MEDICAL FRAUD AND OVERSERVICING— Progress Report

Report

203

Joint Committee of Public Accounts

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THE PARLIAMENT OF THE COMMONWEALTH OF AUSTRALIA

JOINT COMMITTEE OF PUBLIC ACCOUNTS

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MEDICAL FRAUD AND OVERSERVICING - PROGRESS REPORT

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JOINT COMMITTEE OF PUBLIC ACCOUNTS

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DUTIES OF THE COMMITTEE

Section 8.(1) of the Public Accounts Committee Act 1951 reads as follows:

8.(1) Subject to sub-section (2), the duties of the Committee are:

(a) to examine the accounts of the receipts and expenditure of the Commonwealth including the financial statements transmitted to the Auditor-General under sub-section (4) of section 50 of the Audit Act 1901;

(aa) to examine the financial affairs of authorities of the Commonwealth to which this Act applies and of intergovernmental bodies to which this Act applies;

(ab) to examine all reports of the Auditor-General (including reports of the results of efficiency audits) copies of which have been laid before the Houses of the Parliament;

(b) to report to both Houses of the Parliament, with such comment as it thinks fit, any items or matters in those accounts, statements and reports, or any circumstances connected with them, to which the Committee is of the opinion that the attention of the Parliament should be directed;

(c) to report to both Houses of the Parliament any alteration which the Committee thinks desirable in the form of the public accounts or in the method of keeping them, or in the mode of receipt, control, issue or payment of public moneys; and

(d) to inquire into any question in connexion with the public accounts which is referred to it by either House of the Parliament, and to report to that House upon that question,

and include such other duties as are assigned to the Committee by Joint Standing Orders approved by both Houses of the Parliament.

PREFACE

Early this year the Department of Health confirmed that it estimated an annual loss of at least $100m per annum in fraud and overservicing by some members of the medical profession. Consequently the Committee decided to inquire into payments, made under the Medical Benefits Schedule. This progress report, produced in response to a request by the Minister for Health, the Hon. J.J. Carlton, MP, focuses on the performance of the Department of Health and on possible improvements in procedures for pursuing doctors suspected of fraud or overservicing.

The Committee recommends a significant streamlining and strengthening of administrative procedures, for example through the establishment of integrated investigation sections comprising Department of Health and Australian Federal Police investigators; the creation of a new role of medical investigator to ensure that doctors providing excessive services on a large scale are pursued with greater vigour than in the past. As a short term measure, the Committee recommends the establishment of a special national task force to investigate the backlog of medical fraud cases. These and many other specific recommendations form a package which, if implemented in toto, should greatly reduce abuse of the system. The Committee has also suggested a number of options for more fundamental changes in the Medical Benefits Scheme and the legislation concerning medical fraud and overservicing, which we hope will encourage widespread discussion in the Parliament and elsewhere.

The report raises a number of fundamental issues of public administration and policy which extend well beyond the specific area of medical fraud and overservicing. These include the overall performance of the Department of Health, the general relationship between central and state offices of departments, and the adequacy of the current legal system in coping with white collar crime.

This inquiry has been a major undertaking by the Committee. Oral evidence already amounts to over 5,000 pages of transcript, in addition to a significant number of written submissions. All members of the Committee have played an active role in the inquiry. The Committee wishes to express its appreciation to the members of the task force which included officers of the Committee's Secretariat and a range of expert advisers. The Committee also wishes to thank the Secretary of the Department of Prime Minister and Cabinet for making available a senior officer to head the task force. We wish to thank the task force for its valuable assistance in the preparation of this report in the face of difficult time constraints.

Notwithstanding our criticisms of the administration of the Department of Health, the Committee also wishes to thank officers of the Department for their considerable assistance with the inquiry.

Much of the evidence the Committee has taken is not referred to in this progress report, but is being reviewed in the context of the preparation of the final report. Further evidence will be taken in the new year and we welcome contributions from individuals and organisations interested in the provision of health care to the Australian people.

For and on behalf of the Committee

David M. Connolly
Chairman

M.J. Talberg
Secretary
8 December 1982

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CHAPTER 1

INTRODUCTION

1.1 Following widespread reports in the media in February 1982 of abuse by doctors of the Medical Benefits Schedule, the Committee sought detailed briefing from the Commonwealth Department of Health on mechanisms for the detection and apprehension of offending doctors and information on problems associated with the area. As a result, and on the basis of preliminary investigations of the operations of the Department of Health, the Committee announced a formal inquiry on 25 May 1982, with the following Terms of Reference which were agreed to by the Minister for Health:

> To inquire into and report upon payments made under Medical Benefits Schedule with particular reference to:
>
> - Estimates of the extent of fraud and overservicing by practitioners in relation to payments made by or on behalf of the Department of Health under the Commonwealth Medical Benefits Schedule; and
>
> - Present arrangements in relation to such fraud and overservicing and the possibilities for improvements in these procedures.

1.2 In announcing these terms of reference, the Committee stressed that the inquiry should not be interpreted as an attack on the reputation of the medical profession or as an attempt to identify individual fraudulent doctors, but rather as an examination of issues associated with abuse by some members of the medical profession.

1.3 Since May, many submissions have been received from a variety of organisations, including relevant Government departments, medical professional organisations, health funds and private individuals. A list of non-confidential submissions is attached at appendix B.

1.4 The Committee began formal hearings on 8 June 1982 and to date has completed 48 hearings and meetings, covering both public and private hearings. A list of public hearings to date is attached at appendix C.

1.5 Because of the range and complexity of issues which the Committee needs to examine in this inquiry, a great deal more work needs to be done. However, given the magnitude of

the problem and the significant costs of delaying action, the Committee agreed to a request of the Minister for Health, the Hon. J.J. Carlton MP, to produce a progress report. This report consequently does not offer final recommendations in all areas. The Committee is especially concerned to comment on the handling of fraud and overservicing by the Department of Health, the Australian Federal Police and the Crown Solicitor's Office.

1.6 The purposes of this progress report are:

- to provide the Government with an indication of the Committee's views on areas where urgent action should be taken; and
- to offer a number of options for administrative and legal changes to improve current arrangements for pursuing fraud and overservicing by doctors.

1.7 It should be noted that this progress report does not address a number of major areas where the Committee is of the view that significant abuse may be occurring. These include patient fraud, and fraud and overservicing specifically associated with hospitals, pathology and surgery. These and others will be covered in detail in the final report on the inquiry. Consideration may also be given to possible fraud and overservicing associated with Department of Veterans' Affairs programs under which payments are provided to doctors for treating the veteran population.

CHAPTER 2

MAJOR CONCLUSIONS AND RECOMMENDATIONS

2.1 *It must be emphasised that the Committee has not yet* completed its inquiry into medical fraud and overservicing. It is possible at this stage, however, to draw a number of *conclusions.*

Major Conclusions To Date

2.2 The Department of Health has estimated that fraud and overservicing by doctors amounts to at least $100m per annum, or 7% of total medical benefits expenditure by the Commonwealth and health funds $1497m in 1981/82. The Australian Medical Association has accepted that about $100m per annum is being lost through fraud and overservicing.[1] *Although the estimate is far from precise, the Committee* believes it to be conservative, especially if one accepts that some overservicing is built into standard medical practices in *a number of areas.*

2.3 Evidence before us revealed that fraud and overservicing comes in a wide variety of forms. The Committee was alarmed to learn of the ingenuity of some members of the medical profession in abusing the Medical Benefits Scheme, and is concerned that a significant number of medical practitioners are betraying the position of trust in which they are placed. Although the Committee believes that a substantial majority of doctors are not engaging in fraud or conscious overservicing, the procedures associated with the payment of medical benefits and with pursuit of doctors suspected of fraud or overservicing must be brought more into line with procedures and financial ethical standards applying to other professions. The Committee is firmly of the view that doctors should be fully accountable for all aspects of *their practices, including the actions of their employees.*

2.4 This report examines possible changes within the present broad structure of the health insurance system which is based on fee-for-service with substantial third party payment. We believe that improvements can be made within the current system, although we will be considering possible modifications in our final report.

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1 Australian Medical Association Press Release, 3 February 1982.

2.5 The current system of bulk-billing for pensioners and low income earners provides some scope for abuse. In this progress report, the Committee does not recommend abolition of bulk-billing, but rather greater discipline needs to be applied within the system. In particular, procedures need to be changed to ensure better scrutiny by patient with respect to both bulk-billing and patient-billing.

2.6 Under current arrangements, the Commonwealth Department of Health shares responsibility for detecting and responding to medical fraud and overservicing with registered health insurance organisations, the Australian Federal Police, the Crown Solicitor's Division of the Attorney-General's Department, State authorities and the courts. One of the major difficulties is that no single organisation takes full responsibility.

2.7 Of about 17,000 doctors in full-time private practice in Australia, only 39 were penalised for fraud and twelve for overservicing in almost seven years (July 1975 to March 1982), despite at least $100m per annum being lost. The current system thus offers very little deterrent or risk of penalty to those who abuse it.

2.8 A crucial factor in this situation has been the slow reaction of the Department of Health to the problem. It is recognised that over recent years the Department has faced a series of major changes to health insurance arrangements and other areas of policy in an atmosphere of staffing restraint. Nevertheless, the Committee believes that the Department's response to fraud and overservicing has been grossly inadequate. In almost every respect, too little has been done too late. On the evidence available to us, a large part of the responsibility for this must lie with the Department, and especially its senior officers.

2.9 The Department has argued that it did not have responsibility for medical benefits arrangements prior to November 1978, and that the magnitude of the problem was unknown until February 1981. The Committee does not accept either explanation for the Department's poor performance as adequate. Even prior to November 1978 the Department had responsibility for responding to overservicing and overall responsibility for advising on health policy. It is also important to realise that from July 1976 until November 1978 the Director-General of Health was also Chairman of the Health Insurance Commission. Given this and the ample evidence since at least 1975 that medical fraud and overservicing was occurring on a large scale, the Department cannot escape responsibility.

2.10 A major factor in the Department of Health's poor performance has been the way in which responsibility has been decentralised to its state offices. Until June 1982 (after

the commencement of this inquiry), the Department had not issued written guidelines to its state offices on most aspects of the process for handling fraud and overservicing. The Department also failed to introduce adequate management information systems to monitor their performance. The Committee finds this breakdown in accountability totally unacceptable, especially in view of the serious problems that arose in the Victorian office's handling of suspected fraud cases.

2.11 There have also been occasions where the Department has been slow to brief its Ministers, although overall it cannot be said that successive Ministers of Health were unaware of fraud and overservicing. The Committee's evidence in this area is not yet complete, but it seems at this stage that Ministers cannot escape some responsibility for the major problems that have been identified.

2.12 In the Committee's examination of specific aspects of the response to medical fraud and overservicing, a number of significant difficulties have been identified:

(a) There are significant problems in the Department of Health's Fraud and Overservicing Detection System (FODS), which cause much fraud and overservicing to go undetected, and also result in some doctors being falsely suspected of fraud or overservicing. A significant factor has been the failure to allocate adequate priorities for staff resources.

(b) Long delays in the investigation of suspected fraud cases have been brought about by:

- insufficient allocation of staff by both the Health Department and the Australian Federal Police;
- inadequate guidelines on what constitutes fraud and how it should be handled;
- flaws in the procedures for handling suspected fraud cases; and
- inadequate training of both Health and police investigators in this specialised area.

(c) There are long delays in Deputy Crown Solicitors' Offices in bringing fraud cases to court, and significant doubts about the effectiveness of current legislation, including the new provisions to automatically disqualify doctors from receiving medical benefits after conviction for fraud.

(d) Inadequate counselling of doctors with respect to overservicing and ineffective operation of the Medical Services Committees of Inquiry (MSCIs), have resulted from:

- insufficient number of counsellors;
- contradictions in their roles;
- the requirement that MSCIs examine each service alleged to be excessive; and
- the overall emphasis on counselling and peer review, rather than investigation and justice.

Recommendations for Immediate Action

2.13 Final recommendations will be given in a subsequent report, expected to be tabled during the Autumn Sittings of the Parliament in 1983. At this stage, however, the Committee has made a number of recommendations that should be implemented immediately. Specifically, the Committee strongly recommends that:

1. Priority should be given to allocating additional resources to streamline and strengthen procedures for pursuing doctors suspected of fraud or overservicing. (page 27)

2. The Health Insurance Act should be amended to require doctors' accounts and assignment forms to be as comprehensible as possible to patients. In particular, it is recommended that both Medical Benefit Schedule item numbers and simplified descriptions of services be required on all accounts and assignment forms. The legislation should be amended to allow the description of common services (eg consultations) to be specified in regulations. (page 34)

3. A number of changes should be made to bulk-billing arrangements to reduce the scope for fraud:

   (a) strict enforcement of requirements that patients sign the assignment form in the presence of the doctor after the service has been provided, and that patients be given a copy of the completed assignment form;

   (b) amendment of the legislation to provide that failure to fulfil the requirements in (a) is an offence on the part of the doctor and/or the patient, and that assignment forms carry a warning that this is an offence; and

(c) sending a random sample of assignment forms to patients for verification, in line with the practice of some Canadian health plans, sample size to be calculated on the basis of current estimates of the extent to which assignment forms are altered, but to be reviewed in the light of experience with the verification process. (page 36)

4. The conduct of the Victorian office of the Department of Health in handling fraud and overservicing cases should be *investigated by the appropriate authorities, particularly* in respect of possible breaches of the Crimes Act and the Public Service Act. (page 51)

5. The senior management structure and personnel of the Department of Health should be comprehensively reviewed to ensure, amongst other things, that lines of responsibility are clearly defined so that all senior officers can be in no doubt that they are responsible for the efficient and effective administration of the areas of policy assigned to them. (page 59)

6. The lines of responsibility within the Department of Health should be redefined and its management philosophy altered to ensure that Directors of its state offices are fully accountable to the Director-General, who has overall *responsibility for the performance of the Department.* In particular, it is recommended that:

   (a) comprehensive written guidelines be issued to state offices on all aspects of the detection and investigation of suspected fraud and overservicing;

   (b) the Australian Federal Police, the Attorney-General's Department and experienced investigators and counsellors within the Department of Health be consulted in the development of these guidelines;

   (c) adequate management information systems be introduced and utilised;

   (d) independent management expertise be provided to the *Department to assist with (a) and (c) above; and*

   (e) day-to-day contact be maintained between claims review and investigation staff in the central and state offices, especially during implementation of changes arising from this inquiry. (page 63)

7. Medical organisations, especially the medical colleges, should co-operate fully with the Department of Health's efforts in developing appropriate peer group norms for use in the FODS system, and on other aspects of the system. (page 76)

8. The Department of Health and health insurance funds should jointly develop methods for detecting fraud and overservicing that arises where patients receive services from more than one doctor or where doctors treat all the members of a family. (page 77)

9. Regulations should be promulgated to require doctors who actually providing services to indicate their provider numbers on all accounts and receipts that attract Commonwealth Medical Benefits. (page 78)

10. Legislation should be amended to require doctors to submit bulk-billing claims within 2 months of services being provided, with appropriate provision for extensions where this limit would cause hardship. Consideration should also be given to improving a limit on the time patients have to submit claims to health funds. (page 79)

11. The Department should undertake a study into the accuracy of Commonwealth Medical Benefits data as a matter of urgency. In the interim, the Department should ensure that appropriate standards are adhered to by health funds in providing data. (page 79)

12. The output of the FODS system should be simplified to facilitate its use by counsellors and investigators. Also the computer system should be developed to carry out initial screening for particular service patterns known to be frequently associated with fraud or overservicing. (page 80)

13. The health insurance legislation should be amended to require identification of doctors who refer patients for specialist treatment or tests, and to require health funds to include this information in data supplied to the Department. (page 80)

14. The Department should examine doctors' practice patterns over the previous 12 months, as well as the previous quarter. (page 81)

15. Additional staff should be allocated to the development of the Fraud and Overservicing Detection System. Further development of FODS should aim at reducing the number of doctors falsely suspected, as well as identifying major fraud and overservicing that currently goes undetected. (page 82)

16. Steps should be taken to improve the level of communication and co-ordination between health funds and the Department of Health in relation to the provision of data and the transfer of information on possible cases of fraud and overservicing. In particular, the legislative impediments to providing claims information to private

health funds should be relaxed further to enable a free flow of information between funds and the Department, but on the basis that the other secrecy provisions of the legislation are imposed on the officers and employees of the funds. (page 83)

17. All cases of overservicing should be referred for investigation. Where minor overservicing is suspected and detailed investigation does not seem warranted, cases can then be referred to a medical counsellor. (page 86)

18. The Australian Federal Police (AFP) should be responsible for maintaining case load statistics on medical fraud cases referred by the Department of Health, to ensure that the performance of their divisional offices is adequately monitored. (page 88)

19. As a short term measure, a national task force drawn from experienced investigation staff of the Department of Health and the Australian Federal Police should be established immediately to tackle the backlog of fraud cases. This task force should be located within the Health Department and work with state investigation sections, but with the police members formally reporting to the Australian Federal Police. Additional funds should be made available for travel by the task force. (page 93)

20. By the end of June 1983, the task force should present a report directly to the Ministers for Health and Administrative Services and to the Public Accounts Committee on its activities. (page 93)

21. The Department of Health should introduce adequate training in relevant skills for its investigation staff. This training could be through existing police courses or through a special course developed in conjunction with the AFP. (page 94)

22. In addition to the proposed national task force, integrated investigation sections should be established in all state offices of the Department of Health, comprising officers from the Department and the Australian Federal Police, with investigation teams for particular fraud cases being drawn from these sections. (See also recommendation 32). The Committee also recommends that these teams be expanded to include legal staff from the relevant Deputy Crown Solicitor's office and investigation staff from health insurance funds where appropriate. As far as practicable, the AFP and Health personnel involved should be posted on a permanent basis. (page 97)

23. Once FOOS data or other information suggests that a doctor is engaging in fraud, investigators should also seek the most recent claims on which to base prosecutions. This

will involve up-to-date claims information from health funds or from the Department's bulk-billing system. (page 98)

24. AFP and Health Department written procedures should be amended immediately in the light of the new section 19B of the Health Insurance Act which allows automatic disqualification of a doctor for medical benefits purposes, to emphasise that in many cases only a handful of offences need be brought before the courts to take advantage of this provision. (page 98)

25. The proposed national task force should concentrate on investigation of doctors who are already suspected of undertaking large scale fraud, and focus on offences committed by these doctors after 1 November 1982, both to ensure that witnesses have fresh memories and to enable the new disqualification provision to be applied. This will also mean that priority is given to doctors who are continuing their fraudulent practices. (page 99)

26. Additional legal staff should be made available for prosecution of medical fraud cases. The Committee also recommends that consideration be given to appointment of a special prosecutor (being a leading senior counsel) to provide the maximum impact and to clear the backlog of cases. The special prosecutor should be supported by competent legal officers within the Crown Solicitor's Division or lawyers in private practice. (page 102)

27. Legal officers from the Deputy Crown Solicitor's offices or from private practice should be included in the proposed national task force, to ensure that appropriate cases are selected for investigation and to allow the task force itself to proceed to prosecution where possible. These lawyers should work closely with the special prosecutor when appointed. (page 103)

28. The legislation should be amended to allow health funds and patients, as well as the Commonwealth, to recover payments made by them in respect of any account which is fraudulent or is false, misleading or inaccurate in a material particular. Funds should be encouraged to investigate and prosecute cases of fraud to reduce the number of fraudulent claims. Either individually or collectively, all private health funds should establish investigation units. (page 104)

29. State and Commonwealth Governments in consultation should introduce uniform medical registration legislation to provide for national registration of medical practitioners. This legislation should require that, whenever a doctor is convicted of medical fraud or any other criminal offence related to the practice of

medicine, the doctor is automatically deregistered nationally for a period, and should not be re-registered until the relevant board is satisfied that the doctor is fit and proper to be re-registered. A repeated offender could be deregistered for life. (page 109)

30. The Department of Health and the Australian Medical Association should co-operate in standardising their respective schedules of fees to ensure common descriptions and item numbers, although the Association should be free to advise its members on the level of fee for each item (not being the fee on which medical benefits are based). (page 116)

31. A new role of medical investigator should be established within the Department of Health to interview doctors with respect to apparent cases of serious overservicing, and to assist in fraud cases as required. The medical investigators should be qualified medical practitioners, and the duty statements for the positions should emphasise the quite different qualities that are desirable in an investigator, compared to a counsellor whose major activity is to educate and advise. Where a medical investigator has not had prior investigation experience, formal training in investigation techniques should be provided. (page 127)

32. The new positions of medical investigator should be located in the recommended integrated investigation sections, which will examine serious cases of overservicing (as well as fraud) without prior counselling and refer relevant cases directly to the proposed Medical Benefits Tribunals. (page 127)

33. The role of medical counsellors should be limited to educating and advising doctors on the Medical Benefits Scheme, and following up minor cases of overservicing that do not warrant detailed investigation. The counsellors should not be involved in recovery of money from doctors suspected of overservicing. Any suggestion of fraud or major overservicing that arises in the course of counselling should be referred to the investigation section. The Committee also recommends that where counsellors interview doctors suspected of minor overservicing, the doctors' practice patterns be reviewed after six months with a view to possible investigation if the situation has not improved. (page 127)

34. All doctors engaged in any form of private practice should be visited by medical counsellors at least once every three years to update their knowledge of the medical benefits arrangements, in particular any changes to the Schedule, and to offer any advice the doctor requires on these matters. (page 128)

35. The Commonwealth should strongly urge the States to introduce a requirement that all doctors either receive counselling or attend an appropriate course (see recommendation 45) before registration. (page 128)

36. Specialist counsellors should be appointed on a part-time basis, in consultation with the appropriate colleges, to provide counselling to members of their specialty where full-time counsellors are not equipped to do so, and to provide any necessary advice to medical investigators. (page 128)

37. The current Medical Services Committees of Inquiry should be abolished and Medical Benefits Tribunals established in each State to examine suspected cases of overservicing. Medical investigators should consider whether there is a prima facie case for recovery of money, in which case the matter would be referred to a Tribunal; if the overservicing is considered to be minor and recovery is not appropriate, the medical investigator should refer the matter to the counsellors. (See recommendation 33). (page 130)

38. The proposed Medical Benefits Tribunals should be empowered to examine representative samples of services rendered by a doctor and to generalise from such samples in determining the amount of benefit to be repaid. The samples for a doctor could be drawn from claims for a particular type of service, claims with respect to particular patients or from the doctor's overall practice. Advice should be sought from the Australian Bureau of Statistics on the methods to be used in selection of samples. (page 130)

39. Membership of the Tribunals should:

    (a) include specialist expertise where medical specialists are being examined;

    (b) exclude State Directors of Health; and

    (c) be appointed by the Minister for Health who should not be restricted to nominations invited from medical colleges and associations. (page 131)

40. Arising out of its consideration of a particular case, a Tribunal should also be empowered to recommend that:

    (a) the evidence on a particular case be referred to the appropriate Medical Registration Board;

    (b) appropriate authorities consider specific changes to the Medical Benefits Schedule or other aspects of the Medical Benefits Scheme; and

(c) specialist colleges or other elements of the medical profession consider aspects of the quality or form of medical practice. (page 132)

41. Tribunals should adopt streamlined and informal procedures in cases where the doctor acknowledges that excessive services were provided and does not contest the matter before the Tribunal, especially where the overservicing was on a small scale. (page 133)

42. Doctors who are found to have provided excessive services totalling in any one year more than an amount prescribed in legislation, or who are found on two separate occasions to have provided excessive services totalling less than the prescribed amount, should be automatically disqualified for medical benefits purposes, in the same way that current legislation provides for automatic disqualification of doctors convicted of fraud. (page 133)

43. Consideration should be given to replacing the Medical Services Review Tribunal with appeals to the Administrative Appeals Tribunal, with any necessary modification to the latter's powers and procedures. (page 134)

44. The Commonwealth should no longer automatically meet the costs of doctors who appeal against determinations regarding overservicing, but require such doctors to meet their own costs, unless the relevant tribunal or court decides otherwise, in line with the usual practice in courts of law. (page 134)

45. The final year of medical training should include compulsory courses on ethics, health economics, the law associated with medical practice, and the health insurance arrangements with special reference to the Medical Benefits Schedule. (page 135)

2.14 A number of these recommendations involve changes in the process for dealing with suspected fraud and overservicing cases. The effect of these is summarised in diagram 1, which can be compared with the current process illustrated in diagram 2.

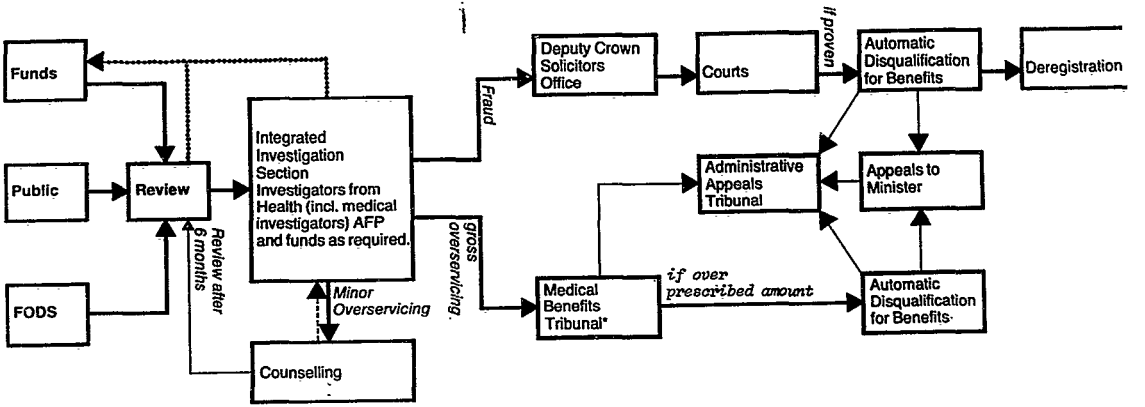
Matters for Future Consideration

2.15 The Committee will be examining further a number of areas for its final report on this inquiry. Major areas include:

- patient fraud;
- fraud associated with hospitals;

Diagram 1

Proposed system for handling Fraud and Overservicing



Key

- Flow of Cases
- *Appeals or Reviews*
- Referred back to Investigation Section where there is new evidence of fraud or gross overservicing
- Information Provided to funds

Footnotes

In addition to this system at the state level, the Committee proposes establishment of a special national task force and a special prosecutor as short term measures.

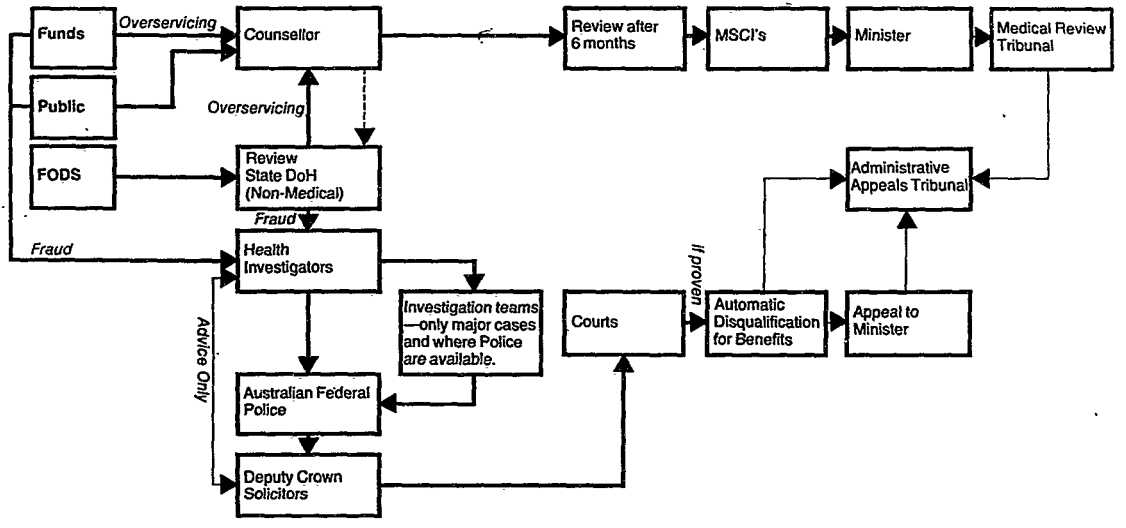
The system assumes integrated and comprehensive data and management information to complement case flow.

In addition to the appeal mechanisms shown, appeals can be made to the courts on points of law at various stages. Matters may also be referred to the Commonwealth Ombudsman.

* The Committee has n made detailed recommendations on th Tribunals, e.g. whether the tribunals should determine amounts to b repaid or make recommendations to the Minister.

Diagram 2

Current system for handling Fraud and Overservicing



Key

- Flow of Cases
- Appeals on Review
- Referred back to investigation section where there is *evidence* of fraud.

Footnote

In addition to the appeals mechanism shown, appeals can be made to the Courts on points of law at various stages. Matters may also be referred to the Commonwealth Ombudsman.

- fraud and overservicing associated with prescription of pharmaceuticals;
- fraud and overservicing associated with pathology;
- unnecessary surgery;
- possible strengthening of the legislation with respect to medical fraud;
- possible measures to reduce growth in the number of doctors;
- peer review mechanisms and the development of guidelines for the use of specific medical procedures;
- modification of the medical benefits system to reduce incentives for overservicing;
- revision of the Medical Benefits Schedule; and
- medical education.

2.16 The Committee is also giving further consideration to the performance of a number of organisations other than the Department of Health on whom this report has focussed. These include the Australian Federal Police, the Crown Solicitor's Division of the Attorney-General's Department and the Auditor-General's office.

2.17 In some of these areas possible options are identified in this report, especially in chapters 8 and 9. The Committee hopes to hear from interested organisations and individuals on these and related issues.

CHAPTER 3

EXTENT OF FRAUD AND OVERSERVICING

What is Meant by Fraud and Overservicing

3.1 *The terms fraud and overservicing are often used* together as a generic expression covering 'abuse' of the medical benefits arrangements. A clear distinction should, however, be drawn between the two:

'Fraud' - usually refers to a breach of the Health Insurance Act 1973, specifically Sections 129, 129AA or 129AAA, such as where a claim is made for a service not rendered to a patient, or where the service is incorrectly described when billing the patient; doctors can also be charged with fraud under the Crimes Act 1914;

'Overservicing' - is defined in Section 79(1B)(a) of the Health Insurance Act, involving the provision of medical services which were not reasonably necessary for the adequate medical care of the patient concerned.

3.2 The relevant sections of the Health Insurance Act are *reproduced at appendix D.*

3.3 Whether or not fraud took place in a particular instance is largely a matter of fact. Did the doctor see the patient on a particular day, or provide the service for which a claim has been made? The Commonwealth simply has to prove in court that the doctor charged for a service that was not provided. It is not necessary to prove that the false statement by the doctor was deliberate, although under Section 129(3) of the Health Insurance Act it is a defence if the doctor proves that he did not know or had no reason to suspect that the statement was false.

3.4 As we shall discuss later in this report, difficulties have arisen in proving cases of fraud, especially where large numbers of individual claims are involved; where patients were very ill or have died; or where the doctor was able to show that a receptionist or other employee was responsible for the error. There is also evidence that

Department of Health officers have at times misunderstood the distinction between fraud and overservicing. Yet, in principle, the definition of fraud is clear.

3.5 Overservicing, on the other hand, is largely a matter of medical judgement, and is therefore often very difficult to identify.

3.6 The term overservicing does not itself appear in the Health Insurance Act. Section 79(1B)(a) of the Act defines excessive services as:

> professional services, being services in respect of which medical benefits has (sic) become or may become payable, that are not reasonably necessary for the adequate medical care of the patient concerned.

3.7 For the purposes of the Health Insurance Act, the determination of what constitutes reasonable necessity and adequate medical care is left to groups of experienced medical practitioners acting as Medical Services Committees of Inquiry.

3.8 Overservicing may cover a variety of circumstances, including:

- provision of services that may actually harm a patient, or unnecessarily expose a patient to risk, as in the case of some unnecessary surgery;
- provision of services of no medical benefit to the patient, such as unnecessary screening tests;
- too frequent visits to patients in hospitals or nursing homes where the frequency of visiting is primarily determined by the doctor; and
- the development of patterns of patient behaviour that are financially advantageous to the doctor but of little medical benefit to the patient, such as encouragement of patients to visit a doctor more often than is necessary.

3.9 In some cases, there may be non-medical benefits to the patient, for example where the social needs of elderly patients are met by a regular home visit by a doctor. The Australian Medical Association (AMA) has raised the question of whether the Medical Benefits Scheme should be limited to medical care alone, or should it also cover services that are supportive in a psychological sense, which can be of very real importance to the welfare of a patient.[1] The Committee notes

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1 Australian Medical Association (AMA), Submission to the Joint Parliamentary Committee of Public Accounts, July 1982, pp. 16-17.

that the current legislative definition is restricted to medical care, and that it is not always efficient to have such services provided by the medical profession, rather than para-medical or welfare personnel.

3.10 In initial stages of investigation it is often difficult to distinguish between fraud and overservicing from an initial examination of statistical information based on claims for medical benefits. Characteristics such as high cost per patient, above average number of consultations per patient, or the use of an unusual combination of item numbers may reflect fraud or overservicing. A doctor treating a particularly ill group of patients or specialising in treating a particular illness may also have these characteristics.

3.11 Overservicing may take place for any one of a number of reasons. For example:

- overuse of diagnostic tests by a relatively inexperienced doctor may reflect a lack of confidence or judgement;
- more generally, unnecessary services are sometimes provided because a doctor is inadequately trained in a particular area of medicine or is less than fully competent;
- 'heroic' overtreatment of advanced malignancy may reflect an interventionist ideology, a set of attitudes which imply that it is better to do than to watch;
- overservicing can also result from an ambitious specialist department within a hospital trying to build its reputation and experience;
- similarly, an individual surgeon or other medical practitioner may carry out certain procedures in order to maintain expertise, especially where the procedure is rare or where there is an oversupply of doctors;
- it has been suggested that some overservicing results from patient pressure, where the doctor writes a prescription or performs a particular procedure that is requested by a patient, even where there is no justification on medical grounds; and
- last, but certainly not least, there is often a very substantial financial incentive for doctors to provide services that are unnecessary, especially where the services can be provided at little or no cost to the patient.

3.12 Some overservicing may also result from legislative provisions, where unnecessary visits to general practitioners are required to obtain either a referral to a specialist or a repeat prescription. For example, it is doubtful that a consultation is always necessary before referral to an opthalmologist for eye tests, or as frequently as currently required when prescribing medication for some chronic illnesses.

3.13 In assessing overservicing, it is important to emphasise that:

- doctors vary in professional training, experience and competence, and also in qualities such as personality, self-esteem, integrity and professional motivation;
- patients vary widely in their personal needs, which may be influenced by family and social factors, economic insecurity, personality, mental illness and a host of other factors; and
- the manifestations of illness are not always present in a clear and ordered fashion.

3.14 There has been much debate in Australia about 'unnecessary' surgery. Those who deny that unnecessary procedures occur often assume that everything which the doctor does is necessary and that it is the responsibility of critics to prove that some procedure is unnecessary. This seems to be a reversal of the responsibility of doctors to their clients and the community.

3.15 There are very significant differences in surgical treatment rates between countries, such as the U.K. or Sweden, where salaried services predominate, and U.S.A. or Australia, where subsidized fee-for-service medicine operates. There are also marked differences in Australia between different regions. While some of these differences may reflect climatic, socio-economic or demographic factors, it seems that the use of surgical procedures is also influenced by factors such as the method of payment and the number of surgeons available[2].

3.16 There is another and more subtle aspect of overservicing. There seems to have been a change in the way in which many people view medical services, for example in the area of psychiatry. Just as demand for goods and services such as restaurants, clothes and cosmetics has been rising with increasing affluence and changing consumer tastes, so too has demand for medical services. A number of witnesses have

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2 Opit, L.J., Submission to the Joint Parliamentary Committee of Public Accounts, 1982, p. 6.

emphasised that people often request their own treatment. This demand sometimes reflects social and personal needs other than any need for treatment of objectively verifiable illness. A witness has used the term 'conspicuous consumption' in this context.[3] One cannot object to the market responding to such social and personal needs, but there seems little justification for doing so at the expense of taxpayers and health fund contributors.

The Department's Estimate

3.17 The Department of Health has estimated that fraud and overservicing is responsible for at least 7% of total medical benefits expenditure by the Commonwealth and health funds.[4] The Department's estimate of the magnitude of the fraud and overservicing problem has been calculated using data obtained from its Fraud and Overservicing Detection System (FODS), which is discussed in detail in chapter 6 of this report.

3.18 For each doctor in the country, the average schedule fees paid per quarter per patient was calculated. This cost was then compared with the same average calculated over those other doctors in the same peer (ie specialty) group within the same State who earned more than $4 000 in the quarter from schedule fees. In those cases where the individual doctor's average cost per patient exceeded that of his peer group, the difference was multiplied by the number of patients seen in the quarter and then summed for all such doctors. Details of the calculation are shown in appendix E.

3.19 In broad terms, the calculation of this 'excess' cost represents the extent to which each doctor's income from Schedule fees is above average, after taking account of:

- the doctor's specialty;
- the State in which he practices; and
- the number of patients seen in the quarter.

3.20 Based on schedule fees paid for the September 1980 quarter, the 'excess' for the year ending June 1981 was estimated to be $160 million.

3.21 A significant proportion of this 'excess' comprises legitimate medical practice, rather than fraud or overservicing. The Department of Health has made a rough approximation that one third of the total 'excess' is fraud, one third is overservicing and the remaining third is

3 Opit, L.J. op. cit., pp. 7-9.
4 Advice from Department of Health, Committee File 1982/9.

legitimate practice by doctors. The Department therefore estimates that fraud and overservicing account for at least *$100m per annum.*

3.22 It should be emphasised that this amount is not all associated with medical benefits paid by the Commonwealth. The Commonwealth directly meets at least 85% of the schedule fee for eligible pensioners and people eligible for a health care card, but only 30% of the schedule fee for services provided to other insured people. The Department estimates that Commonwealth medical benefits comprise roughly half of all medical benefits paid. Thus the estimate implies that at least $50M of Commonwealth medical benefits is lost in fraud or overservicing. There is also an indirect Commonwealth subsidy for benefits paid by health funds, through the tax *rebate for basic health insurance premiums.*

3.23 The estimate of $100m represents about 7% of total medical benefits expenditure by the Commonwealth and health funds, which in 1981/82 amounted to about $1497m.[5]

Reliability

3.24 The Committee has not calculated its own estimate of the extent of fraud and overservicing. However, a number of *points should be noted concerning the Department's estimate.*

3.25 The selection of peer group averages as the benchmark when comparing the cost per patient for individual doctors was arbitrary. There are some objections in principle to regarding above-average payments as either fraud or overservicing. As long as there is variation in the style of individual doctors and in their patient mix, then there will inevitably be some doctors who earn more per patient than their peers.

3.26 The Department has, however, examined the distribution of cost per patient and other variables for *doctors in each specialty, and has found that generally a* small proportion of doctors receive very large amounts per patient, relative to their peers. This can be seen by plotting the number of doctors against average cost per patient for general practitioners, for example see diagram 3. Thus it can be seen that a significant majority of doctors receive less than the average for their peer group.

3.27 The bulk of the total 'excess' of $160m is attributable to a small proportion of doctors, as seen in *Table 1.*

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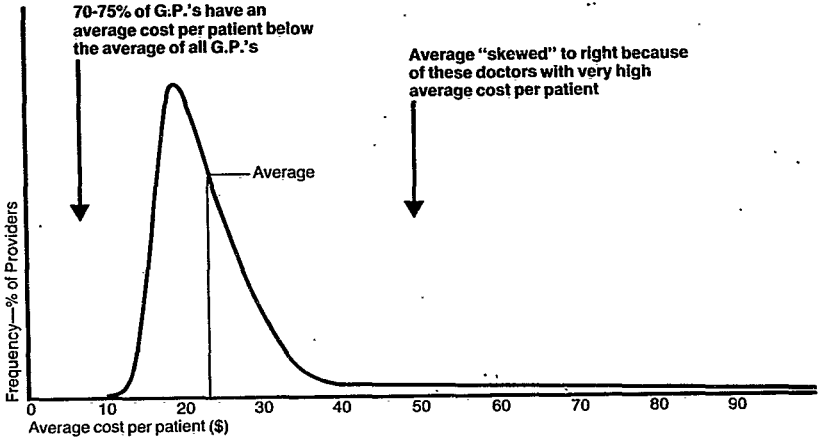
5 Advice from the Department of Health, Committee File, 1982/9.

Diagram 3

Average cost per patient
(General Practitioners in Victoria)



Source: Department of Health

TABLE 1: DISTRIBUTION OF TOTAL 'EXCESS' BY CATEGORY OF PROVIDER 1980/81[6]

Excess for Individual Providers		Total Excess for Category of Providers
from	to	$M
-	$4,000	3
$4,000	$8,000	8
$8,000	$20,000	32
$20,000	$40,000	43
$40,000	-	74
Total		160

3.28 Of the $160m excess, $117m went to the 2,300 providers who received more than $20,000 over their peer group average. This group comprised about 13% of doctors in full-time private practice.

3.29 Because of this concentration, the estimate is not very sensitive to the assumption that the peer group average is the appropriate standard. The Department also claims that a closer examination of the practice profiles of the 13% of doctors mentioned above indicates a high degree of probable fraud and overservicing. It believes that the estimate is conservative.

3.30 There are a number of reasons why the figure of $100m may be a significant underestimate of the extent of fraud and overservicing. For example:

(a) The calculation assumes that the average doctor does not overservice or defraud the system. While it may be safe to assume that the vast majority of doctors are not engaged in fraud, the same cannot be assumed with respect to overservicing. The estimate completely omits any overservicing that is built into standard medical procedures. For example, the estimate does not include overservicing that results from statutory limitations on the size of a prescription or from the requirement that patients see a general practitioner prior to referral to a specialist. Similarly, it has been argued that the medical profession as a whole is inclined to overuse some procedures. The fact that Australia has a very

6 Department of Health, Submission to the Joint Parliamentary Committee of Public Accounts, 1982, p. 61.

much higher incidence of certain types of surgery than countries such as the UK and Sweden lends weight to the view that such overservicing is widespread.

(b) Because the method of calculation is based on average cost per patient, it does not take account of fraud or overservicing that involves an increased number of patients. The Committee has been told, for example, of a doctor who keeps his private nursing home full by 'recruiting' homeless people. Similarly, the estimate takes little account of fraud perpetrated by patients.

(c) Because the estimate is based on only three months data, long term overservicing or fraudulent practices may be underestimated. For example, the method does not distinguish doctors who continue to treat the same patients for years from doctors who have a normal turnover of patients. The former group of doctors may be legitimately treating chronically ill patients, but are probably more likely to be overservicing.

3.31 On the other hand, there are, at least two factors which may lead this method to over-estimate the extent of fraud and overservicing:

(a) Because of wide differences in average cost per patient between the various specialties, misclassification of doctors into peer groups is likely to increase the estimate of fraud and overservicing. It is apparent from statistical profiles of doctors' practices that a significant proportion of doctors do not exclusively work within their own specialties, and other doctors specialise in certain procedures without specific qualifications. For example, a doctor without specialist qualifications may specialise in obstetrics or minor surgery, and therefore have a per patient cost much higher than the average general practitioner. It has also been suggested to the Committee that some specialties, such as psychiatry, should not be treated as a single peer group for these purposes. The Department has not finished refining its information on the major specialties of registered doctors, although an initial study has suggested that, on balance, reclassification may have little effect on the overall estimate.

(b) The current estimate takes no account of the type of patient being seen by doctors, with the result that doctors who concentrate on aged people, for example, will appear to be overservicing or defrauding the system because they receive higher than average

payments per patient. This is so even if they see a smaller number of patients and their overall incomes are below average. The fact that older people use on average more than twice as many medical services as younger people illustrates the importance of this factor.[7] The failure to take account of factors such as patient age and sex undoubtedly adds to the variance between doctors in each peer group, and thereby leads to an overestimate of the extent of fraud and overservicing.

3.32 The Department's estimate of at least $100m per annum is thus far from certain. However, on the basis of points raised above and detailed discussions with the Department, the Committee believes that the estimate is conservative. This is especially true if one accepts that some overservicing is built into standard medical practices in areas such as surgery, as mentioned previously.

3.33 The great increase in utilization of medical services over the last decade or so also suggests that the level of fraud and overservicing exceeds $100m per annum. Between 1974/75 and 1981/82, the number of medical services per capita increased greatly, from 5.5 to an estimated 7.0 per annum.[8] On the basis of 1981/82 expenditure on medical services by the Commonwealth and health funds, this increase represents more than $300m extra each year.[9]

3.34 Part of this increase results from more widespread health insurance and greater government subsidy, which have allowed many people to purchase necessary medical services that they previously could not afford. Some of the increase may also reflect the advent of new treatment methods not previously available. But it seems likely that overservicing is a significant factor.

3.35 Further analysis could be undertaken on a sample of doctors with above average servicing patterns to determine the extent to which the excess is attributable to fraud, to overservicing and to justifiable medical practices. This analysis could be done initially by computer screening of practice patterns to identify those patterns known to be usually associated with fraud or overservicing, followed by interviews with doctors to examine their practicing patterns more closely.

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7 Richardson J.R. and Deeble J.S., Statistics of Private Medical Services in Australia in 1976, Health Research Project Technical Paper No. 1, ANU; table 2.1.2.

8 Harvey, R., Paper prepared for the Committee.

9 In other words, if annual utilisation of medical services was still 5.5 per capita instead of 7.0, expenditure on medical services would be over $300m less.

3.36 However, while further work could be done to refine the aggregate estimate, the Committee believes that sufficient evidence exists that fraud and overservicing are of a magnitude to warrant urgent action.

1. The Committee therefore recommends that priority be given to allocating additional resources to streamline and strengthen procedures for pursuing doctors suspected of fraud or overservicing.

3.37 The Committee notes that other recommendations in this report (eg for further development of the detection system and better management information systems) will enable more accurate estimation in future.

Nature of Fraud and Overservicing

3.38 Evidence before the Committee revealed that fraud and overservicing by some doctors comes in a wide variety of forms. It is useful at this stage to identify some examples.

3.39 Many of the cases of fraud that have been drawn to the Committee's attention and most cases prosecuted to date have involved charging for services that were not provided, for example where doctors have:

- forged signatures of patients who do not receive a service (one doctor claimed for services provided to his mother who was interstate when the consultation allegedly took place, and other doctors have claimed for services to patients who were overseas at the time);
- asked pensioners or Health Card holders to sign blank assignment forms, which enabled the doctor to subsequently claim for services not provided;
- charged for an abdominal operation on a patient, but on investigation the patient was found to have no abdominal scar; and
- claimed for visiting nursing home patients for some months after the patients died.

3.40 Fraud may also involve using inappropriate and more expensive item numbers to describe the procedure carried out. Examples provided to the Committee include:

- claiming to have carried out a 'radical hysterectomy', which attracts a higher benefit than the 'total hysterectomy' actually carried out;
- additional benefit for surgical procedures that are steps in other operations which also attract benefits;

- billing by a surgeon for an assistant at operations where there was no assistant present;

- billing by specialists or consultant physicians at the specialist rate for services carried out on their behalf by junior hospital staff or employed assistants without specialist recognition;

- charging for ultrasound or other procedures when the doctor did not even have the equipment to provide such services, or where the equipment used belonged to a public hospital;

- the exaggeration of services, so that if a patient is seen for a short consulation it is charged as a prolonged consultation, attracting a benefit three or four times that which is payable for the service actually provided;

- falsely itemising accounts for out-of-hours services when the service was provided within normal working hours;

- billing for ECG reports when all that is done is reading the rhythm strip from a monitor; and

- general practioners charging for ante natal visits as standard consultations when ante natal care is already paid for as part of the confinement fee.

3.41 Another widespread form of abuse, which is often fraud, is known by doctors as the 'numbers game'. It consists of itemizing procedures carried out, or said to be carried out, in a way which maximizes the refund. For example, a straight PA film of the chest can be described as an X-ray of the chest and of the mediastinum, thereby allowing the doctor to charge for two items instead of one. Similarly, Keller's operation for hallux valgus (bunions) can be described as six separate procedures, thereby allowing the doctor to receive three times the fee listed in the Schedule for the whole operation.

3.42 In one case mentioned to the Committee, a doctor doubled his fee by charging for 114 grafts when he performed 57 hair transplants, on the dubious grounds that the grafts were taken from one place on the body and replaced elsewhere.

3.43 Another type of abuse arises where medical practitioners treat other doctors or their families. The purpose of these treatments may be either to provide specialist training, or simply to increase income by conspiracy.[10]

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10 Joint Parliamentary Committee of Public Accounts, Inquiry into Payments under the Medical Benefits Schedule - Fraud and Overservicing, Minutes of Evidence, p. 2905.

3.44 The Committee has also been given a wide range of examples of overservicing by some doctors, including where unusual practices have been utilised to attract higher medical benefits. Specific examples include:

- providing home visits of a routine nature at weekends or at night in order to attract the higher 'out of hours' fee, and in some cases conducting a medical practice entirely in 'out of hours' periods but not as an emergency or locum service;
- splitting up procedures such as electrosurgical skin treatment into the most remunerative pattern;
- overuse of X-rays or pathology tests by general practitioners who have their own equipment or laboratory; and
- inappropriately charging at the specialist rate, for example where recognised specialists working in general practice have their own patients referred to them by arrangement with a colleague who has not necessarily seen the patients at all.

3.45 Other particularly notable examples of fraud or overservicing provided to the Committee include:

- the local chemist who had grossed $180,000 for a twelve month period was classified by a doctor in a country town as a disadvantaged patient (the police could not prosecute as, under the Government policy applying at the time, the doctor had a discretion to classify anyone as disadvantaged);
- a doctor gave all members of his son's football team a medical checkup before they played and thus received payment for 15 consultations each game; and
- another doctor paid a pensioner $20 to cut his lawns, then had the pensioner sign an assignment form which enabled the doctor to receive a $22 consultation fee.

3.46 Overall, the Committee was alarmed to learn of the ingenuity of some members of the medical profession in abusing the Medical Benefits Scheme. On the basis of evidence before us, it appears that a significant number of medical practitioners are betraying the position of trust in which they are placed through their ability to control expenditure on medical services.

3.47 In 1976 the then Minister for Health, Mr Hunt, put the medical profession on notice with respect to overservicing. In the second reading speech on the Health Insurance Amendment Bill 1976 he stated:

> The Government attaches considerable importance to this matter and will ask the medical profession to institute systems of professional standards review, designed both to assess the quality of, and to seek the justification for, services rendered. The Government expects the profession to establish review arrangements in close consultation with the Department of Health.... Failure to have workable systems in operation within three years could result in the introduction of mandatory systems.[11]

Within two weeks he repeated this point in answer to a question without notice:

> .... We are hopeful that the medical profession will achieve this within a three year period to obviate any necessity to introduce legislation laying down guidelines for medical practice in Australia.[12]

3.48 The three year period expired in 1979!

3.49 The Committee believes that procedures associated with the payment of medical benefits and pursuit of suspected fraud and overservicing should be brought more into line with procedures applying to other professions and walks of life. Discussion of specific ways of achieving this follows in subsequent chapters of this report.

3.50 It should be emphasised, however, that the Committee believes that a substantial majority of medical practitioners are not engaging in fraud or conscious overservicing.

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11 Australia, House of Representatives, Debates, 29 May 1976, p. 2353.
12 ibid., 1 June 1976, p. 2708.

CHAPTER 4

THE HEALTH INSURANCE SYSTEM

4.1 Most medical services in Australia are delivered by doctors in private practice on a fee-for-service basis. About 70 per cent of all Australians have private health insurance which pays the bulk of medical fees charged, while approximately 15 per cent hold Pensioner Health Benefits Cards, Health Benefits Cards (sickness beneficiaries) or Health Care Cards (low income earners, recent immigrants, etc.).[1] For this latter group, the Commonwealth Government pays medical costs up to a prescribed maximum amount for each service rendered. In general this maximum is 85% of the fee set out in the Medical Benefits Schedule. For other people who have medical insurance with a registered health fund, the Commonwealth Government pays a Commonwealth Medical Benefit equal to 30 per cent of the Schedule fee, as well as allowing a tax rebate of 30 cents per $1 for basic health insurance contributions.

4.2 In total the Commonwealth Government pays, directly or indirectly, about 50 per cent of all payments to private doctors - at the rate of about $1200 million in 1982-83.[2]

4.3 A number of witnesses link fee-for-service medicine, backed by third party payment (whether patient-billing or bulk-billing) of medical costs, with the apparent increase in overservicing.[3] The combination of fee-for-service medicine and widespread third party payment of medical and hospital costs, without appropriate safeguards, provides few incentives for doctors or patients to economize on the provision of necessary or unnecessary medical services.

4.4 The role of the doctor is crucial in understanding the generation of health costs. Doctors are the 'gate-keepers' to hospitals and nursing homes, and the controllers of access to diagnostic services and drugs. Studies of doctors' behaviour in health maintenance

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1 Derived from Health Insurance Survey, Australia, March 1982 - Australian Bureau of Statistics, ABS No 4341.0).

2 This amount includes the value of the tax rebate. The Commonwealth thus has a very substantial stake in the financing of medical services and bears a significant proportion of the cost of fraud and overservicing.

3 Opit, L.J. op. cit.; South Australian Health Commission, Submission to Joint Parliamentary Committee of Public Accounts, 1982; and Tasmanian Department of Health Services, Submission to Joint Parliamentary Committee of Public Accounts, 1982.

organisations and private practice in the USA have suggested that incentives offered by payment systems have some influence on doctors' modes of practice. Further, relativities of fees within the existing Medical Benefits Schedule provide higher hourly rates of return for procedures than for consultations. *Given that much procedural work is carried out in hospitals*, the fee relativities thus provide incentives to utilise the most expensive forms of treatment.

4.5 Given this crucial role of doctors in decision-making on medical services, together with substantial financial incentives to overservice, it is not surprising that utilisation of medical services has risen roughly in line with the supply of doctors.

4.6 In this report, the Committee has examined possible changes within the present broad structure of the health insurance system, which is based on fee-for-service and substantial third party payment. As outlined later in this chapter and in subsequent chapters of this progress report, we believe that improvements can be made within the current system.

4.7 The Committee will, however, be considering possible modification of the system in its final report. For example:

- Where overservicing is associated with the provision of unnecessary surgery or other procedures carried out in private hospitals, *the Commonwealth could make* appropriate clinical review procedures a condition of funding for private hospitals.[4]

- Much overservicing appears to be associated with patients, often elderly, in hospitals, nursing homes or private homes. Regular visits to some of these patients may be justified only on social grounds or for general monitoring of their health status. Many chronically ill patients need regular supervision and reassurance. However, these functions do not necessarily require a doctor to carry them out. Health insurance funds could be encouraged to fund *alternate support services*, rather than pay for expensive medical services. Another approach could be to pay monthly fees or case fees for supervision of these patients, as is done in Canada and Holland.

- The excessive use of diagnostic services has been raised in a number of submissions and elsewhere. A

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4 The Committee notes the inquiry being conducted by a Senate Select Committee into private hospitals and nursing homes. The recommendations of that inquiry could have some bearing on this Committee's final report.

variety of changes are being considered for the final report. Examples of possible options include establishment of diagnostic centres with salaried or contract staff, to which patients would be referred if more than a small number of diagnostic services were to be carried out, or a system whereby medical practitioners are required to meet a proportion of the charges for diagnostic services they order, with some amount built into the referring doctors' consultation fees to cover the expected cost of such services.

- Proposals have also been put to the Committee that the Government should, at the start of each year, establish a pool from which medical benefits would be paid, regardless of the volume of services actually rendered. Significant administrative problems would need to be overcome, for example to protect the rights of patients if the pool was exhausted before the end of the year. The Committee notes that a similar scheme already exists in West Germany.

4.8 At this stage the Committee is not recommending any of the above options. However, there is a need for tighter controls within the fee-for-service system. We hope that the medical profession, government departments and others will give serious consideration to such options and provide further evidence to the Committee in due course.

Methods of Payment of Medical Benefits

4.9 Under existing arrangements, there are two methods by which privately insured patients may pay for medical services and receive medical benefits:

- the patient may pay an account for services rendered and then claim reimbursement for medical benefits from the fund; or

- the patient may submit the unpaid account to the fund and receive a cheque made out to the doctor, which the patient then sends to the doctor.

4.10 Those covered by Pensioner Health Benefits Cards, Health Benefits Cards or Health Care Cards may be billed in the same way as privately insured patients, or they may assign the benefit to the doctor rendering the service, who then bulk-bills the Department of Health for the benefit.

4.11 Scrutiny of doctors' accounts by patients is often suggested as a possible method of controlling overservicing and fraud. However, many bills contain only item numbers from the Medical Benefits Schedule and no accurate description of services, in which case the patient review may well be

ineffective. Many services, especially diagnostic services, are not performed in the patient's presence. At other times the patient may be unconscious, or ignorant of which of many similar procedures is being carried out. There are thus significant limitations to patient scrutiny being able to detect fraud. In addition, doctors may accept the benefit as full settlement of the account, or the patient may have insurance which covers 100% of the schedule fee. In such cases the patient has no direct financial incentive to examine the account.

4.12 With overservicing, medical services are in fact provided, so even informed patient scrutiny would frequently not detect anything abnormal on a detailed bill. Out of pocket expenses and time costs may lead patients to consider whether they are receiving unnecessary care, but as annual per capita use of medical services has increased from 3.8 to 7.0 over the past fifteen years without there being any popular outcry against overservicing, this also would appear unlikely to be effective.[5]

4.13 A prerequisite of significantly greater patient scrutiny is that, wherever possible, doctors' accounts should describe the services provided in terms able to be understood by patients. Many doctors simply use the Medical Benefits Schedule item numbers which give no idea to patients of the service being charged for. The Committee has been told that some other doctors use item numbers from a different schedule issued by the AMA, which uses different definitions of commonly used services such as long consultations and after hours consultations.

2. The Committee recommends that the Health Insurance Act be amended to require doctors' accounts and assignment forms to be as comprehensible as possible to patients. In particular, it is recommended that both Medical Benefit Schedule item numbers and simplified descriptions of services should be required on all accounts, receipts and assignment forms. The legislation should be amended to allow the description of common services (eg standard consultations) to be specified in regulations.

4.14 With increasing computerisation of doctors' accounts, this should add little to the administrative costs of running a practice.

4.15 The Committee has also given consideration to a requirement that doctors providing a service should have to personally certify the account or assignment form. This would help to ensure that the description of the service is correct, and reduce the ability of doctors to argue that they were

5 Harvey, R. Paper prepared for Committee.

unaware of the error, as provided for in Section 129(3) of the Health Insurance Act.

4.16 The AMA has argued that this would be an onerous requirement, for example where specialists work mostly in a hospital and simply telephone details to their staff who prepare the accounts.[6] Recent amendments to the legislation make it harder for doctors to shift the blame for errors on accounts to their employees. The Committee is firmly of the view that doctors should be fully accountable for all aspects of their practice, including the actions of their employees. If the recent legislative provisions prove to be less than effective, the Committee believes that doctors should be required to personally certify the accuracy of their accounts and assignment forms.

4.17 It has been suggested from time to time that bulk-billing arrangements encourage abuse of the Medical Benefits Scheme by doctors. One reason advanced is that if the patient does not have a stake in the bill, the account will not be scrutinized. However, as pointed out above, this criticism does not apply only to bulk-billing. Bulk-billing is more susceptible to fraud than patient billing where a doctor writes additional items on the assignment form after the patient has signed the form. The Committee notes that some Canadian health insurance funds send copies of bulk-billing claims to patients for verification to detect this form of fraud.

4.18 The only statistical analysis that has been carried out on bulk-billing showed that there was no greater use (or abuse) of services where doctors bulk-billed as compared to patient-billing.[7] Evidence from officers and former officers of the Department of Health concerned with detecting fraud and overservicing support this result.

4.19 Present procedures require doctors to provide patients with a copy of the completed assignment form, but it has been suggested to the Committee that this does not always occur. If this is not done, there is considerable scope for a doctor to fraudulently add items to an assignment form after a patient has signed it.

3. The Committee recommends a number of changes to bulk-billing arrangements to reduce the scope for fraud:

(a) strict enforcement of requirements that patients sign the assignment form in the presence of the doctor

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6 Minutes of Evidence, op. cit., pp. 2479-2480.
7 Health Insurance Commission, Briefing to Minister for Health, 20 March 1978, Committee File 1982/9.

after the service has been provided, and that patients be given a copy of the completed assignment form;

(b) amendment of legislation to provide that failure to fulfil the requirements in (a) is an offence on the part of the doctor and/or the patient, and that assignment forms carry the warning that this is an offence; and

(c) sending a random sample of asignment forms to patients for verification, in line with the practice of some Canadian health plans (the sample size to be calculated on the basis of current estimates of the extent to which assignment forms are altered, but to be reviewed in the light of experience with the verification process).

4.20 In the absence of such verification procedures at present, it is difficult to assess the extent to which this form of fraud occurs. The current detection system allows some assessment of large scale fraud of this type, but would not highlight widespread occurence.

4.21 The administrative cost of introducing such changes to the system would be very small compared to the extra administrative cost to the Commonwealth of abolishing bulk-billing, which could be as high as $10m. The Committee is not recommending abolition of bulk-billing, but greater discipline needs to be applied within the system.

CHAPTER 5

ADMINISTRATION

Current Arrangements

5.1 Under current arrangements, the Commonwealth Department of Health shares responsibility for detecting and responding to fraud and overservicing with registered health insurance organisations, the Australian Federal Police, the Crown Solicitor's Division of the Attorney-General's Department and the courts. In addition, the Department of Social Security is responsible for determining eligibility for pensioner health benefits and health care cards, and States have responsibility for registration of medical practitioners. The following briefly describes the role that major participants are supposed to play in the system as it is currently structured.

- Health insurance funds have a statutory requirement to provide data to the Health Department on all claims that attract Commonwealth Medical Benefits. A few funds also maintain their own investigation units which draw the Department's attention to irregular patterns of servicing and take direct action to prosecute or recover money in certain cases.

- The Department of Health is required to use these data, together with information from claims made directly to the Department for pensioner and health card holders, to develop profiles of doctors' practices. These profiles and information provided by patients, other doctors and doctors' employees enable identification of doctors possibly undertaking overservicing or fraud.

  - In cases of suspected overservicing, the first step required is a visit to doctors by a medical counsellor employed by the Department, whose role is to clarify and interpret the Medical Benefit Scheme for doctors and to bring to their attention any perceived deviations from normal medical practice. Where subsequent statistical review of a doctor's practice reveals that any apparent overservicing has not been corrected following counselling, the State Director of Health may refer the doctor to a Medical Services Committee of Inquiry. The Committees

examine particular services that are thought to be excessive and may recommend to the Minister for Health that the doctor be reprimanded, counselled further and/or not be paid benefits for excessive services. If benefits have already been paid for excessive services, the Committees may recommend repayment of those benefits to the Commonwealth or health funds. Doctors are able to appeal to the Medical Services Review Tribunal or the courts against a decision by the Minister.

- In cases of suspected fraud by doctors, Department of Health investigators who are not medical practitioners may interview patients to obtain evidence of breaches of the Health Insurance Act, but do not generally interview doctors suspected of medical fraud. Where fraud becomes evident during counselling, the Department's counsellors are instructed not to discuss it with the doctor concerned.

- Once there is some evidence of fraud, the Australian Federal Police (AFP) are required to carry out the main investigation, with assistance from Department of Health officers, and exercise powers of search, seizure and arrest as required.

- The Deputy Crown Solicitor's Office (DCS) in each State provides the Department of Health with advice on points of law and has the task of prosecuting cases of medical fraud. When there is sufficient evidence to launch a prosecution, cases are formally referred to the DCS by the AFP.

- State Medical Boards are not usually involved in fraud investigations or examination of suspected overservicing patterns, although if a court finds a doctor guilty of fraud it is the practice of the Department of Health to refer the matter to the relevant State Registration Board. What happens then is entirely a matter for State authorities.

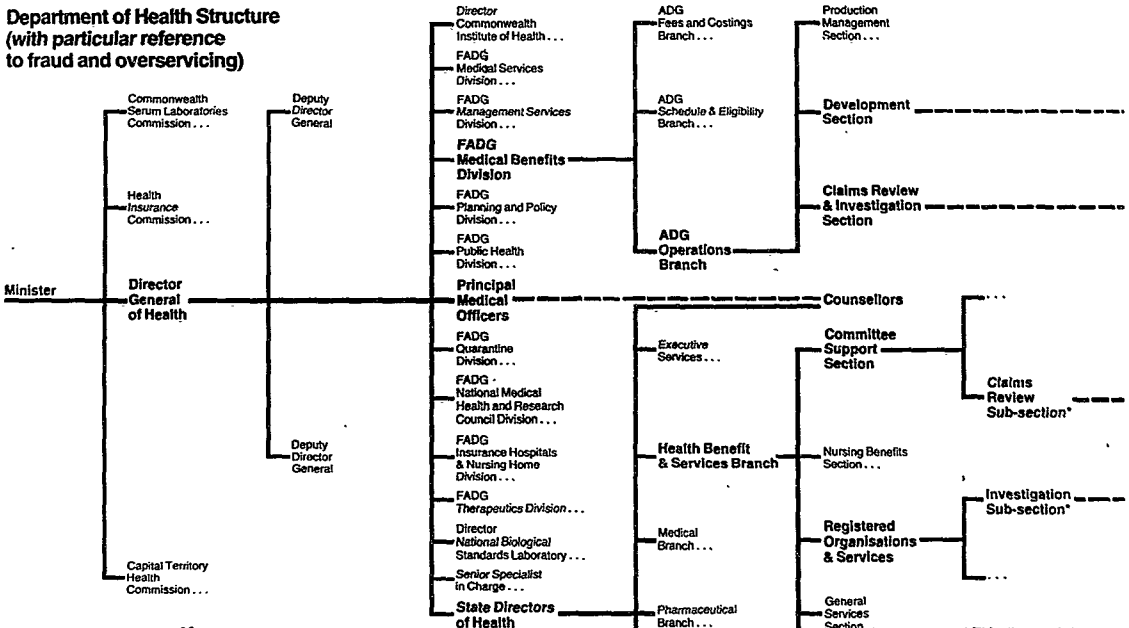
Diagram 2 on page 15 sets out these broad procedures in diagramatic form.

5.2 The system is decentralised geographically, especially within the Department of Health. Diagram 4 outlines the current organisation structure of the Department pertaining to fraud and overservicing.

5.3 In broad terms, the Medical Benefits Division in the Department's central office is responsible for national development and co-ordination of measures to counter medical

Diagram 4

Department of Health Structure (with particular reference to fraud and overservicing)



Key

FADG—First Assistant Director General

ADG—Assistant Director General

——— Formal line of authority

— — — Co-ordination

* This diagram is based on the current structure in N.S.W. There are minor regional variations at sub-section level in different states, but the actual functions are essentially as shown.

fraud and overservicing. The Operations Branch within that Division is responsible for developing policies and procedures covering investigation of all suspected or alleged breaches of the medical benefits legislation. On fraud matters, the Branch has the functions of initiating national measures to counter abuses in specific areas of the Schedule, monitoring State investigation activities and prosecutions by the Australian Federal Police, and reporting unusual or major cases to the Minister. On overservicing matters, the Branch handles administrative tasks associated with Medical Services Committees of Inquiry and Review Tribunals. The Branch has also developed the Fraud and Overservicing Detection System (FODS) which is discussed in the following chapter of this report.

5.4 State offices of the Department are responsible for reviewing medical claims submitted by providers[1], with a view to detecting and investigating possible cases of fraud and overservicing. Most of the action on a day to day basis takes place in the state offices. This includes review of FODS profiles; preliminary investigation of suspected fraud cases; counselling of doctors suspected of overservicing; and referring overservicing cases to Medical Services Committees of Inquiry. Where fraud is suspected, the Director of Health, head of the state office, is responsible for referring the case to the Australian Federal Police.

5.5 The Department has emphasised and defended its decentralised style of management, pointing out that, 'consistent with Departmental policy of delegating powers and responsibilities as far as practicable throughout the organisation, the day-to-day administration of fraud and overservicing investigation is the responsibility of State Divisions'.[2]

Overall Effectiveness of the System

5.6 The above description is our understanding of how the current system is intended to operate. It should be emphasised, however, that actual practice has often deviated from what was intended, particularly in the absence of adequate guidelines to state offices of the Department of Health.

5.7 One of the major difficulties with the current approach is that no single organisation takes full responsibility for responding to medical fraud, and even in

1 The Department of Health uses the term 'provider' to indicate doctors or other individuals or organisations who provide medical services to patients. Most services which attract Benefits under the HIA are provided by Doctors.

2 Department of Health Submission, op. cit., page 75.

the overservicing area the Department of Health relies largely on the Medical Services Committees of Inquiry, the members of which are nominated by the AMA. The Committee has identified a number of points where co-ordination between the various agencies has been inadequate, as discussed elsewhere in this report. With responsibility shared in this way, it is all too easy for those involved to blame others for problems that have arisen.

5.8 With fraud and overservicing probably costing taxpayers and fund contributors in excess of $100m each year, it would be hard to argue that the current response is effective. Indeed the Department of Health has acknowledged that improvements are needed and there have been some recent efforts to increase the effectiveness of the system, especially since this inquiry began.

5.9 The Department has provided evidence to suggest some explanations why fraud and overservicing have flourished. Between 1 July 1975 and 31 March 1982, there were only 48 successful prosecutions against providers.[3] In eight of those cases, charges were proven but no conviction was recorded, as provided for in Section 19B of the Crimes Act. In another case, a conviction was recorded but the defendant was released on a bond without sentence.[4] It needs to be emphasised that in all cases it is necessary to prove each instance of fraud. Even if a doctor is suspected of a large number of offences amounting to tens of thousands of dollars, under current legislation it is usually impracticable to produce evidence to prove more than a small proportion of the offences.

5.10 During the period, 227 cases of suspected fraud by providers were referred to the Australian Federal Police. Apart from the 48 successful prosecutions noted above, ten were unsuccessful and the remainder have either not been prosecuted or are still awaiting prosecution.

5.11 Over the same period, the Department reports that 2184 doctors have been visited by Departmental counsellors with respect to possible overservicing.[5] Many of these visits were simply courtesy calls to explain the Medical Benefits Schedule and the health insurance system in general. In other cases, there was discussion of specific cases and problems that had been identified in a doctor's claiming practice, and in some cases a warning was given that a doctor would be

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3 The Department has provided more up-to-date figures, which show that there has been an additional 14 successful prosecutions between 31 March 1982 and 31 July 1982.

4 Department of Health Submission, op. cit., p. 106, table 5.

5 Department of Health Submission, op. cit., p. 103, table 3.

referred to a Medical Services Committee of Inquiry unless the apparent overservicing ceased. Prior to January 1982 the Department did not require its state offices to keep separate statistics on the purpose of counselling visits.

5.12 The Committee has been told of the objective of counselling each doctor once every three to four years. With about 17,000 doctors in Australia in private full-time practice, 2184 doctors counselled in the three to four years since counselling commenced falls a long way short of this target.[6]

5.13 As shown in Table 2 only a small proportion of doctors counselled were referred for closer examination by Committees of Inquiry. Up to the end of March 1982, only 31 cases had been completed by Committees of Inquiry, and a further 30 were still current. Of the 31 cases completed, the Minister had made determinations in 14 cases, although 4 of these were subsequently set aside or reduced following appeal to the Medical Services Review Tribunal or the Federal Court.

TABLE 2: NUMBER OF DOCTORS COUNSELLED AND EXAMINED FOR OVERSERVICING[7]

(1 July 1975 to 31 March 1982*)

	Number of cases	(as % of Doctors counselled)
Doctors counselled with respect to possible overservicing	2,184	(100%)
Referred to Committees of Inquiry	61	(2.8%)
Committee of Inquiry cases complete	31	(1.4%)
Ministerial determination**	14	(0.6%)
Not reversed on appeal to Tribunal or Federal Court	12	(0.5%)

* Counselling for overservicing under the Health Insurance Act commenced in April 1977.

** In response to recommendations of a Committee of Inquiry the Minister is able to determine that the doctor be reprimanded, further counselling take place, benefits be repaid or benefits be withheld.

6 Advice from Department of Health, Committee File 1982/9.

7 Department of Health Submission op. cit., p. 103, table 3.

5.14 Of about 17,000 doctors in full-time private practice in Australia, the Department of Health estimates that 2,300 received more than $20,000 p.a. in excess of their peer group average, and believes there is a high degree of probable fraud and overservicing amongst this group. Yet only 39 doctors have been penalised for fraud and twelve for overservicing over the last seven years. With such odds, the current system offers very little deterrent or enforcement.

5.15 The chance of a doctor engaging in fraud or overservicing being required to repay the money has also been slim. We do not have an estimate of the total amount lost through fraud and overservicing since mid 1975, but given that the Department has conservatively estimated $100m for the year ending June 1981, the total must amount to many hundreds of millions of dollars. In this period from July 1975 to March 1982, only $1.7m in Commonwealth Medical Benefits was recovered from doctors engaging in fraud and overservicing.[8] This amounts to significantly less than 1% of the likely loss over the period, and probably less than the administrative cost of current efforts to pursue fraud and overservicing.

Performance of the Department of Health

5.16 The Committee has identified a number of factors responsible for the poor response to fraud and overservicing. Subsequent chapters of this report deal with long delays in the handling of cases by the Australian Federal Police and Deputy Crown Solicitors' Offices and problems in the legislation, particularly the need to prove each individual instance of fraud or overservicing. But a crucial factor has been the slow reaction of the Department of Health to this problem.

5.17 We have given considerable attention to the past performance of the Department, as its overall management has an important influence over what can and should be done to improve the Government's response to the problems of fraud and overservicing.

5.18 It must be recognised that over the period in question the Department has been under considerable pressure, with a series of major changes to health insurance arrangements and other areas, within a general policy of restraint in Public Service staffing. Nevertheless, the Committee believes that the Department's response to the problems of fraud and overservicing has been grossly inadequate. In almost every respect, too little has been done too late. On the evidence available to us, a large part of the responsibility for this must lie with the Department itself and especially its senior officers, although the Committee also came into contact with many officers of the

8 Department of Health Submission, op. cit., p. 105 table 4.

Department who were apparently performing their duties very conscientiously.

5.19 It is useful at this stage to examine in some detail three specific areas that reveal inadequacies in the Department's performance. We emphasise that these are not isolated examples of problems in administration of fraud and overservicing programs, and that they are only offered at this stage of the report as examples of the Department's handling of fraud and overservicing. We shall come back to these areas in later chapters.

(i) Allocation of Staff

5.20 Overall staffing levels in the fraud and overservicing areas of the Department have not altered greatly since responsibility for medical fraud was transferred from Medibank to the Department in November 1978. Table 3 indicates little change in the number of investigation and counselling positions in 1978 and 1982.

TABLE 3: ESTABLISHMENT OF CLAIMS REVIEW AND INVESTIGATION AND COUNSELLING AREAS OF THE DEPARTMENT OF HEALTH[9]

	1978	1982
	(no. of positions)	
Central Office	10	11
NSW	20	18
Victoria	14	13
Queensland	7	7
S.A.	5	5
W.A.	7	7
Tasmania	1	2
Total	64	63

5.21 Further staff have been taken on since 1978 to provide secretariat support to Medical Services Committees of Inquiry. Adding these staff brings the total number of fraud and overservicing positions to 70, as at June 1982. The Department has acknowledged that current staffing levels are inadequate.

5.22 This inadequacy applies not only to numbers of staff but also training. The Committee has heard evidence from state offices of the Department that its investigation and review staff are inadequately trained in the use of the fraud and overservicing detection system (FODS). The explanation given for this inadequacy has been that central office staff

9 Department of Health Submission p. 87, table 1.

have not had time nor adequate funds to travel to state offices to provide sufficient training. We have also been told that the staff time available for such training and for further development of FODS has been effectively reduced in recent months because that section of the Department has been given additional functions without being given extra staff commensurate with those responsibilities. This is a prime example of the Department's unsatisfactory allocation of resources.

5.23 With respect to counselling, the Department sought and obtained approval to create five counsellor positions in 1977, in addition to the two positions already existing in NSW and Victoria. Over the last five years these seven counsellors have faced the impossible task of advising Australia's 17,000 doctors in full-time private practice on the Medical Benefits Scheme, as well as on other programs of the Department of Health. Inadequate training in the use of FODS information and often little or no clerical support have made this task even more difficult.

5.24 Even if we accepted the claim by senior officers of the Department that they only became aware of the extent of overservicing in May-June 1981, the Committee cannot understand why it took more than twelve months for the Department to apply to the Public Service Board for approval for additional counselling positions. When the application was finally made in June 1982, approval was quickly given and subsequently an increase in staff ceilings was granted in anticipation of a request from the Department.

5.25 In August 1981 the Department raised with the Minister the need for additional investigation staff, but again the Public Service Board did not receive a formal application until June 1982, almost a year later.

5.26 The Director-General has argued that the question of extra resources had to be considered by the Government in the normal budget context.[10] It should be noted, however, that the $100m per annum estimate was available in May 1981, and it is only in November 1982 that the extra positions are finally being filled. The Committee does not accept that the wheels of government necessarily turn so slowly.

5.27 As far as central office staff levels are concerned, inadequacies were recognised as long ago as November 1980, when a detailed staffing proposal was prepared by the head of the Operations Branch of the Department.[11] This document, a copy of which was provided to the Committee by the Department, described the tasks facing the Claims Review and Investigation and Medical Services Committees of Inquiry areas. These tasks included further development of FODS, training of staff,

10 Minutes of Evidence, op. cit., p. 2957.
11 See appendix F.

required legislative changes and liaison with other authorities. The assessment concluded that, in addition to positions already allocated, eight or nine line staff were required on an ongoing basis. The assessment also noted that further staff were required in state offices.

5.28 No additional staff were provided to the Branch as a result of this assessment, not even after the Department produced its $100m per annum estimate of fraud and overservicing early the following year. Now, two years later, an additional eleven positions have been created, only two of which were allocated to the Branch in central office covered by the 1980 assessment.

5.29 The Department has emphasised that at the time the Government was imposing severe staffing restraint on all departments, and in that environment proposals for additional staff were unlikely to succeed. It has also been pointed out that each year general increases in the Department's staff ceilings were proposed, but not fully accepted.

5.30 The Committee does not believe that enough was done. In this context it is worth noting that on 9 July 1979, in the context of briefing on the collection of statistics from health funds, the then Minister for Health instructed the Department as follows:

> Please keep me informed on the supply of statistical information. Expedite where possible. If more staff is required, please advise and I will approach the Prime Minister.[12]

No evidence has been provided to us that this offer was taken up by the Department.

5.31 The Public Service Board has examined its forward staff estimates and staff ceilings records with a view to identifying specific references to the staffing of work areas directly concerned with medical fraud and overservicing. Although the Department has regularly sought increases in its general ceiling, the Board has informed us that:

- in 1979/80 no increase was sought in the relevant programs (other than an unrelated request for two staff to cover transfer of a function from the Health Insurance Commission);
- in 1980/81 an increase of three was sought to service Committees of Inquiry in NSW and Victoria, to replace

12 Hunt, The Hon R.J., MP Submission to the Joint Parliamentary Committee of Public Accounts, 1982, p. 38 (abbreviations expanded and date corrected on advice from the Department of Health).

reporting staff withdrawn by the Court Reporting Service of the Attorney-General's Department;

- in 1981/82 no increase was sought in the relevant programs; and
- in 1982/83, an increase of four was sought to cover a special group of senior officers to work with the police and the Attorney-General's Department to bring fraud and overservicing under greater control.[13]

5.32 *Since this inquiry began, a ceiling increase of* eleven has been approved by the Government.

5.33 Thus, in the three years to July 1982, the only increases in staff ceiling sought specifically in this area related to transfer of functions between organisations and were not intended to increase the total number of staff available to pursue fraud and overservicing by doctors. Despite claims put forward that the Department was acting on instructions from the Prime Minister that, in allocating staff, *priority should be given to areas directly serving the* public, the Committee believes that, on a cost benefit basis alone, much higher priority should have been given to fraud and overservicing areas of the Department.

5.34 The present staff ceiling of 4572 for the Department is 89 lower than that applying at 30 June 1979. We are very conscious of the severe restraint on staff numbers that the Government imposed during this period. However, after making allowance for functions transferred to and from the Department, the Board's estimate of the real variation in the Department's staff ceiling over that time is a growth of 67. Few of these were allocated to fraud and overservicing areas of the Department.

5.35 An example of the priority given to this area by the Department is the considerable time it took to permanently fill the key position of Director of the Claims Review and Investigation Section when that position fell vacant in June 1981. The Department explained the eight month delay in filling this key position by asserting that the officer selected for the job could not be released immediately from elsewhere in the Department. Given that the Department had *already estimated that at least $100m per annum was being lost* in fraud and overservicing, it is hard to justify such a long delay. One additional person in this area of the Department would have represented a significant increase in the resources available.

5.36 We have also been told of delays in filling the position of Principal Medical Officer in the Medical Benefits Division. While these delays do not themselves amount to

13 Minutes of Evidence, op. cit., p. 3120.

negligence on the part of the Department, they add to the considerable weight of evidence that the Department did not give sufficient priority to responding to the large scale fraud and overservicing that was taking place.

(ii) Handling of Suspected Fraud Cases by Victorian Office

5.37 The Committee received allegations that the Victorian office of the Department of Health, or individual officers within that office, had actively and intentionally condoned criminal fraud by some doctors. As a result of the Committee's concern about these allegations, 41 files from the Victorian Office were examined by Federal Police officers.

5.38 They found in those files:

- no direct evidence of an officer of the Department of Health receiving 'kickbacks';
- apparent evidence of a Health officer exercising influence or authority to waive or to reduce the extent of action against some of the doctors suspected of fraud and overservicing;
- apparent evidence of a Health officer actively condoning possible criminal fraud (as these cases had not even been referred for investigation, one can only speak of possible fraud);
- evidence of Health officers passing information to doctors under scrutiny, in the form of advising them at counselling sessions that they were under investigation; and
- evidence of negotiations with doctors for the recovery of money - although there is no evidence that any member of the Department of Health engaged in criminal conduct in respect of this matter.

5.39 The police officers also pointed out that they had examined photocopies of the files, and could not be certain if all the documents contained in the files had been photocopied. There appeared to be large gaps of time between some of the reports on the files.

5.40 As a result of the police report, 20 of the original 41 cases have been referred to the Australian Federal Police for further investigation of the doctors concerned. As this is still underway, the Committee does not wish to comment in detail.

5.41 The police report, however, brought to light serious problems in the Victorian office's handling of suspected fraud cases. For example:

- many of the cases were not referred to the Australian Federal Police, even where it was apparent that the Department of Health believed that criminal offences had been committed;

- a check of 38 patients of one doctor revealed that eight were privately insured, even though the doctor was bulk billing the Department for services provided to them; despite evidence of possible fraud, the doctor was not referred to the police but simply recommended for medical counselling, and in the end the doctor was not even counselled;

- another doctor who was apparently charging for treating staff at a home for alcoholics and ex-prisoners was not referred to the police, despite advice from the Deputy Crown Solicitor's Office that further evidence should be obtained and the case referred to the police;

- the Department did not appear to even consider referring to the police a doctor who apparently submitted more than 1000 falsely itemised claims; a little over $5,000 was received from the doctor in repayments, but no effort was made to prosecute despite the blatant attempt over a period of years to claim amounts to which the doctor was not entitled.

5.42 Of the 41 files, the police officers found evidence in 13 cases of a Health officer condoning matters which, on investigation, may have revealed offences of a criminal nature.

5.43 Examination of these cases suggests there was an atmosphere in the Victorian office that certain activities of doctors should be not investigated thoroughly, for example where a doctor claimed that errors were unintentional (no matter how frequent). The Committee believes that, under the Department's decentralisation policy, Directors of the state offices must be held responsible for the performance of their staff, although this does not obviate the Director-General's overall responsibility.

5.44 In writing to the Deputy Commissioner of the Australian Federal Police on 22 June 1982, the Director-General stated:

> I have read your officers' comments personally on all the 41 files. Most of the files are old and only a few are at present active. It comes through clearly to me that there was a lack of understanding in my office of the differences between fraud and overservicing and the role of the medical counsellor. I am hopeful that this has now been entirely corrected... (emphasis added)

5.45 The Committee does not accept this 'lack of understanding' as sufficient excuse. The central office of the Department provided no formal guidelines to the Victorian office on the distinction between fraud and overservicing. Guidelines issued in May 1978 on the role of counsellors and committees of inquiry failed to draw the distinction.[14] Even the guidelines issued in June 1982, which indicated how medical counsellors should handle possible fraud cases, did not adequately explain the distinction (see appendix H). Given that this distinction between what is criminal behaviour and what is not is crucial in following up suspected cases of fraud and overservicing, adequate written guidelines should have been provided by the Central Office of the Department at the earliest opportunity, particularly once the loss had been estimated at $100m per annum.

5.46 However, despite this lack of guidance from the central office, the Victorian Office was appraised of the distinction. In January 1980, in response to a query from the Director of Health in Victoria, the Deputy Crown Solicitor in Melbourne wrote to the local office of Health advising that where wrong item numbers were used or where services were not provided, cases should be referred for prosecution and not be treated as overservicing. A copy of this correspondence was subsequently circulated to other state offices.[15]

5.47 In 21 of the cases examined, possible fraud was not referred to the Australian Federal Police, and in some cases was not even referred to the investigators within the Health Department. Although in some cases the events took place prior to January 1980, in every case there was opportunity to refer the case to the police after January 1980. In other words, even after receiving explicit advice from the Deputy Crown Solicitor's Office on what constitutes fraud and how it should be handled, the Department's Victorian Director failed to refer to the Australian Federal Police a significant number of cases of possible fraud by doctors. The police officers who subsequently examined the files found that in a number of cases the evidence against the doctors concerned was strong.

5.48 At this stage of the inquiry, the Committee does not think it appropriate for it to investigate the conduct of individual officers, nor question those involved about their handling of these cases. Some investigation has already been carried out within the Department of Health.

5.49 The Director-General has stated that there is no evidence of criminality on the part of officers of his Department. Also, in correspondence with the Director-General, the Deputy Commissioner of the Australian Federal Police stated that there is no evidence in the files that

14 See appendix G.
15 See appendix I.

would suggest that any officer of the Department of Health has committed any criminal offence. There are apparent inconsistencies between these statements and the report of the two police officers who examined the files.

5.50 The investigation undertaken by the police was limited to examination of Health Department files, which they believed were possibly incomplete. Further investigation of possible breaches of criminal law by officers of the Department of Health should be carried out by the police, rather than by the Department itself.

5.51 Apart from possible breaches of criminal law, there is the further question of whether the conduct of the officers concerned was consistent with the Public Service Act. Section 61 of that Act provides for disciplinary action against an officer who has failed to fulfil his duty.[16]

4. **The Committee recommends that the conduct of the Victorian office of the Department of Health in handling fraud and overservicing cases be investigated by the appropriate authorities, particularly in respect of possible breaches of the Crimes Act and the Public Service Act.**

(iii) Medical Services Committees of Inquiry

5.52 The Health Insurance Act 1973 was assented to in August 1974, ten months before Medibank commenced operations. Section 82(1) of the Act provided for establishment of Medical Services Committees of Inquiry to inquire into:

(a) services rendered to eligible pensioners, and

(b) such other professional services as are prescribed.

The latter part of this subsection was qualified by section 82(2) which required that the AMA be consulted.[17]

5.53 The Department of Health had responsibility for implementation of these provisions from December 1975. In March 1976, a working party established by the Director-General of Health reported:

> The recent reports of alleged abuses of Medibank by medical practitioners have highlighted the need for the establishment of Committees as soon as possible.[18]

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16 See appendix J.

17 This section number refers to the Health Insurance Act as it was in March 1976.

18 Department of Health, Medical Services Committees of Inquiry, March 1976. Committee File 1982/9.

5.54 Although the working party recommended that all parts of the Schedule should be prescribed under section 82(1)(b) of the *Health Insurance Act, to allow Committees of Inquiry to* review services provided to non-pensioners, this was not done. Only in 1977 did the Department ensure that there was a legislative basis for Committees of Inquiry to cover services provided to non-pensioners. But this was not achieved by regulation as allowed for in the 1973 Act. Instead, the Act itself was amended to allow all services after April 1977 to be referred to Committees where there was evidence of overservicing. By failing to utilize the previous provisions of the Act, the Department ensured that excessive services provided between July 1975 and April 1977 could not be reviewed by Committees of Inquiry, and therefore it was impossible to recover any Commonwealth money paid for *overservicing during this period.*

5.55 The result was that the first cases were not referred to Medical Services Committees of Inquiry until July/August 1978, and the first reports went to the Minister in April 1979. This was approximately five years after the Health Insurance Act was assented to.

5.56 During the second half of 1979 discussions were held between the AMA, representatives of Committees of Inquiry and *the Department, following complaints from MSCI members that* procedures for Committees were cumbersome and time consuming. Specific problems discussed were:

(a) where a large number of patients were involved (one case under consideration at the time involved some 3,000 patients), it took many hours to go through every patient's history;

(b) where the case appeared to be one of obviously blatant overservicing, the time involved in prior counselling unnecessarily delayed the recovery of money;

(c) some doctors escaped sanction by refusing to attend hearings and refusing to provide clinical notes;

(d) reprimand and recovery of money was not always an adequate sanction against a recalcitrant doctor; and

(e) it was not possible for a committee with fixed membership to cover all specialities, so that a specialist might be able to escape sanction by claiming that members did not have the necessary medical competence.

5.57 In December 1979, the Government approved a series of proposals, subject to consultation between the Attorney-General and the Minister for Health. They were that:

- where an MSCI is of the opinion that the pattern of servicing of a proportion of a doctor's patients is representative of all the patients covered by the reference to the Committee, the Committee should be able to recommend to the Minister for Health that he make a determination in respect of all patients covered by the reference based on the Committee's examination of the pattern of servicing of the sample;

- medical practitioners be required to attend hearings and provide clinical information when and as requested by a Committee of Inquiry;

- it should be possible for the membership of a Committee to be extended to provide flexibility in their composition;

- Committees should be able to recommend that a practitioner be counselled by a medical counsellor on his pattern of servicing without requirement for a Ministerial Determination and without prejudice to further recommendations; and

- further investigation should be carried out as to whether a Committee may recommend that all or part of the practitioner's medical services be ineligible to attract medical benefits for a set period.

5.58 In June 1981 changes were made to the legislation and procedures associated with Committees of Inquiry to ensure that doctors could not refuse to attend or to produce clinical notes, and allowed the Department to refer doctors to Committees without prior counselling. The other problems identified above, which we believe to be major impediments to the effective functioning of the Committee of Inquiry system, have still not been solved, despite the fact that the Department put forward solutions as long ago as December 1979. In particular, nothing has been achieved to speed up consideration of cases involving large numbers of patients, to impose adequate penalties or to include specialist expertise on the Committees. Since December 1979 the Department has met every three months or so with the AMA or the Attorney-General's Department to discuss these possible changes.

5.59 Responsibility for the delay of almost three years may not rest entirely with the Department of Health. However, if there was difficulty in reaching agreement between departments and with the AMA, the matter should have been referred to Ministerial and, if necessary, Cabinet level to ensure that the Committees of Inquiry were equipped to handle suspected overservicing.

5.60 It should also be pointed out that as far back as 1964 it was recognised that Committees of Inquiry should be allowed to examine patterns of practice. In that year the findings of a Committee established under the National Health Act were overturned by the court in the Perkins case.[19] In this case, there were several thousand services referred to the Committee and it had therefore based its findings on a sample of the services that were possibly excessive. The Commonwealth's Counsel argued:

> The Committee need not examine the claim case by case. It is entitled to take samples (with proper safeguards) and acting on these samples to decide the extent of over-visiting. If it does so then it need not determine the particular instances of over-visiting.

5.61 The Court found in favour of the doctors, although one of the judges commended that:

> ....The resolution of the difficult and delicate questions which may arise in these cases has been entrusted by Parliament to a body of experienced practitioners familiar both with the medical aspects of the illnesses and treatment of the aged and the infirm, and with the problems, usages and standards of medical practice. They are allowed a wide discretion as to the methods by which they inform their minds and reach their conclusions. It cannot be expected that every attendance, or the treatment accorded to every patient, will be examined into separately; such a task could never be completed, nor, for a tribunal possessing the committee's expert qualifications, would it be necessary....[20]

5.62 Despite this recognition in 1964 of the need to examine generalised evidence of overservicing, the Department has still not moved to ensure that such evidence can be used.

The Department's Response

5.63 At a public hearing on 26 October 1982, the Director-General read a prepared statement that responded in general terms to the various criticisms that had been made of his Department, such as those on staffing, on handling of fraud cases in the Victorian office and on establishment of Medical Services Committees of Inquiry. The full text of the Director-General's statement is reproduced at appendix K.

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19 Perkins and Another v. the Commonwealth (65 S.R. (NSW) p. 124).

20 65 S.R. (NSW) Perkins v. The commonwealth, Sugerman J., p. 133.

5.64 The Director-General emphasised that, until 1 November 1978, the Health Insurance Commission and not the Department of Health was responsible for administration of the medical benefits arrangements. Clearly the Department cannot be held formally responsible for the actions of the Commission in the area of fraud investigation over this period.

5.65 Two points should, however, be emphasised. Firstly, the Department has been responsible since December 1975 for Medical Services Committees of Inquiry and other major aspects of the response to overservicing. This is clear from the Department's annual reports for 1976-77 and 1977-78, which acknowledged its responsibility to analyse servicing patterns and provide basic data to Medical Services Committees of Inquiry.[21] A July 1976 circular from the Department to health funds described the data to be provided to the Department. As this information from private funds was only available to the Department, and as all Medibank data was also provided, it was clearly intended that the Department be responsible for detecting possible cases of overservicing. As outlined above, we believe the Department has not given sufficient priority to this function.

5.66 Secondly, and of greater importance, the Department had a responsibility to advise the Minister on general health policy, even where day-to-day responsibility rested with a statutory authority which reported directly to the Minister. In our view this responsibility included the duty of informing itself of major developments in health services, particularly as they affected the Commonwealth. As Mr Hunt, the Minister for Health at the time has stated:

> .... the Commonwealth Department of Health and the Health Insurance Commission (until 1 November 1978) were *respectively responsible for policy formulation and administration*, and the operation of the Commonwealth Health Insurance scheme.[22]

5.67 We also note that from July 1976 until October 1978 Dr Howells, the Director-General of Health, was also Chairman of the Health Insurance Commission. Dr Howells has emphasised that this was a part-time position, and that the general manager of the Commission had permanent head status and had direct access to the Minister.[23] However, the Commission was charged with responsibility for administering most aspects of the Health Insurance Act and clearly that responsibility extended to the members of the Commission itself, as well as its full-time staff.

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21 Department of Health, Annual Report, 1976-77, Parl. Paper Number 289/77 p. 94.
22 Hunt, The Hon. R.J. op. cit., p. 11, (emphasis added).
23 Minutes of Evidence, op. cit., pp. 3175-6.

5.68 In his 26 October statement, the Director-General went on to say:

> ... there are some individuals who apparently claim that they did know of the magnitude of the problem in those early days. I suggest that this is simply incorrect. As I have said to this Committee before, there is nothing new about fraud - in any occupation - or overservicing. What *was not established until 1981 was the magnitude of these* abuses, especially in the overservicing area.

5.69 This is the nub of the Department's explanation of its poor performance - that the extent of the problem was not known until 1981.

5.70 The Committee has no evidence that the Director-General or senior officers of Health were convinced prior to May 1981 that more than $100m per annum was being lost in fraud and overservicing. Too much emphasis has, however, been put on this monetary estimate.

5.71 *We believe that, if the Director-General and his* senior officers had no idea prior to May 1981 that fraud and overservicing were major problems, then they should have known. The benefit of hindsight is recognised, but there were significant signs as early as 1975 and 1976 that fraud and overservicing were taking place on a large scale:

- A number of individuals involved in health insurance at that time have testified before this Committee that they were aware that fraud and overservicing *were major problems. One witness has argued that it* was unlikely that senior officers of the Department of Health were not aware.[24]

- In December 1977 an officer of Medibank stationed in Queensland extrapolated from US data to estimate that abuse of medical benefits was costing $100m per annum. While this did not prove that similar abuses were taking place in Australia, one would expect such an estimate to prompt the Department to examine the matter urgently. The report contained information on ..... cases of possible overservicing or fraud, involving hundreds of thousands of dollars, as *examples of the problems being faced in Queensland* alone. Although the report was written by a Medibank officer, the information crossed the Director-General's desk in January 1979 when the Health Insurance Commission put forward an answer to a

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24 Harvey, R. Submission to the Joint Parliamentary Committee of Public Accounts, 1982, p. 5.

Parliamentary question arising from publicity of the Medibank officer's report.[25]

- At a more general level, the Department should have been alerted by overseas experience with medical fraud and overservicing, and Australian experience with the Pensioner Medical Service.

- There was considerable press coverage of fraud by doctors throughout this period, although there were fewer reports of suspected overservicing. Yet even in the overservicing area, the working party established by the Director-General concluded in March 1976 that 'recent reports of alleged abuses of Medibank by medical practitioners have highlighted the need for the establishment of Committees (of Inquiry) as soon as possible'.

- When responsibility for pursuing medical fraud was transferred from the Health Insurance Commission to the Department on 1 November 1978, a large number of active files on doctors suspected of fraud were transferred from the Commission. The fact that a significant number of doctors were suspected of fraud or overservicing at that time should have given some cause for concern.[26]

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25 The report also recommended a series of changes in procedures and legislation. From the annotations made on the report by key personnel in the Commission's central office, it appears that the recommendations were well received, but were mostly not taken up. It is interesting to note that a number of these ideas have since been accepted by the Department, although some years later. However, despite this apparent support for the report, the Acting General Manager of the Commission advised the Minister in January 1979 that the 'issue now seems dead'. The answer to the Parliamentary question implied that the report was written by a former employee to 'get even' (appendix L). ~~Parliamentary question arising from publicity of the Medibank officer's report.~~25

26 The Department has estimated that at least 173 active files on doctors suspected of fraud were transferred. This figure includes only those cases that had gone beyond the routine preliminary investigation, and does not include cases already referred to the police. In addition, there were many cases of suspected fraud that had not been investigated. In NSW alone approximately 1000 files were transferred to the Department, and the abovementioned report by a Queensland Medibank officer stated that by the end of 1977, 366 files had been created in that State.

5.72 Given all these points, the Director-General and his senior officers should have been aware long before 1981 that medical fraud and overservicing was widespread.

5.73 Furthermore, regardless of the evidence of abuse, there was a responsibility to ensure adequate review mechanisms were in place. Even before he became aware of the scale of fraud and overservicing, the then Minister for Health emphasised this point in a speech in February 1976:

> .... Already there have been reports of abuse of Medibank by doctors, pathologists and radiologists and overuse by patients. We have no proof of this. I have not seen any proof that these reports are correct. However, any health scheme that will cost the Australian taxpayers somewhere between $1,400m and $1,500m, including administration costs in a full year, surely is in need of the closest scrutiny.[27]

5.74 The Director-General also stated in his 26 October 1982 statement that he knew of no criminality amongst officers of the Department. Evidence relating to the Victorian office of the Department has already been discussed and the Committee recommended earlier in this chapter that further investigation be carried out into the conduct of the Victorian office.

5.75 Allegations have been made of 'corruption' within the Department. The Committee understands these allegations refer to a very broad concept of 'corruption', one which includes failure to fully perform one's duty, especially in failing to thoroughly investigate suspected criminal behaviour, rather than corruption in the usual sense of bribery or criminal misconduct for personal gain.

5.76 It is clear to us that much more should have been done by senior managers in the Department and, in particular, in the Victorian office to pursue suspected fraud and overservicing.

5.77 We are unable at this stage to assess the extent to which these inadequacies result from deficiencies in the management skills of senior officers in the Department, from negligence or misjudgement on their part, or from conscious decisions to 'go soft' on doctors suspected of abusing the medical benefits system. But regardless of the reasons, the senior officers of the Department, and the Director-General in particular, must take responsibility for the Department's performance in this as in other areas within the policy parameters set by the Minister and the Government. Under Section 25(2) of the Public Service Act, the Permanent Head is responsible for the general working of the Department.

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27 Australia, House of Representatives, Debates, 19 February 1976, p. 110.

5.78 This inquiry has focussed on the handling of medical fraud and overservicing, and has not examined other areas of the Department's operations. However, on the basis of its performance in this area, there must be doubts about its capacity to operate effectively in others.

5. The Committee recommends that the senior management structure and personnel of the Department be comprehensively reviewed to ensure, amongst other things, that lines of responsibility are clearly defined so that all senior officers can be in no doubt that they are responsible for the efficient and effective administration of the areas of policy assigned to them.

Decentralised Management

5.79 The Committee has identified a number of management problems in the Department of Health, the more specific of which will be dealt with in later chapters. But one aspect of the management of the Department which deserves special mention at this stage is the relationship between the central and state offices of the Department. In various inquiries we have conducted over the years it has become apparent that accountability between central and state offices is inadequate in many departments.

5.80 At our first public hearing with the central office of the Department of Health, the Committee was concerned by the apparent lack of knowledge of, and sense of responsibility for what takes place in the state offices. It was surprising to find that senior central office personnel had little knowledge of actual procedures followed in state offices and little knowledge as to whether state offices were in fact following the few procedures laid down by central office guidelines. Equally disturbing was the paucity of guidelines to state offices and the inadequacy of consultation between central and state offices.

5.81 In hearing evidence from five regional offices, the Committee has discovered major differences in the approach taken by the various offices, for example on the role of medical counsellors. Data supplied by the Department bear this out. For example, the Victorian office has been far less diligent in pursuing fraud cases than its NSW counterpart. Apart from evidence on the 41 files already referred to, the following statistics reveal quite different approaches.

TABLE 4: INVESTIGATION AND PROSECUTION OF FRAUD CASES IN NEW SOUTH WALES AND VICTORIA[28] (1 July 1975 to 31 March 1982)

	Cases per 1,000 Private Doctors*	
	Victoria	NSW
Referred to AFP for prosecution	5.6	17.5
Successful prosecutions	2.0	3.6

* Based on number of providers receiving more than $4,000 in medical benefits in June quarter 1982. The numbers for New South Wales and Victoria are 7,299 and 4,464 respectively.

While there may be some difference in the extent of medical fraud between the two States, this is unlikely to fully explain the very significant difference in the performance of the two offices.

5.82 The Director-General has admitted a previous lack of understanding in the Victorian office of the crucial distinction between fraud and overservicing. While he emphasised that the Department also adopts a decentralised approach in other aspects of its work. He acknowledged that there are certain disadvantages with such an approach, in particular in ensuring uniformity throughout Australia. He went on to state that satisfactory standards have not always been maintained in the past, but claimed there had been consistent improvement.[29] Unfortunately this improvement has not been evident to the Committee.

5.83 The differences between the regional offices are not surprising given the absence of clear guidelines from Canberra. As mentioned previously, it was only on 9 June 1982 that written guidelines were issued covering what to do in suspected fraud cases. A draft training manual was sent at the same time.

5.84 The Committee acknowledges that there have been visits to regional offices by the Director-General and other officers from Canberra. In particular, there have been visits by members of the Medical Benefits Division to explain the operation of the detection system developed in central office, although it has already been pointed out that these visits provided insufficient training to the state office personnel. There have also been regular meetings of Directors and

28 Department of Health Submission, op. cit., p. 106, table 5; and Advice from Department of Health, Committee File 1982/9.

29 Minutes of Evidence, op. cit., p. 751.

Assistant Directors to discuss this and other areas of the Department's work.

5.85 We do not accept, however, that this was sufficient guidance to officers in the states. For example, medical counsellors have not met together since November 1978, and even that meeting was very brief. Since then the central *office has refused requests for a meeting of all* counsellors.[30] Given the difficult role of these counsellors and the fact that there is only one counsellor in most States, regular meetings could have assisted greatly in developing this vital aspect of the Department's operations, by helping the counsellors to take a common approach to their role. Notwithstanding limitations on travel funds, more effort should have been made over the five years since most of the counsellors were appointed.

5.86 Yet even this would not have been sufficient. The absence of written guidelines on handling fraud cases for so long was a very significant omission, and one that cannot be blamed on limited travel funds. No amount of oral instruction can substitute for clear written instructions on how cases should be handled. Even if oral guidelines are understood at the time, new staff who arrive subsequently need to be instructed in the Department's procedures.

5.87 In the overservicing area there were occasional circulars sent from Canberra, but none provided comprehensive guidelines. In some cases there were very specific procedures, for example forms provided in May 1978 for referring cases to Committees of Inquiry. On the other hand, another circular in 1978 stated that 'activity of medical counsellors in each State is to be determined by the Director of Health in each State'. Another recommends that state offices 'ensure that all necessary administrative actions are taken...' This very important area is thus left almost completely to the discretion of State Directors, and it is not surprising that there are significant differences between the approaches taken in the various state offices.

5.88 Clear written guidelines are essential if staff in state offices are to be held accountable for their performance. Without guidelines, accountability can break down because either side can argue that instructions were misunderstood. It is also unacceptable to have doctors treated in quite different ways depending on the State in which they practice and the counsellor or investigator assigned to their case.

5.89 There is no evidence of adequate evaluation mechanisms to review the performance of state offices and they have thus not been held accountable for their performance in

30 Minutes of Evidence, op. cit., p. 1597.

pursuing fraud and overservicing. Accountability requires not only guidelines from central office, but also adequate information flowing to the central office on what is happening in the field. One cannot expect a good manager at any level of an organisation to delegate authority without some way of knowing whether it is being used consistently to advance the overall goals of the organisation.

5.90 State offices provide monthly reports to Canberra on fraud and overservicing. However, the information requested is inadequate as a management tool. A copy of the form provided by central office is at appendix M.

5.91 The information requested by central office gives no idea at all of how quickly suspected fraud cases are handled in regional offices. While there is information on how many cases are opened during the previous month, how many are closed (with reasons) and how many are current, one cannot tell the age of the active files, let alone why they may be delayed. Ironically, the returns give a much better idea how the police and the courts are handling cases than how the Department itself is performing.

5.92 The form requests information (name and date referred) on cases referred for counselling during the month. An examination of the most recent returns for each State revealed that three States did not bother to provide the information, and Victoria reported only two cases referred during the month. Queensland and NSW provided the full details requested. There is no evidence that the other states were questioned about their failure to provide the information.

5.93 Given the Director-General's evidence that he personally examined the fraud and overservicing activities in each State Office in mid 1981, it is surprising that written guidelines and improved management information systems were not introduced at that time.

5.94 The Committee accepts the view put forward by the Department that it is not feasible for investigation of suspected fraud and overservicing to take place in the Canberra office of the Department. However, this does not imply total devolution of authority or abdication of responsibility.

6. **The Committee recommends that the lines of responsibility within the Department of Health be redefined and its management philosophy altered to ensure that Directors of its state offices are fully accountable to the Director-General who has overall responsibility for the performance of the Department. In particular, it is recommended that:**

(a) comprehensive written guidelines be issued to state offices on all aspects of the detection and investigation of suspected fraud and overservicing;

(b) the Australian Federal Police, the Attorney-General's Department and experienced investigators and counsellors within the Department of Health be consulted in the development of these guidelines;

(c) adequate management information systems be introduced and utilised;

(d) independent management expertise be provided to the Department to assist with (a) and (c) above; and

(e) day-to-day contact be maintained between claims review and investigation staff in the central and state offices, especially during implementation of changes arising from this inquiry.

5.95 However, this increase in the accountability of state offices within the Department should not be at the expense of lateral co-ordination. As emphasised later in this report, it is vital that the operations of the Department of Health be adequately linked with those of the Australian Federal Police and the Crown Solicitor's Division.

Involvement of Ministers

5.96 The existence of fraud and overservicing by some doctors has been known for many years, at least since the first involvement of the Commonwealth in some form of medical benefits in the 1950s. Since the first collection of computerised statistics on medical benefits in 1975, there has been a growing awareness of the magnitude of the problem, especially from 1981 when the Department estimated that at least $100m per annum was involved. The Committee has considered in some detail the adequacy of the Department's briefing of successive Ministers for Health on this matter.

5.97 To assist with its inquiries, the Committee sought submissions from those Ministers and ex-Ministers who had a major involvement in health insurance arrangements, the Hon W.G. Hayden, MP, the Hon R.J.D. Hunt, MP and the Hon M.J.R. MacKellar, MP. A submission was also sought from the Hon D.N. Everingham, MP.

5.98 In a letter to the Committee, Mr Hayden advised that at the time he was aware 'there was quite an extraordinary level of overservicing by fee-for-service doctors in that

period'. He went on to point out that computer profiles of medical practitioners were developed by the Health Insurance Commission and prosecutions were commenced.

5.99 *The passage of time has made it difficult to assess* whether adequate briefing was provided to Ministers prior to 1976 by the Health Insurance Commission and the Department of Social Security (which then administered health insurance). Similarly, it is difficult to examine in detail how *effectively the Commission handled fraud and overservicing* cases at that time.

5.100 During the period when Mr Hunt was Minister, the Health Insurance Commission and later the Department of Health *provided him with regular reports on the number of fraud cases* referred to the police, and on the outcome of those cases. From his public statements at the time and annotations on the regular reports, it is quite clear that Mr Hunt pressed the Department to pursue vigorously doctors suspected of fraud. *Between 1976 and October 1979, 121 enquiries concerning* doctors had been referred to the Australian Federal Police, resulting in 22 prosecutions. There was no evidence of regular briefing to Mr Hunt on overservicing.

5.101 *The Committee has had some difficulty in establishing* the nature of the briefing provided to Mr Hunt's successor, Mr MacKellar, and still cannot be certain that all the relevant papers have been identified, but it seems that in the first 17 months in the Health portfolio, Mr MacKellar received:

- at his request, briefs on individual fraud cases that were prosecuted;
- regular briefing for Parliamentary question time, that *included summaries of doctors prosecuted for* fraud or examined for overservicing;
- briefing associated with a Cabinet Submission lodged in May 1980, which estimated that a minimum of $15m *per annum was being lost in fraud and overservicing* and urged immediate changes to the legislation with respect to Medical Services Committees of Inquiry;
- normal budget briefing on activities of the *Department (although Mr MacKellar did not recall any* particular emphasis being placed on the fraud and overservicing area);[31] and
- oral briefing.

5.102 It is difficult to assess the adequacy of this briefing, especially that which was provided orally. In a

31 Minutes of Evidence, op. cit., p. 3298.

hearing before the Committee Mr MacKellar indicated that, at the time, he was satisfied with the briefing he was receiving, although he added that with hindsight perhaps he should not have been. He also indicated that, he was generally satisfied that action was being taken. He requested that he be provided with written briefing on individual cases of fraud to keep himself informed and to act as a reminder to the Department of his continuing concern.[32]

5.103 There is no evidence of any written briefing on fraud and overservicing provided to Mr MacKellar when he first became Minister. The Director-General has testified that oral briefing was provided at the time, although Mr MacKellar has stated that the briefing on this subject was not extensive. Given the complexity of the problems facing the Department, the Committee finds it surprising that a comprehensive written brief was apparently not provided to Mr MacKellar at the time he took over the portfolio. The Department has provided the Committee with copies of the Parliamentary briefs provided to Mr MacKellar, but the first of these was provided in March 1980, some three months after he took over. The material supplied then was very similar to the reports provided to Mr Hunt.

5.104 Given the concern of his predecessor about this issue, the Committee is surprised that the Department did not offer, nor apparently did Mr MacKellar request, a full written briefing on medical fraud and overservicing following his appointment in December 1979. The regular monthly reports prepared for Mr Hunt were not offered to Mr MacKellar, although it is recognised that some information was provided to him in other forms.[33] The Committee believes it should be standard practice for departments to provide full written briefing on major issues when a new Minister takes over.

5.105 Mr MacKellar also advised the Committee that Mr Hunt did not draw his attention to the problem, and that outgoing Ministers do not routinely brief the following Minister on the portfolio.[34] He pointed out that Mr Hunt would have been concentrating on his new responsibilities. It seems to the Committee highly desirable for an outgoing Minister to spend at least a short time briefing his successor to maintain some continuity of policy and indicate areas of concern.

5.106 In May 1981 after 17 months in the portfolio, Mr MacKellar received, at his request, the first substantial briefing (as far as we can determine) on the overall magnitude of fraud and overservicing, in response to a National Times article. This briefing included for the first time the $100m per annum estimate which had been made by the Department two months earlier but had not been drawn to the Minister's

32 Minutes of Evidence, op. cit., pp. 3327 and 3301.
33 Minutes of Evidence, op. cit., p. 3281.
34 Minutes of Evidence, op. cit., p. 3300.

attention previously. The Committee was suprised to learn that seven key paragraphs were deleted from the draft briefing note before it was approved for submission to the Minister.[35] These paragraphs suggested that further staff were required by the Department to adequately respond to the problems of fraud and overservicing. One of the explanations offered for this deletion was that the Director-General, who was then overseas, reserved questions of staff resources for his own consideration. It has not been established that the purpose in deleting these paragraphs was to mislead the Minister. The Committee recognises that senior officers of any Department have the prerogative to amend draft submissions to the Minister, although it should be noted that in this case the Minister's attention was not drawn to the need for more staff until he requested a further briefing in August 1981, in response to an article in The Bulletin. It has already been pointed out that these additional staffing positions were not proposed to the Public Service Board until ~~July~~ June 1982 and the Department has yet to fill them.

5.107 It is important to note that the May 1981 briefing on the extent of fraud and overservicing and the August 1981 briefing, which finally drew attention to the Department's staffing needs in this area, were both prepared in response to press articles. In each case the Minister asked his Department for briefing. It is obviously difficult to know when this information would have been provided if those articles had not appeared. However, the Committee is left with the impression that the Department and the Minister were simply reacting to outside events on this issue, rather than taking the initiative, although it is appreciated that major policy changes in health insurance and other areas were underway at that time.

5.108 The Committee has not received any evidence that the Department sought Mr MacKellar's support prior to August 1981 for additional staffing resources for the fraud and overservicing area, apart from general requests for more staff for the Department. Nor has the Committee any evidence that the Minister raised with his Department the adequacy of its staffing level at that time. The Committee believes that, especially once the Department was aware in March 1981 of the estimated loss of $100m per annum from fraud and overservicing, it had a clear responsibility to make an assessment of its resources to combat the problem and to advise the Minister urgently of its ability or otherwise to police the medical benefits system.

5.109 There were thus crucial times when the Department should have provided advice to Ministers earlier, although overall it cannot be said that either Mr Hunt or Mr MacKellar were unaware of the magnitude of the problem, as it was then

35 See appendix N.

known. Neither has complained that he was inadequately briefed.

5.110 Both former Ministers have drawn the Committee's attention to the steps that were taken during their periods in the portfolio to pursue doctors who committed fraud or overservicing. Both have stated that they were very concerned about fraud and overservicing and instructed the Department to pursue the doctors involved vigorously.[36]

5.111 Mr Hunt's submission draws attention to a number of steps taken during his period as Minister for Health, including:

- changes in medical benefit arrangements for pathologists, recommended by the Working Party on Pathology Services established in April 1976;
- establishment of the Peer Review Resource Centre in February 1979;
- establishment of Medical Services Committees of Inquiry in 1977 and establishment of the Medical Services Review Tribunal in August 1979;
- appointment of medical counsellors;
- changes to bulk-billing arrangements;
- increased penalties for fraud introduced in 1977; and
- allocation of additional police resources in 1979.

5.112 Mr MacKellar has pointed to the action taken while he was Minister:

- efforts to tighten up overservicing provisions in 1980, which led to changes to the legislation in 1981;
- his continuing discussions with the AMA, leading to the public support of the Association for action in this area;
- major proposals put forward to Cabinet on fraud in October 1981, within a few months of his becoming aware of the $100m estimate; and
- discussion with State Ministers on the need for Federal-State cooperation in detecting and dealing with fraud and overservicing.

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36 Minutes of Evidence, op. cit., p. 3275; and Hunt, The Hon. R.J., Submission, op. cit., p. 40.

5.113 Nevertheless, the Committee believes that not enough was done. For example, despite all the concern on the part of Ministers and the increasing knowledge of the magnitude of the problem, adequate staffing positions were not allocated. Similarly, it took almost two and a half years for the Committees of Inquiry to be established and begin considering cases. Although the legislation on Committees of Inquiry was tightened in 1981, other problems which seriously affected their usefulness, and were identified in 1979, have yet to be resolved. In addition the Department failed to provide adequate guidelines for state offices to enable fraud and overservicing cases to be handled in a consistent manner (as evidenced in Victoria).

5.114 In some cases, the Department has failed to do all that it could to gain adequate resources. We have already mentioned that in July 1979, Mr Hunt asked the Department to advise him if more departmental staff were required to ensure adequate statistics and offered to approach the Prime Minister. There is no evidence that this offer was taken up. Only in August 1981 did the Department put forward a proposal for additional staffing resources to Mr MacKellar.[37]

5.115 In some related areas the Department did raise with Ministers the need for additional resources. For example, in May 1981 Mr MacKellar wrote to the Minister for Administrative Services, expressing concern at suggestions that the Australian Federal Police should reduce the priority given to medical fraud investigation.

5.116 Mr MacKellar has acknowledged that he was concerned at the time about the level of resources made available by the AFP.[38] He wrote to Mr Newman again in November 1981, and eventually arrangements were made for Mr Newman to receive a briefing from Health officials in February 1982 on the magnitude of the problem. In view of the evident concern expressed by Mr MacKellar in his letters to Mr Newman, it is difficult to see why it took nine months for the briefing to be arranged. Following that briefing, the Secretary of the Department of Administrative Services acknowledged that previously neither he nor his Minister had any idea of the magnitude of the problem, but that Mr Newman had indicated that he was now firmly convinced that the AFP must give the Department of Health full support and looked to some additional staffing proposals then before the Government to enable the police to do just that.[39]

5.117 However, additional police resources were not provided. We have been advised by the AFP that the number of

37 Minutes of Evidence, op. cit., p. 3298.
38 Minutes of Evidence, op. cit., p. 3309.
39 Letter from Secretary, Department of Administrative Services to Director-General of Health, 26 February 1982, Committee File 1982/9.

police investigators allocated to medical fraud has not changed significantly since then.[40] The Minister for Administrative Services has recently announced recruitment and training of an additional 350 police over a period of three years, although it has not been indicated how many extra police are likely to be available for medical fraud investigation as a result. The Australian Federal Police have stated that the lack of skilled resources in the AFP has adversely affected action against medical fraud.[41] Thus, despite an awareness in May 1981 that police resources were inadequate, the situation is still unsatisfactory.

5.118 The Committee is concerned that the AFP have been unable to provide adequate trained police for the investigation of medical fraud, and wishes to discuss this matter with the Minister for Administrative Services. If necessary we will make further observations in the final report.

5.119 Throughout this report, we have drawn attention to very significant problems in the response to medical fraud and overservicing. At this stage it seems that neither the Department of Health nor Ministers can escape some responsibility for these major problems. Evidence is not yet complete on this question and the Committee will be considering it further before the final report is tabled.

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40 Advice from AFP, 24 November 1982, Committee File 1982/9.
41 Minutes of Evidence, op. cit., pp. 2709-2713.

CHAPTER 6

DETECTION OF FRAUD AND OVERSERVICING

Sources of Information

6.1 There are a number of sources of information available to the Department of Health concerning abuses by some doctors of the medical benefits system. Major sources are:

- the Department's Fraud and Overservicing Detection System (FODS), a computer system which monitors patterns of service and thus provides a review mechanism of doctors' activities;
- health insurance organisations, which also monitor claims for medical benefits; and
- information supplied by patients, other practioners or employees concerning a particular event or pattern of service.

6.2 Much attention during this inquiry has focussed on the FODS system. It is important to note, however, that information supplied by individuals still forms the major source of information on doctors acting fraudulently.[1] In this context it is of some concern to the Committee that two of the major health funds (HCF and Medibank Private) have experienced a great deal of difficulty in obtaining information from the Department of Health on cases they have referred to it.[2] It has been suggested, incorrectly we believe, that Section 130 of the Health Insurance Act has until recently precluded the Department providing such information to the funds.[3]

Description of FODS

6.3 The FODS system is based on claims information available from health funds and from the Department's own

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1 In-camera evidence, Committee File 1982/9. A significant amount of information was collected by the Committee in the course of this inquiry in the form of confidential submissions and in-camera hearings. To protect the interests and wishes of the individuals and organisations providing the information, the sources must remain confidential.

2 Hospitals Contribution Fund. Submission to the Joint Parliamentary Committee of Public Accounts 1982, p. 5; and Minutes of Evidence, op. cit., pp. 863-865.

3 HCF Submission, op. cit., p. 15.

bulk-billing records. This covers all services that attract Commonwealth Medical Benefits, but excludes for example services associated with workers' compensation claims or health screening services. The system is intended to aid the identification of possible overservicing or fraud by doctors and to monitor the effectiveness of Departmental activities directed toward the control of overservicing and fraud. In particular, it allows for review of:

- servicing pattern of any individual doctor, at various levels of detail;
- utilisation of medical services in particular geographic areas;
- claiming pattern for any individual patient; and
- utilisation of specific services or types of service.

6.4 Detailed statistics of medical services which attracted a medical benefit have been held since July 1975 when Medibank was introduced. These details are contained within two statistical systems:

- the Medical Statistics System (MEDSTATS), which contains details of services provided between July 1975 and November 1978; and bulk-billed services since November 1978; and
- the Health Insurance Medical Statistics System (HIMSS), which was established to maintain a separate system for all services which became the direct responsibility of the Department of Health from November 1978.

6.5 FODS is a two level system which utilises this data on medical benefits claims. The first level comprises monitoring reports and scan profiles.[4] When a doctor's practice pattern is identified in the first level as showing possible fraud or overservicing, the second level of information is used to obtain detailed profiles concerning the doctor's practice, although it has been suggested to the Committee that this second level has not been fully utilized, mainly due to the inadequate training of staff in the use of FODS.[5] The reports generated in this group include analysis profiles and speciality profiles.[6]

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4 An example of Monitoring Report is attached at appendix O and a scan profile is at Diagram 5.

5 Minutes of Evidence, op. cit., p. 2539.

6 Examples of Analysis Profiles and Speciality Profiles are attached at appendices P and Q respectively.

6.6 Monitoring reports provide summary information on individual doctors, identifying how the doctor deviates in certain ways from the peer group average. The monitoring report also provides aggregate statistics regarding doctors within a particular region. The monitoring reports can therefore aid identification of doctors for further investigation and planning of the most cost-effective use of counsellor and investigatory resources.

6.7 The scan is a statistical outline of a doctor's servicing pattern and is designed to ascertain the type and size of a doctor's practice, based on claims for medical benefits received over a three month period. The following page gives an example of a doctor's scan. Scans are produced quarterly, but are six to nine months out of date given delays in obtaining data from funds. The main role of the scan is to list items most commonly billed by the doctor, in respect of which the scan lists the number performed, the number of patients involved and the income derived from schedule fees. In addition, the ratio of services to patients is calculated and a breakdown of the patients' insurance cover and billing method is provided. All this information is compared with the average of the doctor's peer group. Thus the scan can readily highlight possible:

- excess servicing (eg excessive use of long consultations);
- high cost per patient;
- possible fraud (e.g. impossible item combinations and frequencies); and
- unusual patterns of billing.

6.8 Analysis profiles, on the other hand, provide much more detailed information on a specific doctor under investigation. For example, if a doctor's scan reveals a small number of nursing home patients receiving frequent services, an analysis profile showing the dates on which services were provided to these patients might reveal that the doctor visited all the patients on the same day each week, apparently regardless of their need for treatment. Alternatively it might reveal that a doctor always carried out certain tests when providing unrelated services. Such profiles can also be used to identify individual patients who should be interviewed to obtain evidence for prosecution or referral to a Committee of Inquiry.

6.9 The analysis profiles have limited application with regard to specialists. The Department is gradually developing specialty profiles applicable to the various specialist groups. Some analysis is now possible in the pathology area, for example linking referring doctors with pathologists.

SCAN PROFILE REPORT

REPORT ISS240 · SPECIALTY GROUP - SERVICE PROFILE - PROVIDER ( ) BASED ON DATE OF CLAIM DATA PAGE
RUN DATE 30/10/82
REQ.DATE 28/10/82 PEER GROUP IS GENERAL PRACTITIONER POSTCODE IS
JOB

FROM APRIL

TO JUNE

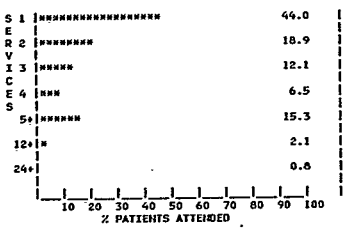
EXPLANATORY NOTES

D1: NOT DEFINED AS YET
D2: NOT DEFINED AS YET
D3: (ABS(<X - 1>/<Y - 1>) - 1) * 100)
D4: NOT DEFINED AS YET
D5: "*" SHOWS GROUP1/GROUP2 DIFFERS FROM AVERAGE BY AT LEAST 50%
NB: "**" WHEN USED INDICATES 100%

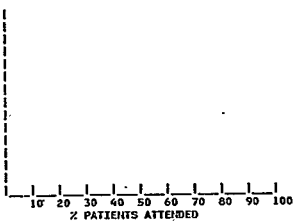
SPECIALTIES
GENERAL PRACTITIONER
PATHOLOGIST (APPROVED)

PRV.NO	P.GRP	ITEM	SERVICES DOC	AVE D 1	NO OF PAT DOC	AVE D 2	SERVS/PATNT DOC (X)	AVE (Y)	D 3	SCHEDULED FEE COST DOC AMT	%	AVE AMT	% OF SERVICES BY BILL TYPE |---P.H.B---|---P.S.N---| % UNINS DR AV	INSRD DR AV	UNINS DR AV	D.BILL INSRD DR AV	UNINS DR AV	D.BILL INSRD DR AV
		0014	905		534		1.7			10094 30			66	16 14	03	01		
		0019	203		145		1.4			3462 10			85	06 06	02	00		
		0075	181		15		12.1			2027 06				**				
		0955	117		100		1.2			302 01			71	20 08	02			
		0025	84		68		1.2			1804 05			55	13 29	04			
		0908	77		75		1.0			1576 05			74	10 14		01		
		0921	67		56		1.2			1163 03			58	19 21	01			
		0069	55		12		4.6			903 03			60	02 38				
		1537	53		51		1.0			278 01			79	06 15				
		0003	40		40		1.0			331 01			85	05 03	08			
		2625	28		28		1.0			754 02			61	07 25	07			
		1674	25		22		1.1			460 01			64	04 28	04			
		1610	22		22		1.0			283 01			64	23 09	05			
		REST	323		279		1.2			10692 31								
		TOT.	2180		738		3.0			34129 **		**	64	12 21	03	00		
							PER PATIENT			46.2								

HISTOGRAM FOR THIS PROVIDER (ALL SERVICES)



AVERAGE HISTOGRAM FOR THIS SPECIALTY GROUP (ALL SERVICES)



ITEM GROUP TABLE (RATIO 1 OVER RATIO 2)

GROUP 1	GROUP 2	DR AV D 5
CONS IN HRS	CON AFT HRS	5.2
SHORT CONS	LONG CONS	13.2
SRGRY CONS	HOME VISITS	73.2
SUBSQ CONS	INITIAL CONS	0.6
PRT-10 OPS	INITIAL CONS	3.8
PRT-6 MISC	INITIAL CONS	16.6
PRT-6 MISC	SRGRY CONS	0.2
SRGRY CONS	CONS NURS HM	4.9

****
OFFICE USE ONLY

Averages have been deleted for reasons of confidentiality.

Diagram 5

Techniques for analysing other speciality groups are to date not far advanced.

Development of FODS

6.10 The Department is vague on the length of time taken to develop FODS. Its first attempt to develop an investigatory statistics system was based on a series of reports which listed details of all services provided by doctors. There were no provisions for the routine use of these profiles to identify doctors who appeared to require further investigation.

6.11 The Department has emphasised that, resulting from changes to the health insurance system in 1976, there was no longer a single data base on medical benefits payments. This national data base had to be reconstructed by developing systems for collecting and integrating data from the various health funds. Evidence before the Committee, however, suggests that the Medibank data base could have produced useful review statistics from early 1976. It has been suggested that within a few months after October 1976 it should have been possible to integrate data from Medibank and six or seven of the major funds which could have covered medical benefits claims from 12 million or more persons.[7]

6.12 The Department's own annual report for 1976/77 indicates that this was occurring:

> Arrangements were made during the year (1976/77), to continue receiving statistical data about basic medical benefits services and payments from 1 October 1976. Data are being obtained from all registered medical benefits organisations and Medibank, and includes, for each service, identification of the organisation, the month in which the benefits were paid, patient identification, the Medical Benefits Schedule item number, the date of the service, identification of the practitioner providing the service, the fee charged and the benefit paid.
>
> The data are being processed on the Department's computer, and are used for: ... analysing servicing patterns and providing basic data for Medical Services Committees of Inquiry.[8]

6.13 The Committee finds it surprising that FODS was not in operation before April 1981, and that it is still in such a primitive stage of development. Frequent changes to the health insurance system no doubt made it difficult to develop

7 Harvey, R., Submission, op. cit., pp. 16-17.
8 Department of Health, Annual Report 1976/77; op. cit., p. 94.

and maintain detection systems, but this does not fully justify the long delay. The Department seems to have largely ignored its previous efforts in this regard, starting from scratch in 1979 to develop FODS, and has devoted inadequate resources to the task ever since.

6.14 FODS has been developed by a small team of three officers, who also had other tasks to perform. As we have emphasised in chapter 5, the Department has failed to allocate more staff to this important function, despite having the need for additional staff drawn to their attention on a number of occasions, including in a detailed paper in November 1980.[9]

6.15 In particular, the Committee was surprised to learn that for the past two years the team developing FODS has not been established on a permanent basis. The positions have been subject to Section 50 of the Public Service Act, with the result that they are not permanent. The Department confirmed on 5 November 1982 that a permanent structure had still not been established. While we recognise that some flexibility was desirable, the Committee is concerned that the absence of a permanent structure illustrates a lack of commitment to FODS on the part of senior management of the Department. Not to have permanent positions to offer could well have made it harder to attract and retain the specialised skills that were required to develop this complex statistical system.

Inadequacies of FODS

6.16 The basis of the FODS system is comparison of individual doctors with a set of 'norms' of practice for each doctor's peer group. For example, general practitioners are compared with others in the same State. The system is still under development and significant inadequacies remain in a number of areas.

(i) Determination of the 'Norm'

6.17 The system itself does not identify which patterns of service are acceptable. The only information the system provides as a 'norm' is the average for the doctor's peer group, for example the average number of long consultations or average cost per patient. The use of these averages as 'norms' is highly questionable, as deviation from the average does not necessarily signify an unacceptable level of servicing. Individual doctors are not all treating a representative cross-section of patients, especially where doctors concentrate on more serious cases or on specific services.

6.18 Much of the work to date has focussed on general practitioners, and the Department itself acknowledges that further development is required for specialists. The

9 See appendix F.

Committee notes that the medical profession, and specialist colleges in particular, have a major role to play. It is important that the norms as far as possible accurately reflect current medical practice.

7. **The Committee recommends to medical organisations, especially the medical colleges, that they co-operate fully with the Department of Health's efforts to develop appropriate peer group norms for use in the FODS system, and other aspects of the system.**

(ii) Categorisation of doctors into peer groups

6.19 Currently doctors are classified into peer groups based on specialist qualifications. However, for a significant proportion of doctors, qualifications are not an accurate guide to the nature of their practice. For example, a doctor with obstetrics and gynecological qualifications may practice as a general practitioner, as may a surgeon. Similarly, a doctor without recognised qualifications may practice as an anaesthesist or may concentrate on minor surgery. Because of the very significant differences between practice patterns of the various specialties, this misclassification of doctors can allow some fraud and overservicing to go undetected, and can also suggest that a doctor's pattern of service is abnormal when it is not. Again, the co-operation of the medical profession is crucial.

(iii) Information on Patients

6.20 At present, the FODS system fails to take account of patient characteristics such as age and sex.

6.21 Most of the review procedures in Canada adjust review statistics, such as number of services per patient, to allow for variation between a doctor's patients and those of the average doctor in the appropriate peer group. Failure to make such adjustments can lead to significant errors in assessing doctors' practice patterns. The importance of these factors is illustrated by the fact that males aged 24-44 years average three services per year, while males aged 65-69 years average ten services per year. Males aged 15-24 years use an average of 2 services per year while females in the same age range use over 5.5.[10]

6.22 The Department has acknowledged that standardising for age and sex of patients should significantly improve reliability of FODS.[11] It now receives data from health funds on the age and sex of patients who receive each service, and has indicated that it plans to utilise these data within FODS

10 Based on 1975-76 Medibank statistics.
11 Department of Health Submission, op. cit., p. 55.

as soon as possible. The Committee believes that the Department should have moved much sooner to take account of such demographic characteristics, and regards this as yet another example of the Department's failure to allocate sufficient resources to the detection and investigation of fraud and overservicing. Subsequent recommendations in this chapter should enable this and other priority tasks to be undertaken sooner.

6.23 It is also important to emphasise that FODS is designed principally to detect abuse by doctors, and is of little use where patients engage in fraud or overservicing. The Committee will be giving further consideration to the question of patient fraud in its final report, but two points should be emphasised at this stage.

6.24 Firstly, the current FODS system assumes a one-to-one relationship between doctors and patients, and therefore does not always detect major fraud or overservicing which arises where patients see more than one doctor. Referral for specialist treatment is discused separately, but this can also arise where patients visit a number of general practitioners, for example in a group partnership, or where a number of doctors provide services to patients in a hospital or nursing home. Thus fraud by patients who claim using a number of doctors' names can go undetected. Similarly, FODS would not necessarily detect conspiracy between doctors to defraud the system.

6.25 Secondly, the system cannot always detect overservicing that arises where doctors treat whole families regardless of medical need. For example there have been media reports recently about a doctor removing the tonsils from all children in the one family in one session.[12]

6.26 At present only health funds keep data based on patients or families, apart from pensioners and health card holders for whom doctors bulk-bill the Department of Health.

8. The Committee recommends that the Department of Health and health insurance funds jointly develop methods for detecting fraud and overservicing that arises where patients receive services from more than one doctor or where doctors treat all the members of a family.

(iv) Identification of Doctors

6.27 Until recently, the data on which FODS is based has at times incorrectly identified specific doctors within group practices, with the result that the doctor named on the account or assignment form may not have been the doctor

12 Sydney Morning Herald, 2 October 1982, 'Brereton Silent as AMA steps into tonsils row'.

providing the service. Prior to recent amendments to the Health Insurance legislation, some group practices indicated only the name of the senior partner on the account or assignment form. The effect on FODS was dramatic, with some senior partners appearing to be consulting for more than 24 hours in any one day, while other partners in the practice appeared to be working for only a few hours each day. Clearly this provided a grossly inadequate basis for analysis of individual doctors' practice patterns.

6.28 There is still no requirement that doctors use their provider numbers when issuing accounts to patients, with the result that funds have to look up the doctor's number before benefits data can be sent to the Department. Errors can arise where doctors are not accurately identified. The Committee notes that Section 19(6) of the Health Insurance Act has been recently amended to allow the Minister to prescribe the information that is required on accounts and receipts.

9. **The Committee recommends that regulations be promulgated to require doctors providing services to indicate their provider numbers on all accounts and receipts that attract Commonwealth Medical Benefits.**

(v) Time Lag in Obtaining Data

6.29 As mentioned already, at present much of the information within FODS is six to nine months out of date. Because of this time lag:

- doctors engaging in fraud and overservicing are not immediately detected through FODS;
- counselling is delayed and, given the usual requirement that a doctor's practice be reviewed six months after counselling before reference to a Committee of Inquiry, the whole process can take well over 18 months; and
- data on suspected fraud cases is often out of date, which can make prosecution difficult as patients can forget which services they received or even die during the intervening months.

6.30 The lag results from delays in patients submitting claims to health funds, doctors submitting bulk-billing claims and the funds providing information to the Department. The legislation has recently been amended to require health funds to provide data within two months of claims being lodged. But there is still no time limit on patients and only a six month limit on bulk-billing claims by doctors. Further steps need to be taken to reduce the lags, especially where doctors are submitting large claims to the Department.

10. **The Committee recommends that legislation be amended to require doctors to submit bulk-billing claims within two months of services being provided, with appropriate provision for extensions where this limit would cause hardship. Consideration should also be given to imposing a limit on the time patients have to submit claims to health funds.**

(vi) Data Errors

6.31 Accurate data is essential if FODS is to be developed to its full potential and if it is to be used effectively. The Department has pointed out[13] that the current error rate is sufficient to cause difficulties in the utilisation of FODS and, along with other problems, precludes the use of FODS as direct evidence of fraud or overservicing before a court or Committee of Inquiry.

6.32 There are instances where resources have been wasted on investigations which have ultimately shown that apparent gross abuse by a doctor has resulted from incorrect data entry.[14] Errors in the information on individual doctors can also seriously undermine the credibility of the system when doctors are challenged by counsellors to explain apparent anomolies.

6.33 The Department has pointed out that no major study has yet been undertaken into the level of accuracy of Commonwealth Medical Benefit data, on which FODS is based.[15] Given the large expenditure of Commonwealth funds involved, the Committee finds this alarming.

11. **The Committee recommends that the Department undertake a study into the accuracy of Commonwealth Medical Benefit data as a matter of urgency. In the interim, the Department should ensure that appropriate standards are adhered to by health funds in providing data.**

(vii) Inadequate Analysis for Non-expert Users

6.34 The current format of scans and profiles requires too high a level of technical expertise. It has been suggested to the Committee that only a handful of people in Australia are able to fully utilise their capability. The result has been that both police investigators and counsellors require extensive training in interpretation of the reports. As very

13 Department of Health Submission, op. cit., Appendix 3, p. 13.
14 Department of Health Submission, op. cit., Appendix 3, p. 13.
15 Department of Health Submission, op. cit., p. 12.

limited resources have so far been devoted to training, the usefulness of the system has been greatly diminished. It is essential that counsellors and investigation staff understand the system they are using and have confidence in it.

6.35 Elsewhere in this report the Committee has recommended that counselling and investigation staff have more thorough training in the use of FODS; nevertheless:

12. **The Committee recommends that the output of the FODS system be simplified to facilitate its use by counsellors and investigators. Also the computer system should be developed to carry out initial screening for particular service patterns known to be frequently associated with fraud or overservicing.**

(viii) Referrals to Specialists

6.36 At present medical benefits information provided to the Department by health funds does not provide the name of the referring doctor where specialist services are provided. It is important to remember that many doctors not only provide medical services themselves, but also generate services by referring their patients to other doctors.

6.37 Over recent years there has been extensive publicity regarding illegal commissions in pathology and other areas, for example where a pathologist pays doctors to utilise a particular pathologist's services. Whilst steps have been taken to reduce the extent of these practices, including the collection of data on which doctors order tests, it has been suggested to the Committee that such practices continue on a significant scale.[16]

6.38 Similar potential exists in other areas of diagnostic services and specialty practice, yet comprehensive data are not provided to the Department. Without information on which doctor orders particular tests or refers a patient for specialist treatment, it is impossible to assess the level of medical services generated by an individual doctor. More sophisticated forms of fraud and overservicing can therefore go undetected.

13. **The Committee recommends that the health insurance legislation be amended to require identification of doctors who refer patients for specialist treatment or tests, and to require health funds to include this information in data supplied to the Department.**

6.39 Abuse by pathologists will be considered in detail in the final report.

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16 National Association of Medical Specialists, Submission to Joint Parliamentary Committee of Public Accounts 1982, p. 3.

(ix) Quarterly Data

6.40 Because FODS is based on claims in a single quarter, considerable errors can be introduced. For example, where doctors submit bulk-billing claims for large amounts, the data for a single quarter will give a seriously distorted picture of a doctor's practice if the claims submitted during the 3 months relate to services provided over a significantly longer or shorter period.

6.41 Basing analysis on only three months data also makes it impossible to identify doctors who continue to treat the same patients intensively for years. While it cannot be assumed that such practicing patterns involve fraud or overservicing, they may well warrant closer examination given the high cost per patient.

14. The Committee recommends that the Department examine doctors' practice patterns over the previous 12 months as well as the previous quarter.

Future Development of FODS

6.42 The Committee believes that the maintenance of a standardised national data base is essential. We are therefore concerned that the 11 new positions recently created by the Department to handle medical fraud and overservicing do not include any further staffing for FODS development. Indeed the staffing available for FODS has been effectively reduced recently when extra functions were given to the FODS team without an adequate increase in staff.

6.43 The Committee has no doubt that there are some doctors who are undertaking fraud and overservicing which under current arrangements are not detected by the FODS system. On the other hand, as the above discussion suggests, there are also many doctors who are identified by FODS at its current stage of development as being likely to be involved in fraud or overservicing when in fact they are not. In the Committee's view, further development of FODS should concentrate on reducing the number of doctors falsely suspected of fraud or overservicing, as well as attempting to identify fraud and overservicing that currently goes undetected. For example, the Department should explore ways to reduce the number of apparent cases of fraud or overservicing that are subsequently shown to be due to an unusual patient mix, specialisation in certain procedures or other legitimate reasons. A small investment in FODS could in this way have considerable impact on the efficiency of the investigation efforts of the Department and the police. It needs to be recognised, of course, that specialised skills are involved and there are therefore limits to how quickly the FODS system is developed.

15. **The Committee recommends that additional staff be allocated to the development of the Fraud and Overservicing Detection System. Further development of FODS should aim at reducing the number of doctors falsely suspected as well as identifying major fraud and overservicing that currently goes undetected.**

Role of Funds

6.44 The Committee is very concerned at the limited co-operation that has existed between the health funds and the Department of Health in detection of fraud and overservicing. This has resulted largely from the reluctance of the Department of Health to provide funds with information on investigation of doctors or even to acknowledge information received from funds on possible cases of fraud or overservicing. While the funds are the source of much of the data used by FODS, individual funds are not in a position to examine a doctor's overall practice. There have even been instances where the Department has ordered funds to pay benefits that were being withheld because the doctor was suspected of large scale fraud or overservicing.

6.45 While private funds are required to supply to the Commonwealth certain information in respect of benefit claims, there is no requirement that the information obtained by the Commonwealth in respect of particular doctors should be reciprocally communicated to the private funds. Indeed, the Department has argued in the past that because of Section 130 of the Health Insurance Act, which concerns the confidentiality of the information on individual claims, the Commonwealth could not divulge this information. While the amendments to section 130 enacted by section 37 of the Health Legislation Amendment Act 1982 may alleviate this position where the Minister so certifies, it is still information which is limited by Section 130(2)(b) which prevents the name of a patient or contributor being disclosed to a fund unless the Minister certifies that he has reasonable grounds for suspecting that the person to whom the service was rendered was committed or is committing an offence of a specified kind.

6.46 It seems preferable for such information to be more readily available to private funds, provided that the other secrecy provisions of the Act are imposed upon the officers and employees of the fund. Such a step would keep the information confidential but may allow more effective detection of doctors and contributors perpetrating fraud.

16. **The Committee recommends that steps be taken to improve the level of communication and co-ordination between health funds and the Department of Health in relation to the provision of data and the transfer of information on possible cases of fraud and overservicing. In particular, the legislative**

impediments to providing claims information to health funds should be relaxed further to enable a free flow of information between funds and the Department, but on the basis that the other secrecy provisions of the legislation are imposed on the officers and employees of the funds.

6.47 The Committee also believes that funds should play a more active role in the investigation and prosecution of fraud, as discussed in chapter 8.

CHAPTER 7

INVESTIGATION OF FRAUD

7.1 It has already been pointed out that in June 1982, after this inquiry commenced, the central office of the Department of Health promulgated a set of procedures for dealing with breaches of the medical benefits legislation to Regional Directors in all States.[1] These procedures, developed in conjunction with the Australian Federal Police (AFP), delineate the various steps to be followed by Department of Health investigators in pursuing their investigations. They also indicate how medical counsellors should handle possible cases of fraud that become evident during counselling sessions.

'Honest Mistakes' by Doctors

7.2 Evidence before the Committee suggests that prior to the promulgation of these guidelines there was significant variation from State to State in the method of handling investigations and in the interpretation of what constituted a breach of the relevant legislation. One area of particular concern has been the tendency of some officers to close off cases where they believed doctors have committed 'honest mistakes'. The Department defines an honest mistake as one where an incorrect statement is made in connection with a claim for medical benefits but where there was no intent to defraud. It should be noted that it is not necessary to prove intent with respect to offences under section 129 of the Health Insurance Act, although section 129(3) of the Act provides a possible defence for doctors:

> In a prosecution of a person for an offence against this section it is a defence if the person proves that he did not know, and had no reason to suspect, that the statement, document, return or information to which the prosecution relates was false or misleading, as the case may be.

7.3 Prior to the promulgation of the guidelines in June 1982, it was usually left to individual counsellors in some States to decide whether a case was to be treated as suspected fraud or as an honest mistake. The recent guidelines state that no possible prosecution is to be abandoned in favour of recovery, nor are Department of Health officers to decide that a provider has made an honest mistake, unless specific advice to that effect is received from the Deputy Crown Solicitor's Office. The Department subsequently amended this to allow

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1 See appendix H.

counsellors discretion to discuss 'small, isolated cases of misitemisation' which are recognised during a counselling visit, but even these cases are required to be discussed with the state Director.[2]

7.4 There is strong evidence that the concept of an 'honest mistake' has not always been properly or uniformly applied by state offices of the Department. For example, in a number of the 41 Victorian cases examined by the Committee, a decision was taken not to proceed to prosecution because the doctor concerned appeared to have made an honest mistake, but subsequent examination by Australian Federal Police officers suggested that the cases should have been referred to the police.

Distinction Between Fraud and Overservicing

7.5 More generally, it is important that fraud is not treated as overservicing, for example as occurred in a number of the Victorian cases.

7.6 Under current arrangements, separate review sections within the state offices of Health examine the output of FODS and, depending on whether the pattern gives the appearance of fraud or overservicing, cases are allocated either to the investigation section or to the medical counsellors. The recommended comprehensive guidelines for state offices and improved training in utilising the output of FODS are both likely to reduce errors in allocating fraud cases to the investigation section and overservicing cases to Counsellors.

7.7 Evidence before the Committee strongly suggests, however, that it will always be difficult to distinguish fraud from overservicing on the basis of computer printouts. In many cases it is simply a matter of too many long consultations or other services appearing on a doctor's profile, with little indication of whether the services were not provided, whether they were provided unnecessarily, or whether they were in fact necessary, for example because the doctor has a high proportion of patients requiring more intensive treatment. Even where heavy overservicing is evident from the profile, it is possible that the doctor is also engaging in fraud. It is often only when patients or doctors are interviewed that it becomes clear whether fraud or overservicing, or both, has occurred.

7.8 Counsellors are now under written instructions not to discuss suspected fraud with doctors they counsel. However, the current system requires a judgement on whether a case of suspected abuse is likely to involve fraud before such a judgement is able to be made in many cases. The current guidelines on dealing with fraud cases attempt to avoid this problem by requiring all cases where there is any suspicion of

2 See appendix R.

fraud to be referred to the Director. The Committee believes that this procedure does not go far enough, given the difficulty of distinguishing fraud from overservicing before patients or doctors are interviewed.

17. *The Committee recommends that all cases where overservicing is suspected be referred for investigation. Where minor overservicing is suspected and detailed investigation does not seem warranted, cases can then be referred to a counsellor.*

7.9 Referring all overservicing cases to investigation sections also ensures that serious overservicing is investigated with the same rigour as cases of suspected fraud. As discussed in chapter 9, the Committee does not accept the proposition implicit in current policy that overservicing cases do not require active investigation before they are considered by a Committee of Inquiry or similar body. Clearly AFP officers attached to an investigation team would not play a major role in overservicing cases once it is establishe that no fraud is involved.

Effectiveness of Investigation

7.10 Table 5 reveals the poor performance of the Department of Health's Victorian and Western Australian offices relative to others, in terms of the number of suspected fraud cases referred to the Australian Federal Police.

TABLE 5: INVESTIGATION OF PROVIDER FRAUD BY STATE[3]

1 July 1975 - 31 March 1982

	N.S.W.	Vic	Qld	SA	WA	Tas	Aust
Cases Referred to Police	128	25	34	22	11	7	227
per 1,000 providers in the State*	17.5	5.6	15.2	12.7	7.9	15.3	12.9

* Based on number of providers receiving more than $4,000 in benefits in the June 1982 quarter. Numbers in each State are: 7299 (NSW), 4464 (Vic), 2240 (Qld), 1730 (SA), 1393 (WA), 458 (Tas).

3 Derived from: Department of Health Submission, op. cit., p. 106, table 5.

7.11 Between 1 July 1975 and 31 March 1982, only $221,117 was recovered throughout Australia from prosecution of medical fraud cases. Wide variation exists between the average amounts recovered per prosecution in each State, as outlined in table 6.

TABLE 6: AVERAGE AMOUNTS RECOVERED PER SUCCESSFUL PROSECUTION[4]

	$ per successful prosecutions*	No. of successful prosecutions**
South Australia	7731	9
Victoria	1833	30
New South Wales	945	92
Western Australia	775	11
Queensland	40	12
Tasmania	0	2

* Some of the averages may be influenced by the small number of successful prosecutions.
** Unlike the preceeding tables this table covers prosectuion of fraud by patients and hospitals as well as providers.

7.12 This and other evidence point to significant differences in the diligence of investigation staff in each State and significant variation in the types of cases investigated, as well as possible differences in attitudes of the courts. State offices have not always concentrated on the cases involving significant levels of fraud. In October 1982, following criticism of the small number of cases referred for prosecution, the Victorian office referred a case to the police where only $5 was involved, with nothing apparent on file or in the doctor's FODS profiles to suggest other fraud. The Committee finds this extraordinary in the light of the Victorian office's inaction on other cases where large sums of money were involved.

7.13 In giving evidence before the Committee, the Australian Federal Police admitted a very significant backlog of 110 cases in their Victorian office. The Acting Commissioner informed the Committee that he only became aware of the backlog a few days prior to appearing before the Committee.[5] He indicated that he would be taking action to redress the problem, and suggested that in a State like Victoria the maximum acceptable backlog is around 20 cases.

7.14 The AFP have since written to the Committee stating that this evidence was in error.[6] It is claimed that the

4 Derived from Department of Health Submission, op. cit., p. 106, table 5.
5 Minutes of Evidence, op. cit., p. 2714.
6 See appendix 5.

incorrect figure came from a Department of Health document which also included files not yet referred formally to the AFP. Subsequent figures supplied to the Committee show 23 cases outstanding with the AFP in Victoria.[7]

7.15 The Committee finds this confusion remarkable, and believes it reveals serious weaknesses in the management information systems within the AFP.

18. **The Committee recommends that the Australian Federal Police be responsible for maintaining case load statistics on medical fraud cases referred by the Department of Health, to ensure that the performance of their divisional offices is adequately monitored.**

7.16 Even if there are not 110 cases currently with the AFP in Victoria, the AFP point out that a large number of these files will be referred by the Health Department at a later date.

7.17 This problem of a backlog of cases is not a new one. One witness has given evidence that in 1979 about 150 medical fraud files on which little or no action had been taken were found in the Redfern office of the AFP. The files had been referred to the Commonwealth Police (prior to establishment of the AFP) by the Department of Health and some of the files allegedly dated back three to five years.[8]

Priority Allocated to Fraud Investigation

7.18 As mentioned in chapter 5, the investigation of fraud is a joint responsibility of the Department of Health and the Australian Federal Police (AFP), with the police exercising powers of arrest, seizure of documents and search which are not held by Department of Health officers. The small number of fraud investigations to date largely reflects the level of priority that has been accorded to medical fraud by both organisations.

7.19 From evidence available to the Committee, the investigation of fraud was accorded little priority by the Department of Health, particularly at the central office level, despite firm instructions from Ministers to pursue vigorously doctors suspected of fraud. In line with its policy of

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7 See appendix T.

8 The discovery of a large number of files has been confirmed with the AFP, although it was not possible to confirm the actual number involved. The Committee notes that if there were 150 such files, the data provided by the Department of Health on the number of cases referred to the AFP appears to be an underestimate. Similarly, the figure seems inconsistent with other evidence that in August 1979 there were 69 cases with the police in Sydney.

decentralisation, prime responsibility has been left to the state offices of the Department with little guidance or direction from central office. The absence of any increase in overall staffing or any proposals for additional staff in this area has been outlined already in chapter 5.

7.20 At the state level, there appears to have been little attempt to improve the capability of fraud investigation sections beyond what was inherited from the Health Insurance Commission in November 1978. Indeed the Committee has been told that, following the transfer of staff from the Commission, a number of experienced investigation staff left the Department and their experience does not appear to have been fully replaced.[9]

7.21 Similarly, the Committee could find little evidence of a structured approach to the allocation of priorities between individual cases within the state offices, and certainly no evidence of interchange of information between state offices on a regular and formalised basis. Decisions on the relative priorities to accord to fraud investigation in each state office seem to have been based largely on the subjective judgement of the Director or his staff.

7.22 Like the Department of Health, the Australian Federal Police efforts in pursuing medical fraud cases have been hampered in many respects by a shortage of adequate staff and increasing demands for their services. Since the creation of the AFP in October 1979 with the amalgamation of the Australian Capital Territory and Commonwealth Police Forces, there have been a series of significant developments affecting the availability of trained staff for investigation of medical fraud. These include an increasing involvement of the AFP in task forces with State police forces, investigative assistance to judicial inquiries and Royal Commissions, investigations of the importation of illicit drugs and major organised crime investigations. In their submission to the Committee, the AFP state:

> The fact is that only so many "high priorities" can be managed when there is clearly a finite source of skilled experienced personnel. Therefore, while Department of Health investigations are of importance, the availability of investigators is influenced by competing interests, some of which are of a most immediate or urgent nature.[10]

7.23 During 1979 and again in 1981 there was considerable correspondence between Ministers for Health and Administrative Services concerning the number of police investigators

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9 Minutes of Evidence, op. cit., pp. 849-354.

10 Australian Federal Police, (AFP), Submission to the Joint Parliamentary Committee of Public Accounts 1982, p. 2.

available for medical fraud cases. In August 1979, there were 69 outstanding cases affecting doctors, 59 of which had been with the Commonwealth Police for more than a year, eight for more than two years. In writing to the Minister for Administrative Services in that month, Mr Hunt pointed out that these cases would 'run into millions of dollars' and expressed concern at the backlog, especially in the Sydney office. Five extra police officers were made available to the Sydney office later in 1979, although it is not clear whether this removed the backlog.

7.24 The issue arose again in March 1981, when the Minister for Administrative Services, Mr Newman, wrote to the Commissioner of the Australian Federal Police stating that the priority given to Health and Social Security cases needed to be reassessed in the light of new priorities. Specifically, he stated:

> ... it seems to me that it is inappropriate for the AFP to continue a carry over deployment from the former Commonwealth Police of allocating investigative officers to meet requests from the Departments of Health and Social Security (cheque matters) in respect of relatively minor offences arising under their special legislation. This also applies to similar carry over deployment in respect of requests from other departments and agencies, including commercial agencies of the Government, in relation to relatively minor offences in their particular legislation. A different situation arises, of course, where major criminal conspiracies under the Crimes Act are involved. This re-assessment of priorities needs to be made in the light of the now much higher priorities to be met by the A.F.P. from the investigative resources made available to you by the Government.

7.25 In this context it should be noted that, even where doctors engage in large scale fraud, this usually comprises many individual offences each involving small sums of money. It should also be emphasised that Department of Health investigators lack powers of arrest and seizure of documents which can be necessary in fraud investigations.

7.26 A copy of Mr Newman's letter was sent to Mr MacKellar as Minister for Health, who subsequently, in replies in both May and November 1981, expressed his concern at the suggestion that the AFP reduce its involvement in medical fraud investigation, and proposed instead an augmentation of effort. In February 1982, Mr Newman was briefed on the magnitude of the problem by Health officers, after which the Secretary of Administrative Services wrote to his counterpart in Health:

> Neither the Minister nor I had any idea that the problem is of the magnitude that the briefing demonstrates. Mr Newman said to me that he is now firmly convinced that the

AFP must give you full support and he looks to some additional staffing proposals which are now before Government to enable the police to do just that.

7.27 Yet, despite this undertaking, little has been done. The AFP have advised that since February 1982 there has been no significant change in the number of police investigators allocated to medical fraud; in fact, in October 1982 the total number of police allocated to this area in Sydney and Melbourne actually decreased from 12 to 8. The AFP have stated that the number of qualified staff currently allocated to medical fraud investigation is inadequate.[11]

7.28 The AFP have a staff ceiling of 2657 (as at September 1982). Of these, 390 are committed to criminal investigation nationally. A total of 12 full-time and 4 part-time staff are allocated to medical fraud investigation, plus 4 on an ad hoc basis. The AFP has stressed that the numbers committed to the investigation of medical fraud vary, depending on changing priorities.

TABLE 7: DEPLOYMENT OF AFP INVESTIGATORS AS AT OCTOBER 1982[12]

Division	Total Investigators	Deployed to Medical Fraud
ACT	91	2 (ad hoc)
Eastern	98	5 (full time)
Southern	96	3 (full time)
Northern	48	2 (ad hoc)
Western	30	4 (part time)
Central	27	4 (full time)

7.29 The AFP informed the Committee that its current priorities for investigation are outlined in a letter from the Minister for Administrative Services to the Commissioner of the AFP in June 1981, which stated, inter alia:

> ... the Government would see the AFP giving less emphasis to some of the traditional policing efforts of the former police organisation which it replaced. For example, guarding of low priority Commonwealth Property and investigation into minor social security and health offences, as distinct from major frauds and conspiracies.[13]

11 Minutes of Evidence, op. cit., pp. 2709-2718.
12 Based on AFP Submission, op. cit., p. 3, amended on the basis of evidence taken in public hearing on 12 October 1982, Minutes of Evidence, op. cit., pp. 2686-2687.
13 Emphasis added.

7.30 Thus, more than 18 months after the problem of inadequate police resources was identified, there is still an insufficient number of investigators, and medical fraud does not receive high priority within the AFP.

7.31 *In a Press Statement of 28 October 1982 announcing* the appointment of the new Commissioner of the Australian Federal Police, the Minister for Administrative Services said that one of the immediate tasks of the new Commissioner would be to supervise the recruitment and training of an additional 350 police over the next three years, including 150 to be recruited in the first year. Additional clerical staff would also be provided to free trained detectives from routine administrative work.

7.32 The Department of Administrative Services and the Australian Federal Police have expressed confidence that these measures will enhance significantly the Australian Federal Police's capacities and expertise, and ensure its effectiveness in the investigation of medical fraud and other areas of criminal activity.[14]

7.33 The Committee notes, however, that these extra police are being recruited over a period of three years, and there is no indication of how many extra police will be allocated to medical fraud as a result. It will be some years before the new recruits are trained and have sufficient experience to effectively investigate suspected medical fraud. The question of training is discussed later in this chapter.

7.34 Staff available to the Department of Health to investigate medical fraud are indicated in table 8:

TABLE 8: DEPARTMENT OF HEALTH INVESTIGATION POSITIONS[15] JUNE 1982

State	Investigator Positions*
NSW	10
Vic	6
Qld	3
SA	3
WA	6
Tas	0.8
Total	28.8

* Not all positions are filled at any one time. In smaller state offices, occupants of positions may be redeployed on other work at times.

14 Letter from AFP to Committee, Committee File 1982/9.
15 Department of Health Submission, op. cit., p. 88, table 2.

7.35 As mentioned already, the Department of Health has recently created eleven new positions, six of which are in its claims review and investigation areas. These positions are currently being filled and are intended to form a central investigation task force to supplement the efforts of State-based investigation teams.[16] This concept was first proposed to the then Minister for Health in August 1981, but the Committee is concerned that more than 12 months later the concept has yet to be realised.

7.36 These extra positions will no doubt achieve improvements in the handling of both fraud and overservicing cases although, as we point out in chapter 5, the increase is long overdue. The Committee is concerned that in the short term the new positions will not greatly assist in removing the immediate backlog of cases or building on the deterrent value of recent publicity of the problem by bringing a number of serious offenders to court. It will take some time for the usual Public Service appointment procedures to be followed, and then weeks of training before new staff are reasonably effective. If existing staff within the area are promoted to the new positions, it will take even longer to obtain additional staff by filling the consequential vacancies. Even when the additional Health staff are on board, there is no guarantee that extra AFP officers will be available to work on the additional cases referred to the AFP as a result of the extra departmental investigation staff.

7.37 The Department should proceed with filling these positions as quickly as possible, but:

19. The Committee recommends, as a short term measure, immediate establishment of a national task force drawn from experienced investigation staff of the Department of Health and the Australian Federal Police, to tackle the backlog of fraud cases. This task force should be located within the Health Department, but with the police members formally reporting to the AFP. Additional funds should be made available for travel by the task force.

7.38 The cost of travel will be high relative to usual travel allocations, but is likely to be insignificant relative to both the amounts involved in the specific cases under investigation and the deterrent effect of such a crack-down.

20. The Committee recommends that, by the end of June 1983, the task force present a report directly to the Ministers of Health and Administrative Services and to the Public Accounts Committee on its activities.

7.39 The major aims of the task force will be to remove the backlog of medical fraud cases and to bring a number of

16 See operational procedures at appendix U.

serious offenders to court quickly in order to provide the maximum deterrent effect. The task force will also provide some training to local staff with whom it is working and illustrate to state offices what can be achieved.

Training

7.40 Central to the effective investigation of fraud is the selection and training of suitable numbers of investigators in the relevant authorities.

7.41 Various witnesses throughout this inquiry have cast doubt on the level of expertise of Department of Health investigators. They have been described as 'inexpert and slow', a judgement which is consistent with the small number of cases that have proceeded to the courts.[17] The Committee stresses, however, that this is not a criticism of individual investigators, but rather of a management that has allocated insufficient priority to the training and development of its investigators. It should be noted also that the AFP have stated that since the advent of the team approach to fraud investigations in NSW, the standard of investigation in that State has improved markedly.[18]

7.42 Indicative of the priority accorded by central office to this area is the level of instruction on the use of the FODS system given to Department of Health investigators. Given the extremely complex nature of the data produced by FODS and the many subleties involved in its interpretation, the Committee regards the priority accorded as inadequate. State Directors expressed the view that much more training is required.

7.43 The Committee has so far heard no evidence to suggest that any effort has been made by the Department to train its investigation officers in basic investigation skills, apart from ad hoc on the job training, although the Department has recruited a number of people with such skills. In this regard, the Committee notes that there are a number of courses run by various police forces which may be available to the Department. In any event, we believe that it would be possible for the Department to develop, in conjunction with the police, a specialised course of its own to address this need.

21. **The Committee recommends that the Department of Health introduce adequate training in relevant skills for its investigation staff. This training could be through existing police courses or through a special course developed in conjunction with the AFP.**

17 In-camera evidence, Committee File 1982/9.
18 In-camera evidence, Committee File 1982/9.

7.44 In contrast to the Department of Health, the Health Insurance Commission has stated that it would not consider appointing applicants to investigatory positions unless they have had at least seven years police experience, have attained the rank of senior constable and have attended a detective training.[19]

7.45 The officers deployed by the AFP to criminal investigation normally have completed a detective training course and a minimum of five years of police experience. Detective training is a multi-disciplinary program designed to train police officers in investigatory practice and develop the necessary investigatory skills. Police officers allocated to medical fraud investigation do not undertake any special instruction on fighting white collar crime, including medical fraud. In particular, as conceded by the Acting Commissioner, there has been insufficient instruction of AFP investigators in the use of FODS data.[20]

7.46 Further, and perhaps more importantly, under current arrangements a police investigator working on white collar crime must go elsewhere for promotion, thus representing a loss of expertise to this important area. Options to avoid this situation include establishment of a special unit to combat white collar crime, which would enable a more attractive career path as well as better supervision and co-ordination of this growing area of investigation. The Committee considers that, with improved organisational arrangements along these lines, the longer term effectiveness of the AFP in investigating medical fraud would be significantly enhanced. Consideration should also be given to greater lateral recruitment of police or others with prior experience in these areas. This issue and the general question of police training will be taken up further in the final report.

Relationship Between the Department of Health and AFP

7.47 Evidence has been received on the effectiveness of the current relationship between the AFP and the Department of Health at the state office level. The Committee has heard allegations in camera that in a number of instances departmental officers, some in senior positions, have obstructed the AFP or have not been as co-operative as they might have been. The Director-General of Health, in correspondence with the Deputy Commissioner of the AFP, has strongly implied that there have been tensions between the two offices in Victoria. It has also been claimed, however, that relationships between the two organisations have improved as a result of the 'team' approach to medical fraud investigations established on a pilot basis in the NSW region over the last 2

19 Minutes of Evidence, op. cit., pp. 836-837.
20 Minutes of Evidence, op. cit., p. 2716.

years. Under this approach the AFP are involved from the initiation of an investigation, regular planning meetings are held and joint interviews of patients are conducted. Once a case is officially referred to the AFP the Department acts as an assistant only. Unfortunately inadequate AFP resources for medical fraud investigations have not yet allowed this approach to be fully implemented in the other States.

7.48 The Attorney-General's Department has pointed out that difficulties arise from having investigations carried out by two separate organisations (AFP and Department of Health). It claims that this has led to considerable duplication of effort and the police have often presented to the Deputy Crown Solicitor's Office briefs for which they have only been partially responsible. This problem is being addressed with the introduction of the team approach, the details of which are spelt out in the June 1982 guidelines to state offices of the Department of Health.[21]

7.49 Whilst the Committee recognises that the guidelines provide a sound starting point, it is considered that a more global approach should be developed. The teams should include not only AFP and Department of Health personnel, but also personnel from the Deputy Crown Solicitor's Office and major health insurance funds on an 'as required' basis. The teams should co-operate to ensure that cases are ready for presentation in court.

7.50 The new guidelines imply that a team should be drawn together for each case. The Committee recognises the need for flexibility in allocating staff to individual cases, but considers that as far as practicable the Health and AFP personnel assigned to medical fraud investigations should be posted on a relatively permanent basis. This would allow for a high level of expertise to be developed which in the long term could result in more successful prosecutions.

7.51 The Committee has considered the option of establishing a permanent investigation unit within the Department of Health, complete with powers of arrest and seizure, in lieu of using AFP resources. While such an approach would in the long run ensure that resources are directed to medical fraud investigations, it would take some time to establish. The Committee does not in general favour the establishment of separate investigation units of this nature outside the AFP, which would only make it more difficult to redirect investigation resources in future.

7.52 The Committee therefore supports the establishment of investigation teams, albeit belated, and believes that the Department should move to establish them immediately in the State offices where they have not yet been formed. However, more is required.

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21 See appendix H.

22. The Committee recommends that integrated investigation sections be established in state offices of the Department of Health, comprising officers from the Department of Health and the Australian Federal Police, with investigation teams for particular fraud cases being drawn from these sections. The Committee also recommends that the teams be expanded to include legal staff from the relevant Deputy Crown Solicitor's office and investigation staff from health insurance funds where appropriate. As far as practicable, the AFP and Health personnel involved should be posted on a permanent basis.

Investigative Difficulties

7.53 Even if additional investigation staff are made available, difficulties would still arise in collecting evidence that can be used in a criminal court.

7.54 Delays in the investigation process cause significant problems in prosecuting medical fraud cases, especially where evidence is required from individual patients. In some cases, patients die or cannot be located before the matter can be fully investigated and in other cases already frail memories are severely taxed by the passage of time. A patient frequently visited by a doctor may not be able to remember and distinguish one visit from another. When the matter comes before a court, witnesses who have no distinct recollection of the occasion will probably prevaricate in such a way as would raise a reasonable doubt in the mind of the jury or court about whether the offence was committed. Other patients are reticent to provide evidence against their doctors.

7.55 The problems of delays are aggravated when cases are based on FODS data which is often well over six months old even before an investigation begins. The Committee has already suggested in the previous chapter how this information could be made more timely. But there will always be some delay and in many cases there is no need to rely entirely on cases identified by FODS when preparing a case for prosecution. Once FODS has raised suspicions that a doctor is committing fraud, the FODS profile could be used only to identify the pattern of the doctors fraud and perhaps patient names for subsequent investigation. This information could then be used to obtain more up to date claims information directly from health funds or from the Department's direct-billing records, which in many cases can give details within a week or so of claims being submitted. Services provided very recently will usually be fresh in the patient's mind, and a clear and coherent statement can be obtained.

23. **The Committee recommends that, once FODS data or other information suggests that a doctor is engaging in fraud, investigators should also seek the most recent claims on which to base prosecutions. This will involve up-to-date claims information from health funds or from the Department's direct-billing system.**

7.56 Fraud in the medical area often involves a series of distinct, separate offences, each usually involving less than $50, which may number in the hundreds or thousands. The standard practice of the AFP is not to proceed to prosecution unless evidence can be presented on 50-60 possible offences so that the court can be given an appreciation of the doctor's overall pattern of service. Under current arrangements, each offence must be investigated separately; each piece of relevant documentation must be retrieved and scrutinised; and each witness must be identified, located and interviewed. The AFP have suggested that it is possible for a single offence to take more than two man days of investigative effort. If each allegation is investigated thoroughly where thousands of offences are alleged, unreasonable man hours would be expended.

7.57 Possible future legislative changes to reduce the burden of having to prove each case separately are discussed in the next chapter. However, at this stage it is important to emphasise the significance of recent amendments to the Health Insurance Act for the investigation process. Under the new provisions, once a doctor is convicted of two offences that occurred after 1 November 1982, the doctor is automatically disqualified from receiving medical benefits for three years. It is thus unnecessary to prove 50-60 offences in order for this provision to come into effect.

7.58 It may be advisable to place charges with respect to more than two offences, in order to guard against unforeseen difficulties with individual witnesses and to rebut a defence of honest mistake or oversight, but this will involve significantly less effort than is currently necessary for medical fraud cases.

24. **The Committee recommends that AFP and Health Department written procedures be amended immediately in the light of the new section 19B of the Health Insurance Act, to emphasise that in many cases only a handful of offences need be brought before the courts to take advantage of this provision which allows automatic disqualification of a doctor for medical benefits purposes.**

25. In particular, the Committee recommends that the national task force concentrate on investigation of doctors who are already suspected of undertaking large scale fraud, and should focus on offences committed by these doctors after 1 November 1982, both to ensure that witnesses have fresh memories and to enable the new disqualification provision to be applied. This will also mean that priority is given to doctors who are continuing their fraudulent practices.

CHAPTER 8

PROSECUTION OF FRAUD

Delays in Reaching Court

8.1 Once investigation by the Australian Federal Police is complete, fraud cases are referred to the Deputy Crown Solicitor (DCS) in the respective States for prosecution.

8.2 The Committee has been told of considerable delays in bringing suspected fraud cases to court. For example, the Australian Federal Police have pointed out 'that it is not uncommon.... for delays of months or even years to occur between the time a brief of evidence leaves the hands of investigators and the time summonses are issued'.[1]

8.3 Although the Crown Solicitor claimed there are few cases of serious delay, he subsequently informed the Committee that there are currently 53 cases outstanding with DCS offices, covering 51 doctors and 2 hospital organisations. Only six of these cases have been referred to DCS offices since 1 September 1982. Table 9 summarises the status of the other cases.

TABLE 9: CASES CURRENTLY WITH DEPUTY CROWN SOLICITORS' OFFICES[2]
(referred prior to 1 September 1982)

charged, arrested or summons issued before case was refered to DCS	7
no summons issued	8
summons issued within 6 months of referral to DCS	11
summons issued more than 6 months after referral to DCS	21
Total	47

8.4 In 15 cases, 12 months or more elapsed before a summons was issued. The reasons given for not issuing a summons or taking a considerable time to do so included:

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1 AFP Submission op. cit., p. 12.
2 Letter to Committee from Attorney-General's Department, Crown Solicitor's Division, 17 November 1982. Committee File 1982/9.

- additional evidence required
- heavy workload
- awaiting counsel's advice.

In one case, it was stated that a prima facie case could not be established.

8.5 Although the Committee accepts that not all of the delays are the responsibility of the Crown Solicitor's Division, such delays are clearly unacceptable, especially in view of their effects on the likelihood of a successful prosecution. It is reasonable to presume that even greater delays would have occurred if the Department of Health and the AFP had referred a larger number of cases for prosecution.

8.6 The AFP have argued that the solution to these delays lies in streamlining the summons system, and propose that a system be instituted which enables the police to serve a summons contemporaneously with detention and interview, in lieu of arrest.[3] The Committee believes that delays arise principally because of insufficient resources allocated to medical fraud within DCS offices, and perhaps inappropriate procedures for issuing summonses.

8.7 Prompt action to bring offenders to court is crucial in this as in many other areas of criminal investigation. In most cases, the evidence of patients that a service was not provided is essential in proving an offence under S 129 of the Health Insurance Act. As discussed in the previous chapter, long delays before witnesses appear in court greatly increases the difficulty of obtaining reliable testimony. In some cases, patients die in the interim. In others, the passage of time combined with limited memories of old or chronically ill patients makes it easier for the defence.

8.8 The Committee has heard allegations that inordinate delays have occurred in some DCS offices[4]. These will be will be further examined before the Committee tables its final report.

8.9 It would clearly be of little value to improve the detection and investigation stages of the process, only to cause even longer delays in bringing cases to court through a shortage of staff resources at the prosecution stage.

8.10 The question arises as to whether additional resources should be made available in the form of further

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3 AFP Submission, op. cit., p. 13.
4 In-camera evidence, Committe File 1982/9.

permanent staff within the Deputy Crown Solicitors' Offices, or whether greater use should be made of private solicitors and barristers. Although private barristers are already used in many cases, appointment of a special prosecutor to handle *major medical fraud cases could assist in removing the backlog* of cases. The Committee believes that private solicitors should be used where necessary to prepare briefs.

8.11 It has also been claimed that the Commonwealth's failure 'to match silk with silk' has sometimes left it under-represented compared with the senior counsel retained by doctors before the courts on fraud charges.

26. The Committee recommends that additional legal staff be made available for prosecution of medical fraud cases. The Committee also recommends that consideration be given to appointment of a special prosecutor (being a leading senior counsel) to provide the maximum impact and to clear the backlog of cases. The special prosecutor should be supported by competent legal officers within the Crown Solicitor's Division or lawyers in private practice.

Priorities

8.12 The Department of Health, the Australian Federal Police and the Crown Solicitor's Division have all emphasised the limited staffing resources available for pursuit of suspected cases of medical fraud. These limitations mean that not all cases can be brought before the courts and, in any event, the courts already take an inordinate time to deal with the small number of cases that do go forward. The allocation of priorities between cases of suspected medical fraud therefore becomes an important decision.

8.13 In the past, the procedure has been for the Department of Health, the Australian Federal Police and the Crown Solicitor's Division to work relatively independently. Health would identify possible cases of fraud, carry out preliminary investigations and then pass matters over to the police. In turn, the police passed the cases on to the Deputy Crown Solicitor's Office once investigations were complete. With major investigations the police occasionally consult with DCS staff early in the process and cases are often sent back to the police by DCS offices for further investigation, but this has been done on an ad hoc case-by-case basis.

8.14 The danger with this sequential approach is that the priorities allocated at each stage do not necessarily take account of later stages in the process. For example, it is important that the cases selected by Health are not only those where large sums may be involved, but those where there is a reasonable chance of successful prosecution given the suitability of witnesses and so on.

8.15 This has already been recognised by Health and the Federal Police, who have begun working together in a team approach to investigations, as discussed in the preceding chapter. But there remains a need for a legal input at an early stage to ensure that cases selected are likely to stand up in court. For example, the Crown Solicitor's Division described one case where witnesses had to be interviewed again by DCS staff to check whether they were suitable.[5]

8.16 The Crown Solicitor has suggested that a solution to this problem would be to establish 'targeting committees' in each State, comprising Health, police and DCS officials, to examine the computer output and to select cases worthy of investigation and subsequent prosecution. The Committee is attracted to this idea and will be giving further consideration to the question.

27. **In the short term, the Committee recommends that legal officers in the Crown Solicitor's Division or private practice be included in the proposed national task force (see recommendation 19) to ensure that appropriate cases are selected for investigation and to allow the task force itself to proceed to prosecution where possible. These lawyers should work closely with the special prosecutor when appointed.**

Role of Health Funds

8.17 To date health funds have launched few prosecutions against doctors, although they have prosecuted a number of patients for fraud. The Committee recognises that individual funds currently do not have access to information on benefits paid by other funds or through bulk-billing, and therefore do not have a complete picture of the practice patterns of doctors. Recent amendments to the legislation should improve the flow of information to health funds, although as suggested in chapter 6 this is still limited. But even if funds do not have complete information on a doctor's practice, this does not prevent them taking legal action against the doctor under civil law.

8.18 The Committee believes that the health funds have a primary responsibility to protect the interests of their contributors, regardless of the effectiveness of the Commonwealth's own measures to pursue doctors under the Health Insurance Act. Some funds have established their own investigation units and monitor benefit payments to detect fraudulent practices, but the Committee is left with the impression that many funds assume this is solely a Commonwealth responsibility. We believe that health funds should have a duty of care with respect to benefit payments,

5 Minutes of Evidence, op. cit., p. 2828.

and should not simply rely on Commonwealth efforts in this regard.

28. **The Committee recommends that the legislation be amended to allow health funds and patients, as well as the Commonwealth, to recover payments made by them in respect of any account which is fraudulent or is false, misleading or inaccurate in a material particular. Funds should be encouraged to investigate and prosecute cases of fraud to reduce the number of fraudulent claims. Either individually or collectively all private health funds should establish investigation units.**

Legal Difficulties

8.19 Many of the problems that have arisen in prosecuting individual cases stem from aspects of the Health Insurance Act. These problems are well known to relevant officers of the Health and Attorney-General's Departments , and were set out in a discussion paper prepared by these two departments in October 1981.[6]

8.20 The problems described in the paper include:

- the possibility that the legal definition of a 'professional service' includes services rendered on behalf of a practitioner, notwithstanding the Health Department's view that benefits should only be paid where the practitioner actually sees the patient (this problem was drawn to the attention of the Health Department in August 1977);
- doubt about whether a 'professional attendance' requires the actual presence of the doctor and the patient in the same room (a Queensland court held that by 'turning his mind' to the patient's problems a doctor had conducted a professional attendance);
- use of the word 'consultation' in the Medical Benefits Schedule, which is not defined in the legislation;
- the difficulty of providing courts with an appreciation of the magnitude of the overall offence, given that under current legislation each individual instance of suspected fraud has to be proved, making it impracticable to prove a large number of minor offences; and
- the need to ensure that offending doctors do not continue with similar activities after they are prosecuted.

6 See appendix V.

8.21 In this discussion paper, the Department of Health and the Attorney-General's Department considered possible options for solving some of these difficulties, and put forward three recommendations. The first was for an urgent review of the Schedule, the legislation and relevant policy, which has not yet been undertaken. The second recommendation was that consideration be given to amendments to allow generalised evidence of the extent of the fraud to be presented to the court before sentencing. No such amendments have been put forward. The third recommendation concerned automatic disqualification for medical benefits purposes of a doctor convicted of fraud, and formed the basis of amendments to the Health Insurance Act passed earlier in 1982.

1982 Amendments

8.22 The amendments to the Health Insurance Act passed in the Autumn Sittings of 1982 introduced, inter alia, significant changes affecting the treatment of practitioners found by a court to have breached Sections 129, 129AA or 129AAA of the Health Insurance Act. Specifically, the amendments provided that a practitioner who has been found by a court to have committed medical benefits fraud on two or more charges will automatically be disqualified from payment of medical benefits for a period of three years. In relation to the initial finding by a court, the practitioner has the usual rights of appeal to a higher court. With respect to a doctor's first disqualification, an application can be made to the Minister for Health to:

- reduce the period of disqualification from three years to some shorter period; or
- permit the continued payments of medical benefits for certain specified types of services or in respect of services provided to specified persons in specified places, for example where it would cause hardship to patients.

Provision was also made for the review of the Minister's decision by the Administrative Appeals Tribunal.

8.23 It should be noted that these provisions relate to cases of medical benefits fraud proven by due legal process. They are limited to the financial aspects of transactions through the Medical Benefits Scheme, and stand apart from any penalties the courts impose in relation to the criminal aspects of such cases.

8.24 Also of significance to the Committee is the provision in the Act to ensure that a practitioner who provides a service to a patient is personally identified on any documentation used with the claiming of benefits. Consistent with the principle of personal accountability of

practitioners, the provisions provide that where a practitioner is an employee of an incorporated practice or some other type of employer, both he and the practice or other employer will be accountable in relation to the making of false statements or claims in respect of medical benefits.

8.25 Although the amending legislation was assented to in March 1982, the disqualification provisions did not come into effect until 1 November 1982. The Health Department has explained that this delay was required to draft regulations associated with the provisions and to develop administrative systems. However, we have been advised that the regulations simply prescribe the manner in which details of disqualifications are to be published. Given that it will take some months after the new provisions are proclaimed before any doctors are disqualified, the Committee does not believe the delay of over seven months in proclaiming the disqualification provisions was justified. There seems to be no reason why the method of publishing details of disqualification could not have been sorted out after proclamation.

8.26 The 1982 Amendments go some way to strengthening the fraud provisions of the Act. In particular, the provision for automatic disqualification for medical benefits purposes imposes a significantly greater penalty than was possible under the previous legislation. There are, however, a number of doubts about the likely effectiveness of the disqualification provision:

- The provision relies on prior conviction, and will not be effective where other defects in the legislation make it difficult to prosecute successfully. Other problems with the legislation have yet to be solved, and are discussed later in this chapter.

- It should be emphasised that the disqualification provision applies only for medical benefits purposes. Unless further action is taken by State Registration Boards, a disqualified doctor will still be able to practice medicine and nothing prevents him taking a salaried job, for example with a hospital. It may also be possible for the doctor to lease his practice or employ another doctor for the duration of the disqualification. Although the doctor may suffer a substantial reduction in income, the penalty falls a long way short of deregistration.

- The disqualification provisions do not require doctors to repay the large amounts that may have been obtained fraudulently. If a doctor is disqualified on the basis of a handful of offences, current legislation limits any reparation orders to those offences that are proven or which the doctor admits

to. Even if there is substantial statistical or other generalised evidence that a doctor has gained tens or hundreds of thousands of dollars from fraudulent practices, the doctor is able to keep most of the ill-gotten gain because of the current difficulty of proving a large number of offences in court.

- Proceeding with only a small number of charges against a doctor may allow evidence of a doctor's good character, together with the relatively small amounts involved, to persuade the jury that what occurred was not a systematic scheme of making false claims, but a small number of honest mistakes on the part of the doctor. If, to avoid this possibility, the Commonwealth has to continue to proceed on a large number of offences, much of the advantage of the new amendments will be lost.

- The effect of the disqualification provision may also be delayed through lengthy appeal procedures. As already mentioned, not only can a doctor convicted of fraud appeal to the Minister to limit the disqualification, but the doctor can also appeal to the Administrative Appeals Tribunal against the Minister's decision and can also appeal through the courts against the original convictions. While there are time limits imposed on appeals to the Minister, there are no time limits for the handling of appeals made to the courts, and it can take some time for all appeal rights to be exhausted. It should also be emphasised that doctors will probably be more inclined to appeal against future convictions for relatively minor fraud because of the automatic disqualification provisions. While appeals are being considered, a doctor can still practice and have access to medical benefits payments, and this could continue for a matter of years.

8.27 Concern has also been expressed that the provision would not be effective if the Minister chooses to reduce the disqualification in a significant proportion of cases. If this occurred the deterrent value of the provision would be greatly weakened. The Committee notes that the Minister's power applies only to a doctor's first disqualification. The circumstances in which the Minister is to exercise his discretion are not outlined in the legislation.

8.28 The Crown Solicitor has argued that consideration of further legislative changes to allow courts to take account of the magnitude of the overall offence of a doctor convicted of fraud should not be considered until the effectiveness of the recent amendments is tested in practice.[7] The Committee does

7 Minutes of Evidence op. cit., p. 3091.

not accept this approach. Given that the disqualification provisions only came into effect on 1 November 1982, a year is likely to pass before any doctors are disqualified, and even longer if there are appeals. A further period will be required to assess the effectiveness of the disqualifications, and then a further year or two would be needed before doctors were directly affected by any further amendments. Thus, if the Government subsequently finds that the recent amendments are not effective, it would be some years before further amendments were made and became fully effective.

8.29 Given doubts about the effectiveness of the recent amendments and the magnitude of the problem, the Committee believes that consideration should be given at an early date to additional legislative changes. Although we will be seeking further evidence in this area, it is possible to identify a number of options and proposals.

Some Possible Legislative Reforms

(i) De-registration as an Alternative Penalty

8.30 Doctors occupy positions of trust, and the manner in which medical services are funded relies heavily on their ethics, honesty and probity. If a doctor has been dishonest in submitting one claim, that dishonesty is very material to the reliance that can then be placed upon any information which the doctor gives for the purpose of making other claims. The question should be asked whether the medical profession should have standards of conduct more lax than other professional groups where public or clients' funds are concerned. For example, a solicitor who does not keep his trust account records properly is guilty of professional misconduct, even where not one cent of the money in his trust account has been misappropriated by him.

8.31 To date, State Governments have not legislated to provide for automatic de-registration of medical practitioners convicted of medical fraud. Once a doctor has been convicted of an offence which amounts to professional misconduct, the State regulatory body can take steps to prevent him from practising his profession or to suspend him from practice or restrict the manner in which he practises. But this does not necessarily happen. There are examples of doctors convicted of fraud not being brought before State registration boards; other cases where only short suspensions have been imposed; and others where a doctor has been struck off in one State or Territory, but has continued to practise in another. Table 10 reveals how State Registration Boards have reacted when doctors convicted of medical fraud have been referred. In another 13 cases over the same period Boards did not even consider the question of deregistration of the doctors concerned.

TABLE 10: DOCTORS REFERRED TO STATE MEDICAL REGISTRATION BOARDS AFTER AT LEAST 2 CONVICTIONS FOR FRAUD* (as at August 1982) [8]

State	Deregistered	Temporary Deregistration	Caution	No Action	Still Under Consideration
NSW	8	3	5	-	10
VIC	-	1	-	-	4
QLD	-	-	-	-	-
SA	1	3	-	-	-
WA	-	2	1	1	-
TAS	-	-	-	-	-
TOTAL	9	9	6	1	14

* Under Health Insurance Act 1973, which came into effect 1 July 1975.

8.32 This record does not give reason for confidence that continued division of responsibility between the Commonwealth and the States, and the apparently varying standards applied by the States, are in the interests of the profession or the Australian public. There is a need for a more uniform approach.

29. **The Committee recommends that State and Commonwealth Governments in consultation introduce uniform medical registration legislation to provide for national registration of medical practitioners. This legislation should require that, whenever a doctor is convicted of medical fraud or any other criminal offence related to the practice of medicine, the doctor is automatically deregistered nationally for a period and should not be re-registered until the relevant board is satisfied that the doctor is fit and proper to be re-registered. A repeated offender could be deregistered for life.**

(ii) Use of Generalised Evidence

8.33 Reference has already been made to the option of allowing generalised evidence to be admitted in cases of alleged medical fraud. The Committee does not believe that such evidence should be used in determining whether a doctor is guilty of fraud, although consideration could be given to admitting such evidence when the court is considering the appropriate sentence, after a doctor has been convicted on a number of offences proved in the usual way.

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8 *Letter to Committee from Department of Health of 10 August* 1982. Committee File 1982/9.

8.34 It has been put to the Committee that, given the failure of the current legal system to cope adequately with medical fraud involving a large number of relatively minor offences, the laws of evidence are out of date and may well require substantial revision before they are adequate to handle large scale white collar crime. The Committee notes that the Law Reform Commission currently has references on evidence and other aspects of the law that relate to white collar crime.

8.35 Examples of the type of generalised evidence that might be considered include:

- FODS profiles showing doctors' patterns of practice;
- evidence on representative samples of services provided by doctors in order to generalise to their overall practices;
- evidence of a particular pattern of fraud (eg frequent overcharging with respect to the length of consultations).

8.36 Statistical evidence of this type is likely to attract appeals and the courts would need to consider how such evidence should be taken into account.

8.37 There are a number of very significant difficulties with this approach. As presently compiled, it would be unsafe to allow FODS data to be used as evidence in criminal proceedings. The fact that a doctor charges for a particular service more often than the average of his peer group does not mean that he did not perform those services. To charge a person with an offence, conviction for which will mean his professional ruin, simply upon the 'law of averages' would be to allow prejudice to give way to fact. It may be that proving a random sample of offences could be taken as proof of a larger number, but this would be a major departure from standards of proof in criminal cases.

8.38 The Committee will be giving further consideration to this area and is seeking the views of the Law Reform Commission. We are also examining a recent report by the Senate Standing Committee on Constitutional and legal Affairs on the Burden of Proof in Criminal Proceedings, which has implications for this and other options.

(iii) Proof by Averment

8.39 A number of submissions to the Committee have suggested that the introduction of proof by averment would facilitate obtaining convictions against doctors alleged to have breached Section 129 of the Health Insurance Act. An averment is a statement on oath of a prosecutor that each of

the ingredients of a criminal offence has been made out, which has the effect in law of proving (in the absence of evidence from the accused) that the offence has occurred. A defendant can then give evidence which raises a reasonable doubt and thereafter the prosecution can call evidence to rebut the defence case. The prosecution must always, even in averment cases, prove the offence beyond reasonable doubt; a defendant does not need to prove his innocence.

8.40 Averment provisions are included in the quarantine and customs legislation, and therefore have the advantage that the concept is already established within the legal system, although usually confined to offences that attract pecuniary penalties, as distinct from criminal offences.[9]

8.41 While such a proposal has the attraction that a large number of charges may be brought without the prosecution needing to prove any, let alone all, of the facts necessary to sustain each charge, the burden which such a method of proof would throw upon the accused may well be intolerable. A person charged with perhaps hundreds of offences, would be required to meet every one of those charges. The defence would have to produce evidence for each charge which creates a reasonable doubt or proves that the doctor did not know and had no reason to suspect that the statements were false (under section 129(3) of the Health Insurance Act). The prosecution does not need to prove guilt, but only needs to allege it before the burden of making out a defence is shifted to the accused who must adduce evidence (on the assumption that the averment is good in law) to contradict the allegations made against him.

8.42 One of the reasons profferred in support of allowing proof by averment is that it would make it easier to obtain convictions when a large number of witnesses are involved or when the witnesses are old or frail. Yet it is for this reason that the task of the accused in meeting the allegation against him would be made far more difficult. For instance, the court could be told by the prosecution that the failure of the doctor to call each patient to testify that they had received the service from the doctor may be probative of the guilt of the accused.[10]

8.43 The Committee is not attracted to this option with respect to initial charges, although it may be that once a doctor is convicted of some minimum number of offences, averment-type provisions could apply to other alleged offences.

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9 Apart from Part IIA of the Crimes Act.

10 See, for example, May v. O'Sullivan (1955) 92 CLR 654 at 658.

(iv) Criminal Penalties

8.44 The Committee is firmly of the view that penalties for medical fraud need to be strengthened. Although the current legislation provides for a maximum penalty of $10,000 or imprisonment for 5 years, courts usually impose far lower penalties, even where a doctor is convicted of a number of offences. Consideration could be given to providing for mandatory penalties in this area. It should be emphasised that medical fraud is a criminal offence committed by individuals who occupy positions of trust in the community.

8.45 Another option would be to set out a number of stages in the Act, whereby conviction on a particular number of counts would attract an automatic level of penalty. Such a provision would be similar to that presently used in narcotics offences, where a person is deemed to be a dealer in narcotics if he is found in possession of more than a certain quantity of drugs. Once such a finding is made, the penalties are substantially greater. A conviction on, say, ten charges could attract a minimum gaol sentence or fine. The next step could be that a conviction upon, say, twenty charges, would attract an increased penalty, and so on.

8.46 The adoption of such a procedure could, to some extent, overcome the present difficulty of informing the court of the magnitude of the frauds which have been committed. Once, say, twenty convictions are recorded, the doctor may be deemed to be engaging in large scale fraud. It may then be possible to bring into play an averment-type provision in respect of all the other alleged offences which the doctor is charged with having committed. The use of such a combination would ensure that initially the doctor had a trial with the full benefit of the criminal law, but that once he had been shown to have committed a substantial number of offences, the onus might then be thrown upon him to show that he ought not be convicted of counts charged in averment-type provisions.

(v) Power to refuse payment of benefit

8.47 If the Commonwealth or health fund had legislative power to refuse payment in respect of a particular doctor unless and until that doctor could satisfy the Commonwealth or the fund that he had in fact performed the service, then much of the present difficulty might be avoided. Once a FODS profile suggests that a doctor is possibly abusing the system or committing fraud, he could be required to substantiate every claim for benefit which is made in respect of services performed by him.

8.48 Discretion to refuse payment and a requirement to provide satisfactory evidence of having performed the service has a number of advantages. If the doctor is engaged in fraudulent practices which are challenged, he may either

withdraw the claim or fabricate false evidence in support of it, the falsity of which could later be investigated and would be an ingredient in establishing fraud on his part in a criminal trial. Secondly, it would require doctors to maintain adequate records in order that they could establish that services had been performed. Thirdly, the provision casts the onus upon the doctors to satisfy the Commonwealth or the health fund that the service has been performed - in much the same way as the provisions of section 190(b) of the Income Tax Assessment Act 1936 place upon the taxpayer the burden of proving that an assessment made by the Commissioner of Taxation is excessive.

8.49 The potential cost of a fraudulent doctor's attempt to make out spurious claims may well become prohibitive. In this way fraud might well be able to be discouraged by an administrative means without involving any criminal prosecutions. If the doctor was dissatisfied with rejection of a claim, then he would be able to appeal, possibly to the Administrative Appeals Tribunal.

8.50 A major difficulty with this overall approach, however, would arise where patients have already paid the doctor and are seeking reimbursement from a health fund. Unless fundamental changes were made to the current health insurance system, it would be difficult to deny payment or to require additional justification in such cases. To limit the discretion to refuse payment to cases where the doctor has not yet been paid would simply encourage unscrupulous doctors to insist on patient payment, without creating any incentive for patients to scrutinise accounts where the amount will be subsequently refunded.

(vi) Contractual Arrangements

8.51 Another approach would be to permit medical practitioners to participate in the Medical Benefits Scheme and to have their fees subsidised both by Government and fund contributions only if they were registered medical practitioners for the purposes of the Health Insurance Act. Practitioners could apply for registration under the Act, which could be granted subject to conditions. These might include a condition that a registered practitioner could, if a FODS computer printout suggested irregularities in his servicing or billing practices, be required to give evidence on oath to verify or justify claims that were suspect, with failure to provide a satisfactory explanation being followed by suspension or cancellation of registration. At present it is the general entitlement of all medical practitioners to participate in the health insurance scheme that creates the necessity to employ the criminal law to protect the funds employed in the scheme. If eligibility depended upon registration as a participating practitioner, more effective administrative control may be able to be exercised without resort to the criminal law.

8.52 This could take the form of a contractual relationship between the Commonwealth and individual doctors, or between health funds and doctors. At present the emphasis in the health insurance arrangements is on the relationship between doctor and patient, not between the doctor and the fund providing benefits. As one medical organisation explained it to us, 'the only contract this Association recognises is the traditional informal one between doctor and patient ...'..[11]

8.53 There are already precedents in the arrangements the Commonwealth has made in the Veterans' Affairs and pathology areas. Such a contract could also include an agreement by the doctor that he has read and understood the medical benefits schedule, thereby making it harder for doctors to argue that they make 'honest mistakes'. One witness has estimated that the most common source of incorrect itemisation is ignorance of the Schedule, and has suggested that it be mandatory for doctors to make themselves aware of the Schedule.[12]

8.54 In legal terms, this approach would have the advantage that breach of contract is much easier to prove than fraud, and would emphasise that the medical benefits arrangements impose certain obligations on doctors to abide by the rules. But it is not clear that such an approach would be effective if applied to the whole population and if doctors need to make separate contracts with each health fund. In any event, it would amount to a fundamental change in health insurance arrangements and therefore would require careful consideration.

(vii) Restitution orders

8.55 Once a conviction is recorded against a doctor in respect of a false or misleading claim, the courts could be empowered by legislation to order repayment of money so obtained, together with interest at commercial rates. While such a provision would not be of great moment in cases where only small amounts are involved, it might be useful if large sums are involved. Such an order would avoid the necessity to resort to the civil courts for reparation. Once a person has been convicted beyond reasonable doubt of fraudulently obtaining a particular sum of money, it should not be necessary to undertake a new trial on a civil basis to recover the money. Such a power may well add to the deterrent effect of any amending legislation suggested herein.

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11 National Association of Medical Specialists, written answers to questions, Committee File 1982/9.

12 Eccles-Smith C., Submission to the Joint Parliamentary Committee of Public Accounts, 1982, p. 8.

(viii) Mode of trial

8.56 At present, prosecutions in respect of offences against Section 129 are made on indictment, unless both the prosecution and the defendant consent and the court thinks it proper to determine the charge summarily, in which case a lesser penalty applies, as provided for in section 129AC of the Act. The effect of making all such offences indictable is to require that a commital proceeding takes place first, at which all the prosecution evidence intended to be used in the trial is given and the magistrate determines whether a prima facie case has been made out. If the magistrate is satisfied that there is a prima facie case and that the accused should be committed, the matter usually proceeds to trial in a superior court. All trials on indictment must be tried by jury where the charge is brought under the law of the Commonwealth, under section 80 of the Constitution. It may be desirable, especially if the option of deeming provisions is taken up, that certain offences of a minor nature might be able to be dealt with summarily unless the prosecution feels it appropriate to proceed on indictment.

(ix) Doctors' records

8.57 A specific difficulty that often arises in prosecuting medical fraud is that doctors are not currently required to keep complete records of all services performed. It has been suggested that keeping complete records would create difficulties. For example, a general practitioner may find it difficult to keep complete or accurate records of the time spent with particular patients. During a consultation with one patient the doctor may receive a phone call from another, or a person urgently in need of treatment may be brought into the reception room at which point the doctor must leave one patient and attend to the other. However, it is important to emphasise that the system already relies heavily on honesty of doctors. Given the current Schedule which distinguishes length of consultation and other details of the services provided, doctors should already keep accurate records to ensure that they only charge for services actually provided. It is also worth noting that any shift in the onus of proof, such as by admitting generalised evidence or through averment provisions, would create a powerful incentive for doctors to keep complete records.

8.59 Because the system is so dependent upon doctors' honesty, a conviction in respect of a dishonest act strikes at the root of the relationship between the doctor, patient, health funds and the Commonwealth. One option could therefore be to impose stricter requirements for accurate records where a doctor has already been convicted of fraud. The Committee believes that, once the trust which the community has placed upon a doctor is shown to have been abused, then his right to rely further upon that trust in relation to submitting claims for benefit should be limited.

(x) Definition of Terms

8.60 Evidence before the Committee suggests that some confusion arises because of differences between the Schedule of fees produced by the Australian Medical Association and that issued by the Department of Health. In particular, the two schedules use different item numbers and different definitions of commonly used services, including after-hours consultations. While ignorance of the law has never been accepted as a defence, doctors could be genuinely confused because a major organisation such as the Australian Medical Association has produced a schedule which is in material respects different to the schedule upon which fees are paid by the Department of Health and the private funds.

30. The Committee recommends that the Department of Health and the Australian Medical Association co-operate in standardising their respective schedules of fees to ensure common descriptions and item numbers, although the Association should be free to advise its members on the level of fee for each item (not being the fee on which medical benefits are based).

8.61 As has also been demonstrated during the course of the Committee's inquiry, certain definitions in the Act and the Medical Benefits Schedule are inadequate. While the Schedule attempts to be an exhaustive list of services in respect of which claims can be made upon the Commonwealth or private funds, it is inevitable that there will be difficulties in the proper classification of particular services. For example, there is a real question as to whether 'an attendance' or a 'professional attendance' within the meaning of section 3(4) of the Act takes place when the doctor writes out a repeat prescription without actually seeing the patient. That section reads:

> 3(4) Unless the contrary intention appears, a reference in this Act to a professional attendance or to an attendance is a reference to an attendance by a medical practitioner on a patient, including an attendance at the medical practitioner's rooms or surgery.

Arguably, because the doctor is thinking of the patient he is attending on him for the purpose of writing out a prescription and therefore may be able to claim such an attendance as a short consultation.

8.62 There is no item in the Schedule other than a short consultation which can conceivably cover this situation. It cannot be denied that the doctor is entitled to charge some fee for writing out the prescription, but the question is whether it is proper to describe this service as a short

consultation for medical benefits purposes. Some doctors charge a nominal fee which does not attract medical benefits; it is possible that others charge patients for a short consultation in order that the patient can receive a refund. One option would be to provide a special item to cover writing prescriptions where the patient is not examined.

8.63 Doubts also surround the circumstances in which benefits are payable where a practitioner treats more than one patient simultaneously. The Department of Health attempts to deal with some of these anomolies in its 'Outline of the Medical Benefits Scheme', which does not have the force of law, being only the Department's interpretation of the law, which is at times contradicted by other opinion.

8.64 These and other anomolies in the Schedule and associated provisions of the Act need to be addressed.

8.65 There is a strong case for simplifying the Schedule overall to reduce the opportunity for 'honest mistakes' and to make it more comprehensible. For example, consideration should be given to reducing the number of items for consultations.

8.66 There has been a dramatic increase in the number of items in the Schedule over the last 10 years or so, despite the efforts of the Schedule Review Committee which comprises representatives of the Commonwealth and the AMA. A Working Party on the General Review of the Schedule was established in 1978 following a decision by the Government that there should be a comprehensive review of the Schedule, but in January 1981 this working party was absorbed into the Schedule Revision Committee and appears not to have achieved any significant reduction in the number of items. In fact there has been an increase over the period and there are now 2175 medical items on the Schedule. The Department has stated that changes to the Schedule designed to curb misuse and overservicing have tended to increase rather than decrease the number of items.[13]

8.67 The Schedule should be thoroughly revised. Yet it would be a mistake to attempt this incrementally, given the confusion that can result each time the Schedule is changed. The most recent example is the series of changes implemented in July 1982, which not only created problems for the detection of fraud and overservicing, but may have made it easier for doctors to argue that they did not knowingly make false statements. In particular the Crown Solicitor has advised the Department of Health that there may be circumstances where a doctor is able to establish a defence under section 129 (3) based on a claim that he did not receive a copy of the changes.[14]

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13 Department of Health Submission op. cit., p. 53.
14 Letter to Committee from the Department of Health, 16 November 1982, Committee file 1982/9.

8.68 The Committee will be seeking further evidence on possible changes to the Schedule and will be making recommendations in its final report on this inquiry.

Possible Changes in the Courts

8.69 The Committee has yet to consider changes that might be made in jurisdiction or in court procedures to facilitate prosecution of cases. Witnesses before the Committee have not emphasised delays in the courts themselves, perhaps because so few cases have reached that stage. There are, however, long delays in some areas, for example delays of two to three years in Sydney courts. If the number of medical fraud cases were significantly increased through improvements in detection, investigation and prosecution, there is no doubt that the burden on the courts would increase.

8.70 Part of the answer lies in reducing the effort required to prove medical fraud, as outlined in some of the legislative options already described, but there may also be a need for the courts themselves to adjust to the changing demands placed on them by all forms of white collar crime.

8.71 In this context the Committee notes that, often when consideration is being given to changes in legislation, little thought is given to how that legislation might affect the courts. Preparation of a 'court impact statement' with respect to proposed legislation could well provide some foresight of the substantial disruption and cost that can result from legislative changes.

8.72 At present, medical fraud cases have to wait their turn in the State court systems where priorities may differ. It is vital that medical fraud offences are not only detected and investigated quickly, but also brought before the courts with a minimum of delay. One option would be to create a special court or tribunal to handle medical fraud cases, or to expand the powers of the current Medical Services Review Tribunal to cover fraud cases as well as appeals in overservicing cases. A special court or tribunal could ensure that cases are handled expeditiously, but the establishment of special bodies of this kind can make the overall judicial system less flexible in meeting new demands. There may be greater justification for special courts for other areas of serious crime. Dealing with medical fraud in the general court system, with doctors appearing before the same court as other members of the community who are charged with criminal offences, helps to emphasise that medical fraud is a serious criminal offence.

8.73 Another option the Committee will be considering is extending the jurisdiction of the Federal Courts system to cover Health Insurance Act offences. Such a move would not necessarily preclude using State courts, especially in cases

best dealt with summarily, but would mean that serious cases of medical fraud could be given greater priority.

8.74 A third possibility, which does not appeal to the Committee, would be to provide special funding to the States to enable their court systems to expand to allow faster handling of medical fraud cases.

8.75 The Committee will be giving further consideration to this aspect of the prosecution of medical fraud cases.

CHAPTER 9

RESPONSE TO OVERSERVICING

9.1 The difficulties of detecting overservicing and of distinguishing between fraud and overservicing have been discussed in previous chapters of this report. The current arrangements for detecting overservicing were discussed in chapter 6.

9.2 There are currently two main steps in seeking to control overservicing. The first comprises counselling of medical practitioners; the second involves referral to Medical Services Committees of Inquiry (MSCIs). Operations of Optometrical Services Committees of Inquiry are similar to those of MSCIs and will not be discussed here.

Present Role of Counsellors

9.3 The Department of Health currently employs seven full-time medical counsellors, who are experienced medical practitioners, to educate doctors on the operation of the health insurance arrangements. This involves advising new medical graduates and doctors migrating to Australia on the operation of the Medical Benefits Scheme, including the Medical Benefits Schedule. Doctors already in practice also seek advice from the counsellors on these matters. In addition, the counsellors advise doctors on a number of other Health Department programs, including the Pharmaceutical Benefits Scheme.

9.4 In relation to overservicing the Director of Health in each State is required to refer doctors for counselling where their patterns of practice differ significantly from the average of doctors in the same specialty. These differences may relate to the average frequency of consultation per patient, the proportion of home visits, the frequency of diagnostic tests or some other specific deviation from the peer group, as indicated by the Fraud and Overservicing Detection System (FODS). As outlined in chapter 6, information is also obtained from the claims processing area of the Department, health funds, other doctors and patients.

9.5 The Department has identified three types of counselling:

9.10 Until mid 1981, on the basis of an agreement between the Department of Health and the AMA, no doctor could be referred to an MSCI without being counselled first. A revised agreement with the AMA provides that in cases of gross overservicing a doctor may be referred directly to an MSCI, although the Department has advised that so far only one doctor has been referred directly.[1] In some cases warnings have been given to doctors in writing.

Medical Services Committees of Inquiry

9.11 Sections 79 to 106 AA of the Health Insurance Act provide for the establishment and operation of MSCIs. One MSCI is established in each state, with the exception of New South Wales which has two. Each consists of five members, all medical practitioners, of whom four are appointed from nominations made by the AMA and one is a Commonwealth Government Medical Officer, usually the Director of the state office of the Department. The Chairman of an MSCI may engage a specialist medical consultant if appropriate, subject to the approval of the Minister.

9.12 Under current legislation, the Minister or his delegate (usually the Director of the state office) may refer cases of apparent overservicing to an MSCI. If the Committee considers that excessive services may have been rendered by the doctor, it conducts a hearing at which the doctor must attend.

9.13 The doctor may be represented by legal counsel, present evidence, call witnesses and address the MSCI. Hearings are held in private and are not bound by the usual rules of evidence. Though hearings are essentially informal, evidence is taken on oath or affirmation and, since 1981, there have been substantial penalties available if a doctor does not attend hearings or does not produce requested documents.

9.14 The Committees are required to consider each individual service under question. This usually involves examination of clinical notes and discussion with the doctor concerned. Under the current legislation, Committees are not permitted to examine patterns of practice or other forms of generalised evidence. Where an MSCI reports to the Minister that it considered excessive services were rendered or initiated, the report must identify the specific services concerned.

9.15 Following the hearings, the Committees may recommend one or more of the following to the Minister for Health:

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1 Advice from Department of Health, Committee File 1982/9.

(a) that the practitioner be reprimanded;

(b) that the practitioner be further counselled;

(c) that medical benefits be repaid to the Commonwealth and/or registered health insurance funds or, where benefits have not yet been paid, payment be withheld.

9.16 The Minister may then make a determination by adopting some or all of the Committee's recommendations.

9.17 Amendments to the Health Insurance Act passed in 1982 included a number of changes in relation to overservicing, two of which deserve mention here. Firstly, the Act now provides that practitioners employed by incorporated practices, or other types of employers, cannot take shelter behind alleged directions by their employers. Such employers are also subject to the operation of MSCIs. Secondly, to further discourage overservicing, the Minister is required to prepare a statement setting out particulars of each determination and lay this statement before each House of Parliament and, if he thinks fit, cause the statement to be published in the Commonwealth Gazette.

Appeals against Ministerial Determinations

9.18 A doctor may appeal against the determination of the Minister to either the Medical Services Review Tribunal (MSRT) or a prescribed court. The legislation provides that the Tribunal comprises a President, who is or has been the holder of judicial office, and two other members, both of whom must be medical practitioners - one nominated by the Minister after consultation with the AMA and the other an employee of a Government Department.

9.19 Both the appellant and the Minister may be legally represented at the hearings and may address the Tribunal. Hearings are conducted in private and with as little formality as considered appropriate. The Tribunal may affirm, set aside or vary the determination and the Tribunal's decision is deemed to be a determination of the Minister.

9.20 The Commonwealth meets the costs of the appellant before the Tribunal or prescribed court, unless the Tribunal or court is of the opinion that the costs were unnecessarily incurred.

9.21 An appeal may also be made on matters of law to the Federal Court of Australia by either party to proceedings before a Tribunal or prescribed court.

Problems with Existing Counselling Arrangements

9.22 As emphasised in chapter 5, the 7 medical counsellors have faced an impossible task in advising about 17,000 doctors in full-time private practice throughout Australia. Bearing in mind that counsellors have to:

- examine FODS material before a counselling visit;
- visit some doctors on a number of occasions to discuss a large number of individual cases and to issue a warning to the doctor;
- travel to country areas;
- routinely counsel new graduates and immigrant doctors; and
- advise doctors on other Department of Health programs;

it is unlikely that a counsellor could adequately counsel more than eight doctors each week. It could take a decade for the current staff to counsel every doctor in Australia. It should have been quite obvious that seven counsellors were inadequate, especially once the Department had estimated in early 1981 that fraud and overservicing was costing at least $100m per annum. Since this inquiry began, the Department has taken steps to recruit five additional counsellors.[2] We doubt that even this will be sufficient. Some counsellors have told the Committee that much of their work is done by telephone because they do not have time or travel funds to visit doctors personally.

9.23 The task facing medical counsellors has been made harder because of inadequate training in using FODS material, little clerical support, and at times difficult relationships between the counsellors and the review and investigation staff.[3] This has been exacerbated by the fact that there is no formal organisational link between the counsellor and the review staff; the counsellors report directly to state Directors, while the review staff are employed within the Health Benefits and Services Branch.

9.24 The Committee has noted considerable differences between counsellors' interpretations of their role, as illustrated by quoting two examples. One counsellor described his role as follows:

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2 Two of these positions will be staffed on a part-time basis for 20 hours per week.

3 Eccles-Smith C., Submission, op. cit., pp. 36-40.

> *Armed with the statistical evidence of possible* overservicing .... the Medical Counsellor meets with the doctor.... It is my policy to take patient histories (with the name of the patient(s) identified) so that I can engage in a clinical discussion regarding the necessity of the services which have been rendered to the patient(s).
>
> A successful counselling is regarded as one where the doctor agrees to lower his service rate, but at the same time the counsellor should make the doctor feel that he is making the decision himself. The counsellor cannot direct the doctor how to run his practice, but he must warn him that adherence to Section 79 of the Act will be necessary *to prevent him being referred to a MSCI. Often this* warning of referral is sufficient.... However, there are some practitioners who resent their clinical practice being called into question and they make their feelings quite clear to the counsellor. In my last 3-1/2 years with this Department it has been my misfortune to counsel a large number of 'difficult' doctors, who certainly did not make me welcome...[4]

9.25 By contrast, the following comments by another counsellor revealed a quite different approach:

> ....occasionally when I mention to doctors that they may be called before a Committee of Inquiry, I also go through the rigmarole of informing them that eventually it may get to the Minister and the Minister may, without prejudice to *the Department, ask for a restitution of funds.*

When the Committee commented to him that such a warning did not amount to much pressure on the doctor, the counsellor added:

> We are public relations men; we cannot get involved in squabbles with doctors.[5]

9.26 Part of the explanation for these diverging approaches to counselling is the failure of the central office of the Department to provide adequate guidelines on the role of counsellors. The Committee believes this has been a *serious failing in the Department's procedures for dealing* with fraud and overservicing, and in chapter 5 we recommended that adequate guidelines be issued as a matter of urgency.

9.27 The Director-General acknowledged that there has been a lack of understanding of the role of medical counsellors in

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4 Eccles-Smith C., Submission op. cit., p. 45.
5 Minutes of Evidence, op. cit., p. 940 (emphasis added).

the Victorian office, but hopes that this has been remedied.[6] It should be emphasised that the statements above were made in *mid-1982 and we believe reflect the current situation not just* in Victoria.

9.28 However, inadequate guidance from the central office is only part of the explanation. *There is often an inherent* tension within the role of counsellor.

9.29 One aspect of this tension is the difficulty in handling evidence of possible fraud which arises in counselling sessions. The Department emphasises that the counsellors role is 'to counsel, to advise, to discuss, to clarify and interpret the Medical Benefits Scheme ... in no circumstance is it the counsellor's role to investigate or to handle anything connected with a possible breach of the law'.[7] By contrast, the Deputy Crown Solicitor's Office in one state advised that, if counsellors became aware of possible fraud, they should collect evidence relating to the suspected breach.[8] Counsellors appearing before the Committee were divided on how to handle evidence of fraud that arises in the course of an interview, although there seems to have been greater uniformity of approach since the Department issued its guidelines on the handling of possible fraud cases on 9 June 1982.

9.30 It is at times very difficult to combine the role of educator and adviser to doctors with the role of investigator into suspected overservicing. This is not to say that some individual counsellors cannot cope with both the educating/ advising role and the investigating/warning role, but it is not surprising that some counsellors find it difficult to perform both roles effectively. The Department has stated that counsellors play a very valuable preventive role in educating doctors about the medical benefits system. It is equally *important, however, for overservicing cases to be actively* investigated. For example, before a case can be referred to a *Committee of Inquiry for examination, there is a need to* interview the doctor concerned to see whether there are *legitimate explanations of the apparent overservicing, and to* identify particular instances of overservicing that should be *referred to the Committee. Counsellors are also asked to warn* doctors that they will be referred to an MSCI if their *practice patterns do not improve.*

9.31 *The Director-General has told the Committee that his* attention was drawn to one of the medical counsellors who 'was becoming a policeman'.[9] *The Committee agrees that an*

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6 Letter from Director-General of Health to Deputy Police Commissioner, 22 June 1982, Committee File 1982/9.
7 Department of Health Submission, op. cit., p. 76.
8 In-camera evidence, Committee File 1982/9.
9 Minutes of Evidence, op. cit., p. 2995.

investigative approach to counselling would make it difficult to perform the educating/advising role. Yet there is no doubt that some 'policing' is required where doctors are suspected of large scale overservicing.

31. The Committee therefore recommends that a new role of medical investigator be established to interview doctors with respect to apparent cases of serious overservicing and to assist in fraud cases as required. The medical investigators should be qualified medical practitioners. The duty statements for the positions should emphasise the quite different qualities that are desirable in an investigator, compared to a counsellor whose major activity is to educate and advise. Where a medical investigator has not had prior investigation experience, formal training in investigation techniques should be provided.

9.32 Consideration will need to be given by the Department and the Public Service Board to the number of such positions required, but it may be possible to redesignate some of the existing 12 counsellor positions, and the occupants of those positions.

32. The Committee recommends that the new positions of medical investigator be located in the recommended integrated investigation units, which would examine serious cases of overservicing (as well as fraud) without prior counselling and refer relevant cases directly to the Medical Benefits Tribunals recommended in the next section.

9.33 With medical investigators concentrating on major cases of overservicing, the medical counsellors should be in a much better position to concentrate on educating doctors about the medical benefits arrangements and responding to inquiries. In particular, the counsellors should ensure that doctors understand the sections of the Schedule that are relevant to their practices, and also understand the instructions that accompany the Schedule.

33. The Committee recommends that the role of medical counsellors should be limited to educating and advising doctors on the Medical Benefits Scheme and other aspects of Department of Health programs, and following up cases of overservicing that do not warrant detailed investigation. The counsellors should not be involved in recovery of money from doctors suspected of overservicing. Any suggestion of fraud or major overservicing that arises in the course of counselling should be referred to the investigation section. The Committee also recommends that where counsellors interview doctors suspected of

minor overservicing, the doctors' practice patterns be reviewed after six months with a view to investigation if the situation has not improved.

34. The Committee recommends that all doctors engaged in any form of private practice be visited by medical counsellors at least once every three years to update their knowledge of the medical benefits arrangements, in particular any changes to the Schedule, and to offer any advice the doctor requires on these matters.

35. The Committee also recommends that the Commonwealth strongly urge the States to introduce a requirement that all doctors either receive counselling or attend an appropriate course (as recommended later in this chapter) before registration.

9.34 Where there are only one or two counsellors in each State, it is impossible to cover adequately all the specialty groups in the medical profession. While all counsellors are trained medical practitioners and most have experience in private practice, they cannot be expected to be expert in all areas of medicine. Questioning whether particular services are necessary can require very detailed knowledge of a particular specialty, for example surgery or psychiatry, especially where a doctor is using new techniques.

36. The Committee recommends that specialist counsellors be appointed on a part-time basis, in consultation with the appropriate colleges, to provide counselling to members of their specialty where full-time counsellors are not equipped to do so, and to provide any necessary advice to medical investigators.

9.35 The Committee expects that the specialist colleges will respond positively to the Committee's recommendation, in view of the links between quality of care and doctors' remuneration.

Peer Review

9.36 There is wide agreement that the current MSCI arrangements are ineffective in dealing with the large number of doctors who appear to be overservicing. Criticism of the current arrangements has come from the AMA, state Directors of the Department, its central office and medical counsellors.[10] The fact that only 31 cases have been completed in around five years of operation of the MSCIs demonstrates the inadequacies of the existing system.[11]

10 In-camera evidence, Committee File 1982/9.
11 This figure of 31 cases refers to the period up until end March 1982.

9.37 Some of the reasons put forward are:

- The process of counselling, follow-up counselling and then referral to MSCIs is very slow.
- As currently constituted, MSCIs are not well equipped to handle cases involving specialists.
- The legislative requirement that each and every service considered to be excessive has to be identified and examined places an intolerable workload on Committees. One of the results is that hearings stretch over long periods of time and members have difficulty in remembering all of the evidence. One witness has estimated that, under current arrangements, an MSCI can deal effectively with a maximum of six doctors per annum, and that each case takes on average 12 months to complete![12]
- Questions have been raised as to the appropriateness of having state Directors of Health as MSCI members, as it is their organisations that initiate referrals to the Committees. In particular, it has been suggested that the Director's prior involvement in referring a case to an MSCI may give rise to allegations of 'technical legal bias'.[13]
- The Committee has heard allegations that at least one MSCI has been biased in favour of doctors appearing before it.[14]

9.38 Existing MSCI arrangements have thus been unable to handle the extent and complexity of overservicing. As mentioned in chapter 5, some of these problems were recognised as long ago as December 1979, when the Department put forward proposals for:

(a) MSCIs to examine doctors' patterns of servicing, rather than individual services;

(b) more flexible membership of MSCIs; and

(c) further consideration of the proposal to allow MSCIs to recommend that all or part of a practitioner's medical services be ineligible to attract benefits for a set period.

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12 Eccles-Smith C., Submission, op. cit., p. 46.
13 Circular to Department of Health state offices from central office, 13 August 1982, Committee File 1982/9.
14 In-camera evidence, Committee File 1982/9.

9.39 While we will be giving further consideration to measures to reduce overservicing, the scale of the problem warrants urgent action in these areas. If amendments are not introduced in the 1983 Autumn Sittings, it will be over 12 months before the changes can be fully implemented.

37. The Committee recommends that the current Medical Services Committees of Inquiry be abolished and Medical Benefits Tribunals be established in each State to examine cases of suspected overservicing. Medical investigators should consider whether there is a prima facie case for recovery of money, in which case the matter would be referred to a Tribunal; if the overservicing is considered to be minor and recovery is not appropriate, the medical investigator should refer the matter to the counsellors (see recommendation 33).

9.40 In the Committee's view it is essential that the Tribunals be empowered to examine medical claims from a representative sample of a doctor's practice. Without this power, the Tribunals would be required to examine each individual service that is thought to be excessive and it would take a very large number of Tribunals to consider all doctors suspected of overservicing.

9.41 This need not be seen as a general precedent for using generalised evidence in other areas of the law. It should be emphasised that the Tribunals would not be considering criminal charges, nor imposing criminal penalties. The use of samples would be confined to calculation of the extent of overservicing for the purpose of determining the amount to be repaid. The Attorney-General's Department has expressed the view that, although it would be contrary to fundamental legal principles to provide for criminal offences to be established on the basis of sampling techniques, these considerations do not necessarily apply with the same weight where the proceedings are of a civil kind and where the question for determination is the amount of money to be repaid.[15]

38. The Committee recommends that the proposed Medical Benefits Tribunals be empowered to examine representative samples of services rendered by a doctor and to generalise from such samples in determining the amount of benefit to be repaid. The samples for a particular doctor could be drawn from claims for a particular type of service, claims with respect to particular patients or from the doctor's overall practice. Advice should be sought from the Australian Bureau of Statistics on the methods to be used in selection of samples.

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15 Attorney-General's Department, Submission to the Joint Parliamentary Committee of Public Accounts, 1982, p. 8.

9.42 *This would be consistent with the approach taken in* Canada, which has the support of the Canadian Medical Association.16

9.43 Particular care needs to be given to the methods of selecting samples, to ensure that the samples are representative of the services that are in question. The doctor would of course be allowed to challenge the selection of the sample if he so wishes. The Committee believes that where decisions are being made that can have a significant impact on a doctor's income and reputation, it is essential that procedures are consistent with principles of natural justice.

9.44 As mentioned already, problems have arisen regarding the membership of MSCIs. Having the head of the Department of *Health's state office as a member of the body examining* overservicing cases can raise questions of natural justice given the state office's involvement in the investigation of doctors suspected of overservicing. A number of witnesses have also pointed out that current MSCIs do not have sufficient specialist expertise to consider adequately suspected overservicing by specialists.

9.45 The Committee believes the current MSCIs are too closely associated with the AMA. The membership of that organisation comprises only 64% of the medical profession and many of its members also belong to other medical bodies.17 The AMA, the colleges and other organisations could be invited to put forward nominations for the Tribunals, but members should be appointed by the Minister for Health, who should not be restricted to the nominations put forward by such *organisations. Doctors from State Health Authorities or* academic institutions could also be considered for appointment.

39. The Committee recommends that membership of the Tribunals:

    (a) include specialist expertise where medical specialists are being examined;

    (b) exclude Directors of Health; and

    (c) be appointed by the Minister for Health who should not be restricted to nominations invited from medical colleges and associations.

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16 Report by an officer of the Department of Health, following a recent visit to Canada.

17 AMA Submission, op. cit., p. 7.

9.46 The current legislation provides that MSCIs can only make recommendations to repay benefits, to reprimand the doctor or to carry out additional counselling. However, other points can arise in the course of hearings. For example, it may become evident that a doctor has rendered poor quality care, or care that may have been harmful to patients. Similarly, a particular case may reveal general problems with the Medical Benefits Schedule.

40. The Committee recommends that, arising out of a particular case, Tribunals also be able to recommend that:

(a) the evidence on a particular case be referred to the appropriate Medical Registration Board;

(b) appropriate authorities consider specific changes to the Medical Benefits Schedule or other aspects of the Medical Benefits Scheme; and

(c) medical colleges or other elements of the medical profession consider aspects of the quality or form of medical practice.

9.47 With respect to other aspects of the membership and operation of the Tribunals, two broad options have been identified.

9.48 One option would be for the Tribunals to be comprised entirely of doctors, which would emphasise that doctors' practices are being reviewed by their peers. As with current MSCIs, hearings could be held in private on the basis of the doctor's clinical notes and his own evidence, and the Tribunal would then make recommendations to the Minister for Health.

9.49 A major advantage of this approach would be that more informal procedures would allow Tribunals to proceed more quickly than may be possible with a more legalistic approach. The Committee has been told that, by considering generalised evidence, the peer review committee in Saskatchewan, Canada, deals with 12-15 doctors suspected of overservicing in each session lasting one or two days.18

9.50 A second option would be to make the mechanism for dealing with overservicing much more akin to a court. For example, each tribunal could be chaired by someone with a legal background, together with two or three private doctors and a Departmental Medical Officer. The chairperson could be appointed on a full-time basis, with the medical members drawn on a part-time basis for the purposes of a particular inquiry from a pool of doctors who are in private practice. Such a

18 Report by an officer of the Department of Health, following a recent trip to Canada.

Tribunal could take evidence in public hearings, with the names of individual patients suppressed, and then determine the amount (if any) to be repaid by the doctor.

9.51 This second approach would emphasise the serious nature of overservicing, which has been described by one former Minister as 'verging on crime'.[19] The Committee believes that, where doctors are providing unnecessary services on a large scale, firm measures are required.

9.52 The first approach outlined above would be more suitable for less serious cases of overservicing, especially where the doctor admits that the services provided were excessive and does not wish to be legally represented. On the other hand, cases of malignant overservicing, where many tens of thousands of dollars may be involved, demand a more rigorous approach, one which ensures that the doctor has adequate opportunity to defend himself against the allegations and also emphasises to the profession the seriousness of such overservicing.

9.53 The Committee has not fully considered all the details of membership and operation of the Tribunals, but favours establishing 'two lanes' whereby proceedings can vary (eg whether hearings are public or private) according to the nature of the suspected overservicing and the extent to which the doctor acknowledges it.

41. The Committee recommends that the Tribunals adopt streamlined and informal procedures in cases where the doctor acknowledges that excessive services were provided and does not contest the matter before the Tribunal, especially where the overservicing was on a small scale.

9.54 The Committee believes that in cases of proven gross overservicing, or in cases where doctors continue to overservice after coming before a Tribunal, a stronger penalty is required. At present the worst that can happen to a doctor is that all monies he has been paid for overservicing can be recovered by the Government or the funds. This leaves the doctor with the patient contribution to cover costs. If Tribunals are conservative in their estimates of overservicing, as they may well be, then such a doctor could still benefit from overservicing even if required to repay some of the benefits received.

42. The Committee recommends that doctors who are found to have provided excessive services totalling in any one year more than an amount prescribed in legislation, or who are found on two separate occasions to have provided excessive services totalling less than the prescribed amount, be

19 Minutes of Evidence, op. cit., p. 3284).

automatically disqualified for medical benefits purposes, in the same way that current legislation provides for automatic disqualification of doctors convicted of fraud.

9.55 The above recommendations suggest a substantial strengthening of the review arrangements with respect to overservicing. There is, however, a major role for the medical profession in dealing with the problem of overservicing. Apart from nominating part-time members of Tribunals and part-time counsellors, as already recommended, it remains the responsibility of the profession to do all it can to reduce the extent of overservicing. For example, there is an urgent need for improved peer review mechanisms to monitor servicing patterns within hospitals. The Government already funds the Peer Review Resource Centre operated jointly by the AMA and the Australian Council of Hospital Standards to help develop peer review activities, especially in hospitals. The Committee will be giving further consideration to this and other areas where the profession has a direct role to play.

Appeal Provisions

9.56 The Attorney-General's Department indicated that some thought has been given to using the Administrative Appeals Tribunal (AAT) as the avenue of appeal against Ministerial determinations, rather than the current Medical Services Review Tribunal (MSRT). It has been pointed out that, wherever practicable, review jurisdiction is now conferred on the AAT in preference to creating specialist review bodies.[20] The AAT already has jurisdiction in a number of areas involving medical issues, and medical practitioners may be appointed to the AAT to sit on cases involving medical issues.

43. The Committee recommends that consideration be given to replacing the Medical Services Review Tribunal with appeals to the Administrative Appeals Tribunal, with any necessary modification of the latters' powers and procedures.

9.57 Sections 120 and 123A of the current Health Insurance Act require the Commonwealth to bear the costs of an appeal by a practitioner to the MSRT or to a court, unless the Tribunal or court is of the opinion that the costs were incurred unnecessarily. This is a major departure from the usual approach to costs. In most other appeal tribunals, including the AAT, the appellant bears his own costs. In view of the high average income of doctors, there seems little justification for according them preferential treatment.

44. The Committee recommends that the Commonwealth no longer automatically meet the costs of doctors who appeal against overservicing decisions, but require

20 Attorney-General's Department Submission op. cit., p. 11-12.

such doctors to meet their own costs, unless the relevant tribunal or court decides otherwise.

Medical Education

9.58 The Committee was surprised to learn that no formal ethical training is provided in medical schools, and believes that university medical schools should provide such instruction. Much of the need for counselling could be reduced if medical schools provided training in the operation of the health insurance system. It should be emphasised to undergraduates that, like most other professional and business groups, doctors have a responsibility to understand the law as it affects their work.

45. It is recommended that the final year of medical training include compulsory courses on ethics, health economics, the law associated with medical practice, and the health insurance arrangements, with special reference to the Medical Benefits Schedule.

9.59 The Committee will be giving further consideration to this area in its final report.

Supply of Doctors

9.60 In chapter 4, we emphasised that the number of medical practitioners appears to be a significant factor determining the aggregate use of medical services. In particular, it has been argued that the ability of doctors to generate health services, unlike other areas of the economy where suppliers have less influence on the level of demand, results in increasing use of medical services as the number of doctors increases.

9.61 The Committee will be giving close consideration to this question for its final report, in particular to the option of reducing the number of places in medical schools.

Changes to the Medical Benefits System

9.62 It is recognised that having more counsellors and strengthening review mechanisms does not tackle the problem of overservicing at its source. There have been a number of submissions which have raised fundamental issues as to the causes and cures of overservicing.

9.63 In particular, recommendations have been made to the Committee concerning the Medical Benefits Scheme itself. Further consideration is being given to specific options, which include:

- requiring appropriate clinical review procedures as a condition of funding for private hospitals;

- *greater use of paramedical or welfare personnel* to provide non-medical care to chronically ill patients;

- establishment of diagnostic centres with salaried or contract staff; and

- limiting annual medical benefits expenditure and leaving the medical profession to allocate available funds.

9.64 One area that warrants close attention is the Medical Benefits Schedule. As one witness described the current arrangements:[21]

> The financial logic apparent in the refund Schedule itself does not represent a proper evaluation or hierarchy of desirable technical skills and encourages the very interventionist style of medical care practised in Australia.
>
> The Medical Benefits Schedule is absurdly complex and this encourages some very questionable billing practices, at the same time this complexity is also an important factor making surveillance of utilization very difficult. The complexity increases each year as more items are added, under pressure from specialist or sub-specialist groups, to incorporate their own particular interest or new technology. It is useful to demonstrate this process by example. The changes between 1958 and 1978 in the Benefit Refund Schedule are set out below.

TABLE 11: CHANGES BETWEEN 1958 AND 1978 IN THE COMMONWEALTH MEDICAL BENEFIT REFUND SCHEDULE

Service Type of Item	Number of Items Concerned With Service Type	
	1958	1978
Attendance by doctor	4	47
Obstetric service	13	30
Other surgical procedures	700	1,300
Radiology services	50	150
Pathology services	200	250
Anaesthesia	5	100

9.65 Many items in the Schedule contain poor descriptions of the procedure or activity for which a refund is paid. In many cases it is not possible to verify the activity either because it is 'internal' or because the Schedule refund supposedly depends on the size of the lesion or abnormality. We have already referred to the technique called the 'numbers game' by which procedures are billed on the basis of

21 Opit, L.J., op. cit., p. 13.

supposedly separable stage components in a procedure.[22] The practice of varying benefit levels depending on the length of the surgeon's cut is one example of the excessive detail in the current Schedule.

9.66 A possible approach to this problem would be to make more use of 'episode of illness' items, rather than 'procedure-based' items. A current example of the former is the single fee now payable for ante-natal and confinement care, although it is at present optional for doctors to use this method of charging. The aim would be to require the doctor to accept the same fee regardless of the actual number of consultations in a particular case. Although doctors would be receiving a lower rate of pay where patients require more intensive treatment, this would be compensated for where other patients require less intensive treatment. For example, the Schedule could specify an overall benefit level covering a specific surgical procedure together with associated consultations.

9.67 A danger with this approach, however, is that unscrupulous doctors would be able to select patients who require less intensive care, and thereby receive a higher average payment for their services. In general, it creates incentives for underservicing. The Committee is giving further consideration to these aspects.

9.68 As noted in chapter 3, the current legislation does not specify in detail what constitutes excessive services, but simply refers to services that are not 'reasonably' necessary for the 'adequate' medical care of the patient. The term 'reasonable' is already well tested in the legal system, although what is 'adequate' is currently left to MSCIs and individual doctors to determine. It is hard to imagine how the Parliament could spell out in detail what constitutes overservicing, especially given the varying needs of individual patients and changing techniques. However, there is room for development of guidelines on the use of specific procedures.

9.69 Some work is already underway to develop criteria for the use of certain procedures. The Australian Medical Association has established a Working Party on Discretionary Surgery to overview investigations of the problem of discretionary or unnecessary surgery. Three studies are either underway or proposed:

- an appendicectomy audit being carried out by the Royal Australian College of Surgeons and the Peer Review Resource Centre, to develop criteria for undertaking appendicectomies being set by the College;

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22 Opit, L.J., op. cit., pp. 7-8.

- a hysterectomy audit being carried out by the Royal Australian College of Obstetricians and Gynaecologists and the Peer Review Resources Centre, which will result in criteria for hysterectomy being set by the College; and

- a proposed tonsillectomy audit, which will involve the College of Surgeons, the College of Pediatricians and the Otolaryngological Society.

9.70 The Committee also notes that the Health Commission of New South Wales has recently distributed to medical practitioners in that State a set of guidelines for tonsillectomy.

9.71 More explicit criteria for performing services would help to reduce unintended overservicing and would provide a firmer basis for doctors' practice patterns to be reviewed. A further step could be to build such guidelines into the medical benefits system, so that expensive services provided outside the guidelines would require special justification before benefits are paid. This justification could take the form of:

- prior approval from health fund or Departmental doctors;

- a second opinion from another doctor; or

- a requirement that more complete diagnostic records be kept and submitted with the claim for benefits.

9.72 The Committee will be examining the work that has been done already in this area and possibilities for the future.