PROFESSIONAL SERVICES REVIEW

annual report

ANNUAL REPORT 2001 – 02

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Professional Services Review
PO Box 136
Yarralumla ACT 2600

Telephone: 02 6281 9100
Facsimile: 02 6281 9199
Internet: www.psr.gov.au

Further information can be obtained from:

Executive Officer
Professional Services Review

Telephone: 02 6281 9100
Facsimile: 02 6281 9199

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PROFESSIONAL
SERVICES REVIEW

DIRECTOR
Dr John Holmes

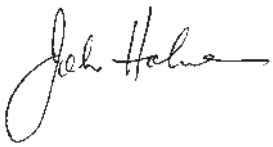
Senator the Hon. Kay Patterson
Minister for Health and Ageing
Parliament House
Canberra ACT 2600

Dear Minister

In accordance with subsection 63(1) of the *Public Service Act 1999* and section 106ZQ of the *Health Insurance Act 1973*, the eighth annual report of Professional Services Review is provided for your presentation to Parliament.

This report has been prepared in accordance with the requirements for annual reports approved by the Joint Committee of Public Accounts and Audit under subsection 63(2) of the *Public Service Act 1999*.

Yours sincerely



John Holmes
18 October 2002

PO Box 136 Yarralumla, ACT 2600
16 Bentham Street, Yarralumla, ACT 2600
TEL: (02) 6281 9100 FAX: (02) 6281 9199
http://www.psr.gov.au

Contents

Director's report

During the past year we have made considerable progress in settling down the PSR scheme, but this was severely impacted upon by the result of a decision in the Federal Court of Australia. Last year I reported on the initial effect of the application by Dr Pradhan of Adelaide to the Federal Court which required some active referrals to be put on hold until the result of that case was known. Following legal advice, further referrals were received from the Health Insurance Commission and were progressed via the investigation process.

However, in early November Mr Justice Finn in the Federal Court of Australia handed down his decision in the *Pradhan* matter finding the Investigative and Adjudicative Referrals to be invalid. The scope of the reasons was such that all the referrals then underway were considered to be legally suspect.

Following legal advice an appeal was lodged to the Full Federal Court and subsequently legislative amendments addressing the possible deficiencies in the legislation have been introduced into Federal Parliament. The appeal is yet to be heard.

Again all the cases in progress were put on hold and, as it was considered they may also be invalid, the option of taking no action under section 93A of the *Health Insurance Act 1973*, was applied to those cases which were yet to be started. The Commission reviewed these referrals and a number of new ones involving the same practitioners were made. These have been dealt with as prescribed by the legislation.

Later in the year, the decision in the *Grey* case would suggest the appeal in *Pradhan* has some prospect of success.

The above Federal Court decisions and their effects are more fully discussed later in this report. It does demonstrate the effect Court decisions have on the process, a problem identified in previous annual reports. I do believe the concerns identified by the *Pradhan* decision have been attended to and the PSR process is becoming increasingly more robust.

More recent court decisions have been supportive of the PSR scheme and the manner in which it is being implemented. The actions and decisions of Professional Services Review Committees have been challenged but the recent decisions in the Federal Court are extremely supportive. It is interesting and instructive to note that overseas experience with similar schemes is that it takes some seven or eight years from initiation of such schemes for them to be accepted by the various courts.

Despite these difficulties the process continued with investigation of the referrals and a considerable number of committees being established. These have held hearings and many are finalising their reports. Should the *Pradhan* appeal decision be in favour of PSR or the current legislative amendments become law, the result will be a considerable number of referrals, now on hold, becoming active. This will translate into a substantially increased workload to the committees and their secretariats and subsequently to the Determining Authority.

Members of the PSR Panel who serve on committees are greatly responsible for the success and professional acceptance of this scheme and their contribution, which goes largely unrewarded, cannot be underestimated. Without this involvement of clinicians the scheme would have great difficulty in being effective and indeed surviving. I thank them for their involvement; acceptance of the difficulties posed, as discussed, and their commitment to ensuring proper and professional judgments are made on their colleagues. It is extremely pleasing to be able to advise professional gatherings that no member of the PSR Panel has raised a significant concern as to the fairness, balance and professionalism given by colleagues to a difficult and sensitive responsibility. There continues to be strong support from the various professional associations.

The PSR Committees and myself are well supported by PSR staff who make a valuable contribution to the effectiveness of the process and

their efforts are much appreciated by the committee members and myself. It is always pleasing to receive laudatory comments on the efforts and performance of the PSR staff who sometimes have to deal with difficult and sensitive situations. I must acknowledge the retirement of Mr Peter Dunnett as Executive Officer in September 2001. Peter was one of the three original staff members who joined me on the establishment of PSR in 1994 and has shared in the development of the scheme. I will always be grateful for his advice, corporate knowledge of the health sector and his counsel. He played a significant role in establishing this unique scheme.

The legal services we have received from our legal advisers in Canberra, their colleagues providing support to PSR Committees in the various capital cities, and the Counsel who have appeared for us in the various legal forums have all provided an excellent service and this is most appreciated. They have always made the effort to keep us fully informed. The training workshops for PSR Panel members were again most successful and this is due to the efforts of those who gave their time and expertise to serve on the various teaching faculties. My especial thanks to Ms Felicity Hampel SC who was the chief coordinator of these workshops which received enthusiastic praise from the attendees.

Counselling by the Director or his nominee is one of the options available in a determination and is a common component of most determinations. Throughout the year I carried out a number of formal counsellings and it has again proven to be a most valuable exercise – I have been pleased by the manner in which counselling has been received. I usually have a Deputy Director or another Panel member accompany me at these meetings and they have expressed similar impressions about the value of counselling.

Following most counsellings it has been my impression that the hearing process and judgement by a peer group has been a salutary experience as well as an educational one. 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 a second finding, with a mandatory referral to a Medicare Participation Review Committee, is stressed at counsellings.

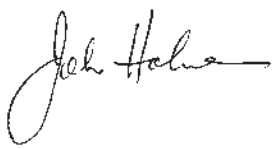
It is of concern that younger practitioners have had adverse findings made with the suspicion being that they have been badly advised by their early mentors. Indeed some of the mentors have also been the subject of adverse findings.

The referrals dealt with over the past year again demonstrate that the advice I have given in previous annual reports is still valid and worth repeating. That is:

- Good record keeping is a vital element of defence in any justification proceeding. This is an essential element of practice under the amended legislation and a requirement of many Medical Boards.
- Advice given by Commission medical advisers raising perceived concerns should make practitioners review their conduct and even seek advice from colleagues and their professional associations. The Commission is available to answer queries regarding Medicare and the interpretation of Medicare Benefit Schedule items. It is essential that such advice be documented.
- Medicine is a collegiate profession and professional associations and colleagues are always pleased to offer guidance. I recommend that practitioners keep in regular contact with these associations. However, advice can only be relevant if all the facts are known.
- 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. Other practitioners have claimed to be unaware of changes to legislative requirements affecting Medicare. It is a practitioner responsibility and this defence has not been accepted by peers.

Despite the difficulties outlined above and later in this report, I believe this past year has been successful with continuous improvement to the framework established in previous years and modified by experience and legal influences. The outcomes of the work of this year will be apparent when the next annual report is presented. It has also become clear that aberrant professional conduct is being modified by practitioners as a result of PSR outcomes and publicity. There nevertheless continues to be a need for an effective efficient accountability process based on a 'peer review' model in any funding system.

The PSR scheme continues to contribute to ensuring the Australian public receives the quality professional health care it deserves.



Dr John Holmes
Director

Agency overview 1

Post 1 August 1999

The role and function of Professional Services Review (PSR) is to administer Part VAA of the *Health Insurance Act 1973* (the Act), through investigating cases of suspected inappropriate practice by persons who render or initiate services attracting a Medicare benefit or by prescribing under the Pharmaceutical Benefits Scheme (see Appendix 3). After an investigation, the Director may:

- dismiss a referral;
- negotiate an agreement; or
- establish a peer review committee.

Dismissal

When a case is dismissed, the Director writes to the person under review, informing them of the outcome of the investigation.

Agreement

If the person under review enters into an agreement with the Director, a formal document is drawn up for signature by both parties and given to the Determining Authority to decide whether or not ratification is appropriate.

Peer review

Where the Director determines the conduct of the person under review requires further examination, a PSR committee is established. The committee comprises members drawn from a panel appointed by the Minister for Health and Ageing.

The committee conducts a hearing where the person under review can provide both oral and written evidence in support of their case. The Act allows for them to be accompanied by a lawyer or another adviser but limits a lawyer's role to providing advice to the person under review, addressing the committee on questions of law and making a final address on the merits of the matter. After considering all the evidence and taking into account any submissions received, the committee produces a draft report containing findings on the conduct of the person under review. After the person under review has been give time to comment on the draft report, a final report is forwarded to the Determining Authority.

In cases where the committee finds that the person under review has engaged in inappropriate practice the Determining Authority issues a draft determination, seeks comments from the person under review, and issues a final determination containing sanctions.

Federal Court

At any stage in the process the person under review may seek judicial review in the Federal Court.

Pre 1 August 1999

The essential differences under the pre 1 August 1999 legislation are as follows:

- the Director did not have the same powers of investigation;
- a Determining Officer (see page 11) determined the sanctions; and
- the person under review could take their case to a Professional Services Review Tribunal after the sanctions were established.

As at 30 June 2002, eight pre 1 August 1999 cases were awaiting finalisation.

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.

Our relationships

Health Insurance Commission

Professional Services Review's workload is dependent on referrals from the Health Insurance Commission (the Commission). The Commission, which administers Medicare and the Pharmaceutical

Benefits Scheme, refers cases of suspected inappropriate practice to PSR for investigation and further action.

Cases of fraud identified during the PSR process are referred back to the Commission for action.

Department of Health and Ageing

The Department of Health and Ageing assumes policy responsibility for providing advice to the Minister on development and maintenance of the PSR scheme. The Department liaises with stakeholders in the scheme and performs the broader tasks of policy review and development of legislation. A senior officer of the Department, the First Assistant Secretary, Health Access and Financing Division, has been appointed by the Minister to the position of Determining Officer for cases referred to PSR prior to 1 August 1999.

Other tasks include overseeing the operation of the Professional Services Review Tribunals and the appointment of Presidents and Members of those Tribunals.

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 Commission prior to that legislation coming into effect in August 1999. (The Tribunals are not empowered to review decisions of the Determining Authority, which took over the role of the Determining Officer for cases referred after August 1999.)

Medical boards

The Act allows for PSR to refer persons under review to State medical boards when a significant threat to the life or health of a patient is identified or to an appropriate professional body where the person under review has failed to comply with professional standards.

Report on performance 2

Outcome and output structure

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

The PSR output specified in the Portfolio Budget Statement 2001–02 was:

Output Groups	Performance Measures
1 Program Management • Examination of health practitioners' conduct to ascertain whether or not the practitioner has practiced inappropriately in relation to services which attract Medicare or pharmaceutical benefits.	**Quality:** Court challenges made in regard to committee processes, findings and Determining Authority determinations are resolved successfully. Rate of re-referral against a target of zero. **Quantity:** Approximately 50 referrals received from the Commission. Approximately 50 referrals finalised. **Price:** $6.946 million

Performance assessment

Court challenges

As reported last year, one of the first referrals made under the 1999 legislative changes was appealed to the Federal Court. An adverse decision was handed down in November 2001 where Finn J held that both the Investigative and Adjudicative Referrals were invalid (see page 33 for a report on Dr Pradhan). This had a severe impact on the PSR processing of similar cases, and required a number of actions to be taken.

At the time of the *Pradhan* ruling, there were 35 referrals in progress containing similar wording to Dr Pradhan's referral and the Director decided to put those referrals on hold pending the outcome of an appeal. For the same reason, PSR took no action on 52 investigative referrals and they were either withdrawn or allowed to lapse. The Commission later referred 33 of these back to PSR with different wording.

The Federal Court decision in *Pradhan* also necessitated further amendments to the legislation to respond to parts of the findings which would be adverse to the continued operation of the PSR scheme. These amendments were introduced into parliament on 27 June 2002.

Since Finn J's decision in *Pradhan*, three decisions have been handed down from the Full Court of the Federal Court where they have disagreed with some aspects of that judgment (see *Grey* on page 34, *Traill* on page 34 and *Hill* on page 30). These decisions allow PSR to be optimistic about its future operations.

Of the five Federal Court decisions this year, three have gone against PSR with only the *Pradhan* judgement being of any significance to the scheme. The other two with adverse findings to PSR were an action by Dr Christie to withdraw a request for review from a Tribunal where the final determination was upheld; and an action by Dr Grey, seeking to stop further action on the referral, that was overturned by the Full Court of the Federal Court in May 2002 (see page 34).

Table 1 – Court actions	2001–02
Court applications	10
Federal Court hearings held	3
Full Federal Court hearings held	2
Decisions handed down in favour of the person under review	3
Decisions handed down in favour of PSR	2
High Court applications	1

Re-referrals

This year, six practitioners were referred for a second time and one for a second and third time. The circumstances applicable to each re-referral is as follows:

Case 1

The Commission originally referred this general practitioner in 1997 because it was concerned that he may not have been able to provide an appropriate level of clinical input when consistently rendering a high volume of services. In the referral period, 1995–96, the practitioner rendered 24 200 services of which 131 were procedural services and the remainder were professional attendances. The matter went before a committee who found the practitioner's conduct would be unacceptable to the general body of general practitioners and therefore he had engaged in inappropriate practice.

In its report, the Committee stated that he 'provided episodic and band aid type care'; kept inadequate medical records; incorrectly itemised services 'to appease the Health Insurance Commission'; and was medically isolated. In June 1998 the Determining Officer issued a determination that the practitioner be counselled.

The practitioner was referred again in May 2002 for high numbers of rendered services and daily servicing and high levels of prescribing. The matter was still under investigation at 30 June 2002.

Cases 2 & 3

This general practitioner was referred in 1996 by the Commission because it was concerned he may not have been able to provide an appropriate level of clinical input when consistently rendering a high volume of services. In the referral period, 1995, the practitioner rendered 24 130 services of which some 23 000 were professional attendances. The matter went before a committee who found the practitioner's conduct would be unacceptable to the general body of general practitioners and therefore he had engaged in inappropriate practice.

In its report, the committee stated that the practitioner had probably not done all the things he claimed to have done during the professional attendances; he also claimed Level B services for repeat prescriptions which does not meet the requirements of the item as listed in the Medicare Benefits Schedule; he did not keep full and complete medical records; and his level of prescribing certain pain killers was undesirable as some patients may become dependent on

those drugs. In November 1997 the Determining Officer issued a determination that the practitioner be counselled and disqualified from certain items in the Medicare Benefits Schedule for six months.

The practitioner was referred again in December 2001 for having rendered 80 or more professional attendances on 20 or more days in 2000. The matter has been referred to a committee for consideration.

The practitioner was referred for a third time in March 2002 for high numbers of rendered services and high prescribing. Because some of the services overlapped those in the period of the December 2001 referral, the Director decided to take no further action on this third referral and it was withdrawn.

Case 4

The Commission first referred this practitioner in June 1997 for high volumes of rendered services and high initiation of pathology. The practitioner rendered 11 400 professional attendances and 5400 procedural items in 1995–96. Following a visit with the practitioner, the Director dismissed the referral in May 1999 on the basis he considered there would be insufficient grounds on which a committee could reasonably find the practitioner had engaged in inappropriate practice.

The practitioner was referred again in December 2001 for having rendered 80 or more professional attendances on 45 days in an eight-month period in 2000. The matter has been referred to a committee for consideration.

Case 5

In January 1997 the Commission referred this practitioner to PSR for services in 1995 as it was concerned he may not have been able to provide an appropriate level of clinical input when consistently rendering a high volume of services, including 24 680 professional attendances. The matter was referred to a committee that found services by the practitioner lacked adequate clinical input and prescribing of benzodiazepines was without indication and tended to maintain patient dependency. An unchallenged determination came into effect in January 2000 where the practitioner was counselled, reprimanded and required to repay Medicare benefits of $7972.

This practitioner was referred again in December 2001 for having rendered high volumes of services (20 500 professional attendances) and prescribing (21 400 items to 4200 patients including 5500 benzodiazepines). Following an investigation and advice from a

specialist in the drug and alcohol area, this practitioner was referred to a committee and the State Medical Board.

Case 6

The Commission first referred this practitioner in June 2000 for his rendered services, daily servicing and initiation of pathology. In the referral period of 1998–99, the practitioner rendered 17 146 services to 3682 patients. The Director entered into an agreement with the practitioner of a reprimand, repayment of $5000 to the Commonwealth and disqualification from providing services listed in group A1 of the Medicare Benefits Schedule for one month.

The practitioner was again referred in December 2001 for a prescribed pattern of services, having rendered 80 or more professional attendances on 24 days in an eleven-month period. The case was referred to a committee and, as at 30 June 2002, hearings had concluded and a report was being drafted.

Case 7

The Commission first referred this practitioner in June 2000 for his rendered services and daily servicing. In the referral period, 1999, the practitioner rendered 21 970 services to 4052 patients. The Director entered into an agreement with the practitioner of a reprimand, repayment of $12 000 to the Commonwealth and disqualification from providing services listed in group A1 of the Medicare Benefits Schedule for three months.

The practitioner was again referred in December 2001 for a prescribed pattern of services having rendered 80 or more professional attendances on 56 days in a six-month period. The case was referred to a committee and, as at 30 June 2002, hearings had concluded and a report was being drafted.

Referrals from the Commission

The Commission sent 94 referrals this year. This may appear to be a high number, but it is skewed because 52 of the 94 were withdrawn, following the *Pradhan* decision, then the Commission subsequently re-referred 33 with different wording.

On completion of an investigation, the Director dismissed 13 cases as he considered there would be insufficient grounds on which a committee could reasonably find the practitioner had engaged in inappropriate practice. Another 31 cases were sent to committees for further examination (see Table 2).

Table 2 – Referrals from the Commission	2001–02	2000–01
Referrals received from the Commission	94	63
Referrals dismissed	13	18
Agreements negotiated	0	16
Referrals withdrawn or lapsed	52	2
Re-referrals	*7	5
Committees established	31	30
Referrals to medical boards	0	5
Disqualifications from Medicare	**1	0
Suspected fraud	0	0

** These are practitioners who have also previously been referred.*

*** Disqualified March 2001 to November 2001.*

Referrals to committees

The Director sent 31 referrals to committees during the year (see Table 3). Seventeen of these were for a prescribed pattern of services. Only one committee reported – a case concerning a prescribed pattern of services. Of the 52 cases in various stages of the process, 35 were put on hold due to the *Pradhan* decision, mentioned earlier.

Four practitioners were referred to medical boards for a possible threat to the life or health of a patient or patients and one of those was also referred back to the Commission for possible fraud. One other practitioner was disqualified from Medicare benefit arrangements for seven days for failing to produce patient records when the committee issued a Notice to Produce Documents.

With the exception of the 18 prescribed pattern of services cases (one case was sent to a committee in the previous financial year) before committees during the year, most committees have used a sampling method to help quantify levels of inappropriate practice and allow for extrapolation of repayment should the Determining Authority choose this as a sanction.

Table 3 – Referrals to committees	2001–02	2000–01
Referrals sent to committees	31	30
Committee sessions held	*105	67
Reports being drafted	41	4
Reports completed	1	6
Adverse findings	1	6
Practitioner cleared	0	0
Hearings in progress	**52	27
Referrals to medical boards	4	1
Disqualifications from Medicare	***1	2
Suspected fraud	1	1

** Includes teleconferences, meetings and sittings.*

*** Includes referrals suspended because of the Pradhan case. Some cases were in progress over both years.*

**** Disqualified November 2001 for seven days.*

Determining Officer

The Determining Officer's role applies to all cases referred by the Commission before 1 August 1999. (For cases referred after that date, the Determining Authority takes the role.) The First Assistant Secretary, Health Access and Financing Division in the Department of Health and Ageing currently holds the position and was appointed ministerially. The Determining Officer makes determinations in respect of practitioners who have been found by a committee of their peers to have engaged in inappropriate practice.

In making a determination, one or more of the directions specified in section 106U of the Act is applied. These include:

- reprimanding and/or 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.

During the year, the Determining Officer issued three final determinations in relation to committee reports (see Table 4). Sanctions in respect of these determinations included repayment of $17 672.

Table 4 – Determining Officer cases	2001–02	2000–01
Committee reports received	1	6
Final determinations issued	3	12
Request for review to PSR Tribunal	2	4

Professional Services Review Tribunal

Practitioners, in respect of whom the Determining Officer has made a final determination, may ask the Minister for Health and Ageing 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 committees, the person under review may be legally represented.

In the year, the Minister received two requests from practitioners who sought a review of their final determinations and one request from the previous year was outstanding (see Table 5). The Tribunal held hearings in respect of two of these requests and handed down decisions in three (two from cases heard in the previous year).

In one case, the Tribunal set aside the final determination and made a determination in lieu, which included all the sanctions of the first but reduced the repayment by $2759 to $116 162. In the other two cases, the Tribunal affirmed the final determinations made by the Determining Officer.

These cases are discussed in full at pages 26–29.

At 30 June 2002, one decision was pending (*Sinnathamby*, decision handed down on 10 July 2002, see page 28) and a hearing had yet to be scheduled for another request.

Table 5 – Professional Services Review Tribunal cases	2001–02	2000–01
Appeals received	2	4
Hearings held	2	5
Decisions handed down in favour of the person under review	0	0
Decisions handed down in favour of PSR	*3	**2
Appeal withdrawn	0	1

**In one case, the Tribunal reduced the repayment amount by $2759 to $116 162.*

*** In one case, the Tribunal reduced the repayment amount by $2343 to $1761.*

Determining Authority

Few cases were sent to the Determining Authority this year, largely due to the *Pradhan* decision in the Federal Court in November 2001. On advice, the Authority refused to ratify all three agreements negotiated between the Director and the respective practitioners as the referrals from the Commission contained words similar to those in *Pradhan*.

At 30 June 2002 the Authority had not completed a final determination on the committee report sent to it this year.

Table 6 – Determining Authority cases	2001–02	2000–01
Negotiated agreements received	3	17
Negotiated agreements ratified	0	16
Negotiated agreements not ratified	*3	1
Committee reports received	1	0
Final determinations issued	0	0

**Based on the Pradhan Federal Court decision.*

Reasons for referral

Commission referrals

The reasons for investigative referrals by the Commission generally fall within select and distinctive categories. As the Commission only has access to claims data, the categories are limited to the results of statistical interrogation. Referrals generally fall into one or more of the following categories:

- prescribed pattern of services*;
- high volume of services;
- high number of services per patient;
- high prescribing of Pharmaceutical Benefits Scheme drugs; and
- high ordering of pathology and diagnostic imaging tests.

**A prescribed pattern of services also forms a reason for a referral from the Director to a committee.*

Table 7 – Types of concerns in Commission referrals	2001–02
Prescribed pattern of services	17
High volume of services	28
High Medicare Benefits Schedule level C and D services	14
High services per patient	13
High ordering of pathology and diagnostic imaging	17
High Pharmaceutical Benefits Scheme prescribing	13
Other	6

Note: some referrals contained more than one of the above concerns.

Committee referrals

Under the changes to the legislation made in 1999, when the Director makes a decision to investigate he has the power to obtain patient records and other relevant documents that are examined by appropriately qualified and experienced practitioners. This gives a greater insight into the particular practitioner's behaviour than was available to the Commission. Consequently, issues that become apparent following an investigation and may be part of reasons for referral to a committee are:

- inadequate clinical input;
- Medicare Benefits Schedule item descriptor not satisfied;
- services not medically necessary;
- particular services or types of services; and
- unacceptable medical records.

Table 8 – Types of services referred to committees	2001–02
Prescribed pattern of services	17
Standard consultations	8
Long consultations	8
Prolonged consultations	3
Other Medicare Benefits Schedule items	4
Pharmaceutical Benefits Scheme prescribing	3

Note: some referrals contained more than one of the above services.

Table 9 – Reasons for referral to committees	2001–02
Inadequate clinical input	12
Unacceptable standard of record keeping	12
Services not medically necessary	6
Medicare Benefits Schedule not satisfied	10

Note: all referrals contained more than one of the above reasons.

Other types of concerns

There are three other areas of concern that can become apparent during an investigation or during a committee process. These are:

- professional isolation;
- unusual medical practice; and
- alteration of documents.

A discussion of the different types of concerns in Commission referrals, reasons for referral to committees and other types of concerns follows.

Prescribed pattern of services

One of the challenging aspects of PSR activity this year has been a new form of referral – the prescribed pattern of services.

Following a 1999 review of the scheme by the Australian Medical Association (AMA), the Commission, the Department of Health and Ageing and PSR,[1] legislative changes were made to include a method of examining the conduct of practitioners who have high volumes of services. The legislation came into effect for services rendered after 1 January 2000, and the first wave of these referrals was received this financial year.

In a significant departure from other types of referrals received at PSR, a practitioner who performs 80 or more professional attendances on 20 or more days in a twelve-month period is automatically deemed by the legislation to have practiced inappropriately, unless they can provide evidence that exceptional circumstances existed. That is, the onus of proof is on the practitioner to demonstrate that he or she did not practice inappropriately.

Although a prescribed pattern of services can be applied to any medical specialty or type of service, so far the regulations[2] only apply to general practitioners and other medical practitioners rendering professional attendances. (Professional attendances are essentially consultations and do not include other services, such as procedural items.)

The combination of 80 or more services on 20 or more days in a twelve-month period was arrived at by the review committee in consultation with the AMA's Federal Council, the AMA Council of General Practice, the Royal Australian College of General Practitioners, the Rural Doctors' Association of Australia and the

[1] The Report of the Review Committee of the Professional Services Review Scheme, March 1999 – a copy is on the PSR website at <www.psr.gov.au>.

[2] *Health Insurance (Professional Services Review) Amendment Regulations 1999 (No.1) – SR1999 No.346.*

Australian Divisions of General Practice. In general, the profession accepted that practitioners providing high volumes of services could not possibly be providing adequate clinical care for their patients.

The Director has limited power in respect of these referrals and although he can receive submissions from the person under review, it must be a committee that hears any claims of exceptional circumstances. The regulations provide guidance: they declare exceptional circumstances to be an unusual occurrence causing an unusual level of need for professional attendances, and an absence of other medical services, for patients of the person under review during the relevant period, having regard to the location of the practice and the characteristics of the patients.

The review committee was firmly of the view that a high level of skill, competence and organisational arrangements were important for practitioners. But while they may have a great effect on a practitioner's ability to provide 50, rather than 20, consultations regularly per day, skill, competence and organisational arrangements would have little effect on the provision of 80 attendances per day.

A single referral, received late in 2000–01, was a practitioner who had rendered 80 or more professional attendances on 92 days in a six-month period. In that period, the practitioner's Medicare profile showed that he rendered some 11 300 consultations plus 3000 procedural items. The practitioner provided 153 consultations on a single day and it was not uncommon for him to regularly provide over 100 consultations per day. This case is currently before the Determining Authority.

Seventeen referrals of this type were received in 2001–02. They vary between a practitioner who rendered 80 or more professional attendances on 129 days in a ten-month period; and a practitioner who rendered 80 or more professional attendance on 22 days in an eleven-month period. Fifteen of these cases have been heard and the committees are preparing draft reports.

High volume of services

It is important to appreciate that the prescribed pattern of services is not a 'speed limit'. Apart from those practitioners referred under this concern, there is a small number who regularly provide a high number of services at the 99th percentile of approximately 15 000 services per annum. Servicing at a level below that prescribed pattern does not prevent a practitioner from being asked to justify their conduct in the PSR process.

The majority of general practitioners have great difficulty understanding how such large numbers of patients can be seen on a regular basis and still be provided with proper medical care. Proper medical care requires a range of activities by the treating practitioner, such as:

- 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, which may involve arranging for relevant diagnostic tests (pathology and/or diagnostic imaging tests);
- a diagnosis; and
- implementation of a management plan that may include prescribing drugs, referral for consultant advice, or treatment and explanation of the management plan to the patient.

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

It may be financially rewarding for a practitioner to see high volumes of patients, but this style of practice generally only allows time for addressing the presenting symptom or complaint and is of little overall benefit to the patient. So far, committees have not accepted arguments that excessively high throughputs can be explained by claims of superior ability and organisation or vast experience.

High number of services per patient

Practitioners who provide, on average, a higher number of services per patient than their peers sometimes try to explain it by claiming to have a smaller and older (and 'sicker' with multiple pathology) patient base. However, it is often been found by committees to be the result of a practitioner acceding too easily to patient demands without having due regard to the medical or clinical necessity for the frequency of service. These practitioners usually also have high unexplainable prescribing rates.

High prescribing of Pharmaceutical Benefits Scheme drugs

A high volume of prescribing under the Pharmaceutical Benefits Scheme often leads to a Commission referral. Many of these referrals involve the prescribing of addictive pharmaceuticals, such as benzodiazepines, painkillers and narcotics. This year, 13 referrals expressed concern about the prescribing of drugs, some of which resulted in referral to the relevant Medical Board. It seems, from evidence gathered by committees, that on occasions, high prescribing

is a result of acceding to patient demand or can be used by the practitioner as a way to end the consultation.

High ordering of pathology and diagnostic imaging tests

This year, 17 referrals contained concerns of high ordering of pathology and diagnostic imaging tests. Practitioners provided a range of reasons in support of their statistically high requests of pathology or diagnostic imaging services. The different reasons included an overly cautious concern about claims of possible malpractice or the style of practice undertaken. As with prescribing, committees often form the view that a pathology test is another convenient way for a practitioner to end a consultation where there is no apparent reason for the testing.

Unacceptable medical records

Twelve of the Director's 14 referrals (other than referrals concerning prescribed pattern of services) to committees contained a concern that the practitioner had failed to keep adequate and contemporaneous medical records. This is a large proportion of referrals and should be of some concern to the profession.

A good record is an important element to justify the service initiated or rendered. In cases where the Director has dismissed a referral, or a committee has not made an adverse finding, the medical records have been such that they supported the practitioner's conduct and claims. This highlights the importance of maintaining comprehensive medical records.

From 1 January 2000, Commonwealth legislation required a committee, in consideration of an adjudicative referral, to have regard to whether a practitioner has kept adequate and contemporaneous medical records. The committee is further required to take this into account when making decisions on whether the practitioner had engaged in inappropriate practice

The Commonwealth's requirement for patient records is broad and not as onerous as some State and Territory legislation. For a record to be adequate, it must:

- clearly identify the patient;
- contain a separate entry for each attendance;
- provide clinical information to explain the service/s rendered or initiated; and
- be sufficiently comprehensible so another practitioner can undertake ongoing care of the patient.

To be contemporaneous, the record must be completed at the time of the service or as soon as is practicable afterwards.

The extent that the practitioners referred for a prescribed pattern of services kept unacceptable records is unknown. The Director does not need to order production of records in these cases. However, if previous experience with the records of other practitioners rendering high volumes of services is an indication, it is suspected that these practitioners' records would also be significantly deficient.

Inadequate clinical input

There were 10 referrals to committees this year that concerned possible inadequate clinical input. During investigation, examination of medical records sometimes suggests the practitioner may not have provided adequate clinical input when treating patients.

The Act defines a professional service on which a Medicare benefit is paid, but leaves the decision of the clinical relevance of that service to what is generally accepted by practitioners' peers as the appropriate treatment for the patients.

Medicare Benefits Schedule item not satisfied

In 10 cases referred to committees this year it appeared to the Director that the item of service the practitioner claimed may not have actually been provided at the appropriate level. In most cases, following examination of patient records and submissions by the practitioner, the Director was of the view the practitioner may have claimed a Medicare Benefits Schedule item of greater value than the records or submissions demonstrated.

Common examples involved claiming a long, rather than a standard, consultation or claiming for suturing a deep wound, rather than a superficial wound. 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, after a lapse of time, of proving intent to defraud.

The other common type of 'error' occurs where a practitioner regularly includes the time for procedural services as part of the overall time spent with the patient and hence itemises a longer consultation than actually took place. Some practitioners claim to be unaware that by billing a separate benefit for procedural services they are not entitled to add the time taken to the consultation component.

Services not medically necessary

This year six referrals to committees contained the concern of services not medically necessary. When a patient consults a practitioner for a particular problem the expectation is that they are going to be treated for that complaint, but it appears that some practitioners also perform services that are not clinically indicated and therefore not medically necessary.

This situation is often revealed upon examination of medical records which show the patient's presenting complaint then the resulting treatment. At times there appeared to be no correlation between the complaint and some of the treatment.

Particular services or types of services

Once the Director has completed an investigation (by examining patient records and submissions from the practitioner) of the broadly framed initial referral from the Commission, it becomes more apparent where the concerns lie. The Director is then able to focus the referral, for specific attention by the committee, on concerns within a particular Medicare Benefits Schedule item or items. Often this will lead to a referral of all Medicare Benefits Schedule item 36 or 44 consultation services. Sometimes the referral will be for a particular procedural or diagnostic service. Questioning in the committee hearing often reveals there was no proper clinical indication for the procedure; the conclusion to be reached is that the indication for the procedure was because the practitioner had access to the necessary equipment.

Professional isolation

Practitioners referred by the Commission are often professionally isolated. They have little contact with professional colleagues and/or fail to keep their professional knowledge up-to-date. Others are manipulated by more senior practitioners or 'employers', or have deluded themselves. In the course of hearings, committees have also come across a few instances of impaired practitioners, mainly due to illness or substance abuse, and have referred these practitioners to the relevant Medical Board.

A number of practitioners who work as independent contractors or employees in medical centres have claimed that office staff are responsible for itemisation on documents for Medicare benefit. This defence has been accorded little weight because the practitioner alone is responsible for the accuracy of the information provided for the purposes of a Medicare claim and this responsibility cannot be abdicated.

Unusual medical practice

It is important for practitioners to remember that the PSR scheme applies to services rendered or initiated under the Medicare benefits arrangements and medications prescribed under the Pharmaceutical Benefits Scheme. Within the legislation encompassing both schemes there are strict criteria about benefit eligibility.

Practitioners providing medicine that can be characterised as alternative or complementary need to be aware that for their services to be eligible for a benefit they must still meet the prescribed criteria.

The most important point is that the service must be clinically relevant. That is, the service must be generally accepted by the medical profession as being necessary for the appropriate treatment of the patient. For example, as prescribing lithium for treating patients with multiple sclerosis would not be generally accepted by the medical profession as appropriate treatment, the person rendering the service would be found to have engaged in inappropriate practice.

Alteration of documents

On a number of occasions, during both the initial investigation and at committee hearings, suspicion has been raised that the medical records produced have been altered subsequent to the notice ordering their production. This is an offence under Commonwealth legislation and arrangements are in place to enable prosecution of cases involving such fraudulent activity. State and Territory Medical Boards are also concerned by such conduct and have significant penalties at their disposal.

Case summaries

The following case summaries are examples of referrals received by PSR.

Case 8 – Prescribed pattern of services

The Commission referred this general practitioner because it had evidence some of his professional attendances constituted a prescribed pattern of services and it considered, therefore, that he may have engaged in inappropriate practice. The Commission's statistics showed the practitioner had rendered 80 or more professional attendances per day for 54 days in a seven-month period.

The Director received a submission from the practitioner claiming exceptional circumstances but, as required by the legislation, only a committee of the practitioner's peers can consider such claims. Consequently, the Director referred this practitioner's case to a committee.

In the practitioner's submission, and at the committee hearing, he claimed the following exceptional circumstances:

- the practice is in a busy new growth area;
- a practice partner had left, leaving him to service that practitioner's patients as well as his own;
- he worked long hours;
- days following public holidays and his days off were extremely busy; and
- he catered for a particular ethnic group with special needs.

Outcome: The committee did not accept the practitioner's claims constituted exceptional circumstances because the situations were foreseeable and could have been addressed through better practice management.

Case 9 – High volume of services

The Commission referred this general practitioner for high volume of services, the number of daily services, and a high volume of acupuncture services. During the twelve-month referral period the practitioner rendered over 17 000 services to 4500 patients, provided 60 or more services on 166 days and 80 or more services on six days, and rendered almost 3000 acupuncture treatments. The Commission believed the statistics showed the practitioner would not be able to sustain an acceptable level of clinical input at this servicing rate on a regular and continuing basis.

A review of a random sample of 60 medical records revealed that the entries were clearly set out with the presenting complaint, history, examination and test results and management advice given. A submission from the practitioner revealed that he lived on the practice premises and worked long hours but had now employed an assistant.

A visit to the practitioner by the Director and a Deputy Director revealed that the practitioner had reviewed his practice and workload since receiving the Commission's referral with the intention of improving his service to patients. The Director advised him to keep in regular contact with the Commission's Medical Advisers and continue his work with the local Division of General Practice.

Outcome: The referral was dismissed.

Case 10 – High volume of services

The Commission referred this practitioner for the volume of his rendered services and his daily servicing. The Commission was concerned that, at that level of servicing, he may not have been

providing appropriate professional services to his patients. The practitioner rendered some 18 000 consultations to 4500 patients in the twelve-month referral period, with over 60 services per day on 200 days.

An investigation revealed the standard of record keeping was poor with the consultation notes barely legible. Management plans, including prescriptions, were hard to follow. There did not appear to be a pattern of seeing patients at regular intervals but the numbers of services per patient were much higher than the average. Blood tests were performed on most patients and it was hard to determine if these were justified. The outcome of the investigation was that the Director considered this practitioner's deficiencies were best addressed through either a negotiated agreement or referral to a committee.

The Director, accompanied by a Deputy Director, met with the practitioner to discuss the outcome of the investigation and the terms of a possible agreement. The practitioner accepted that his deficient medical records reflected a lack of clinical input, his high percentages per patient could not be justified and the reasons for blood tests could not be determined from the medical records.

Outcome: The Director negotiated an agreement of a reprimand with repayment to the Commonwealth of $25 000.

Case 11 – High services per patient

The Commission referred this optometrist for rendering high services per patient. During the twelve-month referral period the practitioner rendered some 1600 services to over 900 patients.

The Director employed a consultant optometrist to review the initial referral from the Commission and then to review patient medical records. The consultant reported that in her opinion there was no evidence of inappropriate practice. The records examined were complete and supported the Medicare item claimed for the service.

At a meeting attended by the practitioner, the principal of the practice, the Director and a PSR Medical Adviser it was revealed that the optometrist's mode of practice was highly skewed to paediatrics, thus explaining the aberrant statistics.

Outcome: The referral was dismissed.

Case 12 – High services per patient and home visits

The Commission referred this practitioner for rendering an average of seven services per patient, a rate which is on the 96th percentile of all active medical practitioners in Australia and for rendering over 6000 services to just under 900 patients, all of which were home visits.

In conducting an investigation, the Director sought copies of the practitioner's medical records for a random sample of patients. The records the practitioner provided had not been prepared for recording details of any consultations, but had been created later to fulfil the Director's request.

The Director referred the case to a committee to consider whether the practitioner had engaged in inappropriate practice by:

- failing to keep medical records of services rendered;
- rendering services that were not medically necessary; and
- failing to meet Medicare Benefits Schedule requirements.

During the hearing, the committee determined that the practitioner did not have a place of practice and only provided services in the homes of his patients. These patients were generally of the same ethnic origin as the practitioner and the visits may have, at times, contained a high social element. No medical records of the visits were ever kept.

Outcome: The committee found the practitioner failed to keep medical records containing details of the consultations. The practitioner was unable to substantiate any of the services provided.

Case 13 – Inadequate clinical input, unacceptable standard of record keeping, services not medically necessary; and Medicare Benefits Schedule not satisfied

The Director referred this practitioner to a committee to consider if he had engaged in inappropriate practice by failing to provide adequate clinical input into services, rendering and initiating services that were not medically necessary, keeping records that were deficient in essential clinical information, failing to satisfy the requirements of the relevant Medicare Benefits Schedule items and initiating pathology services for possible screening purposes.

The practitioner rendered 6950 services to 750 patients at an average of nine services per patient. He also initiated 3700 pathology services for 390 patients at an average of 9.5 tests per patient. In the same period he also wrote 9300 prescription items.

The services referred to the committee were several consultation items, some procedural items and a number of pathology tests.

Outcome: The committee found that the practitioner had a poor standard of record keeping; was professionally isolated; used the Medicare Benefits Schedule incorrectly; and did much of the pathology testing for health screening purposes.

Case 14 – Services per patient, level of home visits and emergency home visits and adequacy of record keeping

The Commission referred this practitioner for his high services per patient, level of home visits and emergency home visits and adequacy of record keeping. During the referral period he had an average of 13.14 services per patient and rendered 1932 services to 147 patients, 1783 of which were home visits or emergency home visits. The Commission's concern about this practitioner's record keeping stemmed from him informing a Commission Medical Adviser during a visit that he did not keep full patient records, relying instead on notes in his diary.

During the investigation the Director determined that this practitioner did not have a place of practice but often worked from home and/or, as the practitioner said, the 'boot of his car'. The Director's investigation resulted in the practitioner being referred to a medical board for his conduct in prescribing narcotics and benzodiazepines and polypharmacy.

The Director then referred several Medicare Benefits Schedule items to a committee to consider whether the practitioner had engaged in inappropriate practice by:

- failing to provide adequate clinical input into the services;
- rendering services that were not medically necessary;
- managing patients with chronic pain in a clinically unacceptable way;
- prescribing narcotics, benzodiazepines and codeine-containing compounds where they were not clinically indicated; and
- failing to keep adequate and contemporaneous records of services rendered during the referral period.

During the course of the hearing the committee discovered the following about the practitioner's methods:

- he performed PAP smears and rectal examinations on the couch in patients' homes using towels to drape the area and a pen torch for illumination;
- his drug supply was stored at his home in the kitchen refrigerator and transported to visits in the boot of his car which he subsequently parked in the shade so it would not overheat;
- he sterilised instruments in a saucepan of boiling water on the kitchen stove of his residence;

- he used household drinking alcohol, supplied by patients, Dettol™ or Savlon™ to cleanse his hands before procedures; and
- his waste disposal method was to put speculums and syringes in a plastic bag he kept in the back of his car.

The committee referred the practitioner's conduct to a medical board because they considered that his behaviour was causing a threat to the life or health of his patients.

Outcome: The committee hearing is yet to be concluded.

Appeals to the Professional Services Review Tribunal

Dr Hildegarde Damato, general practitioner of Stanhope, New South Wales

The Commission referred Dr Damato in 1997 over concerns of high average number of services per patient, high proportion of long and prolonged consultations and home visits. The Commission was concerned that some of these services may not have been reasonably medically necessary for patient care.

A committee was established on 18 March 1999 and on 18 May 1999, Dr Damato applied to the Federal Court for an injunction to stop the committee proceeding because of the delay in establishing it. On 7 June 1999 Whitlam J[3] refused an interim injunction to stop the committee hearing and the application was later discontinued.

The committee reported on 31 March 2000 that Dr Damato had engaged in inappropriate practice in respect of 83 per cent of Medicare Benefits Schedule item 36 consultations, 90 per cent of Medicare Benefits Schedule item 37 home visits, 81 per cent of Medicare Benefits Schedule item 44 consultations, and 86 per cent of Medicare Benefits Schedule item 47 home visits rendered during the referral period. The committee employed a statistical sampling methodology to arrive at these figures. The committee's report also expressed concerns as to Dr Damato's clinical knowledge and competency, the state and content of her medical records, and her understanding of her obligations under Medicare.

On 6 April 2001 the Determining Officer directed that Dr Damato be reprimanded, counselled, repay Medicare benefits totalling $54 260, and be fully disqualified from participating in the Medicare benefit arrangements for four months.

Dr Damato sought review by the Tribunal, initially on 22 grounds, ultimately reduced to those noted below.

[3] *Damato v Holmes* [1999] FCA 758 – all PSR Tribunal and Federal Court decisions are available on the PSR website <www.psr.gov.au>.

Although the committee reported that it had employed the statutory sampling methodology provided under the legislation at the time of the referral, the Tribunal considered that it had failed to do so. Nevertheless, the Tribunal held that the actual methodology used was valid. Dr Damato did not challenge the sampling methodology the committee used, but argued that the Determination should be set aside because of a misunderstanding by the Determining Officer as to what had actually been done. The Tribunal saw no substance in that submission.

Dr Damato submitted that delay in establishing the committee meant it could not offer her a fair hearing, and had led her to believe that investigation of her conduct would not proceed. The Tribunal did not agree because there was no evidence that she was significantly disadvantaged and there was no reasonable basis for her to believe that the investigation would not proceed. It also noted that the Federal Court had earlier declined to intervene.

Nor was she prejudiced by her failure to be accompanied by a lawyer at three hearing days. She had legal assistance on the first hearing day and in other respects.

Dr Damato's main submission was that the committee inquired and made findings about irrelevant matters outside the subject matter of the referral. In the light of the Federal Court's recent decision (*Tisdall*), the Tribunal considered that, in respect of the referred long and prolonged surgery consultations and home visits, the committee was entitled to examine the quality of and the time spent on the services, their medical necessity, the appropriateness of diagnosis and prescribed treatment, the competence and knowledge of the applicant, and the sufficiency of clinical notes. The Tribunal did not consider that the committee went beyond the referral, embarked on an open-ended inquiry, or relied solely on the state of her medical records. On the material in the Report, the Tribunal substantially agreed with the committee's findings and reasons.

On 27 June 2002, the Tribunal affirmed the Determination.[4]

[4] On 17 July 2002 Dr Damato appealed to the Federal Court. Details will be provided next year.

Dr Sivalingam Sinnathamby, general practitioner of Auchenflower, Queensland

The Commission referred Dr Sinnathamby in 1997 over concerns of high average services per patient, a high rate of initiation of pathology and diagnostic imaging, and a high level of hospital consultations. The Commission was concerned that some of these services may not have been reasonably medically necessary for patient care.

After its investigation, on 16 February 2000, the committee reported that Dr Sinnathamby had engaged in inappropriate practice through rendering or initiating services which were not clinically relevant and/or not reasonably medically necessary. The committee also had concerns about dangerous practices; inadequate patient records; deficient medical knowledge; the extent, frequency and cost of pathology; compliance with patient demands; repeated daily and long hospital attendances; failure to initiate particular tests; and aspects of prescribing.

The Determining Officer directed that Dr Sinnathamby be reprimanded, counselled, repay $8879, be fully disqualified from participating in the Medicare benefit arrangements for three months and be partially disqualified for six months.

Dr Sinnathamby sought review by the Tribunal and, on 10 July 2002, the Tribunal made a fresh Determination in the same terms as above, except that the repayment was omitted. The Tribunal considered that, because of the nature of the particular services (where the benefit is derived by the number of patients seen on the one occasion), there was sufficient doubt about the actual amount of benefit paid.

On particular contentions by Dr Sinnathamby, the Tribunal said:

- It was not convinced that the committee had not afforded Dr Sinnathamby procedural fairness – he had been made aware of their concerns in various ways; he had the assistance of a legal adviser; and he failed to make submissions on the draft report.
- His vague or uninformative responses to some questions explained why the questioning was persistent and probing at times.
- Whilst an additional committee member brought pathology expertise to the committee, he was not used improperly as an expert witness.
- The committee was entitled to take deficiencies in Dr Sinnathamby's medical records into account, but these did not dominate its decisions.

- The material before the committee provided no justification for the excessive hospital attendances on certain patients and conclusively demonstrated inappropriate practice.
- The mere fact that a hospital patient was also seen by another practitioner on the same day would not justify a finding of inappropriate practice, but the committee was in a position to make informed general findings as to Dr Sinnathamby's practice from the material before it.

Overall, the Tribunal found that Dr Sinnathamby's conduct during the referral period in connection with rendering surgery and hospital consultations and initiation of pathology and diagnostic imaging services was properly characterised as inappropriate practice – notwithstanding that the finding was not related to particular services or a specific proportion of services.

Given the seriousness of the conduct and the lack of evidence that Dr Sinnathamby had changed his practice to be more acceptable, the Tribunal considered that the periods of disqualification were appropriate.

At the same time Dr Sinnathamby sought a review by the Tribunal, he also appealed to the Federal Court on unspecified grounds. That appeal was dismissed by the Court after the Tribunal published its decision.[5]

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

Last year it was reported that Dr Yohendran had asked the Tribunal to review a Determination that he be counselled, reprimanded, repay Medicare benefits totalling $118 921, and be disqualified from participating in Medicare benefit arrangements for certain periods following a committee report that he had engaged in inappropriate practice.

On 28 August 2001 the Tribunal made a fresh Determination which, in effect, reduced the Medicare repayments to $116 162. The reduction resulted from a merits reassessment of certain services.

No statutory provision existed for sampling at the time of this referral (after the 1994 provision was repealed in 1997 and before the new 1999 provision). The committee followed a sampling methodology recommended by an expert statistician. Dr Yohendran conceded some inappropriate practice but challenged the methodology and the Tribunal upheld the committee's application of the sampling methodology.

[5] On 5 August 2002 Dr Sinnathamby again appealed to the Federal Court against the Tribunal decision.

Professional Services Review Tribunal decision appealed to the Federal Court

Dr Wilvene Hill, general practitioner of Ringwood, Victoria

Last year it was reported that Dr Hill had asked that the Tribunal review a Determination that she be counselled, reprimanded and disqualified from Medicare arrangements for 18 months following a committee report that she had engaged in inappropriate practice.

On 3 July 2001 the Tribunal affirmed the Determination and held that, notwithstanding Dr Hill's failure to provide adequate information, the committee was entitled to draw conclusions from information it had received in the referral and the information that was provided by Dr Hill.

Dr Hill appealed to the Federal Court against the Tribunal decision.[6]

Appeals to the Federal Court and the Full Court of the Federal Court

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

During the referral year of 1995, Dr Christie provided 19 058 services to 11 153 patients at a Medicare benefit cost of $411 044. The committee found that Dr Christie's conduct in relation to the referred services would be unacceptable to the general body of general practitioners and the Determining Officer issued a draft determination of a reprimand.

As reported last year, Dr Christie appealed to the Federal Court against the Tribunal decision that said he could not withdraw an application for review of a determination that he be reprimanded as a result of a committee finding of inappropriate practice.

The Tribunal declined to allow the withdrawal of the application because the Act did not set out when the final determination should take effect in such circumstances. The Tribunal considered that allowing Dr Christie to withdraw the application for review would cause the final determination to be vacated, as the Tribunal had no power to reinstate it or to a fix a date from which it was to take effect.

[6] The grounds of appeal were ultimately reduced to the single issue of the constitutionality of the PSR process. On 20 August 2002 the Full Bench unanimously dismissed the appeal, referring to its recent decision in *Grey* for its reasons: *Hill v Keith* [2002] FCAFC 7.

On 4 October 2001 Conti J held that the application could be withdrawn.[7] He concluded that, as a matter of statutory construction, the withdrawal of the application for review did not render the final determination inapplicable, but rather, crystallised it as being the final and operative decision in relation to the matter. Therefore, Dr Christie was entitled to withdraw his application for review. The Tribunal then no longer had jurisdiction to consider the matter and the final determination (as decided by the Determining Officer) would take effect.

Accordingly, the review by the Tribunal did not proceed.

Dr Paul Crowley, general practitioner of Lowood, Queensland

In December 2001, the Commission made Investigative Referral 296 concerning all services provided by Dr Crowley between 1 January 2000 and 31 October 2000 from his Lowood practice. The concern was an apparent prescribed pattern of services under section 106KA of the Act, and Part 3 of the Regulations as there was evidence that he had rendered 80 or more professional attendances on 129 days during that period.

In February 2002, following an investigation and consideration of a submission from Dr Crowley as to exceptional circumstances, the Director made an Adjudicative Referral to a committee. In March 2002, the committee notified Dr Crowley that it would hold a hearing into the matter.

In May 2002, Dr Crowley applied to the Federal Court for declarations that both the Investigative Referral and the Adjudicative Referral to the committee were invalid and for orders to stop the committee proceeding. He claimed that the Investigative Referral was invalidated by the inclusion of irrelevant and prejudicial information. He further argued that the Adjudicative Referral was affected by the invalidity of the Investigative Referral, that it wrongly included irrelevant and prejudicial information from that referral, and that the Director should have been persuaded by the evidence of exceptional circumstances.

The committee gave an undertaking to the Court at a directions hearing on 22 May 2002 not to hear or proceed to a hearing of the matters which are the subject of the referral until after the Court had made its decision.

The Federal Court has yet to hear the application.

[7] *Christie v The Honourable A R Neaves* [2001] FCA 1401

Dr Tuan Ngoc Doan, general practitioner of Springvale, Victoria

On 18 December 2001, the Commission made an Investigative Referral covering all services provided by Dr Doan during 2000 from his Springvale practice. The concerns the Commission identified were his high total services and aspects of his prescribing.

Dr Doan was informed, in writing on 11 March 2002, that the Director had decided to investigate and a notice, under section 89B of the Act, to produce specified clinical records and appointment books was enclosed.

On 8 April 2002, Dr Doan applied to the Federal Court for review of the Director's decision to investigate. He submitted that the Investigative Referral was invalid because it did not correctly specify conduct and was too wide, vague and uncertain; it did not set out reasons the applicant may have engaged in inappropriate practice; the Director did not have jurisdiction or authority; it was an improper exercise of power; and it was an abuse of power.

The Director gave an undertaking to the Court not to continue with his investigations in relation to the subject of Investigative Referral 312 until judgement had been delivered in this matter. The Director also undertook to extend the time for compliance with the notice issued under section 89 of the Act until one week after the date of judgement in the proceedings.[8]

Dr Jagjit Pradhan, ophthalmologist of Adelaide, South Australia

Last year it was reported that Dr Pradhan had appealed to the Federal Court on the grounds that the scope of the Adjudicative Referral went beyond that of the concerns outlined in the Investigative Referral.

On 8 November 2001, Finn J held[9] that both the Investigative and Adjudicative Referrals were invalid because they did not adequately specify the conduct to be considered or investigated. It is the conduct specified in the Investigative and the Adjudicative Referrals which sets the scope of the Director's or the committee's inquiry:

> Put shortly, … the statutory scheme is one that refers, first, to the Director for investigation and, then, to the Committee for adjudication, identified conduct that the Commission and the Director respectively consider may have constituted engaging in inappropriate practice …

[8] On 18 September 2002 Marshall J dismissed the appeal. *Doan v Health Insurance Commission* [2002] FCA 1160. Dr Doan lodged an appeal to the Full Court of the Federal Court on 8 October 2002.

[9] *Pradhan v Holmes* [2001] FCA 1560.

Finn J held that it is only the conduct that is specified in the Investigative Referral which can be investigated by the Director and subsequently referred to the committee.

A sentence in the Investigative Referral which said, 'The attached material is provided for information only and is not intended in any way to limit the conduct referred', was considered by Finn J to extend the scope of the referral in such a way that Dr Pradhan could not know or address the case against him.

Similarly, a sentence in the Adjudicative Referral which said, 'The Committee is to consider … whether Dr Pradhan's conduct … otherwise constituted engaging in inappropriate practice', was considered by Finn J to extend the scope of the referral in such a way that Dr Pradhan could not know or address the case against him.

The case has implications for all other referrals with similar wording. Three steps have been taken to address the issues which arise from the decision. An appeal has been filed with the Full Court of the Federal Court;[10] remedial amendments to the legislation were introduced to Parliament on 27 June 2002;[11] and later referrals have been worded differently.

It is also noted that the Full Court of the Federal Court recently declined to follow the *Pradhan* decision (see Dr Grey on page 34).

Dr Peter Tisdall, general practitioner of Kyabram, Victoria

Last year it was reported that the Federal Court had rejected an application by Dr Tisdall for orders to, in effect, set aside proceedings. Dr Tisdall has appealed to the Full Court of the Federal Court.[12] The position remains that the committee report is with the Determining Officer for attention when the litigation is resolved.

[10] Hearing has been deferred until the outcome of the *Grey* application to the High Court is known.

[11] *Health Insurance Amendment (Professional Services Review and Other Matters) Bill 2002.*

[12] Hearing has been deferred until the outcome of the *Grey* application to the High Court is known.

Dr Malcolm Traill, general practitioner of Kingsbury, Victoria

Last year it was reported that Dr Traill had appealed to the Federal Court against a Tribunal decision upholding a determination that he be reprimanded, counselled, repay to the Commonwealth the sum of $1103 and be fully disqualified from participating in the Medicare benefit arrangements for two years and partially disqualified for three years. This followed a committee report with a finding of inappropriate practice based mainly on inadequate clinical input, patient management and clinical records and inappropriate use of lithium to treat certain illnesses.[13]

Federal Court cases seeking leave to appeal to the High Court

Dr John Grey, general practitioner of Frankston, Victoria

As reported last year, Dr Grey applied to the Federal Court regarding a draft committee report (see 2000–01 Annual Report for details). He primarily sought to stop further action on the referral.

On 17 September 2001 Finkelstein J rejected Dr Grey's arguments that the committee investigation was not constitutionally valid, but agreed, to a certain extent, that the committee had exceeded its powers.[14] The committee was ordered to confine its inquiry to whether Dr Grey engaged in inappropriate practice by failing to provide an appropriate level of medical care to his patients.

The Director and others appealed. On 15 May 2002,[15] the Full Court of the Federal Court upheld the appeal and also followed the cases of Drs Tankey and Tisdall in dismissing a cross appeal by Dr Grey that contended that parts of the PSR scheme were unconstitutional.

[13] On 16 August 2002 the Full Federal Court dismissed the appeal. *Traill v McRae* [2002] FCAFC 235. The court found that there was no breach of natural justice by the committee or the Tribunal, there was no obligation on the committee to follow the statutory sampling procedures and that the committee could consider, as relevant, inadequate record keeping practices. Details will be reported next year.

[14] *Grey v Health Insurance Commission* [2001] FCA 1257.

[15] *Health Insurance Commission v Grey* [2002] FCAFC 130 The Full court of the Federal Court stated that the inquiry is of **conduct relating to** whether Dr Grey has engaged in **conduct in connection with** rendering or initiating services which would be unacceptable to the general body of practitioners. The **conduct** of Dr Grey was described in the referral and included the descriptive and statistical contents of the referral and its attachments as well as the commentary of the Commission expressing its then concerns. Further, the court considered that the issue before the committee is the adequacy of the clinical input into the particular service, by reference to the components of the service and whether what was done was necessary for the appropriate treatment of the patient.

Review of previous authorities suggested that the purpose of the Act was to 'protect both patients and the Commonwealth against an abuse of the system' and therefore, the PSR scheme should be interpreted as 'public protective' legislation. Furthermore, the legislation ensures the practitioner has procedural fairness; and making a claim under an incorrect item can amount to 'inappropriate practice'.

The court said a referral is not a charge or indictment. In this case, the Commission's concerns, the referral and its attachments, when read together, give an outline of the subject matter of inquiry. The subject matter of the referral defined the inquiry. The court held there was nothing vague, too wide or unspecified about the referral.

Regarding the jurisdiction of the committee, the court also found that:

- a committee could take into account the adequacy of practitioners' clinical records;
- considering whether they provided an appropriate level of clinical input into the referred services was within the scope of the referral;
- 'appropriate treatment' was a different test from the 'adequacy of clinical input'; and
- a committee is not outside its jurisdiction when inquiring into whether the correct item descriptor for a service was applied.

Dr Grey has lodged an application seeking special leave to appeal to the High Court on a constitutional issue.

Agency activities 3

Training workshops for committee members

During the year, PSR conducted training workshops for committee members. The four weekend workshops attended by 77 members were held in Queensland, Victoria, South Australia and New South Wales between September and November 2001.

The main focus of the workshops is to improve committee members in-hearing techniques, legal awareness and report writing. Committee members are given training to help them obtain information from persons under review while ensuring procedural fairness. These sessions, conducted by legal representatives, take the form of lecture and role-play.

The sessions also provide the opportunity for committee members to be updated on any changes to the PSR scheme and legislation and the progress of any Federal Court matters.

Deputy Directors' conferences

Melbourne

The Deputy Directors (committee Chairs) met in Melbourne on 25 August 2001 to discuss the implementation of new legislation concerning a prescribed pattern of services in preparation for the referral of cases to committees. The topics discussed were: the outcomes of the 1999 review committee that proposed the additional

legislation; the legislation and regulations; and the practical application of the legislation.

The meeting also discussed the differences between the current hearing techniques and the change in focus needed for dealing with a prescribed pattern of services referral.

Canberra

A two-day conference for Deputy Directors was held in Canberra on 18 and 19 April 2002. The 16 Deputy Directors attending reviewed past year's activities, discussed legislation covering the prescribed pattern of services, and were informed on the status of current legal cases.

Ms Rhonda Henderson, NSW Barrister and Dr Bryce Phillips, Commissioner, Health Insurance Commission were guest speakers at the conference and Commander Andrew Millar CSC RAN (Rtd) spoke at the workshop dinner.

Royal Australian College of General Practitioners Accreditation Summit

Along with 14 other agencies, PSR attended the Royal Australian College of General Practitioners Accreditation Summit held in Melbourne on 26 June 2002. The primary focus of the summit was the general practice accreditation environment. The summit was convened because, in each State and Territory, accreditation providers were operating under different requirements consequently undermining public confidence through a flawed regulatory framework. This could lead to practices being accredited and gaining inappropriate access to the Practice Incentive Payments Scheme administered by the Health Insurance Commission.

Participants at the summit discussed the strengths and limitations of the current accreditation framework from a regulatory and quality perspective, attempted to determine a process of identifying common concerns and suggested options for improvement.

The PSR representatives attended the Summit to provide information on the range of situations encountered during the PSR investigation and committee processes. It is PSR's experience that findings of inappropriate practice have been made against

practitioners from accredited practices. The PSR process is an examination of individual practitioners conduct and while accreditation of practices is a consideration, it is not a determining factor in making findings.

The summit ended with broad agreement on principles of general practice standards and the accreditation framework. A draft discussion paper is to be circulated to participants and the results will be fed into the Department of Health and Ageing General Practice Accreditation Review.

Council of Australasian Tribunals

The proposal for a council of tribunals was developed by the Administrative Review Council and was supported at a meeting of Commonwealth, State and Territory tribunal heads on 3 October 2001, which was attended by the Director. The proposal was adopted and the inaugural meeting of the Council of Australasian Tribunals was held in Melbourne on 6 June 2002. PSR was represented.

Establishment of the council aims to provide a forum through which tribunal heads come together to examine and compare ideas, working methods, organisation, management, member training and support programs.

The Council of Australasian Tribunals is an informal body, operating largely by consensus. Its objectives are broadly expressed to enhance its appeal to a diverse membership of Commonwealth, State, Territory and New Zealand bodies. Membership is open to any body whose primary function or common feature is to determine matters, but is not acting as a court. Hence the applicability of the Council to the PSR functions and powers of peer review committees and the Determining Authority. PSR can benefit from participating in such a forum especially in developing best practice, training and support and standards of behaviour and conduct of members.

Overseas conferences

England

In June 2002, the Director attended the World Organisation of Family Doctors (WONCA) Europe Regional Conference 2002 – promoting excellence in family medicine – held in London.

The professional and scientific program presented at the conference considered the variety of environments in which family practitioners work and the impact these environments have on patient care.

The conference provided some useful insights for PSR into the changes in health care organisation in European Union countries and the methods they are adopting to deal with similar regulatory problems to those in Australia. The experience in the United Kingdom is particularly relevant as the profession addresses the issues brought to light following both the Bristol[16] events and the case of Dr Shipman.[17]

The conference also examined the issues of professional revalidation and assessment of continuing competence. These are issues of increasing relevance for Australian practitioners.

Canada

Following the conference in England, the Director attended the 5th International Conference on Medical Regulation in Toronto, Canada. This conference was held in conjunction with the Federation of Medical Licensing Authorities of Canada and was attended by a significant number of people from around the world who are involved in registration and regulation of medical practitioners.

The education sessions at the conference focused on a number of issues including expectation and transparency of information availability on practitioners, information exchange among regulatory authorities, ensuring continuing competence, ethical acculturation of practitioners in the new millennium, and regulation of the regulators.

The presentations and discussions at this forum were valuable and relevant in the Australian context because it was apparent many of the other bodies share similar problems with their practitioners and also have similar difficulties with legal and court proceedings while sharing comparable responsibilities to PSR with respect to their benefit programs.

[16] Between 1991 and 1995, 30 to 35 children undergoing heart surgery at Bristol Royal Infirmary in the United Kingdom died. They would probably have survived if they had been treated elsewhere. <www.bristol-inquiry.org.uk>

[17] Harold Shipman, a British former GP was convicted of murdering 15 patients and sentenced to life in imprisonment. A public inquiry also found he murdered at least another 215 patients. <www.the-shipman-inquiry.org.uk>

The conference was also important because it marked the inaugural meeting of the International Association of Medical Regulatory Authorities. Australia is held in high regard in this activity as was shown by the election of Dr Lloyd Toft, President of the Australian Medical Council, as the Inaugural President of the International Association of Medical Regulatory Authorities.

Following the conference, the Director attended a satellite meeting held by the College of Physicians and Surgeons of British Columbia. Again the similarities with the Australian situation were evident and there was much to learn from their experience in the conduct of hearings.

While in Canada, the Director also revisited the Regie de l'assurance maladie du Quebec for discussions with the medical practitioners responsible for monitoring the Provincial Medicare arrangements and physician behaviour. It is evident that the Canadian authorities are aware of the effects of aberrant professional behaviour. The sanctions imposed on people who are found to be abusing their professional trust with respect to the Canadian Medicare arrangements are substantial and significant.

Management and accountability

4

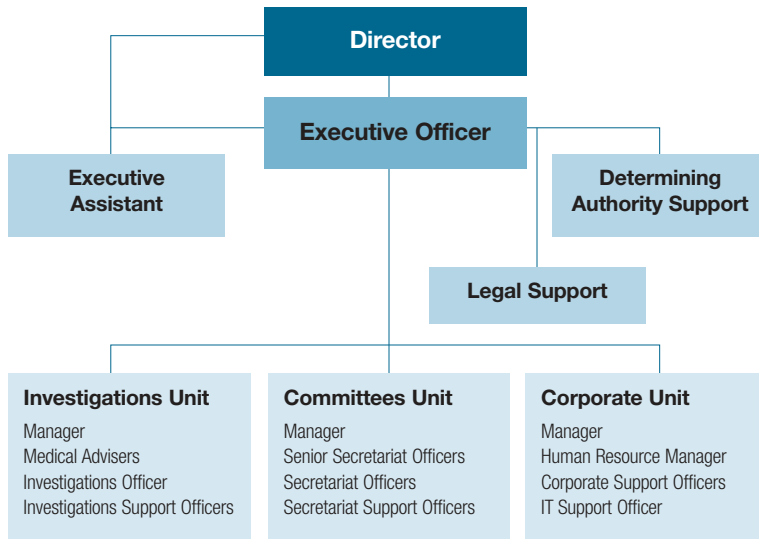
Corporate governance

Structure and organisation chart

The Director, Dr John Holmes, is a statutory officer appointed by the Minister for Health and Ageing (with agreement from the AMA) to manage the PSR process. The Director reports directly to the Minister, and his actions are governed by the Act.

An Executive Officer, three Unit Managers and their staff and legal counsel support the Director in his role (see Figure 1).

Figure 1: Organisation chart



The Acting Executive Officer, Mr John Jenner, reports to the Director and has a leadership role in achieving organisational objectives through management of financial and human resources, policy development and provision of governance advice.

The Investigations Unit assists the Director with investigations of referrals received from the Commission. It also produces the agreements sent to the Determining Authority and the documentation enabling committees to carry out their task. The Committees Unit provides secretariat support to committees. The Corporate Unit provides financial and human resources and information technology services and support for the whole organisation.

Legal assistance is outsourced to the Canberra Office of Minter Ellison Lawyers. A Minter Ellison legal officer is outposted to PSR and Minter Ellison Lawyers in each State provide assistance at committee hearings.

In addition, the secretariat support for the Determining Authority is located within PSR's offices. Legal support is provided to the Authority by Clayton Utz.

Management Committee

The Management Committee, comprising the Director, the Executive Officer and the Unit Managers, meet fortnightly to consider all relevant issues. The committee's agenda varies depending on current issues but they regularly discuss:

- policy maintenance and development;
- human resources;
- occupational health and safety;
- finances; and
- productivity.

Risk management

A risk management plan is in place and reported against. Although the risks to property and other assets had been assessed as low, PSR was burgled three times this year over a short period, despite a back-to-base alarm system being in place. On the first occasion a laptop computer and a computer hard-drive were stolen, the second time a computer hard-drive and the third only two computer mice. After each burglary security was progressively upgraded. Each burglary was reported to the police and they have since recovered the laptop.

To date, PSR has not lodged any insurance claims. Because of the level of excess applicable to our insurance PSR was precluded from claiming losses arising out of the burglaries. All other risks have been managed effectively.

External scrutiny

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 26 to 35. The impact of these cases is discussed in the Performance Assessment.

The Public Service Commissioner fielded one complaint from a previous staff member concerning our processes – it was dismissed as being without foundation.

Management of human resources

All staff, except the Director, were employed under the *Public Service Act 1999* and all ongoing staff were employed on a permanent full-time basis.

To accommodate the expanded legislative role, PSR has actively recruited staff to meet its needs but is yet to reach maximum staffing. The staff turnover was low during the year with only the Executive Officer, Mr Peter Dunnett, retiring in September 2001 and one staff member accepting a temporary transfer to the Department of Health and Ageing.

Tables 10 and 11 show the actual permanent staffing levels against the staffing budget and the classification levels of all staff.

Table 10 – Staffing budget and levels

2001–02 Budget	2001–02 Actual	2000–01 Actual
40	25	22

Table 11– Staff classification levels as at 30 June 2002

Classification	Male	Female	Total
Statutory Office Holder	1		1
Senior Executive Service Officer	1		1
Medical Officer Level 4		1	1
Executive Officer Level 2	1	1	2
Executive Officer Level 1	2	1	3
APS 6		6	6
APS 5		1	1
APS 4	3	5	8
APS 3		1	1
APS 2	1		1
Total	**9**	**16**	**25**

APS = Australian Public Service

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

Staff training and development

Through its performance development scheme, staff training needs were identified which allowed the Human Resources Manager to develop a training schedule of external and internal courses. Those courses included:

- Leadership Skills for Women,
- Managing Underperformance,
- Smart Reading Skills,
- Confidentiality, and
- Dealing with Difficult People.

The expenditure devoted to training in 2001–02 was 6.8 per cent but does not include the training provided to staff through the Memorandum of Understanding with the Department of Health and Ageing. This expenditure is a considerable increase from 2000–01 (1.71%).

There is a strong commitment by Management to developing staff and committee members so they are better able to perform their duties. This year PSR undertook a series of comprehensive training sessions for committee members to hone their questioning techniques and explain the implications of recent legal decisions (see page 37).

Ethical standards

The Australian Public Service values are promoted to staff and, as shown in the Agency Overview, PSR has developed values specific to the organisation. In addition to this, most staff have attended an ethics course and this year, an in-house confidentiality course.

Certified Agreement and Australian Workplace Agreements

Throughout the year 20 PSR staff were covered by the second Certified Agreement which is due to expire on 31 December 2002. Of the five remaining staff: the Director's salary is set by the Remuneration Tribunal; and the Senior Executive Service Officer, the Medical Officer Level 4 and two Executive Level 2 staff were covered by Australian Workplace Agreements.

Some of the major features of the current PSR Certified Agreement include:

- 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 study assistance through Studybank; and
- a fair treatment dispute resolution policy.

The salary ranges for Australian Public Service (APS) employees covered by the Certified Agreement are set out in Table 12.

Table 12 – PSR salary ranges

APS classification	1 January 2001	1 January 2002
APS 1	26 788 to 30 044	27 859 to 31 245
APS 2	30 317 to 34 115	31 529 to 35 479
APS 3	34 530 to 37 819	35 912 to 39 332
APS 4	38 486 to 42 403	40 025 to 44 099
APS 5	42 925 to 46 190	44 642 to 48 037
APS 6	46 363 to 54 044	48 217 to 56 205
EL1	59 435 to 66 176	61 813 to 68 823
EL2	68 549 to 81 501	71 291 to 84 761
MO4	93 441 to 102 844	97 178 to 106 958

APS = Australian Public Service; EL = Executive Level; MO = Medical Officer

Late in the financial year the initial infrastructure was put in place for negotiation of a third Certified Agreement. Staff views were canvassed about the type of agreement (union or non union) and the majority of staff elected to again have the union involved. Staff elected two officers to represent their interests along with the Community and Public Sector Union. The management team comprises the Executive Officer and the Manager Corporate Unit.

Negotiations are expected to start early in the financial year with the aim to reach agreement before the current agreement expires.

Performance pay

Guidelines for performance pay are contained in individual Australian Workplace Agreements. This year PSR paid a total of $23 540 in performance pay to four staff.

Occupational health and safety

In recognition of the 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 equipment. An OH&S Committee has been established and met on a quarterly basis during the year. The OH&S Committee regularly makes recommendations to the PSR Management Committee for consideration. In all cases PSR Management has supported the recommendations of the OH&S Committee.

If required, policy advice relating to OH&S is given by the specialist area in the Department of Health and Ageing as an element of the Memorandum of Understanding. Also included in the Memorandum of Understanding is access for staff and/or their immediate families to counselling services by trained professionals.

There were four minor OH&S incidents in 2001–02 none of which resulted in a claim to Comcare. There were no notices issued or received under any of the relevant sections of the OH&S Act during the year.

Workplace diversity

In its commitment to workplace diversity PSR ensures that all staff are treated fairly and without direct, indirect or systemic discrimination. All staff have had equal access to employment, career and development opportunities and PSR encourages appropriate representation from 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 Ageing.

Industrial democracy

Staff were consulted on all major issues during the year. The minutes of the fortnightly Management Committee meetings are circulated to all staff. Staff meetings are held within Units and information is channelled to and from management meetings. A major review of the Investigations Unit was undertaken during the year and all staff were given the opportunity to provide input into this review.

A PSR specific communications policy was developed with assistance from Minter Ellison Lawyers and distributed to staff and the Community and Public Sector Union for comment.

Staff survey

The results of a staff survey were provided to all staff members on 12 November 2001. The purpose of the survey was to determine the level of staff satisfaction and their awareness of key issues. The survey contained 33 questions and had a 100 per cent participation rate.

The elements staff identified as giving them the most satisfaction at PSR included: the friendly staff and work environment, diversity of the work, client satisfaction, positive outcomes, independence and the lack of bureaucratic processes. The deficiencies staff identified in the survey included: improving the workflow, stopping the duplication of tasks, and establishing system operating procedures.

An action plan is in place to address the issues identified in the report.

Commonwealth Disability Strategy

Our programs and services are not delivered to the general public and, to date, we have not had any person under review claim a disability. If the need arose, PSR considers it is able to satisfactorily cater to any circumstance.

The PSR website <www.psr.gov.au> contains public information about the scheme and meets the Government Online minimum standards with regard to accessible formats for people with disabilities.

With regard to contract tendering, we have adopted the purchasing policies of the Department of Health and Ageing which encompass the Commonwealth Disability Strategy.

There is 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

The 2001–02 budget appropriation was $6.884 million. This was the third year of a four-year funding arrangement to cover growth of the organisation to meet its expanded legislative role.

The Australian National Audit Office's report on our 2001–02 financial statements was unqualified and was signed on 24 September 2002 (see Appendix 1).

Purchasing

Through a Memorandum of Understanding with the Department of Health and Ageing, PSR purchased services, such as payment of accounts, personnel functions, library, registry, training and coverage for programs including workplace diversity, occupational health and safety and industrial democracy. An agreed annual fee is paid for these services. We adopt the Department of Health and Ageing's purchasing policies and participate with it in joint purchasing arrangements for such things as travel, banking and office supplies.

Asset management

All PSR assets are securely housed at our premises in Yarralumla. PSR maintains an asset register and an asset stocktake occurs annually. All assets that are loaned to staff are signed in and out in a register.

Consultants and competitive tendering and contracting

During the year a tender process was undertaken to secure legal services. The tender was in excess of $100 000 and involved applications and presentations from eight Australian major legal firms with the successful contractor being Minter Ellison Lawyers. We have entered into a three-year contract with the option to extend for another two years and then a further option of one more year.

The next two companies involved in the PSR legal services tender were invited later in the year to participate in a select tender for legal services to the Determining Authority. The successful tenderer was Clayton Utz.

A select tender was undertaken to purchase an electronic records management system. Three companies participated in the tender with the successful tenderer being Tower Software.

Any other contracts in excess of $2000 are recorded in the *Commonwealth Purchasing and Disposal Gazette*.

Ecologically sustainable development and 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.

To aid a gradual transition from paper records to electronic record keeping, PSR purchased and installed the Tower Records Information Management (TRIM) system.

The TRIM system will enable PSR to reduce its paper usage because most documents created internally will only be produced electronically and documents received electronically should not need to be printed.

Instead of being filed in-house on separate files pertaining to each referral or corporate issue, all hardcopy documents received at PSR are now scanned into TRIM and the hardcopies stored in date order at our storage facility. If need be, a document can be tracked by a unique identifier and retrieved from the storage facility.

Information technology

Infront Systems continued to provide routine maintenance and second and third level IT support. First level support is provided in-house. During the year, Catalyst Interactive (with LNB Computing) continued to work with staff to finetune MALCOLM (a customised database for tracking and reporting all stages of referrals).

Late in the financial year PSR completed preliminary work for implementing TRIM. From a technological standpoint the installation of TRIM has provided a platform for effective and efficient storage and retrieval of documents. The TRIM system helps PSR apply sound records management principles, ensuring secure, cost-effective and timely record retrieval, retention and disposal.

Publications

The only new publication produced this year was the 2000–01 Annual Report and this document is on PSR's website <www.psr.gov.au>.

Appendixes

5

Appendix 1

Financial statements

Australian National
Audit Office

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 2002. The financial statements comprise:

- Statement by the Chief Executive;
- Statements of Financial Performance, Financial Position and Cash Flows;
- Schedules of Contingencies and Commitments; and
- Notes to and forming part of the Financial Statements.

The Professional Services Review Scheme's Chief Executive is 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 Accounting Standards and other mandatory professional reporting requirements in Australia and statutory requirements so as to present a view which is consistent with my understanding of the Professional Services Review Scheme's financial position, its financial performance and its cash flows.

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

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

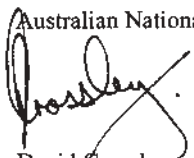
Audit Opinion

In my opinion the financial statements:

(i) have been prepared in accordance with Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*; and

(ii) give a true and fair view, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Finance Minister's Orders, of the financial position of Professional Services Review Scheme as at 30 June 2002, and its financial performance and cash flows for the year then ended.

Australian National Audit Office



David Crossley
Executive Director

Delegate of the Auditor-General

Canberra
24 September 2002

STATEMENT BY THE CHIEF EXECUTIVE

In my opinion, the attached financial statements for the year ended 30 June 2002 give a true and fair view of the matters required by the Finance Minister's Orders made under the *Financial Management and Accountability Act 1997*.

Signed.....
Dr John Holmes
Director
Professional Services Review

23 September 2002

Signed.....
Dean Browne
Resources Manager
Professional Services Review

23 September 2002

PROFESSIONAL SERVICES REVIEW
STATEMENT OF FINANCIAL PERFORMANCE
for the year ended 30 June 2002

	Notes	2002 $	2001 $
Revenues from ordinary activities			
Revenues from Government	3A	**7,390,200**	4,902,200
Sales of goods and services	3B	**1,284**	2,146
Interest	3C	**54,343**	33,917
Other	3D	**219,032**	-
Total revenues from ordinary activities		**7,664,859**	4,938,263
Expenses from ordinary activities (excluding borrowing cost expense)			
Employees	4A	**1,689,886**	1,451,009
Suppliers	4B	**2,936,246**	2,500,208
Depreciation and amortisation	4C	**141,691**	109,260
Write-down of assets	4D	**74,301**	15,807
Net loss from sales of assets	4E	**5,185**	-
Total expenses from ordinary activities (excluding borrowing cost expense)		**4,847,309**	4,076,284
Net operating surplus (deficit) from ordinary activities		**2,817,550**	861,979
Net surplus (deficit)		**2,817,550**	861,979
Net surplus (deficit) attributable to the Commonwealth		**2,817,550**	861,979
Net credit (debit) to asset revaluation reserve		**30,324**	-
Total revenues, expenses and valuation adjustments attributable to the commonwealth and recognised directly in equity		-	-
		-	-
Total charges in equity other than those resulting from transactions with owners as owners		**2,847,874**	861,979

The above statement should be read in conjunction with the accompanying notes.

PROFESSIONAL SERVICES REVIEW
STATEMENT OF FINANCIAL POSITION
as at 30 June 2002

	Notes	2002 $	2001 $
ASSETS			
Financial assets			
Cash	5A	**2,285,647**	1,695,121
Receivables	5B	**50,663**	75,920
Total financial assets		**2,336,310**	1,771,041
Non-financial assets			
Land and buildings	6A,D	**68,166**	180,446
Infrastructure, plant and equipment	6B,D	**184,322**	99,181
Intangibles	6C,D	**267,983**	216,522
Other	6E	**1,502,570**	2,613
Total non-financial assets		**2,023,041**	498,762
Total assets		**4,359,351**	2,269,803
LIABILITIES			
Provisions			
Capital use charge		-	219,032
Employees	7	**547,216**	471,696
Total provisions		**547,216**	690,728
Payables			
Suppliers	8	**298,150**	302,965
Total payables		**298,150**	302,965
Total liabilities		**845,366**	**993,693**
NET ASSETS		**3,513,985**	1,276,110
EQUITY			
Parent entity interest			
Contributed equity	9	**700,000**	700,000
Asset Revaluation Reserve	9	**30,324**	-
Dividends paid	9	**(610,000)**	-
Retained surpluses or accumulated deficits	9	**3,393,661**	576,111
Total parent entity interest		**3,513,985**	1,276,111
Total equity		**3,513,985**	1,276,111
Current assets		**3,838,879**	1,773,654
Non-current assets		**520,471**	496,150
Current liabilities		**455,325**	602,185
Non-current liabilities		**390,041**	391,508

The above statement should be read in conjunction with the accompanying notes.

PROFESSIONAL SERVICES REVIEW
STATEMENT OF CASH FLOWS
for the year ended 30 June 2002

	Notes	2002 $	2001 $
OPERATING ACTIVITIES			
Cash received			
Sales of goods and services			
GST recovered from ATO		**317,185**	132,388
Non-government		**1,284**	2,146
Appropriations		**6,884,000**	4,896,000
Interest		**46,436**	40,367
Total cash received		**7,248,905**	5,070,901
Cash used			
Employees		**1,614,366**	1,431,066
Suppliers		**4,434,847**	2,429,901
GST paid to ATO		**284,219**	-
Total cash used		**6,333,432**	3,860,967
Net cash from / (used by) operating activities	10	**915,473**	1,209,934
INVESTING ACTIVITIES			
Cash received			
Proceeds from sales of property, plant and equipment		**620**	-
Total cash received		**620**	-
Cash used			
Purchase of property, plant and equipment		**121,236**	409,736
Purchase on intangibles		**94,331**	-
Total cash used		**215,567**	409,736
Net cash from / (used by) investing activities		**(214,947)**	(409,736)
FINANCING ACTIVITIES			
Cash received			
Appropriations - contributed equity		**-**	-
Total cash received		**-**	-
Cash used			
Repayment of debt			-
Capital use charge paid			-
Dividends paid		**110,000**	-
Total cash used		**110,000**	-
Net cash from / (used by) financing activities		**(110,000)**	-
Net increase / (decrease) in cash held		**590,526**	800,198
Cash at beginning of the reporting period		**1,695,121**	894,923
Cash at the end of the reporting period	5A	**2,285,647**	1,695,121

The above statement should be read in conjunction with the accompanying notes.

PROFESSIONAL SERVICES REVIEW
SCHEDULE OF COMMITMENTS
as at 30 June 2002

	2002 $	2001 $
BY TYPE		
CAPITAL COMMITMENTS		
Land and buildings	-	-
Infrastructure, plant and equipment	-	-
Total capital commitments	-	-
OTHER COMMITMENTS		
Operating leases	**235,639**	429,909
Total other commitments	**235,639**	429,909
COMMITMENTS RECEIVABLE		
Net commitments	**235,639**	429,909
BY MATURITY		
All net commitments		
One year or less	**192,410**	192,410
From one to five years	**43,229**	237,499
Over five years	-	-
Net commitments	**235,639**	429,909
Operating lease commitments		
One year or less	**192,410**	192,410
From one to five years	**43,229**	237,499
Over five years	-	-
Net commitments	**235,639**	429,909

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

The above statement should be read in conjunction with the accompanying notes.

PROFESSIONAL SERVICES REVIEW
SCHEDULE OF CONTINGENCIES
as at 30 June 2002

	2002 $	2001 $
CONTINGENT LOSSES		
Claims for damages/costs	-	-
CONTINGENT GAINS		
Claims for damages/costs	-	-
Net contingencies	-	-

The above statement should be read in conjunction with the accompanying notes.

PROFESSIONAL SERVICES REVIEW
NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS
for the year ended 30 June 2002

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Note 1: Summary of Significant Accounting Policies

1.1 Objectives 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 practiced inappropriately under the Pharmaceutical Benefits Schedule.

1.2 Basis of Accounting

The financial statements are required by section 49 of the *Financial Management and Accountability Act 1997* and are a general purpose financial report.

The statements have been prepared in accordance with:

- Finance Minister's Orders (being the *Financial Management and Accountability (Financial Statements 2001-2002) Orders*);
- Australian Accounting Standards and Accounting Interpretations issued by the Australian Accounting Standards Board;
- other authoritative pronouncements of the Board; and
- Consensus Views of the Urgent Issues Group.

The statements have also been prepared having regard to the Explanatory Notes to Schedule 1, and Finance Briefs issued by the Department of Finance and Administration.

The Statements of Financial Performance and Financial Position 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 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 unrecognised are reported in the Schedule of Commitments and the Schedule of Contingencies.

Revenues and expenses are recognised in the Statement 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, and with its present programs, is dependent on Government policy and on continuing appropriations by Parliament for the Agency's administration and programs.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

1.3 Changes in Accounting Policy

The accounting policies used in the preparation of these financial statements are consistent with those used in 2000-01, except in respect of:

- . Output appropriations (refer to Note 1.4);
- . Equity injections (refer to Note 1.5); and

1.4 Revenue

The revenues described in this Note are revenues relating to the core operating activities of the Agency.

(a) *Revenues from Government*

The full amount of the appropriation for departmental outputs for the year (less any savings offered up at Additional Estimates and not subsequently released) is recognised as revenue. This is a change in accounting policy caused by the introduction of a new requirement to this effect in the Finance Minister's Orders. (In 2000-01, output appropriations were recognised as revenue to the extent the appropriations had been drawn down from the Official Public Account).

The change in policy has a financial effect in 2001-2002 as the full amount of the output appropriation for 1999-00 had not been recognised in that year. An amount of $500,000 related to1999-00 has been recognised as output appropriation revenue in 2001-02.

(b) *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, unless received from another government agency as a consequence of a restructuring of administrative arrangements (Refer to Note 1.5).

(c) *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.

Dividend revenue is recognised when the right to receive a dividend has been established.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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

Agency revenue from the rendering of a service is recognised by reference to the stage of completion of contracts or other agreements to provide services to Commonwealth bodies. The stage of completion is determined according to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

1.5 Transactions by the Government as Owner

From 1 July 2001, Appropriations designated as 'Capital - equity injections' are recognised directly in Contributed equity according to the following rules determined by the Finance Minister:

- to the extent that the appropriation is not dependent on future events, as at 1 July; and
- to the extent that it is dependent on specified future events requiring future performance, on drawdown.

(In 2000-01, all equity injections were recognised as contributed equity on drawdown).

The change in policy has no financial effect in 2001-02 because the full amounts of the equity injections in both 2000-01 and 2001-02 met the criteria now required by the Finance Minister. 2A

1.6 Employee Entitlements

(a) *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 the Agency 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 2002 and is recognised at the 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 2002. In determining the present value of the liability, the Agency has taken into account attrition rates and pay increases through promotion and inflation.

(c) *Separation and redundancy*

Provision is made for separation and redundancy payments in circumstances where the Agency has formally identified positions as excess to requirements and a reliable estimate of the amount of the payments can be determined.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

(d) *Superannuation*

Staff of Professional Services Review contribute to the Commonwealth Superannuation
Scheme and the Public Sector Superannuation Scheme. Employer contributions amounting to $168,723 (2001: $171,818) in relation to these schemes have been expended in these financial statements.

No liability for superannuation is recognised as at 30 June as the employer contributions fully extinguish the accruing liability, which is assumed by the Commonwealth.
Employer Superannuation Productivity Benefit contributions totalled $33,132 (2001: $6,234).

1.7 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.

1.9 Cash

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

1.10 Financial Instruments

Accounting policies for financial instruments are stated at Note 15A.

1.11 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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

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, unless acquired as a consequence of restructuring administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor agency's accounts immediately prior to the restructuring.

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

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Statement of Financial Position, except for purchases costing less than $2,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total), and Information Technology equipment which has a minimum threshold value of $500.

Revaluations

Land, buildings, infrastructure, plant and equipment are revalued progressively in accordance with the 'deprival' method of valuation in successive 3-year cycles, so that no asset has a value greater than three years old.

Plant and equipment (P&E) assets (including assets under finance leases) and leasehold assets, were revalued in the 2001-02 financial year.

All valuations are independent.

Recoverable Amount Test

Schedule 1 requires the application of the recoverable amount test to departmental 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 the Agency 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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Depreciation and amortisation rates applying to each class of depreciable asset are based on the following useful lives:

	2002	2001
Leasehold improvements	**Lease term**	Lease term
Plant and equipment	**3 to 7 years**	3 to 7 years

The aggregate amount of depreciation allocated for each class of asset during the reporting period is disclosed in Note 4C.

1.13 Inventories

No inventories where held by Professional Services Review during the 2001-02 financial year.

1.14 Intangibles

Professional Services Review's intangibles comprise internally developed software. The asset is carried at cost.

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. In assessing recoverable amounts, the relevant cash flows, including the expected cash inflows from future appropriations by the Parliament, have been discounted to their present value.

No write-down to recoverable amount has been made in 2001-02.

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

Useful lives are:

	2002	2001
• Internally developed software	**7 years**	7 years

1.15 Taxation

The Agency is exempt from all forms of taxation except fringe benefits tax and the goods and services tax.

1.16 Capital Usage Charge

A capital usage charge of 11% (2001: 12%) is imposed by the Government on the net departmental assets of the Agency. The charge is adjusted to take account of asset gifts and revaluation increments during the financial year.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

1.17 Foreign Currency

No foreign currency were held by Professional Services Review during the 2001-02 financial year.

1.18 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.

1.19 Comparative Figures

Comparative figures have been adjusted to conform to changes in presentation in these financial statements where required.

1.20 Rounding

- Amounts have been rounded to the nearest $1

1.21 Reporting of Administered Activities

Professional Services Review did not undertake any administrative activities during the 2001-02 financial year.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

Note 2: Events Occurring after Balance Date

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

Note 3: Operating Revenues	2002 $	2001 $
Note 3A - Revenues from Government		
Appropriations for outputs	**6,884,000**	4,896,000
Extinguishment of 1999-00 appropriation	**500,000**	-
Resources received free of charge	**6,200**	6,200
Total	**7,390,200**	4,902,200
Note 3B - Sales of Goods and Services		
Goods	**1,284**	2,146
Services	**-**	-
Total	**1,284**	2,146
Goods and services were sold as follows:		
Government	**-**	-
Non-Government	**1,284**	2,146
Total	**1,284**	2,146
Cost of sales of goods	**-**	-
Note 3C - Interest		
Interest on deposits	**54,343**	33,917
Note 3D - Other		
Write off of Capital use charge debt	**219,032**	-

Note 4: Operating Expenses

Note 4A - Employee Expenses		
Remuneration (for services provided)	**1,689,886**	1,451,009
Separation and redundancy	**-**	-
Total remuneration	**1,689,886**	1,451,009
Other employee expenses	**-**	-
Total remuneration	**1,689,886**	1,451,009
Note 4B - Supplier Expenses		
Supply of goods and services	**2,749,740**	2,305,865
Operating lease rentals	**186,506**	194,343
Total	**2,936,246**	2,500,208

	2002 $	2001 $
Note 4C - Depreciation and Amortisation		
Depreciation of property, plant and equipment	**141,691**	109,260
Amortisation of leased assets	**-**	-
Total	**141,691**	109,260

The aggregate amounts of depreciation or amortisation expensed during the reporting period for each class of depreciable asset are as follows:

Land and Buildings	**-**	-
Leasehold improvements	**38,210**	45,896
Plant and equipment	**60,613**	45,659
Intangibles	**42,868**	17,705
Total	**141,691**	109,260

No depreciation or amortisation was allocated to the carrying amounts of other assets.

Note 4D - Write Down of Assets		
Intangible write-off	-	12,264
Plant & Equipment write-off	-	3,543
Revaluation decrement	**74,071**	-
Receivable	**230**	-
Total	**74,301**	15,807

Note 4E - Net Loss from Sales of Assets

Infrastructure, plant and equipment:

Proceeds from sale	**620**	-
Net book value at sale	**5,805**	-
Net Gain	**(5,185)**	-
Total net gains from sales of assets	**(5,185)**	-
Less : plant and equipment written off on disposal (Note 4D)	**0**	-
Net gain on disposal of property, plant and equipment	**(5,185)**	-

Note 5: Financial Assets

Note 5A - Cash		
Cash at bank and on hand	**2,285,647**	1,695,121
Cash on deposit	**-**	-
	2,285,647	1,695,121

All cash recognised is a current asset.

Note 5B - Receivables		
Goods and services	-	199
Less: Provision for doubtful debts	-	-
Interest	**18,134**	10,226
	18,134	10,425
GST receivable	**32,529**	65,495
	50,663	75,920

All receivables are current assets.

	2002	2001
	$	$
Receivables (gross) are aged as follows:		
Not overdue	**50,663**	75,920
Overdue by:		
Less than 30 days	-	-
30 to 60 days	-	-
60 to 90 days	-	-
More than 90 days	-	-
	-	-
Total receivables (gross)	**50,663**	75,920

Note 6: Non-Financial Assets

Note 6A - Land and Buildings		
Leasehold improvements	**268,000**	441,056
Accumulated amortisation	**(199,834)**	(260,610)
	68,166	180,446
Note 6B - Infrastructure, Plant and Equipment		
Plant and equipment	**281,987**	190,644
Accumulated depreciation	**(97,665)**	(91,463)
	184,322	99,181
Note 6C - Intangibles		
Computer software	**322,477**	228,147
Accumulated depreciation	**(54,493)**	(11,625)
	267,984	216,522

Note 6D - Analysis of Property, Plant, Equipment and Intangibles

Table A - Reconciliation of the opening and closing balances of property, plant and equipment and intangibles

Item	Total Land	*Buildings on Freehold Land*	*Buildings - Leasehold Improvements*	Total Buildings	Total Land and Buildings	Total Plant & Equipment	Computer Software - Total Intangibles	TOTAL
	$	$	$	$	$	$	$	$
Gross value as at 1 July 2001	-	-	441,056	441,056	441,056	190,644	228,146	859,846
Additions: purchases of assets	-	-	-	-	-	121,236	94,331	215,567
Revaluations: write-ups/(write-downs)	-	-	-	-	-	-	-	-
Assets transferred in/(out)	-	-	-	-	-	-	-	-
Write-offs	-	-	(173,056)	(173,056)	(173,056)	591	-	(172,465)
Disposals	-	-	-	-	-	(30,485)	-	(30,485)
Gross value as at 30 June 2002	-	-	268,000	268,000	268,000	281,986	322,477	872,463
Accumulated depreciation/ Amortisation as at 1 July 2001	-	-	260,609	260,609	260,609	91,463	11,625	363,697
Disposals	-	-	-	-	-	(24,679)	-	(24,679)
Depreciation/amortisation charge for the year	-	-	38,210	38,210	38,210	60,613	42,868	141,691
Revaluations: write-ups/(write-downs)	-	-	(98,985)	(98,985)	(98,985)	(29,733)	-	(128,718)
Assets transferred in/(out)	-	-	-	-	-	-	-	-
Write-offs	-	-	-	-	-	-	-	-
Accumulated depreciation/ amortisation as at 30 June 2002	-	-	199,834	199,834	199,834	97,665	54,493	351,992
Net book value as at 30 June 2002	-	-	68,166	68,166	68,166	184,322	267,984	520,472
Net book value as at 1 July 2001	-	-	180,447	180,447	180,447	99,180	216,521	496,148

	2002 $	2001 $
Note 6E - Other Non-Financial Assets		
Prepayments	**1,502,570**	2,613
Other	**-**	-
	1,502,570	**2,613**

Note 7: Provisions

Salaries and wages	**36,850**	31,931
Leave	**504,228**	435,204
Superannuation	**6,138**	4,560
Workers' compensation	**-**	-
Separation and redundancies	**-**	-
Aggregate employee entitlement liability	**547,216**	471,696
Other	**-**	-
Total	**547,216**	471,696
Current	**157,175**	80,188
Non-Current	**390,041**	391,508

Note 8: Payables

Trade creditors	**298,150**	302,965
Operating lease rentals	**-**	-
	298,150	302,965
Supplier payables are represented by:		
Current	**298,150**	302,965
Non-Current		-
	298,150	302,965

Note 9: Equity

Note 9 - Analysis of Equity

Item	Accumulated Results		Asset Revaluation Reserves		Total Reserves		Contributed Equity		TOTAL EQUITY	
	2002 $	2001 $	2002 $	2001 $	2002 $	2001 $	2002 $	2001 $	2002 $	2001 $
Opening balance as at 1 July	576,111	(142,816)					700,000	700,000	1,276,111	557,184
Net result and extraordinary items	2,817,551	861,979							2,817,551	861,979
Net revaluation increment/(decrement)			30,324		30,324				30,324	
Capital use charge (CUC)		(143,052)								(143,052)
Contribution of equity: appropriation										
Dividends paid	(610,000)								(610,000)	
Closing balance as at 30 June	2,783,662	576,111	30,324	0	30,324	0	700,000	700,000	3,513,986	1,276,111
Less: outside equity interests										
Total equity attributable to the Commonwealth										

Transactional banking arrangements introduced from 1 July 1999 enabled agencies to manage their surplus cash balances and earn interest on them. Reviews have been conducted by the department of Finance and Administration with each agency to determine whether interest earned to 30 June 2002 was consistent with the Government's Budget-neutrality condition for the arrangements. As at the date of signing these financial statements, no decision had been made by the Government on the amount of the distribution of equity, if any, to be made to it by Professional Services Review. Nevertheless, the Professional Services Review returned an amount of $110,000 in June 2002. The amount is disclosed in the table as a dividend paid to the Government.

Note 10: Cash Flow Reconciliation	**2002 $**	2001 $
Reconciliation of cash per Statement of Financial Position to Statement of Cash Flows		
Cash at year end per Statement of Cash Flows	**2,302,863**	1,716,730
Statement of Financial Position items comprising above cash: 'Financial Asset - Cash'	**2,285,647**	1,695,121
Reconciliation of net surplus to net cash from operating activities:		
Net surplus (deficit)	**2,817,551**	861,979
Prior year appropriation	**(500,000)**	-
Depreciation / amortisation	**141,691**	109,260
Write down of non-current assets	**74,071**	15,807
Loss on disposal of assets	**5,185**	-
(Increase) / decrease in net receivables	**25,257**	(58,289)
(Increase) / decrease in prepayments	**(1,499,957)**	15,418
Increase / (decrease) in employee provisions	**75,522**	19,943
Increase / (decrease) in supplier payables	**(223,847)**	245,817
Net cash from / (used by) operating activities	**915,473**	1,209,935

Note 11: Executive Remuneration

The number of executives who received or were due to receive total remuneration of $100,000 or more:		
$110,001 to $120,000	**1**	1
$130,001 to $140,000	**1**	
$190,001 to $200,000		1
$210,001 to $220,000	**1**	
	3	
The aggregate amount of total remuneration of executives shown above.	**460,851**	307,859

Note 12: Remuneration of Auditors	**2002 $**	2001 $
Financial statement audit services are provided free of charge to the agency.		
The fair value of the services provided was:	**6,200**	6,200

No other services were provided by the Auditor-General.

Note 13: Average Staffing Levels

The average staffing levels for the agency during the year were:	**25**	22

Note 14: 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.

Note 15: Financial Instruments

Note 15A - Terms, Conditions and Accounting Policies

Financial Instrument	Notes	Accounting Policies and Methods (including recognition criteria and measurement basis)	Nature of underlying Instrument (including significant terms & conditions affecting the amount, timing and certainty of cash
Financial Assets		Financial assets are recognised when control over future economic benefits is established and the amount of the benefit can be reliably measured.	
Cash	5A	Deposits are recognised at their nominal amounts. Interest is credited to revenue as it accrues.	
Receivables for goods and services	5B	These receivables are recognised at the nominal amounts due less any provision for bad and doubtful debts. Collectability of debts is reviewed at balance date. Provisions are made when collection of the debt is judged to be less rather than more likely.	All receivables are with entities external to the Commonwealth. Credit terms are net 30 days (2001: 30 days)
Financial liabilities		Financial liabilities are recognised when a present obligation to another party is entered into the amount of the liability can be reliably measured.	
Trade creditors	8	Creditors and accruals are recognised at their nominal amounts, being the amounts at which the liabilities will be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).	All creditors are entities that are not part of the Commonwealth legal entity. Settlement is usually made at net 30 days.

Note 15B - Interest Rate Risk

Financial Instrument	Notes	Non-Interest Bearing 2002 $	Non-Interest Bearing 2001 $	Total 2002 $	Total 2001 $	Weighted Average Effective Interest Rate 2002	Weighted Average Effective Interest Rate 2001
Financial Assets						%	%
Cash at bank	5A	**2,285,647**	1,695,121	**2,285,647**	1,695,121	n/a	n/a
Receivables for goods and services	5B	**50,663**	75,920	**50,663**	75,920	n/a	n/a
Total Assets		**2,336,310**	1,771,041	**2,336,310**	1,771,041		
Financial Liabilities							
Trade creditors	8	**298,150**	302,965	**298,150**	302,965	n/a	n/a
Net Financial Assets		**2,038,159**	1,468,076	**2,038,159**	1,468,076		

Note 16 Appropriation of outputs

		2001-02	2000-01
		$	$
Section 7	Appropriation Act Nos 1 & 3 credits	**6,884,000**	4,896,000
Section 12	Comcover Receipts	**0**	0
Section 30A	Appropriations GST Recoverables	**317,185**	132,388
Section 31	Appropriations	**48,340**	24,881
Total Appropriated in the year		**7,249,525**	5,053,269
Balance brought forward from previous period		**1,695,121**	912,555
Total Appropriations available for payment		**8,944,646**	5,965,824
Payments made during the year		**6,658,999**	4,270,703
Balance of appropriations (unspent) at 30 June 2001		**2,285,647**	1,695,121

Note 17 Reporting of Outcomes

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

Appendix 2

Freedom of information statement

During the year ended 30 June 2002, PSR received no requests for access to documents under the provisions of the *Freedom of Information Act 1982*.

Contact officer

All freedom of information requests should be directed to:

The Executive Officer
Professional Services Review
PO Box 136
Yarralumla ACT 2600

Documents

The types of documents PSR holds are:

- referrals and related documents from the Commission pursuant to section 86 of the *Health Insurance Act 1973* regarding the conduct of a person the Commission considers may have engaged in inappropriate practice in connection with rendering or initiating services;
- reports of, and related documents regarding, investigations carried out by PSR;
- lists of Panel members to sit on committees;
- reports of committees;
- administrative files;
- Memorandum of Understanding and other agreements;
- finance and accounting records;
- legal advices;
- computer records;
- consultancy reports and databases;
- contracts;
- minutes of various meetings; and
- general correspondence.

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

- Procedure Guide for Professional Services Review Committees.

Appendix 3

Legislative overview

The PSR 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.

The Act was substantially amended in 1999 following a comprehensive review of the scheme. An adverse decision by the Federal Court in November 2001(*Pradhan v Holmes & Others*) raised concerns that the 1999 amendments to the Act may not have the effect intended. The Full Court of the Federal Court in May 2002 handed down a decision (*Health Insurance Commission v Grey*) which substantially agreed with the way PSR characterises its role, however, further amendment to the Act is required to address the concerns of the Federal Court.

On 27 June 2002, the Health Insurance Amendment (Professional Services Review and Other Matters) Bill 2002 was introduced into Parliament. The Bill proposes a number of amendments to the Act, specifically to

- clarify the roles and responsibilities of the Commission, the Director of PSR and the PSR Committees;
- enhance the procedural fairness processes; and
- validate a number of referrals (that may otherwise have been found to be invalid on the basis of the *Pradhan* decision) which are currently before committees.

The Bill has been developed in consultation with the Director of PSR, the Commission and the AMA and is expected to be debated in Parliament in October 2002.

The Director

Dr A J (John) Holmes was appointed Director of Professional Services Review by the then Minister for Human Services and Health (now Health and Ageing) on 21 July 1994 for a three-year period. Dr Holmes has twice been re-appointed for further three-year periods and his current appointment finishes on 20 July 2003.

At 30 June 2002, 185 members had been appointed for a five-year period by the Minister as panel members to serve on committees.

Of these, 21 were also appointed as Deputy Directors of PSR to serve as Chairpersons. Further nominations for appointment to the panel are in process.

Background

The legislation was developed with the aim of providing an effective peer review mechanism to deal quickly and fairly with concerns about possible inappropriate practice.

The essential features of the review structure are:

- a Director of PSR, who is a medical practitioner, appointed ministerially and able to engage staff and consultants;
- a PSR panel, comprising medical and other health related practitioners, who are appointed ministerially;
- committees, comprising practitioners from the PSR panel appointed by the Director on a case-by-case basis to consider the conduct of practitioners referred by the Director for review; and
- a Determining Authority comprising a medical practitioner as Chair, a lay person and a member of the relevant profession. The Determining Authority's role is to decide on the sanctions for practitioners found by committees to have engaged in inappropriate practice and to consider whether to ratify agreements entered into by the Director and the person under review.

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 (that is, 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 practicing 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 PSR scheme

The PSR scheme gives health professionals 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:

- investigation of referral from the Commission;
- committee hearings and findings; and
- determination of any penalty.

Glossary

Act	*Health Insurance Act 1973*, as amended by the *Health Legislation (Professional Services Review) Amendment Act 1994* and subsequent amendments
Adjudicative Referral	A case prepared by the Director, instituting a referral to a PSR Committee, after an investigation of the concerns contained in an Investigative Referral
AMA	Australian Medical Association
committee	A Professional Services Review committee established by the Director in accordance with section 93 of the Act to examine a case of apparent 'inappropriate practice' referred by the Health Insurance Commission
Determining Authority	A three-person panel responsible for determining the sanction following an adverse PSR Committee finding
Determining Officer	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
Director	The Director of Professional Services Review is an independent statutory officer appointed by the Minister – the occupant must be a medical practitioner and the AMA must agree to the appointment
Disqualification	Exclusion (partial or complete) from eligibility for the practitioner's services to attract Medicare benefits
Inappropriate practice	Professional conduct in relation to Medicare which a committee of peers would reasonably consider would be unacceptable to the general body of the peer group (section 82)
Investigative Referral	A case prepared by the HIC and referred to the Director, containing the HIC's concerns and the reasons it considers a practitioner or other person may have engaged in inappropriate practice in the terms of section 82 of the Act
Minister	Minister for Health and Ageing
OH&S	occupational health and safety
Panel	PSR Panel consisting of medical practitioners, dentists, optometrists, chiropractors, physiotherapists and podiatrists nominated by the relevant professional organisations and who have been appointed by the Minister
PSR	Professional Services Review
Referral	A case prepared by the Health Insurance Commission and referred to the Director PSR, detailing the Health Insurance Commission'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

Compliance index

Alphabetical index