PROFESSIONAL SERVICES REVIEW

ANNUAL REPORT
2000–01
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 seventh annual report on the Professional Services Review Scheme.

You are required to 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

[Signature]

Dr John Holmes
30 September 2001
## CONTENTS

Introduction............................................................................................................................................................................................... vi

Director's Report.................................................................................................................................................................................... 1

Case Summaries................................................................................................................................................................................... 27

Determining Authority’s Report.................................................................................................................................... 32

Determining Officer’s Report............................................................................................................................................. 34

Department of Health and Aged Care Report........................................................................................... 37

Corporate Overview...................................................................................................................................................................... 39

Appendixes

   Financial Statements................................................................................................................................................. 47
   Freedom of Information Statement........................................................................................................ 69
   Legislative Overview.................................................................................................................................................. 71
   Process........................................................................................................................................................................................... 74

Glossary.......................................................................................................................................................................................................... 85

Compliance index ............................................................................................................................................................................ 87

Index.................................................................................................................................................................................................................. 89

### Tables

1: PSR caseload...................................................................................................................................................................................... 2

2: Outcomes of PSRC hearings......................................................................................................................................... 6

3: Staffing levels................................................................................................................................................................................ 42

4: Classification levels as at 30 June 2001.................................................................................................................. 42
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 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 (the Act) 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), which administers Medicare, referring instances of suspected inappropriate practice to the Director for investigation. If the Director decides the person has a case to answer, and a negotiated settlement is not reached or not considered appropriate, 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. If a committee makes a finding of inappropriate practice against the practitioner, the Determining Authority decides the sanction(s) to be imposed from a range of sanctions detailed in the Act.

The Professional Services Review (PSR) was established as a prescribed authority to help the Director carry out the functions which are detailed in Part VAA – Professional Services Review Scheme – in the Act.

Under section 106ZQ of the Act, the Director must prepare and give to the Minister a report on the operation of the Professional Services Review Scheme during the past financial year.
The past year has been a significant one for the Professional Services Review Scheme because of a number of highly successful outcomes from the Federal Court and Professional Services Review Tribunals, including the Tankey, McFarlane, Damato and Hill cases. A summary of each of these, and other important cases, is included at pages 14–22 of this report.

However, there are still some important matters before the Federal Court. A legal challenge to one of the first referrals following the amendments to the Scheme, effective from 1 August 1999, has caused considerable delay in processing referrals. On 25 January 2001 the Federal Court in Adelaide granted an interlocutory injunction to Dr J S Pradhan restraining a PSR Committee from proceeding with its hearing on his referral which had been scheduled for early February 2001.

As a result of this Federal Court action, Senior Counsel engaged by the PSR advised that PSR Committee consideration of eight other similar adjudicative referrals should be suspended pending resolution of legal issues in the Pradhan case. The substantive Federal Court hearing in Pradhan commenced in May 2001 and is to continue in September. A fuller discussion of this case is included at pages 18–19 of this report. However, the case demonstrates that significant delays can occur in the PSR process when legal issues are raised.

An increased workload has resulted in the Agency recruiting more staff and seeking further nominations of health care practitioners to serve on the PSR Panel. The results, as herewith reported, show that there has been considerable progress in dealing with referrals.

**PSR caseload and outcomes**

There were 63 new referrals from the HIC in the past year and 42 were finalised, compared with the projected figures of 40 new referrals and 40 cases being finalised. Of the 63 new referrals, five were re-referrals of practitioners who had previously been referred to PSR.

Table 1 shows the caseload statistics for PSR since commencement of the Scheme.
Table 1: PSR caseload

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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIC referrals received by DPSR</td>
<td>1</td>
<td>16</td>
<td>70</td>
<td>48</td>
<td>11</td>
<td>50</td>
<td>63</td>
<td>259</td>
</tr>
<tr>
<td>Referrals dismissed under section 91</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>23</td>
<td>9</td>
<td>18</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Referrals dismissed under section 92</td>
<td>2300</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Withdrawn or lapsed</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSRCs established by DPSR</td>
<td>1</td>
<td>14</td>
<td>31</td>
<td>35</td>
<td>6</td>
<td>6</td>
<td>30</td>
<td>123</td>
</tr>
<tr>
<td>PSRC Reports to Determining Officer</td>
<td>8</td>
<td>20</td>
<td>23</td>
<td>20</td>
<td>7</td>
<td>6</td>
<td>84</td>
<td></td>
</tr>
</tbody>
</table>

Note: Following an audit of this caseload table, an additional row for 'withdrawn or lapsed' referrals has been added and some corrections made to the figures shown in past annual reports.

It is appropriate this year to comment separately on the cases referred under the legislation prior to 1 August 1999 and the current legislation.

Referrals prior to 1 August 1999

Prior to 1 August 1999, the Director had received 146 referrals from the HIC since PSR was established. At 30 June 2001, 21 of these referrals had not yet been finalised. Of these:

- nine cases were with PSR Committees;
- four cases were with the PSR Tribunal;
- two cases were in the Federal Court in regard to appeals against Final Determinations;
- four cases were with the Determining Officer for the setting of sanctions following adverse findings of ‘inappropriate practice’ by PSR Committees; and
- two practitioners were disqualified from the Medicare arrangements for failing to comply with legislated requirements to attend a hearing or to produce documents to a PSR Committee.

1 Two have subsequently reported to the Determining Officer since the conclusion of the reporting period.
Some of the delays in finalising these cases at the Committee stage occurred because a PSR Committee was required to cease its consideration of a referral and refer the matter back to the HIC if the evidence in the matter suggested fraud. All such effected PSR Committees are now in a position to resume their hearings. Other cases were delayed due to Court proceedings relating to procedural issues arising during hearings.

**Legislative scheme post 1 August 2001**

Since 1 August 1999, 113 referrals have been received from the HIC with 63 being received in the past year. Following investigation as required by the Act, the results in 2000–01 were:

- 30 cases were referred to PSR Committees for consideration;
- 18 cases were dismissed under section 91 of the Act as it was the opinion of the Director that it would be unlikely that a PSR Committee would make a finding of ‘inappropriate practice’;
- 16 negotiated agreements entered into, under section 92 of the Act, by the Director and the practitioner under review were ratified by the Determining Authority and then subsequently dismissed;
- 1 referral was returned to the HIC due to significant legal difficulties related to the referral and its documentation; and
- 1 referral lapsed under section 93C (2).

Five practitioners were referred to Medical Boards as, during the investigative stage, the Director formed the opinion that the conduct of the person under review ‘has caused, is causing, or is likely to cause, a significant threat to the life or health of any other person’. As none of the investigations had indicated fraud, there were no such referrals to the HIC.

**Investigative Process**

The amended legislation requires that an investigation be undertaken on each referral received from the HIC. The investigation usually involves examination of a random selection of medical records relevant to the concerns raised in the HIC referral or subsequently by our consideration of the referral documentation and any submission received from the referred practitioner.
If necessary, expert opinion is sought from a consultant or relevant professional college or professional group and further statistical information is often obtained from the HIC.

The secrecy and privacy provisions of the Act affect all people involved in this process and are made very clear to outside consultants and experts when advice is sought.

Section 91 dismissal

If, following investigation of a HIC referral, it is considered unlikely that a PSR Committee would make a finding of ‘inappropriate practice’, I am required to dismiss the referral under section 91 of the Act. In 2000–01, 18 cases were dismissed under this provision.

The major factor leading to a section 91 dismissal is the quality of the practitioner’s clinical records. The HIC medical advisers have no legal authority to examine clinical records. However, examination of a random sample of these records, carried out by my medical staff and expressly provided for in the PSR legislation, greatly assists my decision-making. The practitioner has the opportunity to make a submission setting out the particular circumstances relating to the practice. After taking these factors into account, a meeting and discussion with the practitioner is usually conducted before a referral is dismissed.

It is obvious from experience to date that the standard of medical record keeping is the most significant factor in the decision to dismiss a referral.

Section 92 negotiated agreements

My report last year noted that no section 92 agreements had been negotiated. The terms of the agreement that the referral be dismissed must include an acknowledgement by the practitioner that there has been ‘inappropriate conduct’ and the agreement can include one or more of the following:

• reprimand,
• repayment of Medicare benefits, and/or
• total or partial disqualification for up to three years.

Any such agreement must be submitted for ratification to the Determining Authority which may reject the agreement. As a section 92 agreement is regarded as an adverse finding, a second adverse finding automatically requires
referral to the Medicare Participation Review Committee. Agreements are confidential and the practitioner is not publicly identified.

As previously noted, 16 agreements have been signed over the past year following the required investigation and a subsequent negotiation with the referred practitioner. Personal face-to-face discussions have taken place, either at the practice or at another venue, with all but two practitioners. Several practitioners have had legal representation at such meetings and this has often been of value to both parties, although the discussion is usually more clinically and professionally based.

At these meetings, I have outlined the Government’s expectations in relation to funding; and the profession’s expectations from a clinical viewpoint, as regards the participation of practitioners in the Medicare program. A significant number of practitioners have advised that the referral process has caused them to review their practice and lifestyle and to make changes which have been to their personal and family’s benefit and to the benefit of their patients.

The Determining Authority considered 17 proposed agreements in 2000–01 and ratified all but one. Following the Determining Authority’s rejection of that agreement, a PSR Committee was established to consider the referral.

**Section 93 establishment of a PSRC**

When dismissal of a referral under either section 91 or section 92 is not appropriate, section 93 requires that a Professional Services Review Committee be established. Thirty PSR Committees have been set up this year. At 30 June 2001, there were 39 current PSR Committees and none has yet reported.

Following the granting of an injunction in the *Pradhan* case in the Federal Court, eight other cases have suspended their hearings on legal advice. Some of these had completed their hearings and were at the stage of preparing a draft report. Continuation of these cases is dependent on the decision in this matter.

Subsequent to that injunction, 21 further cases have had PSR Committees appointed to examine an adjudicative referral following our investigation. These cases are in the various stages of the hearing process and some are also, having completed their hearings, at the stage of preparing a draft report.

The outcomes from the PSR Committee hearings since the Scheme commenced are listed in Table 2.
Table 2: Outcomes of PSRC hearings

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSR Committee established</td>
<td>123</td>
</tr>
<tr>
<td>adverse findings</td>
<td>70</td>
</tr>
<tr>
<td>cleared</td>
<td>14</td>
</tr>
<tr>
<td>current (including 2 practitioners suspended)</td>
<td>39</td>
</tr>
</tbody>
</table>

In 70 cases a PSR Committee 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 PSR Committee hearing is in the nature of a ‘kangaroo court’ and that the referred practitioner is adjudged as guilty before a hearing even commences.

There are currently two cases where the hearing has been suspended. In both cases the practitioners’ rendered services are not eligible to attract Medicare benefits because each failed to comply with notices to give evidence or to produce documents.

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’ and ‘co-coding’;
- particular services; and
- unusual medical practice.

High volume of services

A small number of practitioners regularly claim for providing 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;
• development of a diagnosis; and
• implementation of a management plan which may involve arranging for relevant diagnostic tests (pathology and/or diagnostic imaging tests), prescribing treatment, such as drugs, referral for consultant advice or treatment and explaining the management to the patient.

All of this takes time and no step can be omitted without greatly increasing the risk of patient harm.

Seeing many patients quickly certainly may be financially rewarding for the practitioner but, if 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, PSR Committees 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.

Following the August 1999 amendments to the Act, section 106KA provides that practitioners who exceed a prescribed pattern of services will be automatically deemed to have engaged in inappropriate practice unless a PSR Committee accepts that there were exceptional circumstances. During the review of the PSR Scheme completed in early 1999 the profession endorsed this proposal.

The pattern of services is prescribed in regulations. Currently, for general practitioners, the prescribed pattern is constituted when 80 or more professional attendances are rendered on each of 20 or more days in a 12-month period. It is important to appreciate that this is not a ‘speed limit’ but a reversal of ‘onus of proof’. Servicing at a level below that prescribed pattern does not prevent a practitioner from being asked to justify their conduct in the PSR process. In the past year, 11 referrals of general practitioners have been received where the practitioner has exceeded the prescribed pattern of services. One PSR Committee has been established to deal with the first of these cases. The Committee has commenced the hearing but has not concluded its consideration.

Other concerns of this nature leading to HIC referral are related to initiation of a statistically abnormal high number of diagnostic tests in pathology and
diagnostic imaging. In 2000–01, there were nine referrals in which the HIC expressed concerns about initiation of pathology and nine referrals regarding initiation of diagnostic imaging tests.

A high volume of prescriptions under the Pharmaceutical Benefit Scheme may also lead to a HIC referral. Many of these referrals involve the prescription of addictive pharmaceuticals, such as benzodiazepines, painkillers and narcotics. In 2000–01, eight referrals expressed concern with regard to prescription of drugs. Two of these resulted in referral to the relevant Medical Board, as did another case where pharmaceutical prescribing issues were uncovered during investigation.

**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 (and ‘sicker’ with multiple pathology) 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. Enquiry by a PSR Committee often reveals a very large number of prescriptions for narcotics or benzodiazepines having been issued. In 2000–01, 18 HIC referrals have noted this as a concern requiring examination.

**Up-coding and co-coding**

‘Up-coding’ is a euphemism for claiming payment for a service attracting a higher Medicare benefit than the service actually performed. Although this could be considered 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 intent to defraud. A common example involves the claiming for suture of a ‘deep’ wound rather than a ‘superficial’ wound. Often the practitioner is unable to justify the claim made, most commonly because of a paucity of clinical records.

‘Co-coding’ describes the situation where a practitioner regularly submits claims for one or more services in the Medicare Benefits Schedule in association with another discrete service. The situation may be that the lesser service could be expected to be part of the major claimed service. Another example is the claim for provision of an unnecessary extra service in association with the appropriate service, for example, at the time of a pre-arranged minor surgical procedure.
Particular services

Experience has shown that some practitioners are submitting very high numbers of claims for investigative, diagnostic or therapeutic procedures. Questioning in the PSR Committee hearing often reveals there was no proper clinical indication for the procedure. 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, as indeed in many others, 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’. This requirement is even more important in the prevailing climate of support for Evidence Based Medicine.

Practitioners referred

The most common characteristic of 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. In the course of their hearings, PSR Committees have also come across a few instances of ‘disabled’ practitioners, mainly due to illness or substance abuse, and have referred these practitioners to the relevant Medical Board.

However, the underlying cause of many practitioners’ referral to the PSR would appear to be dishonesty, with greed as the major motivator.

Medical records

As highlighted in past Annual Reports and noted previously, the importance of a comprehensive medical record has again been demonstrated at both the investigative stage and also at PSR Committee 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 requirement of the legislation in section 82(3) of the Act that an adequate and contemporaneous record be required for any service which attracts a Medicare benefit payment.

A PSR Committee is now required to have regard to whether the practitioner has kept adequate and contemporaneous medical records in its consideration of an adjudicative referral and to take this matter into account when making decisions on whether a practitioner had engaged in inappropriate practice.

Some State and Territory Medical Boards have for the past few years issued their registrants with guidelines for the medical records required for safe professional practice. The required standard is usually stated as a record that would enable another practitioner to 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 referral has been dismissed or a PSR Committee has not made an adverse finding, the medical records have been such that they supported the practitioner's conduct.

Regulations under section 81(1) of the Act regarding ‘adequate and contemporaneous records’ have been in effect since 1 November 1999.

**Alteration of documentation**

On a number of occasions, in both the initial investigation and at PSR Committee hearings, suspicion has been raised 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 in place to enable prosecution of cases involving such fraudulent alterations. There are significant penalties on conviction of such an offence. State and Territory Medical Boards are also very concerned by such conduct and have significant penalties at their disposal.

**Professional responsibility**

A number of practitioners who worked as independent contractors or employees in medical centres or such environments have claimed that front office staff were responsible for itemisation on documentation for Medicare benefit. This defence has been accorded little weight. The practitioner alone is responsible for the accuracy of the information provided for the purposes of a Medicare claim. This responsibility cannot be abdicated.
Clinical practice is similarly the professional responsibility of the individual practitioner.

**Regulatory bodies**

The interest of the State and Territory Medical Boards in the PSR process continues. Under the current legislation, the Director, a PSR Committee and the Determining Authority now have the ability to refer significant relevant concerns to medical boards and professional regulatory bodies, and to other organisations as defined in the regulations. The concerns that would lead to a referral to a medical board are those related to ensuring the safety of the public.

The investigative process, as outlined above, which provides access to direct clinical information allows an assessment to be made as to whether there may be a concern meriting the attention of a medical board. Since the establishment of the PSR in 1994, 11 practitioners have been referred to the relevant State Medical Boards – six by a PSR Committee under the pre-1999 legislation and five by the Director in 2000–01 under the new legislation. The recent referrals related to concerns as to possible impairment of a practitioner and the dangerous prescription of drugs.

In June 2001, I attended the Annual Meeting of the Federation of Medical Licensing Authorities of Canada held in St John’s, Newfoundland. Many of these bodies, usually known as the College of Physicians and Surgeons, have similar responsibilities with respect to accountability of practitioners in the Canadian Medicare program as PSR has in Australia. The presentations and discussions generally were very relevant to the conduct of the PSR process and I gained valuable information and made interesting contacts.

I also visited the Regie de l’assurance maladie du Quebec in Quebec City. This provincial government body has responsibilities with regard to their Medicare as does the HIC and PSR. This was a most useful and fascinating day.

A very useful time was spent at an Orientation Day at Albany, NY for new members of the New York State Board of Professional Medical Conduct. While the Board does not have a professional licensing role, it does have both the regulatory responsibility for physician disciplines (as the Medical Boards in Australia) and a PSR-type responsibility for the Medicare and Medicaid programs in NY State. The size of its role can be appreciated when we consider that there are 66,000 registrants in NY State (Australia has about 44,000
medical practitioners) and it employs 40 lawyers. Observing the methods of training of new members was very valuable and will help train new members of the PSR Panel.

The major impression gained and reinforced is that the problems faced are the same all over the world and those causing problems have similar characteristics. I did note, ruefully, that these bodies all experience similar difficulties with respect to the interpretation of their legislation affecting medical practitioners in an accountability process as does Australia.

Attendance at the Third National Health Care Complaints Conference (HCCC) held in Melbourne in March also proved valuable in making and reaffirming appropriate contacts in the various State Medical Boards and Health Care Complaints Commissions. In many States the HCCCs are required to undertake the investigation and any required prosecution of complaints. Accordingly, State HCCCs manage many of the PSR referrals to the State Medical Boards.

**Australian professional organisations**

Opportunities to outline the PSR process to relevant professional organisations are gladly taken. In the past year I continued to accept invitations to address medical professional gatherings and medico-legal meetings.

I attended the Annual Scientific meeting of the Royal Australian College of General Practitioners held in Townsville in October 2000 and made a presentation on the PSR Scheme, including results and lessons learnt. Speaking engagements have included various Divisions of General Practice and meetings of the associations of ethnic medical practitioners. These include the Australian Arabic Medical Association, the Australian Chinese Medical Association, the Australian Vietnamese Medical Association and the Overseas Medical Graduates Association.

The Victorian Branch of the Australian Medical Association (AMA) invited me to attend a Council Meeting to discuss a number of complaints it had received regarding the process leading to referral to a PSR Committee. The issues behind those complaints were addressed – there was obviously considerable misunderstanding of the process and of the roles of those involved. I have also taken the opportunity to meet with representatives and officials of other State Branches of the AMA during the year.
I have found these activities to be extremely worthwhile, eliciting an interest in, and an appreciation of the rationale for the PSR Scheme. After a full explanation is given and questions addressed, strong professional support is evident.

Once again I accepted an invitation to give a lecture to the students of the graduate medical course at the Medical School of the University of Queensland. The lecture was on accountability processes and requirements of professional medical practice. The lecture provoked interesting questions and discussions. It is hoped to expand this activity to other medical schools.

**Workshop for Deputy Directors**

The Deputy Directors who chair PSR Committees met in Canberra in March 2001 to review the past year’s activities and to consider the conduct of hearings in the light of the significant changes made by the 1999 amendments to the Act. With increased legal involvement in the Scheme, a major focus again was on the legal issues which lawyers may raise in hearings and which the Chair of the PSR Committee needs to address. Ms Felicity Hampel, QC of the Victorian Bar, who was the facilitator and lead trainer in the workshops held for panel members in 1999, led extensive discussions on the role of the Deputy Directors.

On a lighter note, Dr John Deeble AO gave a most interesting address at the workshop dinner. Dr Deeble spoke about the development of the Medicare concept and the early days of its establishment. He also shared his thoughts on future developments in health care in Australia.

These workshops are most important in ensuring uniform standards and maintenance of procedural fairness across all PSR Committees, regardless of the State in which they are held.

As in previous years, I continue to be impressed by the commitment shown by the Deputy Directors who fully understand both the community and professional responsibilities involved in their difficult roles.

**Training of Panel Members**

As a result of workshops conducted in late 1999 (see Annual Report 1999–2000, pp. 2–3) PSR Committee members and legal advisers to the Committees have reported an improvement in hearing technique and a reduction in situations
and remarks which could lead to potential legal problems in the event of subsequent legal review of the conduct of the Committee process.

Further training is planned for later in 2001 and will focus on preparation of reports and reason statements as well as refining the hearing process and management. The response from Panel members has been enthusiastic. Members are aware of the importance of conducting the hearing and writing the report in a way that, in any future legal review by a Judge of the Federal Court, the reasons for the PSR Committee reaching its conclusion are clearly expressed.

A significant part of the training is focused on the requirements of procedural fairness (natural justice) and this is the overriding principle during the conduct of the whole of the PSR process.

**PSR Tribunal and Federal Court reviews**

In the past year PSR has had an interest in a number of cases in Professional Services Review Tribunals and/or the Federal Court. A brief discussion of each is below.

**Dr Marie Alexander, medical practitioner of Prospect, South Australia**

As detailed in the court documents, the HIC referred Dr Alexander to PSR in June 1996. A PSR Committee reported that she had engaged in inappropriate practice. The Determining Officer directed that she repay $46,467.12. The HIC eventually commenced action in the District Court of South Australia for recovery of this sum. Dr Alexander then requested review of the Determination by the PSR Tribunal, which was refused on time grounds. She applied to the Federal Court for review of this refusal.

The matter was ultimately resolved with a substantial payment by Dr Alexander and discontinuance of both the Federal and District Court actions.

**Dr Michael Christie, general practitioner of Chatswood, New South Wales**

Dr Christie was referred to PSR in December 1996 in relation to suspected inappropriate practice. A PSR Committee investigated and reported. The Determining Officer directed that Dr Christie be reprimanded.

Dr Christie requested review by the PSR Tribunal. At the beginning of the hearing, Dr Christie sought to withdraw his application. Separately, the Determining Officer submitted that the request for review had been out of
time. The Tribunal ultimately held that the request for review could not be withdrawn on the basis that the legislation did not specifically address withdrawal and, in the Tribunal’s view, the Determination would, therefore, never come into effect. The Tribunal also held it could not receive the relevant evidence that the application was out of time and that it should proceed on the basis of jurisdiction established by the Minister’s request. Any challenge to this should be in curial proceedings.

Dr Christie appealed to the Federal Court regarding the Tribunal decision on withdrawal of his request for review.\(^2\)

**Dr John Grey, general practitioner of Frankston, Victoria**

In November 2000, Dr Grey applied to the Federal Court for review of a ‘decision’ comprising a draft report by a PSR Committee that Dr Grey’s conduct in connection with rendering services referred by the HIC was, in the Committee’s opinion, unacceptable to the general body of general practitioners practising in general medical practice in Australia. The grounds for Dr Grey’s application were, amongst other things, breach of natural justice, apprehended bias, improper exercise of power, lack of jurisdiction, the Committee hearing was unconstitutional, and involved improper or unreasonable exercise of power. Dr Grey sought various permanent remedies, including quashing of the decision, declarations that the Committee hearing was null and void and that the referral was void, and injunctions to restrain further action in relation to the referral. He also sought interim orders to stop any further action on the referral.

In the course of the hearing it emerged that the HIC had referred Dr Grey because it believed the appropriate level of clinical input could not be maintained at Dr Grey’s high servicing rate, and the principal finding in the draft report was that Dr Grey had engaged in inappropriate practice in connection with the rendering of some of the services that were the subject of referral.

The Court heard the matter on 24 May 2001 and has not yet handed down its decision.

\(^2\) The hearing was on 9 August 2001. As at the date of finalising this report, no decision had been handed down.
Dr Wilvene Hill, general practitioner of Ringwood, Victoria

Dr Hill was referred to PSR in August 1997 on account of her high overall volume of services, her high average number of services to certain patients and high use of skin sensitivity testing. A PSR Committee investigated.

In the course of the Committee hearings the Chair notified the Director that Dr Hill had failed to comply with a notice to appear at the hearing and give evidence to the Committee. The Director accordingly fully disqualified Dr Hill under the Act. She appealed to the Federal Court which ordered that the disqualification be set aside. It construed the Act as requiring her to appear at the hearing and give some sort of answer to questions, but not necessarily a responsive or meaningful answer [Hill v Holmes [1999] FCA 760].

The PSR Committee reported that Dr Hill had engaged in inappropriate practice on account of her extraordinary number of services, especially home visits, rendered to a narrow group of patients; her failure to maintain accessible records of relevant services; and her apparent inability to recollect any relevant clinical information about her patients. The Committee also referred aspects of her conduct to the Medical Practitioners Board of Victoria.

The Determining Officer directed that Dr Hill be counselled, reprimanded and fully disqualified from the Medicare arrangements for 18 months.\(^3\)

Dr Jessica Ho, general practitioner of Springvale South, Victoria

Dr Ho was referred to PSR in April 1997 on account of her high overall volume of services. A PSR Committee investigated and noted, inter alia, that Dr Ho had rendered 19,749 services during the year of referral at a cost in Medicare benefits of $420,243.90. It concluded that Dr Ho had consistently rendered brief consultations with questionable clinical input, her rendering of acupuncture was unacceptable, her procedures for storing vaccines at proper temperatures were inadequate, her knowledge about restricted pharmaceutical benefits was inadequate, her care of patients with chronic conditions was sometimes inadequate, her management of some conditions and treatment of some patients was inappropriate, and some treatment was episodic without adequate continuity of care. It noted she had taken action to improve her practice (steriliser and records).

\(^3\) On 3 July 2001 the PSR Tribunal affirmed the Determination. Dr Hill has appealed to the Federal Court.
The Committee found Dr Ho had engaged in inappropriate practice during the referral period in respect of all acupuncture (item 173) services, certain specified consultations, and all item 30026, 30032, 30117 and 30219 services (which require sterilised surgical equipment).

The Determining Officer directed that Dr Ho be reprimanded and counselled, and that she repay Medicare benefits totalling $4,104.85. Dr Ho sought review by a PSR Tribunal which felt the Committee finding in regard to acupuncture procedures could not be supported in the absence of standards and registration or accreditation requirements for acupuncture practitioners. It otherwise broadly agreed with the Committee’s findings. The Tribunal varied the determination by reducing the Medicare repayments to $1,761.70.

**Dr Jean McFarlane, general practitioner of West Chermside, Queensland**

Dr McFarlane was referred to PSR in 1994 on account of the substantial amounts of very similar pathology tests she was ordering. A PSR Committee investigated and reported that she had engaged in inappropriate practice in that she failed to conform with accepted standards of clinical practice in respect of clinical histories, system examinations, adequate records, investigations, prescribing, medical education and pathology investigations. Her views regarding aetiology of disease were unacceptable and she lacked insight into her failure to conform to accepted medical standards. The Determining Officer directed that she be counselled, be disqualified from the Medicare arrangements in respect of specified pathology items for 12 months, and be fully disqualified for six months. The PSR Committee also recommended that she be referred to the Medical Board of Queensland. The PSR Tribunal upheld the Determination.

On 10 November 2000 the Federal Court dismissed her appeal [McFarlane v Batman [2000] FCA 1663]. The Tribunal was not exercising the judicial power of the Commonwealth. Her assertions that the earlier review bodies took a wrong view of the facts in coming to adverse conclusions did not amount to error of law. Her argument that the Committee members were inappropriately qualified to assess her professional conduct did not raise an error of law such as to invalidate the Tribunal decision.

On 23 February 2001 the Full Federal Court dismissed her further appeal [McFarlane v Batman [2001] FCA 107]. No failure of procedural fairness was evident. Examination of individual services was necessary only to the extent necessary to determine whether conduct amounted to ‘inappropriate practice’.
Dr Miguelito Mercado, general practitioner of Essendon, Victoria

As reported in the 1999–2000 Annual Report (pp. 16–17), the Commonwealth parties appealed to the Full Federal Court regarding the issue of bias. The Full Court unanimously reversed the first instance finding. After noting the PSR Committee’s assurances to Dr Mercado that it would not take the disputed counselling report into account, the Full Court said:

The argument put on behalf of Dr Mercado requires the Court to disregard or discount these assurances. The argument has to be, and is, that a fair-minded and informed observer would reasonably have such doubts about the willingness or ability of a lay (as distinct from a legally-trained) tribunal to honour these assurances as to continue to harbour apprehension of bias. We see no basis for that view. The committee comprises three members of the Professional Services Review Panel. Members of the Panel are appointed by the Minister after consultation with the Australian Medical Association (AMA); see s 84(3) of the Act. The committee’s chairman is a Deputy Director of Professional Services Review appointed in consultation with the AMA: see s 95(1)(a) and (2). The three members were required to be, and no doubt were, medical practitioners during the review period. We see no reason to doubt that such people are as capable as lawyers of understanding the concept of putting out of their minds an irrelevant matter, when reaching conclusions on a matter of grave importance to a practitioner, and of doing so.

Dr Jagjit Pradhan, ophthalmologist of Adelaide, South Australia

In January 2001 Dr Pradhan applied to the Federal Court for review of decisions of the Director and of a PSR Committee in relation to the Director's decision to establish that Committee and make an adjudicative referral to it, and various actions or omissions of the Committee preparatory to its hearing of the matter. Orders and declarations were sought which would stop the Committee proceeding, at least until certain particulars were provided.

A preliminary hearing was held on 25 January 2001 at which the court was informed that the HIC had made an investigative referral to PSR because the HIC was concerned that Dr Pradhan might not be able to maintain an appropriate level of clinical input whilst consistently rendering a high volume of services (around 17,000) on a regular and continuing basis, and that his high average number of services per patient meant some of the services rendered by Dr Pradhan might not be reasonably medically necessary for the care of his patients. Dr Pradhan complained that the adjudicative referral did not reflect these concerns, but new ones.
The substantive hearing (before a different judge) commenced in May 2001 and will continue in September. At this stage it appears that the main issues will be the extent to which conduct relevant to possible inappropriate practice must be particularised in the investigative and adjudicative referrals and whether such particularisation (along with the scope of any prior counselling by the HIC) limits the scope of the Director's and the Committee's investigations.

**Dr James Tankey, general practitioner of Ipswich, Queensland**

Dr Tankey was referred to PSR in July 1995 on account of his very high volume of Medicare services. The HIC stated that he rendered 27,048 services during 1994 at a cost to Medicare of $580,576. The HIC doubted whether the appropriate level of clinical input could be maintained. It also queried the medical necessity for his initiations of pathology and diagnostic imaging services, and the medical appropriateness of his referrals to specialists.

A PSR Committee investigated and reported that Dr Tankey, having developed a consistent pattern of extremely high and rapid throughput of patients, had abdicated from the professional responsibility required of allocating an appropriate time to elucidate and address patients’ health problems, and to record a proper medical history. The consistently high throughput inevitably led to a lack of time to address the relevance of investigations, both of pathology and diagnostic imaging, and to allow proper professional transfer of medical information to specialist colleagues.

The Determining Officer directed that Dr Tankey be counselled, that he repay Medicare benefits totalling $258,277.45, that he be fully disqualified from Medicare for six months and that he be disqualified in respect of certain items for 12 months.

Dr Tankey requested review by a PSR Tribunal which increased the repayments to $580,576.00 and otherwise affirmed the original Determination.

Dr Tankey appealed to the Federal Court on nine questions of law. The court restored the original Determination. Dr Tankey appealed to the Full Federal Court.

The full bench of the Federal Court (handed down on 10 August 2000) unanimously found for the Commonwealth on every ground of appeal. In particular it held that the PSR process was constitutionally valid, it upheld the peer review process and considered that peer assessment would generally be
reliable. It said the case against Dr Tankey was quite overwhelming and it would defy commonsense to suggest that the strength of the evidence may not be taken into account.

The Court applied the High Court view that reasons given by statutory decision-makers should not be overzealously scrutinised for legal errors, it said that testimonials and patient surveys were of little weight in a peer review of professional conduct and, importantly, it held the process was procedurally fair. In this regard the PSR Committee had identified and particularised matters of concern which came to its attention during the proceedings, communicated these to Dr Tankey, and invited him to make submissions on them. The Committee had provided a comprehensive list of the adverse matters and Dr Tankey had made no complaint about lack of particulars until the matter first went to court.

Dr Peter Tisdall, general practitioner of Kyabram, Victoria

In November 2000, after receiving a draft PSR Committee report, Dr Tisdall applied to the Federal Court for various interim and permanent orders to, in effect, set aside PSR proceedings. The grounds included breach of natural justice, apprehended bias, and lack of jurisdiction in the Committee.

The court was informed that Dr Tisdall was referred by the HIC to PSR in September 1997 on account of his high total volume of services, high services per patient, and high prescribing which may be inappropriate, contain insufficient clinical input or may not be reasonably necessary for the care of his patients. There was concern about the professional quality of services he rendered and initiated.

After investigation, the Committee had invited Dr Tisdall to comment on its draft findings, inter alia, that his management of specific problems was clinically inadequate, his records were seriously deficient in important, often critical information, particularly clinical findings, and he was unable to provide the Committee with details of many services the Committee examined.

The court declined to grant the interim orders. The PSR process provided further opportunities for Dr Tisdall to seek correction or review of issues which concerned him, particularly the opportunity to comment on the draft Committee report, future opportunity to comment on a draft Determination, and the option of review by a PSR Tribunal. The Committee undertook to
allow Dr Tisdall additional time to put his case before settling the report. The court adjourned the matter indefinitely so Dr Tisdall could reactivate his application at a later stage if he was still concerned.

Dr Malcolm Traill, general practitioner of Kingsbury, Victoria

Dr Traill was referred to PSR in March 1997 on account of his very high volume of Medicare services. A PSR Committee investigated and reported that his clinical input, patient management and medical records were inadequate; his assessment of patients as ‘transients’ was a device to justify that conduct; his use of lithium to treat hepatitis, multiple sclerosis and cancer was experimental and unethical.

The Determining Officer directed that Dr Traill be reprimanded and counselled, that he repay certain Medicare benefits, that he be disqualified from Medicare in respect of general practitioner consultation items for three years, and that he be fully disqualified for two years. On 28 May 2001 a PSR Tribunal affirmed the Determination. Dr Traill has appealed to the Federal Court.

Dr Nayagampillay Yohendran, general practitioner of Leichhardt, New South Wales

Dr Yohendran was referred to PSR in November 1997 on account of his very high volume of Medicare services, high rates of initiation of pathology and diagnostic imaging, and high rendering of item 11709 (continuous ECG – Holter monitor) and 11712 (stress ECG) services. He had provided 15,247 services during the 12-month referral period at a cost in Medicare benefits of $438,079.30. Flow-on costs of initiated pathology, diagnostic imaging and specialist services totalled $376,263.

A PSR Committee investigated and reported, on the basis of statistical sampling, that Dr Yohendran had engaged in inappropriate practice in connection with rendering or initiating between (variously) 64 per cent and 90 per cent of items 23, 36, 11709, 11712 and diagnostic imaging services. The Determining Officer directed that he be reprimanded, counselled, repay Medicare benefits totalling $118,921.45, be partially disqualified from Medicare for 12 months in respect of certain services, and be fully disqualified for six months.
Dr Yohendran requested review by a PSR Tribunal, which heard the matter on 21–22 May 2001. The Tribunal’s decision is awaited.

Formal counselling

One of the sanctions available for inclusion in a determination is that the Director or his nominee is to counsel the practitioner. I carried out eight formal counselling sessions throughout the year. 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 counselling has been received. I usually have a Deputy Director or other Panel member accompany me at these meetings and they have expressed similar impressions about the value of counselling.

Following most counselling sessions, 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 PSR Committee. Nonetheless, I am aware that some practitioners will not learn from this experience. The effect of such a second finding, with mandatory referral to a Medicare Participation Review Committee, is stressed at counselling sessions.

Advice to practitioners

Based on the experience of seven years of the PSR Scheme, I repeat 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. My advice remains basically as given in all previous reports although the emphasis has been altered:

- **Keep good records.** They are a vital element in any defence in a justification proceeding. This is now an essential element of practice under the amended legislation and a requirement of many of the Medical Boards.
- **Listen to the HIC Medical Adviser.** Visits by a HIC medical adviser raising perceived concerns 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

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4 On 28 August 2001, the Tribunal set aside the determination of the Determining Officer and made a similar determination except that the repayment was varied to $116,162. The statistical methodology was supported.
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 and professional associations and colleagues are only too pleased to offer guidance. However, advice can only be relevant if they know all the facts.

- **Accept your personal responsibilities.** A number of practitioners have come to PSR notice due to inappropriate delegation of responsibility for professional and practice management decisions to others – colleagues, employers, management or staff. This defence has not been accepted.

**Publicity**

In previous years publication of the names of those subject to an adverse finding by a PSR Committee was not permitted unless the practitioner had requested review in a public forum, namely, the PSR Tribunal or the Federal Court. The post August 1999 legislative scheme allows the Director to publish the details of reports and determinations made following a Committee finding of inappropriate practice. In the case of a section 92 agreement, the name of the practitioner remains confidential.

It is considered the possibility of such publicity will have a significant deterrent effect on many practitioners.

**PSR Panel**

In January the Minister reappointed to the Panel most of the members whose terms were to expire. Many have been on the Panel since it was first established. Of course, a number of members resigned or did not seek reappointment due to retirement from practice or for personal reasons.

Advice has again been sought from various medical organisations and craft groups for nominations of practitioners considered by those groups to be appropriate persons to sit in judgment on peers called to account for their activities. Over the past year the Minister has made a number of new appointments to the Panel.
With the increase in the number of cases requiring consideration by a PSR Committee, it is necessary to continue to seek nominations of suitable practitioners to the Panel. This is a continuing process and, as the Act requires the Minister to consult with the AMA, relevant associations and Colleges, the appointment process takes time.

At 30 June 2001, the Panel comprised 19 Deputy Directors and 164 members.

**PSR Committees**

I acknowledge with gratitude the contribution and commitment of Committee members. This difficult and onerous task can be stressful on the member and demanding on time. All members who have served in this role have carried out their duties responsibly, carefully and with consideration for the colleague whose conduct they are required to consider.

A special thank you must be made to the Deputy Directors whose role it is to chair the Committees, coordinate and manage the hearing process and manage preparation of the report to the Determining Officer or Determining Authority, as appropriate. All have carried out these responsibilities effectively. Under the post 1999 legislation, they now have increased responsibilities.

**PSR staff**

It is most distressing to record the sudden death in late June of Paul Willems, a most valuable PSR staff member since 1997. Paul had a long association with the Department of Health (1966–96) and had extraordinary knowledge of the Medicare scheme and the Medicare Benefits arrangements. Whilst with the Department of Health, Paul had been part of the team which devised the PSR Scheme. Paul enjoyed the role of Secretary to PSR Committees and they, in turn, appreciated his professionalism and extensive knowledge of the scheme. His writing skills were well recognised by his colleagues. As Director I will miss Paul, his corporate knowledge and his exceptional advice and loyalty. His colleagues share this feeling of loss.

Because of the increasing caseload, recruitment has been undertaken for personnel in both the investigative and secretariat roles. Those who have joined PSR have settled in well.

I again thank my staff for the competent manner in which they provided the investigative, secretariat and corporate 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.

Medical and professional support

The PSR’s organisational structure has provision for two full-time positions, one of which has been filled throughout the year. The services of several experienced part-time medical practitioners have been used to examine medical records in the investigative process. Advice has also been sought from consultants on particular issues and these have included both medical and optometrical practitioners.

Legal support

Operating in a legalistic environment it is essential to have access to, and confidence in, first-class legal advice. Minter Ellison Lawyers have provided PSR’s legal support, including the provision of a lawyer full-time in the PSR office with some part-time assistance. This outsourcing has proved most successful. I am pleased with the efforts of the legal personnel who have appeared on behalf of the PSR before Tribunals and in the Federal Court.

Statistical sampling

I thank Professor Des Nicholls, Head of the Department of Statistics and Econometrics at the Australian National University for his continued advice in relation to appropriate sampling methodologies.

Conclusion

The past year has seen a significant increase in workload (the number of cases referred, hearings held, appeals to PSR Tribunals and the Federal Court, including a major legal challenge to the Scheme). There has also been a significant change in approach with the new investigative process leading to a more focused adjudicative referral to a PSR Committee.

In the professional arena, the PSR Scheme continues to have very strong support, especially from those who have had some involvement. I am pleased to record once again that no member of the Panel who has served on a PSR Committee has raised any concern as to the fairness, balance and
professionalism given by colleagues to this difficult task. Full explanation of the Scheme to professional groups always evinces support for the PSR process.

While I have never underestimated the challenges in establishing and maintaining a fair and effective professional peer review scheme, I believe that the efforts in putting such a scheme in place have the support and encouragement of the Parliament, the general public and the vast majority in the health professions. I am confident that, with the continued cooperation of the relevant professions, we will be able to address, and hopefully change, the professional conduct of those few people who practise in ways that their peers are unable to support. There is an obvious requirement for an effective efficient accountability process in any funding system.

I believe the Scheme will continue to contribute to ensuring the Australian public receives the quality professional health care it deserves.

Dr John Holmes
Director
Professional Services Review
28 September 2001
Case A

This general practitioner migrated to Australia where he graduated and began working in various hospitals before returning overseas to work in the pharmaceutical industry. Following return to Australia, the practitioner established a general practice in a large metropolitan city.

The practitioner was referred by the HIC for his high volume of rendered services. The practitioner had rendered in excess of 19,000 services in a 12-month period, substantially above the 99th percentile for all general practitioners in Australia. The HIC was concerned that the practitioner may not have been able to provide the appropriate level of clinical input while maintaining such a high volume of services.

It was maintained that the practitioner was forced to see such high numbers of patients because of cultural pressures placed upon him by his community.

During the hearing process, the PSR Committee believed that the material before it indicated that the practitioner might have committed an offence to which section 106N of the Act applied and had referred the matter to the HIC for investigation. Twenty-one months later, the Director of Public Prosecutions returned the matter to the Committee after it decided not to proceed with a prosecution.

Following the Committee’s review of around 200 patient files, it found that the practitioner’s level of clinical input was unsatisfactory for the services he had rendered and that in each case the high volume of services rendered was a contributing factor to the unsatisfactory level of clinical input. The Committee considered that there was a consistent pattern of unacceptable conduct in the management of the cases discussed and had no reason to believe that the practitioner’s patient population as a whole would have been dealt with any better than the sample examined. It was clear that the concentration was on the patient’s presenting symptom rather than on whole patient care.
Case B
A psychiatrist was referred by the HIC with concerns regarding inappropriate practice due to the high volume of services rendered on a daily basis. The items used by psychiatrists are time based and approximately 1000 patients had received 6700 services for a Medicare payment of nearly $500,000.

The medical records examined were of a poor standard and did not show an objective assessment of the patient, patient progress or drugs and response to treatment. Given the high daily patient load with approximately 45 patients per day and minimum consultation time of between 12 and 16 hours, the PSR Committee (including two psychiatrists) concluded that this practice would be unacceptable to the general body of psychiatrists.

Case C
Practising in a large city this practitioner attracted the concern of the HIC due to the high number of services rendered in a year and the high daily workload. Eighty services or more were rendered on 74 days with more than 100 on 11 days. The practitioner claimed the ability to work long hours at high efficiency and also that he had a significant group of ethnic patients with particular requirements.

The PSR Committee examined several groups of services and concluded that the evidence at its hearing did not support the claims for the longer (Level C) consultations and the practitioner was practising inappropriately with respect to acupuncture services. It noted significant problems with the standard of record keeping and many of the records examined could not support the Medicare Benefits Schedule item claimed.

The Determining Officer directed that the practitioner be reprimanded and counselled, repay approximately $12,000 and be disqualified from the acupuncture services for 12 months. It is worth noting that the practitioner at the formal counselling accepted the findings of the Committee, advised that this process had caused him to review his practice and accepted it had been a valuable learning experience.
Case D

This solo practitioner was situated in an inner suburban lower socioeconomic area and came to the attention of the HIC for the high volume of services (16,000 in a year), a high number of home visits and the prescribing of benzodiazepines under the Pharmaceutical Benefits Scheme. The doctor worked long hours seven days per week and, speaking several languages, had a significant ethnic-based patient population.

Investigation of the medical records revealed deficiencies – they did not always substantiate the prescribing or the service claimed. The extent of the inappropriate practice was such that it was considered a section 92 agreement could be reached and the practitioner signed such an agreement. Following a personal discussion with the practitioner, it was considered that he was providing an acceptable service but had allowed heavy patient demand to influence his management of individual patients. The practitioner accepted that the records required improvement and such improvement would both allow him to more easily justify his professional conduct and also to more critically reflect on the management of each patient.

The agreement was ratified by the Determining Authority and required an acknowledgement of inappropriate practice, repayment of $25,000 and disqualification from the general practitioner items in the Medicare Benefits Schedule for three months.

Case E

This referral from the HIC involved an older practitioner, working in a medical centre in an outer metropolitan area, who was referred due to concerns regarding prescribing of various drugs, especially benzodiazepines and narcotics. Investigation revealed that in the areas of concern there were two distinct groups of patients – a younger group receiving most of the benzodiazepines and narcotics; and an older group with a range of degenerative diseases.

The clinical notes examined from the practice were generally of reasonable standard although those of the referred practitioner were very poor. They showed evidence of significant misuse of antibiotics, narcotics and benzodiazepines. The concern was such that those concerns were referred to the State Medical Board. The impression gained was that the practitioner lacked up-to-date knowledge of general practice having practised as a specialist in other than general practice for a working lifetime.
Following discussions, the doctor signed a section 92 agreement, acknowledging the inappropriate practice and agreeing to full disqualification from Medicare for a period of three years. The Determining Authority ratified this agreement.

Case F

This vocationally registered practitioner had been working for about five years as a solo practitioner in a large country town and operated an extended hours practice, seven days a week.

During the referral period, the practitioner rendered 19,000 services to 8000 patients. This was significantly more than 99 per cent of all vocationally registered general practitioners in Australia during the referral period. Eighteen thousand of these services were surgery consultation, with over 17,000 being Level B consultations. The practitioner also rendered 885 Level C consultations and 43 Level D consultations.

The PSR Committee found a high level of inappropriate practice in relation to the Level C and Level D consultations. This was primarily because, in the Committee’s opinion, the practitioner frequently charged for a level of service greater than that necessary to treat the presenting complaint, and a competent general practitioner would not have taken the time claimed to provide the service.

Following its examination of the practitioner’s appointment books, the Committee was also concerned that a significant number of Level B consultations appeared to have been claimed for patients who received massages at the practitioner’s surgery on the same day. The Committee identified over 1000 such services and it was evident that the practitioner invariably rendered a Level B consultation for all patients attending for massages. This gave rise to a concern that the practitioner may have been subsidising the cost of providing massages through the attendant Level B consultations claimed against Medicare.

The practitioner told the Committee that the main purpose of the Level B consultations was to assess the effects of the massages. The Committee was unconvinced that an assessment immediately after a massage could provide meaningful information about its clinical benefits, and found over half these services to be inappropriate. The Committee reached this finding where there was little or no other clinical input by the practitioner apparent in the medical records.
Case G

This recently graduated practitioner, who worked in a Men’s Health Clinic, was referred by the HIC for concerns relating to high number of long and prolonged (Level C and D) consultations and high number of claims for Medicare Benefits Schedule item 11603 (ultrasound of peripheral vessels). The HIC noted also that there was a strong association of claims for prolonged consultations with procedural items.

The Committee considered the practitioner was practising inappropriately with respect to the ultrasound investigations due to a lack of proper training and continuing education in a specialised area and an inferior knowledge of current treatment of patients with erectile disorders. This caused unnecessary alarm to patients in suggesting they had significant disease. Evidence that the results of the ultrasound study were not taken into account in clinical management led to a conclusion that it was an unnecessary and costly test.

Another finding of the Committee was that the claims for prolonged consultations involved inappropriate practice. The practitioner claimed that office staff were responsible for completing the Medicare vouchers. The Committee did not accept this defence.

The Final Determination of the Determining Officer required a repayment of some $50,000 and disqualification from Medicare for three months.
DETERMINING AUTHORITY’S REPORT

Overview

The Determining Authority is an independent body within the PSR Scheme established by section 106Q of the Act.

The Determining Authority has two roles:

• to determine the level of sanctions to apply when a Committee has found a practitioner to have engaged in inappropriate practice and to express those decisions in formal determinations; and

• to decide whether or not to ratify agreements reached between the Director and a person under review on the level of sanctions to apply when both parties agree that inappropriate practice has occurred.

The Determining Authority comprises a permanent Chairman, who must be a medical practitioner, a permanent lay person and a person from the profession to which the person under review belongs, that is, medicine, dentistry, optometry, physiotherapy, chiropractic or podiatry.

Under revised arrangements authorised by the Health Insurance Amendment (Professional Services Review) Act 1999, the Determining Authority took over the role of the Determining Officer in respect of all cases referred by the HIC after August 1999.5

In making a determination, the Determining Authority is required to apply one or more of the directions specified in section 106U of the Act. These include:

• reprimand by the Director or his nominee;

• counselling by the Director 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.

5 The Determining Officer continues to be responsible for cases referred before the relevant provisions of the amending legislation came into effect in August 1999.
In ratifying agreements, the same range of sanctions applies, except that the counselling sanction is omitted.

**Determinations**

The Determining Authority did not receive any reports from Professional Services Review Committees and therefore no determinations were issued.

**Ratifications**

During the year, the Determining Authority received 17 agreements entered into by the Director and the person under review for ratification. It ratified 16 of those agreements, which included sanctions of reprimand, repayment of Medicare benefits and, in one case, three years disqualification from Medicare. It refused to ratify one on the grounds that the agreed sanction was inadequate and that further investigation into the doctor’s practice, possibly by a PSR Committee, was warranted.
DETERMINING OFFICER’S REPORT

Overview

Under the Professional Services Review Scheme the Determining Officer makes determinations in respect of practitioners who have been found by Committees of their peers to have engaged in inappropriate practice.

The Determining Officer’s role applies to all cases referred to the Director of Professional Services Review by the HIC before 1 August 1999. For cases referred after that date the Determining Officer’s role has been taken over by the Determining Authority.

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 Professional Services Review Tribunals.

Determinations

During the year, six reports were received from PSR Committees, five of which contained findings that the person under review had engaged in inappropriate practice. In the remaining case, the Committee was unable to make a finding as to whether or not the person under review had engaged in inappropriate practice. Eight draft determinations and 12 final determinations were issued. The recipients of seven final determinations accepted those determinations without seeking any further review. Sanctions in respect of these determinations include repayment of $118,880.10.
Professional Services Review Tribunal Decisions

Practitioners in respect of whom the Determining Officer has made a final determination may ask the Minister for Health and Aged Care to refer the determination to a Tribunal for review. A Tribunal comprises a President, who is a former judicial office holder, and two members of the same profession as the person under review. Proceedings before a Tribunal are conducted with as little formality and legal technicality as a proper consideration of the matter permits. Unlike proceedings before PSR Committees, the person under review may be legally represented.

In 2000–01 the Minister received requests from four practitioners who sought a review of their final determinations and two requests for review in the previous year were outstanding. The Tribunal held hearings in respect of five practitioners. Of the three cases in which the Tribunal handed down its decisions, in one case the Tribunal set aside the final determination and made its determination in lieu, which included repayment of $1,761.70. In another, the Tribunal affirmed the final determination made by the Determining Officer. In the remaining case heard by the Tribunal, it decided to adjourn the hearing to a date to be fixed.

At 30 June 2001 a decision was awaited in two of the remaining cases and the other had yet to be heard by the Tribunal.

Federal Court Decisions

Two decisions relating to the Determining Officer’s activities were handed down in the Federal Court.

In Tankey v Adams the full bench of the Federal Court dismissed Dr Tankey’s appeal and ordered him to pay the Commonwealth’s costs.

A decision also in favour of the Commonwealth was handed down by the full bench in the case of McFarlane v Batman, in which Dr McFarlane’s appeal was dismissed with costs.

At 30 June 2001 decisions on two appeals against decisions handed down by the PSR Tribunal were pending in the Federal Court.
Activities of Determining Officer

The Determining Officer undertook the following actions on cases in 2000–01:

- PSR Committee reports to Determining Officer 6
- PSR Committee reports sent to persons under review 6
- PSR Committee reports indicating the person under review was not practising inappropriately 0
- PSR Committee reports in which no finding was made 1
- Draft Determinations issued 8
- Submissions made to Determining Officer on draft determinations 5
- Final determinations issued 12
- Final determinations accepted without appeal 7
- Requests to the Minister for a review by a PSR Tribunal 4
- Reviews conducted by a PSR Tribunal 5
- Decisions handed down by a PSR Tribunal 3
Overview

The Department of Health and Aged Care assumes policy responsibility for providing advice to the Minister on development and maintenance of the PSR Scheme. This role requires the Department to liaise with stakeholders in the Scheme and to 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 2000–01 is on pages 34–36.

Other more specific tasks include overseeing the operation of the Professional Services Review Tribunals and the appointment of Presidents and Members of those Tribunals. In addition, the Department provides legal and administrative assistance to the Determining Officer, in preparing determinations and responding to challenges to determinations through Tribunals or the Federal Court. The Department also renewed its Memorandum of Understanding with the Administrative Appeals Tribunal whereby the Tribunal acts as Registrar to the various PSR Tribunals.

Legislation

The operation of the PSR Scheme is governed by legislation contained in the Health Insurance Act 1973.

During the year, minor technical amendments were made to the Health Insurance (Professional Services Review) Regulations 1999 to correct anomalies in the definition of ‘Professional Attendance’. These regulations specify the circumstances which constitute a prescribed pattern of services for Part VAA of the Act, and set out the standards to be met in order that a practitioner's medical records are adequate and contemporaneous.
Professional Services Review Tribunals

The *Health Insurance Amendment (Professional Services Review) Act 1999* preserves the right of practitioners to request a review of determinations made by the Determining Officer in relation to matters referred by the HIC prior to that legislation coming into effect in August 1999. PSR Tribunals are not empowered to review decisions of the Determining Authority which takes over the role of the Determining Officer for cases referred after August 1999.
Corporate overview

Outcome and output structure

PSR contributes to Health and Aged Care’s Portfolio Outcome 2 – Access to Medicare. The PSR Scheme is funded to ensure that any suspected cases of inappropriate practice referred by the HIC are investigated and, if necessary, reviewed by a committee of peers. Regulatory activity is the only output for PSR.

The PSR outputs specified in the Portfolio Budget Statements 2000–01 were:

<table>
<thead>
<tr>
<th>Output Groups</th>
<th>Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Court challenges made in regard to committee processes and findings are resolved successfully.</td>
</tr>
<tr>
<td></td>
<td>Rate of re-referral against a target of zero.</td>
</tr>
<tr>
<td></td>
<td>Quantity: Approximately 40 referrals received from the HIC. Approximately 40 referrals finalised.</td>
</tr>
<tr>
<td></td>
<td>Price: $4,950 million</td>
</tr>
</tbody>
</table>

Performance assessment

Legislative changes were implemented and experience over the coming years will show whether they have been successful in assisting PSR obtain successful outcomes to Court challenges in relation to the PSR Scheme and processes. The Pradhan case, which is still in progress, (and referred to earlier in this report) is the first relevant legal challenge under the new legislation.

The past year has been a significant one for the PSR Scheme because of a number of highly successful outcomes from the Federal Court and PSR Tribunals,
including the Tankey, McFarlane, Damato and Hill cases. A summary of each of these, and other important cases, is included at pages 14–22 of this report.

PSR received 63 new referrals from the HIC in the past year and 42 were finalised. Of the 63 new referrals, five were re-referrals of practitioners who had previously been referred to PSR.

**Corporate governance**

Dr John Holmes is the Director of Professional Services Review and is a statutory office holder appointed by the Minister for Health and Aged Care to manage the PSR Scheme. Dr Holmes reports directly to the Minister.

Mr Peter Dunnett is the Executive Officer and reports to the Director. The Executive Officer has a leadership role in achieving organisational objectives, assisting in the day-to-day management of the PSR office and coordinating policy advice on legislative and administrative matters related to the PSR Scheme.

PSR management meets fortnightly and comprises the Director, Executive Officer and section heads from the Investigations, Committees and Corporate units to consider all relevant policy issues, including revision of the Corporate Plan. Operational plans were developed by each of these units.

A risk management plan was adopted this year and assessed by Comcover as a satisfactory plan with sufficient detail for a small agency.

PSR promotes Australian Public Service values and has developed PSR-specific values. All staff attended an ethics workshop ‘Fork in the Road Café’ conducted by the Department of Health and Aged Care.

**Corporate plan**

**Our vision**

As an independent authority, PSR contributes to ensuring access through Medicare to cost-effective medical services, medicines and health care for all Australians.

**Our mission**

Examination of health practitioners’ conduct to ascertain whether or not practitioners have practised inappropriately in relation to services which attract
Medicare benefits or have prescribed inappropriately under the Pharmaceutical Benefits Scheme.

Our values
In doing our job all members of PSR will:
• act with fairness, consistency, impartiality and integrity;
• demonstrate dedication and commitment;
• act with professionalism;
• value and respect each other and work as a team; and
• show timeliness.

Our strategies
The strategies we employ to achieve our mission and values are to:
• investigate referrals expeditiously and effectively to enable courses of action to be decided;
• provide support services to PSR Committees to enable them to carry out the PSR mission;
• provide support to the Determining Authority to enable it to function;
• manage relationships with stakeholders to maintain and enhance credibility of, and provide information about, the PSR Scheme;
• provide effective and efficient human resource management, financial management and corporate planning services; and
• ensure PSR legislation remains relevant.

Internal and external scrutiny
Due to the small size of the organisation, PSR does not have an audit committee.

During the year the PSR Scheme was scrutinised in a number of cases before Professional Services Review Tribunals and/or the Federal Court. A brief discussion of each is set out on pages 14–22.

Management of human resources
The Director of Professional Services Review is employed under the Health Insurance Act 1973. All other staff (except contractors) were employed under
the Public Service Act 1999. All ongoing staff were employed on a permanent full-time basis.

Table 3 shows the actual permanent staffing levels against the staffing budgeted for and Table 4 provides the classification levels of staff.

**Table 3: Staffing levels**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30</td>
<td>22</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 4: Classification levels as at 30 June 2001**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Office Holder</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SES</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Medical Officers Level 4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Executive Officer Level 2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Executive Officer Level 1</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>APS 6</td>
<td></td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>APS 5</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>APS 4</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>APS 3</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Contractor</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>12</td>
<td>13</td>
<td>25</td>
</tr>
</tbody>
</table>

Eight per cent of staff are from non–English-speaking backgrounds, and no staff are of Aboriginal or Torres Strait Islander origin nor do any have a disability.

In this year PSR paid a total of $15,937 in performance pay.
Staff development and training

Through the PSR performance development scheme, staff training needs were clearly identified. This allowed the human resources manager to target courses for particular individuals or coordinate internally-run courses. Training has been identified as a major area of focus for the agency in 2001–02. This ongoing training schedule will be based on the organisation’s and individuals’ identified needs.

PSR expenditure devoted to training in 2000–01 was 1.71 per cent. This decrease from 7.69 per cent in 1999–2000 is a direct result of Committee member training not occurring in 2000–01. This percentage does not include the training provided to PSR staff through the Memorandum of Understanding with the Department of Health and Aged Care.

Workplace reform

The PSR Certified Agreement 1999 expired on 31 December 2000. The majority of staff elected to have a union agreement for PSR’s second certified agreement. Staff elected two officers to represent their interests along with the Community and Public Service Union (CPSU) at the negotiation table with management. The negotiation team met regularly over a six-month period to finalise PSR Certified Agreement 2001. At all stages of the process, PSR staff were kept informed of the progress and were able to express their opinions to their representatives. PSR Certified Agreement 2001 was overwhelmingly endorsed by staff (only one staff member did not support the agreement). The agreement was certified in the Industrial Relations Commission on 20 March 2001. Major features of the agreement include:

- a 5 per cent pay rise, backdated to 1 January 2001;
- a 4 per cent pay rise on 1 January 2002;
- an enhanced performance development scheme;
- an additional two days recreation leave between Christmas and New Year;
- revised travel time arrangements;
- expanded Studies Assistance through Studybank, including options such as HECS payments; and
- a fair treatment dispute resolution policy.

Four senior staff had Australian Workplace Agreements.
Occupational health and safety

PSR recognises that it has a legal responsibility to safeguard the health of its employees while they work. The agency provides and maintains occupational health and safety (OH&S) standards in relation to its offices and its equipment. The PSR OH&S Committee met on a quarterly basis during the year. The Committee developed a PSR OH&S Agreement that has been endorsed by the CPSU and PSR management. If 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 Memorandum of Understanding. Also included in the Memorandum of Understanding is access for PSR staff and/or their immediate families to counselling services by trained professionals.

There were two minor OH&S incidents in 2000–01 and there were no notices issued or received under any of the relevant sections of the OH&S Act.

Workplace diversity

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

Because of its small size, PSR has no separate workplace diversity plan, but has embraced that of the Department of Health and Aged Care.

Industrial democracy

Staff were consulted on all major issues during the year. The minutes of the fortnightly PSR management meetings are circulated to all staff. Staff meetings are held within their units and information is channelled to and from management meetings. A number of meetings to which all staff were invited, occurred during the year to discuss the PSR Certified Agreement 2001.

Commonwealth Disability Strategy

PSR does not deliver any programs or offer any services to the general public. To date, we have not had any person under review claim a disability. PSR considers we are able to satisfactorily cater to any circumstance.
Public information about PSR is available on the PSR website, which meets the Government Online minimum standards as regards accessible formats for people with disabilities.

PSR adopts the purchasing policies of the Department of Health and Aged Care which have regard to the Commonwealth Disability Strategy.

There are currently no staff with a disability employed at PSR. However, our employment policies, procedures and practices comply with the requirements of the Disability Discrimination Act 1992.

Finance

PSR’s 2000–01 budget appropriation was $4.896 million. This was PSR’s second year of a four-year funding arrangement to cover growth of the organisation to meet its expanded legislative role. The fitout of additional space was completed during the year to accommodate extra staff.

Corporate costs as a percentage of total costs were 38 per cent, compared with 36 per cent in 1999–2000. The increased corporate cost can be directly attributed to the PSR contribution to the Department of Health and Aged Care’s new financial and human resource system – SAP. This system is expected to achieve major efficiencies in the corporate area in future years.

A Federal Court injunction put on hold nine cases which also contributed to a slowdown in the flow of Committee expenditure, which also contributed to the decrease in the Committee expense percentage.

The Australian National Audit Office’s report on the PSR’s 2000–01 financial statements was unqualified and was signed on 20 September 2001 (see Appendix 1).

Purchasing

Through a Memorandum of Understanding with the Department of Health and Aged Care, PSR purchased services, such as payment of accounts, personnel functions, library, registry and coverage for programs including workplace diversity, occupational health and safety and industrial democracy. PSR pays an agreed annual fee for these services. PSR adopts the Department’s purchasing policies and participates with it in joint purchasing arrangements for travel, banking and office supplies.
Information technology

PSR refreshed its lease of computers during the year. Infront Systems continued to provide routine maintenance and second and third level support. First level support is provided in-house. During the year, Catalyst Interactive (with LNB Computing) worked with PSR staff to develop a customised database for tracking and reporting committee and investigation data. The database, named MALCOLM in honour of the late Dr Malcolm McKenzie, a past Deputy Director, became operational towards the end of the financial year.

Environmental Performance

On account of its small size, PSR has no formal method of reporting its environmental performance, but has endeavoured to reduce its energy costs and encourages ecologically sustainable practices, such as paper recycling.

Publications

The only new publication produced in 2000–01 was the 1999–2000 Annual Report. This document is on PSR’s Internet site, www.psr.gov.au.
APPENDIX 1:
FINANCIAL STATEMENTS
INDEPENDENT AUDIT REPORT

To the Minister for Health and Aged Care

Scope

I have audited the financial statements of Professional Services Review Scheme for the year ended 30 June 2001. The financial statements comprise:

- Statement by the Director and Resources Manager;
- Statements of Financial Performance, Financial Position and Cashflows;
- Schedules of Contingencies and Commitments; and
- Notes to and forming part of the Financial Statements.

The Director and the 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 in Australia so as to present a view of the Scheme 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.
Audit Opinion

In my opinion,

(i) the financial statements have been prepared in accordance with Schedule 1 of the Financial Management and Accountability (Financial Statements 2000-2001) Orders;

(ii) the financial statements give a true and fair view, in accordance with applicable Accounting Standards, other mandatory professional reporting requirements and Schedule 1 of the Financial Management and Accountability (Financial Statements 2000-2001) Orders, of the financial position of the Professional Services Review as at 30 June 2001 and the results of its operations and its cash flows for the year then ended.

Australian National Audit Office

[Signature]

David Crossley
Executive Director

Delegate of the Auditor-General
Canberra
20 September, 2001
PROFESSIONAL SERVICES REVIEW

STATEMENT BY THE DIRECTOR
AND
RESOURCES MANAGER


Signed
Dr John Holmes
Director
Professional Services Review

20 September 2001

Signed
Dean Browne
Resources Manager
Professional Services Review

20 September 2001
**PROFESSIONAL SERVICES REVIEW**

**STATEMENT OF FINANCIAL PERFORMANCE**

*For the period ended 30 June 2001*

<table>
<thead>
<tr>
<th>Notes</th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Revenues from ordinary activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenues from Government</td>
<td>6A</td>
<td>4,902,200</td>
</tr>
<tr>
<td>Interest</td>
<td>6B</td>
<td>33,917</td>
</tr>
<tr>
<td>Other</td>
<td>6D</td>
<td>2,146</td>
</tr>
<tr>
<td><strong>Total revenues from ordinary activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expenses from ordinary activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employees</td>
<td>7A</td>
<td>1,451,009</td>
</tr>
<tr>
<td>Suppliers</td>
<td>7B</td>
<td>2,500,208</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>7C</td>
<td>109,260</td>
</tr>
<tr>
<td>Write-down of assets</td>
<td>7D</td>
<td>15,807</td>
</tr>
<tr>
<td>Net losses from asset sales</td>
<td>6C</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total expenses from ordinary activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net operating surplus (deficit) from ordinary activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net surplus (deficit)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Equity Interests</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net surplus (deficit) attributable to the Commonwealth</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total revenues, expense and valuation adjustments recognised directly in equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total changes in equity other than those resulting from transactions with owners as owners</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The above statement should be read in conjunction with the accompanying notes.
PROFESSIONAL SERVICES REVIEW  
STATEMENT OF FINANCIAL POSITION  
as at 30 June 2001  

<table>
<thead>
<tr>
<th>Notes</th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

**ASSETS**

<table>
<thead>
<tr>
<th>Financial Assets</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash</td>
<td>1,695,121</td>
<td>894,924</td>
</tr>
<tr>
<td>Receivables 8A</td>
<td>75,920</td>
<td>17,631</td>
</tr>
<tr>
<td><strong>Total financial assets</strong></td>
<td>1,771,041</td>
<td>912,555</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Financial Assets</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infrastructure, plant &amp; equipment 9A</td>
<td>279,628</td>
<td>178,089</td>
</tr>
<tr>
<td>Intangibles 9C</td>
<td>216,522</td>
<td>33,393</td>
</tr>
<tr>
<td>Other 9D</td>
<td>2,613</td>
<td>18,026</td>
</tr>
<tr>
<td><strong>Total non-financial assets</strong></td>
<td>498,763</td>
<td>229,508</td>
</tr>
</tbody>
</table>

| Total assets | 2,269,804 | 1,142,063 |

**LIABILITIES**

<table>
<thead>
<tr>
<th>Provisions</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital use charge</td>
<td>219,032</td>
<td>75,980</td>
</tr>
<tr>
<td>Employees 10</td>
<td>471,696</td>
<td>451,753</td>
</tr>
<tr>
<td><strong>Total provisions</strong></td>
<td>690,728</td>
<td>527,733</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payables</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suppliers 11</td>
<td>302,965</td>
<td>57,146</td>
</tr>
<tr>
<td><strong>Total payables</strong></td>
<td>302,965</td>
<td>57,146</td>
</tr>
</tbody>
</table>

| Total liabilities | 993,693 | 584,879 |

**EQUITY**

| Capital | 700,000 | 700,000 |
| Accumulated surplus (deficit) | 576,111 | (142,815) |
| **Total equity** | 1,276,111 | 557,185 |

| Current liabilities | 602,185 | 279,654 |
| Non-current liabilities | 391,508 | 305,225 |
| Current assets | 1,773,654 | 930,581 |
| Non-current assets | 496,150 | 211,481 |

The above statement should be read in conjunction with the accompanying notes.
PROFESSIONAL SERVICES REVIEW
STATEMENT OF CASH FLOWS
for the period ended 30 June 2001

<table>
<thead>
<tr>
<th>Notes</th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
<td></td>
</tr>
</tbody>
</table>

OPERATING ACTIVITIES
Cash received
- Appropriations 17 4,896,000 2,830,000
- Sales of goods and services 2,146 0
- Interest 40,367 24,877
- GST recovered from taxation authority 132,388 0
Total cash received 5,070,901 2,854,877
Cash used
- Employees 1,431,066 913,305
- Suppliers 2,429,901 1,577,870
Total cash used 3,860,967 2,491,175
Net cash from operating activities 13 1,209,934 363,702

INVESTING ACTIVITIES
Cash received
- Proceeds from sales of property, plant and equipment 0 0
Total cash received 0 0
Cash used
- Purchase of property, plant and equipment 409,736 169,015
Total cash used 409,736 169,015
Net cash from investing activities 13 -409,736 -169,015

FINANCING ACTIVITIES
Cash received
- Equity Appropriation 0 700,000
Total cash received 0 700,000
Cash used
- Capital use paid 0 0
Total cash used 0 0
Net cash from financing activities 0 700,000

Net increase in cash held 800,198 894,687
Cash at the beginning of the reporting period 894,923 236
Cash at the end of the reporting period 16 1,695,121 894,923

The above statement should be read in conjunction with the accompanying notes.
# Professional Services Review

## Schedule of Commitments

as at 30 June 2001

<table>
<thead>
<tr>
<th>Notes</th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Other Commitments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating leases</td>
<td>429,909</td>
<td>163,907</td>
</tr>
<tr>
<td>Other Commitments</td>
<td>-</td>
<td>130,492</td>
</tr>
<tr>
<td>Total other commitments</td>
<td>429,909</td>
<td>294,399</td>
</tr>
</tbody>
</table>

## By Maturity

### All net commitments

- One year or less | 192,410 | 240,446 |
- From one to five years | 237,499 | 53,953 |
- Over five years | -       | -       |

**Net commitments** | 429,909 | 294,399 |

### Operating lease commitments

- One year or less | 192,410 | 109,954 |
- From one to five years | 237,499 | 53,953 |
- Over five years | -       | -       |

**Net operating lease commitments** | 429,909 | 163,907 |

NB: Commitments are GST inclusive where relevant.
Operating leases included are effectively non-cancellable and comprise of leases for office accommodation and computer equipment.

The above schedule should be read in conjunction with the accompanying notes.
<table>
<thead>
<tr>
<th>Notes</th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTINGENT LOSSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CONTINGENT LOSSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Contingencies</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS  
for the period ended 30 June 2001

<table>
<thead>
<tr>
<th>Note</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Objective of Professional Services Review</td>
</tr>
<tr>
<td>2</td>
<td>Summary of Significant Accounting Policies</td>
</tr>
<tr>
<td>3</td>
<td>Reporting by outcome</td>
</tr>
<tr>
<td>4</td>
<td>Economic Dependency</td>
</tr>
<tr>
<td>5</td>
<td>Subsequent Events</td>
</tr>
<tr>
<td>6</td>
<td>Operating Revenues</td>
</tr>
<tr>
<td>7</td>
<td>Operating Expenses – Goods and services</td>
</tr>
<tr>
<td>8</td>
<td>Financial Assets</td>
</tr>
<tr>
<td>9</td>
<td>Non-Financial Assets</td>
</tr>
<tr>
<td>10</td>
<td>Provisions</td>
</tr>
<tr>
<td>11</td>
<td>Payables</td>
</tr>
<tr>
<td>12</td>
<td>Equity</td>
</tr>
<tr>
<td>13</td>
<td>Cash Flow Reconciliation</td>
</tr>
<tr>
<td>14</td>
<td>Remuneration of Officers</td>
</tr>
<tr>
<td>15</td>
<td>Remuneration of Auditors</td>
</tr>
<tr>
<td>16</td>
<td>Financial Instruments</td>
</tr>
<tr>
<td>17</td>
<td>Appropriations</td>
</tr>
<tr>
<td>18</td>
<td>Average Staffing Levels</td>
</tr>
<tr>
<td>19</td>
<td>Act of Grace Payments, Waivers and Defective Administration Scheme</td>
</tr>
</tbody>
</table>
Note 1: Objective of Professional Services Review

The objective of the Professional Services Review Scheme is to examine health practitioners conduct to ascertain whether or not they have practiced inappropriately in relation to services, which attract Medicare rebates or have prescribed inappropriately under the Pharmaceutical Benefits Schedule.

Note 2: Summary of Significant Accounting Policies

2.1 Basis of Accounting

Professional Services Review is required to prepare financial statements under Section 49 of the Financial Management and Accountability Act 1997. The financial statements are a general purpose financial report.

The statements have been prepared in accordance with:
- Schedule 1 of the Financial Management (Financial Statements 2000-2001) Orders for the preparation of Financial Statements in relation to financial years ending on or after 30 June 2001;
- Australian Accounting Standards and Accounting Interpretations issued by Australian Accounting Standards Boards;
- other authoritative pronouncements of the Boards; and
- Consensus Views of the Urgent Issues Group.

The statements have been prepared having regard to:
- Statements of Accounting Concepts;
- the Explanatory Notes to Schedule 1 and Guidance Notes issued by the Department of Finance and Administration.

The financial statements have been prepared on an accrual basis and are in accordance with historical cost convention, except for certain assets which, as noted, are at valuation. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

Assets and liabilities are recognised in the Agency Statement of Financial Position when and only when it is probable that future economic benefits will flow and the amounts of the assets or liabilities can be reliably measured. Assets and liabilities arising under agreements equally proportionately unperformed are however not recognised unless required by an Accounting Standard. Liabilities and assets which are unrecongnised are reported in the Schedule of Commitments and the Schedule of Contingencies.

Revenues and expenses are recognised in the Agency Statements of Financial Performance when and only when the flow or consumption or loss of economic benefits has occurred and can be reliably measured.

The continued existence of the Agency in its present form, is dependent on Government policy and on continuing appropriation by Parliament for the Agency’s administration.
2.2 Changes in Accounting Policy

The accounting policies used in the preparation of these financial statements are consistent with those used in 1999-2000.

2.3 Revenue

The revenues described in this Note are revenues relating to the core operating activities of Professional Services Review.

Revenues from Government – Output Appropriations

Appropriations for outputs are recognised as revenue to the extent they have been received into Professional Services Review’s Bank account or are entitled to be received by the Professional Services Review at year end.

Resources Received Free of Charge

Services received free of charge are recognised as revenue when and only when a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised at their fair value when the asset qualifies for recognition.

Other Revenue

Revenue from the sale of goods is recognised upon the delivery of goods to customers.

Interest revenue is recognised on a proportional basis taking into account the interest rates applicable to the financial assets.

Revenue from disposal of non-current assets is recognised when control of the asset has passed to the buyer.

2.4 Transactions by the Government as Owner

Appropriations to Professional Services Review designated as ‘capital-equity injections’ are recognised directly in equity, to the extent that the appropriations have been received into Professional Services Review’s bank account or are entitled to be received by Professional Services Review at year end.
2.5 Employee Entitlements

Leave

The liability for employee entitlements includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of Professional Services Review is estimated to be less than the annual entitlement for sick leave.

The liability for annual leave reflects the value of total annual leave entitlements of all employees at 30 June 2001 and is recognised at its nominal amount.

The non-current portion of the liability for long service leave is recognised and measured at the present value of the estimated future cash flows to be made in respect of all employees at 30 June 2001. In determining the present value of the liability, Professional Services Review has taken into account attrition rates and pay increases through promotion and inflation.

Superannuation

Employees contribute to the Commonwealth Superannuation Scheme and the Public Sector Superannuation Scheme. Employer contributions amounting to $171,818 (1999-00: $135,280) for Professional Services Review in relation to these schemes have been expensed in these financial statements.

No liability for superannuation benefits is shown in the Statement of Assets and Liabilities as the employer contributions fully extinguish the accruing liability which is assumed by the Commonwealth.

2.6 Leases

A distinction is made between finance leases, which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of leased non-current assets, and operating leases, under which the lessor effectively retains substantially all such risks and benefits.

Where a non-current asset is acquired by means of a finance lease, the asset is capitalised at the present value of minimum lease payments at the inception of the lease and a liability recognised for the same amount. Leased assets are amortised over the period of the lease. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are expensed on a basis which is representative of the pattern of benefits derived from the leased assets. The net present value of future net outlays in respect of surplus space under non-cancellable lease agreements is expensed in the period in which the space becomes surplus.

2.7 Cash

Cash means notes and coins held and any deposits held at call with a bank or financial institution.
2.8 Financial Instruments

Accounting policies for financial instruments are stated at Note 16.

2.9 Acquisition of Assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition.

2.10 Property (Land, Buildings and Infrastructure), Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are capitalized in the year of acquisition where there value is $2,000 or over, except for information technology equipment which has a minimum threshold value of $500.

Revaluations

This requirement has resulted in all property, plant and equipment held by Professional Services Review as at 30 June 1999 being valued under the deprival valuation methodology. No further revaluations have been completed in 2000-01.

Property, plant and equipment are valued at depreciated replacement cost. Any assets which would not be replaced or are surplus to requirements are valued at net realizable value.

All valuations are independent.

Recoverable Amount Test

Schedule 1 requires the application of the recoverable amount test to Professional Services Review non-current assets in accordance with AAS 10 Recoverable Amount of Non-Current Assets. The carrying amounts of these non-current assets have been reviewed to determine whether they are in excess of their recoverable amounts. In assessing recoverable amounts, the relevant cash flows have been discounted to their present value.

Depreciation and Amortisation

Depreciable property plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to Professional Services Review using, in all cases, the straight line method of depreciation. Leasehold improvements are amortised on a straight-line basis over the lesser of the estimated useful life of the improvements or the unexpired period of the lease.

Depreciation/amortisation rates (useful lives) and methods are reviewed at each balance date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate. Residual values are re-estimated for a change in prices only when assets are revalued.
Depreciation and amortisation rates applying to each class of depreciable asset are based on the following useful lives:

<table>
<thead>
<tr>
<th></th>
<th>2000-01</th>
<th>1999-2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leasehold improvements</td>
<td>Lease term</td>
<td>Lease term</td>
</tr>
<tr>
<td>Plant and equipment</td>
<td>3 to 7 years</td>
<td>3 to 7 years</td>
</tr>
</tbody>
</table>

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 7C.

2.11 Intangibles

The carrying amount of each non-current intangible asset is reviewed to determine whether it is in excess of the asset’s recoverable amount. If an excess exists as at the reporting date, the asset is written down to its recoverable amount immediately.

No write-down to recoverable amount has been made in 2000-01.

Intangible assets are amortised on a straight-line basis over their anticipated useful lives.

2.12 Taxation

Professional Services Review is exempt from all forms of taxation except fringe benefits tax and the goods and services tax.

2.13 Capital Usage Charge

A capital usage charge of 12% is imposed by the Government on the net assets of Professional Services Review. The charge is adjusted to take account of asset gifts and revaluation increments during the financial year.

2.14 Insurance

Professional Services Review has insured for risks through the Government’s insurable risk managed fund, called ‘Comcover’. Workers compensation is insured through Comcare Australia.

2.15 Comparative Figures

Comparative figures have been adjusted to conform to changes in presentation in these financial statements where required.
Notes to and forming part of the financial statements

Note 3. Reporting by outcomes

Professional Services Review operates under only one outcome:
Access through Medicare to cost-effective medical services, medicines and acute health care for all Australians.

Note 4. Economic Dependency

Professional Services Review was established in 1994 under PART VAA of Health Insurance Act 1973 and is controlled by the Commonwealth of Australia. The Authority is dependent on appropriations from the Parliament of the Commonwealth for its continued existence and ability to carry out its normal activities.

Note 5. Subsequent Events

There are no events occurring after balance date that impact upon these financial statements.

Note 6. Operating Revenues

<table>
<thead>
<tr>
<th>Note</th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note 6A - Revenues from Government</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriations for outputs</td>
<td>4,896,000</td>
<td>2,830,000</td>
</tr>
<tr>
<td>Resources received free of charge</td>
<td>6,200</td>
<td>6,840</td>
</tr>
<tr>
<td>Total</td>
<td>4,902,200</td>
<td>2,836,840</td>
</tr>
<tr>
<td>Note 6B - Interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deposits</td>
<td>33,917</td>
<td>41,683</td>
</tr>
<tr>
<td>Total</td>
<td>33,917</td>
<td>41,683</td>
</tr>
<tr>
<td>Note 6C - Proceeds and expenses from sale of assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-financial assets - Infrastructure, plant and equipment</td>
<td>0</td>
<td>(214)</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>(214)</td>
</tr>
<tr>
<td>Note 6D - Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2,146</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>2,146</td>
<td>0</td>
</tr>
</tbody>
</table>
Notes to and forming part of the financial statements

**Note 7 - Operating Expenses - goods and services**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount 1</th>
<th>Amount 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note 7A - Employee expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Remuneration (for services provided)</td>
<td>1,451,009</td>
<td>1,190,080</td>
</tr>
<tr>
<td>Seperation and redundancy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total remuneration</td>
<td>1,451,009</td>
<td>1,190,080</td>
</tr>
<tr>
<td>Other employee expenses</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,451,009</td>
<td>1,190,080</td>
</tr>
</tbody>
</table>

| Note 7B - Suppliers expenses                          |          |          |
| Supply of goods and services                          | 2,305,865| 1,571,920|
| Operating lease rentals                                | 194,343  | 133,480  |
| Total                                                  | 2,500,208| 1,705,400|

| Note 7C - Depreciation and amortisation               |          |          |
| Depreciation of property, plant and equipment         | 109,260  | 68,947   |
| Amortisation of leased assets                         | 0        | 11,409   |
| Total                                                  | 109,260  | 80,356   |

| Note 7D - Write-down of assets                        |          |          |
| Non-financial assets:                                 |          |          |
| Intangible write-off                                  | 12,264   | 0        |
| Plant & Equipment - write-off                         | 3,543    | 0        |
| Total                                                 | 15,807   | 0        |

**Note 8 Financial Assets**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount 1</th>
<th>Amount 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note 8A - Receivables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goods and services</td>
<td>199</td>
<td>0</td>
</tr>
<tr>
<td>Interest</td>
<td>10,226</td>
<td>17,631</td>
</tr>
<tr>
<td>GST Receivable</td>
<td>65,495</td>
<td>0</td>
</tr>
<tr>
<td>Total receivables</td>
<td>75,920</td>
<td>17,631</td>
</tr>
</tbody>
</table>

Receivables (gross) which are overdue are aged as follows:

<table>
<thead>
<tr>
<th>Overdue by:</th>
<th>Amount 1</th>
<th>Amount 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>- less than 30 days</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- 30 to 60 days</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- 60 to 90 days</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- more than 90 days</td>
<td>0</td>
<td>412</td>
</tr>
<tr>
<td>Total receivables (gross)</td>
<td>75,920</td>
<td>17,631</td>
</tr>
</tbody>
</table>
Note 9: Non-financial assets

Note 9A: Infrastructure, plant and equipment

<table>
<thead>
<tr>
<th>Item</th>
<th>Buildings - Leasehold Improvements</th>
<th>Plant &amp; Equipment</th>
<th>Computer software - Total intangibles</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross value as at 1 July 2000</td>
<td>319,590</td>
<td>127,505</td>
<td>71,804</td>
<td>518,899</td>
</tr>
<tr>
<td>Additions - Purchase of Assets</td>
<td>121,466</td>
<td>75,172</td>
<td>213,098</td>
<td>409,736</td>
</tr>
<tr>
<td>Revaluations: write-up / (write-downs)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Write-offs</td>
<td>0</td>
<td>(12,033)</td>
<td>(56,755)</td>
<td>(68,788)</td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gross value as at 30 June 2001</td>
<td>441,056</td>
<td>190,644</td>
<td>228,147</td>
<td>859,847</td>
</tr>
</tbody>
</table>

Accumulated Depreciation / Amortisation as at 1 July 2000

<table>
<thead>
<tr>
<th>Item</th>
<th>Buildings - Leasehold Improvements</th>
<th>Plant &amp; Equipment</th>
<th>Computer software - Total intangibles</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>214,713</td>
<td>54,294</td>
<td>38,411</td>
<td>307,418</td>
<td></td>
</tr>
<tr>
<td>Disposals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Depreciation / Amortisation charge for the year</td>
<td>45,896</td>
<td>45,659</td>
<td>17,705</td>
<td>109,260</td>
</tr>
<tr>
<td>Revaluation: write-ups / (write-downs)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Assets transferred in / (out)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Gross value as at 30 June 2001</td>
<td>260,609</td>
<td>91,463</td>
<td>11,625</td>
<td>363,697</td>
</tr>
</tbody>
</table>

Accumulated Depreciation / Amortisation as at 30 June 2001

<table>
<thead>
<tr>
<th>Item</th>
<th>Buildings - Leasehold Improvements</th>
<th>Plant &amp; Equipment</th>
<th>Computer software - Total intangibles</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>104,877</td>
<td>73,211</td>
<td>33,393</td>
<td>211,481</td>
<td></td>
</tr>
<tr>
<td>Net book value as at 1 July 2000</td>
<td>180,447</td>
<td>99,180</td>
<td>216,522</td>
<td>496,150</td>
</tr>
</tbody>
</table>
Note 9C - Intangibles
Software 228,147 71,804
Accumulated depreciation (11,625) (38,411)

216,522 33,393

Note 9D - Other non-financial assets
Prepaid Artbank 1,079 0
Other prepayments 1,534 18,026

2,613 18,026

Note 10 Provisions
Employees
Salaries and wages 31,931 28,256
Rec Leave 145,768 124,735
LSL 289,436 294,634
Superannuation 4,560 4,128
Total 471,696 451,753

Current 80,188 146,528
Non Current 391,508 305,225

Note 11 Payable
Trade Creditors 302,965 57,146

302,965 57,146

Note 12 Equity

<table>
<thead>
<tr>
<th>Item</th>
<th>Capital</th>
<th>Accumulated results</th>
<th>TOTAL EQUITY</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000-01</td>
<td>1999-00</td>
<td>2000-01</td>
</tr>
<tr>
<td>Balance 1 July 2000</td>
<td>700,000</td>
<td>(142,816)</td>
<td>43,544</td>
</tr>
<tr>
<td>Net Surplus Deficit</td>
<td></td>
<td>861,979</td>
<td>(97,557)</td>
</tr>
<tr>
<td>Super on cost</td>
<td></td>
<td>700,000</td>
<td>(12,853)</td>
</tr>
<tr>
<td>Equity Appropriation: Capital</td>
<td></td>
<td>(143,052)</td>
<td>(75,980)</td>
</tr>
<tr>
<td>Capital use Charge</td>
<td></td>
<td>700,000</td>
<td>576,111</td>
</tr>
<tr>
<td>Balance 30 June 2001</td>
<td>700,000</td>
<td>700,000</td>
<td>700,000</td>
</tr>
</tbody>
</table>

65
Notes to and forming part of the financial statements

Note 13 Cash Flow Reconciliation

Reconciliation of Cash per Statement of Financial Position to Statement of Cash Flows
- Cash at year end per Statement of Cash Flows 1,716,730 951,826
- Statement of Financial Position items comprising above cash: 'Financial Asset - Cash' 1,695,121 894,924

Reconciliation of operating surplus to net cash provided by operating activities
Net Surplus (Deficit) 861,979 (97,528)
Depreciation and amortisation of property, plant & equipment 109,260 80,356
Profit on disposal of plant & equipment 0 214
Infrastructure, plant & equipment written off 15,807 0
(Increase) Decrease in receivables (58,289) 56,291
(Increase) Decrease in other assets 15,418 289,626
Increase (Decrease) in employee liabilities 19,943 65,225
Increase (Decrease) in suppliers liabilities 245,817 (17,631)
Increase (Decrease) in other liabilities 0 (12,852)
Net cash provided (used) by operating activities 1,209,935 363,701

Note 14 Executive Remuneration

The number of Executive who received or were due to receive total remuneration of $100,000 or more:

<table>
<thead>
<tr>
<th>Range</th>
<th>Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>100,001 - 110,000</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>110,001 - 120,000</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>140,001 - 150,000</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>190,001 - 200,000</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

The aggregate amount of total remuneration of Executives shown above. 307,859 254,620

Note 15 Remuneration of Auditors

Financial Statement audit services are provided free of charge to the Agency. The fair value of the services provided was:

<table>
<thead>
<tr>
<th></th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>6,200</td>
<td>6,840</td>
</tr>
</tbody>
</table>

No other services were provided by the Auditor General.
### Note 16 Financial Instruments

#### a) Terms, conditions and accounting policies

<table>
<thead>
<tr>
<th>Financial Instrument</th>
<th>Notes</th>
<th>Accounting Policies and Methods (including recognition criteria and measurement basis)</th>
<th>Nature of underlying instrument (including significant terms and conditions affecting the amount, timing and certainty of cashflows)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assets</td>
<td></td>
<td>Financial assets are recognised when control over future economic benefits is established and the amount of the benefit can be reliably measured.</td>
<td></td>
</tr>
<tr>
<td>Receivables for goods and services</td>
<td>14</td>
<td>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.</td>
<td>All receivables are with entities external to the Commonwealth. Credit terms are not 30 days.</td>
</tr>
<tr>
<td>Financial liabilities</td>
<td></td>
<td>Financial liabilities are recognised when a present obligation to another party is entered into and the amount of the liability can be reliably measured.</td>
<td></td>
</tr>
<tr>
<td>Trade Creditors</td>
<td>10</td>
<td>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).</td>
<td>All creditors are entities that are not part of the Commonwealth legal entity. Settlement is usually made not 30 days.</td>
</tr>
</tbody>
</table>

#### b) Interest Rate Risk

<table>
<thead>
<tr>
<th>Financial Instrument</th>
<th>Notes</th>
<th>Non-Interest Bearing</th>
<th>Total</th>
<th>Weighted Average Effective Interest Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2000-01</td>
<td>1999-00</td>
<td>2000-01</td>
</tr>
<tr>
<td>Financial Assets</td>
<td></td>
<td>%</td>
<td></td>
<td>%</td>
</tr>
<tr>
<td>Cash</td>
<td>8</td>
<td>1,695,121</td>
<td>894,924</td>
<td>1,695,121</td>
</tr>
<tr>
<td>Receivables for goods and services</td>
<td></td>
<td>75,920</td>
<td>17,631</td>
<td>75,920</td>
</tr>
<tr>
<td>Total Financial Assets (Recognised)</td>
<td></td>
<td>1,771,041</td>
<td>912,555</td>
<td>1,771,041</td>
</tr>
<tr>
<td>Financial Liabilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade creditors</td>
<td>12</td>
<td>302,963</td>
<td>57,146</td>
<td>302,963</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Financial Liabilities (Recognised)</td>
<td></td>
<td>302,963</td>
<td>57,146</td>
<td>302,963</td>
</tr>
</tbody>
</table>
Note 17 Appropriation of outputs

<table>
<thead>
<tr>
<th></th>
<th>2000-01</th>
<th>1999-00</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Section 7</td>
<td>4,896,000</td>
<td>2,830,000</td>
</tr>
<tr>
<td>Appropriation Act Nos 1 &amp; 3 credits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 12</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Comcover Receipts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 30A</td>
<td>132,388</td>
<td>0</td>
</tr>
<tr>
<td>Appropriations GST Recoverables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 31</td>
<td>24,881</td>
<td>42,509</td>
</tr>
<tr>
<td>Appropriations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Appropriated in the year</td>
<td>5,053,269</td>
<td>2,872,509</td>
</tr>
<tr>
<td>Balance brought forward from previous period</td>
<td>912,555</td>
<td>236</td>
</tr>
<tr>
<td>Total Appropriations available for payment</td>
<td>5,965,824</td>
<td>2,872,745</td>
</tr>
<tr>
<td>Payments made during the year</td>
<td>4,270,703</td>
<td>2,660,190</td>
</tr>
<tr>
<td>Balance of appropriations (unspent) at 30 June 2001</td>
<td>1,695,121</td>
<td>212,555</td>
</tr>
</tbody>
</table>

Note 18 Average Staffing Levels

The average staffing levels during the year was 22 (18 for 1999-00).

Note 19 Act of Grace payments, waivers and Defective Administration Scheme

No Act of Grace payments, waivers of amounts owing to the Commonwealth or payments under Defective Administration Scheme were made during the reporting period.
APPENDIX 2: FREEDOM OF INFORMATION STATEMENT

During the year ended 30 June 2001, the Professional Services Review received one request 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 HIC considers may have engaged in inappropriate practice in connection with rendering or initiating services;
- reports of, and related documents regarding investigations carried out by the PSR;
- 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:
APPENDIX 3: 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 further three-year periods. At 30 June 2001, 183 members had been appointed by the Minister for a five-year period. Of these, 19 were also appointed as Deputy Directors of Professional Services Review. The Deputy Directors serve as Chairpersons of the PSR Committees. Further nominations for appointment to the Panel are in the pipeline.

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, who is a medical practitioner, appointed ministerially and able to engage staff and consultants;
- a Professional Services Review Panel, comprising medical practitioners, who are appointed ministerially;
- Professional Services Review Committees, comprising practitioners from the PSR Panel appointed by the Director on a case-by-case basis to investigate practitioners referred by the Director for review; and
- a Determining Authority\(^6\) comprising a medical practitioner as Chair, a lay person and a member of the relevant profession, whose role it is to decide

---

\(^6\) The Determining Authority replaces the 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 in relation to referrals to the Director before 1 August 1999.
on the sanctions for practitioners found by a Professional Services Review Committee to have practised inappropriately and to consider agreements entered into between the Director and the person under review for ratification.

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 (ie 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) 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 conducts an investigation. The Director has the power to require documents to be produced which then provides the first opportunity under the PSR Scheme for an examination of the records. After an investigation, the Director may:
• dismiss a referral;
• negotiate an agreement (which needs to be ratified by the Determining Authority to become effective); or
• establish a PSR Committee.

The PSR Committee reports on its findings and, if the findings are adverse to the practitioner under review, the Determining Authority 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 Authority 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.

The practitioner may, at any time, seek judicial review in the Federal Court.
APPENDIX 4: 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 (Director). Information on HIC procedures leading to the referral of a case to the Director should be sought from the HIC.

Legislative changes

Following a comprehensive review by the Government and the AMA, extensive changes were made to the PSR Scheme with effect from 1 August 1999. These changes provided for improvements to the Scheme’s administration, in the form of:

• increasing the investigation, case preparation and negotiating powers of the Director;
• providing legal support to the peer review committees and introducing more comprehensive training and operating protocols;
• allowing greater legal support to the person under review;
• replacing the Determining Officer with a Determining Authority comprising a permanent chair (medical practitioner), a permanent lay person and a third member who would be a representative of the profession of the person under review; and
• removing the PSR Tribunals from the process while retaining the right of review on points of law.

Other changes to the PSR Scheme included:

• providing for different methods of investigating inappropriate practice, including the introduction of deeming provisions in respect of high volume servicing per day, sampling methodologies and generic findings; and
• introducing a requirement from 1 November 1999 that a practitioner keep adequate and contemporaneous clinical records.
PSR Committees are to have regard to whether a practitioner keeps adequate and contemporaneous records of the rendering and initiation of services in determining whether that practitioner's conduct was appropriate.

**Investigative referral**

A referral by the HIC to the Director is known as an investigative referral.

When the HIC makes an investigative referral to the Director, 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.

Should the Director request further information on services contained in the referral, the HIC must comply with that request to the extent that it is able.

**Action by Director**

On receipt of an investigative referral, the Director conducts an investigation into the referred services. For that purpose, the Director may require the person under review or any other person to produce patient records and other documents.

The Director may dismiss the investigative referral if satisfied that there are insufficient grounds on which a Committee could reasonably find that the person under review has engaged in inappropriate practice.

The Director and the person under review may enter into a written agreement under which that person and the Director agree to a sanction against the person. Any such agreement must be ratified by the Determining Authority. If an agreement is entered into, the Director must dismiss the referral.

The Director may set up a PSR Committee and make a referral, known as an adjudicative referral to the Committee, to consider whether the person under review's conduct constituted engaging in inappropriate practice.

In reaching a decision as to which course of action to pursue, 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 has nine months in which to refer the matter to a Committee, enter into an agreement with the person under review or dismiss the referral. If none of those steps is taken within those nine months, the referral lapses.

**Adjudicative referral**

The content and form of an adjudicative referral must comply with any guidelines made by the Minister.

The referral must be accompanied by a written report by the Director giving the reasons the Director thinks that conduct by the person under review may have constituted engaging in inappropriate practice.

**Establishing a PSR Committee**

The Director selects a Deputy Director to chair a Committee and at least two other members from the PSR 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 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 written notice of particulars of the matters giving rise to the hearing and the date and place of the hearing at least 14 days prior to 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**

Subject to any reasonable limitations or restrictions the Committee may impose, the person under review may:
• attend the hearing;
• be accompanied by a lawyer or another adviser;
• call witnesses to give evidence (other than evidence as to his or her character);
• produce written statements as to his or her character;
• question a person giving evidence at the hearing;
• address the Committee on questions of law arising during the hearing;
• make a final address to the Committee on questions of law, the conduct of the hearing and the merits of the matters to which the hearing relates.

If a lawyer accompanies the person under review, the lawyer may, subject to any reasonable limitations or restrictions that the Committee may impose:
• give advice to the person under review;
• address the Committee on questions of law arising during the hearing; and
• make a final address to the Committee on questions of law, the conduct of the hearing and the merits of the matters to which the hearing relates.

While a Committee 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.

Obligations of person under review

The notice of hearing given to the person under review must require that person to appear at the hearing and give evidence to a Committee. If the person under review fails to appear at the hearing, or appears but refuses or fails to give evidence or to answer a question that he or she is asked by a Committee member in the course of the hearing, the Committee may fix another day, at least 28 days later, for the taking of evidence from the person under review. Alternatively, the Committee may proceed with the hearing even if the person under review fails to appear.

If the person under review fails to appear or appears but refuses or fails to give evidence or to answer questions, the Chairperson must notify the Director of the failure or refusal. When such a notice is given to the Director, he or she must disqualify the person under review from Medicare and notify the HIC accordingly. If the person under review subsequently appears at a hearing and
gives evidence and answers questions, the Chairperson must inform the Director and, as soon as practicable after being so informed, the Director must revoke the disqualification and give the HIC notice of the revocation.

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.

Committee to inform itself

A Committee 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.

Production of records

A Committee may, at any time before or during a hearing, give a notice to the person under review or to any other person whom the Committee believes to have possession, custody or control of patient records or other documents, requiring him or her to produce them to the Committee. The notice must give the person to whom it is addressed at least 14 days in which to comply. When documents are produced, the Committee may inspect them, retain them for a reasonable period and make copies of them.

Procedure at hearings

Procedure at hearings is within the discretion of the presiding member. The Committee is not bound by rules of evidence and may inform itself on any matter in any way it thinks appropriate.

The Committee may issue a summons to a person other than the person under review requiring that person to appear at the hearing to give evidence and produce documents.

A person, other than the person under review, who appears as a witness at a hearing may be prosecuted for refusing or failing to be sworn or to make an
affirmation, for refusing or failing to answer a question that he or she is required by a Committee member to answer or for refusing or failing to produce a document that he or she is required to produce.

A person who obstructs or hinders the Committee or disrupts a hearing may be prosecuted for an offence.

A Committee member has the same protection and immunity as a Justice of the High Court. This means a Committee member cannot be sued or prosecuted for things that he or she says in the proper performance of his or her duties as a Committee member.

**Findings of committee**

The Committee must only make findings in respect of services that are specified in the adjudicative referral. The Committee is not, however, required to have regard to conduct in connection with the rendering or initiation of all of the referred services.

One of the possible approaches the Committee may take in determining whether or not inappropriate practice has occurred is to apply a sampling methodology. The Committee may sample services included in a particular class of referred services, make findings about specific services in the sample and extrapolate the results to a larger number of similar services in the referral. The sampling methodology the Committee uses must be either specified in a determination by the Minister or approved by an accredited statistician.

Another way the Committee may proceed is by relying on the deeming provision in section 106KA of the *Health Insurance Act 1973*. This provision is designed to assist in cases where the person under review has rendered high volumes of services per day over a minimum number of days in a year. If the number of referred services rendered over a prescribed number of days exceed those specified in the regulations, the burden falls on the person under review to satisfy the Committee that services rendered on those days were rendered appropriately.

If the clinical or practice records of the person under review are absent, deficient or illegible, making it impossible for the Committee to conduct an inquiry based on statistical sampling or patterns of services, the Committee may make a generic finding of inappropriate practice based on information supplied in the adjudicative referral, contained in the report by the Director or given in evidence at hearings held by the Committee.
Reporting

The Committee prepares a draft report of its preliminary findings and gives a copy to the person under review. That person may, within 21 days of receiving the draft report, make submissions in relation to the draft report. The Committee must consider any such submissions.

A final report is then prepared by the Committee and sent to the person under review and the Director. The person under review has 28 days in which to seek judicial review in the Federal Court should he or she wish to do so.

After the expiration of the 28 days, the final report is sent to the Determining Authority. The Committee must ensure the final report is given to the Determining Authority within six months of the day on which it receives the adjudicative referral. That period is, by force of the legislation, extended for any period during which the person under review is unable, because of illness, to attend a hearing of the Committee or during any period during which that person or another person fails to comply with a notice to produce documents. Also, at the request of the Chairperson or, if the Chairperson is not available, another member of the Committee may, before the deadline for reporting, apply to the Director for an extension of time not exceeding one month or further periods not exceeding one month in each case.

The report should refer to the evidence or other material on which those findings were based. It should provide the Determining Authority with sufficient information to assist it in drafting a Determination. If the Committee members are not unanimous in their findings, the report must set out the findings of the Committee members.

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 Committee, in the course of examining a referral, comes to the view that the person under review may have committed fraud, the Committee may send the material, or a copy of the material, which is the cause of its concern to the HIC with a statement of the matters it thinks may have constituted the offence. The Committee may then either continue with its consideration of the referral or suspend its consideration of the referral for such a period as it thinks appropriate.
If a Committee concludes that conduct by a person under review has caused, is causing, or is likely to cause a significant threat to the life or health of another person, it must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

If the person under review is a practitioner and if the Committee concludes that he or she has failed to comply with professional standards, the Committee must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

**Determining Authority**

The Determining Authority is an independent body within the PSR Scheme established by section 106Q of the Act.

It comprises a permanent Chairman, who must be a medical practitioner, a permanent lay person who must not be a member of any of the professions to which the provisions of the PSR Scheme apply, and a panel of persons representative of the professions to which the person under review may belong, eg medicine, dentistry, optometry, physiotherapy, chiropractic or podiatry.

Members are appointed by the Minister on a part-time basis for periods of up to five years after consultation with the AMA and the relevant professions. The Minister can also make acting appointments to the Authority should a member be unable to perform his or her duties for any reason or in the event of a vacancy in that office.

For any specific determination, the Authority is constituted by the Chair, the lay person and the representative of the person under review’s profession. Meetings are held in private and any question arising for decision is decided by majority vote of members present. Authority members are accorded the same protection and immunities as a Justice of the High Court in the performance of their duties.

The Director is required to provide all necessary support to the Authority to enable it to perform its functions and to exercise its powers. However, in doing so, the Director must ensure no-one who has provided investigative services, legal or professional advice at any stage of the inquiry process also provides similar services to the Authority.
Role of Determining Authority

The Authority has two main roles. The first is to determine the level of sanctions to apply when a Committee has found a practitioner to have engaged in inappropriate practice and to express those decisions in formal determinations. The second is to decide whether or not to ratify agreements reached between the Director and a person under review on the level of sanctions to apply when both parties agree that inappropriate practice has occurred.

The Authority must confine its considerations to determining what are appropriate sanctions for the inappropriate practice identified by a Committee and must have regard only to such evidence as is relevant to this task.

Ratified agreements

Upon receipt of an agreement entered into between the Director and person under review, the Authority must make a decision either ratifying or refusing to ratify it within one month after the day the agreement was received. Failure to make a decision within this period means the agreement is deemed to have been ratified with effect from the end of that period.

The Authority must notify the Director and person under review in writing of its decision within seven days of its having been made or taken to have been made. Refusal to ratify decisions must be accompanied by statements of reasons.

Committee reports – finding of inappropriate practice

Where a Committee report contains a finding that the person under review engaged in inappropriate practice, or if a majority report contains such a finding, the Authority must, within one month after the day on which it receives the report, make a draft determination and give copies to the person under review and the Director.

The draft determination must contain one or more of the directions set out in section 106U of the Act.

The draft determination must be accompanied by an invitation to the person under review to make submissions, within 14 days after the day on which he or she receives the draft determination, suggesting changes to the directions contained in the draft determination. The Authority must take any submissions received into account in making its final determination.
Having made a draft determination, the Authority must, within one month after the end of the 14 day period permitted for making submissions, make a final determination. The determination must contain one or more of the directions set out in section 106U of the Act.

Content of draft and final determinations

The Authority may direct that the person under review be:

• reprimanded by the Director or the Director's nominee;
• counselled by the Director or the Director's nominee;
• required to pay the whole or part of the Medicare benefit paid for any service he or she rendered or initiated and in respect of which he or she was found to have engaged in inappropriate practice;
• required to pay the whole or part of the Medicare benefit paid for all or a proportion of any class of services he or she rendered or initiated in respect of which he or she was found to have engaged in inappropriate practice; and
• fully disqualified or partially disqualified from Medicare for periods of up to three years.

Other directions the Authority may make include:

• fully or partially revoking a participating optometrist’s undertaking under section 23 of the Act; and
• revoking or suspending a doctor's or dentist's authority to prescribe or dispense a pharmaceutical benefit.

Date when final determination takes effect

Subject to any appeals, the final determination takes effect on the 35th day after the day on which the Authority gives a copy to the person under review.

Notification of final determination

The Authority must give copies of the final determination to the person under review and the Director as soon as practicable after making the final determination. It must also give copies of the final determination, in the form in which it takes effect, to the Director and the HIC as soon as practicable after the final determination takes effect.
Referral of professional issues to regulatory and other bodies

If the Authority concludes that conduct by a person under review has caused, is causing, or is likely to cause a significant threat to the life or health of another person, it must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

If the person under review is a practitioner and if the Authority concludes that he or she has failed to comply with professional standards, the Committee must give the Director a written statement of its concerns, together with the material or copies of the material on which its opinion is based.

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; Panel members who conduct reviews are active members of the specialty or profession of the person under review; and the Determining Authority which decides the level and scope of sanctions is also independent;

- **appeal rights**: there is provision for appeal or review of every significant decision in the process;

- **privacy**: the deliberations, findings, information and evidence given to a Committee remain confidential and may only be disclosed in circumstances prescribed by the Act, for example, in the case of an appeal 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

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>AMA</td>
<td>Australian Medical Association Limited</td>
</tr>
<tr>
<td>ASL</td>
<td>Average Staffing Level</td>
</tr>
<tr>
<td>Committee</td>
<td>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</td>
</tr>
<tr>
<td>COMNET</td>
<td>Corporate Management Network</td>
</tr>
<tr>
<td>CPSU</td>
<td>Community and Public Service Union</td>
</tr>
<tr>
<td>Determining Authority</td>
<td>A three-person panel responsible for determining the sanction following an adverse PSR Committee finding</td>
</tr>
<tr>
<td>Determining Officer</td>
<td>An officer appointed by the Minister to determine an appropriate sanction to apply where a PSR Committee finds a person under review has engaged in inappropriate practice, as defined in the Act</td>
</tr>
<tr>
<td>Director</td>
<td>Director of Professional Services Review – see DPSR</td>
</tr>
<tr>
<td>Disqualification</td>
<td>Exclusion (partial or complete) from eligibility for the practitioner’s services to attract Medicare benefits</td>
</tr>
<tr>
<td>DPSR</td>
<td>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</td>
</tr>
<tr>
<td>HCCC</td>
<td>Health Care Complaints Conference</td>
</tr>
<tr>
<td>HIC</td>
<td>Health Insurance Commission</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Inappropriate practice</td>
<td>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 (section 82)</td>
</tr>
<tr>
<td>Minister</td>
<td>Minister for Health and Aged Care</td>
</tr>
<tr>
<td>OH&amp;S</td>
<td>Occupational Health and Safety</td>
</tr>
<tr>
<td>Panel</td>
<td>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</td>
</tr>
<tr>
<td>PSR</td>
<td>Professional Services Review</td>
</tr>
<tr>
<td>Referral</td>
<td>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</td>
</tr>
</tbody>
</table>
Abbreviations, 85
Advertising and market research, n/a
Aids to access, v, 89
Asset management, n/a
Commonwealth Disability Strategy, 44
Competitive tendering and contracting, n/a
Consultancy services, n/a
Contact details for further information, ii
Corporate governance, 40
Corporate overview, 39–46
Corporate plan, 40
Department of Health and Aged Care’s report, 37
Determining Authority’s report, 32
Determining Officer’s report, 34
Director’s report, 1–26
Discretionary grants, n/a
Ecologically sustainable development and environmental performance, 46
Financial statements, 47
Freedom of information statement, 69
Glossary, 85
Human resources, 41
Index, 89
Internal and external scrutiny, 41
Internet home page address, ii
Introduction, vi
Letter of transmittal, iii
Occupational health and safety, 44
Corporate plan, 40
Organisational structure, 42
Outcome and output structure, 39
Overview of agency, 74–84
Purchasing, 45
Resources for outcomes, 42, 47
Role and functions, 74–84
Social justice and equity, 43–44
Table of contents, v
accommodation, 45
accidents and incidents, 44
acupuncture, 16–17
adjudicative referrals, see referrals
adverse findings, 4–5
see also inappropriate practice
advice to practitioners, 22–3
agreements under section 92, 2, 4–5, 29–30, 82
Alexander, Dr Marie, 14
alteration of documentation, 10
antibiotics, 29–30
appeals, 14–22
appropriation, 45
audit, 45
Australian Medical Association (AMA), 12, 81
Australian National Audit Office, 45
Australian Public Service values, 40
Australian Workplace Agreements, 43
average staffing level (ASL), 42
benzodiazapines, 8, 29–30
bias, 18, 20
budget appropriation, 45
Canada, 11
case summaries, 14–22, 27–31
caseload, 1–2
Catalyst Interactive, 46
Certified Agreement, 43
Christie, Dr Michael, 14–15
‘co-coding’, 8
Comcover, 40
Commonwealth Disability Strategy, 44–5
computers, 46
consultations (medical), number of, 6–8, 15–19, 21–2, 27–9, 30–1
court cases, see Federal Court
court cases, see Federal Court
director for FOI requests, 69
director for FOI requests, 69
director for FOI requests, 69
director for FOI requests, 69
director for FOI requests, 69
director for FOI requests, 69
Deeble, Dr John, 13
delays, 1, 2–3
determinations, 34, 36, 82–3
Determining Authority, 30, 78, 81–2
Determining Authority, 30, 78, 81–2
Determining Authority, 30, 78, 81–2
Determining Officer, 14, 17, 19, 21, 28, 29
Determining Officer, 14, 17, 19, 21, 28, 29
Director, vi, 40, 41
disability, 75–6
disabilities, people with, 44–5
dismissals, 2, 4–5, 29–30
disqualification from Medicare
arrangements, 2, 16, 31
diversity, 42, 44
doctors, see practitioners
documentation, see medical records
documents (PSR), 69–70
draft determinations, 36, 82–3
drugs, 8, 29–30
Dunnett, Peter, 40

ECG services, 21–2
environmental performance, 46
ethics workshop, 40
ethnic medical association, 12
Executive Officer, 40
external scrutiny, see Federal Court;
  Professional Services Review Tribunals

Federal Court, 1, 14–16, 17–22
decisions relating to Determining
  Officer’s activities, 35
Federation of Medical Licensing
  Authorities of Canada, 11
female staff, 42
final determinations, 36, 83
finance, 42, 43, 45, 47–68
financial statements, 47–68
formal counselling, 22
fraud, 8, 10
freedom of information statement, 69–70
governance, 40
Grey, Dr John, 15

Hampel, Felicity, 13
Health Insurance Act 1973, see legislation
Health Insurance Amendment (Professional
  Services Review) Act 1999, 38
Health Insurance Commission (HIC), vi
  see also referrals
Health Insurance (Professional Services
  Review) Regulations, 37

hearings, 1–3, 5–6, 13–22, 76–9
high number of services per patient, 8, 16,
  18–19, 30
high volume of services, 6–8, 15–17,
  18–20, 21–2, 27–9, 30–1
Hill, Dr Wilvene, 16
Ho, Dr Jessica, 16–17
Holmes, Dr John, 40
human resources, see staff

‘inappropriate conduct’, 4–5
inappropriate practice, 6, 14–22, 27–31
definition, vi, 72
process, 82–3
servicing levels, 7
incidents and accidents, 44
industrial democracy, 44
information technology, 46
Infront Systems, 46
internal scrutiny, 41
international activities, 11–12
investigative process, 3–4, 75
  see also referrals

judicial decisions, see Federal Court
lapsed or withdrawn referrals, 2, 3
legal representation at section 92
  negotiations, 5
legal support, 25
legislation, vi, 37–8, 39, 71, 74–5
  servicing levels, 7
litigation, see Federal Court

MCFarlane, Dr Jean, 17
McKenzie, Dr Malcolm, 46
MALCOLM, 46
male staff, 42
Medical Boards, 3, 10, 11
  referrals to, 16, 17, 29
Medical Officers, 42
medical practice, unusual, 9, 16–17
medical practitioners, see practitioners
medical records, 4, 9–10, 37
practitioners referred, 16, 28–9, 30
production, 78
medical support, 25
Mercado, Dr Miguelito, 18
Minter Ellison Lawyers, 25
mission statement, 40–1

narcotics, 8, 29–30
National Health Care Complaints Conference, Melbourne, 12
negotiated agreements, 2, 4–5, 29–30, 82
New York State Board of Medical Professional Conduct, 11–12
Nicholls, Professor Des, 25
non–English-speaking backgrounds, staff from, 42
number of services, 6–8, 15–17, 18–20, 21–2, 27–9, 30–1

occupational health and safety, 44
office accommodation, 45
operational plans, 40
outcome and output structure, 39
outcomes of PSRC hearings, 1–2, 6

Panel, PSR, 23–4
Pharmaceutical Benefits Scheme, prescriptions under, 8, 29–30
pathology, 7–8, 17, 19, 21–2
patients, services per, 8, 16, 18–19, 30
peer review process, see PSRCs
performance assessment, 39–40
performance pay, 42
powers of Director, 75–6
plans and planning, 40
practitioners, 10–11, 22–3, 77–8
referred, 1, 4–5, 9, 14–22, 27–31
Pradhan, Dr Jagjit, 1, 18–19
prescriptions, 8, 29–30
procedures (medical), 7–8, 9, 16–17, 19, 21–2
process, 3–4, 74–84
procurement, 45–6
professional organisations, 12–13
professional responsibility, 10–11
Professional Services Review Tribunals (PSR Tribunals), 35, 38
cases before, 14–15, 17, 19, 20
PSRCs, 2–3, 5–11, 13–22, 23–4, 76–81
reports, 36
Public Service Act staff, 41–2
publications, 46
publicity, 23
purchasing, 45–6
Quebec, 11

radiology, 8, 19, 21–2
random sampling, 25
ratifications, 4–5, 29–30, 82
re-referrals, 1
reasons for referral, 6–9, 14–22
recruitment of staff, 24
referrals, 1–11, 75–9
Regie de l’assurance maladie du Quebec, 11
regulations, 37
regulatory bodies, 11–12
reports to Determining Authority, 80
reports to Determining Officer, 2
resources, 24–5, 41–2, 45, 47–68
risk management plan, 40
Royal Australian College of General Practitioners, 12
sampling, 25
sanctions, 22, 34
scrutiny, see Federal Court; Professional Services Review Tribunals
section 91 dismissals, 2, 4
section 92 negotiated agreements/dismissals, 2, 4–5, 29–30, 82
section 93 PSRC hearings, 1–3, 5–6, 13–22, 76–9
section 93C (2), referrals lapsed under, 3
Senior Executive Service (SES), 42
services referred, 6–8, 15–19, 21–2, 27–9, 30–1
skin sensitivity testing, 16
specialist treatment, referrals for, 19
staff, 24–5, 41–5
development and training, 40, 43
employment conditions, 43
State and Territory Medical Boards, 10, 11
referrals to, 16, 17, 29
statistical sampling, 25
strategies, 41
suspended PSRC hearings, 6, 80–1

Tankey, Dr James, 19–20
Tisdall, Dr Peter, 20–1
Traill, Dr Malcolm, 21
training, 40, 43
PSRC members, 13–14

ultrasound, 31
University of Queensland Medical School, 13
unusual medical practice, 9, 16–17
'up-coding', 8

values, 40, 41
vision statement, 40
volume of services, 6–8, 15–19, 21–2, 27–9, 30–1

Willems, Paul, 24
withdrawn or lapsed referrals, 2, 3
workplace diversity, 42, 44
workplace reform, 43
workplace health and safety, 44
workshops, 13

Yohendran, Dr Nayagampillay, 21–2