Annual Report 1998–99

PROFESSIONAL SERVICES REVIEW
Annual Report 1998–99

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PROFESSIONAL
SERVICES REVIEW

DIRECTOR
Dr John Holmes

The Hon Dr Michael Wooldridge, MP
Minister for Health and Aged Care
Parliament House
CANBERRA ACT 2600

Dear Minister

In accordance with section 106 ZQ of the *Health Insurance Act 1973*, I present the fifth annual report on the Professional Services Review Scheme. Subsection 25(8) of the *Public Service Act 1922* requires that you cause a copy of this report to be laid before each House of the Parliament on or before 31 October in the year in which the report is given.

Yours sincerely

Dr John Holmes
8 October 1999

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Introduction

The Director of Professional Services Review (DPSR) is a statutory officer appointed by the Minister for Health and Aged Care to manage the process whereby the conduct of a person, who is involved in rendering or initiating services which attract a Medicare rebate or has prescribed inappropriately under the Pharmaceutical Benefits Scheme, can be examined to ascertain whether inappropriate practice is involved.

Inappropriate practice is defined in section 82 of the *Health Insurance Act 1973* essentially as conduct that is unacceptable to the general body of the members of the peer group 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 (HIC) 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* (the Act).

Objective

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

Director's Report

The most significant development during the year was the complete review of the Professional Services Review (PSR) Scheme. The Minister for Health and Aged Care accepted the Review Committee's recommendations and the amending legislation required to implement those recommendations was passed by Parliament on 29 June 1999 with the full support of all parties. As a result, the year ended on a much more positive note, particularly with the knowledge the major medical organisations continued to give the Scheme their full support.

Review of the Professional Services Review Scheme

The Review was necessary as a result of the adverse decision the Full Federal Court handed down in May 1998 in the case of *Adams v Yung & Ors* [1998] 83 FCR 248 (the Yung case) which highlighted deficiencies in the PSR Scheme. On 31 July 1998, the Minister for Health and Aged Care agreed to a comprehensive review of the PSR Scheme to consider the effects of the Court judgment and to make recommendations on any legislative amendments and administrative changes that may be required.

The Review Committee comprised representation from the Australian Medical Association (AMA) (chair), the Department of Health and Aged Care, the HIC and the DPSR. The Committee formulated its recommendations in *The Report of the Review Committee of the Professional Services Review Scheme* which was forwarded to the Minister in March 1999. The Report contains 45 recommendations which are listed at Appendix 1.

The amended Act came into law on 1 August 1999. Subsequently, a plain English brochure was prepared which outlines the basic structure of the revised Scheme. The brochure aims to provide an easy to understand outline of the PSR process. The contents of the brochure are at Appendix 2.

The Report of the Review Committee is comprehensive. I will not, therefore, discuss all the matters raised, but will outline a few of the issues which I believe to be particularly relevant, address the concerns raised by the Federal Court and the shortcomings of the PSR Scheme as it was before the changes.

Referral: The Full Federal Court in the Yung case, determined that the Professional Services Review Committee (PSRC) could only consider concerns specifically identified by the HIC. With the HIC having essentially only statistical data upon which to base its concerns and referral, this finding significantly hampered the PSRC when, as occurred frequently in practice, other areas of professional concern were identified.

This has been addressed by increasing the Director's powers to enable him to summon documents (including the practitioner's records) and to conduct an investigation before deciding whether or not to set up a PSRC. Following this investigative phase the Director can formulate a more focused (adjudicative) referral to a PSRC, clarifying the concerns to be addressed.

Compliance: The amendments to the Act have given the Director greater powers to ensure compliance with the production of summonsed documentation, such as medical records. This was necessary in the light of difficulties experienced in the past with some practitioners.

Dismissal of referral: The dismissal powers in the Act have been altered to allow the Director to also negotiate a repayment of Medicare benefits, in addition to the existing power to partly disqualify, under section 92 of the Act. Any agreement between a practitioner and the Director under section 92 requires the approval of the Determining Authority.

Statistical sampling: The Federal Court ruled that a valid sampling methodology was essential before there could be any extrapolation for the purpose of calculating a repayment of Medicare benefit. Accordingly, expert statistical advice was obtained in the drafting of a sampling methodology which is to be included in a Ministerial Determination made under the Act. It is considered that this statistical methodology will withstand legal challenge.

Deeming: With the agreement of the medical profession, it is proposed that standards regarding the number of services that can be rendered in a given time be identified. Such standards will be outlined in Regulations to the Act. When the regulations are in force the onus of proof will change and the specified conduct will be deemed to be 'inappropriate'.

Initially it has been agreed that, for general practitioners and those practitioners using the non-referred attendance items in the Medicare Benefits Schedule (MBS), 80 or more consultations per day for 20 or more days will be deemed to be 'inappropriate practice'. The only defence available will be that of exceptional circumstances as accepted by a PSRC. The Department of Health and Aged Care has undertaken to negotiate similar standards with other groups within the medical profession and the other professions covered by the PSR Scheme. It must be noted that the deeming provision in no way acknowledges that provision of services below any established levels is automatically acceptable. Such cases will be addressed by other means, such as sampling.

No records: The new provisions enable a PSRC to make a finding about the 'appropriateness of the practice' even when the medical record is unavailable, destroyed or illegible. Under this provision, identification of a quantum of money

for repayment will not be possible. The available range of sanctions will include periods of disqualification from the Medicare program.

Natural justice: The Review Committee endeavoured to ensure the referred practitioner received 'procedural fairness' or 'natural justice' at every stage of the process. There are provisions in the amended Act which entitle the practitioner to make relevant submissions during the referral process, on a draft report of the PSRC and on a draft determination of the Determining Authority.

Legal involvement: The Court's concern, in the Yung case, that the practitioner had been denied procedural fairness has also been addressed by giving an increased level of legal representation to the practitioner under review. Although an accompanying lawyer may not represent the practitioner, he or she is entitled to raise legal points during the hearing and to make a final address to the PSRC on legal issues and the merits of the case. Given these changes, increased legal support is also being provided to PSRCs.

Professional performance: The amended Act gives the Director and the Determining Authority the power previously available only to the PSRC to refer the practitioner to the relevant licensing or regulatory body when significant concerns arise during any part of the process where it is suspected that poor professional performance could pose a significant threat to the life or health of any person.

Determining Authority: Determination of sanctions following an adverse finding by a PSRC was previously the responsibility of a Determining Officer. The then Act required the Determining Officer to be a public servant and the position, in the year of review, was held by a First Assistant Secretary in the Department of Health and Aged Care.

In the revised Scheme, this function will be the responsibility of a Determining Authority which will consist of a three person panel. The permanent chair will be a medical practitioner and the two other members will be a permanent lay person and a representative of the profession of the practitioner for whom a determination is being made. A criticism of the previous process was the lack of consumer involvement.

The range of available sanctions remains unchanged. However, during the review, the medical profession strongly argued that the periods of disqualification should be increased and that those periods should be significant. Its view was that long periods of disqualification were the best deterrent to inappropriate behaviour by professionals.

Administrative, secretariat and legal support for the Determining Authority will be the responsibility of the Director. It is intended to establish a discrete secretariat for this purpose.

Review rights: Appeals may be lodged to the Federal Court on points of law at all stages of the process. Previously a Professional Services Review Tribunal (PSRT) heard appeals on the final determination. In practice the PSRT acted in a 'merits review' capacity. As the members of a PSRT are not necessarily peers of the person under review, unlike a PSRC, it was considered that the PSRT was no longer necessary in light of the increased legal support available to the practitioner and increased opportunities for the practitioner to make submissions. The PSRT will continue to be involved in appeals on those cases referred to the Director before 1 August 1999.

Expansion of Agency: With the increased responsibilities given to the Director by the amendments to the Act, there will be an inevitable increase in Professional Services Review personnel and operational requirements. This expansion has been foreseen and suitable supplementary budgetary provision has been made. Recruitment of suitable personnel has commenced.

Responsibility for litigation: An obvious design fault in the previous process was the confusion in the responsibility for legal representation when court challenges were made. When such challenges were related to the PSR process, the Director was responsible for managing the litigation.

However, most appeals were lodged following a determination and the Determining Officer was the respondent to the appeal. In practice, the appeal points were not only against the quantum of the sanctions imposed but also against matters contained in the PSRC report. As neither the Director nor the PSRCs were a party to such appeals, they had no standing in these cases. In my view this was far from an ideal method of running litigation proceedings as the briefing solicitors were not fully informed of the facts and issues involved in a case, especially the clinical issues.

The amendments ensure the Director assumes responsibility for managing any litigation arising under the revised scheme. The Act also ensures no legal adviser can be involved in more than one part of the process. For example, a legal adviser who provides advice to a PSRC cannot also provide advice to the Determining Authority on that same referral.

Medical records: The Review Committee considered a suggestion made by the Deputy-Directors (chairs of PSRCs) during the consultative phase of the review and recommended that maintenance of an adequate and contemporaneous medical record be a requirement when determining whether a practitioner has engaged in inappropriate practice under the PSR Scheme. With the obvious difficulties inherent in making such a requirement mandatory, the regulations to be drafted will give a PSRC responsibility for making the decision on adequacy of the medical record.

Training of Panel Members: The Review Committee recommended that Panel Members serving on PSRCs receive training in the legal responsibilities involved,

in questioning techniques, in writing reports and in giving reasons for their decisions. Planning has commenced to put this recommendation into effect.

Publicity: The amended legislation will allow the Director to publish the details of cases when final determinations become effective. Previously this was only permitted where the practitioner had appealed to a PSRT. The change will give a greater transparency to the process. It is well known that the worst sanction for professionals is damage to reputation, especially among peers.

It is considered that the changes to the legislation summarised above will significantly improve the process and at the same time give a very substantial degree of protection to the referred practitioner. This belief will only be shown to be correct with the passing of time and the experience of challenge in the Courts. The timeframe for testing this belief is shown by the time involved in the Yung case. Three years elapsed from the initial referral to the time of the judgment in the Full Federal Court. Currently the Tankey case has taken nearly four years and the date for the hearing of the appeal to the Full Federal Court has yet to be set.

PSR caseload

The PSR's caseload during 1998–99 is shown in Table 1 along with the statistics for previous years. The dramatic downturn in the number of referrals received from the HIC reflects the difficulties experienced as a result of the judgment in the Yung case and the need to review all procedures, from preparation of the referral made by the HIC through to the manner in which a PSRC notified the person under review of its concerns, conducted its hearings and drafted its report to the Determining Officer. An internal review of the administrative processes was conducted pending the outcome of the review established by the Minister.

Given the concerns about the process, expressed in the Yung case, reviews were undertaken of those cases which had completed the formal hearings but in which the relevant PSRC had not submitted a report to the Determining Officer. It was obvious that major rewriting of the reports was necessary to identify the individual cases considered by the PSRCs which would lead to their findings of inappropriate practice.

This proved to be a very time consuming exercise requiring a critical analysis of the hearing transcript and often a major revision of the PSRC report. As the PSRC members are involved in active practice this was a slow and resource intensive undertaking. It was therefore very difficult to establish any new PSRCs given the resources, both practitioner and secretariat, available. I acknowledge the commitment of those Deputy-Directors, Panel members and PSR staff involved in this exercise. It was a difficult task. Nonetheless, 20 PSRC reports were forwarded to the Determining Officer.

Table 1: PSR caseload

	1994 –95	1995 –96	1996 –97	1997 –98	1998 –99	Total
HIC referrals received by DPSR	1	16	70	48	11	146
Referrals dismissed under section 91		1	3	11	26	41
Referrals dismissed under section 92			2	3	0	5
PSRCs established by DPSR	1	15	30	35	5	86
PSRC Reports to Determining Officer		8	21	22	20	71
Draft Determination received by DPSR		2	10	24	1	37
Final Determination			1	29	2	32

The result of these difficulties is apparent in the statistics. However, in those PSRCs established since the Yung case and with the process changes implemented, it is clear that the Federal Court's concerns are capable of being addressed in future cases.

Section 91 dismissal

Under section 91 of the Act, the Director can dismiss the referral if satisfied there are insufficient grounds for a PSRC to make a finding of inappropriate practice. With the initial referral from the HIC the practitioner is invited to make a submission to the Director addressing the HIC concerns and such submissions sometimes explain the concerns.

This submission gives the practitioner an opportunity to outline and address the clinical and demographic issues which caused the HIC to make the referral. Following such submissions the Director may, and often did, consult with a Panel member or an appropriate consultant on whether the referral should be dismissed. This discretion was not exercised without a visit to the practitioner's practice to be confident that the submission truly reflected reality and to check that the clinical records supported the submission and were adequate.

The decision was taken to consider all referrals in the light of the workload problems discussed above, the age of some of the referrals, and submissions received;

and to establish PSRCs where there was an obvious reason for a question to be answered and to consider dismissals under section 91 of the Act in other cases. As a result, in the year to 30 June 1998, 26 referrals were dismissed under this section.

Some practitioners commented that the referral had caused them to critically review their activities and to change their professional behaviour. Such statements were supported by the current HIC statistical data on the practitioner. A number of practitioners also commented that such change in behaviour had markedly improved their professional satisfaction and personal and family life.

During these discussions it was made clear to the practitioner concerned that dismissal of the referral did not validate a continuation of the conduct that had led to the referral and it was open to the HIC to refer the practitioner again if it continued to have the same or different concerns about the practitioner's conduct. My impression is that the majority of these practitioners will not come to the attention of the HIC in the foreseeable future. However, it is a sad reflection that some probably will, despite assurances to the contrary for changed behaviour.

Section 92 dismissal

Section 92 of the Act gives the Director the ability to dismiss a referral should the practitioner agree to a period of partial disqualification from the Medicare arrangements. In the aftermath of the Yung case it is not surprising that no practitioners attempted to avail themselves of this section in the past year.

Section 93 PSRC hearings

During the year, five new PSRCs were established and a number set up in the previous year continued with hearings and finalised their reports. The administrative arrangements for PSRC hearings have not led to any complaints and are working satisfactorily. It has become the practice to forward the PSRC draft report to the practitioner under review seeking further submissions addressing the proposed findings. The PSRC, on receipt of a submission, considers it before forwarding its report to the Determining Officer. In the past year, 20 reports have been forwarded to the Determining Officer.

The outcomes from the PSRC hearings since the Scheme commenced are listed in Table 2.

Table 2: Outcomes of PSRC hearings

PSRC – established	86
• adverse findings	52
• cleared	14
• suspended	7
• current	13

A PSRC suspends its hearing when it suspects fraud and returns the matter to the HIC for investigation (five cases), a medical condition precludes the practitioner attending (one case) or the practitioner is suspended for medical non-compliance with provisions of the Act (one case).

In 56 cases a PSRC made a finding of inappropriate practice and in 14 cases they reached a conclusion that no inappropriate practice occurred. These statistics do much to address any perception that a PSRC hearing is in the nature of a 'kangaroo court'.

Brief synopses of some cases PSRCs have considered and the relevant findings are on page 21.

Reasons for referral

Although many and varied, the reasons for referral can be categorised into five distinct types. Many referrals involve more than one of these categories.

High volume of services

High number of services per patient

'Up-coding'

Particular services

Unusual medical practice

High volume of services

A small number of practitioners regularly claim for a very high number of services on a regular basis. Most general practitioners have great difficulty in understanding how such large numbers of patients can be seen in the available time. Proper medical practice requires a number of activities: obtaining the history of the presenting complaint and, on occasions, a family and past history from the patient; an appropriate examination, even if a focused examination; the development of a diagnosis; and implementation of a management plan which may involve arranging for diagnostic tests, prescribing treatment such as drugs and explaining the management to the patient. All of which takes time and no step can be omitted without greatly increasing the risk of patient harm.

Practice in a rapid throughput manner certainly may be financially rewarding for the practitioner but, given that this style of practice only allows time for addressing the presenting symptom or problem, it is of little overall benefit to the patient. In medical practice, sins of omission are as important as sins of commission. To date, PSRCs have not accepted arguments that excessively high throughputs can be explained by claims of superior ability and organisation or vast experience. As noted in previous reports, workforce issues generally do not provide a rationale for such conduct.

High number of services per patient

This category involves practitioners who provide, on average, a higher number of services per patient than their peers. Sometimes, it is explained by the practitioner having a small and older patient base. However, it is often the result of a practitioner acceding too readily to patient demands without having regard to the medical or clinical necessity for the service.

'Up-coding'

This is a euphemism for claiming for payment of a service attracting a higher Medicare benefit than the service actually performed. Although this could be considered to be a fraudulent claim, it would be difficult, if not impossible, to have such a finding upheld in an Australian court because of the difficulty of proving an intent to defraud.

Particular services

Experience has shown that some practitioners are submitting very high numbers of claims for particular services or investigative, diagnostic or therapeutic procedures. Questioning in the PSRC hearing often reveals there was no proper clinical indication for the service. It is hard to escape the conclusion that the indication for the procedure was simply that the practitioner had access to the equipment necessary for that procedure. In such situations it is evident that patients are not able to audit the indications for the procedure or the subsequent claims on Medicare.

Unusual medical practice

Practitioners who engage in practice that can be characterised as alternative or complementary must be prepared to justify their practice and their claims against Medicare in light of the legislative requirements that services attracting a Medicare benefit be 'clinically relevant'.

Practitioners referred

A common factor among practitioners referred by the HIC is that they are professionally isolated and have little contact with professional colleagues. Also, practitioners who fail to keep their professional knowledge up-to-date are more likely to be referred. Others are manipulated by more senior practitioners, 'employers' or have deluded themselves. Another category could be defined as being disabled, due mainly to illness or substance abuse. There is no denying that a common cause of this behaviour is dishonesty, with greed as the major motivator.

Medical records

The importance of the medical record has again been demonstrated at hearings. Maintaining good records is an important element in justifying the service in the PSR

process, as it is in any justification procedure in other jurisdictions. This importance has been reinforced by the acceptance of the Review Committee's recommendation that an adequate and contemporaneous record be required for a PSR inquiry.

State Medical Boards are now issuing guidelines for the medical records required by their registrants for safe professional practice. The required standard is usually stated as a record that would enable another practitioner to safely and easily take over the care of a patient so the care of that patient is not compromised. The professional view of the medical record is that it is a record of the patient's health care over a period of time. In cases where a PSRC has not made an adverse finding, the medical records have been such that they supported the practitioner's conduct.

As noted previously in this report, regulations under the Act will be made in the near future which require a PSRC to consider the adequacy of the medical record when considering a referral.

Alteration of documentation

A number of PSRCs have had the strong impression that the medical records produced have been altered subsequent to the notice requiring their production. This is an offence under the Act and arrangements are now in place to enable prosecution of cases involving such fraudulent alterations. State medical boards are also very concerned by such conduct and have significant penalties at their disposal.

Regulatory bodies

State and Territory medical boards remain interested in the activities of the PSR and have advised of the types of concerns about which they would be pleased to be notified. No medical practitioners were referred to medical boards during this year although five practitioners have been referred over the past few years.

At the annual meeting of the combined medical boards held in Brisbane in November 1998, I presented a paper on the PSR Scheme. Subsequently, I accepted an invitation to attend a meeting of the Uniformity Committee of the Australian Medical Council. This meeting, held in Melbourne, was attended by the presidents and registrars of the various Australian medical boards. The boards are very interested in sharing available information to assist them in their role of ensuring public safety. In late 1998 the Australian Health Ministers Advisory Council (AHMAC) established a group to consider how this sharing of information could be expedited. In the role of Director, I was extended membership of this working party, which has yet to convene.

The Third World Congress of Medical Regulatory Bodies was held in November 1998 in Capetown, South Africa. The Congress built on the success of the previous

Congress (Melbourne 1996) and proved that similar problems are evident all over the world. Several presentations dealt with the problems and concerns faced in Australia.

I attended the Annual Meeting of the Federation of State Medical Boards of the United States, held in Illinois USA in late April 1999. It was a most valuable experience with a large attendance of representatives of regulatory bodies from all over the world—valuable contacts were made. One reason for attending this meeting was to learn of the methods other boards use to train medical practitioners in the hearing process. Management of medical fraud was also well covered: the United States Congress has voted very significant monies to establish processes to investigate and prosecute fraudulent imposts on the US health system. Whilst the Americans tend to take a very aggressive approach, they have yet to show that successful prosecutions can be obtained against the types of behaviours with which the PSR Scheme deals. They have had some success against extensive corporate fraud.

Australian professional organisations

I took the opportunity, during the year, to attend numerous professional medical meetings, such as the Congress of the Australian Medical Association in Perth in July 1998 and the Annual Convention of the Royal Australian College of General Practitioners in Melbourne in October 1998. I have also been the invited speaker at several meetings of Divisions of General Practice throughout Australia and also at meetings of Associations of Medical Practitioners of various ethnic backgrounds.

These invitations are a great opportunity to explain the rationale and process of the PSR Scheme. Professional support is always evident following such talks. On a personal note, I was honoured and delighted to be made an Honorary Member of the Australian Vietnamese Health Professionals Association.

Timelines

The Act contained timelines that were difficult to maintain. In the light of experience, we took the opportunity, when revising the legislation, to make such timelines more realistic.

Administration

No major problems have been experienced with the administrative arrangements in place for conducting PSR hearings and preparing Committee reports. Hearings are audio-recorded and Auscript provides a transcript. Auscript has always provided services to the satisfaction of the PSRCs and secretariat. The need to have hard copy of documents tendered and considered in PSRC hearings gives rise to a very resource-intensive commitment. We are, therefore, considering investigating the feasibility of increased use of computer technology in hearings.

Workshop for Deputy-Directors

The Deputy-Directors (PSRC chairs) met in Canberra in April 1999 to review the past year's activities and to consider approaches to dealing with the problems posed by the Federal Court in the Yung case. This was a valuable exercise with sessions devoted to considering legal issues and how to implement a valid and defensible sampling methodology. A major intent of this annual workshop is to endeavour to have a uniform approach and standard across all the PSRCs.

Litigation

Decisions have been handed down in the Federal Court in two cases relating to machinery provisions of the Act, for which the Director had responsibility. The decisions were interesting, to say the least.

Damato v Holmes [1999] FCA 758 (7 June 1999)

The issue was interpretation of section 89 of the Act which requires the Director to make a decision on a referral within 28 days of receipt. Section 89(2) states that, 'The Director's decision on the referral is not rendered invalid merely because it is not made within the 28-day period.'

Mr Justice Whitlam decided that, although 666 days had elapsed since the referral, section 89(2) allowed the Director to establish a PSRC as there was no other course open if sections 91 and 92 were not appropriate. In the revised legislation, an investigative referral lapses if the Director has taken no action within nine months of receipt of the investigative referral.

Hill v Holmes [1999] FCA 760 (8 June 1999)

Following advice from a PSRC that Dr Hill had failed to answer its questions, the Director disqualified Dr Hill from Medicare. Dr Hill sought an injunction against the disqualification in the Federal Court. The issue was the meaning of the words 'appear at the hearing and give evidence to the Committee' in paragraph 104(1)(a) of the Act and 'failing to answer a question asked by a Committee' in sub-section 105(6) of the Act.

Mr Justice Goldberg determined that the interpretation of the words was that the practitioner 'was required to attend and go through the process of giving evidence rather than to give responsive and meaningful answers'. This judgment poses very considerable problems in the conduct of hearings and has serious potential effects across a range of Commonwealth legislation. The same or similar form of words appears in a number of Acts covering various activities. The Attorney-General's Department has been advised of this decision.

Appeals to the Professional Services Review Tribunals

Table 3 gives a statistical overview of the appeal activity under the PSR Scheme since its inception.

Table 3: Appeals to PSRT and Federal Court

	Lodged	Hearing	Judgment
PSR Tribunal	19	18	11
Federal Court	4	3	3
Full Federal Court	2	1	1

Following the Yung decision, it was not surprising that a number of practitioners who had received final determinations from the Determining Officer lodged appeals to the PSRT. These appeals are against the determination and the Determining Officer is the respondent. It is a matter of record that the argument in these appeals is against the findings of the PSRC and not the quantum of the determination. The PSRC is not represented in the appeal process. This, as previously mentioned, was a major flaw in the design of the Scheme which the recent legislative amendments have addressed.

The Determining Officer's Report (on page 25) discusses the four cases for which formal hearings were held before a PSRT. The result of these hearings was that, in three of the cases, the Tribunal set aside the determination following precedent set in Yung's case and, in the other, reaffirmed the determination. The Determining Officer elected to not contest three further appeals and one appeal was withdrawn when the Determining Officer revoked the final determination and substituted another which the practitioner accepted. At the end of the year four other appeals had not been finalised although it is understood that the Determining Officer intends not contesting these appeals either.

This is a most disappointing result. Internal review by the PSR secretariat and external legal advice suggested that many, if not all, of these cases could be sufficiently distinguished from Yung so that an appeal could be defended. It is a strongly held belief that, in such cases, the PSRT should be asked to hear the matter. This belief was reinforced following the decisions in Tankey and Retnaraja. The PSRT has the power to affirm the determination, set aside the determination or set aside the determination and make another in its place. The Act contains a range of sanctions. The real significance of an effective final determination is that referral to a Medicare Participation Review Committee (MPRC) is mandatory on a second effective final determination.

PSRC Members involved in these cases were extremely disappointed at the outcomes. They consider, as do I, that the decisions they had made were the correct decisions in a professional sense and that the Tribunals, which have two professional representatives, should have considered the matters.

Appeals to the Federal Court

In the past year two judgments relating to PSRC hearings have been handed down in the Federal Court. These have been reported by the Determining Officer (see page 28) but there are issues relevant to the PSRC hearing process which should be raised.

Tankey v Adams [1999] FCA 683 (31 May 1999)

This was an appeal by Dr Tankey against a decision of the PSRT considering a determination made by the Determining Officer. The appeal was based on perceived errors of law in relation to the decision of the Tribunal but some aspects of the Committee process and findings were also cited.

> Dr Tankey argued that the PSRT should not have upheld the findings of the Committee because the Act did not require a Committee to adhere to the rules of evidence and did not specifically allow cross-examination of the makers of statements (only those called by the Committee to give evidence). Nor did the Act allow him the right to call witnesses or have legal representation. Mr Justice Einfeld noted, Dr Tankey did not to invite the Chairman to exercise his discretion in particular ways. He did not tender any evidence, which the Committee refused to receive. He did not ask the Committee to hear evidence from any witnesses, nor did he request an opportunity to cross-examine any 'makers of statements'. The Committee invited him to call three general practitioners as witnesses after he alleged that the Committee was not representative of the general body of general practitioners, but he declined to do so. He was … accompanied at the Committee hearings by ... counsel ... to whose presence with, and assistance to, Dr Tankey the Committee took no objection.

Dr Tankey argued that the Committee's findings were based on a sample of services and that this sample was not produced in accordance with directions from the Minister issued under section 106K of the Act; or were not used only in accordance with directions of the Minister; and were used without any notification to the applicant of any finding the Committee proposed to make on the basis of the sample or samples of services.

Mr Justice Einfeld noted that the Committee had carried out a detailed inquiry into the treatment of less than 10 patients. He noted that the reference in the Act was to a sample of services (section 106H) and not to a sample of patients, and the report stated that Dr Tankey acknowledged that the 117 records examined were representative of the general standard of his records. Einfeld J found that the non

use of the sampling procedure did not invalidate the Committee's findings of 'inappropriate practice'.

However, he found that the Committee should not have received evidence that HIC medical advisers had counselled Dr Tankey on three occasions prior to 1994, as this was not relevant to the issue of whether the appellant engaged in 'inappropriate practice' during 1994. He considered that the admission of evidence of these visits, many years before the year under review, manifested an error of law. He also found that the Committee's failure to give due weight to supporting letters from 18 specialists and around 100 patients was erroneous in that they were entitled to be weighed in the appellant's favour against the unfavourable evidence. However, he said that despite this the available evidence permitted the Tribunal to endorse each of the Committee's findings of fact.

He found that, while the Tribunal's decision involved errors of law, these errors did not vitiate the Tribunal's determination because of the weight of evidence that Dr Tankey's conduct of his practice was inappropriate. Even if other matters had been taken fully into account, the Tribunal would have been entitled to uphold the Committee's findings.

With regard to the repayment he said,

> It is only benefits paid for 'inappropriate services' that may be ordered to be repaid, that is, services which have been found to constitute 'inappropriate practice'. There was no finding that all the services rendered in 1994 were inappropriate … Hence on the issue of restitution and disciplinary action generally, there is required to be applied to all sampling, statistics and overviews commonsense and judgment, the evidence about the doctor's general practices, including the doctor's own evidence, and the experience of GPs in general. As I see the position, Dr Adams' final determination drew the balance in a place that was justified and is justifiable on the material presented. He made an educated estimate of what appeared to follow fairly from the Committee's and his own conclusions. The Tribunal's conclusion that he erred in law in doing so was, in my opinion, not justified by any provision of the statutory scheme.

Mr Justice Einfeld allowed the appeal in part and ordered that the Tribunal's determination that Dr Tankey repay $580,576.00 to the Commonwealth be set aside and that the Determining Officer's decision that Dr Tankey repay $258,277.45 be restored. The appeal was otherwise dismissed.

Dr Tankey has subsequently appealed to the Full Federal Court.

Retnaraja v Morauta [1999] FCA 80 (12 February 1999)

This was an appeal by Dr Retnaraja against a PSRT decision considering a determination made by the Determining Officer. Mr Justice von Doussa, in handing down the decision of the Federal Court, made the following findings.

Dr Retnaraja carried out a number of home visits. He argued that these services were not rendered from his practice location in South Australia. The Court found that the terms of the HIC referral were not invalid in failing to specify a particular practice location at which these services were rendered.

Mr Justice von Doussa also found that, although the Committee reported on nine issues under the heading of 'Other Problems in the Practice' and that not all these matters bore a close and inseparable relationship to the matters of concern stated in the HIC referral, they were matters which arose fairly and were of concern to the Committee. They were also matters on which the Committee merely expressed an opinion and did not purport to make specific findings of fact. Hence the Committee did not stray beyond the terms of the referral.

He also found that the Committee gave Dr Retnaraja procedural fairness. In particular the Committee was entitled to reach a conclusion that he had engaged in inappropriate practice by relating his conduct to its finding that some or all of the services referred would be unacceptable to the general body of medical practitioners in general practice. The Committee was not required to relate its finding of inappropriate practice to specific services, or the provision of services to specific patients. It was entitled to make more general findings of the type which it did in relation to each of the categories of services referred by the HIC. Therefore the Committee did not have to notify Dr Retnaraja that it had identified particular services which could be the subject of an adverse finding before making such a finding.

Dr Retnaraja had adequate notice of the adverse findings which might be made against him and had an opportunity to respond. Although only a few patients and services were discussed at the hearing he knew the Committee was examining the information contained in the referral and he knew which clinical records the Committee was examining. He was informed of the Committee's concerns in relation to these records at the conclusion of the hearing. He had a fair opportunity to persuade the Committee that his conduct in connection with the categories of service did not constitute inappropriate practice.

Concerning the Committee's failure to follow the sampling procedure specified in legislation, Mr Justice von Doussa said the sampling procedure was not mandatory; it was complex, had been found to be unworkable and was later repealed. The Committee was entitled to adopt a less formal sampling process provided the sample examined was sufficiently broad to enable the conclusion that the person under review had engaged in inappropriate practice. He found that the Committee examined a substantial portion of the services rendered. The sample was sufficient to justify the finding of inappropriate practice in respect of each category of service.

However, he also found that the Determining Officer erred in directing that $55,115.90 be repaid. It is a prerequisite to exercising power under paragraph

106U(1)(c) to identify, by number or by percentage of the total, services which constitute the inappropriate services. Such identification provides the starting point for calculating Medicare benefits to be repaid. The Committee made no findings which could enable it to identify services for quantifying repayment. The quantification of services in respect of which Medicare benefits were wrongly paid was not a topic of investigation before the Committee. It was not a topic on which Dr Retnaraja was given an opportunity to respond. It was not open to the Determining Officer or the Tribunal to make findings which would enable the quantification of wrongly paid benefit. He said paragraph 106U(1)(c) of the Act did not confer on the Determining Officer the discretion to order repayment of up to the whole or a discretionary part of all Medicare benefits paid during the referral period.

Although this decision indicates the Committee was not required to relate its finding of inappropriate practice to specific services and was entitled to approach its task by making more general findings in relation to the categories of service about which the Commission expressed concern in the referral, it was necessary that specific services be identified for calculating the amount of Medicare benefits to be repaid.

The facts relating to the Committee hearing procedure in these two cases vary little from those of the Yung case although differences can be identified.

All the relevant findings related to Committee procedures have been considered and adopted in an endeavour to avoid further legal problems.

To a non-lawyer medical practitioner it is somewhat bemusing to note that, on basically similar cases, six judges split three-each-way on these appeals.

Report of Determining Officer

A report provided by the Determining Officer on the role and activities of that position for the year is on page 25.

Department of Health and Aged Care

With responsibility for the policy parameters of the PSR Scheme, the Department has submitted its comments on the Report of the Review Committee. This appears on page 32.

Formal counselling

One of the sanctions available for inclusion in a determination is that the practitioner be counselled by the Director or a nominee. This formal counselling has been carried out in 16 cases since establishment of the Scheme. It is a common component of most determinations. It has proven to be a most valuable exercise and I have been pleased by the manner in which it has been received.

Following most counselling it has been my impression that the hearing process and judgment by a peer group has been a salutary experience as well as an educational process. It is unlikely that most of the counselled practitioners will again be the subject of an adverse finding by a PSRC. The effect of such a second finding, with mandatory referral to an MPRC, is stressed at counselling.

Advice to practitioners

Based on the experience of five years of the PSR Scheme, 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. Such visits should make practitioners review their conduct and even seek advice from colleagues and their professional associations. The HIC Medical Advisers and support staff are available to answer queries regarding Medicare and the interpretation of Medicare Benefit Schedule items. It is essential that such advice be documented.
- **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 guidance but 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. This will be essential under the amended legislation.

PSR Committees

The contribution and commitment of PSRC members is acknowledged with gratitude. This difficult and onerous task can be stressful and demanding on the member's time. All members who have served in this role have carried out the duty responsibly, carefully and with consideration for the colleague upon whom they are required to make a judgment.

A special mention must be made of the Deputy-Directors whose role it is to chair the Committees, coordinate and manage the hearing process and prepare the report to the Determining Officer. All have carried out these responsibilities effectively.

PSR staff

I thank my staff for the competent manner in which they provided the secretariat and other support functions. It is always pleasing, as frequently happens, to receive commendations and laudatory remarks on the performance of the PSR personnel. I am most grateful for their efforts and their support in difficult times.

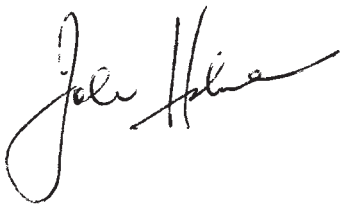
Legal support

Operating in a legalistic environment it is essential to have access to, and confidence in, first class legal advice. We have been fortunate to have on board a person who has both medical and legal qualifications. As well, the lawyers at Minter Ellison (Canberra) have given sterling support. With added responsibilities under the amended legislation, we intend increasing in-house legal personnel.

Conclusion

With the introduction of amendments to the legislation, which I am convinced will redress the concerns expressed in the judgment of the Full Federal Court in the Yung case, I am once again confident the PSR Scheme will deliver on its intent. The passage of the amending legislation through the Commonwealth Parliament showed the process has the support of all political parties. In the professional arena it has very strong support, especially from those who have been involved in any way. Full explanation of the Scheme always brings such support.

I remain convinced there is a need for an effective accountability process in any funding system, particularly one based on trust. Within such a process decisions must be made by involved professionals and those decisions should, as far as possible, be protected. My belief is that the legislative changes reflecting this will, when challenged, be legally sustainable. Time will tell.



Dr John Holmes
Director
Professional Services Review

8 October 1999

Case Summaries

When the legislation establishing the PSR Scheme was first introduced into the Parliament, the then Minister formally advised the Senate Standing Committee on Community Affairs that the Director would, in his Annual Report, provide, in a narrative style, appropriate examples of cases which resulted in findings of 'inappropriate practice'.

The following summaries are provided in accordance with that undertaking. Experience has shown that these cases are of interest to the profession. Often the existence of such behaviour is not even suspected by the majority of practitioners who are unaware of the deviant activities of some of their colleagues. In is not unusual for a practitioner to be unaware of what the neighbouring practitioners are doing—this situation can even occur in the confines of a partnership or group practice.

These illustrative cases are abbreviated and not all the issues involved in an individual case are detailed. For ease of reading, the numbers given are usually rounded.

Case AB

The practitioner graduated in 1967 and practised from three suburban locations in a major capital city. The HIC concerns related to the very high number of services (21,500) claimed in the referral year for 4,750 patients; attracting Medicare benefit payment of $480,000. (In that year the 99th percentile for services claimed was 16,000). On 55 days, more than 80 services per day were claimed and on occasions more than 100 per day. The HIC was also concerned by the high number of pathology requests—there were 7,300 tests costing Medicare $125,000.

Following a number of sittings, the Committee made an adverse finding on both concerns. It found that the doctor failed to provide a sufficient level of clinical input to his patients in that it was apparent a proper examination and assessment of the patient had not been made. A major concern was an obvious lack of up-to-date clinical knowledge and poor diagnostic skills. This was probably the cause of the high rate of initiation of pathology testing as the doctor was unable to give satisfactory reasons for the tests discussed. This concern was further illustrated by the excessive number of electrocardiograms and poor prescribing the Committee noted.

There was also a demonstrable lack of involvement in any continuing medical education activities. The standard of the medical records was poor and the Committee was unable to accept that they would facilitate proper care of the large number of patients seen over the year. In many instances there were large gaps in the records with no written entry at all for many services. The Committee was most disturbed by evidence that the medical records had almost certainly been altered

after they had been requisitioned. The Committee considered the practitioner's veracity to be highly questionable and gave little credence to many of the statements made during the hearing.

Case CD

Graduating in 1984, the practitioner established an extended hours centre after working in several other metropolitan extended hour practices. The practitioner claimed 18,600 services in the year of referral leading to a Medicare benefit payment of $380,000. The 99th percentile for services was approximately 16,000.

The PSRC's concerns, which lead to the finding of 'inappropriate practice', included evidence that patient care was episodic with insufficient clinical input, leading to a poor standard of care. The Committee was also concerned by evidence of antibiotics having been prescribed in inappropriate circumstances. There was no attempt at preventative care and the practitioner's clinical knowledge was judged to be deficient, manifested by poor management of patients with diabetes, asthma and other chronic conditions. The standard of sterilisation and maintenance of the 'cold chain' for vaccines in the practice were obviously deficient. Inadequate records were also of concern in a practice where a number of practitioners were involved in caring for patients.

Case EF

This practitioner had been in solo suburban practice for some 18 years following hospital experience of some two years. The HIC was concerned by the statistical data which showed the practitioner had provided eight services per patient averaged across some 1,400 patients. The practitioner had provided 11,500 services, with a Medicare payment of $350,000. The service per patient was beyond the 99th percentile and the Medicare benefit cost was at the 98th percentile. The statistical data also showed that, although a large majority of patients were more than 50 years old, the service per patient figure was high for all age groups in the practice. The practice had a large ethnic patient-base.

The Committee's concerns related to the high number of long and prolonged consultations and home visits for which there did not seem to be satisfactory clinical indications. The doctor kept no clinical records for home visits and had not done so since the commencement of practice. The Committee found that a significant number of services were in response to patient demand, with no clinical indication.

The Committee was also concerned at the excessive number of electrocardiograms performed with no apparent clinical justification. In light of the very poor standard of medical records and the total lack of any records for out-of-surgery consultations,

the Committee was unable to accept many of the claims made. The discovery that pathology and such results were not kept in the patient's record but were given to the patient was also a significant worry with regard to the continuing management of the patient. Moreover, the Committee was concerned by an apparent practice of mis-itemisation of some services. The Committee noted the demographics of the practice area included a considerable number of elderly patients with multiple complex medical and psycho-social problems but also noted that the practitioner was now endeavouring to address the concerns held by the Committee.

Case GH

This practitioner had worked in solo practice with a high ethnic patient-base in a provincial town for 20 years. The HIC had a number of concerns, mainly related to the high number of services claimed: 17,500 services to 3,000 patients with a Medicare benefit of $420,000. Other concerns were the high number of hospital visits claimed, the treatment of skin lesions, the high ordering of pathology and the high level of prescribing pethidine to a small number of patients.

At the PSRC hearing the practitioner was able to justify his conduct in relation to some of the concerns but the Committee found 'inappropriate practice' in a number of areas; the practitioner often billed for two extra 'item 23 (Level B) GP consultations' in the course of a pre-arranged excision of a skin lesion, one when he carried out the excision and another when he removed the sutures. The medical record did not confirm that a necessary non-related consultation took place at such episodes.

The Committee was also concerned that the level of billing for other MBS items, especially 'item 36 (Level C) consultations', was incorrect and again in the practitioner's favour. This case also illustrates that the failure to keep proper medical records affects both patient care and the ability to justify professional conduct when required to do so.

Case IJ

This practitioner was in a solo general practice in an inner metropolitan suburb and the HIC's referral concerns related to the high volume of services claimed: 19,200 services to 3,000 patients with a Medicare payment of $430,000; and the high number of respiratory function tests (MBS item 11506): 3,300 costing $42,000.

At its hearing, the Committee noted that an item 11506 claim was associated with 25 per cent of the surgery consultations. On specific questioning the Committee found the technique employed was grossly deficient and there were sometimes up to 100 tracings on a single piece of paper. The Committee found the spirometry test was not performed in accordance with accepted practice. Claims of increased skill

and interest in respiratory disease were made but, on the evidence at the hearing, the Committee was also unable to accept such assertions.

It also examined a number of claims for 'item 44 (Level D) consultations' and concluded there was not always clinical justification for such claims. The practitioner had a somewhat cavalier attitude to the legal requirements for correctly itemising claims against Medicare.

The Committee's findings were that performance of the respiratory function tests and itemisation of claims for prolonged consultations by this practitioner would be unacceptable to the general body of general practitioners.

Case KL

This practitioner graduated from an overseas university and, following migration to Australia, had passed the Australian Medical Council examination. The practitioner began a solo practice in an inner metropolitan suburb and continued for some 13 years prior to HIC referral. The HIC's concerns related to the high volume of services the practitioner rendered during a 12 month period. Referral data indicated the practitioner had rendered 23,000 services during that period with a cost to Medicare of $430,000.

In examining the practitioner's conduct, the Committee found the practitioner had been providing episodic care, based on the treatment of patients' presenting symptoms only. It considered this type of treatment was both hazardous and risky. The Committee illustrated this concern with specific examples.

Other concerns the Committee identified included the practitioner's indiscriminate use of medications and inadequate medical records which did not support the practitioner's claims as to what was done during each service.

Particular areas of concern to the Committee were the inappropriate use of steroid medication, the management of asthma and a demonstrable lack of any evidence of follow-up and appropriate management when abnormal results were reported, e.g. positive serology.

Although some positive aspects of the practitioner's conduct were identified, the Committee was unanimous in its finding of 'inappropriate practice'.

Determining Officer's Report

Overview

The role of the Determining Officer within the PSR Scheme focuses on making 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* (the 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 of up to three years.

The Determining Officer also defends requests for reviews of determinations in PSRTs.

Determinations

During the year, the Determining Officer received 20 reports from PSRCs of which 17 contained findings that the person under review had engaged in inappropriate practice. However, because the Determining Officer's resources for the entire year were virtually exclusively directed to the review of the PSR Scheme, only one draft determination and two final determinations were issued. The recipients of the two final determinations accepted those determinations without seeking further review. Sanctions in respect of these determinations include repayment of $8,256.

Professional Services Review Tribunal decisions

Practitioners to whom a determination relates may ask the Minister for Health and Aged Care 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 office 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 PSRCs, the person under review may be legally represented.

Four PSRT decisions were handed down in the year. These were for Dr Monier Gad, Dr Michael Jacob Bar-Mordecai, Dr Christopher Dean Heinrich and Dr Thuryrajah Retnaraja, all of whom were general practitioners.

Three (Dr Leonard Robert Kitson, a general practitioners of Penrith, New South Wales; Dr Tony Ata Marshall, a general practitioner of Frankston, Victoria; and Dr Atalla Abraham, a general practitioner of Templestowe, Victoria) were set aside without a hearing at the request of the parties. One, Dr Kim Fatt Chan, a general practitioner of Reservoir, Victoria, was withdrawn at the Tribunal hearing—the Determining Officer revoked an earlier final determination made on 29 January 1998 and made a new final determination dated 21 September 1998.

Dr Monier Gad of Arncliffe, New South Wales

The HIC referred Dr Gad to the DPSR in December 1995 for all services rendered and initiated by him in 1994. In that year, Dr Gad provided 18,678 services to 3,661 patients at a Medicare benefits cost of $395,918. Of those services, 17,014 (93.69 per cent) were 'Level B consultations'. The HIC's referral also expressed concern about Dr Gad's high average number of services per patient and his high initiation of pathology services.

In May 1996, the PSRC found Dr Gad to have acted inappropriately within the meaning of the Act. It found his medical records to be of very poor quality, that he practised with speed rather than thoroughness, that he ordered pathology indiscriminately and that he prescribed contrary to the requirements of the Pharmaceutical Benefits Schedule. In addition, it found that some aspects of Dr Gad's practice presented a positive danger to his patients.

The Determining Officer made a determination that the DPSR, or his nominee, counsel Dr Gad, that Dr Gad repay $228,152.95 to the Commonwealth, that he be partially disqualified from Medicare for nine months and fully disqualified for six months.

Following a hearing by PSRT No. 11, the Tribunal set aside the original determination.

Dr Michael Jacob Bar-Mordecai of Clovelly, New South Wales

Dr Bar-Mordecai was referred to the DPSR in May 1996 for all services rendered by him between 1 July 1995 and 30 June 1996 inclusive. During that time Dr Bar-Mordecai provided 9,841 services to 2,131 patients at a Medicare benefits cost of $225,908. The HIC's referral expressed concern that Dr Bar-Mordecai may have provided an inappropriately high number of services per patient and that some of the long and prolonged consultations he rendered may not have been reasonably necessary for the care of his patients. In addition, the HIC expressed concern that Dr Bar-Mordecai's high volume of multiple servicing and family servicing and the inappropriate use of MBS item 30219 (incision with drainage of haematoma or furuncle, small abscess or similar lesion) would not be acceptable to the general body of general practitioners.

In January 1997, PSRC No. 14 found that Dr Bar-Mordecai's conduct, in connection with rendering services, which were the subject of the HIC's referral, was unacceptable to the general body of general practitioners practising in general medical practice in Australia.

The Determining Officer made a determination that the DPSR, or his nominee, counsel Dr Bar-Mordecai, that Dr Bar-Mordecai repay to the Commonwealth $61,879.75, and that he be partially disqualified from Medicare for six months and fully disqualified for four months.

Dr Bar-Mordecai sought a review of the determination. That application was referred to PSRT No. 10 which, in its decision of 9 October 1998, set aside the determination.

Dr Christopher Dean Heinrich of Leabrook, South Australia

Dr Heinrich was referred to the DPSR in July 1996 for all services rendered by him during 1995. The referral indicated the HIC was concerned that Dr Heinrich had provided an inappropriately high proportion of Level C and Level D attendances, an inappropriately high proportion of Level C and Level D home, hospital and nursing home visits, an inappropriately high average number of services per patient and a high rate of initiation of pathology.

During the referral period, Dr Heinrich provided 11,160 services to 1,686 patients at a Medicare benefits cost of $355,720. Forty-nine per cent of all attendances provided by Dr Heinrich were billed as Level C or Level D consultations (5,285 and 342 respectively). Just over 50 per cent of Dr Heinrich's hospital attendances were Level C or Level D attendances (440 and 78 respectively) while 42.7 per cent of 1,013 nursing home visits were billed at Level C and Level D rates.

In its report to the Determining Officer of 26 May 1997, PSRC No. 20 concluded that Dr Heinrich's conduct in connection with rendering the services which were the subject of the referral was unacceptable to the general body of general medical practitioners practising in general medical practice and that Dr Heinrich had, therefore, engaged in inappropriate practice as defined in paragraph 82(1)(a) of the Act.

The Determining Officer made a determination that the DPSR, or his nominee, counsel Dr Heinrich, that he repay to the Commonwealth $87,565.75, he be partially disqualified from Medicare for 12 months and fully disqualified from Medicare for three months.

Dr Heinrich sought a review of the determination. That application was referred to PSRT No. 15 which, in its decision of 7 August 1998, set aside the determination.

Dr Thuryrajah Retnaraja of Craigmore, South Australia

Dr Retnaraja was referred to the DPSR in April 1996 for all services rendered by him between 1 July 1994 and 30 June 1995. The HIC's concerns about Dr Retnaraja's practice fell into four categories: the high average number of services per patient, the high proportion of long consultations, the high rate and number of home visits and the high number of multiple services.

During the referral period, Dr Retnaraja provided 5,513 services to 678 patients at a cost to Medicare of $159,533.25. While Dr Retnaraja's total services fell below the 50th percentile (measured against his peer group of all active Australian general practitioners), his services per patient (8.13) placed him above the 99th percentile of all active general practitioners.

In October 1996, PSRC No. 10 provided the Determining Officer with its report, finding that Dr Retnaraja's conduct in connection with rendering the services which were the subject of the HIC referral was unacceptable to the general body of medical practitioners practising in general medical practice in Australia.

The Determining Officer made a determination that the DPSR, or his nominee, counsel Dr Retnaraja, that Dr Retnaraja repay $55,115.90 to the Commonwealth, he be partially disqualified from Medicare for six months and fully disqualified from Medicare for two months.

Following a hearing by PSRT No. 1 in November 1997, the Tribunal affirmed the Determining Officer's determination.

Federal Court Decisions

Practitioners dissatisfied with the outcome of a review of a determination by a PSRT may appeal that decision, on a question of law only, to the Federal Court of Australia. Two Federal Court decisions (Tankey v Adams and Retnaraja v Morauta) were handed down in the year.

Tankey v Adams

Dr Tankey had appealed against a decision of PSRT No. 7 that he repay $580,576 to the Commonwealth, that he be partially disqualified from Medicare for 12 months and fully disqualified from Medicare for six months and that the DPSR, or his nominee, counsel him.

On 31 May 1999, Einfeld J handed down his decision. He ordered that the appeal be allowed, in part, in that the Tribunal's determination of 18 April 1997 that Dr Tankey repay $580,576 to the Commonwealth, be set aside. Justice Einfeld also determined that the Determining Officer's determination of 16 August 1996 that Dr Tankey repay $258,277.45 to the Commonwealth be restored, and that the

appeal be otherwise dismissed. Dr Tankey was also ordered to pay two-thirds of the Determining Officer's costs.

Justice Einfeld found that the PSRT did not exercise judicial power under the current statutory scheme, nor was Dr Tankey denied procedural fairness in the case. He held that it was not open to the applicant to submit that the samples the Committee used were not produced or used in accordance with the Minister's sampling directions as this ground of appeal challenged the actions of the Committee rather than that of the PSRT. Importantly, his Honour noted that, as the Committee's findings were principally concerned with the quality of service given to patients over the year in question, the use of the sampling procedure could not be said to have invalidated the finding of 'inappropriate practice'.

Justice Einfeld found that evidence of previous visits by HIC counsellors was irrelevant to the issue of whether Dr Tankey had engaged in inappropriate practice in 1994 and, therefore, should not have been received by the Tribunal. However, his Honour held that the error was not sufficient to invalidate the Tribunal's determination as there was sufficient other evidence permitting the Tribunal to endorse each of the Committee's findings of fact.

His Honour found that no error of law had been demonstrated by the Tribunal giving weight to factors, such as the number of services Dr Tankey performed, or Dr Tankey's availability, ability to work long hours, organisational talents and superior diagnostic skills. Justice Einfeld noted that the Tribunal was an administrative body whose members are entitled to bring their own knowledge and expertise to the assessment of whether inappropriate practice had been demonstrated.

Justice Einfeld held that the PSRC was required to weigh the numerous letters of support Dr Tankey submitted from specialist colleagues and survey forms completed by his patients attesting to their satisfaction with his practice against other unfavourable evidence. He found the Committee's handling of these two matters inadequate, to the point of causing legal error. However, his Honour concluded that, even if these matters had been fully taken into account, the available evidence nevertheless permitted the Tribunal to endorse each of the Committee's findings of fact. Accordingly, the error did not vitiate the Tribunal's determination.

Finally, his Honour noted that section 106U(1)(c) of the Act provided the Determining Officer with a range of possible directions. In cases such as Dr Tankey's where only a one-day sample was examined, it would be difficult to justify a determination that every service rendered in the whole referral period was inappropriate. His Honour, therefore, concluded that the Tribunal had misconstrued section 106U(1)(c) in concluding that the Determining Officer had no discretion to direct that only a percentage of Medicare benefits be repaid. The Court consequently ordered that the Tribunal's determination that Dr Tankey repay

$580,576 to the Commonwealth be set aside and the Determining Officer's determination of 16 August 1996, in respect of monetary payment to the Commonwealth, be restored.

Retnaraja v Morauta

Dr Retnaraja had appealed against a decision of PSRT No. 1 that the DPSR, or his nominee, counsel him, he repay $55,115.90 to the Commonwealth, he be partially disqualified from Medicare for six months and fully disqualified from Medicare for two months.

On 12 February 1999, von Doussa J handed down his decision, ordering that the Tribunal's decision be varied only insofar as the direction that Dr Retnaraja repay $55,115.90 be set aside.

Justice von Doussa found that the PSRC was not required to relate its finding of inappropriate practice to specific services, or the provision of services to specific patients. He found that the Committee was entitled to make more general findings of the type it made in relation to each category of service about which the HIC expressed concern in its referral.

His Honour also found that the sampling procedure addressed in section 106H of the Act was not mandatory and that the Committee was entitled to adopt a less formal sampling procedure, provided the sample used was sufficiently broad to justify the ultimate conclusion that a practitioner had engaged in inappropriate practice. However, to justify a repayment of Medicare benefits, his Honour found that the services which constituted the 'inappropriate services' needed to be identified either by number or by a percentage of a total.

Determining Officer actions on cases in 1998–99

Type of action	Number of cases
PSRC reports to Determining Officer	20
PSRC reports sent to persons under review	23
PSRC reports indicating the person under review was not practising inappropriately	3
Draft Determinations issued	1
Submissions made to Determining Officer on Draft Determinations	0
Final Determinations issued	2
Final Determinations accepted without appeal	2
Requests to the Minister for a review by a PSRT	0
Applications for review set aside at request of parties or withdrawn at hearing	4
Reviews conducted by PSRTs	5
Decisions handed down by PSRTs	4
Appeals made to the Federal Court on reviews by PSRTs	2
Decisions handed down by Federal Court	2

Department of Health and Aged Care Report

Overview

The Department of Health and Aged Care assumes overarching policy responsibility for advice to the Minister on developing and maintaining 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. The Minister has appointed a senior officer of the Department, the First Assistant Secretary, Health Access and Financing Division, to the position of Determining Officer under the Scheme. The Determining Officer's role and report for 1998–99 is set out in this report.

Other, more specific, tasks falling to the Department include overseeing the operation of the PSRTs and the appointment of Presidents and members of those Tribunals. In addition, the Department provides legal and administrative assistance to the Determining Officer in challenges to determinations to Tribunals or the Federal Court. The Department also renewed its Memorandum of Understanding (MoU) with the Administrative Appeals Tribunal (AAT) whereby the AAT acts as Registrar to the various PSRTs.

Review of Professional Services Review Scheme

As a result of the adverse decision of the full bench of the Federal Court on 15 May 1998 in the Yung case, the Minister for Health and Aged Care, the Hon Dr Michael Wooldridge agreed, on 31 July 1998, to a review of the PSR Scheme. The purpose of the review was to consider the effect of the Court's judgment and to make recommendations on any legislative amendments and administrative changes that may consequently be needed.

The review was undertaken by a committee comprising the AMA, which chaired the review, the HIC, the DPSR and the Department of Health and Aged Care (Health). A working group supported the review committee.

A number of interested parties were consulted during the review, including PSR Deputy-Directors (i.e. Chairs of the PSRCs), the PSRT Presidents and members, State and Territory medical boards, professional bodies and colleges, major medical defence organisations, the AMA's Executive Council, Federal Council and Council of General Practice.

Legal advice was sought from several Senior Counsel on aspects of the proposed changes to the Scheme. Expert advice on appropriate statistical methodologies was also sought from Professor Des Nicholls, Department of Statistics and Econometrics, Australian National University. Consultations with the AMA Federal Council and the AMA Council of General Practice were critical to the review process.

On 4 March 1999, the review committee presented the Minister with its final report which confirmed both Government and professional support for a peer review based PSR Scheme. It found that the general definition of 'inappropriate practice' in the Act, namely conduct unacceptable to the general body of the practitioner's peers, could be retained. However, it also identified a need to distinguish between the different categories of inappropriate practice, and recommended that specific provision be made concerning how a PSRC should approach each category.

In this regard, the review committee recommended that:

- for particular identifiable unacceptable practice, either the particular services should be identified, or a sample of services be examined and extrapolated to the total services of that type within a referral period;
- for high volume of services per day, a deeming provision should be applied or a sampling approach adopted where the deeming provision is not appropriate. The deeming provision would apply when a practitioner reached or exceeded a specified number of services (set at a level agreed with the profession for that discipline). Once that occurred, a practitioner would be deemed to be practising inappropriately unless he or she could demonstrate exceptional circumstances to the satisfaction of a Committee of the practitioner's peers; and
- for general professional issues, matters should be referred to appropriate bodies, such as Medical Boards.

The review also identified changes necessary to improve the administration of the PSR process to meet the needs for legal effectiveness, transparency and natural justice, and to ensure the peer review process was maintained. Those changes included:

- consolidating the existing PSR functions into a single agency with increased funding to support its expanded investigative and administrative functions;
- providing legal support to the peer review committees through a legal adviser who will assist the committee on matters of law, and by introducing comprehensive training and operating protocols for committee members;
- allowing greater legal support to the practitioner under review so his or her legal adviser has a right to address the committee throughout the hearing on matters of law and a right to a final address to the committee on the merits of the case as well as matters of law;

- replacing the Determining Officer (currently in the Department of Health and Aged Care) with a Determining Authority (comprising a permanent medical practitioner chair, a permanent lay person and a third member who is a representative of the profession of the person under review) also to be serviced by the expanded PSR Agency;
- structuring the Agency so that support (including legal support) for investigations, committees and the determining panel will be clearly separated; and
- removing the PSRT from the process in recognition that review on the merits of the final determination is not appropriate in a scheme in which the key judgment is a professional judgment by a practitioner's peers about the practitioner's conduct. The right of review on points of law by the courts will be retained.

The review committee's findings were expressed in the form of 45 recommendations, all of which the Government accepted, and legislation was developed to put them into effect. Following consultations with all parties in the PSR Review, the Health Insurance Amendment (Professional Services Review) Bill 1999 was introduced into Parliament. The House of Representatives passed the Bill on 23 June 1999. It was introduced into the Senate on 28 June 1999 and passed the following day. The Bill received Royal Assent on 16 July 1999 at which time it became the *Health Insurance Amendment (Professional Services Review) Act 1999* and commenced operation on 1 August 1999.

Corporate Overview

Objective

To provide effective and efficient human resource management, financial management and corporate planning services which will 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 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 quite a substantial increase in the corporate costs percentage: 91.14 per cent of total costs, compared to 70.65 per cent in 1997–98. This result does not reflect any corporate inefficiency during the year but rather the slowdown in the committee servicing operations. A major review following the adverse decision the Full Federal Court handed down in May 1998 (Adams v Yung

& Ors), limited the core business of committee servicing to the completion of on-going cases and the commencement of only five new cases near the end of the financial year.

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 information technology (IT) functions have been outsourced. As an interim measure, while investigations were undertaken into outsourcing the new computer infrastructure and support early in 1999–00, PSR purchased its computer equipment at the end of the lease. During 1998–99, PSR continued to show strong commitment to training its staff and Deputy-Directors. Total expenditure on staff training has decreased slightly to 1.95 per cent from 2.33 per cent in 1997–98. There is an identified need to provide more training for the PSRC members. This was not possible until the review was completed and legislation passed. This remains one of the high priorities for training and is likely to occur early in the next financial year. This percentage does not include the training provided to PSR staff through the MoU with the Department of Health and Aged Care.

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

Financial and staffing summary

	Actual 1997–98 ($'000)	Budget 1998–99 ($'000)	Actual 1998–99 ($'000)
Appropriation	1,688	2,283	1,258
Staffing	9.5*	10	8.5**

* Includes 2.5 contractors

** Includes 3.5 contractors

Finance

PSR's 1998–99 budget appropriation was $2.283 million. However, there was a major under-spend of $1.025 million due to the committee process being on hold for most of the year. Forty-six cases were finalised but the majority of them were section 91 dismissals. During the year considerable staffing resources were committed to the review and to modifying Committee reports to take into account the decision in the Yung case.

The Australian National Audit Office's report on the PSR's 1998–99 financial statements was unqualified and was signed on 6 October 1999.

Forward estimates funding

PSR's 1998–99 estimate of $3.330 million is based on a new policy decision to transfer some of the functions relating to the PSR Scheme from the Department of Health and Aged Care to the PSR. The increased funding is to support the new investigation and administration functions, and is a direct result of the review recommendations (see Appendix 1).

Administration

A MoU with the Department of Health and Aged Care, remained in force during this reporting period. The Department provides services such as payment of accounts, personnel functions, preparation of Financial Statements, internal audit, library, registry and coverage for programs including equal employment opportunity (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 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 1999 the PSR had a staffing level of 10 (including four contractors and the statutory officer position of Director of Professional Services Review).

The gender profile for PSR as at 30 June 1999 comprised six males and four females. 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 employed on a permanent full-time basis.

Ten per cent of the staff come from non-English-speaking backgrounds, and no staff are of Aboriginal or Torres Strait Islander origin nor do they 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, financial issues, and resource management.

On-going training is scheduled for 1999–00 based on the organisation's identified needs. There is a need for more training for the PSRC members. This was not possible until the review was completed and legislation passed. This remains a high priority and is likely to occur early in the next financial year.

Workplace reform

PSR staff unanimously voted in favour of the 'The Professional Services Review Certified Agreement 1999'. The Agreement was endorsed in the Industrial Relations Commission on 30 March 1999 and expires on 31 December 2000. The Agreement mirrored that of the Department of Health and Aged Care, except for some minor changes. The major features of the Agreement were:

- a 5 per cent increase and 3.5 per cent bonus on certification of the agreement, and a further 3 per cent or an increment and 1.5 per cent increase on successful completion of the Performance Development Scheme;
- linking of annual salary progression to the Performance Development Scheme;
- personal leave package accessible for personal illness, caring purposes and compelling personal reasons – 18 days annually;
- Higher Duties allowance payable after two weeks of performing the duties;
- standard day increased from 7 hours 21 minutes to 7 hours 30 minutes;
- standard travelling allowance of $65 per night for meals and incidentals for a staff member who is away from the office overnight;
- no travelling allowance for staff travelling but not away overnight;
- time in lieu is the standard form of recompense for all additional duty. Additional duty is calculated at single rate for weekdays, time-and-half for Saturday, and double time for Sunday and public holidays; and
- extended bandwidth of 7.00 a.m. to 8.00 p.m.

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 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 the Department of Health and Aged Care as an element of the MoU.

There were no OH&S incidents in 1998–99 nor were any notices issued or received under any of the relevant sections of the OH&S Act.

Equal employment opportunity

PSR is committed to the principles of EEO which require that all staff be treated fairly and without direct, indirect or systemic 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 embraced that of the Department of Health and Aged Care.

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. There were also a number of meetings with staff on workplace reform and in negotiating the Certified Agreement.

Information technology

The Technology Partnership Agreement (TPA) with Logical Solutions, whereby software, hardware, maintenance support and ongoing training were provided for a single cost, finished on 31 December 1998. PSR purchased the leased hardware at the end of the lease. This was done as an interim measure while we prepared for outsourcing our IT and support early in 1999–00.

Ministerial or Senate inquiries

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

Stationery and publications

The only new publication produced in 1998–99 was the Annual Report.

APPENDIX 1

Recommendations of the Review Committee of the Professional Services Review Scheme

The specific recommendations of the review committee are as follows:

Definition of Inappropriate Practice

Recommendation 1: The general definition of inappropriate practice in the *Health Insurance Act 1973* be maintained as conduct unacceptable to the general body of the practitioner's peers.

Processes to Arrive at Findings

Recommendation 2: The Act be amended to provide the authority for the application of sampling and for Ministerial directions to be made to provide for a range of sampling methodologies to be used by PSRCs to make findings in relation to the provision of particular identifiable services.

Recommendation 3: The Act be amended to provide the authority for the application of a deeming provision in respect of high volume servicing per day. Once the pattern of services specified in regulations under this provision is reached, a practitioner will be deemed to have engaged in inappropriate practice unless he or she can demonstrate to the satisfaction of the PSRC that exceptional circumstances have occurred.

Recommendation 4: With respect to general practice, the deeming provision will apply when a practitioner provides 80 or more consultation services on 20 or more days of a year. If the Committee has concerns about the accuracy of the HIC data such that the threshold limits may not have been met, the Committee may decide not to rely on the deeming provision.

Recommendation 5: With respect to general practice, exceptional circumstances may relate, but not be limited to, the availability of alternative medical services or unusual occurrences.

Recommendation 6: Deeming provisions in respect of high volume services per day will be specialty- and profession-specific, be developed in consultation with relevant groups within the professions, and be introduced in regulations.

Recommendation 7: If a general practitioner is deemed to have engaged in inappropriate practice, the quantum of inappropriate practice be defined in terms of

all consultation services on every day on which 80 or more consultation services were rendered, and where exceptional circumstances cannot be demonstrated to the satisfaction of the PSRC.

Recommendation 8: The Act be amended so that a PSRC can make a finding of inappropriate practice in broad terms without identifying specific services or a number of services when:

– there are no clinical records or the records cannot be used; and
– the finding is based on HIC data and evidence taken at the hearing; and
– the finding focuses on particular categories of services.

Determinations

Recommendation 9: The existing range of sanctions should be retained in the Act, namely counselling, reprimand, repayment of some or all of the Medicare benefits and/or suspension from Medicare.

Recommendation 10: In cases of high volumes of attendances per day by general practitioners and covered by the deeming provisions, Ministerial guidelines (see Recommendation 39) should provide for substantial periods of suspension from Medicare (eg periods of 2 years or more).

Recommendation 11: When a general finding is made as outlined in Recommendation 8, the sanctions must be limited to counselling, reprimand and/or suspension.

Expanded Agency

Recommendation 12: The PSR Agency be expanded to include the functions of investigation, case preparation and administrative support for the proposed Determining Panel (DP).

Recommendation 13: Additional funding be provided to permit the new PSR Agency to perform efficiently and effectively.

Health Insurance Commission and Referral Processes

Recommendation 14: The process of referral be redefined in the Act as a progressive action starting with a notification of a concern or concerns issued by the HIC to the DPSR and, after investigation, a formal referral from the DPSR to a PSRC.

Recommendation 15: A PSRC be able to raise new concerns which may become an additional referral by the DPSR provided that the PUR is given adequate notice and time to consider his or her responses.

Recommendation 16: A Standing Committee comprising representatives of the AMA and HIC be established to review counselling processes, review the Artificial Neural Network (ANN), explore initiatives and encourage the overall concept of good practice.

Director of Professional Services Review (DPSR)

Recommendation 17: The Act be amended to give the DPSR the power to require production of documents, and the power to refer concerns about a practitioner's professional conduct to State and Territory Registration Boards.

Recommendation 18: The DPSR be able to engage case officers, including clinical practitioner advisers, to perform the detailed examination of clinical records and other tasks for the effective work-up of a case for referral to a PSRC.

Recommendation 19: The Act be amended to give the DPSR an option not to action HIC concerns, with the proviso that if the same practitioner is the subject of subsequent HIC concerns, the DPSR must action those subsequent concerns.

Recommendation 20: The Act be amended to increase the powers of the DPSR to negotiate, but not approve, suspension (full or partial) and repayment of Medicare benefits, where a PUR acknowledges inappropriate practice and negotiates a settlement.

Recommendation 21: Where a PUR acknowledges inappropriate practice and negotiates a settlement with the DPSR, the recommended settlement will not be implemented by the DPSR but instead be referred to a DP for concurrence.

Recommendation 22: The Act be amended to specify that a negotiated settlement, once implemented, is considered to be a final determination for the purposes of Section 106X of the Act.

Enhanced Legal Assistance and Processes

Recommendation 23: Legal case officers will assist the DPSR, the PSRCs and the DP. However, the same legal adviser cannot be involved in more than one stage of a case (the stages being investigation, Committee and Determining Panel).

Recommendation 24: The PSRC and PUR be permitted to bring witnesses, other than character witnesses, who would be able to be questioned, subject to the discretion of the Committee, in relation to their evidence.

Recommendation 25: The PSRCs be provided with assistance from a legal adviser who will be available to the PSRC and attend PSRC hearings, but not take part in any decisionmaking process.

Recommendation 26: Members of PSRCs receive training in natural justice and other relevant legal issues.

Recommendation 27: Comprehensive procedural guidelines and operational protocols be developed for PSRCs.

Recommendation 28: The legal adviser to the PUR be given the right to address the PSRC on legal issues during the hearing and on the merits of the case as well as matters of law in a final address.

Recommendation 29: The PUR be given a copy of the draft PSRC report and be invited to make formal written submissions.

Recommendation 30: The PSRC be required to take the submissions by the PUR into account in making its final report.

Recommendation 31: The final report of the PSRC be sent to the PUR and to the DP. The report will be sent to the DP not earlier than 28 days after it has been sent to the PUR to allow the PUR to exercise a right of appeal to the Federal Court on matters of law.

Referral of Professional Issues

Recommendation 32: The Act be amended to empower the DPSR, PSRCs and the DP to refer concerns relating to significant threats to the life or health of persons to State/Territory registration bodies, and matters relating to the practitioner's compliance with professional standards to relevant bodies.

Recommendation 33: The Act be amended to empower PSRCs to notify the HIC of matters of concern arising out of an inquiry, such as instances of doctor shopping.

Determining Panel (DP) [Determining Authority]

Recommendation 34: The position of the Determining Officer (DO) be replaced by an independent DP [Determining Authority] serviced by an expanded PSR Agency.

Recommendation 35: The DP [Determining Authority] comprise a permanent chair (medical practitioner), a permanent lay person and a third member who is a representative of the profession of the PUR, with a lawyer to assist the Panel [Determining Authority]. Members to be appointed by the Minister in consultation with the AMA or relevant bodies.

Recommendation 36: The same DP [Determining Authority] be used for all cases appropriate to the profession of the PUR with allowances being made for replacements in the event of illness or other such reasons.

Recommendation 37: The PUR be given a draft determination and be invited to make formal written submissions addressing the sanctions contained in the draft.

Recommendation 38: The DP [Determining Authority] be required to take the submissions of the PUR into account in making a final determination.

Recommendation 39: The Act be amended to provide that the Minister may, in writing, make guidelines for the DP [Determining Authority] and that decisions by the DP [Determining Authority] be consistent with these guidelines.

Revised Time Periods

Recommendation 40: All the time periods contained in the Act for procedures under the PSR Scheme be examined jointly by the AMA and the Government to see whether they are appropriately and realistically set taking into account the impact on the new PSR Agency of the proposed administrative arrangements.

Review Rights

Recommendation 41: The PSRTs be discontinued. However, review rights by the Federal Court on matters of law be maintained.

Other Matters

Recommendation 42: Details of PSRC reports and DP [Determining Authority] decisions may be published, including names of the practitioners involved, when a final determination has been made, excluding cases where a negotiated settlement has been made.

Recommendation 43: In all cases already within the PSR system on the date the revised legislation takes effect, transitional arrangements should be such as not to disadvantage the PURs in those cases.

Recommendation 44: The Government and the profession review the revised PSR Scheme no later than three years after it comes into effect.

Recommendation 45: The maintenance of adequate and contemporaneous medical records be a legislative requirement for payment of Medicare benefits from 1 November 1999. The nature of this requirement will be the subject of further discussions between the profession and the Government.

APPENDIX 2

Brochure: The Professional Services Review Scheme

The PSR Scheme authorises examination of health practitioners' conduct to ascertain whether or not they have practised inappropriately in relation to services which attract Medicare rebates or have prescribed inappropriately under the Pharmaceutical Benefits Scheme.

Inappropriate practice

'Inappropriate practice' means professional conduct that a committee of the practitioner's peers would reasonably consider unacceptable to the general body of the peer group.

Scheme participants

Health practitioners are medical and dental practitioners, optometrists, chiropractors, physiotherapists and podiatrists.

The Health Insurance Commission (HIC) administers Medicare and refers alleged cases of inappropriate practice to the Director of PSR (Director) for investigation.

The Scheme is managed by the Director of PSR who is an independent statutory officer appointed, subject to Australian Medical Association (AMA) agreement, by the Minister for Health and Aged Care.

The **Professional Services Review Panel** (PSRP) consists of medical practitioners appointed by the Minister after consultation with the AMA; and of dentists, optometrists, chiropractors, physiotherapists and podiatrists appointed by the Minister after consultation with appropriate professional organisations. From the Panel, the Minister appoints Deputy Directors, who chair the Committees.

A **Professional Services Review Committee** (PSRC) consists of a Deputy Director and generally two other Panel members from the same peer group or profession as the practitioner under review. Where the Director considers it desirable to give the Committee a wider range of clinical expertise, up to two more Panel members may be included.

The **Determining Authority** comprises a medical practitioner as Chair, a lay person and a member of the relevant profession. Members are appointed by the Minister following consultation with the appropriate profession.

A **Medicare Participation Review Committee** (MPRC) can disqualify the practitioner, against whom two adverse determinations have been made, from the Medicare program for up to five years.

The **Federal Court** can, at any stage in the process, hear applications and appeals from practitioners.

The process

Counselling: Before referral to the Director, the HIC may offer the practitioner under review counselling and the opportunity to rectify the situation before formal action is initiated.

Referral: The HIC prepares an investigative referral to the Director. A copy is sent to the practitioner, with an invitation to make a written submission to the Director within 14 days.

Investigation: The Director may appoint case officers to investigate the referral. They may enquire into services not included in the HIC's reasons for referral. The Director has the power to require documents to be produced: there are penalties for non-compliance. After an investigation, the Director may:

- dismiss a referral;
- negotiate an agreement; or
- establish a PSRC.

Dismissing a referral: The Director may dismiss a referral if satisfied that a PSRC would not make a finding of inappropriate practice.

Negotiating an agreement: The practitioner may approach the Director to negotiate a conclusion of the matter. The Determining Authority must approve any agreement for it to become effective.

Establishing a PSRC: Unless satisfied that there are insufficient grounds for a finding of inappropriate practice or unless the Determining Authority has approved a negotiated agreement, the Director must establish a PSRC.

Challenging PSRC members: The practitioner may challenge the appointment of a PSRC member on the grounds of perceived bias.

Hearings: A PSRC meets in private in State capital cities. The practitioner is given notice of the time and place of the hearing and must appear to give evidence.
A PSRC may require the practitioner or someone else to produce documents.
A legal officer may assist a PSRC.

Failure to comply: If the practitioner fails to give evidence or to produce the requested documents, a PSRC may notify the Director who will fully disqualify the practitioner from Medicare until he or she complies.

PSRC process: A PSRC must accord the practitioner natural justice, may inform itself in any manner it thinks fit, and is not bound by the rules of evidence.

Medical records: A PSRC must consider whether adequate and contemporaneous records support the practitioner's claims. A PSRC may find the practitioner's practice inappropriate despite the absence, deficiency or illegibility of medical records.

Practitioner's rights at hearings: The practitioner may address a PSRC and question any witness and may be accompanied, but not represented, by a legal or other adviser. A legal adviser may address a PSRC on points of law, and make a final address on the merits of the case. A non-legal adviser may address a PSRC and question witnesses.

Professional concerns: If the Director, a PSRC or the Determining Authority suspects a significant threat to the life or health of any person, or failure to comply with professional standards or fraudulent activity, they must report this to the relevant authority.

PSRC report: A PSRC will send a draft report to the practitioner seeking a submission on its intended findings. A PSRC must consider any responding submission before forwarding its report to the Determining Authority.

Determination: If the PSRC makes a finding of inappropriate practice against the practitioner, the Determining Authority will decide the sanction to be imposed and will prepare a draft determination, upon which the practitioner may make further submission.

The sanctions

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

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

Rights and responsibilities

Natural justice: The Scheme has safeguards to ensure the practitioner receives natural justice. At every major point in the process the practitioner is offered opportunities to make submissions.

Confidentiality: The information and evidence presented to the PSRC, its deliberations and findings remain confidential and may not be disclosed unless specifically authorised by the Act or on appeal. By contrast, the Determining Authority's decisions may be published, when effective.

Appeal rights: The practitioner may, at any stage, seek judicial review in the Federal Court.

Legal protection: Members of PSRCs, the Determining Authority and their consultants, witnesses and those appearing on behalf of practitioners are immune from civil or criminal actions.

Professional autonomy: The Scheme recognises the professional autonomy of the PSRCs in reaching findings of inappropriate practice.

Annual report: The Director's annual report to the Minister outlines the types of behaviour which led to findings of inappropriate practice and guides the professions as to their peers' understanding of inappropriate practice. The report is tabled in Parliament.

More information

Contact the Professional Services Review at PO Box 136 Yarralumla, ACT 2600 or on phone 02 6281 9100; fax 02 6281 9199; or on the Internet at www.psr.gov.au.

The **authority** for this Scheme is the *Health Insurance Act 1973* as amended. Copies of the Act can be obtained from a Government Info Shop. This is a general guide only and is not a legal document. It is published by the Professional Services Review, October 1999.

Appendix 3

Financial Statements

Australian National
Audit Office

F98/380

6 October 1999

Dr John Holmes
Director
Professional Services Review
PO Box 136
Yarralumla ACT 2600

Dear Dr Holmes

Professional Services Review
1998-99 Financial Statements

Please find enclosed the following documents:

- original set of the agency's financial statements; and
- Independent Audit Report on the financial statements.

The Independent Audit Report and a copy of the financial statements have been forwarded to the Minister for Health and Aged Care.

Yours sincerely

Puspa Dash

Puspa Dash
Senior Director

GPO Box 707 CANBERRA ACT 2601
Centenary House 19 National Circuit
BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

Australian National
Audit Office

INDEPENDENT AUDIT REPORT

To the Minister for Health and Aged Care

Scope

I have audited the financial statements of the Professional Services Review for the year ended 30 June 1999. The financial statements comprise:

- Statement by the Director and Resources Manager
- Statements of Revenues and Expenses
- Statement of Assets and Liabilities
- Statement of Cash Flows
- Schedule of Commitments
- Schedule of Contingencies; and
- Notes to and forming part of the Financial Statements.

The Director and Resources Manager are responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of the financial statements in order to express an opinion on them to you.

The audit has been conducted in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards, to provide reasonable assurance as to whether the financial statements are free of material misstatement. Audit procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian Accounting Standards, other mandatory professional reporting requirements and statutory requirements so as to present a view of the Professional Services Review which is consistent with my understanding of its financial position, its operations and its cash flows.

The audit opinion expressed in this report has been formed on the above basis.

GPO Box 707 CANBERRA ACT 2601
Centenary House 19 National Circuit
BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

Audit Opinion

In my opinion,

(i) the financial statements have been prepared in accordance with Schedule 2 of the Finance Minister's Orders; and

(ii) the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and Schedule 2 of the Finance Minister's Orders, of the financial position of the Professional Services Review as at 30 June 1999 and the results of its operations and its cash flows for the year then ended.

Australian National Audit Office

Puspa Dash
Senior Director

Delegate of the Auditor-General

Canberra
6 October 1999

Statement by the Director and Resources Manager

In our opinion, the attached financial statements give a true and fair view of the matters required by Schedule 2 to the Finance Minister's Orders made under section 63 of the *Financial Management and Accountability Act 1997.*

Dr John Holmes
Director
Professional Services Review

30 September 1999

Dean Browne
Resources Manager
Professional Services Review

30 September 1999

PROFESSIONAL SERVICES REVIEW

AGENCY STATEMENT OF REVENUES AND EXPENSES
for the year ended 30 June 1999

	Notes	**1998-99** **$**	1997-98 $
NET COST OF SERVICES			
Expenses			
Employee remuneration	2	**424,364**	472,243
Suppliers	3	**847,810**	1,107,637
Write down of assets	4	**5,242**	7,279
Net losses from asset sales	5	**-**	3,337
Depreciation and amortisation	6	**65,569**	59,931
Total expenses		**1,342,985**	1,650,427
REVENUES FROM INDEPENDENT SOURCES			
Other revenues from independent sources	12	**-**	15,700
Abnormal revenue	16	**51,685**	-
Total revenues from independent sources		**51,685**	15,700
Net cost of services	14	**1,291,300**	1,634,727
REVENUES FROM GOVERNMENT			
Appropriations used for:			
Ordinary annual services (net appropriations)	22	**1,258,496**	1,688,349
Resources received free of charge	15	**77,813**	6,200
Total revenues from government		**1,336,309**	1,694,549
Operating surplus/(deficit)		**45,009**	59,822
Accumulated results at 1 July 1998	21	**(1,465)**	(61,287)
Accumulated results at 30 June 1999	21	**43,544**	(1,465)

The accompanying notes form an integral part of these statements

PROFESSIONAL SERVICES REVIEW

AGENCY STATEMENT OF ASSETS AND LIABILITIES
as at 30 June 1999

	Notes	1998-99 $	1997-98 $
ASSETS			
FINANCIAL ASSETS			
Cash		**236**	1,000
Receivables	12	**-**	15,700
		236	16,700
Total financial assets			
NON-FINANCIAL ASSETS			
Infrastructure, plant and equipment	9,10	**89,988**	149,010
Intangibles	11	**33,051**	42,290
Other	13	**83,251**	40,770
Total non-financial assets		**206,290**	232,070
Total assets		**206,526**	248,770
PROVISIONS AND PAYABLES			
Employees	7	**162,127**	219,576
Suppliers	8	**855**	30,659
Total provisions and payables		**162,982**	250,235
Total Liabilitites		**162,982**	250,235
NET ASSETS		**43,544**	(1,465)
EQUITY			
Accumulated results		**43,544**	(1,465)
Total equity	21	**43,544**	(1,465)
Total for Liabilities and Equity		**206,526**	248,770
Current liabilities		**136,552**	151,504
Non-current liabilities		**26,430**	98,731
Current assets		**83,487**	57,470
Non-current assets		**123,039**	191,300

The accompanying notes form an integral part of these statements

PROFESSIONAL SERVICES REVIEW

AGENCY STATEMENT OF CASH FLOW
for the year ended 30 June 1999

	Notes	**1998-99** **$**	1997-98 $
OPERATING ACTIVITIES			
Cash received			
Appropriations	22	**1,258,496**	1,688,349
Total cash received		**1,258,496**	1,688,349
Cash used			
Employee		**(430,128)**	(425,534)
Other		**(826,582)**	(1,204,180)
Total cash used		**(1,256,710)**	(1,629,714)
Net Cash from operating activities	14	**1,786**	**58,635**
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**(2,550)**	(58,411)
Total cash used		**(2,550)**	(58,411)
Net cash from investing activities		**(2,550)**	(58,411)
Net increase/ (decrease) in cash held		**(764)**	224
add cash at 1 July 1998		**1,000**	776
Cash at 30 June 1999	23	**236**	1,000

The accompanying notes form an integral part of these statements

PROFESSIONAL SERVICES REVIEW

SCHEDULE OF COMMITMENTS
as at 30 June 1999

	1998-99 $	1997-98 $
BY TYPE		
OTHER COMMITMENTS		
Operating leases	**147,112**	165,070
Other Commitments	**204,438**	28,263
Net commitments	**351,550**	193,333
BY MATURITY		
All net commitments		
One year or less	**297,551**	108,514
From one to two years	**54,000**	74,853
Three to five years		9,966
Net commitments	**351,551**	193,333
Operating Lease Commitments		
One year or less	**93,113**	80,251
From one to two years	**54,000**	74,853
Three to five years	-	9,966
	147,113	165,070

SCHEDULE OF CONTINGENCIES
as at 30 June 1999

Contingent losses	-	-
Contingent gains	-	-
Net Contingencies	-	-

The accompanying notes form an integral part of these statements

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
for the year ended 30 June 1999

Note 1 - Summary of Significant Accounting Policies

The objectives of Professional Services Review are enclosed in the corporate overview.

(a) Basis of Accounting:

The financial statements are required by section 49 of *the Financial and Accountability Act 1997* (section 50 of the *Audit Act 1901)* and are a general purpose financial report. The financial statements have been prepared in accordance with *Schedule 2 to the Financial Management and Accountability (FMA) Orders* made by the Minister for Finance and Administration. Section 2 requires that financial statements be prepared in compliance with Australian Accounting Standards, Accounting Guidance Releases and Urgent Issues Group consensus views, and having regard to Statements of Accounting Concepts.

The financial statements have been prepared on an accrual basis and are in accordance with the historical cost convention, or unless otherwise stated.

The continued existence of Professional Services Review in its present form is dependent on Government policy and on continuing appropriations by Parliament.

(b) Cash:

For purposes of the statement of cash flows, cash includes cash on hand and cash equivalents which are readily convertible to cash on hand.

(c) Infrastructure, Plant and Equipment:

Property, plant and equipment are capitalised in the year of acquisition where their value is $2,000 or over, except for information technology equipment and leasehold improvements for which the minimum threshold values are $500 and $50,000 respectively.

The carrying amount of fixed assets recognised in the Statement of Departmental Assets and Liabilities reflects the remaining service potential of those assets and equates to their written down value as at 30 June 1999.

In accordance with Schedule 2, all property plant and equipment held by Professional Service Review as at 30 June 1999 were subject to valuation in accordance with the 'deprival' method of valuation, and will thereafter be revalued progressively on that basis every three years.

Note 1 (cont'd)

The financial effect of the move to progressive charges is that the carrying amounts of assets will reflect current values and that depreciation charges will reflect the current cost of the services potential consumed in each period.

All variations have been performed by officers of the Department of Health and Aged Care and have been reviewed by Australian Valuation Office.

(d) Depreciation of Infrastructure, Plant and Equipment:

All infrastructure, plant and equipment and intangibles are depreciated using the straight line method, at rates based on expected useful economic life. Leasehold improvement is depreciated over the unexpired period of the lease.

(e) Employee Entitlements:

The employee entitlements provision includes entitlements for long service leave and recreation leave. Provision for recreation leave is measured as the amount unpaid at 30 June 1999. The provision for long service leave reflects the present value of the estimated future cash flows to be made in respect of all employees at 30 June 1999. In determining the present value of the liability, Professional Services Review has taken into account attrition rates and pay increases through promotion and inflation.

No provision has been made for sick leave as the average leave taken by Professional Services Review employees is estimated to be less than sick leave annually accrued.

(f) Superannuation:

Staff of Professional Services Review contribute to the Commonwealth Superannuation Scheme and the Public Sector Superannuation Scheme. Employer contributions in relation to these schemes have been expensed in the financial statements

(g) Leases:

All operating leases are recognised in accordance with Australian Accounting Standard AAS17, 'Accounting for Leases'. Property leases are accounted for as non-cancellable operating leases.

Professional Services Review had no finance leases as at 30 June 1999.

Note 1 (cont'd)

(h) Taxation:

Professional Services Review is exempt from all forms of taxation except fringe benefits tax.

(i) Insurance:

In accordance with Commonwealth Government policy, assets are not insured and losses are expensed as they are incurred.

(j) Resources Received Free of Charge:

Resources received free of charge are recognised in the Agency Revenue and Expenses as revenue where the amounts can be reliably measured. Use of those resources is recognised in the Net Cost of Services or where there is a long term benefit an asset is recognised.

(k) Comparative Figures:

Where necessary, comparative figures have been adjusted to conform with changes in the presentation of the financial statements.

(l) Lease Incentives:

Lease incentives taking the form of rent free periods are recognised as liabilities. These liabilities are reduced by allocating lease payments between rental expense and reduction of the liability.

	1998-99 $	1997-98 $
Note 2 Employee Remuneration		
Remuneration and other employee expenses	**424,364**	472,243
Total employee remuneration	**424,364**	472,243
Note 3 Suppliers		
Supply of goods and services	**758,830**	1,003,630
Operating lease expenses	**88,978**	104,007
Total Suppliers' Expenses	**847,810**	1,107,637
Note 4 Write down of assets		
Infrastructure, plant and equipment	**5,242**	7,279
Total write down of assets	**5,242**	**7,279**
Note 5 Net losses from asset sales		
Infrasructure, plant and equipment	-	3,337
Total net losses from asset sales	**-**	**3,337**

		1998-99 $	1997-98 $
Note 6	**Depreciation and Amortisation**		
	Depreciation - infrastructure, plant & equipment	**56,330**	51,701
	Amortisation - intangible assets	**9,239**	8,230
	Total depreciation and amortisation expenses	**65,569**	59,931
Note 7	**Employee liabilities**		
	Salaries and wages	**6,273**	6,736
	Leave	**155,478**	160,125
	Superannuation	**376**	52,715
	Total employee liabilities	**162,127**	219,576
Note 8	**Suppliers**		
	Suppliers	**855**	30,659
	Total suppliers	**855**	30,659
Note 9	**Infrastructure, Plant and Equipment**		
	at historic cost	**84,802**	89,576
	accummulated depreciation	**(39,654)**	(23,643)
		45,148	65,933
	Fitout and leasehold improvements at cost	**211,798**	211,798
	accumulated depreciation	**(166,958)**	(128,721)
		44,840	83,077
	Total infrastructure, plant and equipment	**89,988**	149,010

Note 10 Analysis of Property, Plant, Equipment and Intangible Assets

Movement summary 1998-99 for all assets irrespective of valuation basis

Item	Infrastructure, Plant and Equipment $	Intangible Assets $	Total $
Gross value as at 1 July 1998	**301,374**	**60,053**	**361,427**
Additions	2,550	-	2,550
Disposals	(17,216)	-	(17,216)
Adjustments for revaluations	9,892	-	9,892
Gross value as at 30 June 1999	**296,600**	**60,053**	**356,653**
Accumulated depreciation/amortisation as at 1 July 1998	152,364	17,763	170,127
Depreciation/amortisation charge for assets held 1 July 1998	56,277	9,239	65,516
Depreciation/amortisation charge for additions	53	-	53
Adjustment for disposals	(13,465)	-	(13,465)
Adjustment for Revaluations	11,383	-	11,383
Accumulated depreciation/amortisation as at 30 June 1999	**206,612**	**27,002**	**233,614**
Net book value as at 30 June 1999	**89,988**	**33,051**	**123,039**
Net book value as at 1 July 1998	**149,010**	**42,290**	**191,300**

	1998-99 $	1997-98 $
Note 11 Intangibles		
Software at cost	**60,053**	60,053
accumulated amortisation	**(27,002)**	(17,763)
Total intangibles	**33,051**	42,290
Note 12 Receivables		
Revenues from independent sources	-	15,700
Total net receivables	-	15,700
Receivables (gross) are aged as follows:		
Overdue By:		15,700
Not overdue		
Total net receivables		15,700
Note 13 Other Non-Financial Assets		
Prepayments	**83,251**	40,770
Total other non-financial assets	**83,251**	**40,770**

	1998-99 $	1997-98 $
Note 14 Cash Flow Reconciliation		
Net Cost of Services - gain/(loss)	**(1,291,300)**	(1,634,727)
Revenue from Government	**1,336,309**	1,688,349
Operating Result	**45,009**	53,622
Depreciation and amortisation	**65,569**	59,931
Resources received free of charge	**-**	6,200
Loss on sale of assets	**-**	3,337
Increase in asset base	**-**	(1,473)
Asset revaluation	**1,491**	-
Asset write-offs	**3,751**	7,279
Changes in assets and liabilities:		
Increase (decrease) in suppliers' liability	**(29,804)**	(83,358)
Increase (decrease) in employee liabilities	**(57,449)**	46,709
Increase (decrease) in other liabilities	**-**	(758)
(Increase) decrease in receivables	**15,700**	(15,700)
(Increase) decrease in prepayments	**(42,481)**	(17,154)
Net cash provided (used) by operating activities	**1,786**	58,635
Note 15 Resources Received Free of Charge		
The following resources received free of charge from other departments and entities have been recognised in the Departmental Revenues and Expenses:		
Australian National Audit Office		
Provision of audit services	**6,200**	6,200
Department of Finance and Administration		
Comcover Premium	**71,613**	
Total Resources Received Free of Charge	**77,813**	6,200
Note 16 Abnormal Revenue		
Write back of superannuation liability	**51,685**	-
	51,685	-

	1998-99	1997-98
	$	$

Note 17 Executive Remuneration

The number of executive officers whose total fixed remuneration and performance pay, received and/or receivable for this reporting period, in excess of $100,000 is as follows:

	Number	Number
Salary range		
$150,001 to $160,000	**1**	1
	$	$
Aggregate fixed remuneration received by the officer.	**157,736**	147,413

Note 18 Appropriation for Future Reporting Periods

Appropriations relating to future reporting periods at 30 June 1999 under the 1999-00 Appropriation Bill (No. 1) totalled $3,330,000 (1997-98: $2,283,000).

Note 19 Contingencies

The Professional Service Review is not aware of any contingent gains or losses as at 30 June 1999 (1997-98: Nil).

Note 20 Average Staffing Levels

	Number	Number
Professional Services Review	**6.0**	7.0

Note 21 Equity

Item	Accumulated results $	TOTAL EQUITY $
Balance 1 July 1998	**(1,465)**	**(1,465)**
Operating result	45,009	45,009
Balance 30 June 1999	**43,544**	**43,544**

Note 22 Expenditure from Annual Appropriations

	1998-99 Actual $	1998-99 Appropriation $	1997-98 Actual $
APPROPRIATION ACT Nos 1 and 3			
Division 347 PROFESSIONAL SERVICES REVIEW SCHEME			
1. Professional Services Review Scheme	**1,258,496**	2,283,000	**1,688,349**

Note 23 Receipts and Expenditure of the Reserved Money Funds

	1998-99 Cash $	1997-98 Cash $
Reserved Money Funds		
Opening balance	**1,000**	776
Receipts		
from appropriations	**1,258,496**	1,688,349
	1,258,496	1,688,349
Expenditure		
for operations	**1,256,710**	1,629,714
for purchase of investments	**2,550**	58,411
	1,259,260	1,688,125
Closing balance	**236**	1,000

Note 24 Financial Instruments

a) Terms, conditions and accounting policies

Financial Instrument	Notes	Accounting Policies and Methods (including recognition criteria and measurement basis)	Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cash flows
Financial Assets		Financial assets are recognised when control over future economic benefits is established and the amount of the benefit can be reliably measured.	
Receivables for goods and services	12	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Collectibility of debts is reviewed at balance date. Provisions are made when collection of the debt is judged to be less rather than more likely.	All receivables are with entities external to the Commonwealth. Credit terms are net 30 days (1996-97: 30 days).
Financial liabilities		Financial liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.	
Trade Creditors	8	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).	All creditors are entities that are not part of the Commonwealth legal entity. Settlement is usually made net 30 days.

Note 24 Financial Instruments (cont'd)

b) Interest Rate Risk

Financial Instrument	Notes	Non-Interest Bearing		Total		Weighted Average Effective Interest Rate	
		98-99	97-98	**98-99**	97-98	**98-99**	97-98
						%	%
Financial Assets							
Cash		**236**	1,000	**236**	1,000	n/a	n/a
Receivables for goods and services	12	**-**	15,700	**-**	15,700	n/a	n/a
Total Financial Assets (Recognised)		**236**		**236**	16,700		
Financial Liabilities							
Trade creditors	8	**855**	30,659	**855**	30,659	n/a	n/a
Other Liabilties	9	**-**	0	**-**	0	n/a	n/a
Total Financial Liabilities (Recognised)		**855**	**30,659**	**855**	**30,659**		

APPENDIX 4

Summary Table of Resources

PROFESSIONAL SERVICES REVIEW

SUMMARY TABLE OF RESOURCES
Reconciliation of programs and appropriation elements for 1998-99

Program	Approp Bills 1 & 3 $	Approp Bills 2 & 4 $	Special Approps $	Annotated Approps $	**Program Approps** $	Less Adjustments $	**Program Outlays** $
Professional Services Review	1,258,496	-	-	-	1,258,496	-	1,258,496
TOTAL	1,258,496	-	-	-	1,258,496	-	1,258,496

NOTES:

Figures in tables and generally in the text have been rounded. Discrepancies in tables between totals and sums of components are due to rounding.

APPENDIX 5

Financial and Staffing Resources Summary

PROFESSIONAL SERVICES REVIEW

FINANCIAL AND STAFFING RESOURCES SUMMARY

	1998-99 Actual $	1998-99 Appropriation $	1997-98 Actual $
BUDGETARY (CASH) BASIS			
Components of Appropriations			
Running Costs	**1,258,496**		1,688,349
Program Costs (excluding Running Costs)	**-**	-	-
Total Outlays	**1,258,496**	-	1,688,349
Total Revenue	-		-
ACCRUAL BASIS			
Net cost of service delivery	**1,291,300**		1,650,427
Total assets	**206,526**		248,770
Total liabilities	**162,982**		250,235

	1998-99 Actual	1998-99 Actual
STAFFING		
Staff Years	**6.0**	7.0

APPENDIX 6

Freedom of Information Statement

During the year ended 30 June 1999, 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 6281 9127

Documents

The types of documents the PSR holds are:

- 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 7

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 AJ (John) Holmes was appointed Director of Professional Services Review by the then Minister for Human Services and Health (now Health and Aged Care) 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, 190 practitioners nominated by the relevant professions have been appointed as members of the Professional Services Review Panel. Two members resigned during the year. The appointments for the remaining members expire on 24 January 2000. Seventeen 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 1993–94 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. Further amendments became effective from 1 August 1999.

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 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 practised inappropriately.

The review process is based on the principle of peer review and is instigated only in instances where prior counselling of practitioners by the HIC has been offered.

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 group (i.e. general practitioner, specialist or consultant physician) in which the practitioner was practising 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:

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

The HIC prepares and refers a case for review to the Director of 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 has 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.

APPENDIX 8

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 DPSR, 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 selects a Deputy Director to chair a Committee and at least two other members from the Professional Services Review Panel who must be peers. 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 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, in its opinion, the person under review engaged in inappropriate practice in connection with the referred services.

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 Access and Financing Division of the Department of Health and Aged Care.

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 PSRC report, 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 (PSRT). 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.

Glossary

AAT	Administrative Appeals Tribunal
Act	*Health Insurance Act 1973*, as amended by the *Health Legislation (Professional Services Review) Amendment Act 1994* and subsequent amendments
AHMAC	Australian Health Ministers Advisory Council
AMA	Australian Medical Association Limited
ANAO	Australian National Audit Office
ASL	Average Staffing Level
Commission	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
COMNET	Corporate Management Network
CPSU	Commonwealth Public Sector Union
CTC	Competitive Tendering and Contracting
Determining Authority	a three person panel responsible for the determination of sanction following an adverse finding by a PSRC
Determining Officer (DO)	an officer appointed by the Minister to determine an appropriate sanction to apply where a PSRC finds that a person under review has engaged in inappropriate practice, as defined in the Act
Director (DPSR)	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 for the practitioner's services to attract Medicare benefits
DOFA	Department of Finance and Administration (Cwth)
DPSR	Director of Professional Services Review

EEO	Equal Employment Opportunity
HIC	Health Insurance Commission
Inappropriate practice	professional conduct in relation to Medicare which a committee of peers would reasonably consider would be unacceptable to the general body of the peer group (see section 82 of the Act)
ID	industrial democracy
IT	information technology
MBS	Medicare Benefits Schedule
Minister	Minister for Health and Aged Care
MoU	Memorandum of Understanding
MPRC	Medicare Participation Review Committee
MSCI	Medical Services Committee(s) of Inquiry—sometimes used broadly to include the Optometrical Services Committees of Inquiry
OH&S	Occupational Health and Safety
Panel	PSR Panel consisting of medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists nominated by the relevant professional organisations and who have been appointed by the Minister
POE	Property Operating Expenses
PSR	Professional Services Review
PSRC	Professional Services Review Committee
PSRP	Professional Services Review Panel
PSRT	Professional Services Review Tribunal
Referral	a case prepared by the HIC and referred to the DPSR, detailing the HIC's concerns and the reasons it considers a practitioner or other person has engaged in 'inappropriate practice' in the terms of section 82 of the Act
TPA	Technology Partnership Agreement

Compliance Index

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