities from certain civil liability in respect of the activities.

Re Watmore and WA Country Health Service – Great Southern [2012] WAICmr 29 —

> [2] In April 2011, the complainant applied to the agency under the FOI Act [WA] for access to documents relating to the death of his 17-year old son, Kieran, in the Albany Regional Hospital ('the ARH') on 28 August 2008. Specifically, the complainant sought access to documents containing:
> - the findings of an internal investigation by the ARH into that death;
> - the complaint from the ARH to the Nurses and Midwives Board of Western Australia (now the Australian Health Practitioner Regulation Agency) in

relation to the nursing staff responsible for his son's care at the time of the incident; and

- the decision of the Department of Health ('the Department') or the ARH not to renew the employment contract of a particular staff member.

[3] The State Coroner conducted an inquest into the incident and his report, dated 30 September 2009, is a public document. Kieran Watmore's family subsequently received a public apology in Parliament from the Minister for Health, who said "Kieran should not have died when he did, there were a number of systemic deficiencies that led to his death and these cannot be ignored" and noted that the Department would implement all of the Coroner's recommendations.

[4] On 16 May 2011, the agency refused access to the requested documents – without identifying any of them – under clauses 3(1) and 8(2) of Schedule 1 to the FOI Act, which relate, respectively, to 'personal information' and 'confidential communications'.

[5] The complainant applied to the agency for internal review of its decision, initially in relation to only one of the three documents or categories of document listed in his application but ultimately in relation to all three. Following some additional communication between the parties, the agency confirmed its original decision by way of two separate notices of decision on internal review, dated 15 June 2011 and 22 August 2011.

[6] The complainant applied to the Information Commissioner ('the Commissioner') for external review of both internal review decisions on 10 and 22 August 2011 and, since both applications relate to the one access application, this office dealt with them as one matter.

…

[17] The HI Act prohibits the disclosure of certain information about declared quality assurance activities. The consequence of an activity being a declared quality assurance activity is that it is unlawful to disclose information identifying individuals that is obtained solely as a result of that activity, except for the purposes of that activity, unless those individuals consent or unless that information can be de-identified. …

The agency's submissions

[23] By letter of 16 February 2012 and in its discussions with this office, the agency submits that:

- Part VC of the HI Act sets out a regime for the protection of confidentiality – qualified privilege – in the conduct of 'quality assurance activities'. Section 124Y of the HI Act (which comes within Part VC) provides that it is unlawful to disclose information identifying individuals that became known solely as a result of a declared quality assurance activity, unless those individuals consent. It is unnecessary for the purposes of s.124Y to satisfy ordinary tests of confidentiality. Rather, the information in question must only meet the requirements of the statutory regime.
- By instrument dated 7 June 2006, the then Commonwealth Minister for Health and Ageing ('the Minister') made a declaration under s.124X of the HI Act that

the activity described in the Schedule to the declaration was a quality assurance activity to which Part VC of the HI Act applied. The declaration described the quality assurance activity as being the Advanced Incident Management System ('AIMS').

- The declaration, although ceased by operation of s.124X(4), was in force at the material times so that s.124Y applies pursuant to the operation of s.124Y(7).
- Once satisfied that the disputed matter is matter to which s.124Y of the HI Act applies, there arises an inconsistency between s.124Y of the HI Act and the access provisions of the FOI Act. The mechanism by which inconsistencies between State and Commonwealth laws are resolved is set out in s.109 of the Commonwealth *Constitution*.
- The High Court has recognised that inconsistency between a Commonwealth and a State law may arise directly or indirectly. It seems, in this instance, that s.10(1) (and the operation of s.76(7)) of the FOI Act may give rise to a direct inconsistency with s.124Y(1) and (2) of the HI Act.
- First, s.10(1) of the FOI Act effectively requires the agency to do something which s.124(Y)(1) of the HI Act prohibits, namely to disclose to the complainant personal information that became known solely as a result of the AIMS process, for a purpose other than a purpose of the AIMS process.
- Second, the operation of s.76(7) of the FOI Act requires the agency to do something which s.124Y(2) of the HI Act prohibits, namely to produce to the complainant information which was brought into existence solely for the purposes of the AIMS process. Such a direct conflict clearly constitutes an inconsistency for the purposes of s.109 of the *Constitution* (Cth): see, for example, *R v Brisbane Licensing Court; ex parte Daniell* [1920] HCA 24; (1920) 28 CLR 23.
- An alternative way of viewing the inconsistency is that ss.10 and 76(7) of the FOI Act effectively make or act upon as lawful something which s.124Y(1) of the HI Act makes unlawful. In *Clyde Engineering Co Ltd v Cowburn* ([1926] HCA 6; 1926) 37 CLR 466 at 489, Isaacs J said that "If one enactment makes or acts upon as lawful that which the other makes unlawful, or if one enactment makes unlawful that which the other makes or acts upon as lawful, the two are to that extent inconsistent."
- In this case, an inconsistency arises only to the extent that the disputed matter was brought into existence solely for the purposes of the AIMS study and contains personal information. The High Court has referred to this type of inconsistency as an 'operational inconsistency': see *Commonwealth v Western Australia (the Mining Act Case)* [1999] HCA 5; (1999) 196 CLR 392 at 417 (Gleeson CJ and Gaudron J), at 441 (Gummow J) and at 478 (Hayne J, McHugh J agreeing at 421).
- Since the disputed matter is taken from the Sentinel Event Notification System, which records the AIMS information, the sentinel event root cause analysis is covered by qualified privilege via the HI Act. [I note that, according to the website of the OSQH, a root cause analysis ('RCA') is "a comprehensive and systematic methodology to identify the gaps in hospital systems and the processes of health care that may not be immediately apparent and which may have contributed to the occurrence of an event."]
- Therefore, as s.124Y applies to Documents 2 and 3, it is not open for s.10 of the FOI Act to apply to them and so the agency cannot disclose them pursuant to a decision under s.76(7) of the FOI Act.

- In *Re Yoo and Sir Charles Gairdner Hospital* [2009] WAICmr 10 the former A/Commissioner at least implicitly accepted that there would have been an inconsistency between s.124Y and the provisions of the FOI Act which require disclosure of documents.

Consideration

[24] The qualified privilege to which the agency refers, citing the HI Act, operates to protect certain information from disclosure and clinicians from civil liability. Qualified privilege is used by hospitals and health professionals to investigate the causes and contributing factors of clinical incidents by encouraging frank disclosure and to conduct quality improvement activities in light of the information obtained. If a health service wishes to conduct an investigation under qualified privilege, it has the choice either of conducting the investigation under the *State Health Services (Quality Improvement) Act 1994* or under the Commonwealth HI Act. In the present case, the agency has advised this office that the relevant investigation was conducted under the HI Act.

[25] In my opinion, the questions for my determination in this matter can be summarised as follows:

- What is the disputed matter?
- What is the relevant quality assurance activity and is it a declared quality assurance activity?
- Who is the "person who acquires any information that became known solely as a result of a declared quality assurance activity", pursuant to s.124Y(1) of the HI Act, in this case?
- Is the disputed matter the subject of qualified privilege pursuant to s.124Y of the HI Act?

The disputed matter

[26] The agency claims in effect that the disputed matter is the whole of Documents 2 and 3, being the Form. However, the agency only claims that the second and third paragraphs of bullet point 2 on page 4 of each document is information that is subject to s.124Y(1) of the HI Act, being information that became known solely as a result of a declared quality assurance activity.

[27] Section 124Y(3) provides, among other things, that s.124Y(1) does not apply to information that does not identify a particular individual or individuals. As I understand it, the agency is arguing that the corollary is that s.124Y(1) applies to any information that identifies – expressly or impliedly – 'particular individuals'.

[28] The agency appears to be arguing that, even if the disputed matter was deleted from the Form, the remaining information would identify particular individuals; 'particular individuals' are individuals who have some association with "information that became known solely as a result of a declared quality assurance activity"; therefore, pursuant to s.124Y(3) of the HI Act, the remaining information in the Form is also covered by s.124Y(1).

[29] In my view, the agency has misunderstood the context of s.124Y. That provision concerns documents that were brought into existence solely for the

purposes of a declared quality assurance activity and information that became known solely as a result of such an activity (see ss.124Y(2)-(4)). In the present case, the relevant matter comprises the second and third paragraphs of bullet point 2 on page 4 of the Form, which the agency claims became known solely as a result of a declared quality assurance activity.

[30] In my view, if qualified privilege exists in this case it is applicable only to the disputed matter and not to the whole of Documents 2 and 3.

What is the relevant quality assurance activity and is it a declared quality assurance activity?

[31] The agency advises this office that the relevant quality assurance activity is AIMS. I understand that the APSF, a not-for-profit independent organisation funded through memberships, consultancies and research grants, developed the AIMS software that is used state-wide (and in other Australian jurisdictions) to collect and analyse information about healthcare incidents, using a classification based on its understanding of iatrogenic harm (that is, harm caused by medical care or treatment).

[32] The agency refers to the Minister's declaration of 7 June 2006 ('the Declaration') made under s.124X of the HI Act. I have examined that document. The schedule to the Declaration describes the "Persons engaging in the activity" as the "Australian Patient Safety Foundation" and the quality assurance activity to which Part VC of the HI Act applies as being the following:

> "Advanced Incident Management System.
>
> The Activity is a study of the incidence or causes of conditions or circumstances that affect the quality and safety of health services. The purpose of the Activity is to investigate and analyse (Phase 2) actual and potential adverse patient incidents to develop preventative strategies using the Advanced Incident Monitoring [sic] System."

[33] The Declaration includes an Explanatory Statement and an attachment headed "Overview of the Activity". The latter states, among other things, that:

> "The Activity [described in the schedule] meets the requirements of section 124X(3)(a) of the Act in that the persons engaged in this activity are authorised to do so by the Australian Patient Safety Foundation, which is an association of health professionals and a body established wholly or partly for the purpose of research, and the bodies that provide health services operating AIMS" and that the declared activity is limited "to the investigation and analysis phase (Phase 2) of the existing Advanced Incident Management System. The Activity as described would allow collection of information through a single point without unnecessarily restricting some sorts of information, the disclosure of which is desirable."

[34] I understand from that Explanatory Statement that the quality assurance activity, AIMS, relates to the quality of health services which would be eligible for payment of Medicare benefits and public hospital services, as required by s.124W(1) of the HI Act.

[35] In light of the above, I am satisfied that the relevant quality assurance activity is Phase 2 of AIMS. In this case, that is the investigation and analysis of the clinical events surrounding Kieran Watmore's death via the AIMS process.

[36] I am also satisfied that Phase 2 of AIMS is a declared quality assurance activity, as described in the Declaration. The Declaration expired at midnight on 9 June 2011 and has not since been renewed. However, I am satisfied that it was in force at the material time and that s.124Y continues to apply to the disputed matter, pursuant to s.124Y(7) of the HI Act.

Who is the "person who acquires any information that became known solely as a result of a declared quality assurance activity", pursuant to s.124Y(1) of the HI Act?

[37] In the present case, the agency acquired the disputed matter. Section 124W of the HI Act defines 'person' for the purposes of Part VC of the HI Act to include a committee or other body of persons, whether incorporated or unincorporated and includes a member of such a committee or other body. The disputed matter was also acquired by the staff member who completed the Form. In my view, the agency and the staff member are each a 'person' for the purposes of s.124Y(1) of the HI Act.

Is the disputed matter the subject of qualified privilege pursuant to s.124Y of the HI Act?

[38] The Declaration states that the 'person' engaging in the AIMS activity is the APSF. I accept that the APSF comes within the definition of 'person' in s.124W of the HI Act.

[39] From the APSF's website, I understand that information acquired by a health service under AIMS is intended to be entered into a database specifically maintained for AIMS. Software designed especially for AIMS collates that information in a form that can be reported within the health service and to the APSF. The electronic information can be used to generate reports of aggregated information in relation to incidents within various classifications. The data is used to develop local and national strategies for preventing the occurrence of adverse incidents in the future.

[40] The Explanatory Statement attached to the Declaration appears to extend the description of the persons engaging in the activity by including persons who are authorised to engage in AIMS by the APSF. In the present case, the agency has provided this office with no information to establish either that it provides information to the APSF or that it was authorised by that body.

[41] My understanding of how AIMS operates within the agency is taken from the agency's "Clinical Incident Management Policy - Using the Advanced Incident Management System (AIMS)" ('the AIMS Policy') and from the Commissioner's meeting with the agency's nominated representative for this matter, the Chief Operating Officer, WA Country Health Service – Northern and Remote, and correspondence with that officer.

[42] The Introduction to the AIMS Policy provides, among other things:

> "... Central to risk management is the reporting, monitoring and management of clinical incidents to the Advanced Incident Management System (AIMS).
>
> AIMS is in place across all WA government area health services and covers the reporting, investigation, analysis and monitoring of clinical incidents that occur as a result of the provision of health care. The main objective of AIMS is to improve health care delivery. The reporting of clinical incidents enables hospital and health service staff to commence an investigation to identify contributing factors and system errors that may have caused or contributed to the incident...
>
> A clinical incident is an event or circumstance resulting from health care which could have, or did lead to, unintended harm to a person, loss or damage, and/or a complaint."

[43] The AIMS Policy makes it clear that staff are encouraged, but not required, to report a clinical incident through AIMS. Reporting is voluntary and the reporter can choose to remain anonymous. I understand that the purpose of this is, among other things, to increase the full and frank reporting of incidents to assist in future prevention of clinical incidents.

[44] The process of reporting, investigating and analysing via AIMS is described on pp.7-9 of the AIMS Policy, as follows:

- Health workers voluntarily submitting a report to AIMS complete a Clinical Incident Form ('AIMS form'), which allows for anonymous reporting. Page 1 of the AIMS form is limited to the notification of the clinical incident, which is not a part of the declared quality assurance activity. Consequently, information contained on page 1 is not protected by qualified privilege. However, the information entered on to page 2 of the AIMS form comprises the first part of the investigation and analysis of the clinical incident and is therefore protected.
- Once a clinical incident has been notified to AIMS, the next stage is for the incident to be investigated and analysed. The AIMS Policy notes: "It is important that all relevant information is provided as the quality of the information reported has a direct impact on the ability of senior management to investigate and analyse clinical incidents, and prevent their recurrence."
- The supervisor of the person reporting the clinical incident or a senior staff member is responsible for conducting a risk assessment, undertaking further investigation and analysis and documenting the appropriate remedial action to be taken.
- The Head of Department, Service Head or Director should comment on, among other things, the action taken or needed to prevent a recurrence and manage future risks, and be satisfied that the relevant risk management has occurred.

[45] In this case, the agency advised this office, by letter of 26 July 2012, that an AIMS form was completed and entered onto the AIMS database in relation to Kieran Watmore's death by the end of the day on which he died, 28 August 2008, and that the death was reported as a sentinel event pursuant to its Sentinel Event Policy (2008) ('the SE Policy') by a senior staff member on 15 September 2008.

[46] The SE Policy describes sentinel events as rare events that lead to catastrophic patient outcomes. Unlike the reporting of clinical incidents to AIMS, the SE Policy states that the reporting of sentinel events is mandatory for all public hospital and health service staff.

[47] The agency's SE Policy includes the following advice at pp.4-6:

> "Sentinel events must be reported using the Sentinel Event Notification Form and include the hospital identification code, the date on which the event occurred, a brief description of the sentinel event and whether the investigation will be conducted under qualified privilege or is a coroner's case ... Notifications can be submitted via secure fax, email, post or courier."
>
> "Sentinel events should also be reported to the Advanced Incident Management System (AIMS). See the Clinical Incident Management Policy for WA Health Services using the Advanced Incident Management System for further information."
>
> " Root Cause Analysis (RCA) is one investigation methodology recommended ...Following an investigation, the Sentinel Event Final Report is to be forwarded to the Senior Policy Officer at the Office of Safety and Quality in Healthcare within 45 working days of initial notification. The Office ... acts as a central repository of de-identified recommendations arising from the investigations of sentinel events and where appropriate will disseminate lessons learned to hospitals and health services across the State."

[48] Public hospital and health services can investigate a sentinel event under qualified privilege via the AIMS process. The SE Policy states at p.8:

> "6.2 Conducting sentinel event investigations under the Commonwealth qualified privilege scheme by concurrent reporting to the Advanced Incident Management System (AIMS)
>
> Public hospital and health services can investigate a sentinel event under qualified privilege via the AIMS process. In such cases, the hospital should notify the Senior Policy Officer at the Office of Safety and Quality in Healthcare in the required way and then investigate and analyse the incident using the Commonwealth qualified privilege scheme."

[49] The agency's Chief Operating Officer has advised this office that, in the present case, the Sentinel Event Notification form was not completed in hard copy but that the notification was made directly onto the Sentinel Event Notification System database.

[50] In answer to this office's questions about what the 'study, investigation or analysis' conducted under AIMS in relation to Kieran Watmore's death consisted of, the agency's Chief Operating Officer advised as follows:

> "an incident investigation process was initiated under AIMS led by the Regional Medical Director and with assistance from nursing staff from the hospital, a doctor from another facility and the regional clinical risk manager. Over the course of the investigation assistance was also sought from staff external to the region such as the Executive Directors Medical and Nursing

> Services and the Area Director Safety and Quality. A final report was agreed and submitted to the Department on 13 February 2009. The investigation process was at times referred to as a Root Cause Analysis".

[51] Since the agency is claiming that that investigation process or RCA is subject to qualified privilege, no copy of the final report was provided to this office.

[52] From the above, it is evident that the agency had several avenues available – and used more than one of them – to investigate the circumstances surrounding Kieran Watmore's death at ARH on 28 August 2008.

[53] In order to rely upon the prohibition against disclosure contained in s.124Y(1) of the HI Act, it is necessary for the agency to establish that the disputed matter – and any related matter – became known solely as a result of Phase 2 of AIMS, this being the declared quality assurance activity.

[54] On the information before me, it is not clear whether the agency is claiming that the sentinel event notification made on 15 September 2008 was concurrently reported to AIMS – in view of the fact that the agency has also advised me that an AIMS notification was made on 28 August 2008 – and whether the agency conducted one or two RCAs or investigations in respect of those two separate notifications.

[55] Following Kieran Watmore's death, the Coroner conducted an inquest and handed down his findings on 30 September 2009. In addition, the ARH conducted its own internal investigation, which was completed by way of a report dated 27 October 2009.

[56] I have examined the Form, dated 14 October 2009, which is Documents 2 and 3. The disputed matter contains much of the factual information set out in the Coroner's report, which had been published by the time that the Form was completed.

[57] In my view, it is not clear from the disputed matter, and the related matter surrounding it, whether the former became known solely as a result of Phase 2 of AIMS or from other sources that produced relevant information. Moreover, the relevant AIMS activity described to me by the agency's Chief Operating Officer as being 'the study, investigation or analysis' conducted under AIMS appears to have been a different activity to that described in the disputed matter and undertaken by different officers of the agency.

[58] In addition, Documents 2 and 3 refer to another document that was not included with the Form given to the NMB on the ground that it was protected by qualified privilege. The agency confirmed that the reference there to qualified privilege was a reference to the HI Act. The agency was unable to explain to this office what that document was and why it was said to be the subject of qualified privilege when the disputed matter was not originally claimed to be protected from disclosure to me by virtue of qualified privilege. In answer to this office's questions, the agency advised that the senior officer who filled out the Form was aware of the fact that an entry concerning Kieran Watmore's death had been made onto the AIMS database on 28 August 2008. In light of that, it is not evident why that senior officer, being aware of information that was covered by qualified privilege and

claiming that privilege for other information, did not also claim qualified privilege for the disputed matter.

[59] It appears that Kieran Watmore's death was investigated as being both a sentinel event and as reportable under AIMS. If the agency had conducted a sentinel event investigation concurrently with an AIMS investigation – which it is not clear to me that it did – could it still be said that the disputed matter became known 'solely' as a result of an AIMS investigation rather than a sentinel event investigation?

[60] In dealing with this complaint there have been a number of unknowns and, on occasion, it has been exceedingly difficult to obtain relevant information from the agency to assist this office's understanding of this matter, despite requests over a considerable period of time. Since the agency has raised this claim, the agency bears the onus of persuading me that it has made out the elements of s.124Y(1) of the HI Act and, for the reasons given here, the agency has not done so.

[61] On the information before me, I am not satisfied that the disputed matter acquired by the agency and the officer completing the Form became known "solely as a result of a declared quality assurance activity", that is Phase 2 of AIMS. Consequently, I consider that s.124Y of the HI Act has no application to the disputed matter.

Stanford v DePuy International Ltd (No 3) [2015] FCA 325 —

[4] On 2 April 2015 I gave a preliminary indication that the underlying data should be provided by the applicants to the respondents. When the matter was the subject of argument on 7 April 2015, the applicants submitted that the raw data are not able to be disclosed, including by way of production to the Court, due to the Registry's role in carrying out declared quality assurance activities under s 124Y of the Health Insurance Act 1973 (Cth). I have been provided with a copy of the Minister's declaration, by way of legislative instrument, of the Registry as providing a declared quality assurance activity under s 124X of the *Health Insurance Act*. …

[10] Neither subsection (1) nor subsection (2) [of s 124Y] applies to information or to a document that does not identify, either expressly or by implication, a particular individual or particular individuals: see subsections (3) and (4).

[11] In my opinion, it is too broad a proposition to say that disclosure of the data underlying the analysis would enable the identification of individual patients and may also identify individual surgeons and hospitals associated with the relevant procedures.

[12] In my opinion, a hospital, as such, is not within the words "a particular individual or particular individuals" as, consistently with s 2B of the *Acts Interpretation Act 1901* (Cth), "individual" means a natural person. Thus, it may be not be prohibited to disclose the names of the hospitals, although not where so to do would identify, either expressly or by implication, a particular individual or particular individuals. It may be that disclosure of the names of the three hospitals would identify by implication the names of the individual surgeons.

125A Federal Court may order person to pay a pecuniary penalty for contravening a civil penalty provision

Within 6 years of a person contravening a civil penalty provision under the Act, the Chief Executive Medicare, may apply to the Federal Court for an order that the wrongdoer pay the Commonwealth a pecuniary penalty. In determining the amount of the penalty to impose, the Court must have regard to all relevant matters, including:

- the nature and extent of the contravention; and
- the nature and extent of any loss or damage suffered as a result of the contravention; and
- the circumstances in which the contravention took place; and
- whether the person has previously been found by the Court in proceedings under this Act to have engaged in any similar conduct.

In *Australian Building and Construction Commissioner v Pattinson* [2022] HCA 13, the High Court set out relevant principles for determining a civil penalty:

- The sum of the penalty should be set at an amount that is reasonably necessary to deter further contraventions of a like kind by the wrongdoer or others. The Court must consider what sum would be necessary to make continuation of the non-compliance with the law too expensive to maintain, or to deter repetition by the wrongdoer and others who might be tempted to contravene the relevant law. In this respect, regard may be had to historical non-compliance.
- Unlike for criminal offences, there is no notion of proportionality to the seriousness of the conduct, such that the maximum penalty is not reserved for the most serious examples of offending.
- Nevertheless, proportionality is relevant insofar as that concept is understood to refer to a penalty that strikes a reasonable balance between the need for deterrence and oppressive severity.
- Factors to which the Court will have regard in setting an appropriate penalty will include matters pertaining both to the character of the contravening conduct and to the character of the wrongdoer. The following list of matters was approved by the Court:
    - The nature and extent of the contravening conduct.
    - The amount of loss or damage caused.
    - The circumstances in which the conduct took place.

- The size of the contravening entity.
- The degree of power it has, as evidenced by its market share and ease of entry into the market.
- The deliberateness of the contravention and the period over which it extended.
- Whether the contravention arose out of the conduct of senior management or at a lower level.
- Whether the company has a corporate culture conducive to compliance with the Act, as evidenced by educational programs and disciplinary or other corrective measures in response to an acknowledged contravention.
- Whether the company has shown a disposition to co-operate with the authorities responsible for the enforcement of the Act in relation to the contravention.

- Other factors identified by the Court included:
  - whether the contravention was a 'one-off' result of inadvertence by the wrongdoer, or the latest instance of the wrongdoer's pursuit of deliberate recalcitrance;
  - whether the contravention occurred through ignorance of the law;
  - whether the official responsible for a contravention has been disciplined for his or her actions;
  - whether the wrongdoer has expressed remorse for the contravention; and
  - whether the occasion in which a contravention occurred is unlikely to arise in the future, for example because of changes in the constitution of the management of the wrongdoing entity.

Australian Building and Construction Commissioner v Pattinson (2022) 399 ALR 599 [2022] HCA 13 (per Kiefel CJ, Gageler, Keane, Gordon, Steward and Gleeson JJ) —

> [15] Most importantly, it has long been recognised that, unlike criminal sentences, civil penalties are imposed primarily, if not solely, for the purpose of deterrence. The plurality in the *Agreed Penalties Case* said:
>
> > "[W]hereas criminal penalties import notions of retribution and rehabilitation, the purpose of a civil penalty, as French J explained in *Trade Practices Commission v CSR Ltd*, is primarily if not wholly protective in promoting the public interest in compliance:

> 'Punishment for breaches of the criminal law traditionally involves three elements: deterrence, both general and individual, retribution and rehabilitation. Neither retribution nor rehabilitation, within the sense of the Old and New Testament moralities that imbue much of our criminal law, have any part to play in economic regulation of the kind contemplated by Pt IV [of the Trade Practices Act] ... The principal, and I think probably the only, object of the penalties imposed by s 76 is to attempt to put a price on contravention that is sufficiently high to deter repetition by the contravenor and by others who might be tempted to contravene the Act.'"

[16] In a similar vein, in Construc*tion, Forestry, Maritime, Mining and Energy Union v Australian Building and Construction Commissioner*, the Full Court of the Federal Court cited the decision of French J in *Trade Practices Commission v CSR Ltd* and the reasons of the plurality in the Agreed Penalties Case as establishing that deterrence is the "principal and indeed only object" of the imposition of a civil penalty: "[r]etribution, denunciation and rehabilitation have no part to play".

[17] In explaining the deterrent object of civil penalty regimes such as that found in the Act, the majority of this Court in *Australian Competition and Consumer Commission v TPG Internet Pty Ltd* approved the statement by the Full Court of the Federal Court in *Singtel Optus Pty Ltd v Australian Competition and Consumer Commission* that a civil penalty:

> "must be fixed with a view to ensuring that the penalty is not such as to be regarded by [the] offender or others as an acceptable cost of doing business".

[18] In *CSR*, French J listed several factors which informed the assessment under the *Trade Practices Act 1974* (Cth) of a penalty of appropriate deterrent value:

> "The assessment of a penalty of appropriate deterrent value will have regard to a number of factors which have been canvassed in the cases. These include the following:
>
> 1. The nature and extent of the contravening conduct.
>
> 2. The amount of loss or damage caused.
>
> 3. The circumstances in which the conduct took place.
>
> 4. The size of the contravening company.
>
> 5. The degree of power it has, as evidenced by its market share and ease of entry into the market.
>
> 6. The deliberateness of the contravention and the period over which it extended.
>
> 7. Whether the contravention arose out of the conduct of senior management or at a lower level.
>
> 8. Whether the company has a corporate culture conducive to compliance with the Act, as evidenced by educational programs and disciplinary or other corrective measures in response to an acknowledged contravention.

9. Whether the company has shown a disposition to co-operate with the authorities responsible for the enforcement of the Act in relation to the contravention."

[19] It may readily be seen that this list of factors includes matters pertaining both to the character of the contravening conduct (such as factors 1 to 3) and to the character of the contravenor (such as factors 4, 5, 8 and 9). It is important, however, not to regard the list of possible relevant considerations as a "rigid catalogue of matters for attention" as if it were a legal checklist. The court's task remains to determine what is an "appropriate" penalty in the circumstances of the particular case.

…

Contravention vs contravenor

[56] One way of characterising the error of the Full Court was that, in reasoning to the conclusion that the CFMMEU's contraventions were not deserving of the maximum penalty, it sought to draw a sharp distinction between the circumstances of the contraventions and the circumstances of the contravenor. In focussing upon this distinction, the Full Court concluded that, having regard to the circumstances of the contraventions, which were not examples of the worst sort of conduct comprehended by s 349(1), the primary judge erred in imposing the maximum penalty.

[57] But on the approach in CSR and affirmed in the decisions of this Court referred to above, both the circumstances of the contravenor and the circumstances of the contravention may be relevant to the assessment of whether the maximum level of deterrence is called for. Indeed, as long ago as *Trade Practices Commission v Stihl Chain Saws (Aust) Pty Ltd*, in a passage referred to with evident approval by French J in *CSR*, Smithers J said that a civil penalty "should constitute a real punishment proportionate to the deliberation with which the defendant contravened the provisions of the Act".

[58] The distinction upon which the Full Court sought to insist cannot control the balancing exercise required by s 546. Indeed, it is difficult to see how this distinction serves any useful purpose in this context. Once it is accepted, as it must be, that the maximum penalty is intended by the Act to be imposed in respect of a contravention warranting the strongest deterrence within the prescribed cap, there is no warrant for the court to ascertain the extent of the necessity for deterrence by reference exclusively to the circumstances of the contravention. The categories of circumstances may overlap, in that matters may bear upon both the seriousness of the contravention and the intransigence of the contravenor. Further, circumstances which can be said to relate exclusively to the contravenor may bear strongly on what level of deterrence will be "appropriate".

[59] The majority in Broadway on Ann and the primary judge in this case were correct in concluding that the need for deterrence in each case, demonstrated by a persistent adherence to a strategy of non-compliance, warranted the imposition of the maximum penalty. They were also correct to reject the proposition that the court's assessment of what was reasonably necessary for deterrence was subject to

the constraint that the maximum penalty could not be imposed in any case where the contravening conduct was not the worst example of contravening conduct. But to the extent that the majority in Broadway on Ann and the primary judge reached these conclusions by reasoning that the contravenor's history of contraventions was relevant only because it was a factor that made the circumstances of the contraventions of the most serious kind, their Honours might be said to have adopted an unnecessarily strict focus on the seriousness of the contravening conduct as distinct from the circumstances of the contravenor. It is not necessary that the task of setting a penalty that is "appropriate" to deter further contraventions should proceed by considering characteristics of the contravenor only to the extent that they can be said to bear upon the seriousness of the contravening conduct.

The circumstances of the contravenor

[60] Indeed, in some cases, the circumstances of the contravenor may be more significant in terms of the extent of the necessity for deterrence than the circumstances of the contravention. In this regard, it is simply undeniable that, all other things being equal, a greater financial incentive will be necessary to persuade a well-resourced contravenor to abide by the law rather than to adhere to its preferred policy than will be necessary to persuade a poorly resourced contravenor that its unlawful policy preference is not sustainable. It is equally obvious that, the more determined a contravenor is to have its way in the workplace and the more deliberate its contravention is, the greater will be the financial incentive necessary to make the contravenor accept that the price of having its way is not sustainable.

…

Conclusion

[66] The theory of s 546 of the Act is that the financial disincentive involved in the imposition of a pecuniary penalty will encourage compliance with the law by ensuring that contraventions are viewed by the contravenor and others as an economically irrational choice. Whether or not experience vindicates the theory of the Act is a matter for Parliament. The court's function is to give effect to the intention of the Act. In this regard, the court must do what it can to deter non-compliance with the Act.

[67] Where it is evident that a contravention has occurred as a matter of industrial strategy pursued without regard for the law, it is open to a court acting under s 546 reasonably to conclude that no penalty short of the maximum would be appropriate. The circumstance that the imposition of the maximum penalty might not prove in fact to be effective to deter further contraventions is not a reason to impose a lesser penalty or no penalty at all.

[68] The judicial task of setting an "appropriate" penalty under s 546 of the Act is informed by well-settled principles that have been applied without difficulty, and which require no supplementation by the Full Court's "notion of proportionality", drawn from the criminal law context of *Veen [No 2]*.

128A False statements relating to medicare benefits etc.

It is an offence of strict liability to make or authorise the making of a statement that is false or misleading in a material particular and capable of being used in connection with a claim or benefit or payment under the Act.

El Rakhawy v The Queen [2011] WASCA 209 —

> [50] The respondent provided a schedule setting out sentences imposed for frauds upon Medicare both in this and other States. In respect of Commonwealth offences it is desirable to try and achieve consistency of sentencing on a national basis. The schedule included sentences imposed both at first instance and considered on appeal. It also included sentences for other types of frauds and under both Commonwealth and State law. For present purposes I have limited consideration to those cases that relate to frauds on the Medicare system. They will be referred to in reverse chronological order.
>
> [51] In ***Quetcher v The Queen*** [2010] NSWCCA 257 the offender was a branch manager at Medicare. Over a period of four years and eight months the offender created 65 false identities and processed some 387 fraudulent claims for benefits totalling $156,034.50. The fraud also involved the creation of false supporting documents and departmental records. She denied responsibility when interviewed and falsely implicated other officers. The offender was found guilty after a trial. At the time of sentencing she was 48 years old, with no criminal record and had prior good character. She had not made reparation at the time of sentencing. She was convicted of 65 offences of obtaining financial advantage by deception, contrary to s 134.1(1) of the *Criminal Code* (Cth), for which the maximum sentence is 10 years' imprisonment. She was sentenced to a total effective head sentence of 8 years with a non-parole period of 5 years. An appeal against sentence was dismissed. Consideration was given to other cases involving frauds by Commonwealth officers: *R v Pipes* [2004] NSWCCA 351; *Gok v The Queen* [2010] WASCA 185. Particular emphasis was placed on the applicant's abuse of her responsible position and the sophistication of the fraud. Though the amount defrauded is comparable with the present case, the circumstances and the absence of a plea of guilty justified a very much higher sentence in *Quetcher*.
>
> [52] In ***R v Price*** [2008] QCA 330 the offender was a medical practitioner who provided prescriptions to patients where those patients did not require the drugs for an approved purpose. One hundred and sixty six prescriptions were provided in these circumstances. The offender was charged with one offence of unauthorised writing of prescriptions, contrary to s 103(5)(h) and s 88A of the *National Health Act 1953* (Cth). The maximum penalty for this offence was 2 years' imprisonment and/or a $5,000 fine. The offending conduct had occurred between 27 August 2002 and 2 November 2004. The offender was 40 years of age at the time of sentence, had no prior record and did not obtain any financial advantage from the offending. A sentence of 12 months' imprisonment to be released forthwith upon giving security to be of good behaviour for a period of 2 years, that is a suspended sentence, was upheld on appeal.

[53] In ***R v Squire*** [2008] QCA 19 the offender created 17 false invoices from doctors for services that were not provided. She obtained approximately $45,000 by this means and attempted to obtain a further $5,000 by attempting to make a claim using another person's identity. At the time of sentencing the offender was a single mother of 34 years of age with two children, one having special needs. She had previous convictions for dishonest offending. She did not have the capacity to make reparation of the funds obtained. She had previously worked as a pharmacy assistant and was addicted to prescription drugs. The offender was charged with one count of obtaining a financial advantage by deception, contrary to s 134.2 of the *Criminal Code* (Cth) and one count of attempting to obtain a financial advantage by deception, contrary to s 11.1 and s 134.2 of the *Criminal Code* (Cth). An effective sentence of 2 years and 6 months' imprisonment to be released after 9 months upon entering into a recognisance release order in the amount of $2,500 to be of good behaviour for 3 years was imposed. An appeal against that sentence was dismissed.

[54] In ***Turyn v The Queen*** [2007] ACTCA 23 the offender was a Medicare employee who, over a period of two years, processed 349 false claims for Medicare rebates. The total benefit obtained by the offender was $165,448.45. At the time of sentencing the offender was 33 years of age with three young children and was pregnant with a fourth child. She had no prior convictions, was suffering from depression and was at risk of suicide if imprisoned. The sentencing judge took into account the likely impact a term of imprisonment would have on the offender's children. The sentence imposed was 3 years' imprisonment to be released after serving 4 months on entering into a recognisance release order in the sum of $2,000 to be of good behaviour for 3 years. A prosecution appeal against that sentence was dismissed. In dismissing the appeal the court noted that the sentencing judge was entitled to have regard to the impending birth of the offender's fourth child.

[55] In ***Norvenska v Director of Public Prosecutions (Cth)*** [2007] NSWCCA 158 the offender was an employee of a bulk billing medical practice in Sydney. Over a 13 month period the offender altered Medicare assignment forms in order to claim higher benefits. The offender did not obtain any direct personal benefit from the offending other than the continued viability of the medical practice. The sentencing judge accepted that the offender believed he was making corrections to the forms and was not motivated by personal gain. The offender had cooperated with authorities. The total fraud involved was $133,563.35. The offender was charged with one offence of defrauding the Commonwealth, contrary to s 29D of the Crimes Act. The sentence imposed was 2 years and 6 months' imprisonment to be released forthwith on entering into recognisance in the sum of $1,000 to be of good behaviour for 2 years and 6 months, that is a suspended sentence. An appeal against conviction (seeking to withdraw a plea of guilty) was dismissed. The appropriateness of the sentence was not considered by the appeal court.

[56] In ***Sood v The Queen*** [2006] NSWCCA 114; (2006) 165 A Crim R 453 the appellant was a medical practitioner who obtained cash payments from patients for services rendered and then also made claims for payments to Medicare for the same services. She was charged with 96 offences of obtaining financial advantage by deception, contrary to s 134.2 of the *Criminal Code* (Cth). The total fraud involved was $154,376 and that fraud was said to have occurred between 4 May 2001 and 30 October 2001. The appellant pleaded not guilty and was found guilty at trial.

The appellant was sentenced to 300 hours community service and fined $23,750. An appeal against conviction was allowed and a new trial ordered.

[57] In ***White v Taylor*** [2001] WASCA 350 the offender was a 34-year-old general practitioner practising at two Perth hospitals. On 116 occasions he attended at pharmacies and obtained prescription drugs using his own prescription pad. The prescriptions were written out in the names of two women without their knowledge. The offender was separated and it was said that the break down of his marriage had led to depression and drug abuse which ultimately led to the offending. He had previously been imprisoned for other offences and had suffered assaults whilst in prison. At the time of sentencing the offender was in a stable relationship with another child expected. He was charged with 116 offences of obtaining property by fraud, contrary to s 409(1)(a) of the *Criminal Code* (WA). A total effective sentence of 18 months' imprisonment with eligibility for parole was upheld on appeal.

[58] In ***Lim v Bateman*** [2000] WASCA 77 a medical practitioner was alleged to have made 70 false claims for services in that she had claimed benefits for out-of-hours consultations when in fact the consultations were made within ordinary hours, which attracted a lower fee. It was not disputed that she had provided the medical services. The appellant in that case accepted that she had made a stupid error in ticking the wrong box on the claim form but said that she had no intention of defrauding the system. She was charged with 70 offences of making false statements, contrary to s 128A of the *Health Insurance Act 1973* (Cth). The total fraud involved was said to be $4,211.50. The matter went to trial in the Magistrates Court and on conviction the appellant was fined $15,000 as a global penalty. An appeal against that sentence was dismissed, a subsequent appeal against conviction was allowed and a retrial was ordered: *Lim v Bateman* [2001] WASCA 307; (2001) 125 A Crim R 101.[200]

[59] In ***Jemielita v The Queen*** (Unreported, WASC, Library No 930589, 19 October 1993) the offender was a medical practitioner who claimed higher fees for Medicare benefits than he was entitled to receive. He was charged with 34 offences of making a false or misleading statement, contrary to s 128B of the *Health Insurance Act 1973*. The period of offending was just over 24 months. The information provided by the respondent to this court states that the total fraud was $8,394.30 and the penalty imposed was 12 months' imprisonment to be released forthwith on a 12-month good behaviour bond, that is a suspended sentence, and a fine of $8,400. An appeal against the convictions was dismissed. No challenge to the sentence was made.

[60] In ***Udechuku v The Queen*** (Unreported, WASC, Library No 930318, 25 May 1993) the offender was a medical practitioner who included false claims for services in claims submitted for Medicare benefits. The appellant was charged on an indictment containing 44 counts each alleging a contravention of s 128B of the *Health Insurance Act 1973*. He was convicted of 26 counts and acquitted of the remainder. The period of the offending was 4 months. The amount of the fraud involved was not stated. The offender's wife was a co-offender. She played a subordinate role and had no relevant record and was fined. The offender had a prior

[200] The appeal succeeded on the ground that in admitting liability on behalf of Dr Lim, her counsel appeared not to have appreciated a defence that might have been available to her under s 128B(5).

conviction for similar offending. For the present offences, an effective sentence of 3 years and 6 months' imprisonment with eligibility for parole was ordered. The appeals against conviction and sentence were dismissed.

[61] In ***Corbett*** (1991) 52 A Crim R 112 the offender was a medical practitioner running a practice which employed a number of other doctors. Over a period of approximately 12 months the offender made 439 false statements for services that were not provided contrary to s 128B and s 129 of the *Health Insurance Act 1973*. Ninety-two charges were chosen as being representative of the total. The total fraud involved was in excess of $560,000. At the time of sentencing the offender was 34 years of age and had no previous criminal history. Psychiatric evidence indicated that he suffered from serious depression arising from separation from his wife which preceded the offending conduct. He was described as withdrawn and chronically depressed and was given to overwork and extensive use of stimulants. Psychiatric reports did not cast any substantial light upon the reasons for the offender's behaviour, which appeared mainly to be directed to the acquisition of money for the purpose of buying real estate. The offender pleaded guilty, but at a late stage. A sentence of 8 years' imprisonment with a non-parole period of 6 years was reduced to 7 years and 6 months' imprisonment with a non-parole period of 4 years on appeal.

[62] In ***Canning v Northcott*** (Unreported, WASC, Library No 7194, 14 July 1988) the offender was a medical practitioner who made 39 false claims for services to Medicare. Some of the false claims were for services not actually rendered, others were claims for longer consultations than had actually occurred. The total fraud involved was just over $1,000. The offender was charged with 39 offences of furnishing false documents, contrary to s 129(1) of the *Health Insurance Act 1973* (as it then read). A fine of $17,000 was reduced on appeal to $10,000. In allowing the appeal the court noted that the fine of $17,000 was 16 times the amount of the financial benefit obtained.

[63] In addition to those cases my own researches have disclosed the following case.

[64] In ***R v Zongas*** [1997] NSWSC 533, the offender was an optometrist who pleaded guilty to one count of defrauding Medicare by making fraudulent claims for services over a two-month period to a total value of $61,749. This was said to be part of a larger course of conduct (for which she was not charged). The sentencing judge ordered that the offender be released upon giving security by way of recognisance in the sum of $2,000. She was also required to comply with a number of conditions. The prosecution appealed against the original non-custodial sentence. That appeal was allowed and a sentence of 9 months' periodic detention was imposed. That sentence was reduced by reference to the double-jeopardy principle then applying to a prosecution appeal on sentence. Allowance was made for a psychiatric illness suffered by the offender.

[65] The assistance that can be obtained from these cases is limited. It is not possible to discern a customary range of sentences imposed for offences of this type from the cases referred to. A number of the more serious cases involved internal frauds committed by Medicare employees. The manner in which those frauds were committed was quite different to that in the present case. As to frauds committed

by medical practitioners, the circumstances of the frauds committed in the cases referred to varied significantly and this is reflected in the sentences imposed.

R v Zoghbi [2022] NSWDC 219 —

[148] The Crown provided the court with a Schedule of Cases, together with full copies of each of those decisions. Whilst recognising that individual sentences turn on the particular circumstances of each case, such schedules and decisions are of considerable utility both in illustrating the appropriate range for similar offending and in the attainment of consistency in sentencing for Commonwealth matters in different States. The tendered schedule is divided according to the position of the respective offenders as either a medical practitioner, an employee of medical practices, or an employee of Medicare. Some of the cases relate to defrauding the Commonwealth with respect to tax frauds. I propose to refer to those cases in the chronological sequence in which they were decided.

…

[156] In ***El Rakhawy v R*** [2011] WASCA 209, a 52-year-old medical practitioner pleaded guilty to 11 counts of dishonestly obtaining a gain from Medicare, contrary to the provisions of s 135.1 of the Criminal Code (Cth). The maximum penalty was 10 years' imprisonment and the effective sentence which was passed was 4 years' imprisonment with a single non-parole period of 2 years 4 months.

[157] Over a period of approximately 2 years 4 months between April 2007 and August 2009, the offender made claims for payment to Medicare for services which he represented had been provided to patients. The offender had made additional claims relating to alleged bulk billing for services which had not been provided to the patient. Each of the 11 counts related to a number of separate false claims within an identified period. Within each of those false claims, there were numerous false items which had been fraudulently claimed.

[158] The offender had pleaded guilty at the first available opportunity and had repaid the total amount defrauded, namely $121,599.90. At the time of sentence, he was bankrupt and unemployed. At the time of sentence, the maximum penalty for an offence of carrying out an act with the intention of dishonestly obtaining a gain from a Commonwealth entity, contrary to s 135.1(1) of the Criminal Code (Cth), was imprisonment for 5 years. I am constrained to observe in passing that the fact that there was a lesser maximum penalty available with respect to Dr El Rakhway is a significant fact which does not appear to have made its way into the commentary in the schedule which has been provided. The individual charges related to total amounts defrauded which ranged from approximately $327.00 (Count 3) up to $41,460.85 (Count 6).

[159] The number of false items within the various false claims similarly ranged from as little as 6 false items (Count 3) and up to 640 false items (Count 6). Similarly the variation in the number of false claims ranged from as little as 3 (Counts 3 and 7) up to 35 false claims (Count 11). The judge at first instance imposed sentences of 2 years with respect to each of the 11 counts. He accumulated the 2 years imposed for Count 2 with the 2 years for Count 1 and directed that the remaining 9 sentences of 2 years each were to be served concurrently with each

other and with Count 1. As already indicated, the effective sentence was 4 years with a 2 year 4 month non-parole period.

[160] The offender appealed against the severity of the individual sentences and against the total effective sentence.

[161] In due course, the Western Australian Supreme Court reduced the aggregate sentence to one of 3 years and ordered the release of the appellant on a recognisance release order after serving 20 months imprisonment

[162] In determining that the appeal against the overall sentence should be allowed, Hall J of the Western Australian Court of Appeal undertook a detailed review of some 13 cases which had involved false claims committed on Medicare. Those cases involved fraudulent claims by medical practitioners as well as internal frauds committed by Medicare employees. The related to different maximum penalties in some instances and to a wide range of different amounts which had been defrauded. They ranged from a total fraud of just over $1000 (*Canning v Northcott* (unreported, WASC Library Number 7194, 14 July 1988)) up to an amount in excess of $560,000 (*Corbett v R* (1991) 52 A Crim R 112).

[163] In *Canning v Northcott*, a medical practitioner had made 39 false claims for services to Medicare. Some related to services which had not been rendered whilst others claimed longer consultations than had actually occurred. A pecuniary penalty of $10,000 was imposed.

[164] *Corbett* on the other hand related to 439 false claims for services which had not been provided. The offender was 34 years of age and was a medical practitioner running a practice which employed a number of other doctors. Psychiatric evidence indicated the offender suffering from serious depression following the breakdown of his marriage. He pleaded guilty to 92 charges broadly described as "medifraud". 92 charges, described as representative, were brought with respect to various provisions of the *Health Insurance Act 1973* (Cth). The offences carried a maximum term of imprisonment of 5 years. The sentencing judge, Judge Cooper of the NSW District Court, had imposed head sentences which ultimately involved an overall term of imprisonment for 8 years. His Honour fixed an aggregate minimum term of 6 years.

[165] In *Corbett* the NSW Court of Criminal Appeal, Gleeson CJ, Priestley JA and Matthews J, upheld the appeal against severity and varied the effective orders to result in total head sentences of 7 years 6 months with a non-parole period of 4 years.

[166] It is important to note that the fact of different sentencing regimes, including in Corbett the need to take into account pursuant to s 16G of the Commonwealth Crimes Act the absence of remissions in NSW at that time, leads to particular difficulty in utilising any numerical equivalents by way of comparison. However, whilst noting difficulties involved in relying too heavily upon previous sentencing patterns, the Court made the following observation with respect to dealing with white-collar crime as at 1991:

> "Nevertheless, a feature of past sentencing for "white-collar" crimes involving fraudulent abuse of trust, and sometimes involving fraud on the public purse,

> has been the imposition of lengthy head sentences, but with a substantial gap between head sentence and non-parole periods or minimum terms. This has probably been the consequence of a desire on the part of the courts, on the one hand, to reflect the need for general deterrence and, on the other hand, to give due account to the fact that the offenders involved frequently have no prior criminal history, are unlikely to re-offend, and have good prospects of rehabilitation."

[167] Hall J made the observation that in some respects the case involving Dr El Rakhawy bore similarities to that of *Corbett*. His Honour observed (at [66]):

> "However, the offender in that case obtained a much larger sum of money, was convicted of many more offences and pleaded guilty at a very late stage. Those factors are reflected in the higher total sentence imposed in Corbett."

[168] Hall J noted that the different offences occurred as part of a course of conduct. Taking that context into account, it was not possible to conclude that individual sentences of 2 years were in error. His Honour thought that the real question was whether the total effective sentence was appropriate. After giving consideration to the principle of totality, Hall J came to the view that the total effective sentence was particularly high when compared to a number of the more comparable cases. His Honour noted that systematic frauds committed by professionals such as doctors or lawyers and involving large sums of money were viewed as particularly serious. Hall J said: "they are an abuse of the privilege and responsibility that a member of a profession has and they can impact adversely on the reputation of that profession as a whole." However, his Honour concluded that: "on the other hand, the fast-track plea of guilty, cooperation with authorities, and full restitution were significant mitigating factors." The court accordingly came to the view that the total effective sentence of 4 years was disproportionate and that the total effective sentence should be reduced to one of 3 years. The court ordered that the offender be released on a recognisance release order after serving 20 months imprisonment. Accordingly, the head sentence was reduced by 12 months and the minimum term to be served by 8 months.

…

[175] In ***DPP v Golic*** [2014] VSCA 355, the offender pleaded guilty to a number of offences which had arisen as a consequence of her having made false claims to Medicare and also to her private health insurer with respect to obtaining reimbursement for medical expenses which she had not incurred. The background to the offending indicated that the offender had begun to suffer from a depressive illness when she was in Year 11 at school. She had been prescribed antidepressants since that time.

[176] In 2006, when she was 23, she was diagnosed as having an inoperable brain tumour. She was advised that she might only live for a month, or for a year, or for 10 years. She was working as a bookkeeper at an accountancy firm and was introduced to gambling by her colleagues. She went on to develop a serious gambling addiction. By May 2007, she entered bankruptcy having declared significant debts.

[177] In 2010, she was advised of the possibility of undertaking neurosurgery for her brain tumour notwithstanding that the surgery involved considerable risk. In 2011, she undertook the neurosurgery and made a complete recovery. However, following the operation, her gambling intensified and between March 2012 and May 2013, she committed the offences.

[178] Although systematic and planned, the offending was relatively unsophisticated. The offender simply copied a genuine invoice relating to her earlier neurosurgery and used it as a template to create false invoices which she used to make her claims on Medicare and her private health insurer.

[179] Ultimately, 34 false invoices were lodged with Medicare, at different Medicare offices, resulting in the fraudulent obtaining of rebates in an amount of approximately $200,000. This offending was charged as obtaining a financial advantage by deception contrary to s 134.2(1) of the Criminal Code (Cth).

[180] Two further false invoices were lodged in an unsuccessful attempt to obtain further rebates for approximately $17,000. This was separately charged as an attempt to obtain a financial advantage by deception contrary to the same provision of the Criminal Code (Cth). The obtaining of almost $43,000 from the offender's private health insurer, Bupa Australia, resulted in a Victorian State Crimes Act offence of obtain a financial advantage by deception contrary to s 82(1) of the *Crimes Act 1958* (VIC). Each of the three charges carried a maximum penalty of 10 years imprisonment.

[181] The offender had begun receiving treatment for her depression from a psychiatrist following her neurosurgery in 2011 and prior to the commencement of the commission of the offences. She was also on the maximum dose of an antidepressant drug prior to her offending. A psychiatric report described the sense of hopelessness which the offender had felt following her original diagnosis which had fuelled impulsive and risk-taking behaviour. Despite the success of her neurosurgery, she remained uncertain and overwhelmed by the notion of surviving into her adult years. The psychiatrist expressed the opinion that her thoughts had operated in a manner "which can only be described as diminished responsibility." She had subsequently attended Gamblers Anonymous and had returned to university classes.

[182] A separate consulting psychiatrist expressed the opinion that there was a strong association between the commencement of her gambling and the diagnosis of the brain tumour. He diagnosed pathological gambling and recurrent depressive disorder as set out in the International Classification of Diseases (10th revision) (ICD-10).

[183] The sentencing judge in the County Court of Victoria had concluded that the circumstances gave rise to "an exceptional case" which did not require the offender to serve any time in custody. Following her pleas of guilty to each of the offences, notwithstanding a maximum penalty of 10 years imprisonment for each, she was sentenced to an immediate recognisance release order to be of good behaviour for two years for each of the Commonwealth offences and a two year Community Correction order with 80 hours of community work with respect to the state offence. The statement required under the relevant Victorian sentencing provisions, namely

stating the sentence which would have been imposed if she had not pleaded guilty, was 3 years imprisonment with a non-parole period of 12 months. A Crown appeal against inadequacy was dismissed.

[184] In ***R v Buckman*** [2016] QCA 176, the offender worked in an administrative position in a number of medical practices. She used the Medicare numbers of more than 500 patients of the medical practices at which she worked and fraudulently obtained approximately $189,000 in relation to false claims. The offending occurred over 16 months between May 2011 and November 2012.

[185] She pleaded guilty to three counts of obtaining a financial advantage by deception contrary to s 134.2(1) of the Criminal Code (Cth). The offender was 36 years of age and the offending arose out of difficulties in her life associated with drug use and the development of a significant gambling addiction which remained hidden from her family. She had sought and received counselling and made significant attempts at rehabilitation before being sentenced and subsequently. There had been a delay of between approximately 3 and 5 years between the offending and being sentenced.

[186] At the time of sentence for these matters in January 2016, the offender was already serving a sentence of 2 and a half years imprisonment with a parole release date of 8 months which had been imposed in June 2015. That sentence related to state charges of dishonesty (stealing as a servant) where she had stolen some $35,000 whilst employed as a receptionist in a medical practice. The offending had occurred in 2013.

[187] The offender also had a previous conviction from 2006 where she had been placed on a recognisance to be of good behaviour and make reparation of $4000 with respect to false claims made on Medicare with a previous medical practice.

[188] With respect to the Criminal Code offences, an effective head sentence of 3 years was imposed. The sentencing judge considered that 3 years was "a little light" but was prepared to impose that sentence because of the offender's good conduct in prison and an intention that her release date should be set at about 21 months after the commencement of the pre-existing sentence and close to the mid-point of the total period of incarceration, including the sentence already being served, of 3 years 7 months. Accordingly, the sentencing judge fixed a non-parole period of 14 months and ordered reparation to the Commonwealth in the sum of $189,316 whilst noting that there was no current prospect of that amount being recovered.

[189] The Queensland Court of Appeal (per Fraser JA; Gotterson and Philip McMurdo JJA agreeing) contrasted the situation with that in *El Rakhawy v R* and expressed the view that the guidance supplied by that case indicated that a more severe sentence than 3 years imprisonment could have been imposed for the Commonwealth offences. This was particularly so given the greater maximum penalty which was applicable and the circumstance that the offending by Ms Buckman was significantly more serious, particularly because the amount defrauded was much larger, she was not in a position to make any restitution, and she had a relevant criminal history.

[190] The application for leave to appeal against sentence was refused.

[191] In ***DPP (Cth) v Phan*** [2016] VSCA 170, a medical practitioner dishonestly obtained $854,188.20 from Medicare over a period of almost 7 years. The fraudulent claims related to the provision of medical service which, in fact, had not been provided. Two rolled up charges under s 134.1(1) of the Criminal Code (Cth) related to separate groups of claims. The maximum penalty was 10 years imprisonment (and/or a monetary penalty). The first group of claims related to 3,357 false claims for services not rendered between December 2006 and May 2012. The fraudulently obtained sum with respect to that period was in excess of $211,000. A second period of less than 12 months related to a very substantial increase in the number of fraudulent claims made. 11,208 false claims were submitted between October 2012 and September 2013 resulting in a fraudulent payment of $642,763.10.

[192] The claims were not lodged individually but in batches whereby electronic bulk bill claims were made by means of computer transmissions. The offender obtained details of additional family members of an actual patient from the Medicare card which they would submit and would select a name at random from the other members of the family in respect of whom he would claim a fee for a service which had not been rendered in respect of that person.

[193] A search warrant had been executed by Medicare investigators at the home of the offender in September 2013. He subsequently made full admissions in the course of a recorded interview in November 2013. He was subsequently charged in October 2014 and pleaded guilty at a committal hearing in November 2014. The plea hearing took place in the County Court of Victoria in October 2015 and he was sentenced by the County Court judge, Judge Cotterell, in November 2015.

[194] The offender was 41 years of age at the time of sentence having come to Australia from Vietnam as a refugee in 1978. He had graduated in Medicine in 1998 and had subsequently been married twice. The divorce from his first wife had left him under considerable financial pressure.

[195] He subsequently had a failed importing business which had also left him with substantial debt.

[196] In the County Court, the offender was sentenced to an aggregate term of 3 years imprisonment with respect to both charges. A recognisance release order was made for the offender to be released after 16 months.

[197] A Crown appeal against the inadequacy of sentence succeeded. Ashley JA, with whom Tate and Santamaria JJA agreed, imposed an aggregate sentence of 4 years' imprisonment with a 2 year non-parole period. The court also made a declaration under s 6AAA of the *Victorian Sentencing Act 1991* that, had the respondent not pleaded guilty, a sentence of 6 years imprisonment with a 3 years 9 months non-parole period would have been imposed.

129 False statements etc.

It is an offence of strict liability to furnish, in pursuance of the Act or regulations, a return or information that is false or misleading in a material particular.

R v Harris [1999] TASSC 53 —

[21] The defence contends that *mens rea* is an ingredient of an s129(2) offence. The Crown says the offence is one of strict liability and relies on authorities referable to s129(1) (now repealed) in support of that submission. Section 129(1), (2) and (3) are set out in par7 above.

[22] In ***R v Sender (No 2)*** (1982 - 1983) 44 ALR 139, Everett J held that s129(1) was an offence of strict liability. Whilst he referred to a number of prior authorities which were consistent with his decision, it is clear from 151 and 152 of his judgment that s129(3) was central to his decision. As he observed at 151, if *mens rea* was an element of the offence, the exculpatory provisions of s129(3) would be unnecessary. That observation applies with equal force to an s129(2) offence.

[23] Everett J referred to and followed the decision of the Supreme Court of Queensland sitting in special circumstances as both a Court of Criminal Appeal and a Full Court in *R v White* (1978 - 1979) 23 ALR 432, which held that s129(1) created a strict liability offence. It is pertinent to note that whilst the charges being considered were alleged breaches of s129(1), Stable SPJ, who gave the decision of the court, referred at 438 to s129(1) and (2), when he said that s129(3) strengthened his conclusion that the section was one imposing strict liability.

[24] In ***R v Giordano*** (1982) 71 FLR 309, the South Australian Full Court held by a majority that *mens rea* was not an ingredient of the offence created by s129(1), and approved *R v Sender*. In *P v R* (1986) 82 FLR 351, the South Australian Court of Criminal Appeal declined to review its decision in *R v Giordano*.

[2]5 The defence submits that the authorities referred to are no longer good law when examined in the light of the decision of the High Court in *He Kaw Teh v R* (1984 - [1985] HCA 43; 1985) 157 CLR 523. In that case, the High Court held that the presumption that *mens rea* is required before a person can be held guilty of a grave criminal offence is not displaced in relation to the *Customs Act 1901*, s233B(1)(b). As to a different offence created by that Act, s233B(1)(c), it was held that the prosecution bore the onus of proving that the accused knew of the existence of the prohibited import in his possession. In reaching their decision in relation to s233B(1)(c), the members of the High Court paid regard to exempting statutory provisions applicable to that provision (but not applicable to s233B(1)(b)) which are very loosely equatable with s129(3). As I understand the submission put to me by the defence, it is contended that as the High Court found that to establish a breach of s233B(1)(c), the prosecution bore the onus of proving that the accused knew of the existence of the prohibited import in his possession, notwithstanding the existence of exempting provisions loosely equatable with s129(3), then, by parity of reasoning, a similar decision should be reached in relation to s129(2) and (3). That submission is not supportable. The reasons given by the members of the High Court show that the decision of the court turned on the particular statutory provision under consideration. Matters referred to included the meaning of the words "in his possession" in s233B(1)(c). The judgments focus on the meaning of those words. Gibbs CJ, agreed with by Mason J, referred to this as the critical question at 541. See also Brennan J at 585 and 589, and Dawson J at 598. Importantly, the

> construction adopted by the court did not render the exempting provisions meaningless or nugatory. See Gibbs CJ at 539 and Brennan J at 589.
>
> [26] The decision of the Court of Criminal Appeal in New South Wales in *Ward v R* (supra), was handed down subsequent to *He Kaw Teh v R*. That decision is consistent with prior authorities to which I have referred that *mens rea* is not a mental element of an s129(1) offence. The court held that the offence is one of strict liability. Campbell and Allen JJ at 70 rejected a submission that there was any inconsistency with this construction of s129(1) and the principles declared by the High Court in *He Kaw Teh v R*. I agree. *Mens rea* is not an ingredient of the offence created by s129(2).

A practitioner may claim an income tax deduction for legal costs incurred in successfully defending a prosecution for an offence under this provision.

Re B491-492/84 and Commissioner of Taxation [1986] AATA 401 —

> [11] Notice was taken of the fact that if convicted, this applicant could have been fined or gaoled, and, if gaoled, the outcome would be automatic deregistration. It is not for us to speculate on the likely and, indeed, hypothetical outcome had the applicant been convicted. The outgoings were, in a real sense, directed towards preserving his earning capacity, and therefore readily distinguishable from *Case N9*. 81 ATC 56, relied on by the respondent, where a Taxation Board of Review was unable to find a perceived connection between the expenditure in any year in defending the charges laid against the taxpayer and his income earning activities as a director. The other case, *Case N65* 81 ATC 335 relied on by the respondent, a decision of the No. 2 Board of Review, is one where the observation of the Board is clearly *dicta* on a finding that there was no evidence that the applicant had personally borne the legal expenditure for which the claim was made.
>
> [12] For these reasons the Tribunal varies the decision under review by allowing the costs of defending the proceedings in the two years under review. Save as to that, the decision under review is otherwise affirmed.

129AC Recovery of amounts overpaid etc. and administrative penalties

Where, as a result of giving of false or misleading information, an amount paid, purportedly by way of benefit or payment under the Act, exceeds the amount, if any, that should have been paid, the amount of the excess is recoverable as a debt due to the Commonwealth from the person by or on whose behalf the information was given.

Commonwealth of Australia v Banting [2009] ACTSC 32—

> [15] In December 2005 two investigators employed by Medicare attended at premises in the suburbs of Melbourne where the defendant was employed. He

participated in a question-and-answer interview with them. There was initially an objection by his counsel to their evidence about this, on the basis that they did not caution the defendant that he did not have to say anything or inform him that anything he did say might be used in evidence. I am satisfied that the investigators were not required to caution the defendant within section 139 of the *Evidence Act 1995*. I accepted the oral evidence of each of them that neither formed a belief at any relevant time that there was sufficient evidence to establish that the defendant had committed any offence. Nor is it suggested, even now, that he might have done so. I accordingly admitted the evidence of the interview.

[16] The investigators asked the defendant during the interview whether he made a practice of attending personally on patients when musculoskeletal ultrasounds were conducted, and he said that he did not. Patients were attended by a sonographer, and the defendant examined and reported upon the ultrasound films subsequently. A sonographer is a registered and qualified technician but is not a medical practitioner. The defendant told the investigators that the practice he worked in, which I gather was called Bell Imaging, had three sets of rooms in different areas of suburban Melbourne. Ultrasound scans were conducted at each of the three rooms, but the defendant generally attended at only one of them, and the films were brought to him for opinion and report. The defendant told the investigators that he had a vague notion that a radiologist was required to be in attendance at the rooms where the service was provided, but he was unaware of any requirement for the radiologist to examine the patient in person. Informed that this was stated in the medical benefits schedule provided to doctors by Medicare, he asked them to send him a copy of the schedule and they agreed to do so. I was provided with a copy of page 482 of the medical benefits schedule, which states unequivocally that "Medicare Benefits are only payable for a musculoskeletal ultrasound service (items 55800 to 55854) if the medical practitioner responsible for the conduct and report of the examination personally attends during the performance of the scan and personally examines the patient".

[17] Although the defendant did not give evidence, I have no reason to doubt that he was genuinely unaware of the requirement, one which does not apply to many other radiological services. Indeed, what I might describe as the default position as to diagnostic imaging services is set out in Regulation 4 of the DIST Regulations: unless the contrary intention appears, items relating to diagnostic imaging services apply whether the service is provided by a medical practitioner, or by a person who is employed by the medical practitioner and provides the services under the practitioner's supervision. Regulation 14 in relation to musculoskeletal ultrasound appears to me something of an exception to the general rule.

[18] Following a letter demanding payment of the amount claimed, the defendant in February 2006, some might think understandably, expressed surprise that reimbursement was sought from him rather than from the principals of the practice he worked for. He noted that all of the patients had been referred by a medical practitioner and assessed and examined by a sonographer, and that he had reported on the films.

[19] The evidence of the investigators establishes to my satisfaction that the defendant admitted that he did not, in any of the cases under consideration, personally attend upon and examine the patient. The defendant admits on the

> pleadings that he claimed to have performed musculoskeletal ultrasound services as set out in the tendered schedule, which identifies the dates, patients, items numbers and amounts. The defendant admits that statements were made by him and on his behalf to Medicare, to the effect that he had rendered the services, and claimed payment.
>
> [20] I am satisfied that the claims amounted to representations by the defendant to Medicare that he had carried out services in relation to which he had complied with Regulation 14 of the DIST Regulations. The making of the claims amounted, in the circumstances, to the making of a false or misleading statement within section 129AC of the *Health Insurance Act*.
>
> [21] I am satisfied that the defendant was not entitled to any Medicare benefit in respect of musculoskeletal ultrasound services where he had not attended upon and examined the patient, notwithstanding that he had carried out the work, applying his training and experience, of reporting upon the ultrasound films. In the circumstances I am satisfied that all of the amounts paid by Medicare claimed in the action are recoverable from the defendant, being the person by or on behalf of whom the false or misleading statement was made. The plaintiff is entitled to recovery of the amount claimed.

130 Officers to observe secrecy

It is an offence under this section for a person directly or indirectly to make a record of, or divulge or communicate to any person, any information with respect to the affairs of another person acquired by him or her in the performance of his or her duties, or in the exercise of his or her powers or functions under the Act, except

- in the performance of his or her duties, or in the exercise of his or her powers or functions under the Act; or
- for the purpose of enabling a person to perform functions in relation to a medicare program; or
- for the purposes of enabling a person to perform functions under the *Dental Benefits Act 2008*, the *My Health Records Act 2012*, or indemnity legislation.

Dixon CJ considered the phrase 'except in the performance of any duty as an officer' in *Canadian Pacific Tobacco v Stapleton* (1952), saying that it ought to receive a very wide interpretation. In *Herscu v R* (1991) the High Court approved a statement by McHugh JA (as he then was) in *GJ Coles & Co Ltd v Retail Trade Industrial Tribunal* (1986) elaborating on the scope of the duties of an officer.

Canadian Pacific Tobacco v Stapleton [1952] HCA 32, (1952) 86 CLR 1—

> [20] But, in any case, I think that the words "except in the performance of any duty as an officer" ought to receive a very wide interpretation. The word "duty" there is not, I think, used in a sense that is confined to a legal obligation, but really would

be better represented by the word "function". The exception governs all that is incidental to the carrying out of what is commonly called "the duties of an officer's employment"; that is to say, the functions and proper actions which his employment authorizes.

Herscu v R [1991] HCA 40, (1991) 173 CLR 276—

[8] … As McHugh JA observed in *GJ Coles & Co Ltd v Retail Trade Industrial Tribunal* (1986) 7 NSWLR 503 at p 524:

"A public office holder assumes the burdens and obligations of the office as well as its benefits. By accepting appointment to the office, he undertakes to perform all the duties associated with that office and, as long as he remains in office, he must perform all its duties: *Peery v Coff*man (1964) 137 SE 2d 5 at p 8; *State ex rel Preissler v Dostert* (1979) 260 SE 2d 279 at p 286.

The duties of a public office include those lying directly within the scope of the office, 'those essential to the accomplishment of the main purpose for which the office was created and those which, although only incidental and collateral, serve to promote the accomplishment of the principal purposes': *Nesbitt Fruit Products Inc v Wallace* (1936) 17 F Supp 141 at p 143."

The expression 'performance of … duties' is qualified in the HI Act by adding the words 'under this Act', 'in relation to a medicare program' and 'under the *Dental Benefits Act 2008*, the *My Health Records Act 2012*, or indemnity legislation.

A similar formula applies under section 135A of the *National Health Act 1953*. It was held that this exception applied so as to permit an officer to disclose information for the purpose of complying with procedural fairness obligations in the course of decision-making under that Act.

Martin v Pharmacy Restructuring Authority [1994] FCA 1241—

[8] The first ground relied upon is that the Authority gave no opportunity to the applicants to put forward any matter in opposition to the application.

[9] In *Kioa v West* [1985] HCA 81; (1985) 159 CLR 550 at 584, Mason J said:-

"The law has now developed to a point where it may be accepted that there is a common law duty to act fairly, in the sense of according procedural fairness, in the making of administrative decisions which affect rights, interests and legitimate expectations, subject only to the clear manifestation of a contrary statutory intention."

Clearly the applicants are persons who would be likely to be affected by the grant of the applications for relocation. This is especially so as an intent of the new provisions in the National Health Act, which give effect to an agreement of 6 December 1990 between the then Minister for the Aged, Family and Health Services and the Pharmacy Guild of Australia, was to reduce competition between pharmacists. The interest of the applicants was a relevant interest for the purposes

of the National Health Act. See *Alphapharm Pty Ltd v Smith Kline Beecham (Australia) Pty Ltd* [1994] FCA 996; (1994) 121 ALR 373.

[10] Counsel for the Authority submitted that a contrary intention appeared in s.135A(1) of the National Health Act which provides:-

> "(1) A person shall not, directly or indirectly, except in the performance of duties, or in the exercise of powers or functions, under this Act or for the purpose of enabling a person to perform functions under the *Health Insurance Act 1973*, and while the person is, or after the person ceases to be, an officer, divulge or communicate to any person, any information with respect to the affairs of a third person acquired by the first-mentioned person in the performance of duties, or in the exercise of powers or functions, under this Act. ..."

Counsel submitted that this section was an expression of intent to the contrary and made it wrongful for the Authority to give to a pharmacist information concerning an application made by another pharmacist for approval.

[11] However, the sub-section does not preclude an officer from making a disclosure in the performance of duties or in the exercise of powers or functions under the Act. It follows that neither the Authority nor any officer of the Authority was precluded by the subsection from giving to the applicants such information about the application for relocation as it was required to satisfy the principles of procedural fairness which applied in their case. See *Canadian Pacific Tobacco Co Ltd v Stapleton* [1952] HCA 32; (1952) 86 CLR 1 at 6-7; *Commissioner of Taxation v Nestle Australia Ltd* [1986] FCA 368; (1986) 12 FCR 257 at 262.

The section operates both while the person is an officer and after he or she ceases to be an officer.

Re Harrigan v Department of Health and Australian Medical Association [1986] FCA 390 (Full Court of the Federal Court) —

[1] The Administrative Appeals Tribunal, acting under s.45(1) of the *Administrative Appeals Tribunal Act 1975*, has referred to the Court a question of law arising in a proceeding before the Tribunal, the question being whether s.130 of the *Health Insurance Act 1973* is an enactment of a kind referred to in s.38 of the *Freedom of Information Act 1982*.

[2] The question arises because by letter dated 18th July 1984 the applicant sought from the Department of Health access pursuant to the Freedom of Information Act to information for the period 1st July 1978 to 30th June 1984, the information (as stated in the Special Case referring the question of law to the Court) being:-

> "(i) Yearly breakup of the incidence of all services the subject of claims,
> (ii) Breakup of all money paid to each doctor for each item,
> (iii) Yearly breakup of all abortion claims under item 6469 or any other abortion related item,
> in relation to:-
> (a) Seventeen named medical practititioners ...,

(b) All doctors operating at seven named clinics ...,
(c) All doctors performing abortions at Tweed Heads,
(d) The five doctors in each State and Territory doing the most number of abortions."

The request for access was refused by letter dated 6th December 1984 by the Acting First Assistant Director-General of Health, Medical Benefits Division and in that letter the documents, which are in the form of computer print-outs, were claimed to be exempt by reason of s.38 of the Freedom of Information Act. An internal review of that decision took place pursuant to s.54 of the Freedom of Information Act by the Deputy Secretary of the Department of Health and the earlier decision was upheld. An application was then made to the Administrative Appeals Tribunal for review of that decision.

[3] S.11(a) of the Freedom of Information Act provides that:-

"Subject to this Act, every person has a legally enforceable right to obtain access in accordance with this Act to—
(a) a document of an agency, other than an exempt document."

The Department of Health is an "agency" (see the definition of that term in s. 4(1)) and s.38 is one of a number of provisions defining the circumstances in which documents will be "exempt documents" for the purposes of s.11(a). It is as follows:-

"38. A document is an exempt document if there is in force an enactment applying specifically to information of a kind contained in the document and prohibiting persons referred to in the enactment from disclosing information of that kind, whether the prohibition is absolute or is subject to exceptions or qualifications."

[4] The operation of s.38 has been considered by the Court on several occasions and the effect of those decisions, so far as presently relevant, may be stated as follows:-

(a) An enactment does not satisfy s.38 if it does no more than prohibit the disclosure of information identified only by reference to the capacity of the person who has received or is in possession of the information (*The News Corporation Ltd v National Companies and Securities Commission* (1984) 1 FCR 64 at 70 per Bowen C.J. and Fisher J.).

(b) An enactment does not satisfy s.38 if it does no more than prohibit the disclosure of information identified only as information obtained in pursuance of the enactment in which the prohibition is found (*Kavvadias v Commonwealth Ombudsman* [1984] FCA 55; (1984) 1 FCR 80 at 85).

(c) The two types of enactment to which we have referred do not satisfy s.38 because they do not sufficiently identify the type of information which is the subject of the prohibition upon disclosure. A provision, however, which identifies the information as information "respecting the affairs of another person" will ordinarily be sufficiently specific to satisfy s.38 (*Federal Commissioner of Taxation v Swiss Aluminium Australia Ltd* (1986) 66 ALR 159 at 162-163 (Bowen C.J.) and at 167, 168-169 (Jackson J.)).

[5] With these considerations in mind we turn to s.130(1) of the Health Insurance Act which is as follows:-

> "(1) A person shall not, directly or indirectly, except in the performance of his duties, or in the exercise of his powers or functions, under this Act, and while he is, or after he ceases to be, an officer, make a record of, or divulge or communicate to any person, any information with respect to the affairs of another person acquired by him in the performance of his duties, or in the exercise of his powers or functions, under this Act.
>
> Penalty: $500."

[6] It will be seen that the prohibition in s.130(1) is limited to information which is "with respect to the affairs of another person" and which has been acquired by the officer or former officer in the performance of his duties or in the exercise of his powers and functions under the Act. The provision, in our view, is relevantly indistinguishable from that in consideration in *Federal Commissioner of Taxation v Swiss Aluminium Ltd* (supra) and we see no reason why the Court should not arrive at a similar conclusion in this case, namely that s.130(1) is an enactment to which s.38 applies.

[7] The applicant contended, formally, that *Federal Commissioner of Taxation v Swiss Aluminium Australia Ltd* (supra) was wrongly decided but, on the assumption that it would be followed by the Court, sought to contend that the provisions of s.130 other than s.130(1) were such that the meaning which s.130(1) would prima facie bear should not be attributed to it.

[8] The applicant's contention in this regard was that notwithstanding that s.130(1) appeared to describe the information to which it applied as being information which was:—
(a) with respect to the affairs of another person; and
(b) which had been acquired by the officer in the performance of his duties or in the exercise of his powers or functions under the Act;

the succeeding provisions of s.130 were such that they should be treated as similar in effect to those in issue in *Kavvadias v Commonwealth Ombudsman*, (*supra*) i.e. as covering all information acquired by the officer in the performance of his duties or in the exercise of his powers or functions under the Act, the words "with respect to the affairs of another person" in s.130(1) being inserted only to ensure that the prohibition did not apply to information respecting the affairs of the officer himself. Reliance was then placed upon the fact that provisions such as s.130(3) did not contain any reference to information "with respect to the affairs of another person" but simply dealt with information acquired by an officer in the performance of his duties or in the exercise of his powers or functions under the Act. We should set out s.130(3) which is as follows:-

> "(3) Notwithstanding anything contained in the preceding provisions of this section, the Secretary or the General Manager of the Commission may —
> (a) if the Minister certifies, by instrument in writing, that it is necessary in the public interest that any information acquired by an officer in the performance of his duties, or in the exercise of his powers or functions, under this Act,

should be divulged, divulge that information to such person as the Minister directs;
(b) divulge any such information to any prescribed authority or person; or
(c) divulge any such information to a person who, in the opinion of the Minister, is expressly or impliedly authorised by the person to whom the information relates to obtain it."

[9] We are unable to agree with this submission. In the first place it seems to us to be opposed to the very clear words of s.130(1) — a penal provision — which require that the information be both with respect to the affairs of another person and acquired by the officer in the performance of his duties or in the exercise of his powers or functions under the Act. Secondly, to the extent to which s.130(3) and the succeeding provisions of s.130 are exceptions to the generality of the operation of s.130(1) , they are also exceptions to the generality of the operation of s.130(2) which is as follows:-

"(2) A person who is, or has been, an officer shall not, except for the purposes of this Act, be required —
(a) to produce in court any document that has come into his possession or under his control in the performance of his duties or functions under this Act; or
(b) to divulge or communicate to a court any matter or thing that has come under his notice in the performance of any such duties or functions."

[10] It seems obvious enough that the manner in which the succeeding provisions of s.130 have been drawn does no more than recognize that the information that is the subject of the prohibition in s.130(2) is wider than the information the subject of the different prohibition in s.130(1) and that a reference to information in the wider category will encompass that in the narrower category also.

[11] Thirdly, the succeeding provisions of s.130 do not merely provide exceptions to ss.130(1) and 130 (2). They also confer authority to divulge information on particular persons in particular circumstances. It is not, we think, right to regard them as merely exceptions to ss.130(1) and 130 (2).

[12] We would answer the question referred by saying that:—

" S.130(1) of the *Health Insurance Act 1973* is an enactment of a kind referred to in s.38 of the *Freedom of Information Act 1982*.".

Walker v Secretary, Department of Health and Ageing [2016] FCA 233 —

[41] The first thing to note about the text of s 130(1) of the HI Act is the description of the information which is the subject of the secrecy obligation imposed by that provision. That information is defined by reference to two related qualifications, i.e. "any information" which is:
(a) "with respect to the affairs of another person"; and
(b) which information is "acquired by [the officer] in the performance of his or her duties, or in the exercise of his or her powers or functions under this Act".

[42] It is convenient to focus first on the significance of the words "the affairs of another person". It may be accepted that the reference to "the affairs of" provides some degree of limitation to an alternative hypothetical formulation of "information

with respect to another person". That is not to say, however, that the limitation is as broad as Dr Walker contends, such that the relevant information is confined to private or personal information and does not extend to professional or business information.

[43] The ordinary meaning of the words "the affairs" of a person is broad, as is reflected in leading dictionary definitions of the word "affair". The Macquarie Dictionary (5th edition) provides the following definitions:

> 1. anything done or to be done; that which requires action or effort; business; concern: an affair of great moment; the affairs of state.
>
> 2. *(plural)* matters of interest or concern; particular doings or interests: put your affairs in order.
>
> The relevant definitions in The New Shorter Oxford English Dictionary (1993) are:
>
> 1 What one has to do; business; a concern; a matter...
>
> 2 spec. In pl. Ordinary pursuits of life; business dealings; public matters.

[44] These meanings provide no support for Dr Walker's construction. Rather, they support a construction of "affairs of another person" as being not confined to the personal information of another person and as extending to also include information concerning a person's business or professional activities.

[45] Naturally, s 130(1) of the HI Act needs to be read as a whole. The reference to "information with respect to the affairs of another person" cannot be divorced from the explicit nexus which is drawn in s 130(1) between such information and it having being "acquired by [the officer] in the performance of his or her duties, or in the exercise of his or her powers or functions under this Act". Thus, it is relevant to the task of construction to have regard to the kind of information which is likely to be acquired by such an officer in administering the HI Act.

[46] As noted above, the HI Act provides the legislative underpinning for the Medicare Benefits Scheme which, by its very nature, is elaborate and complicated. The operation of that Scheme necessarily involves the acquisition by Departmental officers of a wide range of information relating to people and institutions, such as hospitals. That information may relate to the administration of provisions which determine whether an eligible person is entitled to a Medicare benefit (see s 10). This may turn on whether the medical practitioner is registered, as is the case under s 3F (which deals with a vocationally registered general practitioner). Or it might depend on whether the medical practitioner is a person who is registered or licensed as a medical practitioner under a relevant law of a State or Territory (which includes a non-vocationally registered general practitioner) or a nurse practitioner who is registered or authorised to practise as such under a law of a State or Territory. Such provisions necessarily require Departmental officers to acquire relevant information concerning such medical practitioners, which information will include not only their names and addresses, but also other information such as whether the medical practitioner is registered or authorised to practise medicine with a particular status. Information may also be acquired in relation to the location at which a particular professional service is provided or whether a medical practitioner

is involved in an "approved placement" for the purposes of the Register which must be kept under s 3GA of the HI Act.

[47] Other information will necessarily be acquired by Departmental officers to administer the Medicare Benefits Scheme in relation to patients who wish to receive Medicare benefits. This information will not be limited merely to a patient's name and address, but will extend to include other information which is required in order to determine whether the person is an "eligible person" within the definition in s 3 (such as whether the person is an Australian resident or an eligible overseas representative). Other relevant information which will be collected in relation to patients who are "eligible persons" is the kind and frequency of any professional service which is the subject of a claim for a Medicare benefit. Such information is relevant, for example, to calculating the Medicare benefit to which the person is entitled, but it will also be relevant to the administration of provisions in the HI Act relating to a "safety-net" which applies to families and individuals (see ss 10AC - 10ADA). For example, where relevant, information will be acquired by the Department concerning family composition to determine the "safety-net" in respect of a family (see s 10AE).

[48] These few examples illustrate the wide nature and range of the information which is likely to be acquired by Departmental officers in administering this legislation. The relevant information may relate to medical practitioners who participate in the Medicare Benefits Scheme, patients, their families, and hospitals. Some of the information might be publicly available but much of it will not. Some of the information will be of a highly sensitive and confidential nature, such as the specific professional medical services obtained by individual patients. Other information may not. Necessarily, however, the information will extend well beyond personal information in the form of a person's name and address.

[49] It is perhaps unsurprising that, faced with the need to protect the sensitivity of much of the information which is acquired by the Department in administering the legislation, the Parliament has chosen to insert a provision such as s 130 and to structure it as it is. In broad terms, that structure involves the imposition on Departmental officers of an obligation of secrecy with respect to information of the kind described in s 130(1). That obligation attaches to both the recording of relevant information by such an officer as well as its disclosure. The obligation operates while the person is an officer of the Department and afterwards. As noted above, it is a criminal offence to breach the obligation imposed by s 130(1).

[50] The scheme of s 130 is then to make specific provision for instances where particular information may lawfully be recorded or disclosed notwithstanding the secrecy obligation imposed by s 130(1). These provisions take different forms. For example, under s 130(3), information acquired by an officer in administering the legislation may be divulged but only where:
(a) the Minister has certified by instrument in writing that it is necessary in the public interest to do so and directed to whom information may be divulged; and
(b) either the Secretary of the Department or the Chief Executive Medicare exercise their discretion under this provision to divulge such information as is included in the Ministerial certificate.

[51] That is not the only provision which empowers the Secretary of the Department or the Chief Executive Medicare to divulge information without contravening s 130(1). For example, in s 130(3A), these persons also have a discretion to divulge information acquired by an officer in administering the HI Act to a prescribed authority or person where the relevant information is also itself prescribed for this purpose.

[52] There are several other specific provisions in both s 130 and elsewhere in the HI Act which create exceptions to the obligations imposed by s 130(1). They include where a person provides a document to the Chief Executive Medicare in relation to a claim for a Medicare benefit and that document is then in turn provided back to that person, or where information relating to a particular person is divulged to that same person (see s 130(4A)(a) and (b) respectively).

[53] Another example is s 3EA, which provides for the Chief Executive Medicare to determine that a medical practitioner is a recognised Fellow of the Royal Australian College of General Practitioners. In summary, provision is made for a medical practitioner to apply to the Chief Executive Medicare for a determination that the applicant is such a Fellow and is eligible, in accordance with the regulations, for a determination under s 3EA. Provision is made in s 3EA(5) for the Chief Executive Medicare to give the Royal Australian College of General Practitioners information about whether or not determinations under the provision are in force in respect of particular persons. In other words, the Chief Executive Medicare has a discretion to give a particular organisation information about whether or not there is a determination in force in respect of particular persons. In addition, there is a discretion conferred upon the Chief Executive Medicare or an authorised officer to disclose certain other information under s 3EA(6), which provides:

> (6) The Chief Executive Medicare or an authorised officer may make available to members of the public, on request:
> (a) the names of medical practitioners in respect of whom determinations under this section are in force;
> (b) the addresses at which they practise.

[54] In my view, these textual considerations support the construction of s 130(1) which was adopted and applied by the Deputy President and do not favour Dr Walker's alternative construction. The text of both s 130(1) and other related provisions indicate that the information which is the subject of s 130(1) is information with respect to the affairs of another person, which information is not confined to private or personal information of that person but extends to include information with respect to the business or professional activities of the person.

[55] Dr Walker's construction effectively invites words to be read into s 130(1) which are not there, so that the provision would read, relevantly, as referring to "any information with respect to the affairs of another person which are of a private or personal nature..." I see no basis for construing the provision that way.

[56] I consider that there is another textual matter which, although not referred to by the Deputy President, strongly favours the construction which was adopted and applied by him. It is to be found in s 130(5A) of the HI Act (which was emphasised by Ms Roughley). That provision is (emphasis added):

> (5A) If a person applies to an authorised officer for information about a hospital, this section does not prohibit that authorised officer or any other authorised officer providing all or any of the following information in respect of the hospital to the applicant:
> (a) the name and address of the hospital;
> (b) the number of beds available in the hospital to patients;
> (c) whether or not the hospital is a private hospital or a recognised hospital;
> (d) the kinds of services (for example, obstetric services or psychiatric services) provided at the hospital;
> (e) whether or not the hospital is a teaching hospital.

For completeness, it might be noted that s 130(5B) provides that, in s 130(5A), "authorised officer" means the Secretary or an APS employee in the Department.

[57] In my view, no contrary intention is manifested in the HI Act which would displace the operation of s 2C of the Acts Interpretation Act in relation to s 130 of the HI Act. The effect of that provision is that a reference in Commonwealth legislation to a "person" includes a body corporate. Judicial notice can be taken of the fact that some hospitals in Australia are owned and operated by corporations in which professional services are provided to patients who may be entitled to Medicare benefits under the HI Act. Significantly, s 130(5A) makes it clear that the secrecy obligation(s) imposed by s 130 do not prohibit an authorised officer from providing inter alia the name and address of a hospital to a person who seeks that information. If Dr Walker's proposed construction is correct, there would be no need for s 130(5A) because, on his construction, the name and address of the hospital is not information of a kind which is caught by s 130(1). Acceptance of Dr Walker's construction would render this aspect of s 130(5A) superfluous. That approach would be inconsistent with the requirement that, in construing a statutory provision, the Court must strive to give meaning to every word of the provision (see *Project Blue Sky* at [71] per McHugh, Gummow, Kirby and Hayne JJ).

[58] In my view, considerations of context and purpose also favour the construction adopted by the Deputy President. Part of the relevant context is the nature and extent of information which is likely to be acquired by Departmental officers in their administration of the legislation. Another part of that context is the structure of s 130 as a whole. Both these matters have been discussed above and need not be repeated. They are also relevant to the question of purpose (see the observations of French CJ and Hayne J in *Certain Lloyd's Underwriters* at [25]).

[59] I am not persuaded that Dr Walker's other submissions in support of his preferred construction carry any weight. First, as to his contention that the general objects stated in s 3 of the FOI Act create a "presumption" in favour of access and require the exemptions to be read down, that approach has been rejected in many cases relating to both Commonwealth and State freedom of information legislation, including *News Corporation Ltd v National Companies and Securities Commission* [1984] FCA 26; (1984) 1 FCR 64 at 66 per Bowen CJ and Fisher J; *Victorian Public Service Board v Wright* [1986] HCA 16; (1986) 160 CLR 145 at 153 and 154 per Gibbs CJ, Mason, Wilson, Deane and Dawson JJ; *Searle Australia Pty Ltd v Public Interest Advocacy Centre* [1992] FCA 317; (1992) 36 FCR 111 at 115 per Davies, Wilcox and Einfeld JJ and *Workcover Authority (NSW) v Law Society of NSW* [2006] NSWCA 84; (2006) 65 NSWLR 502 at [149]- [151] per McColl JA with

> whom Handley and Hodgson JJA agreed. That position is not altered by the fact that s 11 of the FOI Act creates a legally enforceable right to obtain access to information because that right itself is expressed in terms of a right to obtain access "in accordance with this Act...". That necessarily requires that relevant exemptions be construed and applied in their terms.
>
> [60] Secondly, Dr Walker's reliance upon the discretion of the Chief Executive Medicare or an authorised officer under s 3F(9) of the HI Act to make available to members of the public, on request, the names of medical practitioners who are registered as vocationally registered general practitioners under s 3F takes the matter no further. That discretion applies only to vocationally registered general practitioners. It says nothing about the position regarding non-vocationally registered general practitioners. Moreover, it is a discretionary power which is conferred upon specified persons, namely the Chief Executive Medicare or an authorised officer, which puts the matter into a very different regime than that which applies under the FOI Act.

130(2) — Information need not to be disclosed to a court

Unless it is for the purposes of the Act, an officer or former officer shall not be required to produce in court any document that has come into his or her possession or control in the performance of his or her duties or functions under the Act, or divulge or communicate to a court any matter or thing that has come to his or her notice in the performance of any such duties or functions.

This subsection does not prohibit such disclosure to a court, but permits a person to refuse to disclose on the basis of this provision.

An officer may disclose information to a court in order to defend an action against themselves, their agency, their office, or the Commonwealth. In such a circumstance, disclosure to the court would likely be held to be for the purposes of the Act.

The existence of subsection 130(2) does not meant that a court cannot issue a summons to produce to a relevant officer. It is merely a question as to whether the officer wishes to rely on the subsection.

Minister for Community Services and Health & Anor v Carter and Gribbles Pathology Pty Ltd [1990] SASC 2281 —

> [5] It was argued that the Master erred in the exercise of his discretion by ordering discovery of something he knew would not be produced at trial. In my view there are two answers to that argument. If the party seeking discovery is able to prove a demand and refusal to produce a document, that could permit secondary evidence of the contents of documents not produced. Secondly, whilst the present intention is not to produce at the trial any documents discovered, it might be that by the time

of trial, the officers subpoenaed to disclose the documents may not then invoke the immunity conferred by subsection (2) of section 130.

[6] I do not deal with the argument put by the first respondent to this appeal that any claim for privilege is itself open to scrutiny by the court. That is something for another day.

Canadian Pacific Tobacco v Stapleton [1952] HCA 32, (1952) 86 CLR 1—

[22] Sub-section (3) provides that "An officer shall not be required to produce in court" (certain documents) "or to divulge or communicate to any court any matter or thing coming under his notice in the performance of his duties as an officer, except when it is necessary to do so for the purpose of carrying into effect the provisions of this Act or of any previous law".

[23] In spite of the word "exclusion" in the passage that was read from *O'Flaherty v McBride* [1920] HCA 60; (1920) 28 CLR 283, at p 288, I think that this provision gives only a protection to the officer against compulsion, and does not make inadmissible evidence which the officer is prepared to give under instructions from his superiors or the commissioner.

A document or information that came to the attention of an officer outside of their role as an officer does not become protected from disclosure by that officer by section 130 merely by the officer taking it to work and using it in the performance of their duties and functions. While another officer of the agency may be prohibited from disclosing the document or information, a court may require the officer who brought it to work to disclose it.

Carter v Gribbles Pathology Pty Ltd [1991] SASC 2775 —

[26] Section 130(2)(b) is directed towards the protection from publication or communication of:

> "... any matter or thing that has come under his (the officer's) notice in the performance of any such duties or functions".

[27] To my mind, the legislature did not intend, in the enactment of para.(b), to protect from publication or communication "any matter or thing" that came under an employee's notice, not by virtue of his membership of the committee but by virtue of his duties with his employers. It may be that the "matter or thing" (being a document) was later conveyed by the plaintiff to the committee — either as an original document or as a copy thereof — but if it first came to his notice as an employee, public interest immunity would not apply. And that would be so whether he personally copied the document at his employer's premises or caused or requested someone else to copy it.

[28] If, to take an extreme example, the plaintiff was suspected by his employer of being likely to take documents and was prohibited from coming back at night when he might try to make copies and if for this reason he was denied a key or means of

> lawful entry at nights; and if he then broke into his employer's premises and took copies of documents and then conveyed them to the committee, any documents obtained in this unlawful manner would not, in my opinion, have come under his "notice in the performance of a duty". The section would not extend to matters or things of this kind which were later brought by him to the committee's notice by such unlawful acts. That is an extreme example. What is alleged here is that he may have taken some of the documents in item 60 in breach of his duty of confidentiality.
>
> [29] I hold that there is a strong inference from the wording of item 60 that some of the documentary material in item 60 may have come to the notice of the plaintiff (respondent) in his capacity as an officer of the defendant companies and that the onus is upon him, as the person claiming the protection of the public interest immunity in s.130 , to dispel or rebut that prima facie inference. He may do so by filing an affidavit that there are no documents of any kind in item 60 emanating originally from the defendant's practice — or, if there are, by giving full particulars of the facts and circumstances by which he alleges that the said documents first came to his notice whether as a member of the committee and through the committee or as an employee of the defendants and whether they took the document to the committee or arranged for someone else to do so, directly or indirectly. That is to say, it would not be sufficient to establish immunity if it happened to be the case that he caused someone else at the defendants' premises to make copies for him and deliver them to him at a location away from the defendant's premises and if he then took the copies to the committee.
>
> [30] If the plaintiff refuses or fails to file such an affidavit within seven days then I order that the materials in item 60 be produced by the plaintiff to the Master and that the Master then examine the materials in item 60 and segregate those documents, if any, which on the face of them appear to have come from the premises of the appellant company's practice. If he is prima facie satisfied that they do appear to have come from that practice (and there is no other evidence to dispel that suggestion) then the said segregated documents are to be made available by the Master to the defendants' solicitors for inspection and copying.

Subsection 130(2) does not permit an officer to refuse to provide to a court a person's own information upon receiving a subpoena by that person. (Subsection 130(4A) permits disclosure to the person to whom the information relates.)

Ghebretensae Haile v Elwyn Syphers [1996] ACTSC 69 —

> [7] I accept that this means, in effect, that O.36 r.6A is available where such documents could be subject to subpoena. The question for determination then is, can a plaintiff subpoena their own Medicare claims history from the Health Insurance Commission.
>
> [8] Counsel for the Health Insurance Commission says that s.130(2) of the *Health Insurance Act 1973* sets up a complete bar to such a claim. This section says: "(2) A person who is, or has been, an officer shall not, except for the purposes of this Act, be required: (a) to produce in Court any documents that has come into his possession or under his control in the performance of his duties or functions under

this Act; or (b) to divulge or communicate to a Court any matter or thing that has come under his notice in the performance of any such duties or functions."

[9] Counsel for the plaintiff argued that I should look for guidance as to the effect of s.130(2) to the provisions, in very similar terms, found in the *Income Tax Assessment Act 1936* (Cth), in particular s.16(3). The Full Court of the Federal Court of Australia in *Federal Commissioner of Taxation v Nestle Australia Ltd* (1986) Aust. Tax Cases 4.760 held that the equivalent provision in the *Income Tax Assessment Act 1936* did not preclude a taxpayer from obtaining discovery of their own tax records.

[10] That section provides that an officer shall not be required to produce in Court any material, "...except where it is necessary to do so for the purposes of carrying into effect the provisions of this Act."

[11] The Full Court in *Nestle* held that the exception "...for the purposes of carrying into effect the provisions of this Act", should be broadly construed, so that "...it includes the occasions on which (the officer) is required by the judicial process to produce documents or give evidence in courts" (at 4.764). This reasoning was based on the decision of Dixon CJ in *Canadian Pacific Tobacco Co Ltd v Stapleton* [1952] HCA 32; (1952) 86 CLR 1 where, in relation to a secrecy provision prohibiting disclosure to a court other than in accordance with an officer's "duty", Dixon CJ held that in this context the word "duty" "...is not, I think, used in a sense that is confined to a legal obligation, but really would be better represented by the word 'function'. The exception governs all that is incidental to the carrying out of what is commonly called 'the duties of the officer's employment', that is to say, the functions and proper actions which his employment authorises. In a case of this description I should think that did include the making of an affidavit in this Court."

[12] This reasoning has been followed in a number of authorities. In *Re Fortex* (1986) Aust. Tax Cases 4.351 Enderby J said of s.16(3) of the Income Tax Assessment Act, "I am also of the opinion that the subsection does not prevent the Court ordering that, in the interests of justice and the proper fair hearing of an appeal, a litigant such as the applicant should have inspection of the documents if the Court considers them relevant and necessary" (at 4.357).

[13] In *Mann v Board of Health of the Australian Capital Territory*, a decision of this Court (Spender J, unreported, 23 May 1995) it was held simply that in secrecy provisions a prohibition of divulging information to "any person" could not apply to a Court.

[14] I see no reason in principal why I should not follow these decisions and hold that a Medicare levy payer and recipient of services from the Health Insurance Commission is not by reason of s.130(2) of the *Health Insurance Act 1973* precluded from availing themselves of the processes of this Court to obtain discovery of, or to issue a subpoena in relation to, their own Medicare claims files.

130(3) — Public interest certification by the Minister

Subsection 130(3) provides that the Minister may certify that it is necessary in the public interest that certain information be disclosed to a particular person, and if so, then the Chief Executive Medicare or the Secretary to the Department may disclose it to that person. A court cannot make such a decision.

R v Peters [2002] NSWSC 1073 —

> [1] Damien Anthony Peters is charged with two counts of murder, the alleged victims being Andre Tereapii Akai and Bevan James Frost.
>
> [2] The trial is fixed to commence on 25 November 2002. I was told that Mr Peters proposes to acknowledge his involvement in the deaths of the two men, but to raise defences of provocation and intoxication which he claims will reduce his liability from murder to manslaughter.
>
> [3] In order to obtain material and evidence to support those defences or partial defences, his solicitors served on the Health Insurance Commission a subpoena requiring production of:
>
> > "A copy of all records maintained by the Health Insurance Commission in respect of the following persons: Damien Anthony Peters, Andre Tereapii Akai, Bevan James Frost. Specifically all records pertaining to prescriptions issued to each of the abovementioned persons in the period from 1 January 1980 to 30 September 2001."
>
> [4] On receipt of the subpoena and acting promptly, officers of the Health Insurance Commission wrote to Mr Peters' solicitors advising that the legislative provisions of the *Health Insurance Act 1973* and the *National Health Act 1953* precluded production of the documents sought in relation to the two deceased men, but provided the relevant material in relation to himself.
>
> [5] Solicitors for Mr Peters do not accept the construction placed upon the legislation and press for production of the documents. Accordingly, the Health Insurance Commission by notice of motion seeks orders setting aside the subpoena, insofar as it requires production of documents relating to those two men.
>
> [6] Sections 130 of the Health Insurance Act and 135A of the National Health Act are relevantly in similar though not identical terms. I will set out subsections (1) and (2) of section 130 of the Health Insurance Act.
>
> > **130 Officers to observe secrecy**
> >
> > (1) A person shall not, directly or indirectly, except in the performance of his or her duties, or in the exercise of his or her powers or functions, under this Act or for the purpose of enabling a person to perform functions under the Health Insurance Commission Act 1973, and while he or she is, or after he or she ceases to be, an officer, make a record of, or divulge or communicate to any person, any information with respect to the affairs of another person acquired

by him or her in the performance of his or her duties, or in the exercise of his or her powers or functions, under this Act.

Penalty:$500

(2) A person who is, or has been, an officer shall not, except for the purposes of this Act, be required:
(a) to produce in court any document that has come into his or her possession or under his or her control in the performance of his or her duties or functions under this Act; or
(b) to divulge or communicate to a court any matter or thing that has come under his or her notice in the performance of any such duties or functions.

[7] I accept that prima facie these subsections, which are essentially replicated in the National Health Act, have the effect contended for on behalf of the Health Insurance Commission. As I understand it, counsel for Mr Peters also accepts that prima facie construction, but relies upon the provisions of subsection (3) of each Act and I set out the provisions of subsection (3) of 130 of the Health Insurance Act.

(3) Notwithstanding anything in subsection (1), the Secretary may:
(a) if the Minister certifies, by instrument in writing, that it is necessary in the public interest than any information acquired by an officer in the performance of duties, or in the exercise of powers or functions, under this Act, should be divulged, divulge that information to such person as the Minister directs;
(b) divulge any such information to an authority or person if:
(i) the authority or person is a prescribed authority or person for the purposes of this paragraph; and
(ii) the information is information of a kind that may, in accordance with the regulations, be provided to the authority or person; or
(c) divulge any such information to a person who, in the opinion of the Minister, is expressly or impliedly authorized by the person to whom the information relates to obtain it.

[8] It will be seen that limited disclosure of information held by the Commission is permissible in the circumstances set out in those subsections.

[9] Two matters, at least for present purposes, are essential. The first of these is a certificate by the Minister and the second is the Minister's satisfaction that it is necessary in the public interest that relevant information be provided.

[10] Counsel for Mr Peters acknowledged, not only that no certificate has been issued but also that none has been sought, but nevertheless pressed the argument that provision of the material is necessary in the public interest.

[11] In my opinion, the construction of subsection (3) is beyond doubt and it is not for this Court to be satisfied that production of the material is necessary in the public interest. That is a conclusion that must be reached by the Minister and if the Minister reaches that conclusion an appropriate certificate may be issued.

[12] Subsection (3) gives no authority to this Court to override the secrecy provisions of subsections (1) and (2) of each of the relevant sections. Accordingly,

I propose to make the orders sought by the Health Insurance Commission in the notice of motion.

130(4A) — Exceptions to the prohibition

Subsection 130(4) permits a patient to obtain information concerning themselves. Consequently, it does not prevent a relevant decision-maker in another context to require a patient to obtain relevant information for the purpose of determining a claim or application made by that person.

Re Rayson and Repatriation Commission [2009]AATA 231 —

> [98] I have considered whether an order of the sort sought by the [Repatriation] Commission would be oppressive on its face. That is as far as I can go at this stage for it would be for Medicare Australia to raise any problems with Mr Rayson. He would then bring their problems to the Tribunal and ask it to vary its direction. It is difficult to see that this would happen in this case in an age in which information is most likely to be kept in computerised form and in which the legislation governing the Medicare & PBS histories contemplates that they may be obtained by the individuals to whom they relate.
>
> [99] Mr De Marchi submitted that I should have regard to my previous reasons in which I explored the circumstances in which Medicare Australia could reveal the information that it holds. He submitted that:
>
> > "... it would be trespassing on the legislatures [sic] recognition that this information is personal and inherently private. It would render the protection the law affords in these circumstances useless, and respectfully, would undermine the legislative intent that a person have the power to control who can and cannot access such information, information which is personal and inherently private."
>
> [100] I do not accept this submission. The legislation to which Mr De Marchi refers certainly limits those persons who may have access to the information held by Medicare Australia. The individual to whom the information relates is not among those persons. The use that the individual may make of the information is not restricted. If Mr Rayson chose to do so, he could produce that information voluntarily. That would not be in contravention of either the *National Health Act 1953* (NH Act) relating to the disclosure of Mr Rayson's PBS histories or of the *Health Insurance Act 1973* (HIA) relating to the disclosure of his Medicare histories. It would not be a contravention of either the provisions or the spirit of the NH Act or the HIA.
>
> [101] Contrary to Mr De Marchi's submission, it seems to me that Mr Rayson does control who can and cannot have access to his Medicare & PBS histories. As I have said, they are potentially part of the material that is relevant to the review of the decision. Once he decided to apply for review of the Commission's decision, he necessarily, even if not consciously, recognised that the Tribunal would want to decide it on all relevant information. If he does not want it to do so, the solution does not lie in the Tribunal's limiting its attempts to find it but in his deciding what

is more important to him. Is it more important to seek review of the Commission's decision or is it more important to protect Medicare & PBS histories that relate to him and that he may regard as personal and inherently private information? The choice lies in his hands.

130(5E) — Information may be disclosed to a PSR entity

Subsection 130(5E) makes clear that section 130 does not prohibit the Chief Executive Medicare or an employee of the Department from providing information to the Director of PSR, a PSR Committee, or the Determining Authority, or any person providing services to any such entity in order to help such a PSR entity in the performance of functions or duties, or the exercise of powers under Part VAA, or to assist a person to provide services to such an entity.

Subsection 130(5F) defines 'services' for the purposes of section 130(5E) as meaning clerical or administrative services, investigative services, advisory services provided by a practitioner, and legal services.

It is sometimes the case that a PSR Committee may, through officers of the PSR Agency assisting the Committee, make requests for information of the Department or of the Chief Executive Medicare. Such requests are not made under the powers to compel in sections 105A or 106B, but rather under its function in subsections 98(3) and 106(2) to inform itself in any way that it sees fit. The provision of the information by the Chief Executive Medicare or an employee of the Department is then in the performance of a function for the purposes of the Act.

131 Delegation

Section 131 permits the Minister, the Secretary or the Chief Executive Medicare to delegate any of their powers under the Act to an officer. When such a power is exercised by a delegate it is deemed to have been exercised by the Minister, the Secretary or the Chief Executive Medicare, as the case may be. Such a delegation does not prevent the Minister, the Secretary or the Chief Executive Medicare exercising he power themselves.

For the purposes of this section, officer means an officer of the Department, a person performing the duties of an office in the Department, the Chief Executive Medicare, or a 'Departmental employee' within the meaning of the *Human Services (Medicare) Act 1973*.

Section 8B of the *Human Services (Medicare) Act 1973* provides that a 'Departmental employee may assist the Chief Executive Medicare in the performance of any of the functions of the Chief Executive Medicare'. In *Chief Executive Centrelink v Aboriginal Community Benefit Fund Pty Ltd* [2016] FCAFC 153, an equivalent provision (section 16) in the *Human Services (Centrelink) Act 1973*, was taken to import the *Carltona* doctrine such that a Departmental employee, as defined in that Act, could exercise powers on behalf of the Chief Executive Centrelink even if there was not an instrument of delegation to that officer in relation to the power, and thereby 'assist' the Chief Executive Centrelink. It is likely that section 8B of the *Human Services (Medicare) Act 1973* would be similarly interpreted.

132A Regulations relating to the manner of patient referrals

Division 4 of Part 11 of the *Health Insurance Regulations 2018* prescribes the manner in which referrals must be made where an item specifies that a service is to be rendered by a practitioner to a patient who has been referred to the practitioner.

Section 96 of the Regulations specifies which health professionals may make referrals to which other health professionals.

Referring practitioner	**Practitioner to whom a referral may be made**
Medical practitioner	Specialist or consultant physician
Optometrist	Ophthalmologist
Dental practitioner approved by the Minister for purposes of para (b) of definition of ***professional service*** in s.3(1) of the Act	Specialist or consultant physician
Dental practitioner (other than above)	Specialist (but not a consultant physician)
Participating midwife	Obstetrician or paediatrician
Participating nurse practitioner	Specialist or consultant physician

A referral must be in writing, signed by the practitioner, and dated unless it is an emergency. In such a circumstance, the 'emergency referral' is valid only for the one attendance on the patient.[201]

Section 98 of the Regulations defines what classifies an as emergency. The practitioner must decide that it is necessary in the patient's interests for the patient

[201] Subsection 102(6) of the regulations.

to be referred to the specialist or consultant physician as soon as practicable, and the patient is:

> (a) at risk of serious morbidity or mortality requiring urgent assessment and resuscitation; or
> (b) suffering from suspected acute organ or system failure; or
> (c) suffering from an illness or injury where the viability or function of a body part or organ is acutely threatened; or
> (d) suffering from a drug overdose, toxic substance or toxin effect; or
> (e) experiencing severe psychiatric disturbance which puts the health of the patient or other people at immediate risk; or
> (f) suffering acute severe pain where the viability or function of a body part or organ is suspected to be acutely threatened; or
> (g) suffering acute significant haemorrhage requiring urgent assessment and treatment.

A referral must explain the reasons for referring the patient including any information about the patient's condition that the referring practitioner considers necessary to give to the specialist or consultant physician.

If the referring practitioner is a specialist or consultant physician, a written referral must state the name of the general practitioner, participating midwife, or participating nurse practitioner nominated by the patient. If the patient is unwilling or unable to not nominate such a practitioner, the referral must include a statement to that effect.

The specialist or consulting physician to whom a patient is referred cannot render the service to the patient before the specialist or consulting physician receives the referral unless the patient tells them that a written referral has been completed by a referring practitioner, the name of that practitioner, and that the referral has been lost, stolen, or destroyed. In such a circumstance, the referral is valid only for the one attendance on the patient. [202]

The specialist or consulting physician may provide the service without a referral if it is an emergency, that is, if the specialist or consulting physician decides that it is necessary in the patient's interests to render the service as soon as practicable, and one of the emergency criteria referred to in section 98 of the regulations applies (see above), and the service is begun to be rendered to the patient within 30 minutes of

[202] Subsection 102(7) of the regulations.

presentation. In such a circumstance, the referral is valid only for the one attendance on the patient. [203]

Period of validity of a referral

It is a matter for the referring practitioner to determine the length of validity of a referral. If the referral states a fixed period for the validity of the referral, it remains valid for that length of time after the first service rendered by the specialist or consultant physician in accordance with the referral. If a referral states that it is valid indefinitely, it remains valid for an indefinite period. If no period is specified, it remains valid for 12 months after the first service rendered in accordance with the referral.

Nevertheless, if a specialist or consultant physician gives a referral, it is valid for a maximum of 3 months after the first service given in accordance with the referral.

A referral by a participating midwife is valid for a maximum of 12 months after the first service given in accordance with the referral, and for only one pregnancy.

A referral by a participating nurse practitioner is valid for a maximum of 12 months after the first service given in accordance with the referral.

[203] Subsection 102(6) of the regulations.

Human Services (Medicare) Act 1973

Background

The *Human Services (Medicare) Act 1973* was originally enacted under the title *Health Insurance Commission Act 1973*, as cognate legislation to the *Health Insurance Act 1973*. It established the Health Insurance Commission as a statutory body to administer the Medibank scheme. With the title amended, the *Human Services (Medicare) Act 1973* established the office of Chief Executive Medicare to replace the Health Insurance Commission.

Overview

Section 6 provides that the Chief Executive Medicare has 'medicare functions', being the functions conferred on that office by or under the *Health Insurance Act 1973*. Section 7 provides that the Chief Executive Medicare has 'service delivery functions' to provide services, benefits, programs or facilities that are provided for by the Commonwealth for a purpose for which the Parliament has the power to make laws, and to provide services, benefits, programs or facilities that are provided for by a person or body other than the Commonwealth for a purpose for which the Parliament has the power to make laws.

Section 8AD permits a State or Territory to confer functions, or impose duties, on the Chief Executive Medicare, but those functions or duties cannot be performed unless the Minister gives written approval.

Part IID of the *Human Services (Medicare) Act 1973* sets out the investigatory powers of the Chief Executive Medicare.

Section 8L enables the Chief Executive Medicare to make an instrument in writing, authorising the powers under Part IID to be exercised in connection with an investigation that the Chief Executive Medicare is conducting in the performance of his or her functions. Under section 8M, the Chief Executive Medicare may appoint a Departmental employee to be an authorised officer for the purposes of exercising the powers of an authorised officer under the Act.

Section 8P empowers authorised officers to issue notice to produce documents or information if the authorised officer has reasonable grounds for believing that a

relevant offence or relevant civil contravention has been or is being committed and the information or document is relevant to the offence or contravention.

Section 8S provides that a person is no excused from providing a document or giving information on the ground that it may tend to incriminate them, but that the document or information, or information obtained as a direct or indirect result of the person having given the information or produced the document cannot be used against the person, other than in a proceeding for an offence under section 8R for failure to comply with a notice under section 8P.

Section 8U provides that officers may, with the consent of the occupier, conduct searches of premises for the purpose of ascertaining whether a relevant offence or relevant civil contravention has been or is being committed. If the occupier does not consent, the authorised officer must obtain a search warrant under section 8Y before entering the premises to conduct a search.

Under section 8ZN the patient must be advised in writing if an authorised officer or an officer assisting an authorised officer examines a record containing clinical details relating to that individual patient, unless so advising the patient would prejudice the investigation, or, after making reasonable inquiries, the Chief Executive Medicare is unable to locate the patient, or if examination of the record did not result in obtaining any knowledge of any of the clinical details relating to the patient.

In *Gheko Holdings Pty Ltd v The Chief Executive Medicare* judicial review was sought of a search warrant that sought computer records and other documents relating to the suspected commission of offences under Part IIBA of the *Health Insurance Act 1973*. It was alleged that the warrant was defective as it concerned 'prohibited benefits', which was said not to be a defined term. The Court dismissed the application.[204]

Gheko Holdings Pty Ltd v The Chief Executive Medicare [2013] FCA 164 —

> [29] The first point the applicant made is that the references to "prohibited benefits" in the second and fourth paragraphs of the third condition of the warrant are meaningless because there is no such thing as a "prohibited benefit" in the statutory scheme. This argument is without substance. For one thing, it overlooks the effect of s 13 of the *Acts Interpretation Act 1901* (Cth) which provides:

[204] Subsequently an appeal was lodged to the Full Court and an application made for an injunction to stay the inspection of documents seized under the search warrant. The application was dismissed: *Gheko Holdings Pty Ltd (administrator appointed) v Chief Executive Medicare* [2013] FCA 293. The appeal was not pursued.

> (1) All material from and including the first section of an Act to the end of:
> (a) if there are no Schedules to the Act—the last section of the Act; or
> (b) if there are one or more Schedules to the Act—the last Schedule to the Act;
> is part of the Act.
>
> (2) The following are also part of an Act:
> (a) the long title of the Act;
> (b) any Preamble to the Act;
> (c) the enacting words for the Act;
> (d) any heading to a Chapter, Part, Division or Subdivision appearing before the first section of the Act.

[30] Accordingly, headings to sections in the Health Insurance Act form part of the Act, as do the simplified outlines which commence various provisions of that Act. The simplified outline for Div 2 Pt IIBA of the Health Insurance Act states that a benefit is prohibited if it is not a permitted benefit. The headings to ss 23DZZIK, 23DZZIL 23DZZIQ and 23DZZIR all refer to "prohibited benefits" in the context of relevant civil penalty provisions and relevant offences. It is true that in the substance of the sections themselves the reference is to a benefit which is "not a permitted benefit", but there is no doubt from the simplified outline and from the headings that the statute treats a benefit which is not a permitted benefit as a "prohibited benefit".

[31] For another thing, even without the assistance provided by s 13 of the Acts Interpretation Act, the applicant's approach is inconsistent with relevant principles.

[32] In *Different Solutions Pty Ltd v Commissioner, Australian Federal Police (No 2)* (2008) 190 A Crim R 265; [2008] FCA 1686 at [98] – [118] Graham J analysed many authorities dealing with the sufficiency of descriptions of offences in search warrants. At [108] Graham J noted that:

> Although a warrant must comply strictly with the statutory conditions for its issue (see *George v Rockett* [1990] HCA 26; (1990) 170 CLR 104 at 110–11 and *State of New South Wales v Corbett* [2007] HCA 32; (2007) 230 CLR 606 at [1], [3], [18]–[19], [87] and [95]–[100]), it should, like other documents, be read fairly and not perversely. The language used need not be elegant (see per Burchett in *Beneficial Finance* at 544 and 546; see also per Hely J in *Williams v Keelty* at [135]–[139]).

[33] To read the references to "prohibited benefits" in the third condition of the warrant in isolation from their context and without any regard to the relevant statutory scheme established by the legislation which is expressly identified in the third condition is both unfair and perverse.

[34] The second point the applicant made is that the reference to "Intelligent Chiropractic Supplies (ICS)" is itself meaningless or ambiguous because the warrant otherwise contains references to Intelligent Chiropractic Supplies Pty Ltd, Intelligent Chiropractic Supplies and Radiology Reporting Services Pty Ltd, ICS Imaging and Radiology Reporting Services Australasia Pty Ltd, and Gheko Holdings Pty Ltd trading as Intelligent Chiropractic Supplies and Chiropractic Practitioners. This complaint is also not well founded. The warrant is a warrant to enter the premises of Intelligent Chiropractic Supplies Pty Ltd. The warrant

otherwise asserts that Gheko Holdings Pty Ltd trades by Intelligent Chiropractic Supplies Pty Ltd and through the same business name, albeit without the "Pty Ltd". In context the reference to "Intelligent Chiropractic Supplies (ICS)" is a reference to the company Intelligent Chiropractic Supplies Pty Ltd and the business of Intelligent Chiropractic Supplies. Again it would be perverse to read the third condition any other way in the context of the warrant as a whole.

[35] The third point made by the applicant is that the third paragraph of the third condition refers to Medicare provider benefits being "redirected" from Radiology Reporting Services Australia to Intelligent Chiropractic Supplies. The applicant contended that this was meaningless because it is not apparent from the description to where the original Medicare provider benefits were directed. This complaint also involves the perverse reading of the third paragraph. It is apparent that the benefits are being alleged to flow from Radiology Reporting Services Australia to Intelligent Chiropractic Supplies and thence to various chiropractic entities which have entered into service agreements with ICS.

[36] The fourth point made by the applicant is that the first sentence of the fourth paragraph of the third condition is meaningless because it asserts that s 23DZZIJ of the Health Insurance Act details circumstances in which a person can breach the "prohibited practice legislation" when in fact the section does no more than define a person who is connected to another person. It is true that s 23DZZIJ merely defines persons who are connected to other persons. But it does so in the context of Div 2 of Pt IIBA of the Health Insurance Act which deals with civil penalty provisions. Those civil penalty provisions include requirements for persons to be connected with other persons. Read in the context of the third condition as a whole, particularly the references to civil contraventions in the first paragraph of the third condition, it is apparent that the first sentence of the fourth paragraph of the third condition is identifying that the scheme involving the flow of Medicare provider benefits from Radiology Reporting Services Australia to Intelligent Chiropractic Supplies and thence to Chiropractic Entities engages the civil penalty provisions.

[37] The fifth point the applicant made is that the second sentence of the fourth paragraph of the third condition is also meaningless not only because it refers to "prohibited benefits (an argument rejected) above but also because it moves straight from s 23DZZIJ, which is relevant to civil penalty provisions, to s 23DZZIR which concerns offences. The mere fact that one sentence follows on from another and the two sentences deal with two different topics does not make either sentence meaningless, garbled or confused as the applicant contended. It is also apparent that by the second sentence it is being asserted that the scheme referred to in the third condition also engages the offence provisions contained in s 23DZZIR. Another point the applicant made about this same sentence is that the s 23DZZIR contains two offences. The offence in s 23DZZIR(1) involves a person offering or providing a prohibited benefit whereas the offence in 23DZZIR(3) involves the offence of a provider knowing that another person offers or provides a prohibited benefit. The fact that there are two offences does not support the applicant's contention that the warrant fails to state the nature of the relevant offence in relation to which the entry and search is authorised. As disclosed in the reasoning in Different Solutions a broad practical approach is taken to the requirement for the nature of the offence to be disclosed in a warrant rather than a narrow pedantic approach. In particular at [103] Graham J noted that:

> There is no room for a notion that if separate offences are rolled up in a search warrant, the warrant is in some way invalidated on grounds analogous to duplicity (per Hely J in *Williams v Keelty* [2001] FCA 1301; (2001) 111 FCR 175 at [142]).

[38] At [111] and [112] Graham J said:

> [111] The statement of an offence in a search warrant need not be made with the precision required for an indictment. That would be impossible, and indeed to attempt it would be irrational, bearing in mind the stage of the investigation at which a search warrant may issue. The purpose of the statement of the offence in a search warrant is not to define issues for trial, but to set bounds to the area of search which the execution of the warrant will involve, as part of an investigation into a suspected crime. The appropriate contrast is not with the sort of error which might vitiate an indictment, but with the failure to focus the statutory suspicion and belief upon any particular crime, with the result that a condition of the issue of the warrants is not fulfilled (per Burchett J in *Beneficial Finance* at 533 which was cited with approval by Heerey J in *Chong v Shultz* [2000] FCA 582; (2000) 112 A Crim R 59 ('*Chong v Shultz*') at [7]).
>
> [112] What the rule requires is identification (and so limitation) of an area of search by reference to a suspected offence, not the formulation of a pleading before the offence is capable of prosecution (per Burchett J in *Beneficial Finance* at 533–34).

[39] Further, as held in *Beneficial Finance Corporation v Commissioner of Australian Federal Police* (1991) 21 FCR 523 at 525 it is not essential that a warrant refer to a particular offence and authorise seizure by reference to that offence. As Burchett J said at 543, when assessing whether a warrant discloses the nature of the offence:

> The matter should be viewed broadly, having regard to the terms of the warrant in the circumstances of each case ... The precision required in a given case, in any particular respect, may vary with the nature of the offence, the other circumstances revealed, the particularity achieved in other respects, and what is disclosed by the warrant, read as a whole, and taking account of its recitals.

[40] In the present case it is apparent that when the warrant is read as a whole it concerns a complicated scheme involving the applicant and companies and businesses related to the applicant and their arrangements with numerous companies, businesses, medical practitioners and other people asserted to involve asking for, accepting, being offered, or being provided benefits which are not permitted benefits because the benefits are related to the number, kind or value of requests made by requesters. In the context of the warrant as a whole the nature of the potential civil contraventions and offences involved in the scheme are identified.

[41] The sixth point which the applicant made is that the third condition refers to a period from 1 March 2008 which is a period of over four years. The applicant contended that this was such a long period that length of time had to be taken into consideration when considering whether the warrant satisfied the requirements of s 8Y(5) of the Human Services (Medicare) Act. It is not apparent why the length

of time involved places any greater compliance burden under s 8Y(5) than would otherwise be the case. Nor was any cogent argument put by the applicant to support its proposition that the length of time involved otherwise invalidated the warrant.

[42] The final point which the applicant made is that the third condition read as a whole, without the benefit of legal advice, is garbled, confused and meaningless. This submission seems to involve nothing more than wishful thinking on the applicant's part. Whether the third condition may be described as an example of elegant drafting or not is immaterial. What it is not is meaningless. In the context of the subject matter of the warrant the third condition, read in the context of the warrant as a whole satisfies the requirements of s 8Y of the Human Services (Medicare) Act.

[43] For these reasons no inference can be drawn that the magistrate was misled as to the effect of the relevant legislation, nor that Mr McMillan was confused about the operation of the relevant legislation. The assertion by the applicant that the magistrate "must have been completely misled" is simply without foundation. The affidavit put before the magistrate by Mr McMillan does not support the applicant's case. To the contrary it provides further information in the third condition about the scheme said to provide reasonable grounds for suspecting the Commission of offences.

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