



PROFESSIONAL SERVICES REVIEW

ANNUAL REPORT
1997-98

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Copies of this report and further information can be obtained from:

The Executive Officer
Professional Services Review
Telephone: (02) 6285 1651
Facsimile: (02) 6285 1762

LETTER FROM JOHN HOLMES

CRC

PO Box 136 Yarralumla 2600
16 Bentham Street Yarralumla 2600
TEL: (02) 6285 1431 FAX: (02) 6285 1762

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INTRODUCTION

The Director of Professional Services Review is a statutory officer appointed by the Minister for Health and Family Services to manage the process whereby the conduct of a person, who is involved in rendering or initiating services which attract a Medicare rebate, can be examined to ascertain whether *inappropriate practice* is involved.

- Inappropriate practice is defined in the *Health Insurance Act 1973* as conduct that is unacceptable to the general body of the members of the profession or specialty in which the practitioner was practising when he or she rendered or initiated the services in question.

The Director's caseload is dependent upon the Health Insurance Commission investigating instances of suspected inappropriate practice, preparing the case and referring it to the Director for consideration. If the Director decides the person does have a case to answer, a peer review process is initiated. This peer review is conducted by committees with membership drawn from a panel comprising nominees of relevant professions who are appointed by the Minister.

The Professional Services Review was established as a prescribed authority to assist the Director to carry out the functions which are detailed in Part VAA of the Professional Services Review Scheme in the *Health Insurance Act 1973*.

OBJECTIVE

To examine, impartially and expeditiously, cases of suspected inappropriate practice referred by the Health Insurance Commission.

DIRECTOR'S REPORT

This report details a year of mixed results: a number of cases had positive results but the year ended with a major setback. The year brought a very much increased workload as will be seen from statistics in this report but also adverse findings in, initially, a Federal Court appeal and subsequently in an appeal to the Full Federal Court (the *Yung* case—see below).

Following these decisions all the processes involved in the Professional Services Review (PSR) Scheme have been examined and modifications made in an endeavour to comply with Federal Court requirements. However, the Court's findings are such that compliance poses considerable challenges to what was intended to be a 'peer review' process.

Medical professional reaction to the Court judgment has been one of significant concern and a reaffirmation of support for the concept underlying the PSR process. The Federal Court decision, in *Yung*, is such that there needs to be significant changes to the legislation if the promise of the PSR Scheme is to be realised.

Creation of the PSR Scheme was as a result of the Australian Audit Office's Report No 17 1992–93, *Medifraud and excessive servicing: Health Insurance Commission*. The report concluded that the then Medical Services Committee of Inquiry (MSCI) process had significant limitations and could only deal with part of an identified and agreed problem area of abuse of the Medicare arrangements by health care professionals. The Government of the day and the Australian Medical Association (AMA) reached agreement on the details of the PSR Scheme which replaced the MSCI process: the *Health Legislation (Professional Services Review) Amendment Act 1994* came into effect from 1 June 1994.

It was obvious to all involved that an effective accountability process was essential in an open-ended fee-for-service system. Medicare benefits projected cost in the 1998–99 Federal Budget was in the order of \$7 billion.

The accountability model agreed was based on 'peer review': professional peers were required to pass judgment on the conduct of the practitioner who rendered or initiated the professional services which attracted payment of Medicare benefits and who were under review.

With the introduction of the PSR Scheme it was thought that available sanctions would act as a significant deterrent to inappropriate behaviour in the professions. As the MSCJ process had recovered only relatively small amounts of Medicare payments, it was anticipated that the sampling process introduced in the new legislation would enable extrapolation of the findings such that repayments would be more commensurate with the actual extent of moneys involved.

The major intended change, however, was to shift the focus of enquiry from examination of individual services to examination of the practitioner's conduct as a whole by looking at patterns of behaviours. The test inserted in the Act was that the conduct would be 'unacceptable to the general body of the members of the specialty' (or the profession) as appropriate.

The subjective nature of this test is obvious but is well understood and accepted by the vast majority of practising professionals and also by their representative bodies, such as professional associations, Colleges and craft groups.

The Yung Case

The first case the Health Insurance Commission (HIC) referred to the Director of Professional Services Review (DPSR) concerned the conduct of Dr S. Yung and was received by the Director on 8 May 1995.

The HIC referral stated that Medicare benefits had been paid for 19 622 services rendered by Dr Yung in the year, 1 January to 31 December 1994. Dr Yung was a vocationally registered general practitioner. Of these, 17 331 services were rendered from one practice location, an extended hours practice, mostly on three days of the week, so the average number of services on each of those days was over 100. (The HIC referral noted that the 99th percentile for vocationally registered general practitioners was 15 000 services per year).

On 5 June 1995 the Director established PSR Committee No 1 to consider the matter and subsequently held hearings on the substance of the referral over two days. At the end of the hearing Dr Yung was invited to make a written submission. The Committee reported to the Determining Officer with an adverse finding of 'inappropriate practice'.

The Determining Officer, Dr Anthony Adams, issued a draft determination on 22 September 1995 and a final determination on 18 October 1995.

Dr Yung appealed the determination to the Professional Services Review Tribunal (PSRT) constituted under the Act. The hearing was delayed by the untimely death of one of the Tribunal members, the Christmas–New Year period and the 1996 election.

The PSRT was eventually constituted and a hearing held in July 1996. On 7 August 1996, the Tribunal affirmed the finding of the Committee regarding 'inappropriate practice' but set aside the determination and substituted a decision which, in effect, removed the requirement for counselling, the requirement to repay a sum of money (\$42 130) and the requirement for partial disqualification from Medicare (namely, the items in Group A1 of Part 2 of the General Medical Services Table) for nine months but affirmed the total disqualification from the Medicare arrangement for six months.

Dr Yung appealed to the Federal Court and Mr Justice Davies handed down his decision on 11 December 1997. This decision set aside the PSRT's determination and remitted the matter to a differently constituted PSRT to be heard and decided again.

The Determining Officer appealed to the Full Federal Court, which handed down its decision on 15 May 1998. The majority of the Full Federal Court found there had been significant flaws in the processes of both the PSRC and the PSRT such that it would be unsafe to reach any conclusion in the matter. It found it was unable to refer the matter back for further consideration.

It was somewhat galling to me that the reasons given in Beaumont J's minority judgment were in support of the processes carried out and were in line with the legal advice on which we had relied.

It should be noted that the Determining Officer had the responsibility for the legal management of appeals to the PSRT and subsequently to the Federal Court. Much of the argument in the appeals relates to the actions of PSRCs. Thus there is an obvious divided responsibility which needs to be addressed in any future amendments to the process.

The major findings in the Full Federal Court judgment impacting on the PSR process are that the PSRC:

- can only consider the concerns listed in the HIC referral documentation;
- must make its findings only on identified or specified services; and
- must look at sufficient services or use a sampling process which is statistically valid.

The Court also found that:

- Vocational Registration status and Royal Australian College of General Practitioners (RACGP) standards were irrelevant;
- the PSRC could only take into consideration what the doctor did and not what he did not do; and
- there had been failures in affording procedural fairness but it was unable to refer the matter back for reconsideration.

The Court also commented on PSRT processes.

The implications of this decision for the PSR process are addressed below.

Health Insurance Commission concerns

The HIC has only limited information, mainly statistical, and limited investigatory powers. The information to which it has access only raises a suspicion. The PSRC has relevant powers to obtain further information and, most importantly, the professional expertise to fully explore any problems.

Specific or identified services

The problem here lies in the nature of professional practice. If a PSRC has to look at a single service in isolation it will always be difficult to find inappropriate practice. It is, rather, a pattern of behaviour over a period which leads to a PSRC being able to make a finding of 'inappropriate practice'.

Statistical sampling

The previous sampling methodology had both statistical and legal flaws. However, the problem referred to in the preceding paragraph also applies here in relation to a judgment about a single service.

External standards

The RACGP is at this time the only College which has a set of minimum practice standards in the public arena. Documentation on these standards has been sent to all general practitioners in Australia. It is doubtful that other Colleges and craft groups are likely to issue standards documents in their areas of professional practice in the near future.

Omission and commission

Professionally it is difficult to accept a proposition that it is acceptable not to carry out a proper professional examination or perform the service required in a patient's interest.

Procedural fairness

The issues of procedural fairness or natural justice arise in all such enquiries. Issues the Court identified in the PSRC process were never argued in Court. Several reviews of the procedures of PSRCs have been undertaken since the early cases and subsequent to the Court judgment.

PSRT processes

As I have no responsibility in this area I will not comment on this aspect of

the Court findings. However, the DH&FS has forwarded a report regarding the PSR Tribunals which can be found on page 27.

Conclusion

It can be appreciated from this brief overview that the judgment has meant all aspects of the PSR Scheme needed to be examined in the light of the errors of law identified. Given the major impact the findings have on a 'peer review' model of enquiry, it seems evident that legislative amendment is necessary to allow the PSR Scheme to function properly. Before the judgment I was pleased to state, in public forums, my belief that the process protected patients, taxpayers and the profession. With appropriate amendments to the Act I am positive this promise can be realised.

Postscript

Subsequent to the reporting period, the Minister for Health and Family Services, the Hon. Dr Michael Wooldridge, has established a Review Committee to consider the effects of the Court judgment and make recommendations to the Minister on required legislative amendments. Representation on this group is from the AMA, the Department of Health and Family Services (DH&FS), the HIC and the PSR. The Committee will consult widely within the professions and involved parties and seek statistical and legal advice.

PSR Caseload

In the year to 30 June 1998, the HIC referred the conduct of 48 practitioners to the DPSR. These referrals were received before the Federal Court judgment in *Yung* (since then further referrals have been held in abeyance until the impact of that decision and the subsequent Full Federal Court decision on the PSR process can be assessed).

PSRCs were established in 35 cases, 11 referrals were dismissed under section 91, and three referrals were dismissed under section 92 (the practitioners accepted a period of partial disqualification from the Medicare arrangements). In the same period, 22 PSRC reports were forwarded to the

Determining Officer under section 106L with 13 reports containing a finding of 'inappropriate practice'. In nine cases the PSRC findings were that the conduct referred was 'not inappropriate'.

As at 30 June 1998, 34 referrals were awaiting the Director's decision. Twenty-four Draft Determinations were received from the Determining Officer under section 106S and 28 Final Determinations.

Table 1 gives the statistical view of the PSR process over the four years since establishment with the activities for 1997-98 highlighted.

Table 1

	1994-95	1995-96	1996-97	1997-98	Total
HIC referrals received by DPSR*	1	16	70	48	135
Referrals dismissed under section 91		1	3	11	15
under section 92			2	3	5
PSRCs established by DPSR	1	15	30	35	81
PSRC Reports to Determining Officer		8	21	22	51
Draft Determination received by DPSR		2	10	24	36
Final Determination			1	29	30

*Director of Professional Services Review

Table 2 gives a statistical overview of the appeal activity under the PSR Scheme since its inception.

Table 2

	Lodged	Hearing	Judgment
PSR Tribunal	19	10	7
Federal Court	3	2	1
Full Federal Court	1	1	1

Two HIC referrals were regarding the conduct of specialist medical practitioners and the remainder were concerning conduct of general practitioners and other medical practitioners. The PSRC which examined the conduct of a specialist practitioner involved in a surgical discipline found the conduct to be 'not inappropriate'. The enquiry found that the practitioner practiced in a non-metropolitan area with a shortage of practitioners in the particular specialty and the statistical data reflected the workload requirements of this situation.

In this year no referrals were received which related to the conduct of practitioners of the other professional groupings covered by the PSR Scheme, namely, dentistry, optometry, physiotherapy, chiropractic or podiatry.

The HIC continues to advise that the PSR Scheme and the publicity generated to date have acted to encourage positive changes in the behaviour of practitioners following counselling visits by its medical advisers.

Section 91 dismissal

Under section 91 of the *Health Insurance Act 1973*, the Director can dismiss the referral 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 connection with the referred services'.

When the HIC forwards a referral to the person under review it is accompanied by a copy of the relevant section of the legislation and a notice inviting the practitioner to send a written submission to the Director outlining the reasons the Director should dismiss the referral without setting up a PSRC. This is often the first real opportunity the practitioner has to address the clinical issues, as distinct from the statistical concerns, raised previously by the HIC. Section 91 gives the Director a very significant discretion and power which is not exercised lightly.

Following consideration of the practitioner's submission, consultation with a Panel member or consultant may occur, as provided for in the Act. The

consultant is usually nominated by a learned professional body, such as one of the Royal Colleges or specialty groups. In most cases, a visit to the practitioner's practice is made to ensure the submission reflects the reality of the practice and to ensure the clinical records support the statements made in the submission.

Following such a visit and assessment, it is usual practice to further consult a Panel member, invariably a Deputy Director with experience in similar cases, and obtain an endorsement of the belief that it would be unlikely that a Committee would find inappropriate conduct in such a case.

It is only following such a procedure that a referral is dismissed under section 91. The reasons for the decision to dismiss the referral are forwarded to the HIC and the practitioner.

Section 92 dismissal

Section 92 of the Act gives the Director the discretion and power to dismiss a referral if the referred practitioner agrees to a period of partial disqualification. Accepting such a sanction allows the practitioner to avoid the stress and time of a PSR Committee hearing and also ensures no adverse finding is recorded. The significance of the latter relates to section 106X which mandates the referral to a Medicare Participation Review Committee (MPRC) of a practitioner with two effective final determinations following adverse findings by PSRCs. Such referrals can have serious consequences for a practitioner, including disqualification from the Medicare arrangements for a period of up to five years.

In the past year, a number of practitioners or their legal advisers have made section 92 offers, but only three have been accepted. Before considering such an offer, the Director must be convinced the practitioner understands and accepts that aspects of the practice would be considered 'inappropriate' by his or her peers and has instituted, or is committed to instituting, relevant changes to those practices. The difficulties inherent in balancing the requirement for a sanction for past behaviour with the positive outcome of behavioural reform are recognised and are obviously considered in all cases.

In those three cases where partial disqualification was accepted, I am confident the professional behaviour will show a permanent change and the practitioners will not come to the notice of the HIC again. Advice from the HIC is that very different and appropriate conduct by practitioners to whom this section was applied in 1996–97 is now evident.

Section 93 Professional Services Review Committee Hearings

Thirty-five PSRCs were established in the year whilst a number set up in 1996–97 completed hearings and finalised reports. No complaints were received regarding the administrative arrangements made for the hearings in the various capital cities. A representative selection of case summaries can be found on pages 33–37.

Again this year the majority of referrals involved provision of high numbers of services. The graph on page 33 relates to the services performed by general practitioners.

In general, the PSRCs have difficulty accepting arguments from practitioners indicating high patient throughput was due to efficiency, vast experience and superior competence, especially when the medical record or evidence at a hearing does not support such claims. Failure to allocate adequate time to obtaining a relevant history, performing a physical examination, formulating and implementing a management plan, and providing an explanation to the patient, must increase the risk of error and potential harm to the patient. The majority of practitioners accept that proper practice requires time to be made available to, and spent with, each patient.

Workforce issues do not appear to give a rational explanation for this style of practice which often occurs in areas where there are adequate numbers of practitioners. The outcome for the patient seems to be that only the presenting problem or symptom is addressed and no effort is made to offer whole-person care.

Frequently the patient is required to return at which time similar behaviour is repeated. This mode of practice must add to health care costs. It is a truism that the best approach (and least costly in the long term) is to do it right the first time. This applies also to health care.

Medical records

This year has again confirmed the importance of adequate and contemporaneous records both for the proper conduct of professional practice and for the defence of any legal claim or question of accountability such as posed in the PSRT process. Since the *Yung* decision, however, certain comments in PSRT findings and Court hearings seem to indicate that lack of proper records could benefit the practitioner whose conduct is under review. Such an implication is not accepted by the vast majority of the profession and can lead to what can only be described as bizarre results.

Practitioners have claimed before PSRCs that their memory is such that they can recall patient histories and examination findings in detail without the benefit of adequate contemporaneous clinical records. Committees generally have been unable to accept this proposition, especially when it involves several thousand patients over a period of years. The Federal Court decision in *Yung* has compounded this problem.

In this regard it is worth noting that various State Medical Boards are now formulating and issuing guidelines as to what they, as regulatory bodies, regard as essential medical records for proper professional practice. The Boards in Queensland and the Australian Capital Territory have advised their registrants what an acceptable medical record should contain and the New South Wales Board has issued draft regulations on this and other relevant subjects.

In most of the cases considered over the past years, where adverse findings have been made, the records have been found to be inadequate or even non-existent. Invariably, in the cases where the PSRC has found the conduct of the referred practitioner to be 'not inappropriate', the medical record has supported the practitioner's position.

PSRCs support the widely-held professional view that the minimum requirements for a medical record are that it should show:

- presenting complaint and history,
- result of examination, including relevant negative findings,
- management of presenting complaint, and
- justification for any tests or referral,

and should also record, in a reviewable format;

- past history,
- drug allergies,
- current treatment, if any, and
- immunisation history, social history and habits, where appropriate.

It is appreciated and accepted that all records may not satisfy those criteria but such a record is a necessity for managing long-term patients and those with significant medical conditions. Other bodies, including the RACGP in its Entry Standards, consider the record must be capable of being used by another practitioner in the care of the patient.

Alteration of records

The Act makes it an offence for a practitioner under review to produce a false or misleading document to a PSRC. Significant financial penalties apply. Again this year several PSRCs have been suspicious that records may have been altered. The HIC now has regulations in place which allow a PSRC to refer such concerns to it for investigation and possible prosecution. Such investigations may include forensic examination of the records. Practitioners should also be aware that regulatory bodies such as the State Medical Boards, are very concerned by such behaviour and may impose significant sanctions if alteration of medical records for the practitioner's benefit is proven.

Hours of duty

Many practitioners appearing before PSRCs claim extended hours of work and it is often impossible to verify such claims. However, there can be no doubt some practitioners do work apparently excessive hours. At a time when professional groups and industrial organisations are moving to ensure doctors in hospitals or training situations are not required to work excessive hours it would seem appropriate that professional organisations review this situation and consider developing guidelines.

The community recognises that there should be limits on the hours of duty for various groups where fatigue at work could pose significant risk to public safety and it seems hard to argue that medical and health care practitioners should not have a similar code of behaviour in this regard. The exigencies of medical practice are acknowledged but emergencies and epidemics are not occurring all the time.

The AMA is moving to establish a code of practice concerning the hours of duty interns and residents employed in hospitals are required to work.

Regulatory bodies

Continued good relationships exist between the PSR and the State and Territory Medical Boards and regulatory bodies. Following alterations to the legislation, PSRCs may refer matters to Boards where the PSRC considers there is risk to life or health of any person. PSR sought advice from Boards as to the concerns about which they would wish to be informed. All Boards responded and this advice is now available to all PSRCs.

Again this year a number of PSRCs have been concerned during hearings about the clinical competence of the practitioner and this year two medical practitioners were referred to the relevant State Medical Boards. The PSRC, in each case, considered the practitioner's behaviour posed significant risk to patients.

Medical Boards are more and more seeking cooperation and a sharing of relevant information where this is authorised by legislation. It is interesting

to note that a number of the State Medical Boards are currently considering ways they can put in place methods and legislation by which they can monitor and assess the continuing competence and performance of their registrants. The General Medical Council in the United Kingdom has recently initiated such a process and early reports of this initiative are encouraging. The progress of the General Medical Council scheme will be watched with interest by many in Australia.

Suspected fraud

Section 106N of the Health Insurance Act requires that a hearing before a PSRC be suspended if the Committee considers the material before it gives rise to a suspicion of fraud. The matter must be referred back to the HIC along with the reasons for this action. In the past year this provision has been used on four occasions.

The issues involved were varied and included suspicions that the services claimed had not been performed, that the practitioner knowingly claimed for services where it was known the patient was not entitled to treatment under the Medicare arrangements and that the claims for services which were time-tiered exceeded 24 hours in a day. The HIC will undertake the appropriate investigations.

Other legal matters

Dr Tankey's Federal Court appeal against the PSRT Determination was heard in Brisbane before Einfield J in March 1998. This appeal also involved some Constitutional issues relating to the Commonwealth's power in this area. Judgment was reserved and has not as yet been handed down.

The Federal Court heard two further cases seeking injunctions to halt PSRC hearings in the past year and both were unsuccessful. One case confirmed the power of the Director to delay a decision on establishing a PSRC beyond the legislative timelines. This clarified the interpretation of the relevant section of the Act.

The other case involved an extension of time to lodge an application for

judicial review of the decisions of the Committee and the Determining Officer. The Federal Court refused to grant this application and ordered costs against the applicant.

In the early stages of a scheme such as this, it is obvious that challenges will occur concerning various legal issues until the law is clarified and a body of legal precedent established.

Final Determinations

In this year 15 Final Determinations, issued by the Determining Officer, have come into effect where the practitioner has not appealed the Determination. The sanctions accepted included counselling, periods of partial or total disqualification from the Medicare arrangements and repayments to the Commonwealth of Medicare benefits.

It is the Director's responsibility to arrange for, or perform such counselling. In 1997–98 formal counselling, as required by the final Determination, was given to 12 medical practitioners. Although this is often stressful to the practitioner I believe this is a very important role and part of the process. Following this counselling I am of the opinion most of the practitioners have significantly altered their behaviour and are unlikely to be seen in this process again.

PSR Panel

Membership of the PSR Panel carries the likelihood of being required to serve on a PSRC. This is a difficult and responsible task and can indeed be very demanding, especially as it is often a task with which many practitioners have had little experience. However, those members asked to serve have carried out the task responsibly, competently and have always been considerate of the colleague appearing before them. Their contribution and commitment is very much appreciated.

The Deputy Directors, whose task is to chair the committees, have the added onerous responsibility of coordinating the PSRC process and ensuring the process is conducted with fairness and regard to all involved.

This process involves a considerable commitment of time from the Panel members who all have a continuing involvement in full-time professional practice.

It is with regret that I record the deaths of Dr Malcolm M^cKenzie of Melbourne and Dr John Bampton of Adelaide. Both doctors, who had considerable MSCI experience, had been members of the PSR Panel since its inception and had served on PSRCs. Dr M^cKenzie had made a significant contribution as a Deputy Director.

Ethnic practitioners and their communities

It was noted in last year's report that there was the beginnings of an involvement by ethnic medical associations in the PSR process. This has increased over the past year and I have been invited to address a number of such organisations on the role of the PSR Scheme. It is gratifying to note the support received at such meetings which also allow fears and misconceptions of members to be addressed.

This year more members of these associations were appointed to the Professional Services Review Panel and some have sat on PSRCs. Their involvement and interest is important for the process. At the meeting of Deputy Directors held in Canberra in March 1998 a prominent member of one of the ethnic medical associations presented a paper on this subject. His conclusion was that cultural differences were an explanation but were not an excuse for aberrant professional conduct.

Timeliness

The timelines in the legislation have been difficult to maintain over the past year because of Panel member unavailability, workloads and the changed requirements necessary following the *Yung* judgment. It is appreciated that all practitioners appointed to PSRCs and the secretariat of the Committees have made every effort to meet these time requirements.

Administration

No major problems have been encountered this year in the administrative arrangements in place for establishing and conducting PSRC hearings.

Hearings, which are stressful to all involved, are conducted with the minimum of formality having regard to the need for fairness and confidentiality. However, following recent Court decisions, it is apparent that this situation must and will change. Auscript continues to provide transcripts of hearings in a very efficient and timely manner.

Deputy Directors' Workshop

A workshop was held in Canberra in March 1998 for the medical Deputy Directors at which the previous year's activities were reviewed. Several sessions were devoted to legal issues and plans were made to address the requirements of the Courts to ensure the procedures during PSRC hearings are soundly based. This was, as before, a most useful and informative exercise and it helped ensure consistency of decision making across the States and Territories.

Meetings with the profession

Over the past year I have accepted every opportunity to address professional associations and craft groups on the subject of the PSR Scheme. These have provided a valuable means to inform the profession of the Scheme's activities and processes. The support and involvement of these groups is vital as it is their members whom they nominate to the PSR Panel who are the decision makers in this peer review process.

Attendance at meetings such as the AMA Congress and the RACGP Annual Convention provided other valuable forums in which to garner support for the scheme.

Discussions have also taken place with Medical Defence Organisations which support the process as part of their risk management strategies.

In May 1998 I attended the Annual Meeting of the Federation of State

Medical Boards of the United States. This meeting was highly recommended and lived up to all claims. It was attended by representatives from most Australian Medical Boards as well as those from other countries. It was a marvellous forum in which to learn and exchange experiences. It is not surprising that similar problems with professional behaviour, difficulties with enquiries and disciplinary tribunals and the legal systems are experienced around the world.

Determining Officer's Report

The Determining Officer, Dr Louise Morauta, has forwarded a report on the role and activities of the Determining Officer for the past year for inclusion in this Annual Report. Her report is on pages 20–26.

Advice to practitioners

Despite the Federal Court's adverse findings in the first case it considered under this legislation, and with the benefit of another year's experience, my advice to practitioners to help them reduce the possibility and risk of being asked to justify their conduct to a committee of their peers is still:

- **listen to the HIC Medical Adviser** when HIC concerns are explained to the practitioner. Such visits should make practitioners review their conduct and even seek advice from colleagues and their professional associations.
- **discuss problems with professional colleagues**—there may be other professional views on long or strongly-held beliefs. Medicine is a collegiate profession: professional associations and colleagues are only too pleased to offer advice but such advice can only be relevant if they know all the facts.
- **keep good records** as they are a vital element in any defence in a justification proceeding.

Conclusion

Despite the setbacks of the past year the PSR secretariat and supporting staff remain committed to this process and to making it function in the manner intended. I remain most grateful for the efforts of a dedicated and involved staff and the contribution of those members of the PSR Panel who have served on PSRCs.

In a previous report I noted that we were approaching the shoals of legal challenge. It is unfortunate that we have hit a legal reef with the consequences described throughout this report. However, I believe the problems identified can, and must, be addressed and corrected. This will require administrative changes as well as amendments to the legislation.

The PSR process has strong professional support from formal associations, from individuals and most importantly from those professionals who have been, and continue to be, involved. Such support gives a strong message. It is essential for all parties—patients, taxpayers, government and the professions—that an effective accountability process is in place. It will be our task in the following months to ensure this occurs.

A handwritten signature in black ink, appearing to read "John Holmes". The signature is fluid and cursive, with a large initial "J" and a long, sweeping underline.

Dr John Holmes
Director of Professional Services Review

DETERMINING OFFICER'S REPORT

Overview

The role of the Determining Officer within the Professional Services Review Scheme focuses on the making of determinations in respect of practitioners who have been found by Committees of their peers to have engaged in inappropriate practice. In making a determination, the Determining Officer is required to apply one or more of the directions specified in section 106U of the *Health Insurance Act 1973* (Act). These include requiring the practitioner to be reprimanded and/or counselled by the Director of Professional Services Review or his nominee, repaying to the Commonwealth the whole or part of the Medicare benefit paid for services in connection with which the practitioner was found to have engaged in inappropriate practice and full or partial disqualification from Medicare for periods up to three years.

The Determining Officer also defends requests for review of determinations in Professional Services Review Tribunals (PSRTs).

Determinations

During the year, the Determining Officer received 25 reports from Professional Services Review Committees of which 15 contained findings that the person under review had engaged in inappropriate practice. Draft Determinations were issued in respect of 24 cases while Final Determinations, that is, determinations made after the person under review had presented the Determining Officer with submissions on a draft determination, were issued in respect of 29 cases. A number of these Final Determinations relate to cases referred to the Determining Officer in the preceding financial year but, because of the need to seek and consider submissions, were not brought to Final Determination stage until this financial year. Fifteen practitioners accepted final determinations without seeking any further review.

Despite adverse findings by the Courts, there were 16 determinations implemented (that is, after all avenues of appeal had been exhausted) against medical practitioners found to have practised inappropriately, with sanctions put in place that include the repayment of \$1.22 million.

During the year, the Determining Officer also defended in the Federal Court a decision to not provide a PSRT with a draft determination. A summary of this matter is provided under the heading 'Federal Court Decisions—Entitlement of PSR Tribunal to access Draft Determination' below.

Professional Services Review Tribunal (PSRT) Decisions

Practitioners to whom a determination relates may ask the Minister for Health and Family Services to refer the determination to a PSRT for review. Sixteen PSRTs have been established, each of which comprises a President who is a former judicial officer holder and two members of the same profession as the person under review. Proceedings before Tribunals are conducted with as little formality and technicality as proper consideration of the matter permits. Unlike proceedings before Professional Services Review Committees, the person under review may be legally represented.

Five PSRT decisions were handed down in the year. These were for Dr Jean McFarlane, Dr James Demirtzoglou, Dr Chee Wong, Dr Juan Sabag and Dr Kim Lam, all of whom are general practitioners.

Dr McFarlane

Dr McFarlane was a general practitioner with a special interest in viral diseases. She was referred by the HIC to the Director of Professional Services Review in August 1995 for all pathology services initiated by her during the 1994 calendar year. In that year, Dr McFarlane initiated 18 776 pathology services for 1 451 patients at a Medicare benefits cost of \$552 758.25. During the referral period, Dr McFarlane had 1 919 patient episode initiations resulting in 9.8 tests per episode, this comparing with the average for all Australian general practitioners of 1.7 tests per episode.

She requested substantially the same combination of nine or more pathology services on 1 557 out of the 1 919 episodes.

In February 1996, the PSR Committee found that Dr McFarlane failed to take relevant clinical histories, failed to perform a system by system medical examination, failed to document adequate clinical records, failed to perform such investigations that a good history and examination would indicate as necessary and failed to undertake continuing medical education. It also found that Dr McFarlane requested a constant basic block of pathology investigations irrespective of the condition being treated or the medical necessity, repeated many of the pathology tests despite previous normal results, held views regarding the aetiology of disease (particularly viral disease) which are unacceptable to the majority of her peers and demonstrated a lack of insight into the fact that she does not conform to general medical standards.

The Determining Officer made a determination that the Director of Professional Services Review or his nominee counsel Dr McFarlane, she be fully disqualified from Medicare for six months and partially disqualified for 12 months. Following a hearing by PSR Tribunal No 15, the Tribunal affirmed the original determination. Dr McFarlane subsequently appealed the PSR Tribunal's decision to the Federal Court.

Dr Demirtzoglou

Dr Demirtzoglou had been referred by the HIC to the Director of Professional Services Review in August 1995 for all services rendered by him during the 1994 calendar year. In that year, Dr Demirtzoglou provided a total of 17 080 services to 7 552 patients at a Medicare benefit cost of \$435 370. Of those services, 1 817 or 11.1 per cent of all attendances were home visits. Dr Demirtzoglou provided about 10 times as many Level C and D (long and prolonged) home visits than the average of all active general practitioners.

In February 1996, the PSR Committee found Dr Demirtzoglou to have demonstrated a pattern of claiming for higher level home visits than

warranted. In addition, it found that Dr Demirtzoglou had developed a pattern of rapid patient throughput in his surgery consultations.

The Determining Officer made a determination that the Director of Professional Services Review or his nominee counsel Dr Demirtzoglou, that Dr Demirtzoglou repay \$150 226 to the Commonwealth, he be partially disqualified from Medicare for six months and fully disqualified from Medicare for three months.

Following a hearing by PSRT No 7, the Tribunal set aside the original determination and directed that Dr Demirtzoglou be counselled by the Director of Professional Services Review or his nominee.

Dr Wong

Dr Wong was referred to the Director of Professional Services Review in October 1996 for all services rendered by him in the 1995 calendar year. In that year Dr Wong rendered 23 804 services to 5 114 patients for a total Medicare benefits of \$552 601.40, thereby placing him well beyond the 99th percentile of all active general practitioners in Australia.

In June 1997, the PSRC found that Dr Wong had engaged in inappropriate practice. The Committee was critical of a number of aspects of Dr Wong's practice, including his high daily throughput of patients, his inappropriate claiming of Level B and C consultations, his incorrect claiming of services under MBS item 47 918 (ingrowing toenail, radical excision of nailbed), his excessive provision of acupuncture services and his demonstrated reluctance to perform home visits.

It did, however, make a number of positive comments about Dr Wong's practice and offered the view that there was a strong possibility of a good outcome from appropriate counselling, supervision and training.

The Determining Officer made a determination that the Director of Professional Services Review or his nominee counsel Dr Wong, he repay an amount of \$91 230.55 to the Commonwealth, he be partially disqualified from Medicare for six months and fully disqualified from Medicare for one month.

Dr Wong sought a review of the determination. That application was referred to PSR Tribunal No 13 which, upon application by counsel for the Determining Officer that insufficient differences were present between this case and that of Dr Yung (see 'Federal Court Decisions' below) and without the Tribunal entering upon a hearing, the Tribunal set aside the determination.

Dr Sabag

Dr Sabag was referred to the Director of Professional Services Review in June 1996 for all services rendered by him during the period 1 July 1994 to 30 June 1995. During the referral period, Dr Sabag rendered 7 836 services of which 7 335 were professional attendances. Of all attendances, 84 per cent were Level C (long) attendances and 3 per cent were level D (prolonged) attendances. Dr Sabag also claimed 382 regional or field nerve blocks, 159 injections of an anaesthetic agent into lumbar or thoracic nerves (the second ranked provider of this service in Australia provided this service on 15 occasions) and 101 incidences of the destruction of a cranial nerve other than the trigeminal by a neurolytic agent (the second ranked provider of this service in Australia provided the service on 53 occasions).

In November 1996, the PSR Committee found Dr Sabag to have engaged in inappropriate practice. The Determining Officer made a determination that Dr Sabag be counselled by the Director of Professional Services Review or his nominee, he repay an amount of \$148 769.95 to the Commonwealth, he be partially disqualified from Medicare for 12 months and fully disqualified from Medicare for six months.

Following a hearing by PSR Tribunal No 11, the Tribunal set aside the Determining Officer's determination and, in lieu, determined that Dr Sabag be counselled, he repay an amount of \$37 492.70 to the Commonwealth in respect of his rendering of regional or field nerve blocks during the referral period and he be partially disqualified from Medicare for 12 months.

Dr Lam

Dr Lam was referred to the Director of Professional Services Review in September 1996 for all services rendered during the 1995 calendar year. In that year Dr Lam rendered 24 046 services to 7 661 patients at a Medicare benefits cost of \$483 795.

In April 1997, the PSR Committee found Dr Lam to have engaged in inappropriate practice, aspects of which included her high volume of services rendered, her inadequate record keeping, her billing on incorrect item numbers, safety aspects with regard to out of hours performance of procedures, failure to keep operative notes and disposal of clinical waste.

The Determining Officer made a determination that Dr Lam be counselled by the Director of Professional Services Review or his nominee, she repay an amount of \$121 140.45 to the Commonwealth, she be partially disqualified from Medicare for six months and be fully disqualified from Medicare for two months.

Following her request for review of the determination by a PSR Tribunal and upon application by the Determining Officer and with the consent of Dr Lam, the PSR Tribunal set aside the determination without entering upon a hearing into the matter. The Tribunal's determination was that Dr Lam repay an amount of \$191.85 to the Commonwealth, being the difference between the Medicare benefits paid at the higher rate in respect of two particular items in the Medicare Benefits Schedule on the 14 occasions identified in the material before the PSR Committee when the lower rate should have been paid.

Table of Action on Activities of Determining Officer

The following table shows the actions on cases by the Determining Officer in 1997–98.

PSRC Reports to the Determining Officer	25*
PSRC Reports sent to Persons Under Review	24
PSRC Reports indicating the Person Under Review was not practising inappropriately	10**
Draft Determinations issued by the Determining Officer	24
Submissions made to the Determining Officer on Draft Determinations	23
Final Determinations issued by the Determining Officer	29
Final Determinations accepted without appeal	15

* The discrepancy in this figure compared with the figure in Table 1 is due to three Reports from PSRCs being in transit on 30 June 1997 and received by the Determining Officer on 1 July 1997.

** The discrepancy in this figure compared with the figure on page 7 is due to one such Report from a PSRC being in transit on 30 June 1997 and received by the Determining Officer on 1 July 1997.

DEPARTMENT OF HEALTH AND FAMILY SERVICES' REPORT

Overview

The Department of Health and Family Services assumes the overarching policy responsibilities for advice to the Minister on the development and maintenance of the PSR Scheme. This role requires the Department to constantly liaise with the respective stakeholders in the Scheme and perform the broader tasks of policy review and development of legislation. A senior officer of the Department, namely the First Assistant Secretary, Health Benefits Division, has been appointed by the Minister to the position of Determining Officer under the Scheme. The Determining Officer's role and report for the 1997–98 year is set out earlier in this report.

Other more specific tasks falling to the Department include overseeing the operation of the Professional Services Review Tribunals and the appointment of Presidents and members to those Tribunals and the provision of legal and administrative assistance to Tribunals in challenges to determinations to the Federal Court. The Department also renewed its Memorandum of Understanding with the Administrative Appeals Tribunal (AAT) whereby the AAT acts as Registrar to the various PSRTs.

Legislative Changes

Legislative amendments to the PSR Scheme aimed at clarifying certain aspects of the Scheme which had attracted criticism in various forums came into effect on 6 November 1997. Provisions in the then existing section 106U were amended to ensure there could be no doubt that the Determining Officer was exercising anything other than an administrative power under this Scheme. Other major amendments made were designed to:

- define the classes of practitioners so that they were consistent with

other parts of the *Health Insurance Act 1973* (the Act), thereby enabling a better test to be applied in terms of a practitioner's conduct;

- remove the statistical sampling provisions which had proven to be unworkable in practice;
- clarify the test under which a Professional Services Review Committee reports on the conduct of a practitioner;
- reword the sanction provisions to be applied by the Determining Officer following receipt of a Committee report of inappropriate practice;
- provide a clearer approach to calculating the amounts of Medicare benefits to be repaid; and
- increase the periods of partial and full disqualification from access to Medicare up to a maximum of three years in both cases.

Additional amendments introduced minor changes to the Act to improve the administration of the process of reviewing a practitioner's conduct. These included bringing the class of practitioners in Parts VAA and VA of the Act into line with definitions contained elsewhere in the Act.

Another legislative amendment made during the year rectified a possible procedural defect in the referrals made by the Health Insurance Commission to the Director of Professional Services Review. The amendment to what was essentially a technical defect conferred retrospective validity on all HIC referrals up to 6 June 1997.

On 18 December 1997, the Governor-General made a Regulation to allow a general practitioner who had been partially disqualified under paragraphs 19B(b) and (d) of the Act from accessing Medicare benefits for specified services under subsection 92(4) or paragraph 106U(1)(g) of the Act, to access other Medicare benefits.

Establishment of new Professional Services Review Tribunals (PSRTs)

The lack of flexibility in the Act to interchange PSRT members or establish a pool of available persons led to the establishment of an additional nine PSRTs by the Governor-General on 23 July 1997. Included in this process was the appointment of a second PSRT President, the Hon Mr A. N. Neaves, as well as an additional four members.

Federal Court Decisions

Entitlement of PSR Tribunal to access Draft Determination

In the course of a hearing by PSR Tribunal No 7 into an appeal by Dr James Demirtzoglou, the Tribunal directed the Determining Officer to produce the draft determination along with Dr Demirtzoglou's written submission. When the Determining Officer declined to produce the documents, the Tribunal adjourned the review to permit a ruling from the Federal Court.

The grounds for the Determining Officer's refusal were that section 115(1) of the Act lists the documents to be forwarded to the Tribunal, that these listed documents are those to which section 119(1)(a) requires the Tribunal to have regard in coming to a conclusion on the review, and neither the draft determination nor the submission appears in the list. In particular, the definition of 'determination' in section 107 specifically describes it as being a final determination.

On 12 February 1988, Sundberg J handed down his decision that the PSR Tribunal was not entitled to receive and take into account the draft determination of the Determining Officer and submission thereon. Sundberg J reasoned that he did not consider it possible to imply a power in the Tribunal to receive material in addition to that contemplated by those provisions of the Act at sections 115 (request for review to be forwarded to Tribunal) and 119 (proceedings on review). The fact that these provisions only deal with the final determination suggested to

Sundberg J an express legislative intention to exclude the draft determination from the Tribunal's consideration.

Dr Yung

Dr Yung had appealed against a decision of PSR Tribunal No 1 that he be fully disqualified from Medicare for six months.

On 11 December 1997, Davies J handed down his decision, ordering that the decision of the PSR Tribunal be set aside and the proceedings be remitted to a differently constituted Tribunal.

Davies J found the Tribunal decision to be flawed on three grounds. The first was a failure to accord Dr Yung procedural fairness, both in failing to give him reasonable notice of the matters it was to consider and also a reasonable opportunity to respond to findings adverse to him which it proposed to make. The second was that the Committee made global findings, either of or relevant to inappropriate practice, without relating these findings in any meaningful way to the referred services. In particular, it made no attempt to deal with statistical samples. Third, the Committee did not state clearly the findings of inappropriate practice which it made.

Other findings made were:

- the Tribunal failed to make a clear identification of inappropriate practice or practices related to an identified service or services;
- the Tribunal's reasons had to be set aside because of the flaws that had occurred at earlier stages, particularly procedural fairness in the Committee;
- the Determining Officer misapprehended his powers by not taking into account matters falling outside the referral period, such as whether Dr Yung had subsequently changed his ways and reformed the nature of his practice; and
- the Tribunal failed to give adequate reasons for its conclusion that the PSR Committee's decision that the doctor had practised inappropriately was correct.

DEPARTMENT OF HEALTH AND FAMILY SERVICES' REPORT

The Determining Officer appealed Justice Davies' decision to the full Federal Court. On 15 May 1998, the Full Court by majority (Burchett and Hill JJ with Beaumont J dissenting) substantially dismissed the appeal.

Table of Action on activities by the Department

The following table shows the actions on cases by the Department in 1997–98.

Requests to the Minister for a review by a Professional Services Review Tribunal	14
Reviews conducted by Professional Services Review Tribunals	10
Decisions handed down by Professional Services Review Tribunals	5
Appeals made to the Federal Court on reviews by Professional Services Review Tribunal determinations	1

CASE SUMMARIES

The then Minister, at the time of the passage of the legislation, formally advised the Senate Standing Committee on Community Affairs that the Director of Professional Services Review would, in his Annual Report, provide, in a narrative style, appropriate examples of cases having resulted in findings of ‘inappropriate practice’.

The following brief summaries are provided in accordance with that undertaking. The cases selected are examples of various problems considered over the past year and illustrate the range of issues involved in the referrals received. For ease of reading, many of the figures have been rounded and for reasons of brevity, not all issues raised and discussed in the hearings are detailed.

For comparison purposes regarding the case summaries, Graph 1 shows the distribution curve for the number of medical services provided by general practitioners for 1996–97. The shape of the graph in relation to the number of services has altered little over the years.



GRAPH

CRC

Case A

An Australian graduate, this general practitioner worked in a small rural town located in an area being overtaken by metropolitan sprawl. There was rapid residential development and an increasing population. The HIC concerns were with the very high number of services claimed in the year—24 132 (99th percentile <17 000) rendered to 5 700 patients.

At the hearing it was apparent the practitioner was overwhelmed by the rapid expansion of the practice and had not given adequate attention to individual patients. This was exemplified by poor clinical records and a high prescribing rate of benzodiazepines and codeine.

Although the PSRC made a finding of ‘inappropriate practice’ it was sympathetic to the practitioner’s situation and its report reflected this. The Determining Officer also accepted the difficulties faced by this practitioner and the determination was that the practitioner be counselled. Counselling was undertaken and the practitioner advised that he had reviewed his practice procedures and was seeking more permanent assistance.

Case B

This overseas graduate was practising in a developing outer metropolitan area and was referred by the HIC because of the high volume of services (19 966) rendered in the year of referral. The doctor’s initial experience of Australian general practice was obtained by working in a ‘24-hour practice’ where rapid throughput of patients occurred. The doctor adopted this style of practice and replicated it in a conventional family-oriented practice.

The PSRC found that the care provided was episodic, that only the presenting symptom was addressed and this was evident in a poor quality medical record. There was evidence of opportunistic family consultations (all family members seen and charged despite the absence of evidence in the record of a valid reason) and the doctor avoided and discouraged home visits even where these were indicated. The Committee considered that the doctor demonstrated some deficiencies in clinical acumen and saw himself

as superior to his patients and even his peers. It made a finding of 'inappropriate practice'.

Case C

Graduating from an Australian university, this doctor, after hospital experience, commenced general practice in an extended-hours medical centre without any formal general practice training. The HIC was concerned at the high number of services provided (18 400 to 6 000 patients) in one year.

The PSRC made a finding of 'inappropriate practice' based on the following concerns. The clinical input by the doctor was inadequate to address the patients' problems, especially in relation to ongoing and serious ailments such as diabetes, asthma and cardiovascular disease, and the doctor provided episodic rather than holistic care. They were concerned that his knowledge base was inadequate and he was not involved in continuing medical education. Problems were identified with prescribing patterns and excessive and inappropriate prescription of benzodiazapines and narcotics. Despite employment in a group situation there was no professional interaction with the other practitioners.

Case D

This Australian graduate, following 18 months as an associate in general practice, commenced practice in an inner metropolitan lower socio-economic area. The HIC was concerned about a high average number of services per patient. The statistics showed there were 11 540 services to 1 500 patients in one year. The average number of services per patient was 7.97 which was above the 99th percentile for general practitioners.

The PSRC found inappropriate practice in this case because of a large number of Level C and Level D consultations (in both the surgery and the home) in the absence of any evidence of clinical necessity. High numbers of electrocardiographs were performed and again there was little evidence of the need for this service. Services appeared to be provided on a patient demand basis rather than because of clinical need.

Again in this case the medical record was grossly inadequate and did not explain the reason for the consultation. The record was such that another practitioner could not easily take over the care of the patient.

Case E

After graduation from an Australian university and following minimal hospital experience this doctor commenced general practice in a metropolitan area with a high proportion of disadvantaged ethnic patients. The area was well provided with medical practitioners of the same background as the patient population. The practitioner continued with extensive university and post-graduate study as well as general practice.

The concern of the HIC was with the high number of services (22 200 to 6 000 patients in a year). On 140 days more than 80 patients per day were seen and more than 100 patients per day on 28 occasions.

The PSRC made a finding of 'inappropriate practice' based on concerns about the clinical management of patients. Despite involvement in continuing university education, the Committee observed that this doctor was professionally isolated. Another significant concern was antiquated and inadequate sterilization equipment.

Case F

Graduating from an Australian university this doctor, after practising overseas for many years, returned to Australia and commenced practice in an outer metropolitan area with a growing retirement population.

The concern of the HIC was the high volume of services provided in the year of referral (32 600 to 9 200 patients which attracted Medicare benefit payments of nearly \$687 000). For five months of the referral year the doctor practised at a 24-hour medical centre and for the remainder of the year was in solo practice. There was no significant difference in the servicing levels between these two practice locations.

The doctor provided 31 000 Level B consultations. On one day 187 Level B consultations were claimed along with two Level A consultations, three

procedures (including a wedge resection of the toenail) and three pregnancy tests. The RACGP standards recommend a minimum time of consultation of 10 minutes other than in exceptional circumstance.

The PSRC made a finding of 'inappropriate practice' as they could not accept that the doctor was able to adequately assess and treat patients in the times available. The records were sub-standard and there were concerns regarding incorrect itemisation, opportunistic servicing and poor clinical acumen. The doctor was professionally isolated and did not undertake any significant continuing medical education.

CORPORATE OVERVIEW

Objective

To provide effective and efficient human resource management, financial management and corporate planning services which will better enable the PSR to achieve its objective.

Strategies

- Provide the information necessary to enable management to make effective, efficient and timely decisions on finance, staffing and resource issues.
- Secure and maintain adequate financial resources and manage those resources efficiently through the provision of high quality financial and resource management advice.
- Provide and manage accommodation, facilities, stores and office services to enable efficient and cost effective usage.
- Obtain, develop, involve and retain quality staff.
- Ensure full compliance with all statutory and administrative requirements.

Performance indicators

- Corporate costs as a portion of total costs.
- Monthly cashflow projections provided to management within seven days of the end of the month.
- Number of functions that have been through the Competitive Tendering and Contracting (CTC) processes.
- Percentage of funds spent on training.

- Degree to which externally-imposed deadlines and compliance requirements are met.

Performance assessment

This financial year saw a slight increase in the percentage of corporate costs over total cost from 70.65 per cent as compared to 70.47 per cent in 1996–97. This shows PSR financial procedures and practices are effective particularly after taking into account a \$100 000 increase in legal expenses.

Monthly cashflow projections were produced for management within seven days of the end of the month for 11 out of the 12 months.

All PSR corporate and IT functions have been outsourced. In 1997–98 preparatory work was done for PSR’s travel and IT services to again go through the CTC process in 1998–99.

PSR has shown strong commitment to training its staff and Deputy Directors in 1997–98: total expenditure on staff training has increased to 2.33 per cent from 1.92 per cent in 1996–97. This does not include the training provided to PSR staff through the Memorandum of Understanding with DH&FS, which also saw PSR staff attending an increased number of courses.

All externally-imposed deadlines and compliance requirements were met 100 per cent of the time.

Financial and staffing summary

	Actual 1995–96	Actual 1996–97	Budget 1997–98	Actual 1997–98
	(\$'000)	(\$'000)	(\$'000)	(\$'000)
Appropriation	750	1 129	1 855	1 688
Staffing	5.4	7	10	9.5*

* Includes 2.5 contractors

Finance

PSR's 1997–98 budget estimate was \$1.855 million. As a result of the Federal Court judgement in *Yung* (see pages 2–6 of this report) PSRCs have agreed to give each practitioner under review the opportunity to make a submission on the report before it is forwarded to the Determining Officer.

This has necessitated PSRCs going into far more detail in their reports which has, in turn, resulted in each case taking considerably more time to complete than before the *Yung* judgement and has, therefore, increased costs per case.

PSR, therefore funded only 49 cases this year, (against its projected 60 cases). Despite PSR rolling over \$60 000, from its budget allocation, into 1998–99 to allow for asset replacement and provision for long service leave, PSR still underspent its allocation by in excess of \$100 000.

The Australian National Audit Office audit report on the PSR's 1997–98 financial statements was unqualified and was signed on 21 September 1998.

Forward estimates funding

PSR's 1998–99 estimate of \$2.283 million is based on a resource agreement negotiated with the Department of Finance and Administration (DOFA) for an agreed minimum funding and staffing level. Agreement was also reached on a workload formula which is driven by the number of referrals processed by the PSR.

This year's estimate was negotiated before the Federal Court's decision in May 1998. Consequently, PSR and DOFA will need to re-negotiate a new agreement, following the outcome of a review of the PSR process and likely legislative changes. There will be an adjustment to the estimates in the 1998–99 Additional Estimates, but the final outcome of the review, which is due to report to the Minister in October 1998, may not be reflected.

Administration

A Memorandum of Understanding (MoU) and a Service Level Agreement, developed in 1994–95 with the then Department of Human Services and

Health, remained in force during this reporting period. The Department of Health and Family Services, as it is now, provides services such as payment of accounts, personnel, preparation of Financial Statements, internal audit, library, registry and coverage for programs including equal employment opportunities (EEO), occupational health and safety (OH&S) and industrial democracy (ID) for which the PSR pays an agreed annual fee.

Links with other agencies have continued during this reporting period. Staff have attended forums such as COMNET to discuss and exchange information on current human resource management issues. Moreover, the PSR receives all the information from central agencies that is made available to the larger government agencies.

Personnel

At 30 June 1998 the PSR had a staffing level of 10 (including three contractors and the statutory officer position of Director of Professional Services Review). This represents an increase of three over the staffing level for 1996–97 and is the direct result of an increasing caseload for the agency. All new positions were created on a contract basis to meet with the increased caseload. The staff comprised six males and four females. The position profile by gender at 30 June 1998 was:

Position	Local designation	Gender
<i>Statutory Office Holder</i>		
Director	Director	male
<i>Staff</i>		
Senior Officer B	Executive Officer	male
Senior Officer C	Resource Manager	male
Admin Services Officer 6	Secretariat Manager	female
Admin Services Officer 6	Secretariat Manager	male
Admin Services Officer 5	Administrative Assistant	female
Admin Services Officer 4	Secretariat Support	male
Contractor	Secretariat Manager	female
Contractor	Secretariat Manager	male
Contractor	Administrative Assistant	female

The Director of Professional Services Review is employed under the *Health Insurance Act 1973*. All other staff (except the contractors) were employed under the *Public Service Act 1922*. All staff (except the contractors) were full-time and permanent.

None of the staff come from non-English-speaking backgrounds, are of Aboriginal or Torres Strait Islander origin or have a disability.

Staff development and training

During the year a number of PSR staff attended training and development courses. These included courses in computer software applications and legal issues. DH&FS also provided training on financial issues, resource management and computer applications.

On-going training is scheduled for 1998–99 based on the organisation's identified needs. All staff had the opportunity to participate in IT training which was specified in the agreement with Logical Solutions, the service provider.

Workplace reform

Given its small size the PSR chose to participate in the workplace reform discussions (Certified Agreements and Australian Workplace Agreements) being conducted at DH&FS. PSR, in conjunction with staff and the CPSU, is in the process of developing an agreement, based on the Department's.

Occupational health and safety

PSR recognises that it has a legal responsibility to safeguard the health of its employees while they work. The agency provides and maintains occupational health and safety (OH&S) standards in relation to its offices and its equipment. For ongoing elements, because of its limited resources, the PSR has endorsed the Department's OH&S plan and follows the procedures outlined therein. Where required, policy advice relating to OH&S will be provided by the specialist area in DH&FS as an element of the MoU that exists between our agencies.

There were no OH&S incidents in 1997–98 nor were any notices issued or received under any of the relevant sections of the OH&S Act. The Department’s OH&S staff performed a workstation assessment for one PSR staff member during the year. The resulting report indicated minor furniture and computer adjustments and a new ergonomic chair. The chair was purchased and recommended adjustments made.

Equal employment opportunity

PSR is committed to the principles of equal employment opportunity (EEO), which require that all staff be treated fairly and without direct, indirect or systematic discrimination. EEO requires all staff to have equal access to employment, career and development opportunities and encourages appropriate representation of the target groups specified in EEO policies.

Because of its small size, PSR has no EEO plan of its own, instead it has encompassed DH&FS’s EEO program.

Industrial democracy

Regular meetings are held with all staff to discuss ongoing business and management issues, such as the outcome and implications of recent court cases, the future directions of the agency, proposed legislative changes and updates of cases from Committee secretaries.

Information technology

The Technology Partnership Agreement (TPA) with Logical Solutions, whereby software, hardware, maintenance support and on-going training are provided for a single cost, remained in place in 1997–98. The agreement has a further six months to run. In addition to the TPA, the PSR has purchased hardware and software outright to accommodate the additional staff it has recruited. This was done after a careful cost benefit analysis of the purchase versus leasing options. A decision on the PSR’s future IT environment will be made within the coming months, with the options being:

- linking with the DH&FS service provider, or
- undertaking a competitive tendering process for provision of PSR's IT hardware and support.

Ministerial or Senate inquiries

All target dates for budget estimates, responses to estimate committee questions, Ministerial briefings, Ministerials, Department of Finance returns and financial statements were met.

Stationery and publications

The only new publications produced in 1997–98 were the Annual Report and an update of PSR's information pamphlet outlining the process.

APPENDIX 1:
FINANCIAL STATEMENTS

AUDIT OFFICE LETTER

CRC

INDEPENDENT AUDIT REPORT

CRC

INDEPENDENT AUDIT REPORT
(2ND PAGE)

CRC

STATEMENT BY THE
DIRECTOR AND
RESOURCES MANAGER

CRC

AGENCY REVENUES
AND EXPENSES

CRC

AGENCY ASSETS AND LIABILITIES

CRC

AGENCY
CASH FLOW

CRC

SCHEDULE OF
COMMITMENTS

CRC

SCHEDULE OF
CONTINGENCIES

CRC

NOTES TO
AND FORMING

CRC

NOTES TO
AND FORMING
(Con't)

CRC

NOTES TO
AND FORMING
(Con't)

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NOTES TO
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NOTES TO
AND FORMING
(Con't)

CRC

APPENDIX 2:
SUMMARY TABLE OF RESOURCES

SUMMARY TABLE OF
RESOURCES

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APPENDIX 3:
FINANCIAL AND STAFFING
RESOURCES SUMMARY

FINANCIAL AND
STAFFING RESOURCES
SUMMARY

CRC

APPENDIX 4: FREEDOM OF INFORMATION STATEMENT

During the year ended 30 June 1997, the Professional Services Review received no requests for access to documents under the provisions of the *Freedom of Information Act 1982*.

Contact Officer

All freedom of information requests should be directed to:

The Executive Officer
Professional Services Review
PO Box 136
YARRALUMLA ACT 2600
Telephone: 02 6285 1651

Documents

The types of documents the PSR holds are listed below.

- referrals and related documents from the HIC pursuant to section 86 of the *Health Insurance Act 1973* regarding the conduct of a person the Commission considers may have engaged in inappropriate practice in connection with rendering or initiating services;
- lists of Panel members to sit on Professional Services Review Committees;
- reports of Professional Services Review Committees;
- administrative files;
- Memorandum of Understanding and other agreements;
- finance and accounting records;
- legal advice;

- computer records;
- consultancy reports and databases;
- contracts;
- minutes of various meetings; and
- general correspondence.

In respect of section 9 of the *Freedom of Information Act 1982*, this agency has the following document that is provided for the use of, or is used by, the agency or its officers in making decisions or recommendations, under or for the purposes of an enactment or scheme administered by the agency:

- Procedure Guide for Professional Services Review Committees.

APPENDIX 5: LEGISLATIVE OVERVIEW

The Professional Services Review Scheme was established by the *Health Legislation (Professional Services Review) Amendment Act 1993* which amended the *Health Insurance Act 1973*, and came into effect from 1 July 1994.

Dr A. J. (John) Holmes was appointed Director of Professional Services Review by the then Minister for Human Services and Health (now Health and Family Services) on 21 July 1994 for a three year period. Dr Holmes was subsequently re-appointed for a further three years.

Since establishment of the PSR Scheme, 169 practitioners nominated by the relevant professions have been appointed as members of the Professional Services Review Panel. Three members resigned and two died during the year. The appointments for the remaining members expire on 24 January 2000. Sixteen of the Panel Members have been appointed as Deputy Directors of Professional Services Review. The Deputy Directors serve as Chairpersons of the PSRCs.

Background

The legislation was developed in 1994–95 with the aim of providing an effective peer review mechanism to deal quickly and fairly with concerns about inappropriate practice. Legislative amendments to the PSR Scheme came into effect on 6 November 1997.

The essential features of the review structure are:

- a Director of Professional Services Review (PSR), who is a medical practitioner, appointed ministerially and able to engage staff and consultants;
- a Professional Services Review Panel (PSRP), comprising medical practitioners, who are appointed ministerially;
- Professional Services Review Committees (PSRCs), comprising

practitioners from the PSRP appointed by the Director of PSR on a case-by-case basis to investigate practitioners referred by the Director for review; and

- a Determining Officer, who must be a public office holder, appointed ministerially, and whose role it is to decide on the sanctions for practitioners found by a PSRC to have practiced inappropriately.

The whole review process is based on the principle of peer review and will be instigated only in instances where prior counselling of practitioners by the HIC has been considered to have been in vain.

Inappropriate practice

A practitioner engages in inappropriate practice if the practitioner's conduct, in connection with rendering or initiating services, is such that a Committee of his or her peers could reasonably conclude that:

- in the case of a medical practitioner—the conduct would be unacceptable to the general body of the members of the specialty (general medical practice is taken to be a specialty) in which the practitioner was practicing when he or she rendered or initiated the services; or
- in the case of a dental practitioner, optometrist, chiropractor, physiotherapist or podiatrist—the conduct would be unacceptable to the general body of the members of the profession in which the practitioner was practising when he or she rendered or initiated the services.

A person (including a practitioner) or a person who is an officer of a body corporate engages in inappropriate practice if the person knowingly, recklessly or negligently causes or permits, a practitioner employed by the person or body corporate to engage in conduct that constitutes inappropriate practice by the practitioner.

Benefits of the Professional Services Review Scheme

The Scheme gives the profession substantial autonomy in reaching findings on inappropriate practice. At the same time, proper care has been taken to ensure the practitioner under review receives natural justice. At every major point in the review process the practitioner is given the opportunity to make submissions that could influence the review process and outcome. The scheme provides for separation of the three elements of the decision-making processes which are:

- the referral for review;
- the review hearings and findings; and
- the determination of any penalty.

The HIC prepares and refers a case for review to the Director of the Professional Services Review who decides whether to empanel a PSRC. The Review Committee reports on its findings and, if the findings are adverse to the practitioner under review, a Determining Officer, who must be a person holding an office or appointment under the Public Service Act, must determine one or more of the following courses of action:

- reprimand;
- counselling;
- repayment of benefits to the Commonwealth; and/or
- complete or partial disqualification from the Medicare scheme.

The Determining Officer is required to provide the practitioner under review with a draft Determination on which the practitioner will have the opportunity to make submissions before it becomes final.

A practitioner who is subject to an adverse finding may request a review by the PSRT. An appeal may also be made to the Federal Court on a question of law only.

APPENDIX 6: PROCESS

The following material combines legislative requirements and administrative procedures and summarises them to give an overview of what happens after the HIC decides it has concerns of inappropriate practice which should be referred to the Director of Professional Services Review. Information on HIC procedures leading to the referral of a case to the Director should be sought from the Commission.

Referral

When the HIC refers a case for review to the Director, PSR, it must, *within 48 hours*, send a copy of the referral to the person under review and invite that person to make a written submission to the Director *within 14 days*, stating why the Director should dismiss the referral.

Director's decision

The Director must, *within 28 days* of receiving the referral, decide whether to establish a PSRC to consider whether the practitioner has engaged in inappropriate practice, as defined in section 82 of the Act. In reaching this decision, the Director may take advice from appropriate consultants. If the practitioner has taken the opportunity to make a submission to the Director, it is taken into consideration at this stage.

The Director may dismiss the referral, without establishing a PSRC, only if satisfied there are insufficient grounds for a PSRC to find the practitioner had engaged in inappropriate practice or if the practitioner has entered into a written arrangement with the Director agreeing to a partial disqualification from Medicare.

The Director's decision on the referral is not rendered invalid merely because it is not made within the 28 day period.

Establishing a PSRC

The Director will select a Deputy Director to chair a Committee and at least two other members from the Professional Services Review Panel who must be members of the profession or medical specialty in which the practitioner was practising when he or she performed or initiated the services which are believed to have been inappropriate. Where the Director considers it desirable to give the Committee a wider range of clinical expertise, up to two further Panel members from a relevant profession or specialty may be appointed to the Committee.

The Director must notify the person under review and the HIC of the decision, in writing, *within 7 days* of the decision. If the decision is to proceed with the establishment of a PSRC, the notification is to include the proposed membership of the Committee. If the decision is to dismiss the referral, the Director must give the reasons for that decision.

The person under review may challenge the appointment of a Committee member on the grounds of actual or perceived bias.

Committee process

The Committee must meet *within 14 days* after appointment to consider the case. Meetings are held in private.

If the Committee believes the person under review may have engaged in inappropriate practice, it must hold a hearing. The person under review must be given particulars of the matters giving rise to the hearing and *at least 14 days'* notice of the date and place of the hearing. The person is required to appear at the hearing to give evidence and/or to produce documents and to attend to identify those documents specified in the notice.

Hearings

The person under review is entitled to be accompanied by a lawyer or other adviser to question any person giving evidence to the Committee and to address the Committee. The Committee may allow an adviser *other than a*

lawyer to ask questions or to address the Committee on the person's behalf.

While a PSRC has legal powers such as the power to summon witnesses and to require persons to answer questions, it is intended that hearings be conducted without undue formality. Evidence may be taken on oath or affirmation.

If a practitioner fails to attend a hearing or refuses to answer questions or to produce documents, the Committee may fix another day *at least 28 days later* for the hearing and give the person notice of that hearing. If the person again fails to appear or fails to answer, the Director must disqualify the practitioner from access to Medicare benefits and so advise the HIC. If the practitioner subsequently complies with the Committee's requirements, the disqualification is lifted.

A PSRC may inform itself on matters before it as it sees fit. With the approval of the Director, it may engage people with suitable qualifications and experience as consultants for this purpose.

The legislation provides for penalties:

- in the event of a person under review or a witness knowingly giving an answer or producing a document which is false or misleading to the Committee; and
- for the failure or refusal of a witness to attend a hearing, to be sworn or to make an affirmation, to answer a question or to produce a document as required by the Committee.

Reporting

The Committee must give to the Determining Officer a written report setting out its findings on whether the person under review's conduct in relation to the referred services was, in the Committee's opinion, unacceptable to the general body of the members of the profession or specialty involved. Employers can also be found to have acted inappropriately.

The report should refer to the evidence or other material on which those findings were based. It should provide the Determining Officer with sufficient information to assist that officer in drafting a Determination. If the PSRC members are not unanimous in their findings, an additional minority report may be given to the Determining Officer.

A PSRC must report its findings to the Determining Officer *within 120 days* of its being set up. However, the Chairperson of the PSRC may, before the deadline for reporting, apply in writing to the Director for an extension of time. If the Director is satisfied with the reasons given for requiring the extension, he may grant an extension of up to 30 days. The Chairperson is not prevented from seeking further extensions of up to 30 days.

Suspension of proceedings

The PSR Scheme has been established to examine professional practices in relation to Medicare and aspects of the Pharmaceutical Benefits Scheme only. If a PSRC, in the course of its examination of a referral, comes to the view that the person under review may have committed fraud, the Committee must report on its concerns to the HIC and suspend its consideration of the referral. The Commission may subsequently return the referral, possibly modified, to the PSRC, in which case the Committee would recommence its consideration of the referral.

If a PSRC thinks that material before it indicates that action should be taken against the person under review ‘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.

The Determining Officer

The Determining Officer is a person holding an office or appointment under the *Public Service Act 1922* and who is appointed by the Minister for the purpose. The present appointee is the First Assistant Secretary, Health Benefits Division of the DH&FS.

The Determining Officer must, within 7 days of receiving the report of a PSRC, give a copy to the person under review. Within 14 days of receiving the report, the Determining Officer must give the person under review and the Director copies of a draft determination in relation to the report.

If the report of the PSRC is adverse to the person under review, the draft determination will include one or more of the following courses of action:

- a reprimand;
- counselling;
- repayment of benefits to the Commonwealth; and/or
- complete or partial disqualification from the Medicare scheme.

The person under review is given *14 days* in which to make written suggestions for changes to the draft determination.

At the end of the 14 days and *within 35 days* of receiving the report of the PSRC, the Determining Officer must give the person under review a final determination in relation to the report from the PSRC. In the absence of any appeal against the determination, it takes effect *28 days* after it is delivered to the person under review.

Further appeal

A practitioner who is the subject of a Determination may request a review by a Professional Services Review Tribunal. On a question of law, appeal is to the Federal Court.

Essential features

The legislation provides a review mechanism which is characterised by:

- **impartiality:** the Director and his staff are independent of the HIC, which develops cases for review, and the Panel members who conduct reviews are from the specialty/profession of the person under review;
- there is provision for appeal or review of every significant decision in the process;

- **privacy:** the deliberations, findings, information and evidence given to a PSRC remain confidential and may only be disclosed in circumstances prescribed by the Act, for example, in the case of an appeal to a Tribunal or to the Federal Court;
- **competence:** cases are examined by experienced members of the relevant professions; and
- **timeliness:** the legislation imposes timelines which ensure cases will not drag on or be unnecessarily delayed by any party.

APPENDIX 7: GLOSSARY

Act	the <i>Health Insurance Act 1973</i> , as amended by the <i>Health Legislation (Professional Services Review) Amendment Act 1994</i> .
Commission	the Health Insurance Commission (also HIC).
Committee	a Professional Services Review Committee established by the Director in accordance with section 93 of the Act to examine a case of apparent inappropriate practice referred by the HIC.
Determining Officer	an officer appointed by the Minister to determine an appropriate penalty to apply where a PSRC finds that a person under review has engaged in inappropriate practice, as defined in the Act.
Director	the Director of Professional Services Review is an independent statutory officer appointed by the Minister. The occupant must be a medical practitioner and the AMA must agree to the appointment.
Disqualification	(partial or complete) exclusion from eligibility to receive Medicare benefits.
Inappropriate practice	defined fully in section 82 of the Act, but could briefly be described as professional conduct in relation to Medicare which a committee of peers would reasonably consider would be unacceptable to the general body of the members of the specialty or profession.
Minister	the Minister for Health and Family Services.

Panel	the PSR Panel consists of medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists nominated by the relevant professional organisations and who have been appointed by the Minister.
Referral	a case prepared by the Commission and referred to the Director, detailing the Commission's concerns and the reasons it considers that a practitioner or other person has engaged in inappropriate practice in the terms of section 82 of the Act.

APPENDIX 8: ABBREVIATIONS

ASL	Average Staffing Level
AMA	Australian Medical Association
ANAO	Australian National Audit Office
CPSU	Commonwealth Public Sector Union
CTC	Competitive Tendering and Contracting
COMNET	Corporate Management Network
DH&FS	Department of Health and Family Services (Commonwealth)
DOFA	Department of Finance and Administration (Commonwealth)
DPSR	Director of Professional Services Review
EEO	equal employment opportunity
HIC	Health Insurance Commission
MoU	Memorandum of Understanding
MPRC	Medicare Participation Review Committee
MSCI	Medical Services Committee(s) of Inquiry. Sometimes used broadly to include certain other committees with similar functions, such as the Optometrical Services Committee of Inquiry
OH&S	occupational health and safety
POE	Property Operating Expenses
PSR	Professional Services Review
PSRC	Professional Services Review Committee
PSRT	Professional Services Review Tribunal
RACGP	Royal Australian College of General Practitioners
TPA	Technology Partnership Agreement

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